State Fiscal Year 2025 Medicaid Managed Care Capitation Rate Certification

October 1, 2024 through September 30, 2025

State of Michigan Department of Health and Human Services

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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 capitation rates for its Medicaid Managed Care Program effective October 1, 2024. The rates being certified in this report are for the traditional managed care health plan program (MHP), Children's Special Health Care Services (CSHCS), and Healthy Michigan Plan (HMP) populations. Upon approval, these rates will be in effect for 12 months through September 30, 2025.

This letter provides documentation for the development of the actuarially sound capitation rates. It also includes the required actuarial certification in Appendix 1.

To facilitate review, this document has been organized in the same manner as the 2024-2025 Medicaid Managed Care Rate Development Guide, released by the Centers for Medicare and Medicaid Services in January 2024 (CMS guide) along with the rate guide addendum issued in June 2024. Section II of the CMS guide is not applicable to this certification as the covered populations and services do not include long-term services and supports (Section II). Section III of the CMS Guide is only applicable to the HMP population in this certification.

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; and,
- The documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 C.F.R. § 438 and generally accepted actuarial principles and practices.

SUMMARY OF CAPITATION RATES

The capitation rates for the different managed care programs covered under this certification are documented in Appendix 2. These rates are effective for SFY 2025, from October 1, 2024 through September 30, 2025. Tables 1a and 1b provide a comparison of the SFY 2025 rates relative to the average capitation rates effective April 2024 (April 1, 2024 to September 30, 2024) for the different populations. The rates noted in Table 1a reflect base claims costs plus amounts for non-benefit expenses. The comparison of capitation rates in Table 1b includes additional amounts that will be handled on a retrospective basis related to the insurance provider assessment (IPA), graduate medical education (GME), specialty network access fee (SNAF), and hospital reimbursement adjustment (HRA). The composite rates illustrated in these tables have been developed based on estimated average monthly enrollment for SFY 2025.

TABLE 1A: COMPARISON OF PMPM MCO EFFECTIVE RATES

POPULATION	AVERAGE MONTHLY ENROLLMENT	APRIL 2024 RATES	PROPOSED SFY 2025 RATES	PERCENT CHANGE
TANF/Program L	1,030,750	$ 188.83	$ 201.54	6.7%
Aged, Blind, and Disabled	137,400	942.51	1,008.35	7.0%
Dual Eligibles (MME)	33,200	98.66	103.81	5.2%
CSHCS	29,950	1,507.37	1,551.08	2.9%
Healthy Michigan	573,400	461.95	518.58	12.3%
Maternity Case Rate	3,200	6,529.98	6,082.73	(6.8%)
Composite	**1,804,700**	**$ 364.79**	**$ 395.08**	**8.3%**

Notes:

1. April 2024 and SFY 2025 composite rates were developed with average monthly projected enrollment.
2. Values shown in Table 1a do not reflect adjustments related to GME, SNAF, HRA, IPA.
3. Monthly enrollment values are rounded to the nearest fifty.
4. Maternity enrollment represents projected delivery counts across all programs and are not included in the composite enrollment figure.
5. Maternity rates reflect per delivery case rates.

TABLE 1B: COMPARISON OF FULLY LOADED PMPM CAPITATION RATES

Population	AVERAGE MONTHLY ENROLLMENT	APRIL 2024 RATES	PROPOSED SFY 2025 RATES	PERCENT CHANGE
TANF/Program L	1,030,750	$ 345.35	$ 356.57	3.2%
Aged, Blind, and Disabled	137,400	1,602.26	1,667.76	4.1%
Dual Eligibles (MME)	33,200	119.26	127.24	6.7%
CSHCS	29,950	2,816.06	2,807.82	(0.3%)
Healthy Michigan	573,400	819.06	893.11	9.0%
Maternity Case Rate	3,200	13,797.38	13,227.55	(4.1%)
Composite	**1,804,700**	**$ 652.86**	**$ 686.78**	**5.2%**

Notes:

1. April 2024 and SFY 2025 Composite rates were developed with monthly projected enrollment.
2. Monthly enrollment values are rounded to the nearest fifty.
3. Maternity enrollment represents projected delivery counts across all programs and are not included in the composite member month figure.
4. Maternity rates reflect per delivery case rates.
5. Amounts for HRA, GME and SNAF are for illustrative purposes only and subject to change with final certification.

FISCAL IMPACT ESTIMATE

The estimated fiscal impact of the SFY 2025 capitation rates documented in this report represents a $734.7 million increase to aggregate expenditures, based on the PMPM rates noted in Table 1b and the same enrollment assumptions for both rating periods. These amounts are on a state and federal expenditure basis using the average projected monthly enrollment for SFY 2025 which represents an overall decrease in projected enrollment from SFY 2024. Tables 2a and 2b provide the development of estimated total expenditures, as well as federal only expenditures, under the current contracted capitation rates and the proposed SFY 2025 capitation rates illustrated in Tables 1a and 1b. The federal expenditures illustrated in Tables 2a and 2b are based on the Federal Fiscal Year 2025 FMAP of 65.13% for non-HMP populations and 90% for HMP. Enhanced federal match for family planning services, the CHIP population and other applicable services are not reflected in the federal values noted in Tables 2a and 2b.

TABLE 2A: COMPARISON OF MCO EFFECTIVE RATES (AGGREGATE EXPENDITURES $ MILLIONS)

POPULATION	APRIL 2024	PROJECTED SFY 2025	TOTAL CHANGE	PERCENT CHANGE
TANF/Program L	$ 2,335.6	$ 2,492.8	$ 157.2	6.7%
Aged, Blind, and Disabled	1,554.0	1,662.5	108.5	7.0%
Dual Eligibles (MME)	39.3	41.4	2.1	5.2%
CSHCS	541.7	557.5	15.7	2.9%
Healthy Michigan	3,178.6	3,568.2	389.6	12.3%
Maternity Case Rate	250.8	233.6	(17.2)	(6.8%)
Composite	**$ 7,900.0**	**$ 8,556.0**	**$ 655.9**	**8.3%**
Federal	5,951.1	6,474.1	523.0	8.8%
State	1,948.9	2,081.9	133.0	6.8%

Notes:
1. April 2024 and SFY 2025 expenditures were developed with SFY 2025 projected enrollment.
2. Values are rounded.
3. Values shown in Table 2a exclude amounts related to GME, SNAF, HRA, and IPA.
4. State expenditures based on Federal Fiscal Year (FFY) 2025 FMAP of 65.13%
5. State expenditures based on FMAP of 90% for the HMP population.

TABLE 2B: COMPARISON OF FULLY LOADED RATES (AGGREGATE EXPENDITURES $ MILLIONS)

POPULATION	APRIL 2024	PROJECTED SFY 2025	TOTAL CHANGE	PERCENT CHANGE
TANF/Program L	$ 4,271.6	$ 4,410.4	$ 138.8	3.2%
Aged, Blind, and Disabled	2,641.8	2,749.8	108.0	4.1%
Dual Eligibles (MME)	47.5	50.7	3.2	6.7%
CSHCS	1,012.1	1,009.1	(3.0)	(0.3%)
Healthy Michigan	5,635.8	6,145.3	509.5	9.0%
Maternity Case Rate	529.8	507.9	(21.9)	(4.1%)
Composite	**$ 14,138.6**	**$ 14,873.3**	**$ 734.7**	**5.2%**
Federal	10,642.2	11,245.9	603.7	5.7%
State	3,496.4	3,627.4	130.9	3.7%

Notes:
1. April 2024 and SFY 2025 expenditures were developed with SFY 2025 projected enrollment.
2. Values are rounded.
3. State expenditures based on Federal Fiscal Year (FFY) 2025 FMAP of 65.13%
4. State expenditures based on FMAP of 90% for the HMP population.
5. Amounts for HRA, GME and SNAF are for illustrative purposes only and subject to change with final certification.

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 C.F.R. § 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 C.F.R. § 438.4(b).

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 No. 1 (Introductory Actuarial Standard of Practice); ASOP No. 5 (Incurred Health and Disability Claims); ASOP No. 12 (Risk Classification); ASOP No. 23 (Data Quality); ASOP No. 25 (Credibility Procedures); ASOP No. 41 (Actuarial Communications); ASOP No. 45 (The Use of Health Status Based Risk Adjustment Methodologies); ASOP No. 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP No. 56 (Modeling).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the SFY 2025 managed care program rating period.
- The most recent CMS guide published by CMS in January 2024 and addendum in June 2024.
- Throughout this document and consistent with the requirements under 42 C.F.R. 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*."

A. RATE DEVELOPMENT STANDARDS

i. Rate Ranges

All standards and documentation expectations outlined in this rate certification report are applicable for the certified capitation rates and there is no proposed rate range.

ii. Annual basis

The actuarial certification contained in this report is effective for the capitation rates for the one-year rate period from October 1, 2024 through September 30, 2025.

iii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Christopher T. 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 C.F.R. §438 that are effective for the SFY 2025 managed care program rating period.

(b) Certified capitation rates for each rate cell

The certified capitation rates by rate cell are illustrated in Appendix 2. Projected membership and delivery counts illustrated in Appendix 2 represent estimated values for the rating period. These rates represent the contracted capitation rates prior to application of separate factors for regional and risk adjustment.

(c) Program information

(i) Managed Care program

This certification was developed for the State of Michigan's managed care programs listed below which are delivered on a statewide basis. The state has contracted with 9 separate managed care organizations (MCOs) to service the noted populations.

- Medicaid Managed Care Health Plan (MHP)
  Under this program, comprehensive services are provided through managed care organizations on a statewide basis. The populations included in this program are the Temporary Assistance for Needy Families (TANF), children and Pregnant women (Program L), Blind and Disabled, Medicare-Medicaid dually eligible (MME), and Maternity Case Rate payments associated with these populations are also included.

  The MME population was added to the managed care program in November 2011, while the remaining populations have been in a managed care arrangement for over 20 years. Benefits covered under the MHP program are comprehensive in nature, with certain behavioral health services, prescription drugs, and dental services provided under a different managed care contract or on a fee-for-service basis. Additional long-term care supports and services are also not included under these capitation rates. Further detail on covered services may be found in Table 3 of this report.

- Children's Special Health Care Services (CSHCS)
  CSHCS is a program for children and select adults with special health care needs. The CSHCS population has been under a managed care arrangement since October 2012. Benefits covered under the CSHCS program are comprehensive in nature, with certain behavioral health services, prescription drugs, and dental services provided under a different managed care contract or on a fee-for-service basis. Additional long-term care supports and services are also not included under these capitation rates. Further detail on covered services may be found in Table 3 of this report.

- Healthy Michigan Plan (HMP)
  As the Medicaid expansion program, comprehensive services are provided through managed care organizations on a statewide basis. This population was created in April 2014 with the inception of the Healthy Michigan Plan, with managed care enrollment beginning immediately upon inception. Maternity Case Rate payments associated with this population are also included.

  Benefits covered under the HMP program are comprehensive in nature, with certain behavioral health services and prescription drugs provided under a different managed care contract or on a fee-for-service basis. Additional long-term care supports and services are also not included under these capitation rates. Further detail on covered services may be found in Table 3 of this report.

The following table outlines the core benefits covered under the managed care capitation rates.

