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CY 2017 Medicare-Medicaid Joint Rate Report
May 17, 2017

The State of Michigan, in conjunction with the Centers for Medicare and Medicaid Services (CMS), is releasing the Medicare and Medicaid components of the CY 2017 rates for MI Health Link Demonstration.

The general principles of the rate development process for the Demonstration have been outlined in the three-way contract between CMS, Michigan, and the participating health plans.

I. Components of the Capitation Rate

CMS and Michigan will each contribute to the global capitation payment. CMS and Michigan will each make monthly payments to Integrated Care Organizations (ICOs) for their components of the capitated rate. ICOs will receive three monthly payments for each enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services, one amount from CMS reflecting coverage of Medicare Part D services, and a third amount from Michigan reflecting coverage of Medicaid services. A separate payment will be made from Michigan to Prepaid Inpatient Health Plans (PIHPs) for coverage of behavioral health services and certain services for people with intellectual/developmental disabilities.

The Medicare Parts A/B rate component will be risk adjusted using the prevailing Medicare Advantage CMS-HCC and CMS HCC-ESRD models. The Medicare Part D payment will be risk adjusted using the Part D RxHCC model. To adjust the Medicaid component, Michigan assigns each enrollee to a rate cell according to the individual enrollee's nursing facility level of care status, geographic region, and age.

Section II of this report provides information on the Michigan Medicaid component of the capitation rate. Section III includes the Medicare Parts A/B and Medicare Part D components of the rate. Section IV includes information on the savings percentages and quality withhold. Section V includes information on risk mitigation.

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II. Michigan Medicaid Component of the Rate – CY 2017

This section provides an overview of the capitation rate development for the Medicaid component of the MI Health Link program for CY 2017 and has been developed to address the requirements outlined under 42 CFR 438.4 (a) related to actuarial soundness of the capitation rates. The full version of the Medicaid capitation rate report can be found online at www.michigan.gov/mihealthlink >>> MI Health Link Resources Toolkit.

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 set consistent with 42 CFR 438.4(a) in combination with a qualification that the Medicare capitation rates were established by CMS and the Medicare and Medicaid composite savings percentages were established by the State and CMS.

Table 1 illustrates the proposed monthly capitation rates for each rate cell for the Demonstration program Medicaid benefits along with the projected enrollment for each rate cell during CY 2017. The 2% shared savings percentage for the second year of the program, as outlined in the Memorandum of Understanding (MOU), has been applied to these rates.

Table 1
State of Michigan
Department of Health and Human Services
MI Health Link Capitation Rates by Rate Cell
Effective January 1, 2017

Rate Cell	Estimated CY2017 Average Monthly Enrollment	Calendar Year 2017 Rates
Nursing Facility – Subtier A		
Over Age 65	1,664	$6,139.18
Under Age 65	220	$5,442.71
Over Age 65	217	$9,841.41
Under Age 65	14	$9,579.56
Over Age 65	222	$2,147.89
Under Age 65	162	$2,752.78
Over Age 65	14,293	$146.29
Under Age 65	20,892	$120.23

Please note:

- The capitation rates reflect the current benefit package approved by the State and CMS as of the date of this report for January 1, 2017 through December 31, 2017.

- Regional adjustment factors will be applied to the rates noted in Table 1.

- The Nursing Facility population is split into subtiers for publicly owned and privately owned nursing facilities.

- The Nursing Facility capitation rate 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 integrated care organizations (ICOs).

COVERED POPULATION

Target Population

The target population for the Demonstration program 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 Demonstration program will be 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 eligibles (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.

A transition case rate payment will be made after the transition of a Nursing Facility enrollee into a home or community setting (Waiver or Community tier).

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. Demonstration eligible individuals must not be enrolled in the State's MIChoice program. Milliman utilized current MIChoice 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 2017 MIChoice capitation payments and historical FFS costs for services that are not identified as a waiver service. The development of these rates is illustrated in Appendix 2 of the full Medicaid report.

Community Residents Population

This population includes all other qualifying individuals who were not previously categorized. This population is comprised of Demonstration-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 FFS experience and the capitation rates for the Duals Lite program. As certain services are not covered under the Duals Lite capitation rate, fee-for-service costs related to Duals Lite enrollees are also included in the development of this rate. These costs are illustrated separately from fee-for-service experience on non-HMO enrollees in Appendix 2 of the full Medicaid report.

