MILLIMAN CLIENT REPORT

Calendar Year 2021 MI Health Link Medicaid Capitation Rate Certification

January 1, 2021 through December 31, 2021

State of Michigan Department of Health and Human Services

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Table of Contents

INTRODUCTION & EXECUTIVE SUMMARY **1**

SECTION I. MEDICAID MANAGED CARE RATES **4**

1. GENERAL INFORMATION 4

A. Rate Development Standards 5

i. Annual basis 5

ii. Required elements 5

iii. Differences among capitation rates 7

iv. Cross-subsidization of rate cell payment 7

v. Effective dates 7

vi. Medical loss ratio 8

vii. Generally accepted actuarial practices and principles 8

viii. Rate certification for effective time periods 8

ix. Procedures for rate certification and amendment 8

B. Appropriate Documentation 8

i. Documentation of required elements 8

ii. Assumptions and adjustments 8

iii. Index 8

iv. Different FMAP 8

v. Comparison to final certified rates in the previous rate certification. 9

vi. Known amendments 9

2. DATA 10

A. Rate Development Standards 10

B. Appropriate Documentation 10

i. Requested data 10

ii. Data used to develop the capitation rates 10

iii. Data adjustments 12

3. PROJECTED BENEFIT COST AND TRENDS 14

A. Rate Development Standards 14

i. Final Capitation Rate Compliance 14

ii. Basis for Variation in Assumptions 14

iii. Benefit Cost Trend Assumptions 14

iv. In Lieu Of Services 14

v. IMDs as an in lieu of service provider 14

B. Appropriate Documentation 14

i. Projected Benefit Costs 14

ii. Development of Projected Benefit Costs 14

iii. Projected Benefit Cost Trends 17

iv. Mental Health Parity and Addiction Equity Act Service Adjustment 18
v. In Lieu of Services 18
vi. Retrospective Eligibility Periods 18
vii. Impact of Material Changes 19
viii. Documentation of Material Changes 19
4. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT 20
A. Incentive Arrangements 20
i. Rate Development Standards 20
ii. Appropriate Documentation 20
B. Withhold Arrangements 20
i. Rate Development Standards 20
ii. Appropriate Documentation 20
C. Risk Sharing Mechanisms 21
i. Rate Development Standards 21
ii. Appropriate Documentation 21
D. Delivery system and provider payment initiatives 21
i. Rate Development Standards 21
ii. Appropriate Documentation 21
E. Pass-Through Payments 22
i. Rate Development Standards 22
ii. Appropriate Documentation 22
5. PROJECTED NON-BENEFIT COSTS 23
A. Rate Development Standards 23
i. Overview 23
ii. PMPM versus percentage 23
iii. Basis for variation in assumptions 23
iv. Health insurance providers fee 23
B. Appropriate Documentation 23
i. Development of non-benefit costs 23
ii. Non-benefit costs, by cost category 24
iii. Health insurance providers fee 24
6. RISK ADJUSTMENT AND ACUITY ADJUSTMENTS 25
A. Rate Development Standards 25
i. Overview 25
ii. Risk adjustment model 25
iii. Acuity adjustments 25
B. Appropriate Documentation 25
i. Prospective risk adjustment 25
ii. Retrospective risk adjustment 25

iii. Changes to risk adjustment model since last rating period 25
iv. Acuity adjustments 25
SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS 26
1. MANAGED LONG-TERM SERVICES AND SUPPORTS 26
A. Completion of Section I 26
B. MLTSS Rate Structure 26
i. Capitation Rate Structure 26
ii. Methodology 26
C. Managed Care Effect 26
D. Non-Benefit cost 26
E. Experience and Assumptions 27
SECTION III. NEW ADULT GROUP CAPITATION RATES 28
LIMITATIONS 29
APPENDIX 1: ACTUARIAL CERTIFICATION
APPENDIX 2: CY 2021 COST MODELS
APPENDIX 3: CASE MIX EXHIBIT
APPENDIX 4: CY 2021 CAPITATION RATE DEVELOPMENT
APPENDIX 5: TREND ANALYSIS
APPENDIX 6: COVERED SERVICES
APPENDIX 7: JANUARY TO FEBRUARY 2021 CAPITATION RATE DEVELOPMENT

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, 2021. The rates being certified as actuarially sound are to be effective from January 1, 2021 and remain in effect through December 31, 2021. MI Health Link is Michigan's demonstration managed care program for the dual eligible (Medicare-Medicaid) population. Please note that this certification includes acknowledgement of a temporary increase to hourly reimbursement for direct care workers consistent with adjustments applied during calendar year 2020 in response to the COVID-19 pandemic. We note in this report that the increase will be in effect for the two months from January to February 2021. However, it is intended that these rates are paid for the full period that the increased DCW reimbursement is in effect. If it is extended past February 2021, an amended report will be provided that recertifies the rates for entire period, but note the rates documented in Appendix 7 of this report will still be applicable during months where the current policy is extended.

This letter provides documentation for the development of the actuarially sound capitation rates for calendar year (CY) 2021. 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 2020-2021 Medicaid Managed Care Rate Development Guide, released by the Center for Medicare and Medicaid Services in July 2020 (CMS guide). Section III of the CMS guide is not applicable to this certification, since the covered services do not include rates for new adult groups.

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

- The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care.
- The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity.
- The documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR 438 and generally accepted actuarial principles and practices.

SUMMARY OF CAPITATION RATES

The capitation rates for the MI Health Link population are illustrated in Table 1 by rate cell. The underlying capitation rates by rate cell are effective from January 1, 2021 through December 31, 2021. The capitation rates covered under this certification are documented in Appendix 4. The rates in Table 1 are illustrated on a gross basis prior to adjustment for any amounts that are expected to be paid by the beneficiary and recouped by the nursing facilities. The rates in Table 1 reflect the mandatory 3% savings assumption prescribed by CMS and the state for demonstration year 6. The percentage change reflects a comparison with the rates originally certified for calendar year 2020. Also included in Table 1 are the increased rates specifically effective for the January through February 2021 time period. MDHHS is temporarily allowing flexibility to account for increased risk factors associated with COVID-19 in the rates paid to direct care workers (DCW). This flexibility is applicable to authorized services billable to Community Living Supports services in which face-to-face contact is essential for beneficiary health and safety. The increase is being established as a $2 per hour increase for hazard pay to DCW providers. Please note that the rates illustrated in Table 1 exclude amounts associated with the Insurance Provider Assessment (IPA), which will be paid on a retrospective basis. The IPA amounts estimated for CY 2021 are included in Appendix 4 with discussion of those amounts noted later in this report.

TABLE 1: COMPARISON WITH CY 2020 RATES (PMPM RATES)

RATE CELL	AVERAGE MONTHLY ENROLLMENT	ORIGINAL CY 2020 RATES	PROPOSED CY 2021 RATES	% CHANGE	JAN-FEB 2021 RATES WITH DCW ADJUSTMENT	% CHANGE
Nursing Facility – Subtier A						
Over Age 65	1,380	$ 6,671.48	$ 7,008.09	5.0%	$ 7,008.86	0.0%
Under Age 65	225	5,888.57	6,275.22	6.6%	6,276.37	0.0%
Nursing Facility – Subtier B						
Over Age 65	195	$ 10,709.31	$ 11,084.33	3.5%	$ 11,084.40	0.0%
Under Age 65	15	10,450.17	10,847.09	3.8%	10,847.23	0.0%
Nursing Facility LOC-Waiver						
Over Age 65	1,065	$ 2,370.50	$ 2,384.33	0.6%	$ 2,582.27	8.3%
Under Age 65	1,155	2,894.21	2,898.53	0.1%	3,121.80	7.7%
Community Well						
Over Age 65	16,080	$ 168.63	$ 204.78	21.4%	$ 222.81	8.8%
Under Age 65	17,865	148.79	177.99	19.6%	191.71	7.7%
Composite	**37,980**	**$632.27**	**$678.43**	**7.3%**	**$704.90**	**3.9%**

Notes:

1. Values shown are on a gross basis prior to reduction for patient pay amounts and withhold.
2. Distribution of enrollment based on average projected monthly enrollment for CY 2021.
3. Amounts related to the Insurance Provider Assessment are not included in the values listed in Table 1.
4. Percent change values are relative to prior column rates.

The projected CY 2021 enrollment estimates were developed based off July 2020 enrollment in the MI Health Link program.

FISCAL IMPACT ESTIMATE

The estimated fiscal impact of the CY 2021 MI Health Link rate changes on a state and federal basis documented in this report is a $23.0 million increase to aggregate expenditures. This amount is on a state and federal expenditure basis using the projected monthly enrollment for CY 2021 and excluding any amounts related to the IPA. Table 2 provides the development of estimated total expenditures, as well as federal only expenditures, under the current contracted capitation rates and the proposed CY 2021 capitation rates illustrated in Table 1, assuming the DCW increased rates for 2 months. The federal expenditures illustrated in Table 2 are based on the Federal Fiscal Year (FFY) 2021 FMAP of 64.08% for the January to September time period and FFY 2022 FMAP of 65.48% for October to December, with the additional 6.2% FMAP due to COVID-19 applying to the January through June 2021 period.

TABLE 2: COMPARISON WITH CY 2020 RATES ($ MILLIONS)

POPULATION	AGGREGATE EXPENDITURES AT 2020 RATES	AGGREGATE EXPENDITURES AT 2021 RATES	EXPENDITURE CHANGE
Nursing Facility-Subtier A	$ 126.4	$ 133.0	$ 6.6
Nursing Facility-Subtier B	26.9	27.9	0.9
NFLOC – Waiver	70.4	71.6	1.2
Community Well	64.4	78.7	14.3
Total MI Health Link	**$ 288.2**	**$ 311.2**	**$ 23.0**
Total Federal	194.6	210.2	15.6
Total State	93.6	101.0	7.4

Notes:

1. Annualized expenditures were developed with projected enrollment.
2. State expenditures based on Federal Fiscal Year (FFY) 2021 and 2022 FMAPs of 64.08% and 65.48%, plus an additional 6.2% for January through June 2021.
3. Amounts related to the Insurance Provider Assessment are not included in the values listed in Table 2
4. 2021 aggregate expenditures include two months (January and February) of DCW hazard pay.

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); ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification) ; and ASOP 56 (Modeling).

- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the CY 2021 managed care program rating period.

- The most recent CMS Medicaid Managed Care Rate Development Guide.

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

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

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.

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, 2021 through December 31, 2021.

ii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Christopher Pettit, FSA, is in Appendix 1. Mr. Pettit meets the qualification standards established by the American Academy of Actuaries, follows the practice standards established by the Actuarial Standards Board, and certifies that the final rates meet the applicable standards in 42 CFR 438 that are effective for the CY 2021 managed care program rating period.

(b) Certified capitation rates for each rate cell

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

(c) Program information

(i) Managed Care program

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

MI Health Link began a phased-in schedule of enrollment starting in March 2015 among 7 full-risk managed care plans in 4 regions. This certification is for Demonstration Year 6, which coincides with calendar year 2021. Demonstration Year 1 comprised of the partial year 2015 and the complete calendar year 2016 time periods with Demonstration Year 2 being CY 2017, Demonstration Year 3 being CY 2018, Demonstration Year 4 being CY 2019, and Demonstration Year 5 being CY 2020.

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

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

The program pays secondary to Medicare for Medicare covered services.

Table 3 illustrates the counties included in the MI Health Link program along with their implementation dates

TABLE 3: MI HEALTH LINK REGIONS AND IMPLEMENTATION DATES

MI HEALTH LINK REGION	COUNTIES	IMPLEMENTATION DATE
Region 1-Upper Peninsula	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft	March 1, 2015
Region 4-Southwest	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	March 1, 2015
Region 7-Wayne County	Wayne	May 1, 2015
Region 9-Macomb County	Macomb	May 1, 2015

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

(ii) Rating period

This actuarial certification is effective for the one-year rating period January 1, 2021 through December 31, 2021.

