Calendar Year 2020 MI Health Link Medicaid Capitation Rate Certification

January 1, 2020 through December 31, 2020

State of Michigan Department of Health and Human Services

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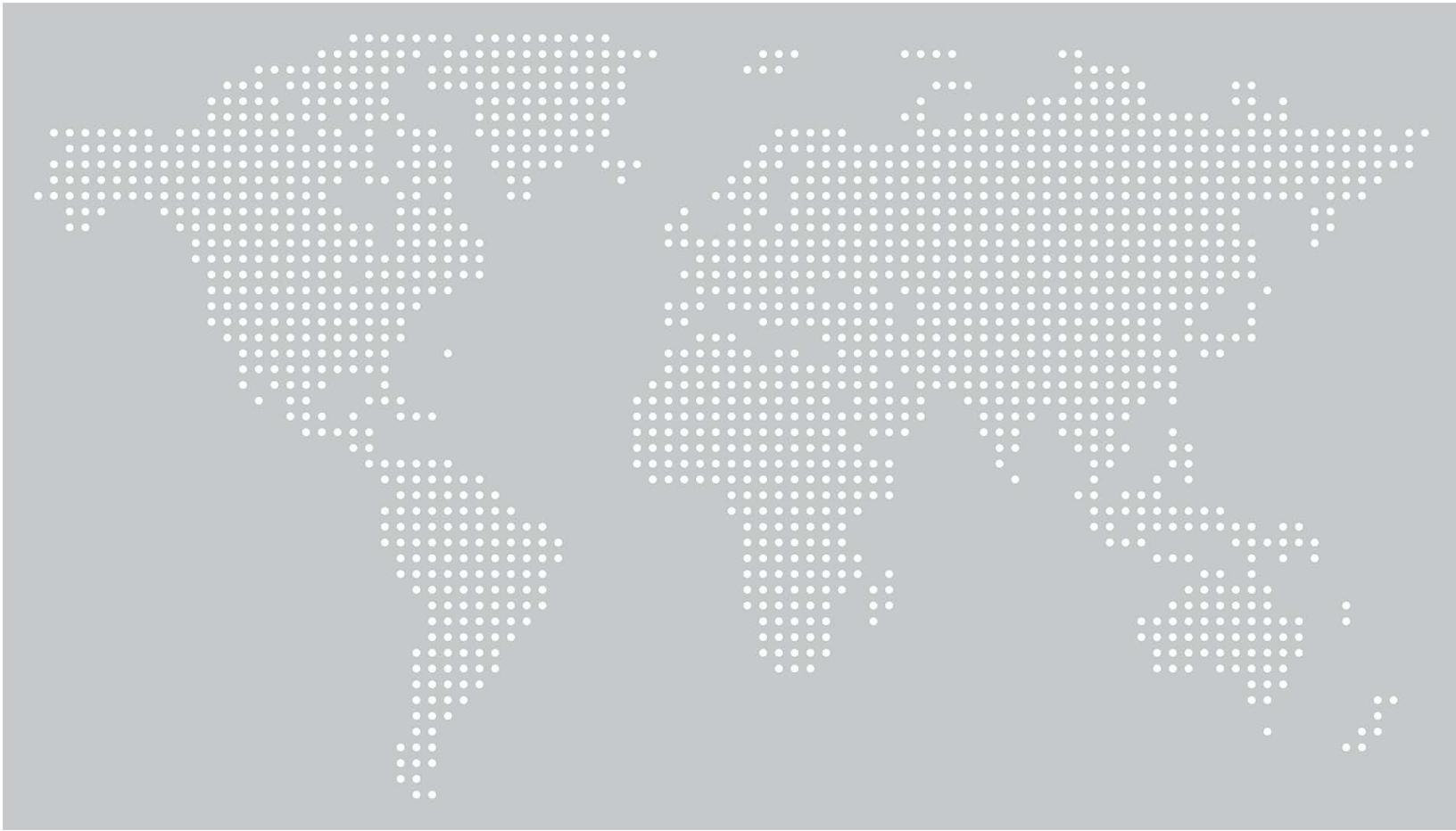

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Introduction & Executive Summary

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of Michigan, Department of Health and Human Services (MDHHS) to provide actuarial and consulting services related to the development of actuarially sound capitation rates for the MI Health Link program to be effective January 1, 2020. The rates being certified as actuarially sound are to be effective from January 1, 2020 and remain in effect through December 31, 2020. MI Health Link is Michigan's demonstration managed care program for the dual eligible (Medicare-Medicaid) population.

This letter provides documentation for the development of the actuarially sound capitation rates for calendar year (CY) 2020. It also includes the required actuarial certification in Appendix 1. Unless otherwise specified, all references to "rates" or "capitation rates" throughout this document refer to the Medicaid-specific component of the MI Health Link capitation rates.

To facilitate review, this document has been organized in the same manner as the 2019-2020 Medicaid Managed Care Rate Development Guide, released by the Center for Medicare and Medicaid Services in March 2019 (CMS guide). Section III of the CMS guide is not applicable to this certification, since the covered services do not include rates for new adult groups.

In developing the capitation rates and supporting documentation herein, we have applied the three principles of the regulation outlined in the CMS Guide:

- The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care.
- 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.
- The documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR 438 and generally accepted actuarial principles and practices.

SUMMARY OF CAPITATION RATES

The capitation rates for the MI Health Link population are illustrated in Table 1 by rate cell. The underlying capitation rates by rate cell are effective from January 1, 2020 through December 31, 2020. The capitation rates covered under this certification are documented in Appendix 4. The rates in Table 1 are illustrated on a gross basis prior to adjustment for any amounts that are expected to be paid by the beneficiary and recouped by the nursing facilities. The rates in Table 1 reflect the mandatory 3% savings assumption prescribed by CMS and the state for demonstration year 5. The percentage change reflects a comparison with the rates paid as of the end of calendar year 2019. Please note that the rates illustrated in Table 1 exclude amounts associated with the Insurance Provider Assessment (IPA), which will be paid on a retrospective basis. The IPA amounts estimated for CY 2020 are included in Appendix 4 with discussion of those amounts noted later in this report.

Table 1 State of Michigan Department of Health and Human Services MI Health Link Capitation Rates by Rate Cell Effective January 1, 2020 Comparison with Final Calendar Year 2019 Rates (PMPM Rates)				
Rate Cell	**Estimated CY2020 Average Monthly Enrollment**	**Final Calendar Year 2019 Rates**	**Calendar Year 2020 Rates**	**% Change**
Nursing Facility – Subtier A				
Over Age 65	1,150	$6,714.33	$6,671.48	(0.6%)
Under Age 65	240	$6,026.92	$5,888.57	(2.3%)
Nursing Facility – Subtier B				
Over Age 65	110	$10,391.54	$10,709.31	3.1%
Under Age 65	10	$10,225.45	$10,450.17	2.2%
Nursing Facility LOC-Waiver				
Over Age 65	900	$2,381.26	$2,370.50	(0.5%)
Under Age 65	1,010	$2,891.03	$2,894.21	0.1%
Community Residents				
Over Age 65	13,780	$152.56	$168.63	10.5%
Under Age 65	16,450	$132.71	$148.79	12.1%
Composite	**33,650**	**$587.27**	**$600.17**	**2.2%**

Notes:
1. Values shown are on a gross basis prior to reduction for patient pay amounts and withhold.
2. Distribution of enrollment based on average projected monthly enrollment for CY 2020.
3. Amounts related to the Insurance Provider Assessment are not included in the values listed in Table 1.

The projected CY 2020 enrollment estimates were developed based off of July 2019 enrollment in the MI Health Link program. The nursing facility tiers have experienced a decrease in enrollment since its peak in the middle of CY 2018, while the Nursing Facility LOC-Waiver tier has had large growth over the past two years.

FISCAL IMPACT ESTIMATE

The estimated fiscal impact of the CY 2020 MI Health Link rate changes on a state and federal basis documented in this report is a $5.2 million increase to aggregate expenditures. This amount is on a state and federal expenditure basis using the projected monthly enrollment for CY 2020 and excluding any amounts related to the IPA. Table 2 provides the development of estimated total expenditures, as well as federal only expenditures, under the current contracted capitation rates and the proposed CY 2020 capitation rates illustrated in Table 1. The federal expenditures illustrated in Table 2 are based on a combination of the Federal Fiscal Year 2020 FMAP of 64.06% for 9 months and 2021 FMAP of 64.08% for 3 months.

Table 2 State of Michigan Department of Health and Human Services MI Health Link Rates Effective January 1, 2020 Comparison with CY 2019 Rates (Aggregate Expenditures $ Millions)			
Population	**Aggregate Expenditures at 2019 Rates**	**Aggregate Expenditures at 2020 Rates**	**Expenditure Change**
Nursing Facility-Subtier A	$ 110.0	$ 109.0	($ 1.0)
Nursing Facility-Subtier B	14.9	15.4	0.4
NFLOC – Waiver	60.8	60.7	(0.1)
Community Well	51.4	57.3	5.8
Total MI Health Link	**$ 237.1**	**$ 242.4**	**$ 5.2**
Total Federal	151.9	155.3	3.3
Total State	85.2	87.1	1.9

Notes:
1. Annualized expenditures were developed with projected enrollment.
2. State expenditures based on Federal Fiscal Year (FFY) 2020 FMAP of 64.06% for 9 months and 2021 FMAP of 64.08% for 3 months.
3. Amounts related to the Insurance Provider Assessment are not included in the values listed in Table 2

RATE CHANGE SUMMARY

Table 3 illustrates the changes from the CY 2019 capitation rates to the CY 2020 capitation rates by major category.

Table 3 State of Michigan Department of Health and Human Services MI Health Link Rates Effective January 1, 2020 Capitation Rate Change Impact Summary								
	Nursing Facility-Subtier A		**Nursing Facility-Subtier B**		**NFLOC-Waiver**		**Community Well**	
Rating Impact Factor	**Over 65**	**Under 65**	**Over 65**	**Under 65**	**Over 65**	**Under 65**	**Over 65**	**Under 65**
Previous Capitation	$6,714.33	$6,026.92	$10,391.54	$10,225.45	$2,381.26	$2,891.03	$152.56	$132.71
Rebasing and Trend[1]	($57.62)	($162.81)	324.66	$187.22	$3.54	$0.84	($8.03)	($2.86)
Patient Pay Update	$14.77	$24.46	($6.89)	$37.50	N/A	N/A	N/A	N/A
Capitation Rate Updates[2]	N/A	N/A	N/A	N/A	($14.30)	$2.35	($3.75)	($4.79)
Selection Factor	N/A	N/A	N/A	N/A	N/A	N/A	$24.78	$19.26
Enrollment blend[3]	N/A	N/A	N/A	N/A	N/A	N/A	$0.00	$0.00
Add-ons	-	-	-	-	-	-	$3.06	$4.46
CY 2020 Capitation Rate	$6,671.48	$5,888.57	$10,709.31	$10,450.17	$2,370.50	$2,894.1	$168.63	$148.79

[1] Rebasing and trend change reflects update to SFY 2018 base data along with completion and trend adjustments to CY 2020 midpoint
[2] Reflects impact of updates to MIChoice and MME capitation rates for SFY 2020
[3] Reflects change in blending of FFS and MCO enrollment in the community well rate development from CY 2019 assumed blend

Section I. Medicaid managed care rates

1. General information

This section provides information listed under the General Information section of CMS guide, Section I.

The capitation rates provided under this certification are "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

Assessment of actuarial soundness, in the context of MI Health Link, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration.

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the CY 2020 managed care program rating period.
- The most recent CMS guide.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" will be defined as in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."[4]

In our development of the capitation rates for the MI Health Link program, we relied on regulatory guidance related to the capitation rate setting methodology and the mandatory joint savings percentage required by the three-way contract.

[4] http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

A. RATE DEVELOPMENT STANDARDS

i. Annual basis

The actuarial certification contained in this report is effective for the capitation rates for the one-year rate period from January 1, 2020 through December 31, 2020.

ii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Christopher Pettit, FSA, is in Appendix 1. Mr. Pettit meets the qualification standards established by the American Academy of Actuaries, follows the practice standards established by the Actuarial Standards Board, and certifies that the final rates meet the applicable standards in 42 CFR 438 that are effective for the CY 2020 managed care program rating period.

(b) Certified capitation rates for each rate cell

The certified capitation rates by rate cell are illustrated in Appendix 4. The rates within this report represent the capitation rates prior to application of the area factors, which are additionally illustrated in Appendix 4. For the Nursing Facility rate cells, the rates are developed on a gross basis, prior to the application of patient liability. On an individual basis, MDHHS will deduct the actual patient pay liability amount from the Nursing Facility capitation rate shown in Table 1 and pay the net capitation rate to the integrated care organizations (ICOs).

(c) Program information

(i) Managed Care program

MDHHS, along with CMS and the MI Health Link ICOs, provides benefits for fully dual eligible members under the MI Health Link program within targeted geographic areas. This letter provides the documentation and certification of the calendar year 2020 capitation rates for the Medicaid component of the MI Health Link program.

MI Health Link began a phased-in schedule of enrollment starting in March 2015 among 7 full-risk managed care plans in 4 regions. This certification is for Demonstration Year 5, which coincides with calendar year 2020. Demonstration Year 1 comprised of the partial year 2015 and the complete calendar year 2016 time periods with Demonstration Year 2 being CY 2017, Demonstration Year 3 being CY 2018, and Demonstration Year 4 being CY 2019.

The rate cell structure was developed based upon level of care and age (over/under age 65) with separate area factors applied based on historical experience. The nursing facility rating tier was divided between privately owned (Subtier A) and county owned (Subtier B) facilities.

The services provided under this contract include complete physical and behavioral health, and long-term services and supports. Appendix 6 provides a listing of the services covered under the MI Health Link program. Detailed benefit coverage information for all benefits can be found in the provider agreements.

The program pays secondary to Medicare for Medicare covered services.

Table 4 illustrates the counties included in the MI Health Link program along with their implementation dates.