TABLE 3: MANAGED CARE BENEFIT PACKAGE

Ambulance services	Nurse-midwife, certified family nurse practitioner, certified pediatric nurse practitioner services, MIHP, and doula
Behavioral health services[1]	Nursing facility stays[4]
Chiropractic services	Outpatient hospital services
Dental services[2]	Physical, occupational, developmental, and speech therapy services
Durable medical equipment and medical supplies	
Family planning services and supplies	Physician services
EPSDT screening	Podiatry services
Hearing aids	Prescription drugs[5]
Home health services	Prosthetics and orthotics
Hospice care	Preventive services
Immunizations	Speech and hearing services
Inpatient hospital services	Services provided at Rural health clinics (RHCs) and federally qualified health centers (FQHCs)
Laboratory and x-ray services	Tobacco cessation
Non-emergency medical transportation[3]	Vision care services, including eyeglasses

Notes:

1. Behavioral health services specific to mild-to-moderate conditions.
2. Dental benefits are limited to adults.
3. Includes NEMT for non-covered services
4. Nursing facility stays are limited to 45 days for restorative and rehabilitative purposes.
5. Certain prescription drugs are carved out of the capitation rate and covered on a fee-for-service basis

(ii) Rating period

This actuarial certification is effective for the one-year rating period October 1, 2024 through September 30, 2025.

(iii) Covered populations

The Medicaid managed care program beneficiaries covered by the capitation rates documented in this report are referenced in Section I.1.A.iii.(c).(i) above. The currently projected enrollment for SFY 2025 represents populations and members enrolled in managed care during CY 2023 with the expiration of continuous eligibility taking place steadily throughout SFY 2024 based on the public health emergency (PHE) unwinding process utilized by MDHHS.

(iv) Eligibility criteria

Medicaid beneficiaries covered under this report are required to enroll in managed care on a mandatory basis. Medicaid beneficiaries on HCBS waivers, institutionalized, or eligible for Medicaid that have a spend-down are served on a fee-for-service basis or under a different Medicaid managed care program. Further detail and clarification on managed care eligibility criteria can be found on the Michigan.gov website[1].

(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
- Risk mitigation arrangements

[1] https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-35199--,00.html

- Incentive programs
- Certain delivery system and provider payment initiatives

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 SFY 2025 capitation rates.

iv. Differences among capitation rates

Any proposed differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or factors used to develop capitation rates do not vary with the rate of Federal Financial Participation (FFP) associated with the covered populations in a manner that increases federal costs.

v. 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.

vi. Effective dates

To the best of our knowledge, the assumptions used for the development of the SFY 2025 capitation rates for the Michigan Medicaid managed care program are consistent with the effective dates of changes to the Medicaid managed care program.

vii. Medical loss ratio

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

viii. Capitation rate ranges

This section is not applicable because a single set of capitation rates by rate cell were developed for the SFY 2025 rating period.

ix. State's responsibility with rate ranges

This section is not applicable because a single set of capitation rates by rate cell were developed for the SFY 2025 rating period.

x. 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. Adjustments that will be performed on a retrospective basis are documented in this report.

(c) Final contracted rates

The SFY 2025 capitation rates certified in this report represent the final contracted rates by rate cell prior to risk adjustment and regional adjustments.

xi. Rate certification for effective time periods

This actuarial certification is effective for the one-year rating period October 1, 2024 through September 30, 2025.

xii. Direct and indirect impacts of COVID-19

The capitation rate development accounts for direct and indirect impacts of COVID-19. In general, this was reflected by accounting for changes in projected enrollment, observed emerging utilization differences, projected differences in acuities, and costs associated with the administration of COVID-19 vaccinations. A two-sided risk corridor was implemented for SFY 2020 and SFY 2021 due to the uncertainty related to the cost of COVID-19. The risk corridor was removed for SFY 2022 and continues to not be included with the SFY 2025 rating period. CY 2023 was selected as the base data period as it represents a more recent time period that better reflects recent utilization patterns.

The capitation rate development assumes that the enrollment level will decrease steadily throughout the end of SFY 2024 based on the proposed redetermination strategy implemented by MDHHS. A rate amendment will be considered to reflect any additional changes in the acuity of the enrolled population as additional data is available regarding the public health emergency unwinding.

Additional information regarding rate adjustments due to the COVID-19 public health emergency are documented in Section 1, subsection 1.B.x.

xiii. Procedures for rate certification and amendment

The state will comply with time limits regarding claims for Federal financial participation. In general, a new rate certification will be submitted if 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 or up to 1% within the certified rate range
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. Certification type

This report is for the certification of capitation rates and not capitation rate ranges.

ii. 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.

iii. Medical loss ratio documentation

Using the values illustrated in Appendix 2, the simplified medical loss ratio (defined as the base benefit expense divided by the effective capitation rate for purposes of this report) is 88.8%. This value is above the minimum standard of 85% and is prior to adjustment for healthcare quality improvement expenses as required in the medical loss ratio definition outlined in 42 CFR § 438.8, which would further increase the pricing medical loss ratio. The MCOs can reasonably achieve a medical loss ratio of at least 85% as required per 42 CFR § 438.4(b)(9).

We considered the historical medical loss ratios, capitation rate changes, and emerging benefit expense trends when developing the SFY 2025 capitation rates as required per 452 CFR § 438.5(b)(5).

iv. Assumptions and adjustments

We attest for all assumptions and adjustments underlying the certified capitation rates which will be disclosed in this rate certification. Rate ranges were not utilized for purposes of the rate development and will not be certified. The

final certified rates reflect specific point estimates and do not represent rates that differ by health plan prior to application of regional and risk adjustment factors.

v. Capitation rate ranges

This section is not applicable because a single set of capitation rates by rate cell were developed for the SFY 2025 rating period.

vi. 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.

vii. Compliance with 42 C.F.R. § 438.4(b)(1)

(a) Description of each assumption, methodology, or factor used that varies by the rate of FFP associated with all covered populations

All assumptions and adjustment factors were considered and evaluated by each covered population. This includes prospective trend, non-benefit expense loads, and program and policy adjustments.

(b) Justification of how each difference in the assumption, methodologies, or factors represents actual cost differences based on the characteristics and mix of the covered services or populations

Assumptions were evaluated based on analysis specific to each covered population utilizing base data and MCO reported values. By using actual experience for each population, the differences in assumptions take into consideration the characteristics and mix of covered services specific to each covered population.

(c) Financial Impact

The financial impact of the capitation rate development assumptions and methodology by population is summarized in Tables 2a and 2b.

viii. Different FMAP

All populations, with the exception of the HMP population, receive the regular state FMAP of 65.13% for FFY 2025. The FMAP for the HMP population is 90%. The enhanced FMAP percentage for CHIP and family planning expenditures in Michigan is 75.59% and 90%, respectively. These enhanced amounts are not reflected in the values noted as federal expenditures in Tables 2a and 2b.

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

The previous rate certification applied to SFY 2024 capitation rates, with amended rates for April to September 2024. A comparison to the rates effective April 2024 is provided in Tables 1a and 1b. The primary drivers behind the rate change are updating the base data to CY 2023, modified prospective trend assumptions, and the application of assumptions related to the unwinding of the PHE.

x. Known amendments

There are currently no known amendments that are not accounted for in this rate certification. If a known amendment exists, the state will submit the expected amendment and its anticipated changes to the rates to CMS along with an explanation as to why the amendment is not currently reflected in the rate certification. Consistent with prior years, we will evaluate the need for potential reimbursement changes over the emerging time period as well as adjustments based on emerging experience in relation to the assumptions documented in this report. To the extent those changes are necessary, we would expect those to occur in April 2025 with accompanying amendments being shared around those times.

xi. COVID-19 Approach

(a) Data used

For the base data summaries, calendar year 2023 experience was utilized and summarized in Appendix 3. We reviewed emerging experience in CY 2024 to evaluate the trend for costs related to COVID-19 to help inform assumptions for funding included in the SFY 2025 rate development. We also reviewed emerging experience in CY 2024 to evaluate the acuity differences of members disenrolling compared to the experience in the base period.

(b) Direct and indirect impact of COVID-19

The capitation rates account for changes in the projected enrollment due to the public health emergency as enrollment increased materially for the HMP and TANF populations since March 2020. Projected enrollment decreased in the HMP and TANF populations following the end of the PHE and disenrollment processes were implemented by MDHHS. Additional funding has been included for morbidity changes due to the fact that lower acuity members have disenrolled from the program, leaving higher level of average acuity for remaining members than reflected in the base period. Assumptions utilized related to the reimbursement and prevalence of these are documented in Section I.2.B.iii.(d) below.

(c) COVID-19 related costs not included in capitation rates

All COVID-19 related costs reported through encounter claims expenses are included in the capitation rates for SFY 2025. This includes COVID-19 testing, vaccine administration, and other treatments. Other COVID-19 related costs, such as beneficiary vaccine incentives, are not included in the capitation rates.

(d) Risk mitigation strategies used

For the SFY 2020 and 2021 rating periods, a two-sided risk corridor was utilized to mitigate risks related to uncertainty in costs due to COVID. For the SFY 2025 rating period, a risk corridor will not be a component of the rate development based on more consistent utilization and cost patterns.

2. Data

This section provides information on the data used to develop the capitation rates. The base CY 2023 experience data described in this section is illustrated in Appendix 3.

A. RATE DEVELOPMENT STANDARDS

In accordance with 42 C.F.R. §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 the 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. As such, there is no separate data request from Milliman to the state specifically related to the base data for the capitation rate development. The remainder of this section details the base data and validation processes utilized in the SFY 2025 capitation rate development. Additionally, Appendix 3 summarizes the unadjusted base data.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

The primary data sources used or referenced in the development of the capitation rates are the following:

- Encounter data submitted by the MCOs (January 2019 through August 2024);
- Historical Medicaid eligibility data;
- Historical capitation payments made by MDHHS to the MCOs;
- SFY 2025 MCO Rate-Setting Survey completed by each MCO, which requested administrative expenses;
- Statutory financial statement data; and,
- SFY 2022-2023 financial summary reports provided by the MCOs (Encounter Quality Initiative (EQI) reports) for base data validation analysis.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during CY 2023. The encounter data for the CY 2023 base period reflected encounters adjudicated and submitted through the monthly encounter data warehousing process through June 2024.

The encounter data provided by MDHHS was also used in the capitation rate development for the following purposes:

- For the purposes of trend development, we reviewed encounter experience from CY 2021 through CY 2023.
- We observed encounter data incurred from January 2024 through August 2024 and paid and submitted through the data warehousing process through August 2024 to evaluate emerging experience and to develop estimated incurred but not paid (IBNP) amounts to apply to the base experience.

We also summarized statutory financial statement data from calendar year 2023, collected using S&P Global Market Intelligence.

(iii) Data sources

Capitation payment and eligibility information

On a monthly basis, we receive capitation payments and beneficiary eligibility and enrollment extracts from the State's Medicaid Management Information System (MMIS) To develop the SFY 2025 capitation rates, we reviewed data from January 2020 through August 2024.

MCO encounter data and EQI reports

We received FFS claims and MCO encounter data extracts from the State's MMIS concurrently with the eligibility and enrollment extracts noted above. Our analysis was based on data submitted to the MMIS through August 2024 and compared to the MCO reported Encounter Quality Initiative submissions.

Financial reports – MCO survey

The MCO survey requests incurred experience during CY 2023 with runout through March 2023 to align with the base data period. The MCO survey is intended to provide additional data used in the development of the SFY 2025 capitation rates, including anticipated provider reimbursement for SFY 2025.

MCO statutory financial statements

CY 2020 through CY 2023 statutory financial statements were accessed through S&P Global Market Intelligence.

(iv) Sub-capitation

The base data summaries also include estimated expenditures for sub-capitated claims, based on sub-capitated units and estimated paid amounts reported by the MCOs in the encounter data. The expenditures related to these claims were developed based on logic for the submitted encounter data for claims identified in the base data as sub-capitated and utilizing the appropriate fields per logic discussed with MDHHS, Optum, and the MCOs. Additionally, sub-capitated encounter reported experience was compared with information provided in the MCO surveys.

(v) Base Data Exception

Not applicable. There is no exception to the base data requirements.