(iii) Covered populations

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

Excluded Populations

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

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

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

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

Nursing Facility Population

This population includes individuals residing in a nursing facility who meet the state definition of nursing home level of care and who are not enrolled in a waiver. Milliman identified the population in the capitation rate-setting process by using fields in the MDHHS eligibility data that denote Medicaid individuals as meeting the nursing home level of care criteria and reside in a nursing facility. The capitation rate for this rate cell was developed based on projected gross nursing facility rates.

On an individual basis, MDHHS will deduct the actual patient pay liability amount from the nursing facility capitation rate shown in Table 1 and pay the net capitation rate to the ICOs. The nursing facility population is divided into subtiers, split by individuals residing in a privately owned (Subtier A) versus a publicly owned (Subtier B) nursing facility. Additionally, members receiving services in a hospital long-term care facility are categorized in Subtier B based on the average cost identified for these beneficiaries.

Nursing Facility Level of Care-Waiver Population

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

Community Residents Population

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

(iv) Eligibility criteria

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

(v) Special contract provisions

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

- Withhold arrangements

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

(vi) Retroactive adjustment to capitation rates

This rate certification report does not include a retroactive adjustment to the CY 2021 capitation rates.

iii. Differences among capitation rates

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

iv. Cross-subsidization of rate cell payment

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

v. Effective dates

To the best of our knowledge, the effective dates of changes to the MI Health Link program are consistent with the assumptions used in the development of the certified CY 2021 capitation rates.

vi. Medical loss ratio

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

vii. Generally accepted actuarial practices and principles

(a) Reasonable, appropriate, and attainable

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

(b) Outside the rate setting process

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

(c) Final contracted rates

The CY 2021 capitation rates certified in this report represent the rates by rate cell prior to application of the regional factors. The regional factors are illustrated in Appendix 4.

viii. Rate certification for effective time periods

This actuarial certification is effective for the one-year rating period January 1, 2021 through December 31, 2021.

ix. Procedures for rate certification and amendment

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

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

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

B. APPROPRIATE DOCUMENTATION

i. Documentation of required elements

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

ii. Assumptions and adjustments

We attest for all assumptions and adjustments underlying the certified capitation rates which will be disclosed in this rate certification. Rate ranges will not be certified but may be used in developing assumptions and adjustments. The final certified rates reflect specific point estimates.

iii. 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.

iv. Different FMAP

All populations receive the regular state FMAP of 64.08% for FFY 2021 through September 2021, and the FFY 2022 FMAP of 65.48% October through December 2021. We have assumed the 6.2% enhanced FMAP due to the public health emergency will be extended through June 2021.

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

The previous rate certification applied to CY 2020 capitation rates. A comparison to the original CY 2020 rates is provided in Table 1. We have not made comparisons to the rates that were adjusted for temporary reimbursement increases due to the COVID-19 pandemic.

vi. Known amendments

There are currently no known amendments that are not accounted for in this rate certification. If a known amendment exists, the state will submit the expected amendment and its anticipated changes to the rates to CMS along with an explanation as to why the amendment is not currently reflected in the rate certification. We have acknowledged the DCW reimbursement increase is in effect for January to February 2021, but will submit an amended report if that policy is extended beyond February.

2. Data

This section provides information on the data used to develop the capitation rates. The base SFY 2019 experience data described in this section is illustrated in Appendix 2.

A. RATE DEVELOPMENT STANDARDS

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

B. APPROPRIATE DOCUMENTATION

i. Requested data

As the actuary contracted by MDHHS to provide consulting services and associated financial analyses for many aspects of the Michigan Medicaid program (and not just limited to capitation rate development), Milliman intakes and summarizes eligibility and expenditure data on a monthly basis from Optum, MDHHS's data administrator. We received eligibility and expenditure information historical time periods. There was no data that was requested from Milliman that was not received. The remainder of this section details the base data and validation processes utilized in the CY 2021 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 2021 MI Health Link capitation rate development:

- Fee-for-service data for the MI Health Link eligible population for October 1, 2018 through September 30, 2019 (base data year) and paid through September 2020
- Detailed fee-for-service and managed care enrollment data for October 1, 2018 through September 30, 2019
- Managed care capitation rates paid to the health plans serving enrollees in the Medicare-Medicaid dually eligible (MME) and MI Choice managed care programs for SFY 2021
- Additional gross adjustment expenditure information outside the MMIS claims system
- Summary of known policy and program changes through state fiscal year 2021 (including changes to fee schedules and other payment rates)
- Monthly enrollment for the MI Health Link program

Appendix 2 illustrates the fee-for-service base data summaries that provide the foundation for the calendar year 2021 MI Health Link capitation rate development. The information is stratified by rate cell and category of service.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during SFY 2019. The fee-for-service data used in our rate development process reflects adjudicated data through September 2020.

For the purposes of trend development and analyzing historical experience, we also reviewed fee-for-service and enrollment experience from state fiscal years 2017 and 2018. We utilized recent average monthly enrollment for purposes of emerging population enrollment patterns.

(iii) Data sources

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

(iv) Sub-capitation

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

(b) Availability and quality of the data

(i) Steps taken to validate the data

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

Completeness

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

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

Accuracy

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

Consistency of data across data sources

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

Following the draft CY 2021 rate development, we modified our methodology of assigning utilization for nursing home services. This change can be observed by comparing the base data utilization metrics included in the draft report compared to values in Appendix 2.

(ii) Actuary's assessment

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

The fee-for-service data represents the most appropriate data to be used for developing the actuarially sound capitation rates for the CY 2021 MI Health Link program.

(iii) Data concerns

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

(c) Appropriate data

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

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

(ii) Use of managed care encounter data

Encounter data was not used for this certification. These rates are intended to be projections of costs "in absence of the demonstration", and as a result, encounter data would not be applicable. We did utilize the SFY 2021 capitation rates for the Medicare-Medicaid dually eligible (MME) and MI Choice programs for purposes of establishing the Community and Waiver tier rates. These rates were based on encounter data, but no updates to these rates were made for purposes of the MI Health Link rate development.

(d) Reliance on a data book

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

iii. Data adjustments

Capitation rates were developed from historical state fiscal year 2019 fee-for-service data, paid through September 2020. As shown in Appendix 2, the primary base data year adjustments include completion, trend, reimbursement, and other program adjustments.

(a) Credibility adjustment

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

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

(b) Completion adjustment

Historical fee-for-service claims experience was run through an internal Milliman claims reserving system to estimate completion factors. Separate sets of factors were developed for each major category of service. The development of the completion factors for SFY 2019 experience was based on a traditional triangle methodology utilizing paid data through September 2020. Average adjustments were applied to SFY 2019 experience to account for the runout applicable to each of the experience periods. The PMPM impact of the applied completion factors are illustrated in Appendix 2.

Non-Emergency Medical Transportation

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

The adjustments made to the Community well tiers were to align transportation costs in the MI Health Link rates with the transportation costs included in the Medicaid-Medicare dual eligible managed care population (referred to as the Duals Lite population) capitation rates. A PMPM amount of $12.37 is included in the Duals Lite rates for transportation. Based on the experience noted in the cost models for transportation on the Community Well populations, we included adjustments to align the transportation costs in the MI Health Link rates with the Duals Lite rates, consistent with prior year rate settings. We did not make adjustments for the NFLOC waiver tier as the MI Choice capitation rates include coverage of NEMT services. We did not make adjustments for the Nursing Facility tiers as NEMT is not an applicable service to institutionalized members.

(c) Errors found in the data

No specific errors were identified in the data.

(d) Program change adjustments

The base data year represents a historical time period from which projections were developed. We reviewed prior rate setting documentation and other materials from MDHHS to identify program changes that were implemented during the base data period. To the extent the program adjustments were estimated to have a material impact on ICO service costs an adjustment was considered for the calendar year 2021 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 relative to the individual rate reflected in the base data. For calendar year 2021, for State of Michigan workers, the Home Help service individual rate remained at the April 2020 effective rate of $9.90. This adjustment is reflected outside of the trend adjustment and is shown in the cost model projections in Appendix 2. As capitation rates are stratified by age, the utilization is specific to each rate cell and the impact of the direct care wage increase had a different impact by rate cell. This adjustment is specific to individual personal care providers.

Effective January 1 through February 28, 2021, MDHHS increased reimbursement for direct care wage (DCW) services by $2.00 per hour for hazard pay in response to the COVID-19 pandemic. The $2.00 per hour increase was grossed up an additional 9.75% to account for the additional anticipated payments made by MDHHS for Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax (FUTA). Additionally, the Nursing Facility LOC-Waiver population capitation rate cells were updated to include the amended January 2021 MI Choice capitation rates. The DCW hazard pay was estimated to increase the MI Choice capitation rates by 8.4%.

Appendix 7 provides the certified capitation rates by rate cell values specific to the January through February 2021 rating period with the additional $2.00 per hour DCW wage increase.

Home Help Agency increase

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

Other

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

(e) Exclusion of payments or services from the data

No specific payments were excluded from the rate development.

3. Projected benefit cost and trends

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

A. RATE DEVELOPMENT STANDARDS

i. Final Capitation Rate Compliance

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

ii. Basis for Variation in Assumptions

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

iii. Benefit Cost Trend Assumptions

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

iv. In Lieu Of Services

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

v. IMDs as an in lieu of service provider

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

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

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

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

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

B. APPROPRIATE DOCUMENTATION

i. Projected Benefit Costs

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

ii. Development of Projected Benefit Costs

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

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

Step 1: Create unadjusted cost model summaries

The capitation rates were developed from historical fee-for-service and enrollment data for members who would be eligible for the MI Health Link program in the noted demonstration regions. This data consisted of state fiscal year 2019 incurred fee-for-service data that is reported by the state in the data warehouse and maintained by Optum.

We received additional data feeds outside of our normal monthly process for claims associated with Home Help and patient pay amounts. This information serves as the starting point of the base experience and is noted as unadjusted SFY 2019 experience in Appendix 2. Certain categorization changes were made in developing the cost models which shifted certain services to align with methodology outlined as part of the encounter quality initiative with the ICOs.

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

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

Step 2: Adjust for completion and prospective trend

As documented in the previous section, utilization and cost per service rates from the base experience period were adjusted for completion and prospectively trended from the midpoint of the base experience period (April 1, 2019) to the midpoint of the CY 2021 rating period (July 1, 2021). We have included one-time specific adjustments to the Inpatient Hospital (approximately 8.0% increase) and Professional (approximately 0.5% increase) cost trend adjustments to account for the changes in Medicaid cost sharing due to the increases in Medicare Part A and Part B deductibles between the base experience period and CY 2021. These represented an increase to $1,484 for the Part A deductible and to $203 for the Part B deductible. Further, we have included additional cost per service adjustment for the Nursing Facility services to align the projected reimbursement level with the fee schedule per diem rate. The adjustments are reflected on Appendix 2 in the columns noted as Cost Trend Adjustment in combination with the applied annualized trend. These explicit adjustments have increased the effective trend to be above the selected trend assumptions identified in Appendix 5.

Step 3: Adjust for additional payments and reimbursement changes

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

- **Quality Assurance Payments** - Nursing facility services include daily costs for members residing in a nursing facility or hospital long-term care unit. The nursing facility cost per day includes gross adjustment payments made by MDHHS to all nursing facilities for Quality Assurance Supplement (QAS) payments. This adjustment is noted in Appendix 2 for Nursing Facility and Inpatient Hospital related claims.
- **Certified Public Expenditures** – Additional nursing facility daily costs for county-owned facilities are included for the Subtier B nursing facility rate cells. This adjustment is noted in Appendix 2 for Nursing Facility related claims specific to Subtier B.
- **FICA/FUTA** - Home help service cost includes all gross adjustment payments made by MDHHS for Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax (FUTA) payments.
- **Supplemental SNF Copayments** - The supplemental nursing facility patient pay amount is reflected on a per member per month (PMPM) basis for members in a nursing facility rate tier in Appendix 4.
- **Capitation payments** - Consistent with historical development of the MI Health Link capitation rates, we have included the SFY 2021 MI Choice capitation rates as part of the Waiver tier rates and Medicare-Medicaid dually eligible (MME) managed care population rates for the MCO component of the Community tier.

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

We included PMPM amounts for additional services not included in the base fee-for-service experience for NEMT as previously described.

