

Michigan Demonstration to Integrate Care for Persons Eligible for Medicare and Medicaid CY 2020 Final Medicare-Medicaid Rate Report March 13, 2020

The Centers for Medicare and Medicaid Services (CMS), in conjunction with the State of Michigan, is releasing the final Medicare and Medicaid component of the CY 2020 rates for the 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.

Included in this report are the final CY 2020 Medicaid rates and Medicare county base rates.

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.

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II. Michigan Medicaid Component of the Rate – CY 2020

This section provides an overview of the capitation rate development for the Medicaid component of the MI Health Link program for CY 2020 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 monthly capitation rates for each rate cell for the Demonstration program Medicaid benefits along with the projected enrollment for each rate cell during CY 2020. The 3% shared savings percentage for the fifth 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, 2020		
Rate Cell	Estimated CY2020 Average Monthly Enrollment	Calendar Year 2020 Rates
Nursing Facility – Subtier A		
Over Age 65	1,150	\$6,671.48
Under Age 65	240	\$5,888.57
Nursing Facility – Subtier B		
Over Age 65	110	\$10,709.31
Under Age 65	10	\$10,450.17
Nursing Facility LOC-Waiver		
Over Age 65	900	\$2,370.50
Under Age 65	1,010	\$2,894.21
Community Residents		
Over Age 65	13,780	\$168.63
Under Age 65	16,450	\$148.79

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, 2020 through December 31, 2020.

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- 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, the state 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).
- 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 and vary by ICO. The IPA amounts estimated for CY 2020 are included in Appendix 4 of the Medicaid report.
- There is no allocation in the rate development for purposes of the Health Insurer Fee (HIF) outside of the potential piece attributed to the Medicare-Medicaid Eligible (MME) Duals Lite capitation portion of the rate documented in Appendix 4 of the Medicaid report. After the actual amount of the HIF is known for the MI Health Link program, the capitation rates will be retrospectively adjusted as appropriate to include the HIF.

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;

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- 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 the State 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. The population was identified in the capitation rate-setting process by using fields in the State's 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, the State 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, beneficiaries residing in a hospital long-term care unit were moved to Subtier B to better align with historical costs.

Payments associated with members transitioning from a Nursing Facility into a home or community setting are prospectively incorporated in the applicable rates (Waiver or Community tier) noted in Table 1.

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 1915(c) MIChoice Waiver program. The State 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 2020 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 4 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 the 1915(c) MIChoice Waiver program. The development of the capitation rates for this population is a blend of historical FFS experience and the SFY 2020 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 4 of the full Medicaid report.

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EXPERIENCE DATA ADJUSTMENTS REFLECTED IN THE MEDICAID CAPITATION RATES

The base fee-for-service (FFS) experience for state fiscal year 2018 (October 1, 2017 to September 30, 2018) paid through October 2019 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 2016 to 2018.
- 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 the State during the historical base experience period and those that have taken effect by or will take effect in CY 2020.
- Risk Selection
 - Community Well - Prospective risk selection factors were applied to the base data in order to reflect the voluntary and opt-out nature of the Demonstration. Based on the lack of FFS data for MI Health Link enrollees in the SFY 2018 experience, the state developed a blended selection factor for the CY 2020 rate development process based on a 50% mix of the historical rate setting selection factor and a 1.000, resulting in a 0.85 selection factor applied to the benefit expense. This is to reflect that the historical experience utilized to develop the original selection factors is no longer an appropriate timeframe to utilize independently.

A comprehensive description of the adjustments utilized in the capitation rate-setting process, as well as the 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 the State to develop the actuarially sound capitation rates for the January 1, 2020 – December 31, 2020 contract period.

- Detailed fee-for-service claims data incurred October 1, 2017 through September 30, 2018, and paid through October 2019.
- Detailed fee-for-service enrollment data for period October 1, 2017 through September 30, 2018.

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- Managed care capitation rates paid to the health plans serving enrollees in the Medicare-Medicaid Eligible (MME) Duals Lite and MIChoice managed care programs.
- Additional gross adjustment expenditure information outside the MMIS claims system.
- Summary of policy and program changes through calendar year 2020 (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. The State 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 2020

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 enrolled population in each program prior to 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 Demonstration enrollees were enrolled prior Demonstration.

Medicare A/B Component Payments: Final CY 2020 Medicare A/B Baseline County rates are provided below.

The final rates represent the weighted average of the CY 2020 FFS Standardized County Rates, updated to incorporate the adjustment noted below, and the Medicare Advantage projected payment rates for CY 2020 based on the actual enrollment of beneficiaries from Medicare FFS and Medicare Advantage prior to the demonstration at the county level.

Bad Debt Adjustment: The FFS component of the CY 2020 Medicare A/B baseline rate has been updated to reflect a 1.87% 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 2020, as in Medicare Advantage, is 5.90%.

