Calendar Year 2018 Medicaid Capitation Rate Certification:

MI Health Link

January 1, 2018 through December 31, 2018

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 actuarially sound capitation rates for the MI Health Link program to be effective January 1, 2018. The rates being certified as actuarially sound are to be effective retroactive to January 1, 2018 and remain in effect through December 31, 2018. MI Health Link is Michigan's managed care program for the dual eligible (Medicare-Medicaid) population.

This letter provides documentation for the development of the actuarially sound capitation rates for calendar year 2018. It also includes the required actuarial certification in Appendix 1. Unless otherwise specified, all references to "rates" or "capitation rates" throughout this document refer to the Medicaid-specific component of the MI Health Link capitation rates.

To facilitate review, this document has been organized in the same manner as the 2017-2018 Medicaid Managed Care Development Guide, released by the Center for Medicare and Medicaid Services in April 2017 (CMS guide). Section III of the CMS guide is not applicable to this certification, since the covered services do not include rates for new adult groups.

SUMMARY OF CAPITATION RATES

The capitation rates for the MI Health Link population are illustrated in Table 1 by rate cell. The underlying capitation rates by rate cell are effective from January 1, 2018 through December 31, 2018. The capitation rates covered under this certification are documented in Appendix 2. The rates in Table 1 are illustrated on a gross basis prior to adjustment for any amounts that are expected to be paid by the beneficiary and recouped by the nursing facilities. The rates in Table 1 reflect the mandatory 3% savings assumption prescribed by CMS and the state for demonstration year 3. The percentage change reflects a comparison with the rates paid as of the end of calendar year 2017 rates.

Table 1
State of Michigan
Department of Health and Human Services
MI Health Link Capitation Rates by Rate Cell
Effective January 1, 2018
Comparison with CY 2017 Rates (PMPM Rates)

Rate Cell	Estimated CY2018 Average Monthly Enrollment	Calendar Year 2017 Rates	Calendar Year 2018 Rates	% Change
Nursing Facility – Subtier A				
Over Age 65	1,484	$6,139.18	$6,422.77	4.6%
Under Age 65	200	$5,442.71	$5,722.72	5.1%
Nursing Facility – Subtier B				
Over Age 65	189	$9,841.41	$10,320.65	4.9%
Under Age 65	8	$9,579.56	$10,337.99	7.9%
Nursing Facility LOC-Waiver				
Over Age 65	360	$2,147.89	$2,323.20	8.2%
Under Age 65	366	$2,752.78	$2,785.13	1.2%
Community Residents				
Over Age 65	15,261	$146.29	$163.47	11.7%
Under Age 65	20,652	$120.23	$134.53	11.9%

Notes:
1. Values shown are on a gross basis prior to reduction for patient pay amounts and withhold.
2. CY 2018 rates include amounts estimated to be paid for the Insurance Provider Assessment in CY 2018.
3. Distribution of enrollment based on actual enrollment as of March 2018.
4. A Nursing Facility transition case rate of $900 is paid to ICOs who successfully transition a member from a nursing facility into either an HCBS or Community setting consistent with the MI Choice HCBS program transition case rate.

FISCAL IMPACT ESTIMATE

The estimated fiscal impact of the CY 2018 MI Health Link rate changes on a state and federal basis documented in this report is a $14.5 million increase to aggregate expenditures, with $4.5 million represented by the Insurance Provider Assessment (IPA). This amount is on a state and federal expenditure basis using the projected monthly enrollment for CY 2018. Table 2 provides the development of estimated total expenditures, as well as federal only expenditures, under the current contracted capitation rates and the proposed CY 2018 capitation rates illustrated in Table 1. The federal expenditures illustrated in Table 2 are based on a combination of the Federal Fiscal Year 2018 FMAP of 64.78% for 9 months and 2019 FMAP of 64.45% for 3 months.

Table 2
State of Michigan
Department of Health and Human Services
MI Health Link
Rates Effective January 1, 2018
Comparison with Previous Rates (Aggregate Expenditures $ Millions)

Population	Aggregate Expenditures at 2017 Rates	Aggregate Expenditures at 2018 Rates	Expenditure Change
Nursing Facility-Subtier A	$ 122.4	$ 128.1	$ 5.7
Nursing Facility-Subtier B	23.2	24.4	1.2
NFLOC – Waiver	21.4	22.3	0.9
Community Well	56.6	63.3	6.7
Total MI Health Link	**$223.6**	**$238.1**	**$14.5**
Total Federal	**144.6**	**151.1**	**6.4**
Total State	**78.9**	**87.0**	**8.1**

Notes:
1. Annualized expenditures were developed with projected enrollment.
2. Values are rounded and include estimated amounts associated with the IPA.
3. State expenditures based on Federal Fiscal Year (FFY) 2018 FMAP of 64.78% for 9 months and 2019 FMAP of 64.45% for 3 months. Amounts associated with the IPA are 100% state funded for the MI Health Link program.

RATE CHANGE SUMMARY

Table 3 illustrates the changes from the CY 2017 capitation rates to the CY 2018 capitation rates by major category.

Table 3
State of Michigan
Department of Health and Human Services
MI Health Link
Rates Effective January 1, 2018
Capitation Rate Change Impact Summary

	Nursing Facility-Subtier A		Nursing Facility-Subtier B		NFLOC-Waiver		Community Well	
Rating Impact Factor	**Over 65**	**Under 65**	**Over 65**	**Under 65**	**Over 65**	**Under 65**	**Over 65**	**Under 65**
Previous Capitation	$ 6,139.18	$ 5,442.71	$ 9,841.41	$ 9,579.56	$ 2,147.89	$ 2,752.78	$ 146.29	$ 120.23
Rebasing and Trend[1]	(113.88)	(92.09)	483.40	836.70	(6.02)	(11.01)	17.71	13.30
Patient Pay Update	(75.45)	(60.87)	81.08	9.83	N/A	N/A	N/A	N/A
Capitation Rate Updates[2]	N/A	N/A	N/A	N/A	195.29	62.07	1.64	1.66
Selection Factor	$521.58	475.56	N/A	N/A	N/A	N/A	(10.84)	(9.22)
Blending cost mix[3]	N/A	N/A	N/A	N/A	N/A	N/A	0.35	(0.06)
Mandatory savings[4]	(58.57)	(53.50)	(95.15)	(98.01)	(23.87)	(28.61)	(1.59)	(1.29)
IPA	9.91	9.91	9.91	9.91	9.91	9.91	9.91	9.91
CY 2018 Capitation Rate	$ 6,422.87	$ 5,722.72	$ 10,320.65	$ 10,337.99	$ 2,323.20	$ 2,785.13	$ 163.47	$ 134.53

[1] Rebasing and trend change reflects update to SFY 2016 base data along with completion and trend adjustments to CY 2018 midpoint

[2] Reflects impact of updates to MIChoice and Duals Lite capitation rates for SFY 2018

[3] Reflects change in blending of FFS and HMO enrollment in the community well rate development

[4] Reflects increase in mandatory savings from 2% to 3%

SECTION I. MEDICAID MANAGED CARE RATES

1. GENERAL INFORMATION

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

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

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

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

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).

- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the CY 2018 managed care program rating period.

- The *2017-2018 Medicaid Managed Care Rate Development Guide* published by CMS in April 2017.

- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" will be defined as in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."[5]

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

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

A. RATE DEVELOPMENT STANDARDS

i. Annual basis

The actuarial certification contained in this report is effective for the capitation rates for the one year rate period from January 1, 2018 through December 31, 2018.

ii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Christopher Pettit, FSA, is in Appendix 1. Mr. Pettit meets the qualification standards established by the American Academy of Actuaries, follows the practice standards established by the Actuarial Standards Board, that certify that the final rates meet the standards in 42 CFR §438.3(c), 438.3(e), 438.4 (excluding paragraphs (b)(3), (b)(4) and (b)(9)), 438.5, 438.6, and 438.7 (excluding paragraph (c)(3)..

(b) Certified capitation rates for each rate cell

The certified capitation rates by rate cell are illustrated in Appendix 2. Projected membership illustrated in Appendix 2 represents estimated values for the rating period. The rates within this report represent the capitation rates prior to application of the area factors, which are additionally illustrated in Appendix 2. For the Nursing Facility rate cells, the rates are developed on a gross basis, prior to the application of patient liability. On an individual basis, MDHHS will deduct the actual patient pay liability amount from the Nursing Facility capitation rate shown in Table 1 and pay the net capitation rate to the ICO.

(c) Certified rate ranges

This certification does not include a rate range. This section is not applicable.

(d) Program information

(i) Managed Care program

MDHHS, along with CMS and the MI Health Link ICOs, provides benefits for fully dual eligibles under the MI Health Link program within targeted geographic areas. This letter provides the documentation and certification of the calendar year 2018 capitation rates for the Medicaid component of the MI Health Link program.

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

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

The services provided under this contract include complete physical and behavioral health, and long-term services and supports. Appendix 5 provides a listing of the services covered under the MI Health Link program. Detailed benefit coverage information for all benefits can be found in the provider agreements.

The program pays secondary to Medicare for Medicare covered services.

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

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

Beneficiaries who reside in a hospice facility are no longer excluded from the program following a change in the three-way contract during calendar year 2016. However, beneficiaries will not be allowed to enroll from a hospice setting, but rather transition to hospice during enrollment.

(ii) Rating period

This actuarial certification is effective for the one year rating period January 1, 2018 through December 31, 2018.

(iii) Covered populations

Target Population

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

Excluded Populations

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

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

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

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

Nursing Facility Population

This population includes individuals residing in a nursing facility who meet the state definition of nursing home level of care and who are not enrolled in a waiver. Milliman identified the population in the capitation rate-setting process by using fields in the MDHHS eligibility data that denote Medicaid individuals as meeting the nursing home level of care criteria and reside in a nursing facility. The capitation rate for this rate cell was developed based on projected gross nursing facility rates. On an individual basis, MDHHS will deduct the actual patient pay liability amount from the nursing facility capitation rate shown

in Table 1 and pay the net capitation rate to the ICOs. The nursing facility population is divided into subtiers, split by individuals residing in a privately owned (Subtier A) versus a publicly owned (Subtier B) nursing facility.

A transition case rate payment will be made after the transition of a Nursing Facility enrollee into a home or community setting (Waiver or Community tier). In order for the transition to qualify for the case rate, the ICO must have been paid three consecutive Nursing Facility tier capitation payments for the individual.

Nursing Facility Level of Care-Waiver Population

This population includes individuals who meet the state definition of nursing home level of care, but do not reside in a nursing facility. Eligible individuals must not be enrolled in the State's MIChoice program. Milliman utilized current MIChoice enrollee experience in the rate-setting process to determine the capitation rates for this population. The development of the rates is a combination of SFY 2018 MIChoice capitation payments and historical fee-for-service costs for services that are not identified as a waiver service as there are no substantive differences between the services provided to populations enrolled in MIChoice versus MI Health Link. The development of these rates is illustrated in Appendix 2.

Community Residents Population

This population includes all other qualifying individuals who were not previously categorized. This population is comprised of eligible individuals who are neither institutionalized nor participating in a 1915(c) waiver program. The development of the capitation rates for this population is a blend of historical fee-for-service experience and the capitation rates for the Duals Lite program. As certain services are not covered under the Duals Lite capitation rate, fee-for-service costs related to Duals Lite enrollees are also included in the development of this rate. These costs are illustrated separately from fee-for-service experience on non-HMO enrollees in Appendix 2.