Step 5: Regional adjustments

The rates noted in Table 1 represent the statewide rate for each rate cell. Capitation rates paid to each of the ICOs will be dependent upon the demonstration region for which the covered life resides. Consistent with the four regions identified in Table 4, regional adjustment factors were calculated for each applicable region and rating tier. The relative cost per service differences for key service lines was utilized to develop the regional adjustment factors applied to the capitation rates.

For the nursing facility populations, the regional adjustment factor was developed by comparing the nursing home per diem rates specific to each demonstration region to the composite per diem rate across all demonstration regions for each population. The community well regional factor was based on comparing the proportion of home help experience provided by individual versus agency providers. Individuals are reimbursed at the $9.90 per hour rate compared with $16.08 per hour for agency providers. The variation in availability of providers for each of these provider types has led to significant differences in home help expenditures by demonstration region. The regional factors adjust the composite rate in line with the expected cost variation as a result of fee schedule differences for each rating tier and region.

The regional adjustment factors to be applied are documented in Appendix 4. Separate regional adjustments were not developed for Over/Under 65 rate cells.

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

The primary change from the prior year rate-setting is utilizing SFY 2019 experience and re-basing rate cells for CY 2021. 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.

During prior rate setting processes, prospective risk selection factors were applied to the base data in order to reflect the voluntary and opt-out nature of the MI Health Link program. These selection factors were developed reviewing historical experience for the target populations and identifying differences between members that are ultimately enrolled in MI Health Link versus those that remain in FFS. Based on the lack of recently available FFS data for MI Health Link enrollees in the SFY 2019 experience, we have removed the selection factor for the CY 2021 rate development as noted in Appendix 4. We do not believe sufficient experience exists to support a selection factor as has been applied in prior year rate settings.

A review of the Quality Assurance Payments adjustment supported a change in methodology for the CY 2021 rate development compared to what was utilized in prior rate setting processes. For the CY 2021 rating period, facility specific per diem rates were used as the basis of this adjustment, and on average equaled roughly $42 dollars per day.

We reviewed the emerging ICO encounter data as a comparison against the developed Medicaid capitation rates at a rate cell level. At this time, we do not believe the ICO encounter data can be deemed fully credible across all ICOs, therefore we did not perform a detailed evaluation of the encounter data against the selection factors. Please note that encounter data was not utilized to establish or inform any aspect of the rate development per CMS rate setting requirements for this program.

(c) Overpayments to providers

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

iii. Projected Benefit Cost Trends

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (SFY 2019) to the CY 2021 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 2017 through 2019 fee-for-service data specific to the MI Health Link eligible population.

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

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

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

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

(ii) Methodology

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

(iii) Comparisons

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

(iv) Chosen trend rates

Appendix 5 provides the selected trend rates by category of service. These trends include both utilization and cost per service components. As noted above, the cost trend adjustment reflected in Appendix 2 is higher than the selected cost trend to align with the projected reimbursement level based on the fee schedule per diem rate.

(b) Benefit cost trend components

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

(c) Variation

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

(i) Medicaid populations

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

(ii) Rate cells

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

(iii) Subsets of benefits within a category of services

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

(d) Material adjustments

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

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

(e) Any other adjustments

(i) Impact of managed care

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

(ii) Trend changes other than utilization and cost

We 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

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

v. In Lieu of Services

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

vi. Retrospective Eligibility Periods

(a) ICO responsibility

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

(b) Claims treatment

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

(c) Enrollment treatment

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

(d) Adjustments

No adjustments are necessary.

vii. Impact of Material Changes

This section relates to material changes to covered benefits or services since the last rate certification. The last rate certification was for the CY 2020 rating period.

(a) Change to covered benefits

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

(b) Recoveries of overpayments

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

(c) Change to payment requirements

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

(d) Change to waiver requirements

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

(e) Change due to litigation

There were no material changes due to litigation.

viii. Documentation of Material Changes

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

4. Special Contract Provisions Related to Payment

A. INCENTIVE ARRANGEMENTS

i. Rate Development Standards

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

ii. Appropriate Documentation

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

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of the Withhold Arrangement

(i) Time period and purpose

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

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

The withhold arrangement is applicable to all enrollees, services, and providers under the MI Health Link program.

(iii) Purpose of the withhold arrangement

The purpose of the withhold arrangement is to ensure MI Health Link ICOs meet certain performance measures identified in the managed care contract.

(iv) Description of total percentage withheld

MDHHS has established a quality withhold of 4.0% of the capitation rate for demonstration year 6 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 2021 capitation rates documented in this report are actuarially sound after considering the portion of the withhold that ICOs are estimated to earn back.

(v) Estimate of percent to be returned

The withhold measures that are in place for Demonstration Year 6 of the MI Health Link program do reflect changes from prior Demonstration Years but mainly with additional metrics being included and one being removed. As of the timing of this report, the calculations of the withhold for Demonstration Year 6 have not been determined. We anticipate that the ICOs will be able to earn back greater than 80% of the withheld amounts.

(vi) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 4.0% 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.

(vii) Effect on the capitation rates

The CY 2021 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable.

(b) Capitation payments minus withhold

The CY 2021 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable, and the capitation rates are certified as actuarially sound.

C. RISK SHARING MECHANISMS

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of Risk-sharing Mechanism

No risk sharing arrangements exist for the covered populations.

(b) Medical Loss Ratio

Description

Beginning Demonstration Year 2, each ICO was 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 was established at 85%. Effective Demonstration Year 6, the target MLR is being increased to 86%.

Financial consequences

If an ICO has an MLR below the target of 86%, the ICO will remit 50% of the difference between its MLR and 86%. Additionally, if the calculated MLR is below 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 plus 0.5% multiplied by the total capitation rate revenue of the contract. Any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis.

(c) Reinsurance Requirements and Effect on Capitation Rates

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

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

i. Rate Development Standards

This section is not applicable.

ii. Appropriate Documentation

(a) Description of Delivery System and Provider Payment Initiatives

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

This section is not applicable.

E. PASS-THROUGH PAYMENTS

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of Pass-Through Payments

(i) Description

There are no pass-through payments reflected in the CY 2021 capitation rates.

(ii) Amount

Not applicable.

(iii) Providers receiving the payment

Not applicable.

(iv) Financing mechanism

Not applicable.

(v) Pass-through payments for previous rating period

Not applicable.

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

Not applicable.

5. Projected non-benefit costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

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

Certain non-benefit expenses are included in the development of the MME and MI Choice population capitation rates that are utilized in the development of the Community and Waiver rates. No other changes were made to those rates under the CY 2021 MI Health Link rate development process. The addition of the IPA is noted as a non-benefit expense and discussed in more detail below.

ii. PMPM versus percentage

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

The IPA is applicable to insurance providers in the State of Michigan. The IPA assesses a PMPM rate of $53.55 to each covered member month, by managed care entity, up to 1.2 million members in a given state fiscal year. The PMPM amount decreases to $1.20 for each member month above 1.2 million. The ultimate amount paid for the IPA will be vary by managed care entity based on actual enrollment utilized in the calculation of the assessment. The IPA became effective October 1, 2018 and will be paid on a retrospective basis at the end of each quarter. We have included a PMPM estimate for CY 2021 in Appendix 4 based on a complete 12 months' worth of payments over the calendar year.

The estimated IPA load of $36.80 reflected in Appendix 4 was based on enrollment information provided by MDHHS and the PMPM payment structure of the IPA being consistent with the amounts noted in the CY 2020 MI Health Link certification. The MI Health Link portion of the IPA liability was calculated based on the proportion of a plan's total membership across the various Michigan Medicaid managed care programs. Please note that we have developed a singular PMPM across all ICOs but acknowledge that ultimate amounts paid will vary by ICO. Note that the IPA will be 100% state funded for the MI Health Link program.

iii. Basis for variation in assumptions

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

iv. Health insurance providers fee

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

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

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

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

(b) Material changes

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

(c) Other material adjustments

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

ii. Non-benefit costs, by cost category

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

iii. Health insurance providers fee

This section is not applicable.

6. Risk Adjustment and Acuity Adjustments

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

A. RATE DEVELOPMENT STANDARDS

i. Overview

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

ii. Risk adjustment model

Not applicable.

iii. Acuity adjustments

Not applicable.

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data and adjustments

Not applicable.

(b) Risk adjustment model

Not applicable.

(c) Risk adjustment methodology

Not applicable.

(d) Magnitude of the adjustment

Not applicable.

(e) Assessment of predictive value

Not applicable.

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

Not applicable.

ii. Retrospective risk adjustment

Not applicable.

iii. Changes to risk adjustment model since last rating period

Not applicable.

iv. Acuity adjustments

Not applicable.

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

1. Managed Long-Term Services and Supports

A. COMPLETION OF SECTION I.

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

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

B. MLTSS RATE STRUCTURE

i. Capitation Rate Structure

The MI Health Link rate structure for calendar year 2021 did not change from the 2015-2020 rate structure. Rates continue to vary by region consistent with current geographic definitions. The rate cells continue to represent population groups split by place of setting and represent a non-blended rate cell structure.

Nursing Facility

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

Transition Rules

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

NFLOC-Waiver

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

Community

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

ii. Methodology

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

C. MANAGED CARE EFFECT

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

D. NON-BENEFIT COST

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

E. EXPERIENCE AND ASSUMPTIONS

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

Section III. New adult group capitation rates

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

Limitations

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

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

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

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

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.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to develop actuarily sound capitation rates. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

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

Milliman's data and information reliance includes:

- Fee-for-service data for the MI Health Link eligible population for October 1, 2018 through September 30, 2019 (base data year) and paid through September 2020
- Detailed fee-for-service and managed care enrollment data for October 1, 2018 through September 30, 2019
- Managed care capitation rates paid to the health plans serving enrollees in the Medicare-Medicaid dually eligible (MME) and MI Choice managed care programs for SFY 2021
- Additional gross adjustment expenditure information outside the MMIS claims system
- Summary of policy and program changes through state fiscal year 2020 (including changes to fee schedules and other payment rates)
- Monthly enrollment for the MI Health Link program

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

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

Appendix 1: Actuarial Certification

State of Michigan, Department of Health and Human Services
MI Health Link Program
Calendar Year 2021 Medicaid Component Capitation
Actuarial Certification

I, Christopher Pettit, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Michigan, Department of Health and Human Services, to perform an actuarial review and certification regarding the development of capitation rates for the MI Health Link program effective January 1, 2021. 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 2021.