(b) Availability and quality of the data

(i) Steps taken to validate the data

The base experience used in the capitation rates relies on encounter data submitted to MDHHS by participating health plans. Managed care eligibility is maintained in the data warehouse by MDHHS. The actuary, the health plans, and MDHHS all play a role in validating the quality of encounter data used in the development of the capitation rates. The plans play the initial role, collecting and summarizing data sent to the state. MDHHS works with the data warehouse managers on data quality and health plan performance measurement. Additionally, we perform independent analysis of encounter data to evaluate the quality of the data being used in the rate development process. Below is a summary of measures specific to each quality area that are applied by MDHHS or the actuary.

The remainder of the validation section relates to encounter data used in the rate development.

Completeness

MDHHS reviews the submitted encounter data to evaluate the completeness of the data. A sample of measures focused on the completeness of the data include:

- Encounter data volume measures by population and service category;
- Verifying rendering provider data;
- NPI provider number usage without Medicaid / reporting provider numbers;
- Percentage of encounters that are submitted by a health plan that are accepted by the data warehouse.

As the actuary, we also summarize the encounter data to assess month to month completeness of the encounter data. These measures include:

- Encounter per member per month (PMPM) by health plan and high-level service categories;
- Distribution of members by encounter-reported expenditures; and,
- Review of month to month activity across health plans.

These measures are applied to identify any months where encounter data volume is unusually large or small, indicating a potential issue with the submitted encounter data.

The CY 2023 encounter base data used in the development of the rates was adjudicated through June 2024. However, as noted in this report, claims completion is applied to the encounter data for estimated CY 2023 claims adjudicated after June 2024.

Encounter data is summarized through the encounter quality initiative (EQI) process. Separate sets of summaries, by rate group, are prepared for each MCO. Each summary illustrates utilization, cost per service, and per member per month cost for the population, stratified by category of service.

The format of each exhibit is similar to the base data exhibits that are provided in Appendix 3, allowing most data issues to be discovered before the annual capitation rate development process.

The EQI reconciliation process allows for two months of run-out from the end of the reported evaluation period. The actuary compares the EQI summaries to summary totals submitted by the MCOs. We provide all the individual encounter claims back to the MCOs for analysis. This allows the MCOs to identify any claims that need to be resubmitted or research any discrepancies that may exist in the final summary.

Accuracy

Checks for accuracy of the data begin with the MCOs' internal auditing and review processes. MDHHS reviews the accuracy of the encounter data by reviewing the percentage of accepted encounters between the MDHHS encounter data files and the files submitted by the health plans. As the state actuary we also review the encounter data to ensure each claim is related to a covered individual and a covered service. Claims utilized in the rate development process are those that have matching beneficiary IDs that are eligible for the noted service date.

We summarize the encounter data into an actuarial cost model format. Base period data summaries are created to ensure that the data for each service is consistent across the health plans and with prior historical periods. Stratification by rate cell facilitates this review, as it minimizes the impact of changes in population mix. This process identifies health plan and service category combinations that may have unreasonable reported data.

Consistency of data across data sources

As historical encounter data is the primary source of information used in the development of capitation rates effective October 1, 2024, it is important to assess the consistency of the encounter data with other sources of information. The main sources of comparison were the MCO-submitted EQI reports, in which each MCO submitted exposure and expenditure information that covered the time periods starting from January 2022 through January 2024. We utilized the EQI reported data to validate the encounter data being utilized for rate development was appropriate and consistent between the two sources of information.

We also reviewed the consistency of other data sources that have been used to inform assumptions in the rate setting process:

- Eligibility – Monthly enrollment in eligibility and capitation payment files received by MDHHS was reconciled with publicly available values.
- Financial statement information - From a high level, we compared submitted encounter data with health plan reported financial information. As the financial statement information is not at a detailed level akin to the encounter data, aggregate expenditures developed from the encounter data were compared to aggregate expenditures in the financial statements for reasonableness.

(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, primarily the MCOs. The values presented in this letter are dependent upon this reliance.

We found the encounter to be of appropriate quality for purposes of developing actuarially sound capitation rates. The following actions were performed to ensure compliance with ASOP 23:

- Selected data that were both appropriate and sufficiently current for the intended purpose: we used data that reflected the covered population and services under the contract;
- Reviewed the data for reasonability, consistency, and comprehensiveness: documented in the certification report;
- Disclosed any known limitations of the data: documented in the certification report; and,
- Placed reliance on the data supplied by MDHHS and its vendors: documented in the certification report.

While there are areas for data improvement, as detailed in the *Data concerns* section below, we found the encounter data to be of appropriate quality for the purposes of developing the base experience data for the capitation rates, as well as specific adjustments for reimbursement and program changes that impact health plan expenditures beyond the base experience period.

(iii) Data concerns

We have not identified any material concerns with the quality or availability of the data specific to CY 2023. Based on a review of encounter data at the population and category of service level for each MCO, we deemed the encounter data experience to be of sufficient quality. This analysis was done on a consistent basis across each MCO.

Additionally, we reviewed the historical experience to identify duplicate claims in the base experience. We do not believe these concerns are material enough to exclude them from the encounter data. We believe the encounter data using in our rate development process is reasonable and credible.

(c) Appropriate data

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

All populations enrolled in managed care during the rate period were included in the risk-based managed care delivery system in the CY 2023 base experience period. As such, expenditure data for populations enrolled in FFS during CY 2023 is not reflected in the base experience cost models used to develop the capitation rates.

(ii) Use of managed care encounter data

Managed care encounter data was the primary data source used in the development of the capitation rates.

(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. We created data books summarizing CY 2023 encounter data, which are included in the CY 2023 Base Experience section of Appendix 3.

iii. Data adjustments

Capitation rates were developed primarily from CY 2023 encounter data. Adjustments were made to the base experience for completion, reimbursement changes, and other program adjustments.

(a) Credibility adjustment

The MDHHS managed care program populations, as represented in the base experience, were fully credible. No specific credibility adjustments were made to the submitted encounter data as we evaluated the data at a statewide level. We believe the encounter data is an appropriate source of utilization and expenditures for the covered populations.

We summarized the information on a statewide basis for the covered populations and compared each MCO's separate encounter data submission for each of these splits against the statewide average on a monthly basis. Regional adjustment factors are developed and applied to account for differences in the cost of providing services across the state.

(b) Completion adjustment

The encounter data submitted by the MCOs used in developing the capitation rates was analyzed separately to estimate claim completion factors. The base period encounter data reflect claims incurred during CY 2023 (January 1, 2023 through December 31, 2023) and paid through June 2024. Separate sets of completion factors were developed by summarizing the claims data and applying traditional actuarial techniques to develop estimates of IBNP liability. The table below summarizes the increase to the encounter data by service category.

COMPLETION ADJUSTMENT INCREASE

SERVICE CATEGORY	INCREASE FOR IBNP
Outpatient Hospital	1.0%
Professional	1.2%
LTSS	4.3%
Ancillary	1.1%
Inpatient Hospital	4.8%
Pharmacy	0.0%
Composite	**1.5%**

First, we stratified the data by category of service for each health plan grouping. Claims for each of these health plan-service category stratifications were analyzed and formed into lag triangles by paid and incurred month.

Claim completion factors were developed for each month of the base experience period, based on historical completion patterns. The monthly completion factors were applied to CY 2023 experience to estimate the remaining claims liability for the calendar year. Results were aggregated into annual completion factors for the calendar year. The applied completion factors are reflected in the actuarial models in Appendix 3 and represented approximately $113.9 million.

(c) Errors found in the data

As previously noted, we reviewed claims that were identified as duplicates. Potential duplicate claims were identified based on service date, beneficiary ID, applicable service codes (e.g., CPT-4 procedure code), and paid amounts. We did not see a material amount of duplicates, so no adjustment to the base data was made.

(d) Program change adjustments

All program and reimbursement changes that have occurred in the Medicaid managed care program since January 1, 2023, the beginning of the base experience period used in the capitation rates, are described below. The impact of these changes by rate cell and service category are reflected in the actuarial models in Appendices 3 and 4. Appendix 6 provides the aggregate impact of each program adjustment by population. We have made additional adjustments based on emerging experience that are discussed in further detail in Section 3.

Retrospective Changes to Base Data

Retrospective Professional Fee Schedule Updates

We have adjusted the reimbursement for professional services to reflect historical changes to the Medicaid fee schedules as of January 1, 2024. DHHS maintains a record of the current and historical fee schedules by provider type on the DHHS website[2]. Based on a survey of managed care plans participating in the program, the majority of professional reimbursement methodologies employed by the plans are linked to the fee-for-service schedule.

[2] https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/information-specific-to-different-providers

A large portion of this adjustment is on procedure codes for which reimbursement is based on the Medicare relative values units (RVU), specifically the updates implemented with the CY 2024 Medicare RVU fee schedule. A further adjustment was incorporated as part of the state's fee schedule effective January 2024, specific to primary care providers. The projected fiscal impact of this change is a $71.2 million increase to the base data and is reflected in the retrospective actuarial models in Appendix 3.

Retrospective Inpatient Hospital Fee Schedule Updates

The state reimburses inpatient discharges utilizing the All-Patient Refined Diagnosis Related Group (APR-DRG) payment system. We have updated the APR-DRG rates associated with inpatient admissions for SFY 2025 utilizing the most recent APR-DRG weights (version 41). In addition, base rates for Level I and Level II Trauma Centers were increased effective October 1, 2023. We developed relative impacts by rate cell and service category based on CY 2023 experience. This was then applied for 9 months of the base data period as the updated APR-DRG rates were effective starting October 2023. The projected fiscal impact of these changes is a $34.8 million increase to the base data and is noted in the Program Adjustments column of Appendix 3 for the Inpatient Hospital category of service.

Other Fee Schedule Updates

In addition to inpatient and professional services, other fee schedule increases were implemented prior to June 1, 2024. This includes increases for ambulance, anesthesia, and skilled nursing facility rates. As noted previously, a record of the current and historical fee schedules by provider type can be found on the DHHS website[3]. The composite projected impact of the additional fee schedule updates is $9.1 million and is reflected in the Program Adjustments column of Appendix 3.

Adult Dental Redesign Adjustments

Effective April 2023, MDHHS implemented policy to include dental coverage for adults under managed care for all populations. As part of these changes, the reimbursement level of dental services was set at the average commercial rate, based on information provided to MDHHS by commercial dental insurers. This change represents over a 200% increase in reimbursement from historical FFS levels. The fee schedule effective January 2024 is published on the MDHHS website at www.michigan.gov/medicaidproviders.

Material utilization increases have been observed following implementation of the adult dental redesign. Therefore, we reviewed emerging experience during SFY 2024 with a focus on the most recently available and completed experience. Projected utilization levels prior to applied prospective trend were based on SFY 2024 Q1 (January to March 2024). The combined impact of these changes is illustrated by rate cell in Appendix 3 under the program adjustment columns for the Dental category of service. The composite projected fiscal impact of these changes is a $109.7 million increase to the base data.

Net Reinsurance

We made an adjustment to the encounter data base experience period to reflect the impact of net reinsurance claims for purposes of accounting for the ultimate cost borne by the MCOs. This adjustment was developed by including the additional costs paid for reinsurance premiums and subtracting the recoveries received from these arrangements.

We utilized reported financial statement information related to reinsurance contracts and the information provided in the MCO survey submissions for amounts that are not currently reflected in the base experience data. The adjustments for this are reflected by rate cell in Appendix 3 and represent a $10.2 million increase to the base data.