(iv) Eligibility criteria

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

(v) Special contract provisions

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

- Withhold arrangements

Please see Section I, item 4 for additional detail and documentation.

(vi) Retroactive adjustment to capitation rates

This rate certification report does not include a retroactive adjustment to the CY 2018 capitation rates.

iii. Differences among capitation rates

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

iv. Cross-subsidization of rate cell payment

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

v. Effective dates

To the best of our knowledge, the effective dates of changes to the MI Health Link managed care program are consistent with the assumptions used in the development of the certified CY 2018 capitation rates.

vi. 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. To our knowledge, we have not excluded any reasonable, appropriate, and attainable costs inform the rates documented in this certification.

(b) Outside the rate setting process

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

(c) Final contracted rates

The CY 2018 capitation rates certified in this report represent the rates by rate cell prior to application of the regional factors. The regional factors are illustrated in Appendix 2.

vii. Rate certification for effective time periods

This actuarial certification is effective for the one year rating period January 1, 2018 through December 31, 2018.

viii. Procedures for rate certification and amendment

In general, a new rate certification will be submitted when the rates change. The following exceptions are allowed:

1. A contract amendment that does not affect the rates.
2. 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. No risk adjustment process is proposed for this contract.

B. APPROPRIATE DOCUMENTATION

i. Documentation of required elements

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

ii. Index

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

iii. Different FMAP

All populations receive the regular state FMAP of 64.78% for FFY 2018.

iv. Assumptions and Methodology for development and certification of rate ranges

This certification does not include a rate range. This section is not applicable.

v. Documentation of development and certification of rate ranges

This certification does not include a rate range. This section is not applicable.

2. DATA

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

A. RATE DEVELOPMENT STANDARDS

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

B. APPROPRIATE DOCUMENTATION

i. Requested data

As the actuary contracted by MDHHS to provide consulting services and associated financial analyses for many aspects of the Michigan Medicaid program (and not just limited to capitation rate development), Milliman intakes and summarizes eligibility and expenditure data on a monthly basis from Optum, MDHHS's data administrator. We received eligibility and expenditure information historical time periods. There was no data that was requested from Milliman that was not received. The remainder of this section details the base data and validation processes utilized in the CY 2018 capitation rate development.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

The following experience served as the primary data sources for the calendar year 2018 MI Health Link capitation rate development:

- Fee-for-service data for the MI Health Link eligible population for October 1, 2015 through September 30, 2016 (base data year) and paid through September 2017
- Detailed fee-for-service and managed care enrollment data for October 1, 2015 through September 30, 2016
- Managed care capitation rates paid to the health plans serving enrollees in the Duals Lite and MI Choice managed care programs for SFY 2018
- Additional gross adjustment expenditure information outside the MMIS claims system
- Summary of policy and program changes through state fiscal year 2017 (including changes to fee schedules and other payment rates)
- Monthly enrollment for the MI Health Link program

Appendix 3 illustrates the fee-for-service base data summaries that provide the foundation for the calendar year 2018 MI Health Link capitation rate development. The information is stratified by rate cell and category of service.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during state fiscal year 2016 (October 1, 2015 to September 30, 2016). The fee-for-service data used in our rate development process reflects adjudicated data through September 2017.

For the purposes of trend development and analyzing historical experience, we also reviewed fee-for-service and enrollment experience from state fiscal years 2014 and 2015. We utilized enrollment as of March 2018 for purposes of emerging population enrollment patterns.

(iii) Data sources

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

(iv) Sub-capitation

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

(b) Availability and quality of the data

(i) Steps taken to validate the data

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

Completeness

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

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

Accuracy

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

Consistency across data sources

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

(ii) Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that Milliman has relied upon certain data and information provided by the State of Michigan and their vendors, primarily the state's fiscal agent. The values presented in this letter are dependent upon this reliance.

The fee-for-service data represents the most appropriate data to be used for developing the actuarially sound capitation rates for the CY 2018 MI Health Link program.

(iii) Data concerns

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

(c) Appropriate data

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

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

(ii) Use of managed care encounter data

Encounter data was not used for this certification. The encounter data is not of sufficient quantity or quality to be relied upon for the development of actuarially sound capitation rates. We did utilize the SFY 2018 capitation rates for the Duals Lite and MI Choice programs for purposes of establishing the Community and Waiver tier rates. These rates were based on encounter data, but no updates to these rates were made for purposes of the MI Health Link rate development.

Additionally, as these rates are intended to be projections of costs "in absence of the demonstration" encounter data would not be applicable.

(d) Reliance on a data book

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

iii. Data adjustments

Capitation rates were developed from historical state fiscal year 2016 fee-for-service data, paid through September 2017. As shown in Appendix 3, the primary base data year adjustments include completion, trend, reimbursement, and other program adjustments.

(a) Credibility adjustment

The MI Health Link eligible populations, in aggregate, were considered fully credible. No adjustments were made for credibility in the aggregate; however, we did implement data smoothing among population groups and regions as discussed in a later section of this report.

(b) Completion adjustment

Historical fee-for-service claims experience was run through an internal Milliman claims reserving system to estimate completion factors. Separate sets of factors were developed for each demonstration tier and major category of service. Milliman combined the nursing facility sub-tiers for purposes of the completion factor analysis. The development of the completion factors for SFY 2016 experience was based on a traditional triangle methodology utilizing paid data through September 2017. Average adjustments were applied to SFY 2016 experience to account for the runout applicable to each of the experience periods. Applied completion factors are illustrated in Appendix 3.

(c) Errors found in the data

No specific errors were identified in the data.

(d) Program change adjustments

The base data year represents a historical time period from which projections were developed. We reviewed prior rate setting documentation and other materials from MDHHS to identify program changes that were implemented during the base data period. To the extent the program adjustments were estimated to have a material impact on ICO service costs an adjustment was considered for the calendar year 2018 rate development process. Adjustments were made to the portion of the base data prior to the implementation of each program change in order to ensure the entire base period was on a consistent basis.

Direct care wage increase

Based on a review of the specific policy and program changes that have occurred across other Medicaid populations in the State of Michigan, an adjustment was made to reflect a reimbursmeent increase for personal care services. Due to the minimum wage increase effective January 1, 2018 for State of Michigan workers, we have incorporated an adjustment of 8.8% to the Home Help service line to reflect the change from $8.50 that was in place during SFY 2016 (the base period) to the new rate in CY 2018 of $9.25. this adjustment is reflected outside of the trend adjustment and is shown in the cost model projecitons in Appendix 3. As capitation rates are stratified by age, the utilization is specific to each rate cell and the impact of the direct care wage increase had a different impact by rate cell.

Travel time for Home Help

Pursuant to Medical Bulletin 17-39, members who qualify for the Home Help program and receive assistance with instrumental activities of daily living (IADLs), may receive payment for travel time to shop for food, prescriptions, medical necessities and household items required specifically for the health and maintenance of the client. Travel time is not included in the current shopping or travel task limitation, but is in addition to the time to complete the task. Payment for travel cannot exceed the number of approved trips for these tasks, and the cost of mileage will not be included in the payment. Based on the lack of historical experience tied to this benefit, we considered this benefit change in the development of the prospective trend rates to account for the increased in reimbursement associated with this change.

Hearing Aid Coverage

Effective September 1, 2018, all managed care contracts in the State of Michigan will include coverage for hearing aids and battery replacements. Currently, hearing aid coverage is only applicable to the Healthy Michigan population. Based on the lack of recently available experience for this benefit for a comparable population to MI Health Link, we have estimated an amount utilizing external sources of information. We reviewed internal Milliman utilization and cost information along with hearing aid coverage in additional state Medicaid programs for a comparable population. For purposes of the CY 2018 rate development process we have included an expenditure amount for the 4-month coverage period (September 1 to December 31, 2018) and allocated across the entire 12-monht rating period. The amount allocated to each rate cell is identified separately in Appendix 2. The underlying cost and utilization to support this adjustment was based on utilization experience from a state similar to Michigan in size and dual demonstration operation which included hearing aid coverage as part of their benefit plan. The experience was repriced utilizing the Michigan fee schedule for hearing aid services.

Other

No additional adjustments were made to the services covered by the MI Health Link program. Although other reimbursement changes may have occurred or are expected to change (e.g., NEMT and Laboratory fees), these are accounted for in the base data and consideration of future trend. Policy and program changes that were noted in prior MI Health Link capitation rate development were for time periods prior to the base data utilized in the CY 2018 rate development process. Thus, the base data would include these adjustments.

(e) Exclusion of payments or services from the data

No specific payments were excluded from the rate development.

3. PROJECTED BENEFIT COST AND TRENDS

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

A. RATE DEVELOPMENT STANDARDS

i. Final Capitation Rate Compliance

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

ii. Basis for Variation in Assumptions

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

iii. Benefit Cost Trend Assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends is historical claims and enrollment from the 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.

iv. In-Lieu-Of Services

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

v. Benefit expenses associated with members residing in an IMD

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), both stays less than and more than 15 days in a month. Therefore, we have not included an adjustment to the base experience data for IMD and associated expenses.

vi. IMDs as an in lieu of service provider

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

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

The adjusted fee-for-service base data year described in the previous section reflects benefits and program requirements as of the end of the data period (September 30, 2016). Additional adjustments were made for completion and trend to the midpoint of the effective period of the capitation rates. Development of the projected benefit cost stratified by population group, and category of service is provided in Appendix 3.

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:

The historical expenditures were stratified using date of service, category of service, and provider type. The following provides additional details regarding the expenditures.

- **Date of Service** – The base data utilized for rate development was limited to SFY 2016.
- **Category of Service** – Claim line detail provided by MDHHS was used to summarize the expenditure data for the base data summaries. Milliman internal software was used to group services using detailed procedure and diagnosis code information for all service categories with the exception of institutional claims. For these expenditures, procedure code and MDHHS-specific information was used to categorize the expenditure data. Service category lines are contained within the appropriate provider types outlined below.
- **Provider Type** – Expenditures were stratified by provider type. The provider type includes nursing facility, inpatient hospital, outpatient hospital, prescription drugs, other ancillary services, and physician services. The following provides additional information regarding the provider type.
    - Nursing facility services include daily costs for members residing in a nursing facility. The Nursing Facility cost per day includes gross adjustment payments made by MDHHS to all nursing facilities for Quality Assurance Supplement (QAS) payments and Certified Public Expenditures on county-owned facilities.
    - Inpatient hospital services include all services performed and billed on the hospital facility claim, including any outpatient services that may have occurred in conjunction with that inpatient admission. This would include emergency room services that may have been incurred if the individual was admitted to the hospital.
        - Hospital Inpatient services were split between general and psychiatric services based on the DRG on the claim. Utilization rates have been shown for the number of admissions, length of stay, and days.
    - Outpatient hospital services include all services performed and billed on the hospital facility claim that were not associated with an inpatient admission. These services were split between general and hospice service based on the procedure and revenue codes on the claim.
    - Prescription drug claims were identified by the invoice type H, noted on the claim.
    - Ancillary services were stratified using HCPCS code and MDHHS code information. Utilization for other ancillary services represents the number of units billed on each individual claim.
        - A separate line item was included for services that are covered under the 1915c waiver. Please note that for the Nursing Facility Level of Care-Waiver tier, waiver services in the historical fee-for-service actuarial models are removed as the MI Choice capitation rates were used to represent the expected cost of these services for this population.
        - Home help service cost includes all gross adjustment payments made by MDHHS for Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax (FUTA) payments.
    - Physician services were stratified by CPT-4 code for the majority of service categories. Milliman performed additional stratifications for physician services by CPT-4 code to provide details regarding the services provided. Utilization represents the count of claim lines associated with each individual claim number.