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

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

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

Christopher T. Pettit, FSA
Member, American Academy of Actuaries

January 15, 2021
Date

Appendix 2: CY 2021 Cost Models

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 6 Rate Development
Projected Base Experience

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

Member Months: 66,423	Fiscal Year 2019 Base Experience								Trended/Adjusted to CY 2021		
Category of Service	Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	687.2	$ 218.46	$ 12.51	$ 0.09	$ 0.14	$ 1.17	$ 0.00	$ 0.00	700.1	$ 238.48	$ 13.91
Inpatient Well Newborn	24.0	214.37	0.43	0.01	0.01	0.04	-	-	24.6	232.23	0.48
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Inpatient Maternity Delivery	14.8	90.50	0.11	-	-	0.01	-	-	14.8	98.98	0.12
Other Inpatient	1,138.5	185.67	17.62	0.13	0.20	1.64	-	-	1,160.0	202.62	19.59
Subtotal Inpatient Hospital			**$ 30.67**								**$ 34.10**
Outpatient Hospital											
Outpatient Emergency Room	17.0	$ 267.11	$ 0.38	$ 0.00	$ 0.02	$ 0.01	$ 0.00	$ 0.00	18.0	$ 271.26	$ 0.41
Outpatient Surgery	6.0	418.45	0.21	-	0.01	0.01	-	-	6.2	434.26	0.23
Outpatient Radiology	19.3	38.29	0.06	-	0.00	-	-	-	20.2	38.29	0.06
Outpatient Pathology/Lab	41.6	45.68	0.16	-	0.01	-	-	-	44.7	45.68	0.17
Outpatient Pharmacy	15.4	387.21	0.50	-	0.03	0.01	-	-	16.3	394.59	0.54
Outpatient MH/SA	0.5	147.97	0.01	-	-	-	-	-	0.5	147.97	0.01
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	1,445.3	28.42	3.42	0.02	0.19	0.04	-	-	1,535.8	28.72	3.68
Subtotal Outpatient Hospital			**$ 4.73**								**$ 5.08**
Professional											
Inpatient and Outpatient Surgery	337.1	$ 23.53	$ 0.66	$ 0.01	$ 0.00	$ 0.01	$ 0.00	$ 0.00	341.7	$ 23.95	$ 0.68
Anesthesia	13.9	47.78	0.06	-	-	-	-	-	13.9	47.78	0.06
Inpatient Visits	4,408.1	17.62	6.47	0.05	0.04	0.14	-	-	4,465.5	18.01	6.70
MH/SA	47.5	29.08	0.12	-	-	0.00	-	-	47.5	29.54	0.12
Emergency Room	143.6	23.51	0.28	-	-	0.01	-	-	143.6	24.27	0.29
Office/Home Visits/Consults	474.8	30.25	1.20	0.01	0.01	0.03	-	-	481.5	30.96	1.24
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	93.9	6.94	0.05	-	-	-	-	-	93.9	6.94	0.05
Radiology	204.7	14.12	0.24	-	-	0.01	-	-	204.7	14.71	0.25
Office Administered Drugs	222.8	31.75	0.59	0.00	0.01	0.01	-	-	226.5	32.48	0.61
Physical Exams	2.9	95.19	0.02	-	-	-	-	-	2.9	95.19	0.02
Therapy	3.3	-	-	-	-	-	-	-	-	-	-
Vision	376.5	25.08	0.79	0.01	0.00	0.02	-	-	380.8	25.56	0.81
Other Professional	484.4	20.73	0.84	0.01	0.00	0.02	-	-	490.7	21.24	0.87
Subtotal Professional			**$ 11.31**								**$ 11.71**
Pharmacy											
Pharmacy	2,743.3	$ 14.35	$ 3.28	$ 0.00	$ 0.02	$ 0.44	$ 0.00	$ 0.00	2,759.2	$ 16.28	$ 3.74
Subtotal Pharmacy			**$ 3.28**								**$ 3.74**
Ancillary											
Emergency Transportation	155.2	$ 148.57	$ 1.92	$ 0.01	$ 0.01	$ 0.03	$ 0.00	$ 0.00	157.4	$ 150.76	$ 1.98
Non-Emergency Transportation	-	-	-	-	-	-	-	-	-	-	-
DME/Prosthetics	1,501.5	54.16	6.78	0.05	0.04	0.11	-	-	1,521.5	55.06	6.98
Dental	1,434.6	32.47	3.88	0.03	0.02	0.07	-	-	1,452.7	33.06	4.00
Other Ancillary	2.5	8,844.70	1.86	0.01	0.01	0.04	-	-	2.6	9,010.14	1.92
Subtotal Ancillary			**$ 14.44**								**$ 14.88**
LTSS											
Hospice	18,838.2	$ 204.33	$ 320.77	$ 0.00	$ 3.62	$ 29.93	$ 0.00	$ 0.00	19,050.7	$ 223.18	$ 354.32
Nursing Home	300,821.3	158.20	3,965.86	-	44.76	957.53	-	1,039.89	304,216.1	236.99	6,008.04
HCBS	217.3	270.53	4.90	-	0.05	0.46	0.50	0.71	219.7	361.62	6.62
Subtotal LTSS			**$ 4,291.53**								**$ 6,368.98**
Total Medical Costs			**$ 4,355.97**								**$ 6,438.50**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 6 Rate Development
Projected Base Experience

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

Member Months: 14,231 Category of Service	Fiscal Year 2019 Base Experience Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2021 Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	1,479.0	$ 287.81	$ 35.47	$ 0.26	$ 0.41	$ 3.30	$ 0.00	$ 0.00	1,506.9	$ 314.09	$ 39.44
Inpatient Well Newborn	21.1	411.84	0.72	0.01	0.01	0.07	-	-	21.4	448.74	0.80
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	1,557.4	296.74	38.51	0.29	0.44	3.59	-	-	1,586.7	323.86	42.82
Subtotal Inpatient Hospital			**$ 74.71**								**$ 83.07**
Outpatient Hospital											
Outpatient Emergency Room	24.5	$ 300.85	$ 0.61	$ 0.00	$ 0.04	$ 0.00	$ 0.00	$ 0.00	26.0	$ 301.75	$ 0.65
Outpatient Surgery	21.9	572.59	1.05	0.01	0.06	0.02	-	-	23.3	580.57	1.13
Outpatient Radiology	13.5	52.30	0.06	-	0.00	-	-	-	14.1	52.30	0.06
Outpatient Pathology/Lab	67.5	67.20	0.38	-	0.02	0.00	-	-	71.5	67.83	0.40
Outpatient Pharmacy	55.7	520.50	2.41	0.01	0.14	0.02	-	-	59.2	525.49	2.59
Outpatient MH/SA	12.6	48.78	0.05	-	0.00	0.00	-	-	13.0	50.10	0.05
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	1,608.9	38.95	5.22	0.03	0.30	0.06	-	-	1,709.7	39.37	5.61
Subtotal Outpatient Hospital			**$ 9.78**								**$ 10.50**
Professional											
Inpatient and Outpatient Surgery	337.3	$ 32.27	$ 0.91	$ 0.01	$ 0.00	$ 0.02	$ 0.00	$ 0.00	341.5	$ 32.97	$ 0.94
Anesthesia	31.2	52.33	0.14	-	-	0.01	-	-	31.2	55.42	0.14
Inpatient Visits	5,502.1	15.66	7.18	0.05	0.04	0.16	-	-	5,577.2	15.99	7.43
MH/SA	70.0	29.94	0.17	-	-	0.01	-	-	70.0	31.41	0.18
Emergency Room	271.5	22.51	0.51	0.00	0.01	0.01	-	-	276.9	22.94	0.53
Office/Home Visits/Consults	624.0	29.43	1.53	0.01	0.01	0.03	-	-	633.2	30.00	1.58
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	97.8	5.77	0.05	-	-	-	-	-	97.8	5.77	0.05
Radiology	307.8	12.59	0.32	0.00	-	0.01	-	-	308.3	13.00	0.33
Office Administered Drugs	446.1	47.99	1.78	0.02	0.01	0.04	-	-	452.0	49.07	1.85
Physical Exams	4.2	106.39	0.04	-	-	-	-	-	4.2	106.39	0.04
Therapy	13.5	5.54	0.01	-	-	-	-	-	13.5	5.54	0.01
Vision	461.2	24.88	0.96	0.01	-	0.03	-	-	466.1	25.56	0.99
Other Professional	592.8	18.91	0.93	0.01	0.00	0.02	-	-	599.8	19.39	0.97
Subtotal Professional			**$ 14.52**								**$ 15.05**
Pharmacy											
Pharmacy	3,435.3	$ 17.06	$ 4.88	$ 0.00	$ 0.03	$ 0.66	$ 0.00	$ 0.00	3,453.4	$ 19.36	$ 5.57
Subtotal Pharmacy			**$ 4.88**								**$ 5.57**
Ancillary											
Emergency Transportation	442.7	$ 160.01	$ 5.90	$ 0.04	$ 0.04	$ 0.10	$ 0.00	$ 0.00	448.6	$ 162.75	$ 6.08
Non-Emergency Transportation	-	-	-	-	-	-	-	-	-	-	-
DME/Prosthetics	2,628.3	64.15	14.05	0.11	0.08	0.24	-	-	2,662.6	65.24	14.48
Dental	1,870.3	30.74	4.79	0.03	0.03	0.08	-	-	1,896.1	31.25	4.94
Other Ancillary	2.5	9,227.95	1.95	0.01	0.01	0.03	-	-	2.6	9,380.40	2.00
Subtotal Ancillary			**$ 26.69**								**$ 27.50**
LTSS											
Hospice	8,165.0	$ 208.09	$ 141.59	$ 0.00	$ 1.60	$ 13.21	$ 0.00	$ 0.00	8,257.0	$ 227.29	$ 156.40
Nursing Home	284,478.7	150.39	3,565.11	-	40.23	949.79	-	987.76	287,689.1	231.20	5,542.90
HCBS	285.9	282.57	6.73	-	0.08	0.62	0.69	0.97	289.2	377.50	9.10
Subtotal LTSS			**$ 3,713.43**								**$ 5,708.39**
Total Medical Costs			**$ 3,844.02**								**$ 5,850.08**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 6 Rate Development
Projected Base Experience

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

Member Months: 6,513 Category of Service	Fiscal Year 2019 Base Experience: Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2021: Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	6,857.7	$ 302.25	$ 172.73	$ 1.30	$ 1.97	$ 16.06	$ 0.00	$ 0.00	6,987.2	$ 329.84	$ 192.05
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	36,565.6	290.72	885.85	6.64	10.07	82.39	-	160.25	37,255.7	368.87	1,145.21
Subtotal Inpatient Hospital			**$ 1,058.58**								**$ 1,337.27**
Outpatient Hospital											
Outpatient Emergency Room	27.6	$ 194.20	$ 0.45	$ 0.00	$ 0.03	$ 0.00	$ 0.00	$ 0.00	29.5	$ 194.20	$ 0.48
Outpatient Surgery	9.2	183.33	0.14	-	0.01	-	-	-	9.9	183.33	0.15
Outpatient Radiology	136.3	30.50	0.35	-	0.02	0.01	-	-	144.5	30.93	0.37
Outpatient Pathology/Lab	245.0	9.66	0.20	-	0.01	0.00	-	-	262.1	9.73	0.21
Outpatient Pharmacy	14.7	59.02	0.07	-	0.01	-	-	-	15.8	59.02	0.08
Outpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	1,147.9	28.53	2.73	0.02	0.15	0.04	-	-	1,219.1	28.89	2.93
Subtotal Outpatient Hospital			**$ 3.93**								**$ 4.23**
Professional											
Inpatient and Outpatient Surgery	237.7	$ 38.67	$ 0.77	$ 0.00	$ 0.00	$ 0.02	$ 0.00	$ 0.00	240.6	$ 39.48	$ 0.79
Anesthesia	14.7	54.77	0.07	-	-	-	-	-	14.7	54.77	0.07
Inpatient Visits	2,877.9	28.34	6.80	0.05	0.04	0.15	-	-	2,916.7	28.96	7.04
MH/SA	35.0	35.93	0.10	-	-	0.00	-	-	35.0	36.43	0.11
Emergency Room	95.8	26.17	0.21	0.00	-	0.00	-	-	96.5	26.77	0.22
Office/Home Visits/Consults	748.0	33.57	2.09	0.02	0.01	0.05	-	-	756.8	34.37	2.17
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	24.0	18.58	0.04	-	-	-	-	-	24.0	18.58	0.04
Radiology	263.5	12.90	0.28	-	0.01	0.00	-	-	268.3	12.97	0.29
Office Administered Drugs	169.5	105.37	1.49	0.01	0.01	0.03	-	-	171.6	107.59	1.54
Physical Exams	1.8	75.60	0.01	-	-	-	-	-	1.8	75.60	0.01
Therapy	-	-	-	-	-	-	-	-	-	-	-
Vision	206.4	28.01	0.48	0.00	-	0.01	-	-	208.4	28.67	0.50
Other Professional	296.6	52.75	1.30	0.01	0.01	0.03	-	-	301.2	53.80	1.35
Subtotal Professional			**$ 13.64**								**$ 14.11**
Pharmacy											
Pharmacy	2,017.5	$ 10.43	$ 1.75	$ 0.00	$ 0.01	$ 0.23	$ 0.00	$ 0.00	2,026.8	$ 11.82	$ 2.00
Subtotal Pharmacy			**$ 1.75**								**$ 2.00**
Ancillary											
Emergency Transportation	66.3	$ 170.48	$ 0.94	$ 0.01	$ 0.00	$ 0.02	$ 0.00	$ 0.00	67.1	$ 173.30	$ 0.97
Non-Emergency Transportation	-	-	-	-	-	-	-	-	-	-	-
DME/Prosthetics	617.2	39.98	2.06	0.02	0.01	0.04	-	-	624.4	40.66	2.12
Dental	867.8	71.86	5.20	0.04	0.03	0.09	-	-	879.1	73.07	5.35
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 8.20**								**$ 8.44**
LTSS											
Hospice	165.8	$ 323.93	$ 4.48	$ 0.00	$ 0.05	$ 0.42	$ 0.00	$ 0.00	167.6	$ 353.95	$ 4.94
Nursing Home	299,119.3	243.19	6,061.83	-	68.41	1,819.76	-	1,413.64	302,495.0	371.46	9,363.65
HCBS	31.3	169.80	0.44	-	0.00	0.04	0.05	0.06	31.7	227.11	0.60
Subtotal LTSS			**$ 6,066.75**								**$ 9,369.19**
Total Medical Costs			**$ 7,152.86**								**$ 10,735.23**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 6 Rate Development
Projected Base Experience