EXPERIENCE DATA ADJUSTMENTS REFLECTED IN THE MEDICAID CAPITATION RATES

The base fee-for-service (FFS) experience for state fiscal year 2015 (October 1, 2014 to September 30, 2015) paid through March 2016 was adjusted for the following components to utilize in the Medicaid portion of the Demonstration capitation rates:

- Trend
  - Trend rate assumptions were developed for the populations and services covered under the proposed Dual Demonstration program based on claims experience data from SFY 2013 to 2015.
- Completion
  - Completion factors were developed by rate cell and applied to base data at the provider type level. Average adjustments were used for each fiscal year to account for claims run-out applicable to each of the experience periods.
- Policy and program changes (both historical and prospective)

- Adjustments were made for known policy and program changes that were made by MDHHS during the historical base experience period.

- Risk Selection
  - Prospective risk selection factors were applied to the base data in order to reflect the voluntary and opt-out nature of the Demonstration. These selection factors were developed by blending previous selection factors developed from using claims probability distributions (CPDs) by population and applying penetration assumptions by cost category, and SFY 2014 experience cost relationships between members enrolled in the MI Health Link program and all eligible Community residents. The selection factors for the CY 2017 MI Health Link rates are consistent with those applied in the CY 2016 MI Health Link rates.

A comprehensive description of the adjustments utilized in the capitation rate-setting process, as well as the actual factors that were applied by category of service, population and applicable time period are available in the full Medicaid report at www.michigan.gov/mihealthlink >>> MI Health Link Resources Toolkit

DATA RELIANCE

The following information was provided by MDHHS to develop the actuarially sound capitation rates for the January 1, 2017 – December 31, 2017 contract period.

- Detailed fee-for-service claims data incurred October 1, 2014 through September 30, 2015, and paid through March 2016.
- Detailed fee-for-service enrollment data for period October 1, 2014 through September 30, 2015.
- Managed care capitation rates paid to the health plans serving enrollees in the Duals Lite and MIChoice managed care programs.
- Additional gross adjustment expenditure information outside the MMIS claims system.
- Summary of policy and program changes through state fiscal year 2016 (including changes to fee schedules and other payment rates).

Although the data was reviewed for reasonableness, the data was accepted without audit. To the extent the data was incomplete or was otherwise inaccurate, the information presented in this report will need to be modified. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter. MDHHS provides no guarantee, either written or implied, that the data and information is 100% accurate or error free. The capitation rates provided in this document will change to the extent that there are material errors in the information that was provided.

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III. Medicare Components of the Rate – CY 2017

Medicare A/B Services

CMS has developed baseline spending (costs absent the Demonstration) for Medicare A and B services using estimates of what Medicare would have spent on behalf of the enrollees absent the Demonstration. With the exception of specific subsets of enrollees as noted below, the Medicare baseline for A/B services is a blend of the Medicare Fee-for-Service (FFS) Standardized County Rates, as adjusted below, and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the target population that would otherwise be enrolled in each program in the absence of the Demonstration. The Medicare Advantage baseline spending includes costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.

Both baseline spending and payment rates under the Demonstration for Medicare A/B services are calculated as PMPM standardized amounts for each Demonstration county. Except as otherwise noted, the Medicare A/B portion of the baseline is updated annually based on the annual FFS estimates and benchmarks released each year with the annual Medicare Advantage and Part D rate announcement, and Medicare Advantage bids (for the applicable year or for prior years trended forward to the applicable year) for products in which potential Demonstration enrollees would be enrolled absent the Demonstration.

Medicare A/B Component Payments: CY 2017 Medicare A/B Baseline County rates are provided below.

The rates represent the weighted average of the CY 2017 FFS Standardized County Rates, updated to incorporate the adjustment noted below, and the Medicare Advantage projected payment rates for CY 2017 based on the expected enrollment of beneficiaries from Medicare FFS and Medicare Advantage prior to the demonstration start at the county level.

Please Note: *In CY 2016, CMS updated the FFS component of the Medicare A/B baseline rate to better align MI Health Link Plan payments with Medicare fee-for-service costs, by offsetting underprediction in the CMS-HCC risk adjustment model for full-benefit dual eligible beneficiaries in the community. In CY 2017 CMS will implement a new HCC risk adjustment model across all of Medicare Advantage, as well as for Medicare-Medicaid Plans, that will increase risk scores for community full-benefit dual eligible beneficiaries in order to address this underprediction issue. As a result, CMS will not be making such an adjustment to the FFS component of the Medicare A/B baseline in 2017. While this means that the standardized (non-risk adjusted) rates generally decline from CY 2016 to CY 2017, we expect these decreases will be offset by implementation of the new risk adjustment model.*

The FFS component of the CY 2017 Medicare A/B baseline rate has been updated to reflect a 1.74 % upward adjustment to account for the disproportionate share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS (in the absence of the Demonstration).