Actuarial Models

Each actuarial model illustrates annual utilization rates per 1,000, average cost per unit, and per member per month (PMPM) claims cost developed using fee-for-service data. Appendix 3 contains actuarial models for services incurred during SFY 2016 and paid through September 2017. Additional factors are reflected to illustrate the adjustments applied to the calendar year 2018 base data. The following provides a brief description of each of the data fields.

- **Annual Admits Per 1,000** – This value represents the annual number of admissions per 1,000 member months for both the nursing facility and inpatient hospital service categories. The value was calculated by dividing the total number of admissions for each service category by the member months in the corresponding period and multiplying by 12 times 1,000.

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

Regional adjustments

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

To limit the amount of fluctuation from year to year that can occur with base data, we have blended the regional adjustment factors developed from SFY 2016 experience utilized in the CY 2018 MI Health Link rates (67% weight) with the regional adjustment factors from the CY 2017 MI Health Link rates (33% weight). This process is consistent with updates to the regional adjustment factors in CY 2017. The regional adjustment factors to be applied are documented in Appendix 2. Separate regional adjustments were not developed for Over/Under 65 rate cells.

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

The primary change from the prior year rate-setting is utilizing SFY 2016 experience and re-basing rate cells for CY 2018. All material assumptions are documented in this rate certification report and the overall methodology utilized to develop the capitation rates is consistent with the prior rate-setting analysis.

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

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

During the prior rate setting processes, assumptions were made regarding community resident enrollment percentages with varying penetration levels based on members' annual cost and types of services that were utilized. The composite selection factor that was estimated for the Community population assumed to participate in MI Health Link was approximately 0.760 for the Over Age 65 and Under Age 65 population in CY 2016 and 2017 rates. Based on the lack of FFS data for MI Health Link enrollees in the SFY 2016 experience, we calculated selection factors for the CY 2018 rate development process based on comparison of historical cost relativities between MI Health Link and FFS individuals. As such, the selection factor utilized for the CY 2018 rate development is the relativity between the CY 2017 applied selection factor and relativity between the composite SFY 2015 base data and the portion assumed to remain in FFS. The comparison of the Community Tier and related selection factor analysis is documented in Table 5 below.

Table 5 State of Michigan Department of Health and Human Services Selection Factor Development		
Assumptions	**Over 65 Rate Cell**	**Under 65 Rate Cell**
CY 2017 Rate Development		
% base experience enrolling in MI Health Link	31.7%	34.7%
MI Health Link Relative to SFY 15 Base Data	0.760	0.760
% base experience not enrolling in MI Health Link	68.3%	65.3%
Remaining FFS Population Relative to SFY 15 Base Data	1.111	1.127
Composite Experience	1.000	1.000
CY 2018 Rate Development		
% base experience enrolling in MI Health Link	0.0%	0.0%
MI Health Link Relative to SFY 16 Base Data	0.684 = 0.760 / 1.111	0.674 = 0.760 / 1.127

The process utilized for developing the selection factor for the FFS component of the community well rate was based on an assumed relativity in cost and an estimated percentage of members in the base experience that would be enrolled in the MI Health Link program. The primary difference between the CY 2017 rate development and CY 2018 rate development is the estimated percentage of members in in the base experience that were enrolled in the MI Health Link program (68.3% or 65.3% for over 65 and under 65 rate cells, respectively, versus 0.0%).

The methodology used and the cost relativity were consistently applied as the prior year. The distribution of members was updated to reflect that the base experience did not include any members enrolling in the MI Health Link program, since the base period represented a time period after the implementation of the program and members enrolled in the MI Health Link program are no longer part of the FFS data

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

For the CY 2018 rate development process, we are applying additional selection factors to the Nursing Facility Subtier A rate cells. Based on a review of the SFY 2016 experience identified as Nursing Facility enrollment, we observed a variance in the utilization of nursing facility services across the members. We separated the nursing facility members into categories for those utilizing 20+ days in a month, 11-20 days in a month, less than 10 days in a month, and those in a hospice setting. Based on how the nursing facility capitation rate is paid, we determined that the historical experience of the nursing facility FFS population does not align with the population that would enroll in MI Health Link and be categorized in the Nursing Facility tier. We have applied a selection factor adjustment of 10% to the Nursing Facility Subtier A rates to account for this adjustment. The 10% adjustment was based on the percent of lives in the FFS population that were in the less than 10 days category. Based on discussions with MDHHS, it was determined that, as part of the MI Health Link program, a majority of the members flagged with the nursing facility level of care (and subsequently assigned to NF Subtier A) would not be reimbursed with the Nursing Facility capitation rate. We assumed that 50% of the FFS population that were grouped in the less than 10 days category would not result in an ICO receiving the nursing facility capitation rate. The Subtier B population nursing facility utilization was consistent with the experience assumed for the MI Health Link population, and no adjustment was made. Application of the selection factor is illustrated in Appendix 2. Table 6 below provides analysis that was reviewed for consideration of the Nursing Facility selection factors that were applied.

Table 6 State of Michigan Department of Health and Human Services Nursing Facility Selection Factor Development				
	Subtier A		Subtier B	
	Member Months	PMPM	Member Months	PMPM
Nursing Facility Recipient	5,011	$4,872.18	29	$ 5,565.60
Less than 10 days	18,340	577.86	101	978.55
Between 11 and 20 days	2,603	2,297.96	160	2,904.19
Greater than 20 days	58,272	4,686.88	5,486	6,504.38
Composite Experience	84,226	$3,729.35	5,776	$ 6,303.31
Exclude 50% < 10 days		$4,114.38		$ 6,350.27
Cost relativity		10.3%		0.7%

iii. Projected Benefit Cost Trends

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (SFY 2016) to the CY 2018 rating period of this certification. We evaluated prospective trend rates using historical experience for the Michigan Medicaid managed care program, as well as external data sources.

(a) Required elements

(i) Data

The primary source of data used in the development of historical fee-for-service trends was SFY 2014 through 2016 fee-for-service data specific to the MI Health Link eligible population.

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

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

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

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

(ii) Methodology

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

(b) Benefit cost trend components

Appendix 4 provides the trend rates by population and category of service. These trends include both utilization and cost per service components.

(c) Variation

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

(d) Material adjustments

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

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

(e) Any other adjustments

(i) Impact of managed care

We did not adjust the trend rates to reflect a managed care impact on utilization or unit cost. The capitation rates have an explicit adjustment for the demonstration savings assumed under mutual agreement in the MOU.

(ii) Trend changes other than utilization and cost

We did not adjust the benefit cost trend for changes other than utilization or unit cost.

iv. Mental Health Parity and Addiction Equity Act Service Adjustment

It was not necessary for projected benefit costs to include additional services for compliance with the Mental Health Parity and Addiction Equity Act.

v. In–Lieu-of Services

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

vi. Retrospective Eligibility Periods

(a) ICO responsibility

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

(b) Claims treatment

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

(c) Enrollment treatment

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

(d) Adjustments

No adjustments are necessary.

vii. Impact of Material Changes

This section relates to material changes to covered benefits or services since the last rate certification. The last rate certification was for the CY 2017 rating period.

(a) Change to covered benefits

The addition of travel time for Home Help services was acknowledged and accounted for in the trend development.

(b) Recoveries of overpayments

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

(c) Change to payment requirements

There were no material changes related to payment requirements.

(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

We have documented any material changes earlier in the document.

4. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT

A. INCENTIVE ARRANGEMENTS

i. Rate Development Standards

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

ii. Appropriate Documentation

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

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of the Withhold Arrangement

(i) Time period and purpose

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

(ii) Description of total percentage withheld

MDHHS has established a quality withhold of 3.0% of the capitation rate for demonstration year 3, and will determine the return of the withhold based on review of each ICO's data and the ICO's compliance with the quality measures established in each ICO's three-way contract with MDHHS and CMS.

The capitation rates shown in this letter are illustrated before offset for the withhold amount; however, the CY 2018 capitation rates documented in this report are actuarially sound after considering the portion of the withhold that ICOs are estimated to earn back.

(iii) Estimate of percent to be returned

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

(iv) Reasonableness of withhold arrangement

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

(v) Effect on the capitation rates

The rate is certified as actuarially sound after adjustment for the expected amount of the withhold not earned back.

C. RISK SHARING MECHANISMS

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of Risk-sharing Mechanism

No risk sharing arrangements exist for the covered populations.

(b) Medical Loss Ratio

Description

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

Financial consequences

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

(c) Reinsurance Requirements and Effect on Capitation Rates

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

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

i. Rate Development Standards

This section is not applicable.

ii. Appropriate Documentation

This section is not applicable.

E. PASS-THROUGH PAYMENTS

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

i. Rate Development Standards

This section is not applicable.

ii. Appropriate Documentation

(a) Description of Pass-Through Payments

(i) Description

This section is not applicable.

(ii) Amount

This section is not applicable.

(iii) Providers receiving the payment

This section is not applicable.

(iv) Financing mechanism

This section is not applicable.

(v) Pass-through payments for previous rating period

This section is not applicable.

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

This section is not applicable.

(b) Hospital Pass-Through Payments

This section is not applicable.

5. PROJECTED NON-BENEFIT COSTS

A. RATE DEVELOPMENT STANDARDS

i. Overview

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

Certain non-benefit expenses are included in the development of the Duals Lite and MI Choice population capitation rates that are utilized in the development of the Community and Waiver rates. No other changes were made to those rates under the CY 2018 MI Health Link rate development process. The addition of the IPA is noted as a non-benefit expense and discussed in more detail below.

ii. PMPM Versus Percentage

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 2, however the estimated IPA amount is on a PMPM basis.

The IPA is applicable to insurance providers in the State of Michigan. The IPA assesses a PMPM rate of $60.20 to each covered member month, by managed care entity, up to 987,188 members in a given state fiscal year. The PMPM amount decreases to $1.20 for each member month above 987,188. The ultimate amount paid for the IPA will be vary by managed care entity based on actual enrollment utilized in the calculation of the assessment. The IPA is set to be effective October 1, 2018 and will be paid on a retrospective basis at the end of each quarter. We have included a PMPM estimate for CY 2018 in Appendix 2 based on spreading 3 months' worth of payments over the calendar year. Note that the IPA will be 100% state funded for the MI Health Link program.

iii. Basis for Variation in Assumptions

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 2, however there are no differences between estimated IPA amounts by rating tier.

iv. Health Insurance Providers Fee

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

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

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

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 2 outside of the IPA.

(b) Material changes

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 2 outside of the IPA which has been identified as a change for CY 2018.

(c) Other material adjustments

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 2 outside of the IPA.

ii. Non-Benefit Costs, by Cost Category

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 2 outside of the IPA.

iii. Health Insurance Providers Fee

(a) Whether the fee is incorporated in the rates

There is no allocation in the rate development for purposes of the Health Insurer Fee (HIF). As these rates are to be developed "in absence of the demonstration," no HIF would be applicable under a fee-for-service arrangement. The only consideration for HIF in the MI Health Link rates would be attributed to the Duals Lite capitation portion of the rate documented in the development of the Community tier in Appendix 2.

(b) Fee year or data year

To the extent HIF expenses are provided for the Duals Lite component of the rate, it will be calculated based on the fee year. Potential amended calendar year 2018 rates will be based on the 2018 HIF attributable to the 2017 data year.