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

Member Months: 920 Category of Service	Fiscal Year 2019 Base Experience Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2021 Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	847.8	$ 202.56	$ 14.31	$ 0.11	$ 0.16	$ 1.33	$ 0.00	$ 0.00	863.8	$ 221.08	$ 15.91
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	39,495.7	282.23	928.91	6.97	10.56	86.40	-	173.80	40,240.9	359.82	1,206.64
Subtotal Inpatient Hospital			**$ 943.23**								**$ 1,222.55**
Outpatient Hospital											
Outpatient Emergency Room	65.2	$ 70.47	$ 0.38	$ 0.00	$ 0.02	$ 0.00	$ 0.00	$ 0.00	69.0	$ 71.24	$ 0.41
Outpatient Surgery	13.0	429.30	0.47	0.00	0.03	0.00	-	-	13.9	433.10	0.50
Outpatient Radiology	78.3	12.83	0.08	-	0.00	-	-	-	82.4	12.83	0.09
Outpatient Pathology/Lab	117.4	42.88	0.42	-	0.03	0.00	-	-	125.0	43.18	0.45
Outpatient Pharmacy	13.0	68.85	0.07	-	0.00	-	-	-	13.8	68.85	0.08
Outpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	1,643.5	21.60	2.96	0.01	0.17	0.04	-	-	1,745.2	21.86	3.18
Subtotal Outpatient Hospital			**$ 4.39**								**$ 4.71**
Professional											
Inpatient and Outpatient Surgery	365.2	$ 26.76	$ 0.81	$ 0.01	$ 0.01	$ 0.02	$ 0.00	$ 0.00	370.8	$ 27.34	$ 0.84
Anesthesia	-	-	-	-	-	-	-	-	-	-	-
Inpatient Visits	5,478.3	20.47	9.35	0.07	0.05	0.21	-	-	5,548.7	20.92	9.68
MH/SA	13.0	56.70	0.06	-	-	-	-	-	13.0	56.70	0.06
Emergency Room	208.7	14.58	0.25	-	-	0.01	-	-	208.7	15.00	0.26
Office/Home Visits/Consults	860.9	30.89	2.22	0.01	0.02	0.05	-	-	872.3	31.57	2.30
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	-	-	-	-	-	-	-	-	-	-	-
Radiology	456.5	12.84	0.49	0.00	-	0.02	-	-	460.6	13.25	0.51
Office Administered Drugs	482.6	5.09	0.20	-	0.00	0.00	-	-	489.8	5.17	0.21
Physical Exams	-	-	-	-	-	-	-	-	-	-	-
Therapy	-	-	-	-	-	-	-	-	-	-	-
Vision	417.4	30.51	1.06	0.01	0.01	0.02	-	-	423.5	31.10	1.10
Other Professional	430.4	44.03	1.58	0.01	0.01	0.04	-	-	435.6	45.01	1.63
Subtotal Professional			**$ 16.03**								**$ 16.59**
Pharmacy											
Pharmacy	2,321.7	$ 12.33	$ 2.39	$ 0.00	$ 0.01	$ 0.32	$ 0.00	$ 0.00	2,334.4	$ 14.00	$ 2.72
Subtotal Pharmacy			**$ 2.39**								**$ 2.72**
Ancillary											
Emergency Transportation	39.1	$ 166.05	$ 0.54	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	39.8	$ 168.71	$ 0.56
Non-Emergency Transportation	-	-	-	-	-	-	-	-	-	-	-
DME/Prosthetics	1,395.7	122.92	14.30	0.10	0.08	0.25	-	-	1,414.0	125.00	14.73
Dental	1,591.3	39.70	5.26	0.04	0.03	0.09	-	-	1,611.9	40.37	5.42
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 20.10**								**$ 20.71**
LTSS											
Hospice	378.3	$ 342.08	$ 10.78	$ 0.00	$ 0.12	$ 1.01	$ 0.00	$ 0.00	382.5	$ 373.68	$ 11.91
Nursing Home	315,482.6	240.82	6,331.27	-	71.45	2,038.95	-	1,481.67	319,042.9	373.24	9,923.34
HCBS	78.3	186.18	1.21	-	0.01	0.11	0.12	0.17	79.1	248.92	1.64
Subtotal LTSS			**$ 6,343.27**								**$ 9,936.90**
Total Medical Costs			**$ 7,329.39**								**$ 11,204.18**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 6 Rate Development
Projected Base Experience

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

Member Months: 22,631 Category of Service	Fiscal Year 2019 Base Experience Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2021 Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	335.6	$ 120.71	$ 3.38	$ 0.02	$ 0.04	$ 0.31	$ 0.00	$ 0.00	341.9	$ 131.71	$ 3.75
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	1.6	438.90	0.06	-	-	0.01	-	-	1.6	485.10	0.06
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	300.6	127.90	3.20	0.03	0.04	0.30	-	-	306.4	139.61	3.56
Subtotal Inpatient Hospital			**$ 6.64**								**$ 7.38**
Outpatient Hospital											
Outpatient Emergency Room	43.5	$ 157.50	$ 0.57	$ 0.00	$ 0.03	$ 0.01	$ 0.00	$ 0.00	46.0	$ 159.94	$ 0.61
Outpatient Surgery	8.5	384.40	0.27	-	0.02	0.00	-	-	9.1	385.22	0.29
Outpatient Radiology	52.5	41.80	0.18	-	0.01	0.01	-	-	55.4	43.17	0.20
Outpatient Pathology/Lab	103.9	40.85	0.35	0.00	0.02	0.01	-	-	110.0	41.54	0.38
Outpatient Pharmacy	31.3	236.17	0.62	0.00	0.04	0.01	-	-	33.3	238.44	0.66
Outpatient MH/SA	2.1	69.30	0.01	-	-	-	-	-	2.1	69.30	0.01
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	166.0	74.68	1.03	0.00	0.06	0.01	-	-	176.7	75.47	1.11
Subtotal Outpatient Hospital			**$ 3.04**								**$ 3.27**
Professional											
Inpatient and Outpatient Surgery	254.5	$ 24.43	$ 0.52	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	259.4	$ 24.85	$ 0.54
Anesthesia	4.2	38.33	0.01	-	-	-	-	-	4.2	38.33	0.01
Inpatient Visits	142.1	22.46	0.27	-	-	0.01	-	-	142.1	23.21	0.27
MH/SA	16.4	30.95	0.04	-	-	-	-	-	16.4	30.95	0.04
Emergency Room	134.7	23.40	0.26	-	-	0.01	-	-	134.7	24.20	0.27
Office/Home Visits/Consults	2,185.7	33.93	6.18	0.05	0.03	0.14	-	-	2,213.8	34.68	6.40
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	89.6	11.35	0.08	-	-	-	-	-	89.6	11.35	0.08
Radiology	197.3	18.38	0.30	-	0.00	0.01	-	-	199.3	18.98	0.32
Office Administered Drugs	1,133.7	41.65	3.93	0.03	0.02	0.09	-	-	1,148.4	42.58	4.08
Physical Exams	3.2	55.81	0.01	-	-	-	-	-	3.2	55.81	0.01
Therapy	59.9	9.48	0.05	-	-	-	-	-	59.9	9.48	0.05
Vision	212.6	33.31	0.59	0.00	0.01	0.01	-	-	216.2	33.83	0.61
Other Professional	2,918.5	6.53	1.59	0.01	0.01	0.03	-	-	2,957.5	6.67	1.64
Subtotal Professional			**$ 13.84**								**$ 14.33**
Pharmacy											
Pharmacy	4,816.2	$ 11.30	$ 4.54	$ 0.00	$ 0.03	$ 0.61	$ 0.00	$ 0.00	4,844.3	$ 12.82	$ 5.17
Subtotal Pharmacy			**$ 4.54**								**$ 5.17**
Ancillary											
Emergency Transportation	140.5	$ 116.45	$ 1.36	$ 0.01	$ 0.00	$ 0.03	$ 0.00	$ 0.00	142.1	$ 118.60	$ 1.40
Non-Emergency Transportation	-	-	-	-	-	-	-	-	-	-	-
DME/Prosthetics	24,483.1	20.22	41.24	0.31	0.23	0.71	-	-	24,807.0	20.56	42.50
Dental	780.0	78.55	5.11	0.04	0.03	0.08	-	-	790.4	79.84	5.26
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 47.71**								**$ 49.16**
LTSS											
Hospice	38.2	$ 169.04	$ 0.54	$ 0.00	$ 0.01	$ 0.05	$ 0.00	$ 0.00	38.6	$ 184.32	$ 0.59
Nursing Home	2,218.0	96.69	17.87	-	0.20	1.67	-	8.04	2,242.9	148.64	27.78
HCBS	32.9	194.15	0.53	-	0.00	0.05	0.06	0.08	33.0	261.50	0.72
Subtotal LTSS			**$ 18.94**								**$ 29.09**
Total Medical Costs			**$ 94.71**								**$ 108.41**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 6 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: FFS-NF Level of Care-Under 6

Member Months: 10,332 Category of Service	Fiscal Year 2019 Base Experience Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2021 Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	249.7	$ 169.88	$ 3.53	$ 0.03	$ 0.04	$ 0.33	$ 0.00	$ 0.00	254.5	$ 185.33	$ 3.93
Inpatient Well Newborn	47.6	98.75	0.39	0.00	0.00	0.03	-	-	48.8	107.18	0.44
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	277.6	233.50	5.40	0.04	0.06	0.50	-	-	282.8	254.87	6.01
Subtotal Inpatient Hospital			**$ 9.33**								**$ 10.37**
Outpatient Hospital											
Outpatient Emergency Room	48.8	$ 120.74	$ 0.49	$ 0.00	$ 0.03	$ 0.01	$ 0.00	$ 0.00	51.8	$ 122.61	$ 0.53
Outpatient Surgery	15.1	314.76	0.40	-	0.02	0.01	-	-	16.0	319.89	0.43
Outpatient Radiology	72.0	47.97	0.29	-	0.02	0.01	-	-	76.3	48.77	0.31
Outpatient Pathology/Lab	92.9	50.45	0.39	-	0.03	0.00	-	-	98.9	50.99	0.42
Outpatient Pharmacy	39.5	428.98	1.41	0.00	0.08	0.02	-	-	42.0	433.85	1.52
Outpatient MH/SA	18.6	39.68	0.06	-	-	0.01	-	-	18.6	44.89	0.07
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	224.2	87.79	1.64	0.01	0.10	0.02	-	-	238.3	88.68	1.76
Subtotal Outpatient Hospital			**$ 4.68**								**$ 5.03**
Professional											
Inpatient and Outpatient Surgery	223.0	$ 63.05	$ 1.17	$ 0.01	$ 0.00	$ 0.03	$ 0.00	$ 0.00	225.6	$ 64.56	$ 1.21
Anesthesia	4.6	25.31	0.01	-	-	-	-	-	4.6	25.31	0.01
Inpatient Visits	128.9	34.44	0.37	-	0.01	0.00	-	-	131.7	34.79	0.38
MH/SA	16.3	35.77	0.05	-	-	-	-	-	16.3	35.77	0.05
Emergency Room	167.2	21.89	0.31	-	-	0.01	-	-	167.2	22.56	0.31
Office/Home Visits/Consults	2,500.6	31.67	6.60	0.05	0.04	0.15	-	-	2,533.4	32.36	6.83
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	195.1	14.56	0.24	-	0.00	0.00	-	-	199.2	14.86	0.25
Radiology	228.8	15.26	0.29	-	0.00	0.01	-	-	229.8	15.78	0.30
Office Administered Drugs	1,393.7	37.71	4.38	0.03	0.03	0.10	-	-	1,411.8	38.54	4.53
Physical Exams	23.2	61.64	0.12	-	-	0.00	-	-	23.2	61.96	0.12
Therapy	119.6	12.12	0.12	-	-	0.01	-	-	119.6	12.74	0.13
Vision	236.9	31.43	0.62	0.00	0.01	0.01	-	-	240.3	31.96	0.64
Other Professional	3,054.6	5.64	1.44	0.01	0.01	0.03	-	-	3,095.8	5.76	1.49
Subtotal Professional			**$ 15.71**								**$ 16.26**
Pharmacy											
Pharmacy	4,761.9	$ 14.35	$ 5.69	$ 0.00	$ 0.03	$ 0.76	$ 0.00	$ 0.00	4,791.1	$ 16.26	$ 6.49
Subtotal Pharmacy			**$ 5.69**								**$ 6.49**
Ancillary											
Emergency Transportation	245.1	$ 167.00	$ 3.41	$ 0.02	$ 0.02	$ 0.06	$ 0.00	$ 0.00	248.3	$ 169.75	$ 3.51
Non-Emergency Transportation	-	-	-	-	-	-	-	-	-	-	-
DME/Prosthetics	25,483.2	21.95	46.61	0.35	0.26	0.80	-	-	25,818.8	22.32	48.03
Dental	1,390.2	66.46	7.70	0.06	0.04	0.13	-	-	1,408.1	67.61	7.93
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 57.72**								**$ 59.47**
LTSS											
Hospice	9.3	$ 192.99	$ 0.15	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	9.5	$ 209.08	$ 0.17
Nursing Home	1,789.8	95.65	14.27	-	0.16	1.33	-	6.43	1,810.3	147.10	22.19
HCBS	122.0	231.63	2.35	-	0.03	0.22	0.24	0.34	123.4	309.48	3.18
Subtotal LTSS			**$ 16.77**								**$ 25.54**
Total Medical Costs			**$ 109.90**								**$ 123.17**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 6 Rate Development
Projected Base Experience