Table 4 State of Michigan Department of Health and Human Services MI Health Link Regions and Implementation Dates		
MI Health Link Region	**Counties**	**Implementation Date**
Region 1-Upper Peninsula	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft	March 1, 2015
Region 4-Southwest	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	March 1, 2015
Region 7-Wayne County	Wayne	May 1, 2015
Region 9-Macomb County	Macomb	May 1, 2015

Beneficiaries who reside in a hospice facility are not excluded from the program, however, beneficiaries will not be allowed to enroll from a hospice setting, but rather transition to hospice during enrollment

(ii) Rating period

This actuarial certification is effective for the one-year rating period January 1, 2020 through December 31, 2020.

(iii) Covered populations

The target population for MI Health Link was limited to full Medicare-Medicaid dual eligible individuals who are age 21 and over and entitled to benefits under Medicare Parts A, B, and D. The program is offered only in select counties across the State of Michigan. These counties include those in the Upper Peninsula, Southwestern Michigan, Macomb county, and Wayne county.

Excluded Populations

The following populations are not eligible for the Demonstration program and will be excluded from enrollment:

- Individuals under age 21;
- Partial dual eligible members (those without both Part A and B coverage or who do not qualify for full Medicaid benefits);
- Individuals who reside in a state psychiatric hospital;
- Individuals with comprehensive third-party insurance coverage (other than Medicare);
- Individuals who are incarcerated in a correctional facility;
- Individuals living in a geographic area other than those counties included in the demonstration.

Additional detail related to the eligible and excluded populations can be found in the MOU between MDHHS and CMS.

The following describes each of the distinct populations which correspond directly with the capitation rate cells.

Nursing Facility Population

This population includes individuals residing in a nursing facility who meet the state definition of nursing home level of care and who are not enrolled in a waiver. Milliman identified the population in the capitation rate-setting process by using fields in the MDHHS eligibility data that denote Medicaid individuals as meeting the nursing home level of care criteria and reside in a nursing facility. The capitation rate for this rate cell was developed based on projected gross nursing facility rates. On an individual basis, MDHHS will deduct the actual patient pay liability amount from the nursing facility capitation rate shown in Table 1 and pay the net capitation rate to the ICOs. The nursing facility population is divided into subtiers, split by individuals residing in a privately owned (Subtier A) versus a publicly owned (Subtier B) nursing facility. Additionally, members receiving services in a hospital long-term care facility are categorized in Subtier B based on the average cost identified for these beneficiaries.

Nursing Facility Level of Care-Waiver Population

This population includes individuals who meet the state definition of nursing home level of care, but do not reside in a nursing facility. Eligible individuals must not be enrolled in the State's MI Choice program. Milliman utilized current MI Choice enrollee experience in the rate-setting process to determine the capitation rates for this population. The development of the rates is a combination of SFY 2020 MI Choice capitation rates and historical fee-for-service costs for services that are not identified as a waiver service as there are no substantive differences between the services provided to populations enrolled in MI Choice versus MI Health Link. The development of these rates is illustrated in Appendix 4.

Community Residents Population

This population includes all other qualifying individuals who were not previously categorized. This population is comprised of eligible individuals who are neither institutionalized nor participating in a 1915(c) waiver program. The development of the capitation rates for this population is a blend of historical fee-for-service experience and the capitation rates for the Medicare-Medicaid dually eligible (MME) managed care program. As certain services are not covered under the MME capitation rate, fee-for-service costs related to MME enrollees are also included in the development of this rate. These costs are illustrated separately from fee-for-service experience on non-MCO enrollees in Appendix 4.

(iv) Eligibility criteria

Enrollment in MI Health Link is not mandatory for eligible individuals. Eligible individuals who do not voluntarily enroll in the program are passively enrolled but can opt-out. Those individuals who opt-out of the program are placed back in fee-for-service or the applicable managed care programs.

(v) Special contract provisions

This rate certification report contains documentation of the following special contract provisions related to payment included within rate development.

- Withhold arrangements

Please see Section I, item 4, Special Contract Provisions Related to Payment, for additional detail and documentation.

(vi) Retroactive adjustment to capitation rates

This rate certification report does not include a retroactive adjustment to the CY 2020 capitation rates.

iii. Differences among capitation rates

Any proposed differences among capitation rates according to covered populations are based on valid rate development standards and are not based on the rate of federal financial participation associated with the covered populations.

iv. Cross-subsidization of rate cell payment

The capitation rates were developed at the rate cell level and neither cross-subsidize nor are cross-subsidized by payments from any other rate cell.

v. Effective dates

To the best of our knowledge, the effective dates of changes to the MI Health Link program are consistent with the assumptions used in the development of the certified CY 2020 capitation rates.

vi. Medical loss ratio

Capitation rates were developed in such a way that the ICOs would reasonably achieve a medical loss ratio, as calculated under 42 CFR 438.8, of at least 85% for the rate year.

vii. Generally accepted actuarial practices and principles

(a) Reasonable, appropriate, and attainable

In our judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs, and have been included in the certification.

(b) Outside the rate setting process

There are no adjustments to the rates performed outside the rate setting process.

(c) Final contracted rates

The CY 2020 capitation rates certified in this report represent the rates by rate cell prior to application of the regional factors. The regional factors are illustrated in Appendix 4.

viii. Rate certification for effective time periods

This actuarial certification is effective for the one-year rating period January 1, 2020 through December 31, 2020.

ix. Procedures for rate certification and amendment

In general, a new rate certification will be submitted when the rates change. The following exceptions are allowed per §438.7 of CMS 2390-F:

1. A contract amendment that does not affect the rates.
2. An increase or decrease of up to 1.5% in the capitation rate per rate cell.
3. Risk adjustment, under a methodology described in the initial certification, changes the rates paid to the MCOs

In case 1 listed above, a contract amendment must still be submitted to CMS.

B. APPROPRIATE DOCUMENTATION

i. Documentation of required elements

This report contains appropriate documentation of all elements described in the rate certification, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

ii. Index

The index to this rate certification is the table of contents, found immediately after the title page. The index includes section numbers and related page numbers. Sections not relevant to this certification continue to be provided, with an explanation of why they are not applicable.

iii. Different FMAP

All populations receive the regular state FMAP of 64.06% for FFY 2020 through September 30, 2020 and 64.08% for FFY 2021 from October 1 to December 31, 2020.

iv. Comparison to final certified rates in the previous rate certification.

The previous rate certification applied to CY 2019 capitation rates. A comparison to rates paid at the end of CY 2019 is provided in Table 1.

2. Data

This section provides information on the data used to develop the capitation rates. The base SFY 2018 experience data described in this section is illustrated in Appendix 2.

A. RATE DEVELOPMENT STANDARDS

In accordance with 42 CFR §438.5(c), we have followed the rate development standards related to base data. The remainder of Section I, item 2 provides documentation of the data types, sources, validation process, material adjustments and other information relevant to the documentation standards required by CMS.

B. APPROPRIATE DOCUMENTATION

i. Requested data

As the actuary contracted by MDHHS to provide consulting services and associated financial analyses for many aspects of the Michigan Medicaid program (and not just limited to capitation rate development), Milliman intakes and summarizes eligibility and expenditure data on a monthly basis from Optum, MDHHS's data administrator. We received eligibility and expenditure information historical time periods. There was no data that was requested from Milliman that was not received. The remainder of this section details the base data and validation processes utilized in the CY 2020 capitation rate development.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

The following experience served as the primary data sources for the calendar year 2020 MI Health Link capitation rate development:

- Fee-for-service data for the MI Health Link eligible population for October 1, 2017 through September 30, 2018 (base data year) and paid through October 2019
- Detailed fee-for-service and managed care enrollment data for October 1, 2017 through September 30, 2018
- Managed care capitation rates paid to the health plans serving enrollees in the Medicare-Medicaid dually eligible (MME) and MI Choice managed care programs for SFY 2020
- Additional gross adjustment expenditure information outside the MMIS claims system
- Summary of policy and program changes through state fiscal year 2019 (including changes to fee schedules and other payment rates)
- Monthly enrollment for the MI Health Link program

Appendix 2 illustrates the fee-for-service base data summaries that provide the foundation for the calendar year 2020 MI Health Link capitation rate development. The information is stratified by rate cell and category of service.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during SFY 2018. The fee-for-service data used in our rate development process reflects adjudicated data through October 2019.

For the purposes of trend development and analyzing historical experience, we also reviewed fee-for-service and enrollment experience from state fiscal years 2016 and 2017. We utilized recent average monthly enrollment for purposes of emerging population enrollment patterns.

(iii) Data sources

The historical claims and enrollment experience for the data obtained through the warehousing process was provided to Milliman by Optum, the data administrator for MDHHS. The sources of other data are noted in (i) and (ii) above.

(iv) Sub-capitation

The fee-for-service data does not contain sub-capitated amounts.

(b) Availability and quality of the data

(i) Steps taken to validate the data

The majority of the data used in this certification is fee-for-service data provided by MDHHS. Optum, as the data warehouse manager, is responsible for ensuring accuracy and completeness of the fee-for-service claims data. MDHHS and Milliman reviewed the data for reasonableness and compared to historical financial reports.

Completeness

Milliman, Optum, and MDHHS all play a role in validating fee-for-service data for completeness. The fiscal agent plays the initial role, creating the files sent to Milliman. Milliman summarized the fee-for-service data to look for anomalies in the base data year. The data is segmented by rate cell and service category.

The state provides final review and approval of the base data used for capitation rate development.

Accuracy

Checks for accuracy of the data begin with Optum's audit and review process. The data is subjected to a series of validation checks. For example, it must contain a valid Medicaid recipient ID for an individual who was enrolled at the time the service was provided. It is also checked to ensure it is a covered service under the state plan and contains a valid provider ID and other codes necessary to provide payment, such as procedure codes, revenue codes, or DRG codes. Milliman also reviews the data to ensure each claim is related to a covered individual and a covered service.

Consistency of data across data sources

The MI Health Link program began in March 2015 with phased enrollment by geographic region. The fee-for-service base data year used in the capitation rate development includes incurred claims and enrollment prior to implementation of MI Health Link. The fee-for-service base data summaries were developed by Milliman and verified for reasonableness by MDHHS. The data was compared against MDHHS reports to check for consistency.

(ii) Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that Milliman has relied upon certain data and information provided by MDHHS and their vendors. The values presented in this letter are dependent upon this reliance.

The fee-for-service data represents the most appropriate data to be used for developing the actuarially sound capitation rates for the CY 2020 MI Health Link program.

(iii) Data concerns

We have not identified any material concerns with the quality or availability of the fee-for-service data. The only concern is that it requires additional assumptions and adjustments to reflect the coverage, service delivery, and timing of the MI Health Link managed care program.

(c) Appropriate data

(i) Use of encounter and fee-for-service data

We confirm that fee-for-service claims and enrollment were used as the primary data source for this certification. The base data used reflects the historical experience and covered services most closely aligned with the MI Health Link program.

(ii) Use of managed care encounter data

Encounter data was not used for this certification. These rates are intended to be projections of costs "in absence of the demonstration", and as a result, encounter data would not be applicable. We did utilize the SFY 2020 capitation rates for the Medicare-Medicaid dually eligible (MME) and MI Choice programs for purposes of establishing the Community and Waiver tier rates. These rates were based on encounter data, but no updates to these rates were made for purposes of the MI Health Link rate development.

(d) Reliance on a data book

Development of the capitation rates did not rely on a data book or other summarized data source. We were provided with detailed claims data for all covered services and populations

iii. Data adjustments

Capitation rates were developed from historical state fiscal year 2018 fee-for-service data, paid through October 2019. As shown in Appendix 2, the primary base data year adjustments include completion, trend, reimbursement, and other program adjustments.

(a) Credibility adjustment

The MI Health Link eligible populations, in aggregate, were considered fully credible. No adjustments were made for credibility in the aggregate; however, we did implement data smoothing in the development of the regional adjustment factors, which is further described in a later section of this report.

We did not utilize any other smoothing techniques in the FFS base experience. Although the Nursing Facility Subtier B population is relatively small, we reviewed multiple years of historical experience and acknowledge that the difference in cost per day between Subtier A and Subtier B have been consistent dating back to time periods prior to MI Health Link program inception. We also evaluated the utilization and cost per day of the nursing facility population in total to determine the credibility of the data.

(b) Completion adjustment

Historical fee-for-service claims experience was run through an internal Milliman claims reserving system to estimate completion factors. Separate sets of factors were developed for each demonstration tier and major category of service. Milliman combined the nursing facility sub-tiers for purposes of the completion factor analysis. The development of the completion factors for SFY 2018 experience was based on a traditional triangle methodology utilizing paid data through October 2019. Average adjustments were applied to SFY 2018 experience to account for the runout applicable to each of the experience periods. The PMPM impact of the applied completion factors are illustrated in Appendix 2.

Non-Emergency Medical Transportation

We have also included an adjustment for non-emergency medical transportation (NEMT) that was not fully reported in the fee-for-service data for Community members. Based on the state's contracted vendor for NEMT services, the historical experience related to NEMT is not fully represented in the summarized data as the NEMT services provided in the FFS environment are not reported on a claim by claim basis as we typically receive in managed care encounter data. We included additional expenditures for the fee-for-service components of the Community tier to align with the transportation costs summarized for the Medicare-Medicaid dually eligible (MME) managed care population that operates outside of the MI Health Link program. We did not make a separate adjustment for the Waiver tier as NEMT costs are summarized in the MI Choice capitation rates.

The adjustments made to the Community well tiers were to align transportation costs in the MI Health Link rates with the transportation costs included in the Medicaid-Medicare dual eligible managed care population (referred to as the Duals Lite population) capitation rates. A PMPM amount of $11.57 is included in the Duals Lite rates for transportation. Based on the experience noted in the cost models for transportation on the Community Well populations, we included adjustments to align the transportation costs in the MI Health Link rates with the Duals Lite rates, consistent with prior year rate settings. We did not make adjustments for the NFLOC waiver tier as the MI Choice capitation rates include coverage of NEMT services. We did not make adjustments for the Nursing Facility tiers as NEMT is not an applicable service to institutionalized members.

(c) Errors found in the data

No specific errors were identified in the data.

(d) Program change adjustments

The base data year represents a historical time period from which projections were developed. We reviewed prior rate setting documentation and other materials from MDHHS to identify program changes that were implemented during the base data period. To the extent the program adjustments were estimated to have a material impact on ICO service costs an adjustment was considered for the calendar year 2020 rate development process. Adjustments were made to the portion of the base data prior to the implementation of each program change in order to ensure the entire base period was on a consistent basis.