Third Party Liability

In addition to actual cost avoidance reflected in the encounter data, we applied additional adjustment reduction factors for third party liability (TPL) and fraud recoveries based on data provided by the managed care health plans and work performed by MDHHS' Third Party Liability division. The process was to identify claims that were for members who had additional insurance coverage for which MCOs could have a reduced responsibility. We worked with MDHHS' TPL division to ensure claims were appropriately reflected in the rate development process. We removed a portion of these claims (25% for commercial and 80% for Medicare). This adjustment reflects a decrease of $14.3 million to the base data.

[3] https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/information-specific-to-different-providers

Insulin List Price Reduction Adjustment

Insulins comprised approximately $180 million dollars of MCO expenditures in the CY 2023 base period. Throughout the SFY 2024 rating period, the primary manufacturers of decreased the list price of their insulin drug products. Lilly materially lowered the cost of Humalog and Humulin drugs. Sanofi and Non Nordisk substantially lowered the cost of most of their insulin drugs (Lantus and Novolog, respectively) as well. These price reductions represented approximately a 70% decrease from historical list prices. These manufacturers supplied the majority of the insulin drugs in the CY 2023 base period. This change reflects a projected decrease of $120.8 million to the base data in the actuarial models in Appendix 3 specific to the lower cost per script.

Prospective Changes to Base Data

Projected Enrollment Acuity Adjustment

During the public health emergency, enrollment for the HMP and TANF populations increased materially. As the public health emergency ended on May 11, 2023, these populations began to experience decreases in enrollment following with the redetermination process being implemented by MDHHS. We observed that the members who disenrolled exhibited a lower level of utilization of services on average compared to the population that is projected to remained in the managed care program for SFY 2025.

Section I.7 provides additional details supporting the development of the projected enrollment and acuity adjustment assumptions.

Appendix 4 reflects the projected enrollment for each of the rate cells, with a composite decrease in case load size of approximately $1,444.1 million. The acuity adjustment factors were applied uniformly across all service categories in Appendix 4 with a composite projected impact of a $316.8 million increase.

Inpatient Managed Care Adjustment

We applied managed care adjustments to reflect higher levels of care management relative to the CY 2023 base experience period. We identified potentially avoidable admissions using the AHRQ PQIs. Inpatient hospital managed care adjustments were developed by applying a reduction to potentially avoidable inpatient admissions for select PQIs. No adjustments were made to corresponding inpatient physician charges to account for the potential shift of these services to an ambulatory setting. Additionally, nursing facility claims were excluded from this analysis. For the SFY 2025 rating period, we reduced the inpatient hospital projected costs by $8.5 million.

The following figure outlines the PQIs included in our analysis.

PREVENTION QUALITY INDICATORS

PQI Number	Description
PQI #01	Diabetes short-term complications admission rate
PQI #03	Diabetes long-term complications admission rate
PQI #05	Chronic obstructive pulmonary disease (COPD) admission rate
PQI #07	Hypertension admission rate
PQI #08	Congestive heart failure (CHF) admission rate
PQI #11	Bacterial pneumonia admission rate
PQI #12	Urinary tract infection admission rate
PQI #14	Uncontrolled diabetes admission rate
PQI #15	Adult asthma admission rate
PQI #16	Rate of lower-extremity amputation among patients with diabetes

Substance Use Disorder Coverage Expansions

Effective January 1, 2024, MDHHS expanded coverage of substance use disorder (SUD) services to include consultation services when performed by a qualified physician in a hospital setting. Services include a comprehensive assessment to establish a treatment plan, dosing and maintenance therapy for individuals with pre-existing MAT treatment plans, and discussion of outpatient therapies and resources following a discharge. Additionally, eligible primary care office-based services related to substance use treatment will also be covered effective January 1, 2024. The projected fiscal impact of these policy changes is $2.2M and is noted in the program adjustment column of Appendix 4 for the inpatient visit service line.

Recuperative Care Adjustment

Effective September 1, 2024, recuperative care providers may be reimbursed for eligible services (such as case management or room and board services) when provided to adult beneficiaries. This short term program allows those who are experiencing homelessness and discharging from an inpatient hospital admission to recover post-hospitalization, receive case management services, access medical care or other Medicaid services, and receive supportive services. The projected fiscal impact of these policy changes is $2.5M and is noted in the program adjustment column of Appendix 4 for the other professional service line.

Non-Emergency Medical Transportation (NEMT) Coverage Expansion

Effective October 1, 2024, MDHHS established coverage of enrollee transportation to all Medicaid covered services. This represents an expansion of NEMT services required to be provided by the MCOs as it will not include coverage of NEMT for services that are not covered under this managed care contract (e.g., children's dental and behavioral health). We reviewed historical experience for these additional services to develop an estimated utilization rate for the addition of NEMT services. An adjustment was applied to account for the additional NEMT trips that could accompany these services. Following discussion with MDHHS, we added more funding in SFY 2025 based on historical costs reported by the state's NEMT subcontractor. These additional costs represent NEMT trips handled through the state's voucher program and administered by ModivCare.

The projected fiscal impact of this policy change is $10.0M and is noted in the program adjustment column of Appendix 4 for the non-emergency transportation service line. We will monitor experience during SFY 2025 to help understand the impact of this program change on MCO experience.

Behavioral Health Provider Rate Increase

Effective October 1, 2024, MDHHS is increasing the behavioral health practitioner reimbursement level. The projected fiscal impact of this policy change is $20.3M and is noted in the program adjustment column of Appendix 4 for the professional MH/SA service line.

Child Vaccine Administration Rate Increase

Effective October 1, 2024, MDHHS established a minimum fee schedule of $23.03 per vaccine for vaccine administration costs for recipients ages 18 and younger. As noted previously, a record of the current and historical vaccine administration fee schedules type can be found on the DHHS website. The projected fiscal impact of this policy change is $2.7M and is noted in the program adjustment column of Appendix 4 for the Other Outpatient and Physical Exams service lines.

Prospective Professional Fee Schedule Updates

We have adjusted the reimbursement for professional services to reflect changes to the Medicaid fee schedules as of April 1, 2024. Following methodology like the retrospective professional fee schedule update, the projected fiscal impact of this policy change is a $0.7M decrease. It is noted in the program adjustment column of Appendix 4 for the professional service lines.

Other Fee Schedule and Program Updates

We have adjusted the reimbursement for additional services to reflect changes to the Medicaid fee schedules and service coverage effective as of October 1, 2024. Benefit coverage included in this rate adjustment component includes doula, speech therapy, and orthotic services with a combined projected fiscal impact of $2.9M increase. It is noted in the program adjustment column of Appendix 4 for the appropriate service lines.

(e) Exclusion of payments or services from the data

The following adjustments were made to the base experience data to reflect uncollected cost sharing, additional provider payments, and provider settlements.

Uncollected Cost Sharing

Adjustments were made to reflect copay amounts that were not reflected in the summarized encounter data. Based on information provided by the managed care health plans, the encounter data was reported on a gross basis. Pursuant to CMS policy on 42 C.F.R. 447.56(d), the capitation rate development must be calculated to be net of cost sharing irrespective of whether health plans impose the cost sharing or are able to collect the full amounts.

Copay amounts were estimated by applying copay policies under the Michigan Medicaid program to the encounter data. Separate adjustments were made for the different categories of service including certain office visits, non-emergent uses of the emergency room, dental, vision, and pharmacy based on the uncollected copay amounts as a percentage of CY 2023 expenditures. These adjustments were not considered for children, pregnant women, and other beneficiaries who qualify for copayment exclusions. Following changes to the Healthy Michigan program in SFY 2024, copay amounts for this population are consistent with the remaining adult populations.

Family Centered Medical Home

Additional costs have been added to each of the CSHCS rate cells (including HMP-CSHCS) for covering services related to Family Centered Medical Home (FCMH). These payments are made to the plans to assist in transitioning beneficiaries into family centered medical homes. Payments of $4 PMPM and $8 PMPM have been added to the TANF/Program L and Disabled populations, respectively within the CSHCS program. An average rate of $6 PMPM has been included for the Less than 1 rate cells and HMP-CSHCS as these are a blend of TANF and Disabled lives. The PMPM amounts allocated to the CSHCS rate cells for the FCMH adjustment are consistent with the historical amounts and align with costs from prior to the managed care program for this population when the program operated solely in a FFS arrangement. The payments are intended to cover care coordination for CSHCS members, which require a significant amount of services based on their higher morbidity and qualifying conditions. These adjustment factors are illustrated in Appendix 2.

Patient Centered Medical Home

Effective January 1, 2017, an additional payment was added to the program for the Patient Centered Medical Home (PCMH) initiative. The state began making a payment to the participating health plans for reimbursement to primary care providers that are qualified for and serving beneficiaries in the PCMH program. For the SFY 2025 rating period, the anticipated expenditures for the PCMH program total $20.0 million.

Child and Adolescent Health Center Outreach

Child and adolescent health care center outreach is a service being provided under the Medicaid risk contract in the TANF population.

The program works to provide important health information and care to reach uninsured children who may qualify for Medicaid and assist in obtaining important services. The utilization experience is not included in the encounter data. The total pool is approximately $25.1 million on an annual basis.

The cost is distributed across the 5 to 14 year old and 15 to 20 year old TANF rate cells. The outreach payments support activities that inform eligible or potentially eligible individuals about Medicaid and how to access Medicaid programs. The outreach activities are targeted at school personnel, parents and guardians, and community members to assist them in providing education and helping eligible children and youth obtain important prevention services. Based on the type of service being provided, the outreach activities are not reported in service utilization (encounter) data. The PMPM amounts were developed based on the state's budget appropriation for these services allocated across the impacted rate cells. Adjustments for these payments are reflected in Appendix 2.

Provider Settlements and Incentives

We have included additional funding for provider settlements and incentives that were not reflected in CY 2023 encounter data but represent allowable expenditures. This is limited to expenditures related to medical services including lump sum provider settlements not adjudicated through the claims system, provider withholds paid, and provider bonus payments. This adjustment was developed based on amounts reported by the MCOs in the submitted surveys. The adjustment reflects an increase of approximately $70.5 million.

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 C.F.R. § 438.4(b)(6) and are only based on services outlined in 42 C.F.R. § 438.3(c)(1)(ii) and 438.3(e). Non-state plan services provided by the MCOs have been excluded from the capitation rate development process. Prior to the SFY 2025 rating period, MCOs have not provided any in-lieu of services.

ii. 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 covered populations. Additionally, consideration of other factors and data sources appropriate for benefit cost trend development is further documented in Section I, item 3.B.iii.

iii. In Lieu Of Services

The projected benefit costs reflect the inclusion of in-lieu-of services (ILOS) for SFY 2025 related to food and nutritional therapy. The following provides a brief description of each ILOS reflected in the SFY 2025 rate development:

- Home delivered meals
    - Medically tailored home delivered meal – A fresh or frozen meal medically tailored for a specific disease or condition. The cost includes an initial evaluation with a certified nutrition professional along with preparation and delivery of the meal.
    - Healthy home delivered meal - A nutritionally, balanced home delivered meal consisting of a hot, cold, frozen or shelf-stable meal.
- Nutrition Prescriptions
    - Healthy food pack – Consists of an assortment of medically-tailored or nutritionally-appropriate foods provided to an enrollee.
    - Produce prescription – A voucher for a member to purchase any variety of fruits and vegetables or plants/seeds that produce fruits and vegetables from a participating food retailer.

The population to be eligible for these ILOS must meet one of the clinical risk factors and the social risk factor:

1. Clinical risk factors - Individuals with nutrition-sensitive conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, hypertension, human immunodeficiency virus (HIV), cancer, obesity, oral health disease, gestational diabetes, other high-risk perinatal conditions, or mental/behavioral health disorders. Additionally, other at-risk populations also would meet the clinical risk factors, such as disabled individuals and children eligible for the CSHCS program.
2. Social risk factor - The member is at risk for nutritional deficiency or nutritional imbalance due to food insecurity, defined as being unable to obtain nutritionally adequate, medically appropriate, and/or safe foods.