(c) Determination of fee impact to rates

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

(d) Timing of adjustment for health insurance providers fee

The CY 2018 capitation rates in this certification **do not** reflect the incorporation of the HIF. After the actual amount of the HIF is known, the capitation rates will be retrospectively adjusted as appropriate to include the HIF. We anticipate completing the analysis to amend the CY 2018 rates in the last quarter of CY 2018.

(e) Identification of long-term care benefits

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

6. RISK ADJUSTMENT AND ACUITY ADJUSTMENTS

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

A. RATE DEVELOPMENT STANDARDS

i. Overview

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

ii. Risk adjustment model

This section is not applicable as no specific risk adjustment is being applied to the MI Health Link capitation rates at this time.

iii. Acuity adjustments

This section is not applicable as no specific risk adjustment is being applied to the MI Health Link capitation rates at this time.

B. APPROPRIATE DOCUMENTATION

i. Prospective Risk Adjustment

(a) Data and adjustments

This section is not applicable as no specific risk adjustment is being applied to the MI Health Link capitation rates at this time.

(b) Risk adjustment model

This section is not applicable as no specific risk adjustment is being applied to the MI Health Link capitation rates at this time.

(c) Risk Adjustment methodology

This section is not applicable as no specific risk adjustment is being applied to the MI Health Link capitation rates at this time.

(d) Magnitude of the adjustment

This section is not applicable as no specific risk adjustment is being applied to the MI Health Link capitation rates at this time.

(e) Assessment of predictive value

This section is not applicable as no specific risk adjustment is being applied to the MI Health Link capitation rates at this time.

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

This section is not applicable as no specific risk adjustment is being applied to the MI Health Link capitation rates at this time.

ii. Retrospective Risk Adjustment

Not applicable.

iii. Changes to Risk Adjustment Model Since Last Rating Period

This section is not applicable as no specific risk adjustment is being applied to the MI Health Link capitation rates at this time.

iv. Acuity Adjustments

This section is not applicable as no specific risk adjustment is being applied to the MI Health Link capitation rates at this time.

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

1. MANAGED LONG-TERM SERVICES AND SUPPORTS

A. COMPLETION OF SECTION I

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

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

B. RATE DEVELOPMENT STANDARDS

(a) Capitation rate structure

The MI Health Link rate structure for calendar year 2018 did not change from the 2015-2017 rate structure. Rates continue to vary by region consistent with current geographic definitions. The rate cells continue to represent population groups split by place of setting and represent a non-blended rate cell structure.

Nursing Facility

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

Transition Rules

Members who had met the criteria for inclusion in the Nursing Facility cell, but later do not, will be transitioned to the community or waiver category. The ICO will immediately receive the alternative category rate upon switching from the Nursing Facility, but will receive a transitional case rate payment ($900 for CY 2018) if the member is kept out of the facility for a minimum of 3 months. For members who transition from community or waiver setting to a nursing facility, the ICO will not receive the Nursing Facility rate until 3 months have passed.

NFLOC-Waiver

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

Community

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

C. APPROPRIATE DOCUMENTATION

i. Considerations

(a) Capitation rate cell structure

The structure of the capitation rate cells is documented in B. above.

(b) Methodology

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

(c) Payment incentives or disincentives

There are no additional incentives or disincentives outside of the withhold arrangement discussed in Section I of the report.Payment of the transitional case rate is documented in Section I of the report.

(d) Managed care effect

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

ii. Projected non-benefit costs

Non-benefit costs are not explicitly defined for this program outside of the estimated IPA amounts.

iii. Experience and assumptions

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

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SECTION III. NEW ADULT GROUP CAPITATION RATES

Section III of the CMS Medicaid Managed Care Rate Development Guide is not applicable to the MI Health Link program.

LIMITATIONS

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved February 27, 2017.

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

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for MDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

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

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

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

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

APPENDIX 1: ACTUARIAL CERTIFICATION

State of Michigan
Department of Health and Human Services
Calendar Year 2018 Capitation Rates
MI Health Link Program

Actuarial Certification

I, Christopher Pettit, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Michigan, Department of Health and Human Services, to perform an actuarial review and certification regarding the development of capitation rates for the MI Health Link program effective January 1, 2018. I am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

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

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

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

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

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

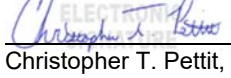
"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition,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

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of Michigan. The "actuarially sound" capitation rates that are associated with this certification are effective for calendar year 2018.

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

October 19, 2018
Date

APPENDIX 2: CAPITATION RATE DEVELOPMENT

State of Michigan
Department of Health and Human Services
MI Health Link
Demonstration Year 3 Rate Development

Nursing Facility - Subtier A	Base FFS Experience	Patient Pay Amount	Selection Factor	Hearing Aid Benefit	Savings Percentage	Estimated IPA PMPM	Proposed Rate	Current Rate	Percent Change
Over 65	$5,322.30	$733.00	1.100	$1.00	0.030	9.91	$6,422.77	$6,139.18	4.6%
Under 65	$4,862.85	$523.82	1.100	$0.33	0.030	9.91	$5,722.72	$5,442.71	5.1%

Nursing Facility - Subtier B	Base FFS Experience	Patient Pay Amount	Selection Factor	Hearing Aid Benefit	Savings Percentage	Estimated IPA PMPM	Proposed Rate	Current Rate	Percent Change
Over 65	$9,512.58	$1,082.57	1.000	$1.00	0.030	9.91	$10,320.65	$9,841.41	4.9%
Under 65	$9,799.84	$821.92	1.000	$0.33	0.030	9.91	$10,337.99	$9,579.56	7.9%

Waiver C (NF Level of Care)	Base FFS Experience	MIChoice Capitation	Fully Loaded Cost	Selection Factor	Hearing Aid Benefit	Savings Percentage	Estimated IPA PMPM	Proposed Rate	Current Rate	Percent Change
Over 65	$91.62	$2,292.22	$2,383.84	1.000	$1.00	0.030	9.910	$2,323.20	$2,147.89	8.2%
Under 65	$105.01	$2,755.71	$2,860.72	1.000	$0.33	0.030	9.910	$2,785.13	$2,752.78	1.2%

Community Well	Base FFS Experience	NEMT Adjustment	Selection Factor	Hearing Aid Benefit	Total FFS Cost	Percent of FFS
Over 65	$214.65	$8.52	0.684	$0.25	$152.91	62.7%
Under 65	$163.78	$8.52	0.674	$0.17	$116.38	63.8%

	Duals Lite Capitation	Duals Lite FFS Cost	Hearing Aid Benefit	Total HMO Cost	Percent of MCO	Blended Cost	Savings Percentage	Estimated IPA PMPM	Proposed Rate	Current Rate	Percent Change
Over 65	$80.95	$86.18	$0.25	$167.38	37.3%	$158.31	0.030	9.91	$163.47	$146.29	11.7%
Under 65	$80.95	$68.67	$0.17	$149.79	36.2%	$128.48	0.030	9.91	$134.53	$120.23	11.9%

Regional Adjustment Factors (on Proposed Rate)

	Nursing Facility - Subtier A	Nursing Facility - Subtier B	Waiver (NF Level of Care)	Community Well
Region 1	100.2%	98.5%	96.1%	92.0%
Region 4	103.8%	103.6%	104.7%	102.6%
Region 7	98.8%	0.0%	96.4%	101.2%
Region 9	99.6%	99.9%	111.4%	97.1%

APPENDIX 3: BASE ACTUARIAL COST MODELS

State of Michigan
Department of Health and Human Services
MI Health Link
Demonstration Year 3 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: Nursing Subtier A- 65+
Total Member Months: 71,879

Type of Service	Fiscal Year 2016 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	QAS/CPE FICA/FUTA Adjustment	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Minimum Wage Adjustment	Adjusted Fiscal Year 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility													
Nursing Facility	11,170.4	22.7	253,448.8	$ 158.54	$ 3,348.45	1.391	1.002	1.011	1.034	1.000	262,661.2	$ 222.94	$ 4,879.87
Inpatient Hospital													
General	261.8	20.6	5,398.2	$ 240.62	$ 108.24	1.000	1.002	1.034	1.011	1.000	5,472.7	$ 248.83	$ 113.48
Psychiatric	0.8	4.4	3.7	274.40	0.08	1.000	1.002	1.034	1.011	1.000	3.7	291.89	0.09
Subtotal	262.6	20.6	5,401.9	$ 240.64	$ 108.33						5,476.4	$ 248.86	$ 113.57
Outpatient Hospital													
General			210.5	$ 121.33	$ 2.13	1.000	1.001	0.989	1.034	1.000	218.0	$ 120.00	$ 2.18
Hospice			19,022.0	185.13	293.47	1.000	1.001	0.989	1.034	1.000	19,699.4	183.06	300.51
Subtotal			19,232.5	$ 184.44	$ 295.60						19,917.4	$ 182.37	$ 302.69
Prescription Drugs			2,072.0	$ 5.93	$ 1.02	1.000	1.000	1.069	1.046	1.000	2,166.4	$ 6.31	$ 1.14
Other Ancillaries													
Transportation			117.5	$ 132.47	$ 1.30	1.000	1.002	1.011	1.023	1.000	120.4	$ 133.55	$ 1.34
DME/Prosthetics/Orthotics			1,406.5	47.07	5.52	1.000	1.002	1.011	1.023	1.000	1,440.8	47.64	5.72
Waiver Services			47.1	4.99	0.02	1.000	1.002	1.011	1.023	1.000	48.2	4.98	0.02
Other Ancillary			995.8	33.04	2.74	1.000	1.002	1.011	1.023	1.000	1,020.1	33.41	2.84
Home Help			199.2	350.64	5.82	1.155	1.002	1.011	1.023	1.088	204.0	445.88	7.58
Subtotal			2,766.1	$ 66.79	$ 15.40						2,833.5	$ 74.11	$ 17.50
Physician													
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	-	-	-	-	-	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			326.2	27.24	0.74	1.000	1.002	1.011	1.023	1.000	334.2	27.65	0.77
Phys Visit Other			2,355.8	21.42	4.20	1.000	1.002	1.011	1.023	1.000	2,413.1	21.68	4.36
Surgery/Anesthesia			6.3	41.79	0.02	1.000	1.002	1.011	1.023	1.000	6.5	36.92	0.02
Lab/Pathology			339.9	8.63	0.24	1.000	1.002	1.011	1.023	1.000	348.2	8.62	0.25
Surgery			350.4	19.14	0.56	1.000	1.002	1.011	1.023	1.000	359.0	19.39	0.58
Vision/Hearing			507.7	20.56	0.87	1.000	1.002	1.011	1.023	1.000	520.0	20.77	0.90
Therapeutic Inj.			166.3	31.24	0.43	1.000	1.002	1.011	1.023	1.000	170.3	31.71	0.45
Other			138.1	17.21	0.20	1.000	1.002	1.011	1.023	1.000	141.4	17.82	0.21
Subtotal			4,190.7	$ 20.82	$ 7.27						4,292.7	$ 21.08	$ 7.54
Total Claims/Benefit Cost					$ 3,776.07								$ 5,322.31
Supplemental SNF Copayments			7,359.5	$ 1,140.39	$ 699.40	1.000	1.002	1.011	1.034	1.000	7,627.0	$ 1,153.27	$ 733.00
Total Adjusted Gross Cost					**$4,475.46**								**$6,055.31**