Direct care wage increase

Based on a review of the specific policy and program changes that have occurred across other Medicaid populations in the State of Michigan, an adjustment was made to reflect a reimbursmeent increase for personal care services. Due to the minimum wage increase effective January 1, 2020 for State of Michigan workers, we have incorporated an adjustment to the Home Help service line to reflect the change to the new rate in CY 2020 of $9.65. An additional increase to $9.90 is reflected at April 1, 2020. This adjustment is reflected outside of the trend adjustment and is shown in the cost model projections in Appendix 2. As capitation rates are stratified by age, the utilization is specific to each rate cell and the impact of the direct care wage increase had a different impact by rate cell. This adjustment is specific to individual personal care providers.

Home Help Agency increase

Effective October 1, 2019, Michigan passed legislation that facilitated an increase in reimbursement rates for home help agency providers. Per hour agency rates will be increased from approximately $13.83 on average to $16.08. Based on historical experience, home help agency providers consist of about 33% of home help expenditures. This change is incorporated in the wage adjustment column illustrated in Appendix 2.

Personal Care Supplement reimbursement increase

The reimbursement associated with revenue codes ‘0401’, ’0402’, ’9401’, and ‘9402’ increased from $213.10 to $250.92 per month effective October 1, 2018 based on the state’s fee schedule. We have reflected an additional 0.8% increase to the Home Help Service line to reflect the projected impact of this change. The identified codes represented roughly 4.3% of the total Home Help service line This adjustment is reflected outside of the trend adjustment and is incorporated in the wage adjustment column illustrated in Appendix 2.

Hearing Aid Coverage

Effective September 1, 2018, all managed care contracts in the State of Michigan included coverage for hearing aids and battery replacements. Based on the lack of recently available experience for this benefit for a comparable population to MI Health Link, we estimated an amount utilizing external sources of information. We reviewed internal Milliman utilization and cost information along with hearing aid coverage in additional state Medicaid programs for a comparable population. For purposes of the CY 2018 rate development process we included an expenditure amount for the 4-month coverage period (September 1 to December 31, 2018) and allocated across the entire 12-month rating period. We have annualized that benefit amount for purposes of the CY 2020 MI Health Link capitation rates consistent with the CY 2019 MI Health Link capitation rates. The amount allocated to each rate cell is identified separately in Appendix 4. The underlying cost and utilization to support this adjustment was based on utilization experience from a state similar to Michigan in size and dual demonstration operation which included hearing aid coverage as part of their benefit plan. The experience was repriced utilizing the Michigan fee schedule for hearing aid services.

Nursing Facility Transitions

Prior to SFY 2019, a transition case rate payment was paid to ICOs after the transition of a Nursing Facility enrollee into a home or community setting (Waiver or Community tier). The historical rate was based on the transition case rate payment associated with the MI Choice managed care program. Effective October 1, 2018, the transition case rates were removed from the managed care program and became a state plan service. We have included the estimated cost of the transitions in both the Waiver and Community tiers based on historical experience. Projected transition expenditures previously associated with the MI Choice program were included in the Waiver tier, with transitions that historically were operated through the Centers for Independent Living priced into the Community tier. A PMPM adjustment to the rates is documented in the rate development in Appendix 4.

Other

No additional adjustments were made to the services covered by the MI Health Link program. Although other reimbursement changes may have occurred or are expected to change (e.g., NEMT and Laboratory fees), these are accounted for in the base data and consideration of future trend. Policy and program changes that were noted in prior MI Health Link capitation rate development were for time periods prior to the base data utilized in the CY 2020 rate development process. Thus, the base data would include these adjustments.

(e) Exclusion of payments or services from the data

No specific payments were excluded from the rate development.

3. Projected benefit cost and trends

This section provides information on the development of projected benefit costs in the capitation rates.

A. RATE DEVELOPMENT STANDARDS

i. Final Capitation Rate Compliance

The final capitation rates are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.3(c)(1)(ii) and 438.3(e). The ICOs do not provide any in-lieu-of services.

ii. Basis for Variation in Assumptions

Any assumption variation between covered populations is the result of program differences and is in no way based on the rate of Federal financial participation associated with the population.

iii. Benefit Cost Trend Assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends is historical claims and enrollment from the populations deemed to be consistent with the enrolled population. Additionally, consideration of other factors and data sources appropriate for benefit cost trend development is further documented in Section I, item 3.B.iii.

iv. In Lieu Of Services

The projected benefit costs do not include costs for in lieu of services.

v. IMDs as an in lieu of service provider

Not applicable. The projected benefit costs do not include costs for in lieu of services.

(a) Costs associated with an IMD stay of more than 15 days

We reviewed benefit costs for enrollees aged 21 to 64 during the base experience period and determined that projected benefit costs do not include costs associated with an Institution for Mental Diseases (IMD) stay of more than 15 days in a month. Therefore, we have not included an adjustment to the base experience data for IMD and associated expenses.

(b) Other costs for services during the time an enrollee is in an IMD for more than 15 days

We have not included any costs in the base experience data for associated expenses when a member is in an IMD for more than 15 days.

B. APPROPRIATE DOCUMENTATION

i. Projected Benefit Costs

This section provides the documentation of the methodology utilized to develop the benefit cost component of the capitation rates at the rate cell level.

ii. Development of Projected Benefit Costs

(a) Description of the data, assumptions, and methodologies

This section of the report outlines the data, assumptions, and methodology used to project the benefit costs to the rating period. The baseline benefit costs were developed using the following steps:

Step 1: Create unadjusted cost model summaries

The capitation rates were developed from historical fee-for-service and enrollment data for members who would be eligible for the MI Health Link program in the noted demonstration regions. This data consisted of state fiscal year 2018 incurred fee-for-service data that is reported by the state in the data warehouse and maintained by Optum. We received additional data feeds outside of our normal monthly process for claims associated with Home Help and patient pay amounts. This information serves as the starting point of the base experience and is noted as unadjusted SFY 2018 experience in Appendix 2. Certain categorization changes were made in developing the cost models which shifted certain services that were previously grouped under the nursing facility service line to other service lines. These services were billed by the nursing facility for other professional services, such as waiver services or physical therapy.

Each actuarial model illustrates annual utilization rates per 1,000, average cost per unit, and per member per month (PMPM) claims cost developed using fee-for-service data. Appendix 2 contains actuarial models for services incurred during SFY 2018 and paid through October 2019. The following provides a brief description of each of the data fields.

- Annual Utilization Per 1,000 – This value represents the annual utilization rates per 1,000 members by type of service. The value was calculated by dividing the total utilization for each service category by the member months in the corresponding period and multiplying by 12 times 1,000.
- Cost per Service – This value represents the net paid amount per unit of service, which represents the paid amount divided by total utilization. The supplemental nursing facility patient pay amount is reflected below the base data cost model on a per member per month (PMPM) basis.
- Member Months – This value represents the number of enrollee months in each rate cell during each experience period. Each enrollee was assumed to be eligible for the entire month.
- PMPM – The PMPM value represents the net claim cost for each type of service. The value was calculated by multiplying the annual utilization per 1,000 times the average cost per unit and dividing by the product of 12 times 1,000.

Step 2: Adjust for completion and prospective trend

As documented in the previous section, utilization and cost per service rates from the base experience period were adjusted for completion and prospectively trended from the midpoint of the base experience period (April 1, 2018) to the midpoint of the CY 2020 rating period (July 1, 2020). We have included one-time specific adjustments to the Inpatient Hospital (approximately 3.5% increase) and Professional (approximately 0.5% increase) cost trend adjustments to account for the changes in Medicaid cost sharing due to the increases in Medicare Part A and Part B deductibles between the base experience period and CY 2020. These represented an increase from $1,340 to $1,408 for Part A and $183 to $198 for Part B. The adjustments are reflected on Appendix 2 in the columns noted as Cost Trend Adjustment in combination with the applied annualized trend. These explicit adjustments have increased the effective trend to be above the selected trend assumptions identified in Appendix 5.

Step 3: Adjust for additional payments and reimbursement changes

We further adjusted the base experience for the impact of the minimum wage increase, home help agency adjustment and personal care supplement reimbursement increase noted in Section 2.B.iii.d. Additional adjustments were applied to the base experience to reflect the impact of the following:

- **Quality Assurance Payments** - Nursing facility services include daily costs for members residing in a nursing facility or hospital long-term care unit. The nursing facility cost per day includes gross adjustment payments made by MDHHS to all nursing facilities for Quality Assurance Supplement (QAS) payments. This adjustment is noted in Appendix 2 for Nursing Facility and Inpatient Hospital related claims.
- **Certified Public Expenditures** – Additional nursing facility daily costs for county-owned facilities are included for the Subtier B nursing facility rate cells. This adjustment is noted in Appendix 2 for Nursing Facility related claims specific to Subtier B.
- **FICA/FUTA** - Home help service cost includes all gross adjustment payments made by MDHHS for Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax (FUTA) payments.
- **Supplemental SNF Copayments** - The supplemental nursing facility patient pay amount is reflected on a per member per month (PMPM) basis for members in a nursing facility rate tier in Appendix 4.
- **Capitation payments** - Consistent with historical development of the MI Health Link capitation rates, we have included the SFY 2020 MI Choice capitation rates as part of the Waiver tier rates and Medicare-Medicaid dually eligible (MME) managed care population rates for the MCO component of the Community tier.

Step 4: Include PMPM adjustments for program changes and data adjustments

We included PMPM amounts for additional services not included in the base fee-for-service experience for hearing aid coverage, nursing facility transition services, and NEMT previously described.

Step 5: Regional adjustments

The rates noted in Table 1 represent the statewide rate for each rate cell. Capitation rates paid to each of the ICOs will be dependent upon the demonstration region for which the covered life resides. Consistent with the four regions identified in Table 4, regional adjustment factors were calculated for each applicable region and rating tier. The relative experience in the base data across the regions was utilized to develop the regional adjustment factors applied to the capitation rates. Regional factors were developed by comparing the PMPM amount specific to each demonstration region compared to the composite PMPM across all demonstration regions for each population. The regional factors adjust the composite rate in line with the cost variation observed through the relative difference observed in the FFS experience based on MI Health Link membership for each rating tier and region.

The development of the regional adjustments was limited to comparing the relative cost of the fee-for-service components of the MI Health Link capitation rates as any managed care capitation rate components (i.e., MI Choice and Medicare-Medicaid dually eligible (MME) were on a statewide basis and do not change by demonstration region. Appendix 3 provides an illustration of the regional distribution of enrollment identified in historical FFS data compared to the ICO enrollment projected for the MI Health Link program. We have recomposited the FFS data by region to the ICO regional distribution for purposes of developing the capitation rates. This ensures the final regional adjustments that are applicable to the MI Health Link capitation rate as the managed care capitation rate components reflect a budget neutral basis. Therefore, the final adjusted CY 2020 PMPMs illustrated in Appendix 2 were adjusted for the enrollment distribution noted in Appendix 3. The ICO enrollment adjusted PMPMs are documented in Appendix 3 and tie to the Base Benefit Expense column in Appendix 4. The impact of the enrollment distribution is shown in the Case Mix Adjustment column on Appendix 3.

To limit the amount of fluctuation from year to year that can occur with base data, we have blended the regional adjustment factors developed from SFY 2018 experience utilized in the CY 2020 MI Health Link rates (50% weight) with the regional adjustment factors from the CY 2019 MI Health Link rates (50% weight). In order to utilize multiple years of experience and weight them appropriately, we applied the noted blending percentages. This results in a 50% weight to the SFY 2018 experience and 50% to the CY 2019 regional adjustments which results in varying percentages applied to prior historical year experience. We wanted to ensure that more weight is being given to more recent experience, but still allow for smoothing from year to year changes

This process is consistent with updates to the regional adjustment factors in CY 2019. The regional adjustment factors to be applied are documented in Appendix 4 Separate regional adjustments were not developed for Over/Under 65 rate cells.

(b) Material changes to the data, assumptions, and methodologies

The primary change from the prior year rate-setting is utilizing SFY 2018 experience and re-basing rate cells for CY 2020. All material assumptions are documented in this rate certification report and the overall methodology utilized to develop the capitation rates is consistent with the prior rate-setting analysis.

Prospective risk selection factors were applied to the base data in order to reflect the voluntary and opt-out nature of the MI Health Link program. These selection factors were developed reviewing historical experience for the target populations and identifying differences between members that are ultimately enrolled in MI Health Link versus those that remain in FFS.

The selection factors applied to the Community Well population were initially based on claims probability distributions (CPDs) by population and applying penetration assumptions by cost category, which reflects a more favorable mix of enrollment than the historical fee-for-service experience. Evaluation of the CPDs showed that this risk selection is applicable only to the Community population, because the majority of service cost for the Nursing Facility and waiver populations is determined by the nursing facility and waiver services.

During prior rate setting processes, assumptions were made regarding community resident enrollment percentages with varying penetration levels based on members' annual cost and types of services that were utilized. Based on the lack of FFS data for MI Health Link enrollees in the SFY 2018 experience, we are developing a blended selection factor for the CY 2020 rate development process based on a 50% mix of historical factors and a 1.000. This is to reflect that the historical experience utilized to develop the original selection factors is no longer an appropriate timeframe to utilize independently. Therefore, we are blending with a no selection factor scenario to develop the 0.85 factors being applied in the rate development noted in Appendix 4.

We continue to monitor ICO encounter data to validate the selection factor assumptions. This adjustment is applied to the total PMPM cost after application of trend, program and rating period adjustments only for the fee-for-service component of the Community rate. It is assumed that the MME component of the Community rate already reflects the selection inherent in the base experience.

The selection factors are being applied to reflect the voluntary nature of managed care enrollment in the MI Health Link program. Consistent with our explanation in the CY 2019 rate development report, experience for members covered in the MI Health Link program only exists in the encounter data for the base experience period (SFY 2018 experience for CY 2020). The lack of FFS experience for these members limits the ability to develop a proxy population for the demonstration regions. We reviewed the emerging ICO encounter data as a comparison against the developed Medicaid capitation rates at a rate cell level. Our review identified that reported ICO experience is less than FFS experience, which supports the application of a selection factor. At this time, we do not believe the ICO encounter data can be deemed fully credible across all ICOs, therefore we did not perform a detailed evaluation of the encounter data against the selection factors. Please note that encounter data was not utilized to establish the selection factors per CMS rate setting requirements for this program.