Coding Intensity Adjustment: CMS annually applies a coding intensity factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for CY 2017 in Medicare Advantage is 5.66%. For CY 2017, CMS will apply the full prevailing Medicare Advantage coding intensity adjustment and there will be no upward adjustment to the Medicare A/B baseline rates to offset this reduction in the risk scores.

Impact of Sequestration: Under sequestration, for services beginning April 1, 2013, Medicare payments to providers for individual services under Medicare Parts A and B, and non-exempt portions of capitated payments to Part C Medicare Advantage Plans and Part D Medicare Prescription Drug Plans are reduced by 2%. These reductions are also applied to the Medicare components of the integrated rate. Therefore, under the Demonstration CMS will reduce non-exempt portions of the Medicare components of the integrated rate by 2%, as noted in the sections below.

Default Rate: The default rate will be paid when a beneficiary's address on record is outside of the service area. The default rate is specific to each ICO and is calculated using an enrollment-weighted average of the rates for each county in which the ICO participates.

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2017 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County [1]					
County	**2017 Published FFS Standardized County Rate**	**2017 Updated Medicare A/B FFS Baseline** (updated by CY 2017 bad debt adjustment)	**2017 Updated Medicare A/B Baseline** (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	**2017 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 2% savings percentage)	**2017 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Alger	$799.92	$813.84	$813.45	$797.19	$781.25
Baraga	895.53	911.11	909.58	891.39	873.56
Barry	729.86	742.56	751.45	736.43	721.70
Berrien	755.52	768.67	769.09	753.71	738.64
Branch	789.04	802.77	803.10	787.04	771.30
Calhoun	761.15	774.39	775.70	760.19	744.99
Cass	790.45	804.20	804.90	788.80	773.02
Chippewa	827.14	841.53	840.17	823.37	806.90
Delta	723.26	735.84	740.48	725.67	711.16
Dickinson	756.54	769.70	772.23	756.79	741.65
Gogebic	745.21	758.18	760.52	745.31	730.40
Houghton	747.05	760.05	762.07	746.82	731.88
Iron	892.52	908.05	904.30	886.21	868.49
Kalamazoo	720.36	732.89	752.33	737.28	722.53
Keweenaw	790.65	804.41	808.77	792.59	776.74
Luce	936.80	953.10	949.98	930.98	912.36
Mackinac	857.76	872.69	872.02	854.58	837.49
Macomb	824.24	838.58	833.88	817.20	800.86

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2017 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County [1]					
County	**2017 Published FFS Standardized County Rate**	**2017 Updated Medicare A/B FFS Baseline** (updated by CY 2017 bad debt adjustment)	**2017 Updated Medicare A/B Baseline** (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	**2017 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 2% savings percentage)	**2017 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Marquette	$699.08	$711.24	$719.83	$705.43	$691.32
Menominee	726.79	739.44	742.57	727.72	713.17
Ontonagon	815.73	829.92	828.67	812.09	795.85
St. Joseph	735.31	748.10	748.25	733.28	718.61
Schoolcraft	855.49	870.38	868.56	851.18	834.16
Van Buren	778.65	792.20	794.26	778.38	762.81
Wayne	856.23	871.13	856.62	839.49	822.70

[1]Rates do not apply to beneficiaries with ESRD or those electing the Medicare hospice benefit. See Section IV for information on savings percentages.

Note: For CY 2017 CMS will apply the full prevailing Medicare Advantage coding intensity adjustment of 5.66%.

The Medicare A/B PMPMs above will be risk adjusted at the beneficiary level using the prevailing CMS-HCC risk adjustment model.

Beneficiaries with End-Stage Renal Disease (ESRD): Separate Medicare A/B baselines and risk adjustment models apply to enrollees with ESRD. The Medicare A/B baselines for beneficiaries with ESRD vary by the enrollee's ESRD status: dialysis, transplant, and functioning graft, as follows:

- **Dialysis**: For enrollees in the dialysis status phase, the Medicare A/B baseline is the CY 2017 Michigan ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2017 ESRD dialysis state rate for Michigan is $6,761.47 PMPM; the updated CY 2017 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $6,626.24 PMPM. This applies to applicable enrollees in all counties and will be risk adjusted using the prevailing HCC-ESRD risk adjustment model.

- **Transplant**: For enrollees in the transplant status phase (inclusive of the 3-months starting with the transplant), the Medicare A/B baseline is the CY 2017 Michigan ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2017 ESRD dialysis state rate for Michigan is $6,761.47 PMPM; the updated CY 2017 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $6,626.24 PMPM. This applies to applicable enrollees in all counties and will be risk adjusted using the prevailing HCC-ESRD risk adjustment model.