State of Michigan
Department of Health and Human Services
MI Health Link
Demonstration Year 3 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: Nursing Subtier A- Under 65
Total Member Months: 12,347

Type of Service	Fiscal Year 2016 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	QAS/CPE FICA/FUTA Adjustment	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Minimum Wage Adjustment	Adjusted Fiscal Year 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility													
Nursing Facility	11,361.5	20.3	230,301.4	$ 161.38	$ 3,097.22	1.382	1.002	1.011	1.034	1.000	238,672.5	$ 225.56	$ 4,486.23
Inpatient Hospital													
General	391.7	16.9	6,611.8	$ 274.10	$ 151.03	1.000	1.002	1.034	1.011	1.000	6,703.0	$ 283.45	$ 158.33
Psychiatric	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal	391.7	16.9	6,611.8	$ 274.10	$ 151.03						6,703.0	$ 283.45	$ 158.33
Outpatient Hospital													
General			430.5	$ 310.31	$ 11.13	1.000	1.001	0.989	1.034	1.000	445.9	$ 306.80	$ 11.40
Hospice			9,573.2	193.07	154.03	1.000	1.001	0.989	1.034	1.000	9,914.1	190.90	157.72
Subtotal			10,003.7	$ 198.12	$ 165.16						10,360.0	$ 195.89	$ 169.12
Prescription Drugs			3,107.2	$ 7.91	$ 2.05	1.000	1.000	1.069	1.046	1.000	3,248.7	$ 8.46	$ 2.29
Other Ancillaries													
Transportation			420.8	$ 148.54	$ 5.21	1.000	1.002	1.011	1.023	1.000	431.1	$ 150.31	$ 5.40
DME/Prosthetics/Orthotics			3,086.7	39.42	10.14	1.000	1.002	1.011	1.023	1.000	3,161.9	39.85	10.50
Waiver Services			146.8	23.47	0.29	1.000	1.002	1.011	1.023	1.000	150.3	23.95	0.30
Other Ancillary			1,372.3	30.42	3.48	1.000	1.002	1.011	1.023	1.000	1,405.7	30.73	3.60
Home Help			432.5	360.06	12.98	1.155	1.002	1.011	1.023	1.088	443.0	457.52	16.89
Subtotal			5,459.1	$ 70.54	$ 32.09						5,592.0	$ 78.73	$ 36.69
Physician													
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	-	-	-	-	-	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			601.6	27.11	1.36	1.000	1.002	1.011	1.023	1.000	616.2	27.46	1.41
Phys Visit Other			3,485.2	19.01	5.52	1.000	1.002	1.011	1.023	1.000	3,570.0	19.23	5.72
Surgery/Anesthesia			22.4	58.36	0.11	1.000	1.002	1.011	1.023	1.000	22.9	57.64	0.11
Lab/Pathology			594.8	9.24	0.46	1.000	1.002	1.011	1.023	1.000	609.3	9.26	0.47
Surgery			405.3	20.54	0.69	1.000	1.002	1.011	1.023	1.000	415.1	20.81	0.72
Vision/Hearing			551.1	19.65	0.90	1.000	1.002	1.011	1.023	1.000	564.5	19.77	0.93
Therapeutic Inj.			341.1	16.18	0.46	1.000	1.002	1.011	1.023	1.000	349.4	16.49	0.48
Other			246.9	16.29	0.34	1.000	1.002	1.011	1.023	1.000	252.9	16.61	0.35
Subtotal			6,248.3	$ 18.89	$ 9.84						6,400.3	$ 19.11	$ 10.19
Total Claims/Benefit Cost					$ 3,457.39								$ 4,862.85
Supplemental SNF Copayments			6,290.1	$ 953.51	$ 499.81	1.000	1.002	1.011	1.034	1.000	6,518.7	$ 964.28	$ 523.82
Total Adjusted Gross Cost					**$3,957.20**								**$5,386.67**

State of Michigan
Department of Health and Human Services
MI Health Link
Demonstration Year 3 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: Nursing Subtier B- 65+
Total Member Months: 5,090

Type of Service	Fiscal Year 2016 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	QAS/CPE FICA/FUTA Adjustment	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Minimum Wage Adjustment	Adjusted Fiscal Year 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility													
Nursing Facility	12,950.1	26.3	341,009.8	$ 219.52	$ 6,238.27	1.449	1.002	1.011	1.034	1.000	353,404.9	$ 321.61	$ 9,471.57
Inpatient Hospital													
General	47.2	5.0	235.8	$ 161.36	$ 3.17	1.000	1.002	1.034	1.011	1.000	239.0	$ 166.69	$ 3.32
Psychiatric	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal	47.2	5.0	235.8	$ 161.36	$ 3.17						239.0	$ 166.69	$ 3.32
Outpatient Hospital													
General			363.1	$ 48.69	$ 1.47	1.000	1.001	0.989	1.034	1.000	376.0	$ 48.19	$ 1.51
Hospice			971.3	243.01	19.67	1.000	1.001	0.989	1.034	1.000	1,005.9	240.26	20.14
Subtotal			1,334.4	$ 190.14	$ 21.14						1,381.9	$ 188.00	$ 21.65
Prescription Drugs			2,958.7	$ 5.52	$ 1.36	1.000	1.000	1.069	1.046	1.000	3,093.6	$ 5.90	$ 1.52
Other Ancillaries													
Transportation			47.2	$ 186.15	$ 0.73	1.000	1.002	1.011	1.023	1.000	48.3	$ 188.82	$ 0.76
DME/Prosthetics/Orthotics			417.3	55.23	1.92	1.000	1.002	1.011	1.023	1.000	427.4	55.87	1.99
Waiver Services			7.1	10.12	0.01	1.000	1.002	1.011	1.023	1.000	7.2	16.67	0.01
Other Ancillary			910.0	35.42	2.69	1.000	1.002	1.011	1.023	1.000	932.2	35.79	2.78
Home Help			23.6	206.77	0.41	1.155	1.002	1.011	1.023	1.088	24.1	263.90	0.53
Subtotal			1,405.1	$ 49.11	$ 5.75						1,439.2	$ 50.61	$ 6.07
Physician													
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	-	-	-	-	-	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			1,445.2	28.96	3.49	1.000	1.002	1.011	1.023	1.000	1,480.4	29.26	3.61
Phys Visit Other			1,419.3	22.46	2.66	1.000	1.002	1.011	1.023	1.000	1,453.8	22.70	2.75
Surgery/Anesthesia			2.4	26.99	0.01	1.000	1.002	1.011	1.023	1.000	2.4	50.00	0.01
Lab/Pathology			99.0	10.69	0.09	1.000	1.002	1.011	1.023	1.000	101.4	10.65	0.09
Surgery			249.9	23.61	0.49	1.000	1.002	1.011	1.023	1.000	256.0	23.91	0.51
Vision/Hearing			327.7	24.14	0.66	1.000	1.002	1.011	1.023	1.000	335.7	24.31	0.68
Therapeutic Inj.			44.8	191.32	0.71	1.000	1.002	1.011	1.023	1.000	45.9	193.46	0.74
Other			58.9	12.52	0.06	1.000	1.002	1.011	1.023	1.000	60.4	11.92	0.06
Subtotal			3,647.2	$ 26.86	$ 8.16						3,736.0	$ 27.14	$ 8.45
Total Claims/Benefit Cost					$ 6,277.86								$ 9,512.58
Supplemental SNF Copayments			10,561.9	$ 1,173.59	$ 1,032.94	1.000	1.002	1.011	1.034	1.000	10,945.8	$ 1,186.83	$ 1,082.57
Total Adjusted Gross Cost					**$7,310.80**								**$10,595.15**

State of Michigan
Department of Health and Human Services
MI Health Link
Demonstration Year 3 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: Nursing Subtier B- Under 65
Total Member Months: 686

Type of Service	Fiscal Year 2016 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	QAS/CPE FICA/FUTA Adjustment	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Minimum Wage Adjustment	Adjusted Fiscal Year 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility													
Nursing Facility	13,906.7	24.8	344,414.0	$ 224.28	$ 6,437.05	1.444	1.002	1.011	1.034	1.000	356,932.9	$ 327.52	$ 9,741.85
Inpatient Hospital													
General	157.4	5.2	822.2	$ 186.47	$ 12.78	1.000	1.002	1.034	1.011	1.000	833.5	$ 192.78	$ 13.39
Psychiatric	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal	157.4	5.2	822.2	$ 186.47	$ 12.78						833.5	$ 192.78	$ 13.39
Outpatient Hospital													
General			105.0	$ 34.48	$ 0.30	1.000	1.001	0.989	1.034	1.000	108.7	$ 34.22	$ 0.31
Hospice			70.0	266.47	1.55	1.000	1.001	0.989	1.034	1.000	72.5	263.17	1.59
Subtotal			174.9	$ 127.27	$ 1.86						181.2	$ 125.83	$ 1.90
Prescription Drugs			3,183.7	$ 6.89	$ 1.83	1.000	1.000	1.069	1.046	1.000	3,328.7	$ 7.35	$ 2.04
Other Ancillaries													
Transportation			227.4	$ 154.28	$ 2.92	1.000	1.002	1.011	1.023	1.000	232.9	$ 156.12	$ 3.03
DME/Prosthetics/Orthotics			577.3	339.46	16.33	1.000	1.002	1.011	1.023	1.000	591.3	343.38	16.92
Waiver Services			35.0	1.50	0.00	1.000	1.002	1.011	1.023	1.000	35.8	-	-
Other Ancillary			1,609.3	29.47	3.95	1.000	1.002	1.011	1.023	1.000	1,648.5	29.77	4.09
Home Help			139.9	208.70	2.43	1.155	1.002	1.011	1.023	1.088	143.3	265.46	3.17
Subtotal			2,588.9	$ 118.86	$ 25.64						2,651.8	$ 123.13	$ 27.21
Physician													
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	-	-	-	-	-	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			2,081.6	31.74	5.51	1.000	1.002	1.011	1.023	1.000	2,132.3	32.08	5.70
Phys Visit Other			3,795.9	15.25	4.82	1.000	1.002	1.011	1.023	1.000	3,888.3	15.43	5.00
Surgery/Anesthesia			17.5	61.70	0.09	1.000	1.002	1.011	1.023	1.000	17.9	60.34	0.09
Lab/Pathology			174.9	9.18	0.13	1.000	1.002	1.011	1.023	1.000	179.2	9.38	0.14
Surgery			367.3	25.67	0.79	1.000	1.002	1.011	1.023	1.000	376.3	25.83	0.81
Vision/Hearing			699.7	19.89	1.16	1.000	1.002	1.011	1.023	1.000	716.7	20.09	1.20
Therapeutic Inj.			279.9	4.74	0.11	1.000	1.002	1.011	1.023	1.000	286.7	4.60	0.11
Other			192.4	22.49	0.36	1.000	1.002	1.011	1.023	1.000	197.1	22.53	0.37
Subtotal			7,609.3	$ 20.45	$ 12.97						7,794.5	$ 20.66	$ 13.42
Total Claims/Benefit Cost					$ 6,492.12								$ 9,799.81
Supplemental SNF Copayments			10,618.1	$ 886.31	$ 784.24	1.000	1.002	1.011	1.034	1.000	11,004.0	$ 896.31	$ 821.92
Total Adjusted Gross Cost					**$7,276.36**								**$10,621.73**