(c) Overpayments to providers

Consistent with 42 CFR 438.608(d), MDHHS outlines the program integrity guidelines and reporting requirements related to overpayments, recoveries, and refunds in the ICO contract.

iii. Projected Benefit Cost Trends

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (SFY 2018) to the CY 2020 rating period of this certification. We evaluated prospective trend rates using historical experience for the Michigan Medicaid managed care program, as well as external data sources.

(a) Required elements

(i) Data

The primary source of data used in the development of historical fee-for-service trends was SFY 2016 through 2018 fee-for-service data specific to the MI Health Link eligible population.

External data sources that were referenced for evaluating trend rates developed from MDHHS data include:

- *National Health Expenditure (NHE) projections* developed by the CMS office of the actuary, specifically those related to Medicaid. Please note that as these are expenditure projections, projected growth reflects not only unit cost and utilization, but also aggregate enrollment growth and enrollment mix changes such as aging.

  For trends used in this certification, we are interested only in unit cost and utilization trends, so in general, our combinations of unit cost and utilization trends should be lower than NHE trends. NHE tables and documentation may be found in the location listed below:
  - https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html

Other sources: We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries.

(ii) Methodology

For internal MDHHS data, historical utilization and PMPM cost data was stratified by month, rate cell, and major category of service. The data was adjusted for completion and normalized for historical program and reimbursement changes. We used linear regression to project experience during the contract period. Contract period projections were compared to base period experience to determine an appropriate annualized trend.

(iii) Comparisons

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We did not explicitly rely on the historical encounter data trend projections. We referred to the sources listed in the prior section, the impact of reimbursement changes on utilization, and shifting population mix.

(iv) Chosen trend rates

Appendix 5 provides the selected trend rates by category of service. These trends include both utilization and cost per service components.

(b) Benefit cost trend components

Separate utilization and cost per unit trend components were developed and illustrated in Appendix along with the results of the regression analyses performed to evaluate the historical trend experience.

(c) Variation

We developed trends by major category of service. Trend variations between service categories reflect observed variation in the underlying historical experience and actuarial judgement based on the sources identified in the section above.

(i) Medicaid populations

To limit the variation in benefit cost that is present across the Medicaid population, we developed trends by major category of service. Minor trend variations between populations and service categories reflect observed variation in the underlying historical experience and actuarial judgement based on the sources listed in the section above.

(ii) Rate cells

Benefit cost trends are evaluated by major category of service. For population categories comprised of multiple rate cells, the benefit cost trends are consistent across all rate cells.

(iii) Subsets of benefits within a category of services

We did not vary trend assumption within a category of service.

(d) Material adjustments

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We did not solely rely on the historical FFS data trend projections due to anomalies observed in the historical trend data. We referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in the populations, and shifting population mix.

We made adjustments to trend rates derived from historical experience in cases where the resulting trends did not appear reasonably sustainable or were not within consensus parameters derived from other sources. For many rate cells and categories of services, raw model output was outside of a range of reasonable results. In these situations, we relied on the methodologies identified to develop prospective trend.

(e) Any other adjustments

(i) Impact of managed care

We did not adjust the trend rates to reflect a managed care impact on utilization or unit cost. The capitation rates have an explicit adjustment for the managed care adjustments.

(ii) Trend changes other than utilization and cost

We made an adjustment in the benefit cost trend to account for an additional day of service in calendar year 2020, but no other changes were made other than utilization or unit cost.

iv. Mental Health Parity and Addiction Equity Act Service Adjustment

We have reviewed MDHHS's state plan benefits regarding compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as required by 42 CFR 438.3(c)(1)(ii). Results of the analysis indicate full compliance with MHPAEA for financial requirements and both quantitative and non-quantitative treatment limits with no remediation needed that would constitute a program adjustment. Based on the final results, we have not made any rating adjustments to accommodate parity compliance.

v. In Lieu of Services

The projected benefit costs do not include costs for in lieu of services.

vi. Retrospective Eligibility Periods

(a) ICO responsibility

ICOs are not responsible for paying claims incurred during the retrospective eligibility period.

(b) Claims treatment

As noted earlier, ICOs are not responsible for paying claims incurred during the retrospective eligibility period; therefore, claims for retrospective eligibility periods are not reflected in the base data.

(c) Enrollment treatment

Enrollment is treated consistently with claims. We have not included retrospective eligibility in the base experience period.

(d) Adjustments

No adjustments are necessary.

vii. Impact of Material Changes

This section relates to material changes to covered benefits or services since the last rate certification. The last rate certification was for the CY 2019 rating period.

(a) Change to covered benefits

Material changes to covered benefits have been described in program adjustments described in Section I, item 2.B.iii Program Change Adjustments.

(b) Recoveries of overpayments

To the best of our knowledge, all information related to any payment recoveries is reflected in the base period data.

(c) Change to payment requirements

Material changes to required provider payments have been described in program adjustments described in Section I, item 2.B.iii Program Change Adjustments.

(d) Change to waiver requirements

There were no material changes related to waiver requirements or conditions.

(e) Change due to litigation

There were no material changes due to litigation.

viii. Documentation of Material Changes

Material changes to covered benefits and provider payments have been described in program adjustments described in Section I, item 2.B.iii Program Change Adjustments. This information includes the data, assumptions, and methodology used in developing the adjustment, and aggregate impact on the managed care program's benefit expense.

4. Special Contract Provisions Related to Payment

A. INCENTIVE ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the incentive payment structure in the MI Health Link program.

ii. Appropriate Documentation

There are currently no explicit incentives in the ICO contracts. Based on distribution of the withhold, as documented below, certain ICOs may receive back an amount greater than what was withheld from their capitation payments. This results in those plans receiving an amount above the certified capitation rate as a form of incentive payment, but these additional amounts will not exceed 105% of the capitation rates.

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the withhold arrangement in the MI Health Link program.

ii. Appropriate Documentation

(a) Description of the Withhold Arrangement

(i) Time period and purpose

The withhold arrangement is measured on a calendar year basis. The withhold measure evaluates quality-based performance by the ICOs in delivery of services.

(ii) Description of total percentage withheld

MDHHS has established a quality withhold of 3.0% of the capitation rate for demonstration year 5 and will determine the return of the withhold based on review of each ICO's data and the ICO's compliance with the quality measures established in each ICO's three-way contract with MDHHS and CMS.

The capitation rates shown in this letter are illustrated before offset for the withhold amount; however, the CY 2020 capitation rates documented in this report are actuarially sound after considering the portion of the withhold that ICOs are estimated to earn back.

(iii) Estimate of percent to be returned

The withhold measures that are in place for Demonstration Year 5 of the MI Health Link program are consistent with those from Demonstration Years 2, 3 and 4, but different from Demonstration Year 1. As of the timing of this report, the calculations of the withhold for Demonstration Year 4 have not been determined. We anticipate that the ICOs will be able to earn back greater than 80% of the withheld amounts.

(iv) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 3.0% of capitation revenue, indicates that it is reasonable within the context of the capitation rate development. The capitation rates have been established with consideration of the withhold metrics and ensuring adequate utilization is reflected in the development of the capitation rates to meet the targeted metrics.

(v) Effect on the capitation rates

The CY 2020 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable.

(b) Capitation payments minus withhold

The CY 2020 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable, and the capitation rates are certified as actuarially sound.

C. RISK SHARING MECHANISMS

i. Rate Development Standards

This section provides documentation of the risk-sharing mechanisms in the MI Health Link managed care program.

ii. Appropriate Documentation

(a) Description of Risk-sharing Mechanism

No risk sharing arrangements exist for the covered populations.

(b) Medical Loss Ratio

Description

Beginning Demonstration Year 2, each ICO will be required annually to meet a minimum medical loss ratio (MMLR) threshold which regulates the minimum amount (as a percentage of the gross joint Medicare and Medicaid payments) that must be used for expenses either directly related to medical claims or those which are related to the care and quality of enrollees. This will be established at 85%.

Financial consequences

If an ICO has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment, the ICO must remit the amount by which the eighty-five percent (85%) threshold exceeds the ICOs actual MLR multiplied by the total capitation rate revenue of the contract. Any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis.

(c) Reinsurance Requirements and Effect on Capitation Rates

The standard contract language between the state and the ICOs requires contractors to maintain certain insurances as identified in the contract terms. These would include general liability insurance. Contractors are also required to utilize subcontractors with similar insurance coverages.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

i. Rate Development Standards

This section is not applicable.

ii. Appropriate Documentation

(a) Description of Delivery System and Provider Payment Initiatives

(i) Description of delivery system and provider payment Initiatives included in the capitation rates

This section is not applicable.

E. PASS-THROUGH PAYMENTS

i. Rate Development Standards

This section is not applicable because there are no pass-through payments for the MI Health Link program. We assume that incentive payments, as listed in this section of the CMS rate consultation guide as a pass-through, were intended to indicate payments to medical or LTSS service providers and not incentive payments to the ICOs.

ii. Appropriate Documentation

(a) Description of Pass-Through Payments

(i) Description

There are no pass-through payments reflected in the CY 2020 capitation rates.

(ii) Amount

Not applicable.

(iii) Providers receiving the payment

Not applicable.

(iv) Financing mechanism

Not applicable.

(v) Pass-through payments for previous rating period

Not applicable.

(vi) Pass-through payments for rating period in effect on July 5, 2016

Not applicable.

5. Projected non-benefit costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

Based on the process utilized to establish the rates for the MI Health Link program, no specific allowance was made for non-benefit costs that would typically be included in managed care capitation rate development. The basis for the Medicaid rates began with costs developed prior to the application of the Medicare and Medicaid composite savings percentages established by the State and CMS, informed by estimates from CMS and its contractors. The final Medicaid capitation rates were established by applying composite savings percentages established by the State and CMS and documented in the MOU.

Certain non-benefit expenses are included in the development of the MME and MI Choice population capitation rates that are utilized in the development of the Community and Waiver rates. No other changes were made to those rates under the CY 2020 MI Health Link rate development process. The addition of the IPA is noted as a non-benefit expense and discussed in more detail below.

ii. PMPM versus percentage

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 4, however the estimated IPA amount is on a PMPM basis.

The IPA is applicable to insurance providers in the State of Michigan. The IPA assesses a PMPM rate of $53.55 to each covered member month, by managed care entity, up to 1.2 million members in a given state fiscal year. The PMPM amount decreases to $1.20 for each member month above 1.2 million. The ultimate amount paid for the IPA will be vary by managed care entity based on actual enrollment utilized in the calculation of the assessment. The IPA became effective October 1, 2018 and will be paid on a retrospective basis at the end of each quarter. We have included a PMPM estimate for CY 2020 in Appendix 4 based on a complete 12 months' worth of payments over the calendar year.

The estimated IPA load of $37.06 reflected in Appendix 4 was based on enrollment information provided by MDHHS and the PMPM payment structure of the IPA being consistent with the amounts noted in the CY 2019 MI Health Link certification. The MI Health Link portion of the IPA liability was calculated based on the proportion of a plan's total membership across the various Michigan Medicaid managed care programs. Please note that we have developed a singular PMPM across all ICOs but acknowledge that ultimate amounts paid will vary by ICO. Note that the IPA will be 100% state funded for the MI Health Link program.

iii. Basis for variation in assumptions

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 4 outside of the IPA.

iv. Health insurance providers fee

Detail regarding the health insurance providers fee is provided in Section I, item 5.B.iii below.

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

(a) Description of the data, assumptions, and methodologies

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 4 outside of the IPA.

(b) Material changes

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 4 outside of the IPA.

(c) Other material adjustments

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 4 outside of the IPA.

ii. Non-benefit costs, by cost category

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 4 outside of the IPA.

iii. Health insurance providers fee

(a) Whether the fee is incorporated in the rates

There is no allocation in the rate development for purposes of the Health Insurer Fee (HIF). As these rates are to be developed "in absence of the demonstration," no HIF would be applicable under a fee-for-service arrangement. The only consideration for HIF in the MI Health Link rates would be attributed to the MME capitation portion of the rate documented in the development of the Community tier in Appendix 4.

(b) Fee year or data year

To the extent HIF expenses are provided for the MME component of the rate, it will be calculated based on the fee year. Potential amended calendar year 2020 rates will be based on the 2020 HIF attributable to the 2019 data year.

(c) Determination of fee impact to rates

The calculation of the fee for each ICO that will be subject to payment by the state will be based on the final Form 8963 premium amounts reported by the insurer, aggregate HIF premium base, final IRS invoices provided to the health plans subject to the HIF, Form 8963 premium amounts attributable to MDHHS, fee year HIF tax percentage, and adjustments for premium revenue based on benefits described in 26 CFR 57.2(h)(2)(ix) such as nursing home and home health care. Final fee amounts are adjusted for applicable fees and taxes that are applied to MDHHS capitation rate revenue associated with the MME component of the Community rate.

(d) Timing of adjustment for health insurance providers fee

The CY 2020 capitation rates in this certification **do not** reflect the incorporation of the HIF. After the actual amount of the HIF is known, the capitation rates will be retrospectively adjusted as appropriate to include the HIF. We anticipate completing the analysis to amend the SFY 2020 rates in the last quarter of CY 2020.

(e) Identification of long-term care benefits

Identification of long-term care benefits within the MME capitation rate for purposes of determining capitation revenue subject to the HIF is discussed in the MME rate certification.

(f) Application of health insurance providers fee in 2014, 2015, and 2016 capitation rates

The ICOs in Michigan were required to pay the HIF in 2016, but were exempt for 2014 and 2015 based on the MI Health Link program not beginning until CY 2015. The initially certified capitation rates were amended to include the HIF and associated income tax impacts to reflect the non-tax-deductibility of the HIF.

6. Risk Adjustment and Acuity Adjustments

This section provides information on the risk adjustment included in the contract.