MCOs that take up ILOS would be required to provide services to members if they meet at least one of the clinical risk factors and the social risk factor as noted above. The need for services must be documented, for example, in the enrollee's care plan or medical record.

iv. ILOS cost percentage

The ILOS cost percentage provides an estimate of the portion of the total capitation payments attributable to all ILOSs in this specific managed care program. For purposes of the SFY 2025 rate development we have assumed that implementation of food and nutritional therapy will be budget neutral to the state. The following settings and services were identified as the substitutes for these services:

- Emergency Services
- Emergency Medical Transportation
- Home Health Services
- Inpatient and Outpatient Hospital Services
- Intermittent or short-term restorative or rehabilitative services, in a nursing facility, up to 45 days

These services were identified as areas that would be reduced with the implementation of the food and nutritional therapy ILOS. The calculated ILOS Cost Percentage applicable to the CHCP program represents the portion of the total capitation payments attributable to all ILOSs divided by the total projected dollar amount of capitation payments specific to the CHCP program, which must include all state directed payments in accordance with 42 CFR § 438.6(c) and pass-through payments in accordance with 42 CFR § 438.6(d). The projected ILOS Cost Percentage is shown in Section 1, Subsection 3.B.v.b.

Milliman acknowledges the requirement to update and document the ILOS cost percentage with each applicable amendment along with producing a separate actuarial report that must be submitted to CMS no later than 2 years after the completion of SFY 2025 documenting the final ILOS Cost Percentage applicable to this program.

v. IMDs as an in lieu of service provider

Not applicable. The projected benefit costs do not include costs for IMDs as 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 any costs in the base experience data for IMD.

(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 for the managed care population**

  The capitation rates were primarily developed from historical claims and enrollment data from the managed care enrolled populations.

The data utilized to prepare the base period cost models consisted of CY 2023 incurred encounter data that has been submitted by the MCOs. The information is summarized in Appendix 3 and is stratified by capitation rate cell and by major category of service.

The experience utilized as the starting point in Appendix 3 reflect unadjusted summaries of the CY 2023 base period data.

- **Step 2: Apply historical and other adjustments to cost model summaries**
  As documented in the previous section, utilization and cost per service rates from the base experience period were adjusted for a number of items, including but not limited to: incomplete data adjustments, additional payment amounts, and policy and program changes that occurred during CY 2023.
- **Step 3: Trend to SFY 2025**
  Prospective utilization trend factors were applied to project utilization to the midpoint of the rating period (April 1, 2025). Unit cost values were projected by applying the prospective cost per service assumed trend factors over 21 months from the midpoint of the base experience period (July 1, 2023) to the midpoint of the rate period (April 1, 2025).
- **Step 4: Adjust for prospective program and policy changes**
  As documented in the previous section, utilization and cost per service rates from the base experience period were further adjusted for policy and program changes that occurred after CY 2023. The PMPMs resulting from the application of these adjustments established the adjusted benefit expense by population rate cell for the rating period.
- **Step 5: Regional adjustments**

  The rates noted in Appendix 2 represent the statewide rate for each rate cell. Capitation rates paid to each of the managed care health plans will be further adjusted by the MSA region in which the covered life resides. Regional adjustment factors were calculated at the program level for the TANF/Program L, HMP, CSHCS, Disabled, and maternity case rate (MCR) capitation rates. The regional adjustment factors were developed based on the variation in base rates for inpatient and outpatient hospital providers located within each geographic region. Additional considerations were made for transportation expenditure, dental expenditure, and proportion of qualified pharmacies with seven or fewer outlets variances across the state. Please note that morbidity differences are reflected in the MCO specific risk adjustment factor development as documented in Section I, item 6. The following table provides a summary of the regional adjustments to be applied to the impacted populations.

TABLE 4: REGIONAL ADJUSTMENT FACTORS

REGION	MHP-TANF	MHP-DISABLED	CSHCS	HMP	MCR
01	0.9961	0.9879	1.0047	0.9930	0.9304
02	0.9913	0.9945	1.0042	0.9913	0.9603
03	0.9966	1.0043	1.0153	0.9999	0.9551
04	0.9821	0.9884	0.9909	0.9777	0.9876
05	0.9873	0.9965	1.0210	0.9838	0.9999
06	1.0073	1.0079	1.0208	1.0055	1.0255
07	0.9935	0.9957	1.0021	0.9891	0.9956
08	0.9737	0.9770	0.9932	0.9673	0.9654
09	0.9894	0.9941	1.0100	0.9866	1.0181
10	1.0134	1.0075	0.9950	1.0166	1.0096

Material adjustments that were previously noted

The following material adjustments were applied to recognize data quality issues, changes to provider reimbursement, prospective program adjustments, and changes to covered populations and were documented in Section I, item 2.B.iii (Data Adjustments):

- Claims completion
- Physician and inpatient hospital reimbursement changes
- Fee schedule changes including ambulance, anesthesia, skilled nursing, and insulin drugs
- Addition of outreach services and FCMH payments
- Increase reimbursement and projected utilization for adult dental
- Projected membership and acuity changes as a result of the continuous eligibility expiration
- New services including SUD consultations and expansion of NEMT services

Additionally, the following adjustments were applied to either reduce or increase the base data benefit cost for certain service and payment exclusions:

- Net reinsurance
- Third party liabilities
- Uncollected cost sharing

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

All rate development data and 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.

(c) Overpayments to providers

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

Overpayments to providers as a result of fraud, waste, and abuse and TPL activity are reported by the MCOs in the MCO Survey and discussed in greater detail in Section 3.B.vii.b, recoveries of overpayments.

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 (CY 2023) to the SFY 2025 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 data used to develop benefit cost trends is historical claims and encounters from the covered populations. Data prior to the pandemic was reviewed as well as emerging trends observed through the second quarter of CY 2024.

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 per member per month cost data was stratified by month, rate cell, and category of service. The data was adjusted for completion and normalized for historical program and reimbursement changes. We developed trend rates to adjust the base experience data (midpoint of July 1, 2023) forward 21 months to the midpoint of the contract period, April 1, 2025. Rolling 12-month trends were calculated to identify changes in the underlying patterns over time, and annualized trends were utilized to smooth out significant fluctuations from year to year. Prospective trends are documented below in Table 5.

Pharmacy trends

We developed a Medicaid Pharmacy model (trend model) for the purposes of studying and projecting detailed pharmacy trend information. Please note that the application of the selected pharmacy trends result in a significant increase to the composite pharmacy PMPM from the SFY 2024 capitation rates. The prospective trend coupled with the updated base data and previously noted pharmacy program changes represents a composite PMPM for the pharmacy benefit of $119.04 for SFY 2025.

The trend model summarizes pharmacy claims data by month, drug type (brand, generic, and specialty), covered population. Projected values were estimated using the base period data as a starting point and applying anticipated shifts and trends. There are several areas for consideration.

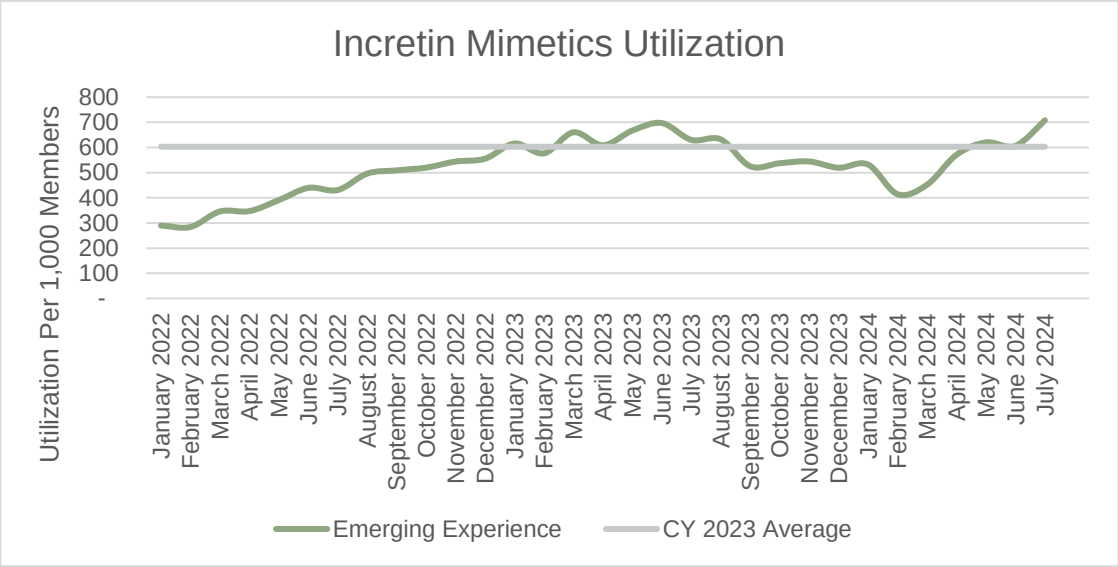
Cost per script trends

Projected costs per script assumptions are based on the average costs per script in the most recent three months of the experience period, adjusted for any anomalies in the data. These costs are trended forward using separate cost trend assumptions for brand, generic, and specialty products. In developing cost trends, we relied on a combination of Milliman research, publicly available industry trend reports, and the historical trends using repriced MCO encounter data.

Changes in utilization

Utilization levels for the first projection month reflect the average utilization in the last six months of the experience period, adjusted for anomalies in the data. We applied monthly utilization trends to this starting point to estimate the projection period utilization. To develop these utilization trend assumptions, we relied on a combination of Milliman research, publicly available industry trend reports, and the historical utilization trends using Michigan Medicaid encounter data. Monthly seasonality is accounted for in our trend development.

Due to the rapid increase in utilization observed for this drug class since originally covered February 2022, anti-obesity medications and other GLP-1s were reviewed separately. The following graph provides utilization levels of GLP-1 medication by incurred month.



We recognize that recent utilization levels of GLP-1s may have been impacted by supply shortages and that recent FDA indication approvals may have an impact on the projected utilization of GLP-1s and other available treatment. As such, we intend to continue to monitor experience and account for these treatments as needed.

Carved-out drugs

The drugs that are currently carved-out from the managed care contract are not included in the pharmacy trend analysis. The cost impact of other high cost drugs not excluded from the Michigan Medicaid program was reviewed and included within the pharmacy trend rates. Please note that certain prescription drugs will continue to be carved-out from the risk-based managed care contract and have not been included in the capitation rate development.

Recently released high cost drugs

No adjustments were made to the base data to account for any recently released high cost drugs. To the extent that changes are made to the state's preferred drug list or coverage rules, we will modify trends as necessary.

(iii) Comparisons

As noted above, we did not explicitly rely on the historical MCO encounter data trend projections due to anomalies observed in the historical trend data. In addition to referencing external data sources and emerging experience in the encounter data, we also reviewed the utilization trends assumed in the SFY 2024 capitation rate development to determine if any adjustment to the trend assumption was appropriate for the SFY 2025 rating period.

Explicit adjustments were made outside of trend to reflect all recent or planned changes in reimbursement from the base period to the rating period.

(iv) Chosen trend rates

Table 5 illustrates the proposed PMPM trend by population and category of service. The chosen trend rates do not include any outlier or negative trends. The TANF/Program L PMPM trends were developed separately for adults and children. The table below shows the trend for these two age groups separately. Additionally, trends for dental services and all other ancillary services were developed separately. The ancillary trend represents all ancillary services except for dental services. These trend rates are applied to the adjusted experience following the application of the emerging experience adjustments, where applicable.