State of Michigan
Department of Health and Human Services
MI Health Link
Demonstration Year 3 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: NF Level of Care- 65+
Total Member Months: 25,576

Type of Service	Fiscal Year 2016 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	QAS/CPE FICA/FUTA Adjustment	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Minimum Wage Adjustment	Adjusted Fiscal Year 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility													
Nursing Facility	120.1	13.7	1,646.9	$ 137.69	$ 18.90	1.000	1.005	0.945	1.034	1.000	1,712.3	$ 130.07	$ 18.56
Inpatient Hospital													
General	81.2	6.7	546.1	$ 177.27	$ 8.07	1.000	1.000	1.034	0.989	1.000	540.1	$ 183.30	$ 8.25
Psychiatric	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal	81.2	6.7	546.1	$ 177.27	$ 8.07						540.1	$ 183.30	$ 8.25
Outpatient Hospital													
General			335.5	$ 120.15	$ 3.36	1.000	1.001	1.057	0.989	1.000	332.0	$ 126.87	$ 3.51
Hospice			10.8	210.06	0.19	1.000	1.001	1.057	0.989	1.000	10.7	224.30	0.20
Subtotal			346.3	$ 122.95	$ 3.55						342.7	$ 129.91	$ 3.71
Prescription Drugs			5,673.0	$ 4.59	$ 2.17	1.000	1.000	1.046	1.069	1.000	6,063.1	$ 4.81	$ 2.43
Other Ancillaries													
Transportation			93.8	$ 109.52	$ 0.86	1.000	1.001	1.023	1.011	1.000	95.0	$ 112.42	$ 0.89
DME/Prosthetics/Orthotics			23,876.1	21.15	42.09	1.000	1.001	1.023	1.011	1.000	24,169.1	21.63	43.57
Waiver Services			2,200.0	4.90	0.90	1.000	1.001	1.023	1.011	1.000	2,227.0	5.01	0.93
Other Ancillary			715.5	48.26	2.88	1.000	1.001	1.023	1.011	1.000	724.3	49.37	2.98
Home Help			24.4	245.91	0.50	1.155	1.001	1.023	1.011	1.088	24.7	315.79	0.65
Subtotal			26,909.9	$ 21.06	$ 47.22						27,240.1	$ 21.59	$ 49.02
Physician													
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	-	-	-	-	-	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			1,696.1	26.58	3.76	1.000	1.001	1.023	1.011	1.000	1,716.9	27.19	3.89
Phys Visit Other			261.3	21.90	0.48	1.000	1.001	1.023	1.011	1.000	264.5	22.23	0.49
Surgery/Anesthesia			5.2	32.07	0.01	1.000	1.001	1.023	1.011	1.000	5.2	23.08	0.01
Lab/Pathology			293.2	11.95	0.29	1.000	1.001	1.023	1.011	1.000	296.8	12.13	0.30
Surgery			158.1	25.07	0.33	1.000	1.001	1.023	1.011	1.000	160.1	25.48	0.34
Vision/Hearing			252.0	25.57	0.54	1.000	1.001	1.023	1.011	1.000	255.0	26.35	0.56
Therapeutic Inj.			540.5	75.67	3.41	1.000	1.001	1.023	1.011	1.000	547.1	77.43	3.53
Other			549.9	11.15	0.51	1.000	1.001	1.023	1.011	1.000	556.6	11.43	0.53
Subtotal			3,756.3	$ 29.79	$ 9.33						3,802.2	$ 30.46	$ 9.65
Total Claims/Benefit Cost					$ 89.23								$ 91.62

State of Michigan
Department of Health and Human Services
MI Health Link
Demonstration Year 3 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: NF Level of Care- Under 65
Total Member Months: 10,183

Type of Service	Fiscal Year 2016 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	QAS/CPE FICA/FUTA Adjustment	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Minimum Wage Adjustment	Adjusted Fiscal Year 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility													
Nursing Facility	110.8	14.1	1,561.4	$ 131.12	$ 17.06	1.000	1.005	0.945	1.034	1.000	1,623.4	$ 123.89	$ 16.76
Inpatient Hospital													
General	94.3	6.5	612.8	$ 162.53	$ 8.30	1.000	1.000	1.034	0.989	1.000	606.0	$ 168.12	$ 8.49
Psychiatric	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal	94.3	6.5	612.8	$ 162.53	$ 8.30						606.0	$ 168.12	$ 8.49
Outpatient Hospital													
General			440.7	$ 152.29	$ 5.59	1.000	1.001	1.057	0.989	1.000	436.1	$ 160.97	$ 5.85
Hospice			35.4	166.67	0.49	1.000	1.001	1.057	0.989	1.000	35.0	174.86	0.51
Subtotal			476.1	$ 153.35	$ 6.08						471.1	$ 162.00	$ 6.36
Prescription Drugs			6,778.4	$ 5.56	$ 3.14	1.000	1.000	1.046	1.069	1.000	7,244.5	$ 5.81	$ 3.51
Other Ancillaries													
Transportation			265.1	$ 154.91	$ 3.42	1.000	1.001	1.023	1.011	1.000	268.4	$ 158.27	$ 3.54
DME/Prosthetics/Orthotics			25,786.5	21.42	46.04	1.000	1.001	1.023	1.011	1.000	26,102.9	21.91	47.66
Waiver Services			2,554.8	11.93	2.54	1.000	1.001	1.023	1.011	1.000	2,586.2	12.20	2.63
Other Ancillary			1,573.2	41.90	5.49	1.000	1.001	1.023	1.011	1.000	1,592.5	42.88	5.69
Home Help			27.1	348.56	0.79	1.155	1.001	1.023	1.011	1.088	27.4	446.72	1.02
Subtotal			30,206.8	$ 23.15	$ 58.28						30,577.4	$ 23.76	$ 60.54
Physician													
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	-	-	-	-	-	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			2,140.0	26.71	4.76	1.000	1.001	1.023	1.011	1.000	2,166.3	27.31	4.93
Phys Visit Other			287.5	20.21	0.48	1.000	1.001	1.023	1.011	1.000	291.1	20.61	0.50
Surgery/Anesthesia			15.3	54.10	0.07	1.000	1.001	1.023	1.011	1.000	15.5	54.19	0.07
Lab/Pathology			317.0	17.34	0.46	1.000	1.001	1.023	1.011	1.000	320.9	17.58	0.47
Surgery			154.4	30.73	0.40	1.000	1.001	1.023	1.011	1.000	156.3	31.48	0.41
Vision/Hearing			321.7	24.50	0.66	1.000	1.001	1.023	1.011	1.000	325.7	25.05	0.68
Therapeutic Inj.			1,070.0	15.55	1.39	1.000	1.001	1.023	1.011	1.000	1,083.1	15.95	1.44
Other			915.6	10.71	0.82	1.000	1.001	1.023	1.011	1.000	926.9	11.00	0.85
Subtotal			5,221.6	$ 20.75	$ 9.03						5,285.8	$ 21.23	$ 9.35
Total Claims/Benefit Cost					$ 101.90								$ 105.01

State of Michigan
Department of Health and Human Services
MI Health Link
Demonstration Year 3 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: Community Well- 65+
Total Member Months: 327,027

Type of Service	Fiscal Year 2016 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	QAS/CPE FICA/FUTA Adjustment	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Minimum Wage Adjustment	Adjusted Fiscal Year 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility													
Nursing Facility	64.8	23.0	1,487.6	$ 168.96	$ 20.95	1.000	1.000	0.945	0.989	1.000	1,471.2	$ 159.62	$ 19.57
Inpatient Hospital													
General	61.9	9.3	576.6	$ 444.87	$ 21.38	1.000	1.021	1.034	1.011	1.000	595.4	$ 459.93	$ 22.82
Psychiatric	0.2	3.8	0.8	410.94	0.03	1.000	1.021	1.034	1.011	1.000	0.9	400.00	0.03
Subtotal	62.1	9.3	577.5	$ 444.82	$ 21.41						596.3	$ 459.84	$ 22.85
Outpatient Hospital													
General			236.6	$ 109.08	$ 2.15	1.000	1.003	1.011	0.989	1.000	234.8	$ 110.39	$ 2.16
Hospice			19.4	186.17	0.30	1.000	1.003	1.011	0.989	1.000	19.3	186.53	0.30
Subtotal			256.1	$ 114.94	$ 2.45						254.1	$ 116.17	$ 2.46
Prescription Drugs			7,018.4	$ 4.56	$ 2.67	1.000	1.000	1.069	1.011	1.000	7,099.6	$ 4.87	$ 2.88
Other Ancillaries													
Transportation			25.1	$ 120.87	$ 0.25	1.000	1.001	1.046	0.989	1.000	24.8	$ 125.81	$ 0.26
DME/Prosthetics/Orthotics			5,080.8	17.39	7.36	1.000	1.001	1.046	0.989	1.000	5,030.5	18.18	7.62
Waiver Services			386.3	7.50	0.24	1.000	1.001	1.046	0.989	1.000	382.5	7.84	0.25
Other Ancillary			1,155.6	43.02	4.14	1.000	1.001	1.046	0.989	1.000	1,144.2	44.99	4.29
Home Help			3,299.5	402.37	110.64	1.155	1.001	1.046	0.989	1.088	3,266.9	528.65	143.92
Subtotal			9,947.3	$ 147.94	$ 122.63						9,848.9	$ 190.49	$ 156.34
Physician													
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	-	-	-	-	-	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			1,302.0	37.00	4.01	1.000	1.001	1.046	0.989	1.000	1,289.1	38.72	4.16
Phys Visit Other			192.4	34.67	0.56	1.000	1.001	1.046	0.989	1.000	190.5	36.54	0.58
Surgery/Anesthesia			9.4	40.69	0.03	1.000	1.001	1.046	0.989	1.000	9.3	38.71	0.03
Lab/Pathology			305.8	14.52	0.37	1.000	1.001	1.046	0.989	1.000	302.8	15.06	0.38
Surgery			167.0	33.86	0.47	1.000	1.001	1.046	0.989	1.000	165.3	35.57	0.49
Vision/Hearing			381.6	28.95	0.92	1.000	1.001	1.046	0.989	1.000	377.8	30.17	0.95
Therapeutic Inj.			975.9	37.93	3.08	1.000	1.001	1.046	0.989	1.000	966.3	39.62	3.19
Other			378.3	23.35	0.74	1.000	1.001	1.046	0.989	1.000	374.6	24.35	0.76
Subtotal			3,712.4	$ 32.92	$ 10.18						3,675.7	$ 34.41	$ 10.54
Total Claims/Benefit Cost					$ 180.29								$ 214.64

State of Michigan
Department of Health and Human Services
MI Health Link
Demonstration Year 3 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: Community Well- Under 65
Total Member Months: 430,065