A. RATE DEVELOPMENT STANDARDS

i. Overview

The MI Health Link rates have been developed as full risk rates. The ICOs assume risk for the cost of services covered under the contract and incur losses if the cost of furnishing the services exceeds the payments under the contract. In demonstration year 1 (ending December 31, 2016), there was a risk corridor established for gains/losses. There is no risk corridor established beyond demonstration year 1.

ii. Risk adjustment model

Not applicable.

iii. Acuity adjustments

Not applicable.

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data and adjustments

Not applicable.

(b) Risk adjustment model

Not applicable.

(c) Risk adjustment methodology

Not applicable.

(d) Magnitude of the adjustment

Not applicable.

(e) Assessment of predictive value

Not applicable.

(f) Any concerns the actuary has with the risk adjustment process

Not applicable.

ii. Retrospective risk adjustment

Not applicable.

iii. Changes to risk adjustment model since last rating period

Not applicable.

iv. Acuity adjustments

Not applicable.

Section II. Medicaid Managed care rates with long-term services and supports

1. MANAGED LONG-TERM SERVICES AND SUPPORTS

A. COMPLETION OF SECTION I.

MI Health Link is Michigan's managed care program for the dual eligible (Medicare-Medicaid) population. Eligible individuals are required to either receive both Medicare and Medicaid services through the managed care plan or opt-out to fee-for-service. A significant portion of services provided to these members are long-term services and support (LTSS) including nursing facility, home care, and home and community based (HCBS) waiver services.

We completed Section I of this report for MLTSS and other medical services.

B. MLTSS Rate structure

(a) Capitation Rate Structure

The MI Health Link rate structure for calendar year 2020 did not change from the 2015-2019 rate structure. Rates continue to vary by region consistent with current geographic definitions. The rate cells continue to represent population groups split by place of setting and represent a non-blended rate cell structure.

Nursing Facility

The Nursing Facility category represents MI Health Link eligible members (as outlined earlier) who meet nursing facility level of care and reside in a facility. Separate rates were established based on age (Over/Under 65) and the type of facility (Private or County-Owned). ICOs will receive the Nursing Facility rate for beneficiaries who enroll into MI Health Link program from the nursing facility setting.

Transition Rules

Members who had met the criteria for inclusion in the Nursing Facility cell, but later do not, will be transitioned to the community or waiver category. The ICO will immediately receive the alternative category rate upon switching from the Nursing Facility.

NFLOC-Waiver

The waiver category represents eligible dual members who meet the NFLOC standard (including the transition rules), but do not reside in a facility. Members cannot be dually enrolled in MI Health Link and the state's MI Choice program simultaneously.

Community

The community category represents eligible dual members who do not meet the NFLOC standard. Within the community well category, capitation rates vary by region and age (Over/Under 65).

(b) Methodology

The description of the rates and rate cells, data, assumptions, and methodology are detailed in Section I. of the report.

C. Managed Care effect

The rate cell structure encourages ICOs to manage the population towards lower cost settings. This is the basis for management efficiencies in LTSS programs. This transition between settings (e.g. nursing facility to HCBS waiver services) is gradual in nature and is not an immediate transition. Most often, individuals who reside in a nursing facility for a long period of time have lost their community supports and it becomes difficult to change the setting away from a nursing facility.

D. Non-Benefit cost

Non-benefit costs are not explicitly defined for this program.

E. Experience and Assumptions

Section I details the experience and assumptions employed for the LTSS and non-MLTSS services included in the MI Health Link program.

Section III. New adult group capitation rates

Section III of the guidance is not applicable to the MI Choice program as these are not new adult groups.

Limitations

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved September 13, 2019.

The information contained in this letter, including the appendices, has been prepared for the State of Michigan, Department of Health and Human Services and their consultants and advisors. It is our understanding that this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for MDHHS 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.

In performing this analysis, we relied on data and other information provided by MDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Appendix 1: Actuarial Certification

State of Michigan, Department of Health and Human Services
MI Health Link Program
Calendar Year 2020 Medicaid Component Capitation
Actuarial Certification

I, Christopher Pettit, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Michigan, Department of Health and Human Services, to perform an actuarial review and certification regarding the development of capitation rates for the MI Health Link program effective January 1, 2020. I am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- the capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the MCO for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

Assessment of actuarial soundness, in the context of MI Health Link, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration.

As allowed by ASOP 49 and ASOP 1 (Section 3.1.5), we relied upon a capitation rate setting methodology selected by another party. Specifically, we followed guidance prescribed by CMS in the Joint Rate-Setting Process for the Financial Alignment Initiative's Capitated Model (Joint Rate-Setting Process), updated April 25, 2017, for Medicare-Medicaid plans (MMPs) participating in the demonstration. The Joint Rate-Setting Process prescribes that projected baseline expenditures for the Medicaid component of the capitation rate must be estimated as if the demonstration did not exist. Additionally, an aggregate savings percentage must be applied to projected expenditures in compliance with percentages established by CMS and MDHHS for each year of the demonstration, as documented in the MOU.

For the purposes of this certification and consistent with the requirements under 42 CFR 438.4(a), "actuarial soundness" is defined as in ASOP 49:

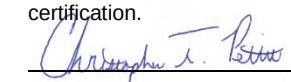
"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition,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

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of Michigan. The "actuarially sound" capitation rates that are associated with this certification are effective for calendar year 2020.

The "actuarially sound" capitation rates are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the rates.

In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by the State. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency.

The capitation rates developed may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State of Michigan. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.



Christopher T. Pettit, FSA
Member, American Academy of Actuaries
January 27, 2020
Date

Appendix 2: CY 2020 Cost Models

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 5 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: FFS-Nursing Subtier A-65+

Member Months: 65,251 Category of Service	Fiscal Year 2018 Base Experience Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2020 Annual Utilization per 1,000	Cost per Service	PMPM
Nursing Facility											
Nursing Facility	283,792.2	$ 163.46	$ 3,865.82	$ 9.66	$ 176.58	$ 231.50	$ 0.00	$ 1,407.41	297,464.4	$ 229.58	$ 5,690.96
Subtotal Nursing Facility			**$ 3,865.82**								**$ 5,690.96**
Inpatient Hospital											
Inpatient General	1,598.3	$ 261.79	$ 34.87	$ 0.17	$ 0.80	$ 1.66	$ 0.00	$ 0.00	1,642.8	$ 273.91	$ 37.50
Inpatient Psychiatric	1.5	427.08	0.05	-	-	0.01	-	-	1.5	469.78	0.06
Subtotal Inpatient Hospital			**$ 34.92**								**$ 37.56**
Outpatient Hospital											
Outpatient General	427.0	$ 81.83	$ 2.91	$ 0.00	$ 0.20	$ 0.14	$ 0.00	$ 0.00	457.5	$ 85.59	$ 3.26
Outpatient Hospice	802.0	4,664.82	311.77	0.78	21.50	15.22	-	-	859.3	4,877.33	349.26
Subtotal Outpatient Hospital			**$ 314.68**								**$ 352.53**
Prescription Drugs											
Prescription Drugs	2,355.1	$ 15.78	$ 3.10	$ 0.00	$ 0.04	$ 0.32	$ 0.00	$ 0.00	2,383.1	$ 17.42	$ 3.46
Subtotal Prescription Drugs			**$ 3.10**								**$ 3.46**
Other Ancillaries											
Transportation	162.9	$ 131.11	$ 1.78	$ 0.01	$ 0.01	$ 0.01	$ 0.00	$ 0.00	164.1	$ 132.01	$ 1.80
DME/Prosthetics/Orthotics	31,371.1	2.62	6.85	0.02	0.04	0.04	-	-	31,632.5	2.63	6.94
Waiver Services	3,658.0	0.50	0.15	-	-	-	-	-	3,658.0	0.50	0.15
Other Ancillary	1,480.6	32.54	4.01	0.01	0.02	0.03	-	-	1,492.4	32.76	4.07
Home Help	171.0	312.19	4.45	0.01	0.03	0.03	0.50	0.49	191.4	344.65	5.50
Subtotal Other Ancillaries			**$ 17.25**								**$ 18.47**
Physician											
Phys Visits Office/Consult	318.5	$ 31.16	$ 0.83	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	321.6	$ 31.41	$ 0.84
Phys Visit Other	3,849.3	17.84	5.72	0.01	0.04	0.06	-	-	3,881.1	18.03	5.83
Anesthesia	8.8	27.55	0.02	-	-	-	-	-	8.8	27.55	0.02
Lab/Pathology	285.1	11.09	0.26	-	-	0.01	-	-	285.1	11.39	0.27
Surgery	330.3	22.66	0.62	-	0.00	0.01	-	-	331.3	23.02	0.64
Vision/Hearing	457.7	21.21	0.81	-	0.01	0.00	-	-	462.8	21.33	0.82
Therapeutic Inj.	211.7	24.28	0.43	-	0.00	0.01	-	-	213.1	24.74	0.44
Subtotal Physician			**$ 8.69**								**$ 8.86**
Total Medical Costs			**$ 4,244.46**								**$ 6,111.84**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 5 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: FFS-Nursing Subtier A-Under 65

Member Months: 13,317 Category of Service	Fiscal Year 2018 Base Experience Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2020 Annual Utilization per 1,000	Cost per Service	PMPM
Nursing Facility											
Nursing Facility	268,876.8	$ 157.62	$ 3,531.62	$ 8.83	$ 161.31	$ 211.48	$ 0.00	$ 1,235.79	281,830.6	$ 219.24	$ 5,149.04
Subtotal Nursing Facility			**$ 3,531.62**								**$ 5,149.04**
Inpatient Hospital											
Inpatient General	3,365.6	$ 353.39	$ 99.11	$ 0.50	$ 2.25	$ 4.72	$ 0.00	$ 0.00	3,459.0	$ 369.75	$ 106.58
Inpatient Psychiatric	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 99.11**								**$ 106.58**
Outpatient Hospital											
Outpatient General	509.1	$ 172.95	$ 7.34	$ 0.02	$ 0.51	$ 0.36	$ 0.00	$ 0.00	545.5	$ 180.84	$ 8.22
Outpatient Hospice	355.9	4,521.48	134.11	0.33	9.25	6.55	-	-	381.4	4,727.57	150.24
Subtotal Outpatient Hospital			**$ 141.45**								**$ 158.46**
Prescription Drugs											
Prescription Drugs	3,433.2	$ 28.84	$ 8.25	$ 0.00	$ 0.09	$ 0.87	$ 0.00	$ 0.00	3,471.8	$ 31.85	$ 9.21
Subtotal Prescription Drugs			**$ 8.25**								**$ 9.21**
Other Ancillaries											
Transportation	408.2	$ 148.81	$ 5.06	$ 0.02	$ 0.03	$ 0.02	$ 0.00	$ 0.00	411.6	$ 149.53	$ 5.13
DME/Prosthetics/Orthotics	61,280.5	2.70	13.77	0.04	0.08	0.08	-	-	61,780.0	2.71	13.96
Waiver Services	7,705.3	0.96	0.62	-	0.01	-	-	-	7,805.6	0.96	0.63
Other Ancillary	1,967.1	30.57	5.01	0.01	0.03	0.03	-	-	1,983.2	30.74	5.08
Home Help	254.1	282.17	5.98	0.02	0.03	0.03	0.67	0.65	284.7	310.96	7.38
Subtotal Other Ancillaries			**$ 30.43**								**$ 32.17**
Physician											
Phys Visits Office/Consult	515.4	$ 27.29	$ 1.17	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	520.0	$ 27.58	$ 1.20
Phys Visit Other	5,165.1	15.55	6.69	0.02	0.03	0.07	-	-	5,206.5	15.72	6.82
Anesthesia	26.1	53.10	0.12	-	-	-	-	-	26.1	53.10	0.12
Lab/Pathology	379.4	15.04	0.48	-	-	0.01	-	-	379.4	15.29	0.48
Surgery	326.2	28.47	0.77	-	0.01	0.00	-	-	329.4	28.59	0.78
Vision/Hearing	507.3	22.86	0.97	-	0.01	0.01	-	-	512.6	23.09	0.99
Therapeutic Inj.	470.4	49.73	1.95	0.00	0.01	0.02	-	-	474.1	50.26	1.99
Subtotal Physician			**$ 12.15**								**$ 12.37**
Total Medical Costs			**$ 3,823.02**								**$ 5,467.84**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 5 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: FFS-Nursing Subtier B-65+

Member Months: 6,627 Category of Service	Fiscal Year 2018 Base Experience Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2020 Annual Utilization per 1,000	Cost per Service	PMPM
Nursing Facility											
Nursing Facility	260,863.7	$ 265.77	$ 5,777.45	$ 14.45	$ 263.90	$ 345.97	$ 0.00	$ 2,330.62	273,431.6	$ 383.24	$ 8,732.38
Subtotal Nursing Facility			**$ 5,777.45**								**$ 8,732.38**
Inpatient Hospital											
Inpatient General	45,043.0	$ 263.43	$ 988.79	$ 4.94	$ 22.50	$ 47.04	$ 0.00	$ 423.52	46,293.2	$ 385.40	$ 1,486.80
Inpatient Psychiatric	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 988.79**								**$ 1,486.80**
Outpatient Hospital											
Outpatient General	1,479.4	$ 38.58	$ 4.76	$ 0.01	$ 0.33	$ 0.23	$ 0.00	$ 0.00	1,584.7	$ 40.35	$ 5.33
Outpatient Hospice	27.2	3,131.79	7.09	0.02	0.49	0.35	-	-	29.1	3,275.56	7.94
Subtotal Outpatient Hospital			**$ 11.85**								**$ 13.27**
Prescription Drugs											
Prescription Drugs	1,828.9	$ 7.56	$ 1.15	$ 0.00	$ 0.01	$ 0.12	$ 0.00	$ 0.00	1,850.4	$ 8.36	$ 1.29
Subtotal Prescription Drugs			**$ 1.15**								**$ 1.29**
Other Ancillaries											
Transportation	52.5	$ 134.02	$ 0.59	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	52.8	$ 135.48	$ 0.60
DME/Prosthetics/Orthotics	10,696.2	3.30	2.94	0.01	0.01	0.02	-	-	10,776.4	3.32	2.98
Waiver Services	907.2	0.14	0.01	-	-	-	-	-	907.2	0.14	0.01
Other Ancillary	1,055.7	32.23	2.84	0.01	0.01	0.02	-	-	1,064.5	32.40	2.87
Home Help	43.5	320.76	1.16	-	0.01	0.01	0.13	0.13	48.6	354.56	1.44
Subtotal Other Ancillaries			**$ 7.54**								**$ 7.90**
Physician											
Phys Visits Office/Consult	306.0	$ 55.20	$ 1.41	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	309.0	$ 55.78	$ 1.44
Phys Visit Other	2,654.6	30.47	6.74	0.01	0.04	0.08	-	-	2,675.4	30.81	6.87
Anesthesia	1.8	-	-	-	-	-	-	-	-	-	-
Lab/Pathology	124.9	14.24	0.15	-	-	-	-	-	124.9	14.24	0.15
Surgery	253.5	23.62	0.50	-	0.01	0.00	-	-	256.1	23.79	0.51
Vision/Hearing	344.0	26.26	0.75	-	0.01	0.01	-	-	346.3	26.60	0.77
Therapeutic Inj.	146.7	96.71	1.18	0.00	0.00	0.01	-	-	147.6	97.87	1.20
Subtotal Physician			**$ 10.73**								**$ 10.93**
Total Medical Costs			**$ 6,797.51**								**$ 10,252.58**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 5 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: FFS-Nursing Subtier B-Under 65