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

Member Months: 352,750 Category of Service	Fiscal Year 2019 Base Experience Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2021 Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	226.6	$ 174.62	$ 3.30	$ 0.03	$ 0.04	$ 0.30	$ 0.00	$ 0.00	231.2	$ 190.33	$ 3.67
Inpatient Well Newborn	2.6	137.69	0.03	-	-	0.00	-	-	2.6	148.71	0.03
Inpatient MH/SA	1.8	32.21	0.00	-	-	-	-	-	1.8	32.21	0.00
Inpatient Maternity Delivery	1.5	143.73	0.02	-	-	-	-	-	1.5	143.73	0.02
Other Inpatient	134.4	146.51	1.64	0.01	0.02	0.15	-	-	136.7	160.06	1.82
Subtotal Inpatient Hospital			**$ 4.99**								**$ 5.55**
Outpatient Hospital											
Outpatient Emergency Room	32.8	$ 121.82	$ 0.33	$ 0.00	$ 0.02	$ 0.00	$ 0.00	$ 0.00	35.0	$ 122.37	$ 0.36
Outpatient Surgery	8.2	436.46	0.30	0.00	0.02	0.01	-	-	8.6	446.20	0.32
Outpatient Radiology	45.7	52.38	0.20	-	0.01	0.00	-	-	48.7	53.08	0.22
Outpatient Pathology/Lab	57.0	50.79	0.24	-	0.01	0.01	-	-	60.1	52.09	0.26
Outpatient Pharmacy	12.6	186.90	0.20	-	0.01	0.01	-	-	13.1	193.87	0.21
Outpatient MH/SA	9.7	71.80	0.06	-	0.00	0.00	-	-	10.2	72.36	0.06
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	128.1	69.73	0.74	0.00	0.05	0.00	-	-	136.2	70.12	0.80
Subtotal Outpatient Hospital			**$ 2.07**								**$ 2.22**
Professional											
Inpatient and Outpatient Surgery	161.8	$ 38.66	$ 0.52	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	164.9	$ 39.39	$ 0.54
Anesthesia	10.5	40.39	0.04	-	-	-	-	-	10.5	40.39	0.04
Inpatient Visits	66.3	46.36	0.26	-	0.00	0.01	-	-	66.4	48.17	0.27
MH/SA	12.0	34.02	0.03	-	-	-	-	-	12.0	34.02	0.03
Emergency Room	90.9	30.46	0.23	-	-	0.01	-	-	90.9	31.78	0.24
Office/Home Visits/Consults	1,622.2	41.96	5.67	0.04	0.03	0.13	-	-	1,644.4	42.88	5.88
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	155.9	8.08	0.11	-	-	-	-	-	155.9	8.08	0.11
Radiology	214.1	17.84	0.32	-	0.00	0.01	-	-	214.5	18.40	0.33
Office Administered Drugs	1,081.1	48.56	4.38	0.03	0.03	0.09	-	-	1,095.8	49.59	4.53
Physical Exams	22.7	63.10	0.12	-	-	0.00	-	-	22.7	64.36	0.12
Therapy	87.7	8.98	0.07	-	-	-	-	-	87.7	8.98	0.07
Vision	303.4	34.22	0.87	0.01	0.00	0.02	-	-	307.0	35.03	0.90
Other Professional	881.9	20.74	1.52	0.01	0.01	0.04	-	-	891.6	21.24	1.58
Subtotal Professional			**$ 14.12**								**$ 14.62**
Pharmacy											
Pharmacy	6,539.7	$ 12.93	$ 7.05	$ 0.00	$ 0.04	$ 0.95	$ 0.00	$ 0.00	6,577.8	$ 14.67	$ 8.04
Subtotal Pharmacy			**$ 7.05**								**$ 8.04**
Ancillary											
Emergency Transportation	27.3	$ 120.16	$ 0.27	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	27.4	$ 123.01	$ 0.28
Non-Emergency Transportation	1.8	40.90	0.01	-	-	-	-	-	1.8	40.90	0.01
DME/Prosthetics	4,652.8	17.84	6.92	0.05	0.04	0.12	-	-	4,715.5	18.14	7.13
Dental	1,053.0	56.06	4.92	0.04	0.03	0.08	-	-	1,067.3	56.95	5.07
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 12.12**								**$ 12.48**
LTSS											
Hospice	11.0	$ 286.30	$ 0.26	$ 0.00	$ 0.00	$ 0.02	$ 0.00	$ 0.00	11.1	$ 310.88	$ 0.29
Nursing Home	124.5	163.16	1.69	-	0.02	0.16	-	0.42	125.7	219.26	2.30
HCBS	3,270.1	491.05	133.81	-	1.51	12.48	13.68	19.38	3,307.0	656.27	180.86
Subtotal LTSS			**$ 135.77**								**$ 183.44**
Total Medical Costs			**$ 176.12**								**$ 226.35**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 6 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: FFS-Community Well-Under 6

Member Months: 395,792 Category of Service	Fiscal Year 2019 Base Experience Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2021 Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	161.2	$ 265.59	$ 3.57	$ 0.03	$ 0.04	$ 0.33	$ 0.00	$ 0.00	164.3	$ 289.84	$ 3.97
Inpatient Well Newborn	2.8	539.82	0.13	-	-	0.02	-	-	2.8	605.08	0.14
Inpatient MH/SA	0.5	166.72	0.01	-	-	-	-	-	0.5	166.72	0.01
Inpatient Maternity Delivery	0.3	-	-	-	-	-	-	-	-	-	-
Other Inpatient	122.8	202.27	2.07	0.02	0.02	0.19	-	-	125.1	220.87	2.30
Subtotal Inpatient Hospital			**$ 5.77**								**$ 6.42**
Outpatient Hospital											
Outpatient Emergency Room	63.7	$ 106.59	$ 0.57	$ 0.00	$ 0.03	$ 0.01	$ 0.00	$ 0.00	67.7	$ 108.48	$ 0.61
Outpatient Surgery	10.1	531.00	0.45	-	0.03	0.00	-	-	10.8	533.69	0.48
Outpatient Radiology	47.2	46.00	0.18	-	0.01	0.00	-	-	50.8	46.16	0.20
Outpatient Pathology/Lab	66.7	69.65	0.39	-	0.02	0.01	-	-	70.6	71.05	0.42
Outpatient Pharmacy	20.5	234.56	0.40	0.00	0.03	0.00	-	-	21.9	235.89	0.43
Outpatient MH/SA	37.6	87.51	0.27	0.00	0.01	0.01	-	-	39.5	90.23	0.30
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	146.4	78.85	0.96	0.00	0.06	0.01	-	-	155.4	79.62	1.03
Subtotal Outpatient Hospital			**$ 3.22**								**$ 3.46**
Professional											
Inpatient and Outpatient Surgery	133.6	$ 38.63	$ 0.43	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	136.5	$ 39.35	$ 0.45
Anesthesia	16.7	42.42	0.06	-	-	-	-	-	16.7	42.42	0.06
Inpatient Visits	45.2	47.91	0.18	-	-	0.01	-	-	45.2	49.93	0.19
MH/SA	42.3	40.57	0.14	-	-	0.00	-	-	42.3	41.06	0.14
Emergency Room	116.6	30.97	0.30	-	-	0.01	-	-	116.6	32.00	0.31
Office/Home Visits/Consults	1,671.9	43.20	6.02	0.05	0.04	0.13	-	-	1,694.9	44.10	6.23
Maternity	5.9	83.93	0.04	-	-	-	-	-	5.9	83.93	0.04
Pathology/Lab	170.9	13.20	0.19	-	-	0.01	-	-	170.9	13.73	0.20
Radiology	224.1	17.42	0.33	-	-	0.01	-	-	224.1	17.96	0.34
Office Administered Drugs	1,191.3	39.61	3.93	0.03	0.02	0.09	-	-	1,207.1	40.50	4.07
Physical Exams	47.8	70.26	0.28	-	-	0.01	-	-	47.8	72.77	0.29
Therapy	79.3	14.90	0.10	-	-	0.00	-	-	79.3	15.16	0.10
Vision	306.9	34.53	0.88	0.01	-	0.02	-	-	310.4	35.37	0.91
Other Professional	697.2	15.34	0.89	0.01	-	0.02	-	-	705.0	15.72	0.92
Subtotal Professional			**$ 13.77**								**$ 14.25**
Pharmacy											
Pharmacy	4,287.4	$ 17.37	$ 6.21	$ 0.00	$ 0.03	$ 0.84	$ 0.00	$ 0.00	4,310.5	$ 19.71	$ 7.08
Subtotal Pharmacy			**$ 6.21**								**$ 7.08**
Ancillary											
Emergency Transportation	26.4	$ 122.73	$ 0.27	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	26.4	$ 126.49	$ 0.28
Non-Emergency Transportation	4.4	48.85	0.02	-	-	-	-	-	4.4	48.85	0.02
DME/Prosthetics	3,765.9	20.46	6.42	0.05	0.03	0.11	-	-	3,815.3	20.82	6.62
Dental	1,673.5	51.03	7.12	0.06	0.04	0.12	-	-	1,695.4	51.87	7.33
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 13.83**								**$ 14.24**
LTSS											
Hospice	1.4	$ 225.01	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	1.4	$ 239.68	$ 0.03
Nursing Home	25.9	140.81	0.30	-	0.01	0.03	-	0.09	26.4	192.66	0.42
HCBS	2,554.4	486.04	103.46	-	1.17	9.65	10.57	14.98	2,583.2	649.60	139.84
Subtotal LTSS			**$ 103.79**								**$ 140.29**
Total Medical Costs			**$ 146.58**								**$ 185.75**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 6 Rate Development
Projected Base Experience