Type of Service	Fiscal Year 2016 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	QAS/CPE FICA/FUTA Adjustment	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Minimum Wage Adjustment	Adjusted Fiscal Year 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility													
Nursing Facility	9.7	19.7	190.0	$ 165.11	$ 2.61	1.000	1.000	0.945	0.989	1.000	188.0	$ 155.74	$ 2.44
Inpatient Hospital													
General	41.8	7.3	307.1	$ 286.21	$ 7.32	1.000	1.021	1.034	1.011	1.000	317.1	$ 295.93	$ 7.82
Psychiatric	0.9	4.9	4.3	226.10	0.08	1.000	1.021	1.034	1.011	1.000	4.4	245.45	0.09
Subtotal	42.7	7.3	311.4	$ 285.39	$ 7.40						321.5	$ 295.24	$ 7.91
Outpatient Hospital													
General			300.0	$ 130.31	$ 3.26	1.000	1.003	1.011	0.989	1.000	297.6	$ 131.85	$ 3.27
Hospice			-	-	-	-	-	-	-	-	-	-	-
Subtotal			300.0	$ 130.31	$ 3.26						297.6	$ 131.85	$ 3.27
Prescription Drugs			5,222.8	$ 7.57	$ 3.29	1.000	1.000	1.069	1.011	1.000	5,283.2	$ 8.09	$ 3.56
Other Ancillaries													
Transportation			25.3	$ 112.31	$ 0.24	1.000	1.001	1.046	0.989	1.000	25.0	$ 115.20	$ 0.24
DME/Prosthetics/Orthotics			3,975.5	19.81	6.56	1.000	1.001	1.046	0.989	1.000	3,936.2	20.73	6.80
Waiver Services			352.6	14.13	0.42	1.000	1.001	1.046	0.989	1.000	349.1	14.78	0.43
Other Ancillary			1,974.6	32.48	5.35	1.000	1.001	1.046	0.989	1.000	1,955.1	33.94	5.53
Home Help			2,713.7	419.58	94.88	1.155	1.001	1.046	0.989	1.088	2,686.8	551.27	123.43
Subtotal			9,041.7	$ 142.60	$ 107.45						8,952.2	$ 182.88	$ 136.43
Physician													
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	-	-	-	-	-	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			1,341.9	37.09	4.15	1.000	1.001	1.046	0.989	1.000	1,328.6	38.75	4.29
Phys Visit Other			176.3	31.54	0.46	1.000	1.001	1.046	0.989	1.000	174.5	33.01	0.48
Surgery/Anesthesia			11.3	44.43	0.04	1.000	1.001	1.046	0.989	1.000	11.2	42.86	0.04
Lab/Pathology			319.1	14.60	0.39	1.000	1.001	1.046	0.989	1.000	315.9	15.19	0.40
Surgery			140.7	35.08	0.41	1.000	1.001	1.046	0.989	1.000	139.3	37.04	0.43
Vision/Hearing			361.3	29.53	0.89	1.000	1.001	1.046	0.989	1.000	357.7	30.86	0.92
Therapeutic Inj.			1,136.1	28.21	2.67	1.000	1.001	1.046	0.989	1.000	1,124.8	29.45	2.76
Other			350.7	27.76	0.81	1.000	1.001	1.046	0.989	1.000	347.2	29.03	0.84
Subtotal			3,837.3	$ 30.72	$ 9.82						3,799.2	$ 32.09	$ 10.16
Total Claims/Benefit Cost					$ 133.84								$ 163.77

State of Michigan
Department of Health and Human Services
MI Health Link
Demonstration Year 3 Rate Development
Projected Base Experience

Region: Non-Demonstration
Rate Cell: Duals Lite- 65+
Total Member Months: 117,868

Type of Service	Fiscal Year 2016 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	QAS/CPE FICA/FUTA Adjustment	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Minimum Wage Adjustment	Adjusted Fiscal Year 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility													
Nursing Facility	7.4	10.8	80.3	$ 186.19	$ 1.25	1.000	1.000	0.945	0.989	1.000	79.4	$ 175.31	$ 1.16
Inpatient Hospital													
General	1.1	18.5	20.7	$ 572.73	$ 0.99	1.000	1.021	1.034	1.011	1.000	21.3	$ 591.55	$ 1.05
Psychiatric	0.2	8.0	1.6	351.99	0.05	1.000	1.021	1.034	1.011	1.000	1.7	352.94	0.05
Subtotal	1.3	16.8	22.3	$ 556.61	$ 1.03						23.0	$ 573.91	$ 1.10
Outpatient Hospital													
General			1.3	$ 82.57	$ 0.01	1.000	1.003	1.011	0.989	1.000	1.3	$ 92.31	$ 0.01
Hospice			0.7	238.64	0.01	1.000	1.003	1.011	0.989	1.000	0.7	171.43	0.01
Subtotal			2.0	$ 137.19	$ 0.02						2.0	$ 120.00	$ 0.02
Prescription Drugs			10.6	$ 21.14	$ 0.02	1.000	1.000	1.069	1.011	1.000	10.7	$ 22.43	$ 0.02
Other Ancillaries													
Transportation			0.2	$ 134.75	$ 0.00	1.000	1.001	1.046	0.989	1.000	0.2	$ 0.00	$ 0.00
DME/Prosthetics/Orthotics			5.6	14.91	0.01	1.000	1.001	1.046	0.989	1.000	5.5	21.82	0.01
Waiver Services			0.3	300.36	0.01	1.000	1.001	1.046	0.989	1.000	0.3	400.00	0.01
Other Ancillary			1,422.5	40.00	4.74	1.000	1.001	1.046	0.989	1.000	1,408.4	41.83	4.91
Home Help			1,960.2	368.36	60.17	1.155	1.001	1.046	0.989	1.088	1,940.8	484.01	78.28
Subtotal			3,388.8	$ 229.93	$ 64.93						3,355.2	$ 297.60	$ 83.21
Physician													
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	-	-	-	-	-	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			6.3	47.39	0.02	1.000	1.001	1.046	0.989	1.000	6.2	58.06	0.03
Phys Visit Other			0.9	26.23	0.00	1.000	1.001	1.046	0.989	1.000	0.9	-	-
Surgery/Anesthesia			-	-	-	-	-	-	-	-	-	-	-
Lab/Pathology			1.6	12.16	0.00	1.000	1.001	1.046	0.989	1.000	1.6	-	-
Surgery			2.2	75.92	0.01	1.000	1.001	1.046	0.989	1.000	2.2	54.55	0.01
Vision/Hearing			0.8	39.37	0.00	1.000	1.001	1.046	0.989	1.000	0.8	-	-
Therapeutic Inj.			21.9	4.76	0.01	1.000	1.001	1.046	0.989	1.000	21.7	5.53	0.01
Other			14.3	496.71	0.59	1.000	1.001	1.040	0.990	1.000	14.1	519.15	0.61
Subtotal			48.1	$ 160.84	$ 0.64						47.5	$ 166.74	$ 0.66
Total Claims/Benefit Cost					$ 67.90								$ 86.17

State of Michigan
Department of Health and Human Services
MI Health Link
Demonstration Year 3 Rate Development
Projected Base Experience

Region: Non-Demonstration
Rate Cell: Duals Lite- Under 65
Total Member Months: 240,937

Type of Service	Fiscal Year 2016 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	QAS/CPE FICA/FUTA Adjustment	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Minimum Wage Adjustment	Adjusted Fiscal Year 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility													
Nursing Facility	1.9	11.1	21.6	$ 185.23	$ 0.33	1.000	1.000	0.945	0.989	1.000	21.4	$ 173.83	$ 0.31
Inpatient Hospital													
General	0.4	9.7	4.3	$ 350.15	$ 0.13	1.000	1.021	1.034	1.011	1.000	4.5	$ 346.67	$ 0.13
Psychiatric	0.2	7.2	1.8	65.19	0.01	1.000	1.021	1.034	1.011	1.000	1.9	63.16	0.01
Subtotal	0.7	8.8	6.1	$ 266.75	$ 0.14						6.4	$ 262.50	$ 0.14
Outpatient Hospital													
General			1.4	$ 59.38	$ 0.01	1.000	1.003	1.011	0.989	1.000	1.4	$ 85.71	$ 0.01
Hospice			-	-	-	-	-	-	-	-	-	-	-
Subtotal			1.4	$ 59.38	$ 0.01						1.4	$ 85.71	$ 0.01
Prescription Drugs			452.3	$ 136.78	$ 5.16	1.000	1.000	1.069	1.011	1.000	457.6	$ 146.07	$ 5.57
Other Ancillaries													
Transportation			1.2	$ 55.07	$ 0.01	1.000	1.001	1.046	0.989	1.000	1.2	$ 100.00	$ 0.01
DME/Prosthetics/Orthotics			6.4	31.51	0.02	1.000	1.001	1.046	0.989	1.000	6.4	37.50	0.02
Waiver Services			0.3	12.47	0.00	1.000	1.001	1.046	0.989	1.000	0.3	-	-
Other Ancillary			2,390.6	32.50	6.47	1.000	1.001	1.046	0.989	1.000	2,367.0	33.97	6.70
Home Help			1,293.5	395.54	42.64	1.155	1.001	1.046	0.989	1.088	1,280.7	519.65	55.46
Subtotal			3,692.1	$ 159.69	$ 49.13						3,655.6	$ 204.15	$ 62.19
Physician													
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	-	-	-	-	-	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			8.1	37.11	0.02	1.000	1.001	1.046	0.989	1.000	8.0	45.00	0.03
Phys Visit Other			2.2	22.22	0.00	1.000	1.001	1.046	0.989	1.000	2.2	-	-
Surgery/Anesthesia			0.2	26.83	0.00	1.000	1.001	1.046	0.989	1.000	0.2	-	-
Lab/Pathology			1.4	10.17	0.00	1.000	1.001	1.046	0.989	1.000	1.4	-	-
Surgery			2.7	80.70	0.02	1.000	1.001	1.046	0.989	1.000	2.7	88.89	0.02
Vision/Hearing			0.7	27.91	0.00	1.000	1.001	1.046	0.989	1.000	0.7	-	-
Therapeutic Inj.			24.8	66.11	0.14	1.000	1.001	1.046	0.989	1.000	24.6	68.29	0.14
Other			21.2	137.25	0.24	1.000	1.001	1.026	0.994	1.000	21.0	142.86	0.25
Subtotal			61.4	$ 84.01	$ 0.43						60.8	$ 86.84	$ 0.44
Total Claims/Benefit Cost					$ 55.20								$ 68.66

APPENDIX 4: PROSPECTIVE TREND RATES

State of Michigan
Department of Health and Human Services
6-Month Rolling Average Normalized Util/1000s by Category of Service and Population
Region: All Demonstration Regions; Population: Nursing Facility (Tier 1)

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Professional	All Claims
2/15/2016	6,881	23,043.9	496.4	1,291.0	214.1	557.0	25,602.4
1/15/2016	7,145	23,043.9	496.4	1,313.1	213.2	557.0	25,623.6
12/15/2015	7,296	23,034.0	496.4	1,336.2	212.7	557.0	25,636.4
11/15/2015	7,364	22,994.3	484.4	1,341.2	201.0	536.0	25,556.9
10/15/2015	7,477	22,858.9	482.5	1,345.5	198.5	526.4	25,411.9
9/15/2015	7,564	22,837.0	482.5	1,356.5	197.3	514.6	25,388.0
8/15/2015	7,691	22,810.6	482.3	1,356.5	194.9	514.6	25,358.9
7/15/2015	7,684	22,810.6	468.0	1,356.5	194.2	514.6	25,343.9
6/15/2015	7,714	22,810.6	454.5	1,356.5	191.5	514.6	25,327.8
5/15/2015	7,694	22,784.1	454.1	1,356.6	190.6	517.9	25,303.4
4/15/2015	7,744	22,783.4	453.6	1,356.6	190.6	526.4	25,310.7
3/15/2015	7,754	22,782.8	451.8	1,345.9	190.6	531.2	25,302.2
2/15/2015	7,685	22,686.0	445.9	1,340.6	191.2	536.4	25,200.1
1/15/2015	7,617	22,686.0	430.3	1,338.6	191.4	538.0	25,184.2
12/15/2014	7,574	22,686.0	426.2	1,322.0	193.6	546.4	25,174.1
11/15/2014	7,565	22,782.8	395.1	1,319.8	193.6	551.7	25,243.0
10/15/2014	7,967	22,807.9	387.1	1,302.0	192.4	551.7	25,241.1
9/15/2014	7,877	22,833.0	378.6	1,286.8	193.6	551.7	25,243.7
12 month regression		1.5%	12.9%	(3.9%)	15.2%	7.9%	1.6%
24 month regression		0.9%	20.0%	0.8%	7.2%	(0.6%)	1.2%
Selected Trend		0.5%	1.5%	(0.5%)	3.0%	0.5%	