Member Months: 856 Category of Service	Fiscal Year 2018 Base Experience Utilization per 1,000	 Cost per Service	 PMPM	Trended/Adjusted to CY 2020 Completion Adjustment	 Utilization Trend Adjustment	 Cost Trend Adjustment	 Minimum Wage Adjustment	 QAS/CPE FICA/FUTA Adjustment	 Annual Utilization per 1,000	 Cost per Service	 PMPM
Nursing Facility											
Nursing Facility	261,140.2	$ 262.41	$ 5,710.56	$ 14.27	$ 260.85	$ 341.96	$ 0.00	$ 2,032.30	273,721.4	$ 366.50	$ 8,359.95
Subtotal Nursing Facility			**$ 5,710.56**								**$ 8,359.95**
Inpatient Hospital											
Inpatient General	53,509.3	$ 253.61	$ 1,130.87	$ 5.65	$ 25.73	$ 53.79	$ 0.00	$ 450.07	54,994.5	$ 363.55	$ 1,666.13
Inpatient Psychiatric	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 1,130.87**								**$ 1,666.13**
Outpatient Hospital											
Outpatient General	1,710.3	$ 50.73	$ 7.23	$ 0.02	$ 0.50	$ 0.36	$ 0.00	$ 0.00	1,831.9	$ 53.06	$ 8.10
Outpatient Hospice	14.0	2,673.32	3.12	0.01	0.22	0.15	-	-	15.0	2,796.00	3.50
Subtotal Outpatient Hospital			**$ 10.35**								**$ 11.60**
Prescription Drugs											
Prescription Drugs	2,186.9	$ 6.77	$ 1.23	$ 0.00	$ 0.01	$ 0.13	$ 0.00	$ 0.00	2,212.6	$ 7.47	$ 1.38
Subtotal Prescription Drugs			**$ 1.23**								**$ 1.38**
Other Ancillaries											
Transportation	42.1	$ 132.53	$ 0.46	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	42.3	$ 132.53	$ 0.47
DME/Prosthetics/Orthotics	13,359.8	2.17	2.41	0.01	0.01	0.02	-	-	13,464.7	2.18	2.45
Waiver Services	2,803.7	0.03	0.01	-	-	-	-	-	2,803.7	0.03	0.01
Other Ancillary	1,486.0	17.38	2.15	0.01	0.01	0.01	-	-	1,499.4	17.48	2.18
Home Help	42.1	624.34	2.19	0.01	0.01	0.02	0.24	0.24	47.0	689.92	2.70
Subtotal Other Ancillaries			**$ 7.23**								**$ 7.81**
Physician											
Phys Visits Office/Consult	504.7	$ 36.43	$ 1.53	$ 0.00	$ 0.01	$ 0.02	$ 0.00	$ 0.00	508.5	$ 36.87	$ 1.56
Phys Visit Other	4,766.4	19.86	7.89	0.02	0.04	0.08	-	-	4,803.6	20.07	8.03
Anesthesia	-	-	-	-	-	-	-	-	-	-	-
Lab/Pathology	140.2	14.70	0.17	-	-	0.00	-	-	140.2	15.08	0.18
Surgery	322.4	25.28	0.68	-	0.01	0.01	-	-	325.0	25.57	0.69
Vision/Hearing	546.7	24.77	1.13	-	0.01	0.01	-	-	552.8	24.94	1.15
Therapeutic Inj.	392.5	2.13	0.07	-	-	-	-	-	392.5	2.13	0.07
Subtotal Physician			**$ 11.47**								**$ 11.68**
Total Medical Costs			**$ 6,871.72**								**$ 10,058.54**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 5 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: FFS-NF Level of Care-65+

	Fiscal Year 2018 Base Experience								Trended/Adjusted to CY 2020		
Member Months: 24,616 **Category of Service**	**Utilization per 1,000**	**Cost per Service**	**PMPM**	**Completion Adjustment**	**Utilization Trend Adjustment**	**Cost Trend Adjustment**	**Minimum Wage Adjustment**	**QAS/CPE FICA/FUTA Adjustment**	**Annual Utilization per 1,000**	**Cost per Service**	**PMPM**
Nursing Facility											
Nursing Facility	1,497.6	$ 119.53	$ 14.92	$ 0.04	$ 0.68	$ 0.89	$ 0.00	$ 8.10	1,569.9	$ 188.21	$ 24.62
Subtotal Nursing Facility			**$ 14.92**								**$ 24.62**
Inpatient Hospital											
Inpatient General	695.6	$ 152.55	$ 8.84	$ 0.04	$ 0.20	$ 0.42	$ 0.00	$ 0.00	715.2	$ 159.55	$ 9.51
Inpatient Psychiatric	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 8.84**								**$ 9.51**
Outpatient Hospital											
Outpatient General	879.9	$ 77.32	$ 5.67	$ 0.01	$ 0.39	$ 0.28	$ 0.00	$ 0.00	942.6	$ 80.89	$ 6.35
Outpatient Hospice	0.5	593.20	0.02	-	0.00	-	-	-	0.5	593.20	0.03
Subtotal Outpatient Hospital			**$ 5.69**								**$ 6.38**
Prescription Drugs											
Prescription Drugs	5,406.2	$ 12.65	$ 5.70	$ 0.00	$ 0.06	$ 0.60	$ 0.00	$ 0.00	5,467.3	$ 13.96	$ 6.36
Subtotal Prescription Drugs			**$ 5.70**								**$ 6.36**
Other Ancillaries											
Transportation	121.9	$ 110.31	$ 1.12	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	122.9	$ 111.22	$ 1.14
DME/Prosthetics/Orthotics	1,338,089.7	0.36	40.64	0.10	0.23	0.23	-	-	1,349,056.5	0.37	41.20
Waiver Services	133,711.3	0.04	0.41	-	-	0.01	-	-	133,711.3	0.04	0.42
Other Ancillary	1,769.1	40.51	5.97	0.01	0.03	0.04	-	-	1,782.5	40.75	6.05
Home Help	9.3	305.50	0.24	-	-	0.00	0.03	0.03	10.5	336.73	0.29
Subtotal Other Ancillaries			**$ 48.38**								**$ 49.11**
Physician											
Phys Visits Office/Consult	1,986.0	$ 26.72	$ 4.42	$ 0.01	$ 0.03	$ 0.04	$ 0.00	$ 0.00	2,003.1	$ 26.98	$ 4.50
Phys Visit Other	301.3	25.63	0.64	-	0.01	0.00	-	-	305.5	25.67	0.65
Anesthesia	4.4	22.81	0.01	-	-	-	-	-	4.4	22.81	0.01
Lab/Pathology	282.7	13.83	0.33	-	-	0.01	-	-	282.7	14.18	0.33
Surgery	235.0	25.01	0.49	-	-	0.01	-	-	235.0	25.52	0.50
Vision/Hearing	300.3	25.68	0.64	-	0.01	0.00	-	-	303.6	25.86	0.65
Therapeutic Inj.	1,085.6	55.36	5.01	0.01	0.03	0.06	-	-	1,094.5	55.99	5.11
Subtotal Physician			**$ 11.54**								**$ 11.76**
Total Medical Costs			**$ 95.07**								**$ 107.74**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 5 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: FFS-NF Level of Care-Under 65

	Fiscal Year 2018 Base Experience								Trended/Adjusted to CY 2020		
Member Months: 10,630 **Category of Service**	**Utilization per 1,000**	**Cost per Service**	**PMPM**	**Completion Adjustment**	**Utilization Trend Adjustment**	**Cost Trend Adjustment**	**Minimum Wage Adjustment**	**QAS/CPE FICA/FUTA Adjustment**	**Annual Utilization per 1,000**	**Cost per Service**	**PMPM**
Nursing Facility											
Nursing Facility	1,391.9	$ 147.20	$ 17.07	$ 0.04	$ 0.78	$ 1.03	$ 0.00	$ 7.75	1,458.8	$ 219.38	$ 26.67
Subtotal Nursing Facility			**$ 17.07**								**$ 26.67**
Inpatient Hospital											
Inpatient General	917.8	$ 138.09	$ 10.56	$ 0.06	$ 0.24	$ 0.50	$ 0.00	$ 0.00	943.3	$ 144.48	$ 11.36
Inpatient Psychiatric	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 10.56**								**$ 11.36**
Outpatient Hospital											
Outpatient General	976.5	$ 98.45	$ 8.01	$ 0.02	$ 0.55	$ 0.39	$ 0.00	$ 0.00	1,046.6	$ 102.89	$ 8.97
Outpatient Hospice	-	-	-	-	-	-	-	-	-	-	-
Subtotal Outpatient Hospital			**$ 8.01**								**$ 8.97**
Prescription Drugs											
Prescription Drugs	5,741.5	$ 14.80	$ 7.08	$ 0.00	$ 0.08	$ 0.74	$ 0.00	$ 0.00	5,806.0	$ 16.34	$ 7.91
Subtotal Prescription Drugs			**$ 7.08**								**$ 7.91**
Other Ancillaries											
Transportation	345.4	$ 147.38	$ 4.24	$ 0.01	$ 0.03	$ 0.02	$ 0.00	$ 0.00	348.5	$ 148.13	$ 4.30
DME/Prosthetics/Orthotics	1,286,230.7	0.41	43.85	0.11	0.24	0.25	-	-	1,296,660.6	0.41	44.45
Waiver Services	206,137.0	0.05	0.83	-	0.01	0.00	-	-	207,807.4	0.05	0.84
Other Ancillary	3,405.8	35.90	10.19	0.03	0.06	0.06	-	-	3,433.5	36.10	10.33
Home Help	10.2	292.87	0.25	-	-	-	0.03	0.03	11.5	321.95	0.31
Subtotal Other Ancillaries			**$ 59.36**								**$ 60.23**
Physician											
Phys Visits Office/Consult	2,317.6	$ 24.41	$ 4.72	$ 0.01	$ 0.03	$ 0.05	$ 0.00	$ 0.00	2,337.0	$ 24.67	$ 4.80
Phys Visit Other	348.8	26.73	0.78	-	0.01	0.01	-	-	352.5	26.90	0.79
Anesthesia	15.8	49.18	0.06	-	-	-	-	-	15.8	49.18	0.06
Lab/Pathology	352.2	13.79	0.40	-	-	0.01	-	-	352.2	14.00	0.41
Surgery	186.3	35.46	0.55	-	0.00	0.00	-	-	187.9	35.67	0.56
Vision/Hearing	368.0	26.19	0.80	-	0.01	0.01	-	-	372.6	26.40	0.82
Therapeutic Inj.	1,769.0	61.46	9.06	0.02	0.06	0.10	-	-	1,783.8	62.10	9.23
Subtotal Physician			**$ 16.38**								**$ 16.68**
Total Medical Costs			**$ 118.46**								**$ 131.82**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 5 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: FFS-Community Well-65+

Member Months: 343,295 Category of Service	Fiscal Year 2018 Base Experience Utilization per 1,000	 Cost per Service	 PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2020 Annual Utilization per 1,000	 Cost per Service	 PMPM
Nursing Facility											
Nursing Facility	147.9	$ 196.70	$ 2.42	$ 0.00	$ 0.12	$ 0.14	$ 0.00	$ 1.27	155.1	$ 306.01	$ 3.96
Subtotal Nursing Facility			**$ 2.42**								**$ 3.96**
Inpatient Hospital											
Inpatient General	489.3	$ 211.93	$ 8.64	$ 0.04	$ 0.20	$ 0.41	$ 0.00	$ 0.00	502.9	$ 221.72	$ 9.29
Inpatient Psychiatric	1.2	48.34	0.00	-	-	-	-	-	1.2	48.34	0.00
Subtotal Inpatient Hospital			**$ 8.65**								**$ 9.30**
Outpatient Hospital											
Outpatient General	545.2	$ 77.45	$ 3.52	$ 0.01	$ 0.24	$ 0.17	$ 0.00	$ 0.00	584.3	$ 80.98	$ 3.94
Outpatient Hospice	0.6	4,376.65	0.20	-	0.02	0.01	-	-	0.6	4,571.89	0.23
Subtotal Outpatient Hospital			**$ 3.72**								**$ 4.17**
Prescription Drugs											
Prescription Drugs	6,971.6	$ 11.50	$ 6.68	$ 0.00	$ 0.08	$ 0.70	$ 0.00	$ 0.00	7,051.3	$ 12.70	$ 7.46
Subtotal Prescription Drugs			**$ 6.68**								**$ 7.46**
Other Ancillaries											
Transportation	30.4	$ 104.65	$ 0.27	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	30.4	$ 104.65	$ 0.27
DME/Prosthetics/Orthotics	185,053.6	0.46	7.09	0.02	0.03	0.04	-	-	186,489.3	0.46	7.18
Waiver Services	26,728.9	0.19	0.42	-	0.00	-	-	-	26,948.2	0.19	0.42
Other Ancillary	1,855.3	39.45	6.10	0.01	0.03	0.04	-	-	1,869.9	39.68	6.18
Home Help	3,299.1	460.54	126.61	0.31	0.72	0.72	14.12	13.89	3,693.9	507.99	156.37
Subtotal Other Ancillaries			**$ 140.48**								**$ 170.42**
Physician											
Phys Visits Office/Consult	1,388.0	$ 36.59	$ 4.23	$ 0.01	$ 0.02	$ 0.05	$ 0.00	$ 0.00	1,398.5	$ 37.00	$ 4.31
Phys Visit Other	161.0	33.53	0.45	-	-	0.01	-	-	161.0	34.27	0.46
Anesthesia	7.2	39.46	0.02	-	-	-	-	-	7.2	39.46	0.02
Lab/Pathology	278.4	15.17	0.35	-	-	0.01	-	-	278.4	15.60	0.36
Surgery	168.7	33.07	0.46	-	0.00	0.01	-	-	169.1	33.70	0.47
Vision/Hearing	397.1	30.47	1.01	-	0.01	0.01	-	-	401.0	30.77	1.03
Therapeutic Inj.	1,160.1	41.04	3.97	0.01	0.02	0.04	-	-	1,168.9	41.49	4.04
Subtotal Physician			**$ 10.50**								**$ 10.70**
Total Medical Costs			**$ 172.45**								**$ 206.02**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 5 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: FFS-Community Well-Under 65