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

Member Months: 166,886 Category of Service	Fiscal Year 2019 Base Experience Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2021 Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	0.6	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	-	$ 0.00	$ 0.00
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 0.00**								**$ 0.00**
Outpatient Hospital											
Outpatient Emergency Room	0.9	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	-	$ 0.00	$ 0.00
Outpatient Surgery	-	-	-	-	-	-	-	-	-	-	-
Outpatient Radiology	0.3	-	-	-	-	-	-	-	-	-	-
Outpatient Pathology/Lab	2.6	-	-	-	-	-	-	-	-	-	-
Outpatient Pharmacy	0.3	-	-	-	-	-	-	-	-	-	-
Outpatient MH/SA	1.4	-	-	-	-	-	-	-	-	-	-
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	1.7	-	-	-	-	-	-	-	-	-	-
Subtotal Outpatient Hospital			**$ 0.00**								**$ 0.00**
Professional											
Inpatient and Outpatient Surgery	8.6	$ 13.91	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	8.6	$ 13.91	$ 0.01
Anesthesia	0.6	-	-	-	-	-	-	-	-	-	-
Inpatient Visits	3.5	-	-	-	-	-	-	-	-	-	-
MH/SA	3.2	-	-	-	-	-	-	-	-	-	-
Emergency Room	0.9	-	-	-	-	-	-	-	-	-	-
Office/Home Visits/Consults	52.9	11.34	0.05	-	-	-	-	-	52.9	11.34	0.05
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	0.6	-	-	-	-	-	-	-	-	-	-
Radiology	4.3	-	-	-	-	-	-	-	-	-	-
Office Administered Drugs	45.2	2.66	0.01	-	-	-	-	-	45.2	2.66	0.01
Physical Exams	1.2	-	-	-	-	-	-	-	-	-	-
Therapy	0.9	-	-	-	-	-	-	-	-	-	-
Vision	6.0	19.87	0.01	-	-	-	-	-	6.0	19.87	0.01
Other Professional	66.2	110.65	0.61	-	0.01	0.01	-	-	67.2	112.44	0.63
Subtotal Professional			**$ 0.69**								**$ 0.71**
Pharmacy											
Pharmacy	217.2	$ 20.45	$ 0.37	$ 0.00	$ 0.00	$ 0.05	$ 0.00	$ 0.00	217.2	$ 23.21	$ 0.42
Subtotal Pharmacy			**$ 0.37**								**$ 0.42**
Ancillary											
Emergency Transportation	0.3	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	-	$ 0.00	$ 0.00
Non-Emergency Transportation	-	-	-	-	-	-	-	-	-	-	-
DME/Prosthetics	42.6	5.64	0.02	-	-	-	-	-	42.6	5.64	0.02
Dental	4,701.5	17.38	6.81	0.05	0.04	0.12	-	-	4,763.6	17.68	7.02
Other Ancillary	1.7	417.22	0.06	-	-	-	-	-	1.7	417.22	0.06
Subtotal Ancillary			**$ 6.89**								**$ 7.10**
LTSS											
Hospice	2.3	$ 52.15	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	2.3	$ 52.15	$ 0.01
Nursing Home	28.2	55.34	0.13	-	-	0.01	-	-	28.2	59.60	0.14
HCBS	7,412.3	113.70	70.23	-	0.79	6.55	7.18	10.17	7,495.7	151.96	94.92
Subtotal LTSS			**$ 70.37**								**$ 95.07**
Total Medical Costs			**$ 78.32**								**$ 103.30**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 6 Rate Development
Projected Base Experience

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

Member Months: 266,359 Category of Service	Fiscal Year 2019 Base Experience Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	QAS/CPE FICA/FUTA Adjustment	Trended/Adjusted to CY 2021 Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	3.2	$ 36.99	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	3.2	$ 36.99	$ 0.01
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	0.2	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 0.01**								**$ 0.01**
Outpatient Hospital											
Outpatient Emergency Room	2.5	$ 47.56	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	2.5	$ 47.56	$ 0.01
Outpatient Surgery	1.1	-	-	-	-	-	-	-	-	-	-
Outpatient Radiology	1.3	-	-	-	-	-	-	-	-	-	-
Outpatient Pathology/Lab	2.2	-	-	-	-	-	-	-	-	-	-
Outpatient Pharmacy	0.4	-	-	-	-	-	-	-	-	-	-
Outpatient MH/SA	8.5	14.17	0.01	-	-	-	-	-	8.5	14.17	0.01
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	4.3	27.75	0.01	-	-	-	-	-	4.3	27.75	0.01
Subtotal Outpatient Hospital			**$ 0.03**								**$ 0.03**
Professional											
Inpatient and Outpatient Surgery	11.4	$ 10.57	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	11.4	$ 10.57	$ 0.01
Anesthesia	0.9	-	-	-	-	-	-	-	-	-	-
Inpatient Visits	18.0	13.32	0.02	-	-	-	-	-	18.0	13.32	0.02
MH/SA	9.9	12.11	0.01	-	-	-	-	-	9.9	12.11	0.01
Emergency Room	4.1	-	-	-	-	-	-	-	-	-	-
Office/Home Visits/Consults	120.9	10.92	0.11	-	-	-	-	-	120.9	10.92	0.11
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	4.5	-	-	-	-	-	-	-	-	-	-
Radiology	4.9	-	-	-	-	-	-	-	-	-	-
Office Administered Drugs	55.0	30.57	0.14	-	-	-	-	-	55.0	30.57	0.14
Physical Exams	0.5	-	-	-	-	-	-	-	-	-	-
Therapy	1.1	-	-	-	-	-	-	-	-	-	-
Vision	4.0	-	-	-	-	-	-	-	-	-	-
Other Professional	14.1	42.69	0.05	-	-	-	-	-	14.1	42.69	0.05
Subtotal Professional			**$ 0.34**								**$ 0.34**
Pharmacy											
Pharmacy	1,722.4	$ 37.62	$ 5.40	$ 0.00	$ 0.03	$ 0.73	$ 0.00	$ 0.00	1,732.0	$ 42.68	$ 6.16
Subtotal Pharmacy			**$ 5.40**								**$ 6.16**
Ancillary											
Emergency Transportation	4.1	$ 28.95	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	4.1	$ 28.95	$ 0.01
Non-Emergency Transportation	-	-	-	-	-	-	-	-	-	-	-
DME/Prosthetics	60.2	7.97	0.04	-	-	-	-	-	60.2	7.97	0.04
Dental	7,129.2	15.55	9.24	0.07	0.05	0.16	-	-	7,221.8	15.82	9.52
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 9.29**								**$ 9.57**
LTSS											
Hospice	-	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	-	$ 0.00	$ 0.00
Nursing Home	16.8	42.96	0.06	-	-	0.01	-	-	16.8	50.12	0.07
HCBS	5,303.2	118.59	52.41	-	0.59	4.89	5.36	7.59	5,362.9	158.51	70.84
Subtotal LTSS			**$ 52.47**								**$ 70.91**
Total Medical Costs			**$ 67.54**								**$ 87.02**

Appendix 3: Case Mix Exhibit

State of Michigan Department of Health and Human Services
MI Health Link
CY 2021 Capitation Rate Development
Enrollment Case Mix Exhibit

	Base FFS Benefit Expense			
	Region 1	Region 4	Region 7	Region 9
Nursing Subtier A-65+	$ 5,986.20	$ 6,497.71	$ 6,468.05	$ 6,529.39
Nursing Subtier A-Under 65	5,587.82	6,037.24	5,832.54	5,839.93
Nursing Subtier B-65+	10,155.04	11,049.64	8,423.53	12,138.35
Nursing Subtier B-Under 65	10,144.33	11,228.14	9,050.61	13,105.72
NF Level of Care-65+	97.34	111.53	105.26	139.09
NF Level of Care-Under 65	113.28	130.53	122.75	109.55
Community Well-65+	128.42	166.70	208.26	320.05
Community Well-Under 65	146.40	145.39	207.26	169.10
	Base FFS Enrollment			
	Region 1	Region 4	Region 7	Region 9
Nursing Subtier A-65+	6,493	11,926	34,769	13,235
Nursing Subtier A-Under 65	752	2,025	8,866	2,588
Nursing Subtier B-65+	3,395	2,158	15	945
Nursing Subtier B-Under 65	405	280	6	229
NF Level of Care-65+	2,442	6,930	11,866	1,393
NF Level of Care-Under 65	1,342	3,285	5,061	644
Community Well-65+	16,773	39,527	212,703	83,747
Community Well-Under 65	26,774	68,924	231,402	68,692
	Projected ICO Enrollment			
	Region 1	Region 4	Region 7	Region 9
Nursing Subtier A-65+	2,390	3,326	7,950	2,894
Nursing Subtier A-Under 65	278	351	1,610	460
Nursing Subtier B-65+	2,105	136	-	99
Nursing Subtier B-Under 65	180	-	-	-
NF Level of Care-65+	684	1,236	9,108	1,752
NF Level of Care-Under 65	386	1,928	9,642	1,904
Community Well-65+	20,151	30,820	112,154	29,836
Community Well-Under 65	28,968	48,636	110,472	26,304
	Composite Base Benefit Expense			**Case Mix**
	FFS Enroll	ICO Enroll		Adjustment
Nursing Subtier A-65+	$ 6,438.50	$ 6,415.19		0.9964
Nursing Subtier A-Under 65	5,850.08	5,835.18		0.9975
Nursing Subtier B-65+	10,735.23	10,291.06		0.9586
Nursing Subtier B-Under 65	11,204.18	10,144.33		0.9054
NF Level of Care-65+	108.41	110.08		1.0154
NF Level of Care-Under 65	123.17	121.76		0.9885
Community Well-65+	226.35	210.57		0.9303
Community Well-Under 65	185.75	180.32		0.9708

Appendix 4: CY 2021 Capitation Rate Development

State of Michigan Department of Health and Human Services
MI Health Link CY 2021 Capitation Rate Development
Demonstration Year 6 Rate Development

Region: All Demo Regions	Projected Exposure	Base Benefit Expense	Patient Pay Expense	Capitation Payments	NEMT Adjustment	Selection Factor	Savings Percentage	Proposed Effective Rate	Prior Effective Rate	% Change	Estimated IPA PMPM
Nursing Subtier A											
Over 65	16,560	$ 6,415.19	$ 785.35	$ 0.00	$ 0.00	1.000	0.030	$ 7,008.09	$ 6,671.48	5.0%	$ 36.80
Under 65	2,700	5,835.18	615.10	-	-	1.000	0.030	6,275.22	5,888.57	6.6%	36.80
Subtotal Nursing Subtier A	**19,260**	**$ 6,333.88**	**$ 761.48**	**$ 0.00**	**$ 0.00**			**$ 6,905.35**	**$ 6,561.73**	**5.2%**	**$ 36.80**
Nursing Subtier B											
Over 65	2,340	$ 10,291.06	$ 1,102.01	$ 0.00	$ 0.00	1.000	0.030	$ 11,084.33	$ 10,709.31	3.5%	$ 36.80
Under 65	180	10,144.33	1,007.09	-	-	1.000	0.030	10,847.09	10,450.17	3.8%	36.80
Subtotal Nursing Subtier B	**2,520**	**$ 10,280.58**	**$ 1,095.23**	**$ 0.00**	**$ 0.00**			**$ 11,067.39**	**$ 10,690.80**	**3.5%**	**$ 36.80**
NF Level of Care											
Over 65	12,780	$ 110.08	$ 0.00	$ 2,347.99	$ 0.00	1.000	0.030	$ 2,384.33	$ 2,370.50	0.6%	$ 36.80
Under 65	13,860	121.76	-	2,866.42	-	1.000	0.030	2,898.53	2,894.21	0.1%	36.80
Subtotal NF Level of Care	**26,640**	**$ 116.15**	**$ 0.00**	**$ 2,617.71**	**$ 0.00**			**$ 2,651.85**	**$ 2,642.97**	**0.3%**	**$ 36.80**
FFS-Community Well											
Over 65	130,995	$ 210.56	$ 0.00	$ 0.00	$ 12.37	1.000	0.030				
Under 65	128,145	180.31	-	-	12.37	1.000	0.030				
Subtotal FFS-Community Well	**259,140**	**$ 195.60**	**$ 0.00**	**$ 0.00**	**$ 12.37**						
MHP-Community Well											
Over 65	61,965	$ 103.31	$ 0.00	$ 82.81	$ 0.00	1.000	0.030				
Under 65	86,235	87.02	-	82.80	-	1.000	0.030				
Subtotal MHP-Community Well	**148,200**	**$ 93.83**	**$ 0.00**	**$ 82.80**	**$ 0.00**						
Community Well											
Over 65	192,960							$ 204.78	$ 168.63	21.4%	$ 36.80
Under 65	214,380							177.99	148.79	19.6%	36.80
Subtotal Community Well	407,340							**$ 190.68**	**$ 158.19**	**20.5%**	**$ 36.80**
Total	**455,760**							**$ 678.43**	**$ 632.27**	**7.3%**	**$ 36.80**