State of Michigan
Department of Health and Human Services
6-Month Rolling Average Normalized Util/1000s by Category of Service and Population
Region: All Demonstration Regions; Population: NF Level of Care-Waiver (Tier 2)

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Professional	All Claims
9/15/2017	3,162	127.53	52.89	34.16	527.35	2,470.54	3,212.47
8/15/2017	3,164	142.52	52.89	34.18	524.57	2,480.14	3,234.30
7/15/2017	3,125	145.81	52.89	34.18	516.33	2,480.14	3,229.34
6/15/2017	3,123	145.81	50.96	34.16	513.21	2,468.19	3,212.32
5/15/2017	3,118	145.81	50.96	34.08	513.21	2,446.64	3,190.69
4/15/2017	3,117	149.09	53.20	30.72	513.21	2,446.64	3,192.87
3/15/2017	3,115	154.60	51.51	29.44	510.96	2,459.05	3,205.57
2/15/2017	3,089	154.60	51.51	29.44	510.96	2,459.05	3,205.57
1/15/2017	3,099	160.11	46.42	29.44	510.09	2,459.05	3,205.11
12/15/2016	3,091	164.07	45.97	29.44	510.09	2,459.05	3,208.63
11/15/2016	3,112	161.61	44.92	28.17	510.96	2,459.05	3,204.70
10/15/2016	3,095	168.03	44.73	28.02	493.37	2,459.05	3,193.20
9/15/2016	3,133	171.25	44.73	27.87	493.25	2,446.64	3,183.74
8/15/2016	3,093	171.25	44.73	25.14	489.12	2,433.64	3,163.87
7/15/2016	3,093	176.06	44.54	24.55	487.93	2,403.13	3,136.20
6/15/2016	3,076	184.09	44.23	24.24	486.74	2,372.61	3,111.91
5/15/2016	3,030	184.38	43.92	23.34	485.04	2,321.29	3,057.97
4/15/2016	2,987	184.68	43.39	20.33	479.54	2,261.26	2,989.19
12 month regression		(21.2%)	22.1%	29.6%	4.7%	0.8%	0.8%
18 month regression		(20.2%)	18.2%	38.8%	6.4%	4.3%	3.7%
Selected Trend		(2.5%)	1.5%	2.5%	2.0%	1.0%	

State of Michigan
Department of Health and Human Services
6-Month Rolling Average Normalized Util/1000s by Category of Service and Population
Region: All Demonstration Regions; Population: Community Well (Tier 3)

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Professional	All Claims
9/15/2017	64,256	35.74	39.13	15.76	505.38	755.76	1,351.77
8/15/2017	65,027	36.06	39.13	16.21	505.38	755.76	1,352.53
7/15/2017	65,547	36.16	38.40	16.68	501.42	755.76	1,348.42
6/15/2017	65,711	36.24	37.20	16.68	500.57	748.33	1,339.01
5/15/2017	65,814	37.57	37.15	16.65	499.72	744.68	1,335.77
4/15/2017	65,859	39.43	36.85	16.65	499.45	744.68	1,337.06
3/15/2017	65,524	42.24	36.85	16.65	499.17	744.68	1,339.60
2/15/2017	65,558	48.13	37.15	16.65	499.15	744.68	1,345.75
1/15/2017	65,552	55.97	37.17	16.65	499.12	744.68	1,353.59
12/15/2016	65,229	65.27	37.17	16.65	498.87	744.68	1,362.64
11/15/2016	65,193	79.48	37.15	16.65	498.17	744.68	1,376.12
10/15/2016	64,746	83.27	36.39	16.65	491.64	744.68	1,372.63
9/15/2016	64,308	84.03	35.48	16.65	477.78	744.68	1,358.62
8/15/2016	63,743	84.45	34.58	16.16	476.78	744.68	1,356.65
7/15/2016	63,130	84.81	33.47	15.50	467.16	730.35	1,331.29
6/15/2016	62,744	86.69	33.11	15.36	465.62	706.74	1,307.52
5/15/2016	68,749	91.84	32.91	15.36	458.22	691.96	1,290.28
4/15/2016	68,091	100.19	32.34	15.36	454.97	690.74	1,293.60
12 month regression		(62.8%)	6.5%	(3.5%)	2.1%	1.8%	(2.0%)
18 month regression		(57.9%)	13.0%	4.3%	7.4%	5.1%	1.8%
Selected Trend		(2.5%)	1.5%	0.5%	3.0%	2.0%	

State of Michigan
Department of Health and Human Services
6-Month Rolling Average Normalized CPSs by Category of Service and Population
Region: All Demonstration Regions; Population: Nursing Facility (Tier 1)

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Professional	All Claims
9/15/2017	6,881	$160.70	$237.18	$200.33	$8.73	$26.95	$160.00
8/15/2017	7,145	160.26	237.44	199.76	7.21	26.95	159.61
7/15/2017	7,296	159.01	242.02	200.11	6.49	26.95	158.62
6/15/2017	7,364	157.49	243.33	199.53	6.84	27.92	157.42
5/15/2017	7,477	156.56	241.15	198.90	6.49	28.43	156.58
4/15/2017	7,564	155.65	240.62	197.29	6.41	29.16	155.76
3/15/2017	7,691	155.26	239.32	197.29	6.48	29.11	155.40
2/15/2017	7,684	155.26	246.10	197.29	6.51	29.11	155.48
1/15/2017	7,714	155.26	249.39	197.29	6.58	29.11	155.51
12/15/2016	7,694	155.44	249.62	194.69	6.40	28.78	155.52
11/15/2016	7,744	155.44	249.10	193.89	6.34	28.25	155.41
10/15/2016	7,754	155.44	249.31	194.30	6.40	27.96	155.39
9/15/2016	7,685	155.87	247.33	194.08	6.38	27.69	155.66
8/15/2016	7,617	155.87	248.00	191.60	6.38	27.66	155.47
7/15/2016	7,574	155.87	241.80	193.11	6.39	27.24	155.34
6/15/2016	7,565	155.21	236.96	191.44	6.30	27.02	154.44
5/15/2016	7,967	155.04	234.97	194.02	6.28	27.02	154.35
4/15/2016	7,877	154.87	235.35	193.77	6.47	26.93	154.13
12 month regression		3.8%	(5.6%)	3.8%	22.5%	(6.4%)	3.3%
18 month regression		2.0%	(0.1%)	3.2%	11.3%	1.4%	2.1%
Selected Trend		1.5%	0.5%	1.5%	2.0%	1.0%	

State of Michigan
Department of Health and Human Services
6-Month Rolling Average Normalized CPSs by Category of Service and Population
Region: All Demonstration Regions; Population: NF Level of Care-Waiver (Tier 2)

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Professional	All Claims
9/15/2017	3,162	$109.74	$154.11	$105.56	$9.80	$21.42	$26.10
8/15/2017	3,164	103.12	154.20	108.65	6.19	21.63	25.80
7/15/2017	3,125	108.39	155.14	108.65	5.56	21.67	26.12
6/15/2017	3,123	108.39	161.01	109.41	5.43	21.78	26.24
5/15/2017	3,118	115.39	161.98	112.73	5.17	21.93	26.71
4/15/2017	3,117	118.28	158.29	126.40	5.14	21.77	26.88
3/15/2017	3,115	115.79	161.38	133.30	4.96	21.66	26.81
2/15/2017	3,089	115.79	160.25	141.19	4.93	21.66	26.86
1/15/2017	3,099	110.14	175.70	141.19	4.91	21.66	26.74
12/15/2016	3,091	105.01	173.02	146.01	4.85	21.66	26.56
11/15/2016	3,112	106.35	177.07	149.42	4.79	21.90	26.73
10/15/2016	3,095	104.94	182.49	145.16	4.93	22.56	27.49
9/15/2016	3,133	104.53	182.49	140.85	4.93	23.34	28.12
8/15/2016	3,093	104.53	182.49	156.15	4.95	23.46	28.29
7/15/2016	3,093	104.31	178.58	165.67	4.95	23.83	28.72
6/15/2016	3,076	99.76	164.81	161.94	4.94	24.14	28.68
5/15/2016	3,030	102.13	150.85	150.81	4.94	24.61	28.94
4/15/2016	2,987	99.55	148.94	163.51	4.99	25.34	29.39
12 month regression		1.5%	(16.5%)	(35.5%)	62.0%	(2.5%)	(4.6%)
18 month regression		7.5%	(4.8%)	(27.9%)	25.3%	(10.0%)	(8.2%)
Selected Trend		1.5%	(0.5%)	(0.5%)	3.0%	0.5%	

State of Michigan
Department of Health and Human Services
6-Month Rolling Average Normalized CPSs by Category of Service and Population
Region: All Demonstration Regions; Population: Community Well (Tier 3)

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Professional	All Claims
9/15/2017	64,256	$120.04	$355.08	$133.81	$6.22	$23.92	$30.71
8/15/2017	65,027	123.00	375.34	132.16	6.01	24.08	31.42
7/15/2017	65,547	122.86	384.06	132.96	5.84	24.08	31.54
6/15/2017	65,711	128.42	394.83	140.00	5.82	24.32	31.95
5/15/2017	65,814	129.87	360.02	150.89	5.81	24.44	31.34
4/15/2017	65,859	124.48	359.17	155.61	5.76	24.44	31.27
3/15/2017	65,524	131.16	359.17	156.62	5.77	24.50	31.73
2/15/2017	65,558	127.20	356.35	158.64	5.76	24.50	32.04
1/15/2017	65,552	128.70	359.79	158.64	5.75	24.50	32.75
12/15/2016	65,229	140.90	368.40	158.64	5.71	24.50	34.22
11/15/2016	65,193	144.93	368.65	158.64	5.72	24.50	35.57
10/15/2016	64,746	150.35	367.50	158.64	5.80	25.03	36.44
9/15/2016	64,308	149.55	370.26	158.64	5.99	25.03	36.69
8/15/2016	63,743	148.98	373.17	160.34	6.00	25.03	36.54
7/15/2016	63,130	148.39	381.70	162.16	6.14	25.52	37.10
6/15/2016	62,744	146.14	373.25	161.54	6.16	26.20	37.39
5/15/2016	68,749	150.59	362.86	159.45	6.24	26.13	38.10
4/15/2016	68,091	153.16	365.57	154.88	6.34	26.02	38.97
12 month regression		(18.6%)	2.4%	(20.7%)	6.3%	(3.4%)	(14.6%)
18 month regression		(16.7%)	(0.0%)	(11.9%)	(3.3%)	(5.7%)	(16.3%)
Selected Trend		(0.5%)	0.5%	(0.5%)	0.5%	(0.5%)	

APPENDIX 5: COVERED SERVICES

State of Michigan
Department of Health and Human Services
MI Health Link Covered Services

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

*Must meet level of care requirements