TABLE 5: PMPM TREND BY POPULATION AND COS

POPULATION	INPATIENT HOSPITAL	OUTPATIENT HOSPITAL	PROFESSIONAL	DENTAL	ANCILLARY	PHARMACY	LTSS
TANF/Program L (Adults)	0.50%	2.00%	0.50%	4.50%	4.00%	15.00%	1.00%
TANF/Program L (Children)	0.50%	1.50%	3.00%	4.50%	4.00%	15.00%	3.00%
Aged, Blind, and Disabled	0.50%	2.00%	1.50%	4.50%	4.00%	9.00%	3.50%
Maternity Case Rate	3.00%	1.00%	1.00%	0.00%	0.00%	0.00%	0.00%
Dual Eligibles	0.50%	1.50%	2.00%	4.50%	4.00%	2.00%	3.00%
CSHCS	1.00%	2.00%	1.00%	4.75%	0.50%	10.00%	3.00%
Healthy Michigan	1.00%	2.00%	0.50%	4.00%	2.50%	15.00%	3.00%

Trend analysis specific to the MDHHS data is reflected in Appendix 6. Trend rates were developed by population (TANF/Program L, Blind & Disabled, CSHCS, HMP, MCR, and Dual Eligibles (MME)) and by service category.

Historical trends should not be used in a simple formulaic manner to determine future trends; actuarial judgment is also required. We also referred to alternative sources, both publicly available and internal Milliman information. We also considered changing practice patterns, shifting population mix, and the impact of reimbursement changes on utilization in this specific population.

(b) Benefit cost trend components

Separate utilization and cost per unit trend components were developed and illustrated in the cost models in Appendix 4. Appendix 5 provides the results of the regression analyses performed to evaluate the historical trend experience.

(c) Variation

We evaluated and selected trend assumptions by Medicaid population and category of service.

(i) Medicaid populations

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 population category and 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

For the pharmacy trend assumption development, we further reviewed experience for specialty, brand and generic drugs. The variation that occurs between these high-level prescription drug stratifications and further within each major population category contributes to the variation in the pharmacy trend assumptions applied across the managed care program in the SFY 2025 capitation rate development.

(d) Material adjustments

We made explicit adjustments to the historical data analyzed for trends in an effort to normalize the data for historical reimbursement adjustments and changing populations, and extract underlying trend information; however, as noted above, there were still anomalies that were present in the data and contributed to unreasonable trend patterns.

As a result, we used actuarial judgment to adjust the trends 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 sources 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.

(ii) Trend changes other than utilization and cost

No trend 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 C.F.R. § 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

(a) Description of ILOSs

The following provides a brief description of each ILOS in the managed care program and whether the ILOS was provided as benefit during the base data period.

IMD

The use of IMDs is not applicable for the CHCP program.

Food and nutritional therapy

The implementation of food and nutritional therapy as ILOS will be effective October 1, 2024. The description for these services is described in Section 3.A.iii.

(b) ILOS Cost Percentages

The ILOS cost percentage for the food and nutritional therapy is 0.50%. The ILOS cost percentage was developed based on an assumed level of ILOS to be provided during SFY 2025 as a percentage of the total paid amounts for all services. As these services were not part of the base period data, this represents a new calculation for the program that will be updated in future reports.

(c) Incorporation into rate development

Food and nutritional therapy were incorporated into rate development based on an assumed utilization and cost level as they were not part of the base experience. Cost and utilization associated with these services is assumed to be budget neutral to the CHCP program and will be monitored as experience emerges with actual utilization and cost being utilized in future rating periods

(d) Inclusion of IMD services

The use of IMDs is not applicable for the CHCP program.

vi. Retrospective Eligibility Periods

(a) MCO responsibility

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

(b) Claims treatment

As noted earlier, MCOs 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 April to September 2024 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 not reflected in the base period encounter data that have already been recovered were reported in the either the submitted MCO surveys or quarterly TPL reports. In addition, the MDHHS TPL division identified additional potential recoverable claims. These sources were utilized in combination to project an estimated $14.3 million dollars of recoveries not fully accounted for in the encounter data. Projected amounts for the recoveries are noted in Appendix 2 based on information shared by MDHHS and the Third Party Liability division.

(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. Non-material changes to covered benefits or provider payments have also been described in that section of the report.

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 Michigan Medicaid managed care program.

ii. Appropriate Documentation

Incentive payments under this plan are below 105% of the certified capitation rates paid under the contract. An incentive pool is determined by the portion of withhold that is not returned to the MCOs. By design, the incentive amount represented by the bonus pool is significantly less than 5% of the certified rates.

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the withhold arrangement in the Michigan Medicaid managed care program. The targets are distinct from general operational requirements under the contract.

The capitation rates shown in this letter are illustrated gross of the withhold amount; however, the SFY 2025 capitation rates documented in this report are actuarially sound after adjustment for the amount of the withhold not expected to be earned.

ii. Appropriate Documentation

(a) Description of the Withhold Arrangement

(i) Time period and purpose

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

(ii) Enrollees, services, and providers covered by withhold

The withhold arrangement is applicable to all enrollees, services, and providers under the managed care program. The performance metrics are based on a diverse set of services across multiple categories.

(iii) Purpose of the withhold arrangement

The purpose of the withhold arrangement is to ensure managed care health plans meet certain performance measures identified in the managed care contract.

(iv) Description of total percentage withheld

MDHHS has established a quality withhold of 2.0% of the capitation rate net of directed payments and will determine the return of the withhold based on review of each MCO's data and the MCO's compliance with the quality measures established in each MCO's contract with MDHHS. Note that the withhold for SFY 2025 increased from the previous rate setting period where the withhold was 1%.

(v) Estimate of percent to be returned

Based on calculations for the withhold payments in prior fiscal years, all of the withheld payments are being delivered back to the health plans, but for some health plans it may result in a larger amount than what was effectively paid in. If the amount received back from the health plan were to be capped at the amount withheld from initial payment, the effective recoupment is approximately 97%.

(vi) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 2.0% of capitation revenue, net of directed payments, indicates that it is reasonable within the context of the capitation rate development and the magnitude of the withhold does not have a detrimental impact on the health plan's financial operating needs and capital reserves.

Our interpretation of financial operating needs relates to cash flow needs for the health plan to pay claims and administer benefits for its covered population. We evaluated the reasonableness of the withhold within this context by reviewing the health plan's cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by MDHHS. To evaluate the reasonableness of the withhold in relation to capital reserves, we reviewed each health plan's risk-based capital ratio. The data source utilized to calculate these metrics was each plan's calendar year 2023 NAIC annual statement.

(1) Risk-Based Capital (RBC) Levels: RBC levels were reviewed to assess surplus levels and financial stability of each MCO to pay all policyholder obligations. Surplus levels for CY 2023 on a composite basis reflect an RBC-level of approximately 460% across the MCOs.

(2) Cash available for operating expenses: We reviewed cash and cash equivalent levels in relation to the withhold arrangement. We believe the withhold arrangement is reasonable based on current cash levels and the following withhold level.

(vii) Effect on the capitation rates

The SFY 2025 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable.

(b) Capitation payments minus withhold

The SFY 2025 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 Michigan managed care program.

ii. Appropriate Documentation

(a) Description of Risk-sharing Mechanism

Based on the historical variability observed in the utilization of dental services in the managed care program, MDHHS is establishing a loss ratio arrangement specific to the benefit expense associated with adult dental services. This arrangement is being implemented to ensure managed care health plans are providing an appropriate level of services in comparison to the amount of benefit expense included in the development of the capitation rates. The arrangement reflects a loss ratio based on claim cost with a financial remittance component. The comparison is applicable only to the dental benefit expense component and does not consider any other medical benefit expense or the administrative load for either the dental or medical components. For the SFY 2025 rating period, the loss ratio considers the Healthy Michigan and MHP adult populations.

(i) Methodology

The SFY 2025 capitation rates were developed based on a desired level of dental utilization for the MHP adults and the Healthy Michigan program. The loss ratio methodology will provide health plans the ability to provide an appropriate level of dental services with the recognition that underutilizing the services may result in recoupments by MDHHS. The loss ratio is being established as a percentage of the dental costs incurred compared to the benefit expense for the dental component included in the SFY 2025 capitation rates. The calculation is dependent upon managed care health plans meeting a minimum utilization target. The managed care health plans must meet the minimum utilization target of 80% of the base utilization included in the paid dental capitation rates. If the health plan meets the dental loss ratio of 80%, no rebate is collected.

If the health plan meets the dental loss ratio of 70%, MDHHS will recover a rebate in the amount equal to 50% of the difference between the incurred dental benefit expense and the benefit expense included in the dental capitation rate paid to the health plan. If the health plan fails to meet the dental loss ratio of 70%, MDHHS will recover a rebate in the amount equal to 100% of the difference between the incurred dental benefit expense and the benefit expense included in the dental capitation rate paid to the health plan.

(ii) Summary of Results

SFY 2022 was the first year that this arrangement was reconciled and was limited to the HMP population. For SFY 2023, none of the health plans met the targeted minimum utilization threshold and a total of $68.6 million was recouped. However, actual utilization levels for SFY 2024 are much closer to the targeted utilization levels.

(iii) Attestation of the use of generally accepted actuarial principles and practices

Generally accepted actuarial principles and practices were followed in the development of the capitation rates and consideration of the loss ratio for the dental benefit.

(iv) Consistency with pricing assumptions

In the development of the capitation rates, we have included additional funding to target utilization and pricing levels desired as part of this program. These assumptions will be used consistently in the settlement of the arrangement following the review of actual utilization from the SFY 2025 incurred period.

(v) Remittance

As noted in the methodology section, failure to meet the minimum utilization target will result in a performance penalty in which MDHHS will recover 100% of the difference between the incurred dental benefit expense and the benefit expense component of the dental capitation rate paid to the managed care health plans. The resulting experience will not result in remittance if the MCOs meet minimum utilization targets incorporated in the capitation rates.

(b) Medical Loss Ratio

Description

MDHHS's provider agreement establishes a minimum medical loss ratio (MLR) of 85.0% for the Medicaid managed care population. The specific language from the provider agreement between MDHHS and the MCOs should be referenced for final contract specifications and definitions. The MLR is calculated in accordance with guidance presented in the final Medicaid and Children's Health Insurance Program rule, released on May 6, 2016.

Financial consequences

For SFY 2025, MDHHS has outlined in the contract a financial consequences for having a medical utilization ratio (MUR) below 85.0%. The MUR is calculated similar to the CMS MLR calculation but excludes state-directed payments. To the extent that the calculated MUR is below 85.0%, the MCOs will remit payment back to MDHHS.

Summary of reported MLR

The following table provides a summary of draft reported medical loss ratios for SFY 2023 as reported by the participating health plans that submitted MLR reports.

REPORTED SFY 2023 MLR

Health Plan	Reported MLR
Aetna Better Health	92.5%
Blue Cross Complete	94.0%
HAP Empowered Health Plan	89.0%
McLaren Health Plan	96.1%
Meridian Health Plan	95.1%
Molina Health Care	90.6%
Priority Health HMO	92.7%
United Healthcare Community Plan	91.7%
Upper Peninsula	89.9%

(c) Reinsurance Requirements and Effect on Capitation Rates

The standard contract language between the state and the health plans requires contractors to maintain certain insurances as identified in Section 6.1 of the contract terms. These would include general liability insurance. Contractors are also required to utilize subcontractors with similar insurance coverages.

D. STATE DIRECTED PAYMENTS

i. Rate Development Standards

Consistent with guidance in 42 C.F.R. §438.6(c), the Michigan managed care capitation rates reflect consideration of the following delivery system and provider payment initiatives (i.e., state directed payments):

- Hospital reimbursement adjustment (HRA) program;
- Graduate Medical Education (GME); and,
- Specialty Network Access Fee (SNAF).