Member Months: 410,988 Category of Service	Fiscal Year 2018 Base Experience Utilization per 1,000	 Cost per Service	 PMPM	Trended/Adjusted to CY 2020 Completion Adjustment	 Utilization Trend Adjustment	 Cost Trend Adjustment	 Minimum Wage Adjustment	 QAS/CPE FICA/FUTA Adjustment	 Annual Utilization per 1,000	 Cost per Service	 PMPM
Nursing Facility											
Nursing Facility	29.9	$ 149.47	$ 0.37	$ 0.00	$ 0.02	$ 0.02	$ 0.00	$ 0.25	31.4	$ 251.61	$ 0.66
Subtotal Nursing Facility			**$ 0.37**								**$ 0.66**
Inpatient Hospital											
Inpatient General	359.0	$ 229.83	$ 6.88	$ 0.03	$ 0.16	$ 0.33	$ 0.00	$ 0.00	368.9	$ 240.60	$ 7.40
Inpatient Psychiatric	3.3	157.37	0.04	-	-	0.00	-	-	3.3	163.67	0.05
Subtotal Inpatient Hospital			**$ 6.92**								**$ 7.44**
Outpatient Hospital											
Outpatient General	799.6	$ 79.85	$ 5.32	$ 0.01	$ 0.36	$ 0.26	$ 0.00	$ 0.00	856.5	$ 83.50	$ 5.96
Outpatient Hospice	0.1	944.47	0.01	-	-	-	-	-	0.1	944.47	0.01
Subtotal Outpatient Hospital			**$ 5.33**								**$ 5.97**
Prescription Drugs											
Prescription Drugs	4,855.0	$ 16.43	$ 6.65	$ 0.00	$ 0.07	$ 0.70	$ 0.00	$ 0.00	4,909.5	$ 18.15	$ 7.43
Subtotal Prescription Drugs			**$ 6.65**								**$ 7.43**
Other Ancillaries											
Transportation	37.9	$ 92.92	$ 0.29	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	37.9	$ 92.92	$ 0.29
DME/Prosthetics/Orthotics	156,976.7	0.49	6.42	0.02	0.03	0.03	-	-	158,299.7	0.49	6.51
Waiver Services	31,621.9	0.25	0.66	-	0.01	0.00	-	-	31,901.9	0.25	0.67
Other Ancillary	2,585.6	40.45	8.72	0.02	0.05	0.05	-	-	2,606.6	40.70	8.84
Home Help	2,624.4	459.76	100.55	0.26	0.56	0.57	11.22	11.03	2,938.5	507.14	124.19
Subtotal Other Ancillaries			**$ 116.64**								**$ 140.50**
Physician											
Phys Visits Office/Consult	1,361.8	$ 36.37	$ 4.13	$ 0.01	$ 0.02	$ 0.05	$ 0.00	$ 0.00	1,372.0	$ 36.78	$ 4.21
Phys Visit Other	175.1	33.46	0.49	-	-	0.01	-	-	175.1	34.15	0.50
Anesthesia	12.8	36.62	0.04	-	-	-	-	-	12.8	36.62	0.04
Lab/Pathology	315.8	15.87	0.42	-	-	0.01	-	-	315.8	16.25	0.43
Surgery	150.1	37.49	0.47	-	-	0.01	-	-	150.1	38.29	0.48
Vision/Hearing	378.0	31.63	1.00	-	0.01	0.01	-	-	381.8	31.95	1.02
Therapeutic Inj.	1,334.1	33.56	3.73	0.01	0.02	0.04	-	-	1,345.5	33.90	3.80
Subtotal Physician			**$ 10.27**								**$ 10.47**
Total Medical Costs			**$ 146.18**								**$ 172.46**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 5 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: MHP-Community Well-65+

Member Months: 157,488 Category of Service	Fiscal Year 2018 Base Experience Utilization per 1,000	 Cost per Service	 PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2020 Annual Utilization per 1,000	 Cost per Service	 PMPM
Nursing Facility											
Nursing Facility	58.8	$ 40.80	$ 0.20	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	61.8	$ 42.74	$ 0.22
Subtotal Nursing Facility			**$ 0.20**								**$ 0.22**
Inpatient Hospital											
Inpatient General	8.5	$ 56.25	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	8.5	$ 56.25	$ 0.04
Inpatient Psychiatric	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 0.04**								**$ 0.04**
Outpatient Hospital											
Outpatient General	29.0	$ 12.43	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	29.0	$ 12.43	$ 0.03
Outpatient Hospice	-	-	-	-	-	-	-	-	-	-	-
Subtotal Outpatient Hospital			**$ 0.03**								**$ 0.03**
Prescription Drugs											
Prescription Drugs	65.8	$ 14.58	$ 0.08	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	65.8	$ 16.41	$ 0.09
Subtotal Prescription Drugs			**$ 0.08**								**$ 0.09**
Other Ancillaries											
Transportation	0.9	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	-	$ 0.00	$ 0.00
DME/Prosthetics/Orthotics	263.6	0.46	0.01	-	-	-	-	-	263.6	0.46	0.01
Waiver Services	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	5,042.9	18.37	7.72	0.02	0.04	0.05	-	-	5,082.1	18.49	7.83
Home Help	7,693.1	102.25	65.55	0.16	0.37	0.38	7.31	7.19	8,613.2	112.79	80.96
Subtotal Other Ancillaries			**$ 73.28**								**$ 88.80**
Physician											
Phys Visits Office/Consult	22.9	$ 10.50	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	22.9	$ 10.50	$ 0.02
Phys Visit Other	6.7	-	-	-	-	-	-	-	-	-	-
Anesthesia	-	-	-	-	-	-	-	-	-	-	-
Lab/Pathology	9.1	-	-	-	-	-	-	-	-	-	-
Surgery	7.6	15.75	0.01	-	-	-	-	-	7.6	15.75	0.01
Vision/Hearing	5.5	-	-	-	-	-	-	-	-	-	-
Therapeutic Inj.	72.2	1.66	0.01	-	-	-	-	-	72.2	1.66	0.01
Subtotal Physician			**$ 0.04**								**$ 0.04**
Total Medical Costs			**$ 73.67**								**$ 89.22**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 5 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: MHP-Community Well-Under 65

Member Months: 276,699 Category of Service	Fiscal Year 2018 Base Experience Utilization per 1,000	 Cost per Service	 PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2020 Annual Utilization per 1,000	 Cost per Service	 PMPM
Nursing Facility											
Nursing Facility	51.5	$ 25.62	$ 0.11	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	56.2	$ 25.62	$ 0.12
Subtotal Nursing Facility			**$ 0.11**								**$ 0.12**
Inpatient Hospital											
Inpatient General	13.2	$ 45.51	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	13.2	$ 45.51	$ 0.05
Inpatient Psychiatric	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 0.05**								**$ 0.05**
Outpatient Hospital											
Outpatient General	64.9	$ 22.20	$ 0.12	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	70.3	$ 22.20	$ 0.13
Outpatient Hospice	0.3	691.75	0.02	-	-	-	-	-	0.3	691.75	0.02
Subtotal Outpatient Hospital			**$ 0.14**								**$ 0.15**
Prescription Drugs											
Prescription Drugs	2,249.1	$ 38.63	$ 7.24	$ 0.00	$ 0.08	$ 0.76	$ 0.00	$ 0.00	2,273.9	$ 42.64	$ 8.08
Subtotal Prescription Drugs			**$ 7.24**								**$ 8.08**
Other Ancillaries											
Transportation	2.1	$ 57.65	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	2.1	$ 57.65	$ 0.01
DME/Prosthetics/Orthotics	432.8	0.55	0.02	-	-	-	-	-	432.8	0.55	0.02
Waiver Services	117.4	-	-	-	-	-	-	-	-	-	-
Other Ancillary	7,706.7	15.34	9.85	0.02	0.06	0.06	-	-	7,769.3	15.43	9.99
Home Help	5,386.9	106.95	48.01	0.12	0.27	0.27	5.36	5.27	6,032.0	117.97	59.30
Subtotal Other Ancillaries			**$ 57.89**								**$ 69.32**
Physician											
Phys Visits Office/Consult	70.3	$ 6.83	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	70.3	$ 6.83	$ 0.04
Phys Visit Other	17.3	6.92	0.01	-	-	-	-	-	17.3	6.92	0.01
Anesthesia	0.7	-	-	-	-	-	-	-	-	-	-
Lab/Pathology	9.4	-	-	-	-	-	-	-	-	-	-
Surgery	14.4	16.67	0.02	-	-	-	-	-	14.4	16.67	0.02
Vision/Hearing	4.3	-	-	-	-	-	-	-	-	-	-
Therapeutic Inj.	71.6	20.10	0.12	-	-	-	-	-	71.6	20.10	0.12
Subtotal Physician			**$ 0.19**								**$ 0.19**
Total Medical Costs			**$ 65.62**								**$ 77.91**

Appendix 3: Case Mix Exhibit

State of Michigan Department of Health and Human Services
MI Health Link
CY 2020 Capitation Rate Development
Enrollment Case Mix Exhibit

	Base FFS Benefit Expense			
	Region 1	**Region 4**	**Region 7**	**Region 9**
Nursing Subtier A-65+	$ 5,728.52	$ 6,069.15	$ 6,114.83	$ 6,336.18
Nursing Subtier A-Under 65	5,155.11	5,331.77	5,577.14	5,288.94
Nursing Subtier B-65+	9,867.80	10,877.57	7,249.01	10,045.03
Nursing Subtier B-Under 65	9,815.98	9,873.15	-	10,576.73
NF Level of Care-65+	114.87	113.43	102.48	113.41
NF Level of Care-Under 65	124.54	144.63	128.21	107.41
Community Well-65+	160.92	169.10	194.01	264.01
Community Well-Under 65	148.71	141.41	188.79	156.93
	Base FFS Enrollment			
	Region 1	**Region 4**	**Region 7**	**Region 9**
Nursing Subtier A-65+	6,378	11,984	34,166	12,723
Nursing Subtier A-Under 65	670	1,948	8,288	2,411
Nursing Subtier B-65+	3,294	2,360	2	971
Nursing Subtier B-Under 65	387	212	-	257
NF Level of Care-65+	2,512	7,415	13,112	1,577
NF Level of Care-Under 65	1,237	3,451	5,281	661
Community Well-65+	15,848	37,641	210,039	79,767
Community Well-Under 65	27,265	70,737	241,856	71,130
	Projected ICO Enrollment			
	Region 1	**Region 4**	**Region 7**	**Region 9**
Nursing Subtier A-65+	1,680	2,430	7,425	2,250
Nursing Subtier A-Under 65	240	375	1,815	420
Nursing Subtier B-65+	1,170	120	15	15
Nursing Subtier B-Under 65	120	-	-	-
NF Level of Care-65+	690	885	7,770	1,500
NF Level of Care-Under 65	420	2,040	8,115	1,530
Community Well-65+	18,585	28,710	94,185	23,895
Community Well-Under 65	28,440	47,565	99,240	22,140
	Composite Base Benefit Expense			**Case Mix**
	FFS Enroll	**ICO Enroll**		**Adjustment**
Nursing Subtier A-65+	$ 6,111.84	$ 6,095.83		0.9974
Nursing Subtier A-Under 65	5,467.84	5,466.84		0.9998
Nursing Subtier B-65+	10,252.58	9,931.85		0.9687
Nursing Subtier B-Under 65	10,058.54	9,815.98		0.9759
NF Level of Care-65+	107.74	105.67		0.9808
NF Level of Care-Under 65	131.82	128.22		0.9727
Community Well-65+	206.02	196.08		0.9518
Community Well-Under 65	172.46	168.02		0.9743

Appendix 4: CY 2020 Capitation Rate Development

State of Michigan Department of Health and Human Services
MI Health Link CY 2020 Capitation Rate Development
Demonstration Year 5 Rate Development