- **Functioning Graft:** For enrollees in the functioning graft status phase (beginning at 4 months post-transplant) the Medicare A/B baseline is the Medicare Advantage 3.5% bonus county rate/benchmark (see table below). This Medicare A/B component will be risk adjusted using the prevailing HCC-ESRD functioning graft risk adjustment model.

A savings percentage is not applied to the Medicare A/B baseline for enrollees with ESRD (inclusive of those enrollees in the dialysis, transplant and functioning graft status phases).

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2017 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	**2017 3.5% Bonus County Rate (Benchmark)**	**2017 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Alger	$823.77	$807.29
Baraga	895.53	877.62
Barry	863.06	845.80
Berrien	802.63	786.58
Branch	844.93	828.03
Calhoun	844.88	827.98
Cass	845.78	828.86
Chippewa	827.14	810.60
Delta	806.12	790.00
Dickinson	808.29	792.12
Gogebic	806.00	789.88
Houghton	806.11	789.99
Iron	892.52	874.67
Kalamazoo	871.47	854.04
Keweenaw	877.62	860.07
Luce	922.75	904.30
Mackinac	844.89	827.99
Macomb	853.09	836.03
Marquette	828.41	811.84
Menominee	808.45	792.28
Ontonagon	823.89	807.41
St. Joseph	769.26	753.87
Schoolcraft	855.49	838.38
Van Buren	862.35	845.10
Wayne	843.39	826.52

Beneficiaries Electing the Medicare Hospice Benefit: If an enrollee elects to receive the Medicare hospice benefit, the enrollee will be disenrolled from the Demonstration. *Please note: This part of the rate report will be updated once the pending three-way contract amendment is finalized.*

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Medicare Part D Services

The Part D plan payment is the risk adjusted Part D national average monthly bid amount (NAMBA) for the payment year, adjusted for payment reductions resulting from sequestration applied to the non-premium portion of the NAMBA. The non-premium portion is determined by subtracting the applicable regional Low-Income Premium Subsidy Amount from the risk adjusted NAMBA. To illustrate, the NAMBA for CY 2017 is $61.08 and the CY 2017 Low-Income Premium Subsidy Amount for Michigan is $34.17. Thus, the updated Michigan Part D monthly per member per month payment for a beneficiary with a 1.0 RxHCC risk score applicable for CY 2017 is $60.54. This amount incorporates a 2% sequestration reduction to the non-premium portion of the NAMBA.

CMS will pay an average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be 100% cost reconciled after the payment year has ended. These prospective payments will be the same for all counties, and are shown below.

- Michigan low income cost-sharing: $172.00 PMPM
- Michigan reinsurance: $127.74 PMPM

The low-income cost sharing and reinsurance subsidy amounts are exempt from mandatory payment reductions under sequestration.

A savings percentage will not be applied to the Part D component of the rate. Part D payments will not be subject to a quality withhold.

Additional Information: More information on the Medicare components of the rate under the Demonstration may be found online at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf

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IV. Savings Percentages and Quality Withholds

Savings Percentages

One of the components of the capitated financial alignment model is the application of aggregate savings percentages to reflect savings achievable through the coordination of services across Medicare and Medicaid. This is reflected in the rates through the application of aggregate savings percentages to both the Medicaid and Medicare A/B components of the rates.

CMS and Michigan established composite savings percentages for each year of the Demonstration as shown in the table below. The savings percentage will be applied to the Medicaid and Medicare A/B components of the rates, uniformly to all population groups, unless otherwise noted in this report. The savings percentage will not be applied to the Part D component of the joint rate.

Year	Calendar Dates	Savings Percentage
Demonstration Year 1	March 1, 2015 - December 31, 2016	1%
Demonstration Year 2	January 1, 2017 – December 31, 2017	2%
Demonstration Year 3	January 1, 2018 – December 31, 2018	4%

Note: In the event that at least one-third of ICOs experience losses in Demonstration Year 1 exceeding 3% of revenue, the savings percentage for Demonstration Year 3 will be reduced to 3%. CMS and the State will make such a determination following completion of the Demonstration Year 1 risk corridor calculation.

Quality Withhold

In Demonstration Year 1, a 1% quality withhold will be applied to the Medicaid and Medicare A/B components of the rate. The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3.

More information about the DY 1 quality withhold methodology is available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf.

More information about the DY 2 and 3 quality withhold methodology is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY2and3QualityWithholdGuidance042916.pdf.