Regional Adjustment Factors (on Proposed Rate)

Demonstration Region	Nursing Facility - Subtier A	Nursing Facility - Subtier B	Waiver (NF Level of Care)	Community Well
Region 1	92.4%	100.0%	100.0%	95.8%
Region 4	97.4%	100.0%	100.0%	99.0%
Region 7	101.8%	100.0%	100.0%	99.2%
Region 9	103.0%	100.0%	100.0%	102.2%

Appendix 5: Trend Analysis

State of Michigan, Department of Health and Human Services
MI Health Link CY 2021 Capitation Rate Development
Prospective Trend Analysis
All Demonstration Regions; Normalized Population Case Mix

		12x2 Rolling Median Adjusted Util/1000				
Incurred Month	**Member Months**	*Inpatient Hospital*	*Outpatient Hospital*	*Pharmacy*	*LTSS*	*Professional*
4/1/2018	162,322	1,387.1	406.4	4,104.0	27,731.8	12,093.7
5/1/2018	160,532	1,387.1	410.0	4,091.6	27,770.5	12,184.8
6/1/2018	160,755	1,387.1	410.0	4,041.4	27,770.5	12,184.8
7/1/2018	160,897	1,383.6	410.0	4,001.0	27,870.0	12,184.8
8/1/2018	160,714	1,374.3	410.0	4,001.0	27,904.7	12,184.8
9/1/2018	160,489	1,365.0	410.0	3,960.7	27,939.5	12,184.8
10/1/2018	161,045	1,357.8	410.0	3,957.9	27,945.3	12,093.7
11/1/2018	160,396	1,338.2	410.0	3,970.7	28,062.7	12,055.3
12/1/2018	159,416	1,302.8	413.5	3,955.0	28,181.2	11,978.8
1/1/2019	158,998	1,281.7	448.1	3,933.6	28,077.5	11,978.8
2/1/2019	159,269	1,276.3	452.2	3,929.9	28,077.5	11,902.2
3/1/2019	158,600	1,281.7	452.2	3,919.5	28,077.5	11,664.6
4/1/2019	158,387	1,292.3	454.7	3,909.1	28,077.5	11,664.6
5/1/2019	157,991	1,302.8	456.2	3,870.2	28,077.5	11,664.6
6/1/2019	154,389	1,330.8	456.2	3,836.7	28,077.5	11,664.6
7/1/2019	155,186	1,334.5	456.2	3,722.9	28,077.5	11,664.6
8/1/2019	153,836	1,338.2	456.2	3,691.1	28,077.5	11,664.6
Low Estimate		**(4.83%)**	**(1.24%)**	**(7.36%)**	**0.50%**	**(12.92%)**
High Estimate		**(2.77%)**	**2.54%**	**(6.43%)**	**1.37%**	**6.22%**
Selected Trend		**0.50%**	**2.50%**	**0.25%**	**0.50%**	**0.25%**

State of Michigan, Department of Health and Human Services MI Health Link CY 2021 Capitation Rate Development Prospective Trend Analysis All Demonstration Regions; Normalized Population Case Mix						
		12x2 Rolling Median Adjusted CPS				
Incurred Month	**Member Months**	*Inpatient Hospital*	*Outpatient Hospital*	*Pharmacy*	*LTSS*	*Professional*
4/1/2018	162,322	$ 244.84	$ 94.57	$ 13.52	$ 196.42	$ 28.48
5/1/2018	160,532	244.84	95.39	13.56	196.14	28.40
6/1/2018	160,755	244.03	93.75	13.73	196.14	28.40
7/1/2018	160,897	242.13	91.31	13.95	196.16	28.40
8/1/2018	160,714	243.77	91.31	13.97	196.14	28.40
9/1/2018	160,489	245.77	91.31	14.13	195.90	28.40
10/1/2018	161,045	247.08	91.31	14.15	195.86	28.62
11/1/2018	160,396	250.00	91.31	14.11	195.04	28.93
12/1/2018	159,416	255.07	92.15	14.17	194.44	29.38
1/1/2019	158,998	251.27	85.04	14.26	196.08	29.38
2/1/2019	159,269	252.34	84.26	15.19	199.38	29.80
3/1/2019	158,600	257.79	84.26	15.34	199.79	30.41
4/1/2019	158,387	257.29	80.98	15.38	199.79	30.41
5/1/2019	157,991	257.50	80.72	15.54	199.87	30.48
6/1/2019	154,389	254.98	80.32	15.67	199.87	30.48
7/1/2019	155,186	257.15	80.32	16.03	199.70	30.48
8/1/2019	153,836	267.90	80.32	16.17	199.70	30.48
Low Estimate		**4.42%**	**(16.32%)**	**9.74%**	**1.31%**	**(0.18%)**
High Estimate		**7.05%**	**(9.82%)**	**14.16%**	**3.11%**	**5.50%**
Selected Trend		**0.50%**	**0.50%**	**5.75%**	**4.00%**	**0.75%**

State of Michigan, Department of Health and Human Services
MI Health Link CY 2021 Capitation Rate Development
Prospective Trend Analysis
All Demonstration Regions; Normalized Population Case Mix

		12x2 Rolling Median Adjusted PMPM				
Incurred Month	**Member Months**	*Inpatient Hospital*	*Outpatient Hospital*	*Pharmacy*	*LTSS*	*Professional*
4/1/2018	162,322	$ 28.30	$ 3.20	$ 4.62	$ 453.91	$ 28.70
5/1/2018	160,532	28.30	3.26	4.62	453.91	28.84
6/1/2018	160,755	28.21	3.20	4.62	453.91	28.84
7/1/2018	160,897	27.92	3.12	4.65	455.58	28.84
8/1/2018	160,714	27.92	3.12	4.66	456.11	28.84
9/1/2018	160,489	27.96	3.12	4.66	456.11	28.84
10/1/2018	161,045	27.96	3.12	4.67	456.11	28.84
11/1/2018	160,396	27.88	3.12	4.67	456.11	29.06
12/1/2018	159,416	27.69	3.18	4.67	456.63	29.33
1/1/2019	158,998	26.84	3.18	4.68	458.78	29.33
2/1/2019	159,269	26.84	3.18	4.97	466.52	29.56
3/1/2019	158,600	27.53	3.18	5.01	467.47	29.56
4/1/2019	158,387	27.71	3.07	5.01	467.47	29.56
5/1/2019	157,991	27.96	3.07	5.01	467.65	29.63
6/1/2019	154,389	28.28	3.05	5.01	467.65	29.63
7/1/2019	155,186	28.60	3.05	4.97	467.25	29.63
8/1/2019	153,836	29.88	3.05	4.97	467.25	29.63
Low Estimate		**1.25%**	**(9.13%)**	**3.54%**	**2.51%**	**(1.42%)**
High Estimate		**3.80%**	**(7.99%)**	**7.93%**	**3.56%**	**(1.05%)**
Selected Trend		**1.00%**	**3.00%**	**6.00%**	**4.50%**	**1.00%**

Appendix 6: Covered Services

State of Michigan, Department of Health and Human Services MI Health Link CY 2021 Capitation Rate Development List of Covered Services		
Adult Day Program	Inpatient Hospital Psychiatric Admissions	Physician/Practitioner (PCP) Services
Ambulatory Surgical Centers	Inpatient Hospital Psychiatric Services	Podiatry Services
Anesthesia	Inpatient Hospital Services - Acute	Preventative Care and Screening
Assertive Community Treatment Program*	Laboratory, Diagnostic & X-ray	Preventive Nursing Services*
Assessments*	Medical Equipment and Supplies	Prevocational Services*
Behavior Treatment Review*	Adaptive Medical Equipment and Supplies	Private Duty Nursing*
Cardiac and Pulmonary Rehab	Assistive Technology*	Psychiatric Services
Certified Mid-Wife Services	Durable Medical Equipment	Respiratory Care
Childbirth and parenting classes	Enhanced Medical Equipment and Supplies*	Respite
Chiropractic Services	Medical Supplies	Restorative or Rehabilitative Nursing
Chore Services*	Prosthetics and Orthotics	Rural Health Clinic Services
Clubhouse Psychosocial Rehabilitation*	Medication Administration	Service Animals
Community Transition Services	Medication Review	Skill Building Assistance*
Crisis Services - Crisis Residential Services*	Mental Health Specialty Services- Non physician*	Substance Abuse
Crisis Services - Intense Crisis Stabilization Services*	Nursing Home Care: Custodial Care	Supported/Integrated Employment Services*
Dental	Nursing Home Care: Skilled Nursing & Rehabilitation services	Supports Coordination*
Diabetic Supplies and Services & Diabetic	Nursing Facility Mental Health Monitoring*	Targeted Case Management*
Diabetic Therapeutic Shoes and Inserts	Organ & Bone Marrow Transplant	Telemedicine
Emergency Services/Care	Other Health Care Professional Services	Therapy: Family
End Stage Renal Disease Services	Out-of-Home Non-vocational Habilitation*	Therapy: Inidividual or Group
Environmental Modifications*	Out-of-State Services	Therapy: Occupational
Eye Exams	Outpatient Blood Services	Therapy: Physical
Eye Wear	Outpatient Hospital Services	Therapy: Speech, Hearing and Language
Family Planning	Outpatient Mental Health Services	Tobacco cessation
Family Training*	Outpatient Partial Hospitalization Services	Transplants and Immunosuppressive Drugs
Fiscal Intermediary Services*	Peer-Delivered or Operated Support Services	Emergency Ambulance Transportation
Good and Services*	Personal Care and Personal Care Supplement	Non-emergency Medical Transportation
Health Services*	Personal Care Supplement	Non-Medical Transportation*
Hearing aids	Personal Care in Licensed Specialized Residential Setting*	Travel time for Home Help
Home Delivered Meals*	Personal Emergency Response System (PERS)	Treatment for STD
Home Health	Pharmacy	Treatment Planning*
Housing Assistance*	Pharmacy-Enhanced Pharmacy*	Urgent Care Clinic Services
Immunizations	Psychiatric Services	Wellness Visits (Annual Exams)

*Must meet level of care requirements

Appendix 7: January to February 2021 Capitation Rate Development

State of Michigan Department of Health and Human Services
MI Health Link CY 2021 Capitation Rate Development
Capitation Rate Change Summary

	CY 2021 Rates	DCW Wage Adjustment	Proposed Jan-Feb 2021 Rates
Nursing Subtier A			
Over 65	$ 7,008.09	$ 0.77	$ 7,008.86
Under 65	6,275.22	1.15	6,276.37
Subtotal Nursing Subtier A	**$ 6,905.35**	**$ 0.82**	**$ 6,906.17**
Nursing Subtier B			
Over 65	$ 11,084.33	$ 0.06	$ 11,084.40
Under 65	10,847.09	0.15	10,847.23
Subtotal Nursing Subtier B	**$ 11,067.39**	**$ 0.07**	**$ 11,067.46**
NF Level of Care			
Over 65	$ 2,384.33	$ 197.93	$ 2,582.27
Under 65	2,898.53	223.28	3,121.80
Subtotal NF Level of Care	**$ 2,651.85**	**$ 211.12**	**$ 2,862.97**
Community Well			
Over 65	$ 204.78	$ 18.03	$ 222.81
Under 65	177.99	13.72	191.71
Subtotal Community Well	**$ 190.68**	**$ 15.76**	**$ 206.44**
Total	**$ 678.43**	**$ 26.46**	**$ 704.90**

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