Region: All Demo Regions	Base Benefit Expense	Capitation Payments	NEMT Adjustment	Selection Factor	Hearing Aid	Transition Payment	Savings Percentage	Patient Pay Expense	Proposed ICO Effective Rate	Current ICO Effective Rate	Effective % Change	Estimated IPA PMPM
Nursing Subtier A												
Over 65	$ 6,095.83	$ 0.00	$ 0.00	1.000	$ 3.00	$ 0.00	0.030	$ 755.62	$ 6,671.48	$ 6,714.33	(0.6%)	$ 37.06
Under 65	5,466.84	-	-	1.000	1.00	-	0.030	584.76	5,888.57	6,026.92	(2.3%)	37.06
Subtotal Nursing Subtier A	**$ 5,988.07**	**$ 0.00**	**$ 0.00**		**$ 2.66**	**$ 0.00**		**$ 726.35**	**$ 6,537.35**	**$ 6,596.56**	**(0.9%)**	**$ 37.06**
Nursing Subtier B												
Over 65	$ 9,931.85	$ 0.00	$ 0.00	1.000	$ 3.00	$ 0.00	0.030	$ 1,072.51	$ 10,709.31	$ 10,391.54	3.1%	$ 37.06
Under 65	9,815.98	-	-	1.000	1.00	-	0.030	927.70	10,450.17	10,225.45	2.2%	37.06
Subtotal Nursing Subtier B	**$ 9,922.20**	**$ 0.00**	**$ 0.00**		**$ 2.83**	**$ 0.00**		**$ 1,060.44**	**$ 10,687.72**	**$ 10,377.70**	**3.0%**	**$ 37.06**
NF Level of Care												
Over 65	$ 105.67	$ 2,329.56	$ 0.00	1.000	$ 3.00	$ 5.59	0.030	$ 0.00	$ 2,370.50	$ 2,381.26	(0.5%)	$ 37.06
Under 65	128.22	2,848.06	-	1.000	1.00	6.44	0.030	-	2,894.21	2,891.03	0.1%	37.06
Subtotal NF Level of Care	**$ 117.57**	**$ 2,603.04**	**$ 0.00**		**$ 1.95**	**$ 6.04**		**$ 0.00**	**$ 2,646.73**	**$ 2,650.14**	**(0.1%)**	**$ 37.06**
FFS-Community Well												
Over 65	$ 196.08	$ 0.00	$ 11.28	0.850	$ 1.00	$ 0.73	0.030	$ 0.00				
Under 65	168.02	-	11.27	0.850	0.50	0.73	0.030	-				
Subtotal FFS-Community Well	**$ 181.77**	**$ 0.00**	**$ 11.27**		**$ 0.75**	**$ 0.73**		**$ 0.00**				
MHP-Community Well												
Over 65	$ 89.22	$ 74.62	$ 0.00	1.000	$ 1.00	$ 0.00	0.030	$ 0.00				
Under 65	77.91	74.62	-	1.000	0.50	-	0.030	-				
Subtotal MHP-Community Well	**$ 82.39**	**$ 74.62**	**$ 0.00**		**$ 0.70**	**$ 0.00**		**$ 0.00**				
Community Well												
Over 65									$ 168.63	$ 152.56	10.5%	$ 37.06
Under 65									148.79	132.71	12.1%	37.06
Subtotal Community Well									**$ 157.83**	**$ 141.76**	**11.3%**	**$ 37.06**
Total									**$ 600.17**	**$ 587.27**	**2.2%**	**$ 37.06**

Regional Adjustment Factors (on Proposed Rate)

Demonstration Region	Nursing Facility - Subtier A	Nursing Facility - Subtier B	Waiver (NF Level of Care)	Community Well
Region 1	98.9%	99.4%	100.0%	89.0%
Region 4	99.3%	106.2%	100.4%	93.0%
Region 7	99.6%	100.8%	99.9%	104.1%
Region 9	102.8%	101.4%	100.3%	105.4%

Appendix 5: Trend Analysis

State of Michigan, Department of Health and Human Services
MI Health Link CY 2020 Capitation Rate Development
Prospective Trend Analysis
All Demonstration Regions; Normalized Population Case Mix

		12x2 Rolling Median Adjusted Util/1000				
Incurred Month	**Member Months**	*Nursing Facility*	*Inpatient Hospital*	*Outpatient Hospital*	*Prescription Drugs*	*Physician*
4/1/2017	165,227	33,473.9	1,397.1	541.6	4,782.0	268,624.9
5/1/2017	165,043	33,473.9	1,410.2	652.1	4,825.0	269,170.8
6/1/2017	164,750	33,473.9	1,416.6	752.7	4,906.8	269,170.8
7/1/2017	164,874	33,473.9	1,416.6	840.9	4,906.8	269,170.8
8/1/2017	165,184	33,548.6	1,418.6	929.1	4,906.8	268,187.0
9/1/2017	165,268	33,711.6	1,418.6	940.4	4,884.6	265,630.7
10/1/2017	165,612	33,816.4	1,423.1	1,003.6	4,854.8	264,630.4
11/1/2017	165,143	33,816.4	1,423.9	1,025.0	4,825.0	264,630.4
12/1/2017	165,221	33,908.5	1,424.7	1,026.9	4,782.0	263,630.1
1/1/2018	165,902	33,908.5	1,434.5	1,091.7	4,145.5	263,351.3
2/1/2018	164,897	33,915.2	1,449.5	1,106.9	4,111.6	263,109.2
3/1/2018	164,895	33,915.2	1,449.7	1,110.9	4,052.8	263,109.2
4/1/2018	164,294	33,890.9	1,449.7	1,114.9	4,052.0	261,662.9
5/1/2018	162,482	33,890.9	1,449.7	1,133.5	4,051.3	260,280.0
6/1/2018	162,671	33,890.9	1,449.5	1,133.5	3,999.5	260,280.0
7/1/2018	162,828	34,070.3	1,442.0	1,133.5	3,965.9	260,280.0
8/1/2018	162,642	34,094.6	1,442.0	1,133.5	3,965.9	260,585.5
9/1/2018	162,432	34,094.6	1,442.0	1,133.5	3,932.3	262,481.6
10/1/2018	163,010	34,094.6	1,434.5	1,133.5	3,924.6	263,843.2
11/1/2018	162,350	34,094.6	1,433.6	1,133.5	3,938.4	264,511.1
12/1/2018	161,187	34,118.9	1,432.8	1,133.5	3,916.8	265,178.9
1/1/2019	162,498	34,131.5	1,417.7	1,133.5	3,910.6	265,284.7
2/1/2019	162,603	34,364.0	1,407.4	1,133.5	3,910.6	267,542.8
3/1/2019	161,713	34,531.5	1,398.3	1,152.0	3,916.8	269,800.8
Low Estimate		**4.76%**	**(2.18%)**	**0.04%**	**(7.18%)**	**(0.03%)**
High Estimate		**5.01%**	**(0.88%)**	**4.64%**	**(2.04%)**	**0.96%**
Selected Trend		**2.00%**	**1.00%**	**3.00%**	**0.50%**	**0.25%**

State of Michigan, Department of Health and Human Services
MI Health Link CY 2020 Capitation Rate Development
Prospective Trend Analysis
All Demonstration Regions; Normalized Population Case Mix

		12x2 Rolling Median Adjusted CPS				
Incurred Month	**Member Months**	*Nursing Facility*	*Inpatient Hospital*	*Outpatient Hospital*	*Prescription Drugs*	*Physician*
4/1/2017	165,227	$ 170.48	$ 251.34	$ 926.51	$ 11.48	$ 1.09
5/1/2017	165,043	171.33	248.32	778.67	12.73	1.10
6/1/2017	164,750	171.65	247.19	687.93	12.62	1.10
7/1/2017	164,874	171.97	247.39	631.41	12.75	1.10
8/1/2017	165,184	172.26	247.04	583.86	12.75	1.10
9/1/2017	165,268	172.09	246.65	589.08	12.81	1.12
10/1/2017	165,612	171.94	245.34	565.21	12.89	1.13
11/1/2017	165,143	172.32	246.13	561.66	12.83	1.14
12/1/2017	165,221	171.89	247.03	562.11	12.84	1.17
1/1/2018	165,902	171.89	245.35	530.18	14.18	1.18
2/1/2018	164,897	173.54	242.81	524.44	14.21	1.18
3/1/2018	164,895	174.40	242.77	523.16	14.13	1.20
4/1/2018	164,294	174.52	242.44	521.28	13.98	1.23
5/1/2018	162,482	175.15	242.44	513.35	13.89	1.24
6/1/2018	162,671	175.15	242.48	513.36	14.07	1.24
7/1/2018	162,828	174.46	243.75	513.36	14.23	1.24
8/1/2018	162,642	174.50	243.75	513.36	14.33	1.24
9/1/2018	162,432	174.50	244.08	513.36	14.56	1.23
10/1/2018	163,010	174.99	245.35	513.37	14.64	1.22
11/1/2018	162,350	175.26	244.83	518.37	14.71	1.22
12/1/2018	161,187	178.62	242.24	519.45	14.84	1.24
1/1/2019	162,498	179.40	244.65	525.79	15.16	1.26
2/1/2019	162,603	179.82	247.03	531.81	15.81	1.25
3/1/2019	161,713	180.18	248.63	535.57	15.84	1.24
Low Estimate		**1.47%**	**0.60%**	**(2.86%)**	**6.42%**	**(3.03%)**
High Estimate		**2.18%**	**1.42%**	**9.47%**	**9.86%**	**(1.25%)**
Selected Trend		**2.50%**	**0.50%**	**2.00%**	**4.50%**	**0.25%**

State of Michigan, Department of Health and Human Services
MI Health Link CY 2020 Capitation Rate Development
Prospective Trend Analysis
All Demonstration Regions; Normalized Population Case Mix

		12x2 Rolling Median Adjusted PMPM				
Incurred Month	**Member Months**	*Nursing Facility*	*Inpatient Hospital*	*Outpatient Hospital*	*Prescription Drugs*	*Physician*
4/1/2017	165,227	$ 475.56	$ 29.26	$ 41.82	$ 4.57	$ 24.46
5/1/2017	165,043	477.91	29.18	42.31	5.12	24.69
6/1/2017	164,750	478.81	29.18	43.15	5.16	24.69
7/1/2017	164,874	479.70	29.20	44.25	5.21	24.69
8/1/2017	165,184	481.58	29.20	45.21	5.21	24.69
9/1/2017	165,268	483.46	29.16	46.16	5.21	24.69
10/1/2017	165,612	484.53	29.09	47.27	5.21	24.93
11/1/2017	165,143	485.61	29.20	47.97	5.16	25.03
12/1/2017	165,221	485.70	29.33	48.10	5.12	25.78
1/1/2018	165,902	485.70	29.33	48.23	4.90	25.88
2/1/2018	164,897	490.46	29.33	48.37	4.87	25.98
3/1/2018	164,895	492.89	29.33	48.43	4.77	26.38
4/1/2018	164,294	492.89	29.29	48.43	4.72	26.78
5/1/2018	162,482	494.67	29.29	48.49	4.69	26.82
6/1/2018	162,671	494.67	29.29	48.49	4.69	26.82
7/1/2018	162,828	495.31	29.29	48.49	4.70	26.82
8/1/2018	162,642	495.79	29.29	48.49	4.74	26.82
9/1/2018	162,432	495.79	29.33	48.49	4.77	26.82
10/1/2018	163,010	497.17	29.33	48.49	4.79	26.82
11/1/2018	162,350	497.94	29.25	48.96	4.83	26.97
12/1/2018	161,187	507.87	28.92	49.06	4.84	27.34
1/1/2019	162,498	510.28	28.90	49.66	4.94	27.89
2/1/2019	162,603	514.95	28.97	50.23	5.15	27.89
3/1/2019	161,713	518.49	28.97	51.42	5.17	27.89
Low Estimate		**6.22%**	**0.25%**	**7.52%**	**1.27%**	**(2.30%)**
High Estimate		**6.82%**	**0.84%**	**9.36%**	**6.35%**	**0.21%**
Selected Trend		**4.50%**	**1.50%**	**5.00%**	**5.00%**	**0.50%**

Appendix 6: Covered Services

State of Michigan, Department of Health and Human Services
MI Health Link CY 2020 Capitation Rate Development
List of Covered Services

Adult Day Program	Inpatient Hospital Psychiatric Admissions	Physician/Practitioner (PCP) Services
Ambulatory Surgical Centers	Inpatient Hospital Psychiatric Services	Podiatry Services
Anesthesia	Inpatient Hospital Services - Acute	Preventative Care and Screening
Assertive Community Treatment Program*	Laboratory, Diagnostic & X-ray	Preventive Nursing Services*
Assessments*	Medical Equipment and Supplies	Prevocational Services*
Behavior Treatment Review*	Adaptive Medical Equipment and Supplies	Private Duty Nursing*
Cardiac and Pulmonary Rehab	Assistive Technology*	Psychiatric Services
Certified Mid-Wife Services	Durable Medical Equipment	Respiratory Care
Childbirth and parenting classes	Enhanced Medical Equipment and Supplies*	Respite
Chiropractic Services	Medical Supplies	Restorative or Rehabilitative Nursing
Chore Services*	Prosthetics and Orthotics	Rural Health Clinic Services
Clubhouse Psychosocial Rehabilitation*	Medication Administration	Service Animals
Community Transition Services	Medication Review	Skill Building Assistance*
Crisis Services - Crisis Residential Services*	Mental Health Specialty Services- Non physician*	Substance Abuse
Crisis Services - Intense Crisis Stabilization Services*	Nursing Home Care: Custodial Care	Supported/Integrated Employment Services*
Dental	Nursing Home Care: Skilled Nursing & Rehabilitation services	Supports Coordination*
Diabetic Supplies and Services & Diabetic	Nursing Facility Mental Health Monitoring*	Targeted Case Management*
Diabetic Therapeutic Shoes and Inserts	Organ & Bone Marrow Transplant	Telemedicine
Emergency Services/Care	Other Health Care Professional Services	Therapy: Family
End Stage Renal Disease Services	Out-of-Home Non-vocational Habilitation*	Therapy: Inidividual or Group
Environmental Modifications*	Out-of-State Services	Therapy: Occupational
Eye Exams	Outpatient Blood Services	Therapy: Physical
Eye Wear	Outpatient Hospital Services	Therapy: Speech, Hearing and Language
Family Planning	Outpatient Mental Health Services	Tobacco cessation
Family Training*	Outpatient Partial Hospitalization Services	Transplants and Immunosuppressive Drugs
Fiscal Intermediary Services*	Peer-Delivered or Operated Support Services	Emergency Ambulance Transportation
Good and Services*	Personal Care and Personal Care Supplement	Non-emergency Medical Transportation
Health Services*	Personal Care Supplement	Non-Medical Transportation*
Hearing aids	Personal Care in Licensed Specialized Residential Setting*	Travel time for Home Help
Home Delivered Meals*	Personal Emergency Response System (PERS)	Treatment for STD
Home Health	Pharmacy	Treatment Planning*
Housing Assistance*	Pharmacy-Enhanced Pharmacy*	Urgent Care Clinic Services
Immunizations	Psychiatric Services	Wellness Visits (Annual Exams)

*Must meet level of care requirements

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