(a) Description of Managed Care Plan Requirement

MDHHS requires the MCOs to participate in a state directed initiative to reimburse hospitals and qualifying physicians through the HRA and SNAF programs above the state's FFS fee schedule to ensure access to Medicaid beneficiaries. Additionally, Graduate Medical Education (GME) payments are made in the State of Michigan Medicaid program to teaching hospitals for purposes of funding graduate medical education within the state. These amounts are paid to the teaching hospitals by the health plans but are not included in the contracted rates between the plans and the hospitals.

(b) Written Approval

MDHHS is awaiting written approval for the HRA and SNAF state directed payment delivery systems for SFY 2025.

(c) Actuarial Standards

Payments for the HRA and SNAF delivery systems were developed in accordance with 42 C.F.R. § 438.4, the standards specified in § 438.5, and generally accepted actuarial principles and practices.

(d) How Payment Arrangement is Reflected in Managed Care Rates

The payments within the various directed payment initiatives are made on a retrospective basis to the managed care health plans.

(i) Documentation related to payment term included in the rate certification

Documentation related to the separate payment term is addressed in Section I, Item 4.D.ii(a)(iii).

(ii) PMPM estimate of state-directed payments addressed through separate payment term

PMPM estimates related to the state directed payments are included in Appendix 2 of this certification report.

(iii) Final documentation of total state-directed payment amount by rate cell

To the extent the final state-directed PMPM payments by rate cell vary from the initial estimates an amendment will be developed including a certification of the final capitation rates.

(iv) Change from initial base rate certification

As indicated above, the rate certification will be updated through a rate amendment if the total payment amount or distribution methodology varies from the initial estimates.

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

Utilization of the following delivery system and provider payment initiatives will be included in the final capitation rates:

CONTROL NAME	TYPE OF PAYMENT	BRIEF DESCRIPTION	RATE ADJUSTMENT OR SEPARATE PAYMENT TERM
MI_Fee_IPH.OPH_Renewal_20241001-20250930 (pending approval)	Uniform percentage increase	See description below	Separate payment term
MI_Fee_PC.SP_Renewal_20241001-20250930 (pending approval)	Uniform percentage increase	See description below	Separate payment term

- **Hospital reimbursement adjustment program**. The Hospital Reimbursement Adjustment (HRA) program was developed to ensure continued access by Medicaid beneficiaries to high quality hospital care. The program was introduced into the managed care program beginning January 2007. This was introduced to incentivize hospitals to contract with the managed care health plans to align with the State's approved hospital supplemental upper payment limit program under the FFS program. Effective October 1, 2017, the State of Michigan re-defined the HRA program as a state-directed payment and is connecting payments to utilization.

  The payments within the HRA program are done on a retrospective basis to the managed care health plans. The actual payment amounts will be an adjustment to both hospital inpatient and hospital outpatient expenditures associated with reported utilization. For purposes of the SFY 2025 438.6(c) pre-print, the HRA program is based on a percentage of an Average Commercial Rate (ACR) consistent with the SFY 2024 rating period.

- **Specialty Network Access Fee**. The Specialty Network Access Fee (SNAF) program was developed to allow greater network access for Medicaid enrollees by encouraging physicians to accept Medicaid patients through payments that are higher than Medicaid fee levels. The program was introduced into the managed care program beginning October 2008. This program was developed to be consistent with the Physician Adjustor Payment program under the fee-for-service environment which reimburses certain services at an average commercial level. The physician reimbursement is limited to a specific set of specialty care physicians belonging to certain publicly affiliated networks within the State of Michigan.

(ii) Description of payment arrangement if incorporated as a rate adjustment

The state-directed payments will be reflected through a separate payment term as described in Section I, Item 4.D.i(b).

(iii) Description of payment arrangement if incorporated as a separate payment term

The payment arrangements will be incorporated through a separate payment term in which the monthly capitation rate will be directed to the eligible hospitals and qualifying physicians based on actual utilization.

CONTROL NAME	AGGREGATE AMOUNT	PMPM MAGNITUDE	PREPRINT CONSISTENCY CONFIRMATION	SUBMIT REQUIRED DOCUMENTATION REQUIREMENT
HRA (pending approval)	$5,068.2 million	Listed by rate cell in Appendix 2	This state directed payment is consistent with the preprint.	MDHHS will provide required documentation following SFY 2025 with actual amounts paid on a retrospective basis.
SNAF (pending approval)	$610.0	Listed by rate cell in Appendix 2	This state directed payment is consistent with the preprint.	MDHHS will provide required documentation following SFY 2025 with actual amounts paid on a retrospective basis.

(b) Additional directed payments not addressed

- **Graduate Medical Education Payments**. The GME payments are received by teaching hospitals with an accredited medical education program. The GME payments are funded through state general funds. GME payments are made for both direct and indirect graduate medical education to teaching hospitals throughout the state. The payments are used to fund residencies for Primary Care Physicians as well as other specialties. Allocation of the GME amount is based upon projected aggregate hospital inpatient expenditures across the rate cells, including the maternity case rate. The specific PMPM amounts allocated to each rate cell are included in the rates noted in this report in Appendix 2.

(c) Requirements regarding reimbursement rates

There are no requirements regarding the reimbursement rates the managed care plan(s) must pay to any providers unless specifically specified in the certification as a state directed payment or authorized under applicable law, regulation, or waiver.

E. PASS-THROUGH PAYMENTS

i. Rate Development Standards

This section provides documentation of the pass-through payments reflected in the SFY 2025 capitation rates.

ii. Appropriate Documentation

There are no pass-through payments reflected in the SFY 2025 capitation rates.

5. Projected non-benefit costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 C.F.R. §438.5(e), the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to MCO operation of the Michigan Medicaid managed care program.

The remainder of Section I, item 5 provides documentation of the data, assumptions and methodology that we utilized to develop the non-benefit cost component of the capitation rate.

ii. PMPM versus percentage

The non-benefit cost was developed as a percentage of the capitation rate for all populations with the exception of the Dual Eligibles (MME) population which receives an $8.00 PMPM administrative load.

An additional component of the non-benefit expense is the insurance provider assessment (IPA) that 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 MCO, up to 1.2 million member months 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 vary by MCO based on actual enrollment over the course of SFY 2025. The IPA was effective starting October 1, 2018 and is paid on a retrospective basis at the end of each quarter.

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

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

Data

The primary data sources used in the development of the state fiscal year 2025 non-benefit costs are listed below:

- Historical non-benefit costs included in prior rate certifications.
- Statutory financial statement data for each of the health plans.
- Survey information provided by the managed care health plans.
- Average non-benefit costs from the financial statements of Medicaid MCOs nationally, as summarized by Palmer, Pettit, McCulla, and Miller. A link to the 2023 report published in July 2024 here: https://us.milliman.com/en/insight/medicaid-managed-care-financial-results-2023

Assumptions and methodology

In developing non-benefit costs, we reviewed historical administrative expenses for the managed care program along with national Medicaid MCO administrative expenses. We considered the size of participating MCOs and the resulting economies of scale that could be achieved, along with the benefits covered and the demographics of the population.

Historical reported administrative expenses by MCO were compared to statutory financial statements for consistency. Calendar year 2023 administrative expenses were adjusted for the assumed economies of scale that could be achieved due to continued maturity of the managed care program.

(b) Material changes

There are no material changes to the data, assumptions, or methodology used to develop the projected non-benefit cost. We utilized updated MCO reported information and made adjustments to the non-benefit expense loads to account for changes in the required administrative functions in the MCO contracts.

(c) Other material adjustments

There are no other material adjustments.

ii. Non-benefit costs, by cost category

Administrative expenses have not been developed from the ground up (based on individual components). However, individual components were reviewed within MCO-reported survey information and financial statement data. We did rely on MCO-reported information to estimate the allocation of the administrative expense percentage between general administrative costs and care coordination & care management expenses.

The SFY 2025 non-benefit cost allowance is applied as a percentage of the capitation rates excluding directed payments and taxes, as illustrated in Table 7 below.

TABLE 7: NON-BENEFIT EXPENSE COST AS PERCENTAGE OF MCO EFFECTIVE RATE

NON-BENEFIT EXPENSE	TANF-MEDICAL	DISABLED-MEDICAL	CSHCS LESS THAN 1	CSHCS OVER 1	HMP-MEDICAL	MCR
Administrative Expenses	10.75%	8.00%	3.00%	8.00%	10.75%	2.00%
Risk Margin	1.50%	1.25%	1.00%	1.25%	1.50%	1.00%
Total Non-Benefit Expense	**12.25%**	**9.25%**	**4.00%**	**9.25%**	**12.25%**	**3.00%**

Additionally, a flat dollar amount of $8.00 was added to the Dual Eligibles (MME) base experience. The HMP and adult MHP Dental component was adjusted by 10.0% for non-benefit expenses, rather than the Medical administrative expense. In addition to the administrative allowance, the capitation rates reflect an additional $0.08 PMPM of administrative load for in the TANF/Program L and Disabled populations and an additional $0.72 PMPM for the Healthy Michigan population to reflect funding for the Kidney Foundation to support patient education and outreach.

iii. Historical non-benefit costs

Part of the MCO Rate-Setting Survey responses included historical non-benefit costs for CY 2023. Based on information provided, we established non-benefit expense loads in line with historically reported expenditures for administrative cost allowances. We maintained historical non-benefit cost allowance assumptions in the SFY 2025 rate development as utilized in the SFY 2024 rate development period following a review of the historical assumptions and MCO reported experience. The table below shows the administrative costs reported in the MCO Rate-Setting Survey for CY 2023 compared to the administrative costs assumed in the SFY 2025 rate development.

SFY 2025 ADMINISTRATIVE COSTS (IN MILLIONS)

POPULATION	Composite
CY 2023 Reported Total Admin PMPM	$ 31.64
Original SFY 2024 Projected Admin PMPM	$ 34.24
SFY 2025 Projected Admin PMPM	$ 38.34

6. Risk Adjustment

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

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 C.F.R. §438.5(g), we will follow the rate development standards related to budget-neutral risk adjustment for the Medicaid managed care program. The composite rates for all populations (TANF/Program L, Blind and Disabled, Healthy Michigan, and CSHCS) will be prospectively risk adjusted by MCO to reflect estimated prospective morbidity differences in the underlying population enrolling with each MCO.

ii. Risk adjustment model

The populations will be prospectively risk-adjusted using CDPS+Rx risk scoring models. Risk adjustment is performed on a budget neutral basis for each of the defined populations, and the analysis uses generally accepted actuarial principles and practices.

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data and adjustments

The risk adjustment analysis will utilize SFY 2023 FFS and encounter data for the populations enrolled in managed care at July 2024 as the underlying data source populations. Full documentation of the results and methodology for the risk adjustment analysis is documented in a separate report.

(b) Risk adjustment model

Full documentation of the results and methodology for the risk adjustment analysis on the populations to be specifically risk-adjusted using CDPS+Rx risk scoring models is documented in a separate report.

(c) Risk adjustment methodology

The MDHHS risk adjustment is designed to be cost neutral for each of the defined populations. Relative risk scores will be normalized to result in a composite risk score of 1.000 for each population group, across all MCOs. The risk adjustment methodology uses generally accepted actuarial principles and practices.

(d) Magnitude of the adjustment

The magnitude of the adjustment per MCO is not known at this time. We will provide full documentation of the results and methodology for the risk adjustment analysis when it is complete.

(e) Assessment of predictive value

We will provide full documentation of the results and methodology for the risk adjustment analysis when it is complete.

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

At this time, we have no concerns with the risk adjustment process.

ii. Retrospective risk adjustment

Not applicable. The risk adjustment analysis will utilize a prospective methodology.

iii. Changes to risk adjustment model since last rating period

We used the CDPS+Rx risk adjustment model, Version 7.0 for the last rating period, and we continued to use version 7.0 for the SFY 2025 rating period.