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-

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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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2020 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County¹					
County	2020 Published FFS Standardized County Rate	2020 Updated Medicare A/B FFS Baseline (updated by CY 2020 bad debt adjustment)	2020 Medicare A/B Baseline (incorporating Medicare A/B FFS baseline and Medicare Advantage component)	2020 Medicare A/B Baseline PMPM, Savings Percentage Applied (after application of 3% savings percentage)	2020 Final Medicare A/B PMPM Payment (2% sequestration reduction applied and prior to quality withhold)
Alger	\$954.79	\$972.64	\$970.46	\$941.35	\$922.52
Baraga	1,058.63	1,078.43	1,073.53	1,041.32	1,020.49
Barry	823.95	839.36	858.40	832.65	816.00
Berrien	844.01	859.79	861.41	835.57	818.86
Branch	888.25	904.86	905.66	878.49	860.92
Calhoun	849.47	865.36	869.69	843.60	826.73
Cass	869.96	886.23	891.08	864.35	847.06
Chippewa	891.50	908.17	907.33	880.11	862.51
Delta	839.05	854.74	858.58	832.82	816.16
Dickinson	910.90	927.93	923.95	896.23	878.31
Gogebic	895.50	912.25	910.08	882.78	865.12
Houghton	887.85	904.45	903.07	875.98	858.46
Iron	1,065.57	1,085.50	1,075.59	1,043.32	1,022.45
Kalamazoo	813.62	828.83	841.96	816.70	800.37
Keweenaw	959.45	977.39	976.49	947.20	928.26
Luce	1,015.40	1,034.39	1,026.34	995.55	975.64
Mackinac	1,012.14	1,031.07	1,023.81	993.10	973.24
Macomb	919.13	936.32	911.96	884.60	866.91
Marquette	840.99	856.72	863.42	837.52	820.77

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2020 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County¹					
County	2020 Published FFS Standardized County Rate	2020 Updated Medicare A/B FFS Baseline (updated by CY 2020 bad debt adjustment)	2020 Medicare A/B Baseline (incorporating Medicare A/B FFS baseline and Medicare Advantage component)	2020 Medicare A/B Baseline PMPM, Savings Percentage Applied (after application of 3% savings percentage)	2020 Final Medicare A/B PMPM Payment (2% sequestration reduction applied and prior to quality withhold)
Menominee	\$846.39	\$862.22	\$867.41	\$841.39	\$824.56
Ontonagon	914.01	931.10	929.66	901.77	883.73
St. Joseph	845.61	861.42	862.38	836.51	819.78
Schoolcraft	1,003.13	1,021.89	1,016.99	986.48	966.75
Van Buren	884.64	901.18	903.47	876.37	858.84
Wayne	939.23	956.79	927.15	899.34	881.35

¹Rates do not apply to beneficiaries with ESRD or those electing the Medicare hospice benefit.

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

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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 2020 Michigan ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2020 ESRD dialysis state rate for Michigan is \$7,439.92 PMPM; the updated CY 2020 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$7,291.12 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 2020 Michigan ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2020 ESRD dialysis state rate for Michigan is \$7,439.92 PMPM; the updated CY 2020 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$7,291.12 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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2020 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	2020 3.5% bonus County Rate (Benchmark)	2020 Sequestration-Adjusted Medicare A/B Baseline (after application of 2% Sequestration reduction)
Alger	\$988.21	\$968.45
Baraga	1,042.75	1,021.90
Barry	1,005.22	985.12
Berrien	914.28	895.99
Branch	973.13	953.67
Calhoun	974.77	955.27
Cass	996.10	976.18
Chippewa	922.70	904.25
Delta	924.78	906.28
Dickinson	927.99	909.43
Gogebic	925.45	906.94
Houghton	925.04	906.54
Iron	1,049.59	1,028.60
Kalamazoo	992.62	972.77
Keweenaw	993.03	973.17
Luce	1,000.17	980.17
Mackinac	996.96	977.02
Macomb	951.30	932.27
Marquette	967.92	948.56
Menominee	929.04	910.46
Ontonagon	946.00	927.08
St. Joseph	884.79	867.09
Schoolcraft	988.08	968.32
Van Buren	1,005.83	985.71
Wayne	972.10	952.66

Beneficiaries Electing the Medicare Hospice Benefit: If an existing ICO enrollee elects hospice services, the enrollee may remain enrolled in the Demonstration and will only be disenrolled at the Enrollee’s request, or under the terms of the three-way contract, Section 4.2.2.2.5.

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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 2020 is \$47.59 and the CY 2020 Low-Income Premium Subsidy Amount for Michigan is \$30.15. 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 2020 is \$47.24. 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: \$185.64 PMPM
- Michigan reinsurance: \$137.12 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. 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	3%
Demonstration Year 4	January 1, 2019 – December 31, 2019	3%
Demonstration Year 5	January 1, 2020– December 31, 2020	3%

Quality Withhold

The quality withhold is 3% in Demonstration Years 3-5.

More information about the quality withhold methodology is available in the CMS core and state-specific quality withhold technical notes, which are posted at the following link:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html>.