7. Acuity Adjustments

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

A. RATE DEVELOPMENT STANDARDS

i. Overview

An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered an acuity adjustment, which is a permissible adjustment under 42 C.F.R. § 438.5(f).

The following table summarizes the buildup of the acuity adjustment.

TABLE 8: MODELED ACUITY RATE ADJUSTMENT BY RATE CELL

POPULATION	AVERAGE NET % ENROLLMENT CHANGE	NET LEAVERS RELATIVE ACUITY	RATE ADJUSTMENT
HMP	(27.1%)	0.791	1.078
MHP-TANF-Kids	(14.9%)	0.732	1.047
MHP-TANF-Adults	(21.2%)	0.829	1.046
MHP-Disabled	(10.9%)	0.594	1.050

To assess the relative difference in acuity between the base data period (CY 2023) and the rating period (SFY 2025), we assigned risk scores to all members enrolled from CY 2023 through July of 2024 based on historical diagnosis and drug information. Experience was summarized monthly to evaluate the change in risk scores because of the significant drops in enrollment following MDHHS resuming Medicaid enrollment redetermination. The average relative for SFY 2025 was projected based on the trend in relative acuity by rate cell. Adjustment factors were incorporated for the HMP, MHP-TANF, and MHP-Disabled populations.

Based on that review, members who were anticipated to disenroll the program by SFY 2025 exhibited an acuity profile approximately 20-40% lower than members projected to stay. We will continue to review the members who disenroll from the program and analyze their historical benefit expense against members who remain in the CHCP program and modify the relative acuity factors as needed.

(a) Timing of acuity adjustments

The composite rates for TANF/Program L, Healthy Michigan, and Disabled rate cells will be prospectively adjusted to reflect estimated acuity differences in the underlying population disenrolling in the program.

B. APPROPRIATE DOCUMENTATION

i. Description

Starting July 2023, DHHS ended the continuous eligibility policy and resumed redeterminations on the enrolled population. Over the course of the proceeding 12 months, eligibility was reviewed causing significant changes in enrollment count. The members who were disenrolled exhibited a lower level of utilization of services on average compared to the retained population in the program.

(a) Uncertainty

Data reviewed in the capitation rate development reflected experience through July 2024, which accounts for the anticipated entirety of the 12-month PHE unwinding process. This has contributed to greater confidence in the enrollment projections, with the remaining greatest uncertainty attributed to the actual relative cost of members disenrolled from the program.

(b) Acuity adjustment model

The acuity factors were developed based on a review of relative acuity, measured by relative risk scores, for emerging members disenrolled as part of the PHE unwinding process. Actual relative costs from CY 2023 were also reviewed as part of the process when selecting the acuity adjustment factors.

(c) Data utilized

Modeled relative risks scores for members enrolled from CY 2023 through July 2024 were utilized when evaluating the acuity differences.

(d) Potential interactions

We have assumed limited interaction with other rate development components and have chosen not to make an explicit adjustment. We will monitor relationships on an MCO and regional level and make appropriate adjustments as needed.

(e) Frequency

We calculated the average relative acuity factor monthly based on actual members enrolled (and subsequently disenrolled). We intend to review the results with updated experience as more data becomes available.

(f) Application to capitation rates

We developed one adjustment factor for each rate cell based on a review of relative modeled risk scores. We applied the factor uniformly across all service categories with the PMPM impact outlined in Appendix 4.

(g) Documentation

We developed the acuity factors in accordance with generally accepted actuarial principles and practices.

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

Section II of the CMS Guide is not applicable to the MDHHS Medicaid managed care program. Managed long-term services and supports (MLTSS) are not covered benefits. Enrollees who have been approved for long term institutional care, waiver services, or institutional hospice care will be dis-enrolled from the managed care program and served under the FFS delivery system. Skilled nursing facility services are covered under this program only for stays generally less than 90 days. ICF/IID, and home and community-based services (HCBS) are not covered.

Section III. New adult group capitation rates

MDHHS implemented the Affordable Care Act's Medicaid expansion on April 1, 2014. As of July 2024, approximately 555,000 individuals receive Medicaid medical benefits through managed care health plans under MDHHS's expansion population, known as the 'Healthy Michigan' population.

1. Data

A. DATA USED IN CERTIFICATION

The data used to develop the Healthy Michigan capitation rates for SFY 2025 is CY 2023 HMP population encounter data. This is consistent with information previously described in Section I.

B. CONSISTENCY WITH HISTORICAL RATING

i. New data

Although the CY 2023 base experience represents a new set of base data, this only represents a new year of a similar data source.

ii. Monitoring of experience

We have continued to monitor emerging experience and are re-basing the rates for SFY 2025 using CY 2023 experience. Adjustments described and documented in other sections of this report represent updates we are making to the base experience based on emerging experience.

iii. Actual Experience vs. Prior Assumptions

We acknowledge that the ultimate enrollment in the Healthy Michigan plan has exceeded initial projections even prior to the impact of the PHE. Although 500,000 individuals were expected to receive coverage under this plan, the recent enrollment is over 723,000 lives, with around 75% of those enrolled with a managed care plan.

We have adjusted the HMP capitation rates over the prior fiscal years based upon actual HMP experience. The subsequent rate changes are consistent with initial expectations that rates would decrease from the initial rating periods following inception, but trend in the direction of the traditional managed care programs on year-over-year changes.

iv. Adjustments for differences between projected and actual experience

For SFY 2025, we are applying trends to account for emerging experience. We have made an additional adjustment to the dental benefit expense to reflect differences in projected versus actual experience. A separate risk sharing mechanism is in place to account for variances in SFY 2025 emerging experience.

2. Projected benefit costs

A. NEW ADULT GROUP CONSIDERATIONS

i. New adult groups covered in previous rating periods

(a) Experience Used in Rate Development

Actual Healthy Michigan experience is being utilized as the base experience for the SFY 2025 rating period, consistent with the rate setting process for SFY 2024. We continue to review the emerging experience as a reasonableness check against the developed capitation rates.

(b) Changes in Data Sources, Assumptions, or Methodologies Since Last Certification

As mentioned previously, we have updated the base experience period and assumptions documented in Section I for purposes of this rate certification.

(c) Assumption Changes Since Prior Certification

Differences in provider reimbursement rates or provider networks – Reimbursement levels were reviewed for this program and determined to be consistent with other managed care populations in the State of Michigan Medicaid program.

Other material adjustments – We did not make any other adjustments in the Healthy Michigan rate development process other than those previously outlined in the report.

B. REQUIRED ELEMENTS

i. Acuity or health status adjustments

Not applicable, no acuity adjustments were applied in the development of Healthy Michigan capitation rates that differ from the acuity adjustments previously described related to the unwinding of the PHE.

ii. Adjustments for pent-up demand

Not applicable, no pent-up demand adjustments were applied in the development of Healthy Michigan capitation rates.

iii. Adjustments for adverse selection

Not applicable, no adverse selection adjustments were applied in the development of Healthy Michigan capitation rates.

iv. Adjustments for demographics

Not applicable, no demographic adjustments were applied in the development of Healthy Michigan capitation rates.

v. Differences in provider reimbursement rates or provider networks

No adjustments for provider reimbursement or provider network were applied in the development of Healthy Michigan capitation rates, other than those documented in Section I of this report.

vi. Other material adjustments

No other material adjustments were applied in the development of Healthy Michigan capitation rates.

C. CHANGES TO BENEFIT PLAN

No benefit changes have been made to the Healthy Michigan benefit plan outside of those previously discussed. These changes were not specific to Healthy Michigan enrollees.

D. OTHER MATERIAL CHANGES OR ADJUSTMENTS TO BENEFIT COSTS

We did not make any other adjustments in the Healthy Michigan rate development process other than those previously outlined in the report.

3. Projected Non-Benefit costs

A. NEW ADULT GROUP CONSIDERATIONS

i. Changes in Data Sources, Assumptions, or Methodologies Since Last Certification

The development of the non-benefit costs was discussed in Section I.5.

ii. Assumption Differences Relative to Other Medicaid Populations

The non-benefit cost percentages are higher in the Healthy Michigan program from the traditional Medicaid managed care program based on the additional list of administrative services that are required for this population.

iii. Key assumptions

Key assumptions related to the Healthy Michigan population are documented in Section I of this report.

4. Final certified rates

A. REQUIRED ELEMENTS

i. Comparison to Previous Certification

Fiscal impact and rate changes for the Healthy Michigan population are illustrated in Tables 1 and 2 of Section I along with Appendix 2.

ii. Description of Other Material Changes to the Capitation Rates

We have addressed all material changes to the Healthy Michigan rate development methodology.

5. Risk mitigation strategies

A. DESCRIPTION OF RISK MITIGATION STRATEGY

The HMP rates have been developed as full risk rates. The health plan assumes risk for the cost of services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract. Prior to January 1, 2016, a shared savings risk corridor was in place for the first 21 months of the Healthy Michigan program. Effective January 1, 2016, separate area factors were developed for the capitation rates based on a blend of morbidity and cost per service on a regional basis. Effective October 1, 2024, the Healthy Michigan program rates will be risk adjusted at the MCO level consistent with the description in Section I of this report.

A 2% withhold is applied to all capitation rates. The rates being paid to the health plans without the withhold are also actuarially sound. The amounts being withheld from payments to the plans can be earned back based upon metrics that consistent with cost and utilization assumptions included in the rate development process. The withhold will not result in payments that are outside of the certified capitation rates and is considered actuarially sound under 42 C.F.R. 438.6. An additional loss ratio arrangement for the dental benefit is being discussed and described in Section I of the report.

B. NEW ADULT GROUPS COVERED IN PREVIOUS RATE SETTING

i. Changes to Risk Mitigation Strategy Relative to Prior Certifications

The shared savings risk corridor arrangement that was in place for the first 21 months of the Healthy Michigan program was eliminated and replaced with the regional and MCO risk adjustment factors.

ii. Rationale for changes in risk mitigation strategy

The shared savings risk corridor was only intended to be effective for a limited time period as the Healthy Michigan program matured and reflected ultimate enrollment and included sufficient experience with which to establish capitation rates.

iii. Relevant Experience, Results, or Preliminary Information

The shared savings analysis for the risk corridor that was in place during the first year of the program resulted in an approximate 90% claims cost ratio for base claims.

Limitations

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.

Milliman has developed certain models to estimate the values included in the capitation rate development. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as inputs to the models. We have relied upon certain data and information provided by MDHHS and its vendors for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

The models, including all inputs, calculations, and outputs may not be appropriate for any other purpose.

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
Medical Services Risk Based Managed Care Program
Capitation Rates Effective October 1, 2024 through September 30, 2025
Actuarial Certification

I, Christopher T. 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 and 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 C.F.R. 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 C.F.R. 438.4(b).

For the purposes of this certification and consistent with the requirements under 42 C.F.R. 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."

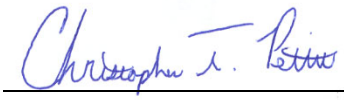
The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of Michigan. The "actuarially sound" capitation rates that are associated with this certification are effective for the rate period October 1, 2024 through September 30, 2025.

The capitation rates are considered actuarially sound after adjustment for the amount of the withhold not expected to be earned.

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. 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

September 20, 2024
Date

Appendix 2: Capitation Rate Comparison (Provided Separately in Excel)

Appendix 3: Retrospective Cost Models (Provided Separately in Excel)

Appendix 4: Prospective Cost Models (Provided Separately in Excel)

Appendix 5: Trend Analysis (Provided Separately in Excel)

Appendix 6: Adjustment Factor Impact (Provided Separately in Excel)

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