Calendar Year 2022 MI Health Link Medicaid Capitation Rate Certification

January 1, 2022 through December 31, 2022

State of Michigan Department of Health and Human Services

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Introduction & Executive Summary

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of Michigan, Department of Health and Human Services (MDHHS) to provide actuarial and consulting services related to the development of actuarially sound capitation rates for the MI Health Link program to be effective January 1, 2022. The rates being certified as actuarially sound are to be effective from January 1, 2022 and remain in effect through December 31, 2022. 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 years 2020 and 2021 in response to the COVID-19 pandemic. The capitation rates documented in this report reflect the increase for the full 12-month time period. It is intended that these rates are paid for the full period that the increased DCW reimbursement is in effect. If it is determined that the hourly adjustment changes during calendar year (CY) 2022, an amended report will be provided that recertifies the rates for the effected time period.

This letter provides documentation for the development of the actuarially sound capitation rates for calendar year CY 2022. 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 2021-2022 Medicaid Managed Care Rate Development Guide, released by the Center for Medicare and Medicaid Services in July 2021 (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, 2022 through December 31, 2022. 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 percentage change reflects a comparison with the rates certified for the time period of October to December 2021, the most recently certified capitation rates. 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 $2.35 per hour increase for hazard pay to DCW providers. Please note that the rates illustrated in Table 1 include amounts associated with the Insurance Provider Assessment (IPA) and Quality Assurance Assessment Payments (QAS), which will be paid on a retrospective basis. The estimated amounts for these items are documented in Appendix 4 with discussion of those amounts noted later in this report.

TABLE 1: COMPARISON WITH OCT-DEC 2021 RATES (PMPM RATES)

RATE CELL	AVERAGE MONTHLY ENROLLMENT	OCT-DEC 2021 RATES	PROPOSED CY 2022 RATES	% CHANGE
Nursing Facility – Subtier A				
Over Age 65	1,590	$ 7,045.77	$ 7,357.25	4.4%
Under Age 65	315	6,313.33	7,155.11	13.3%
Nursing Facility – Subtier B				
Over Age 65	255	$ 11,121.20	$ 10,587.97	(4.8%)
Under Age 65	15	10,884.05	10,036.65	(7.8%)
Nursing Facility LOC-Waiver				
Over Age 65	1,115	$ 2,643.80	$ 2,092.64	(20.8%)
Under Age 65	1,275	3,186.48	2,290.53	(28.1%)
Community Well				
Over Age 65	17,235	$ 262.14	$ 314.96	20.1%
Under Age 65	18,645	230.43	323.18	40.3%
Composite	**40,485**	**$793.41**	**$829.78**	**4.6%**

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 2022.
3. Amounts related to the Insurance Provider Assessment and QAS are included in the values in Table 1.
4. Percent change values are relative to prior column rates.

The projected CY 2022 enrollment estimates were developed based off July 2021 enrollment in the MI Health Link program.

FISCAL IMPACT ESTIMATE

The estimated fiscal impact of the CY 2022 MI Health Link rate changes on a state and federal basis documented in this report is a $17.7 million increase to aggregate expenditures. This amount is on a state and federal expenditure basis using the projected monthly enrollment for CY 2022 and including any amounts related to the IPA and QAS. 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 2022 capitation rates illustrated in Table 1. The federal expenditures illustrated in Table 2 are based on the Federal Fiscal Year (FFY) 2022 FMAP of 65.48% for the January to September time period and FFY 2023 FMAP of 64.71% for October to December, with the additional 6.2% FMAP due to COVID-19 applying to the full 12-month time period.

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

POPULATION	AGGREGATE EXPENDITURES AT OCT-DEC 2021 RATES	AGGREGATE EXPENDITURES AT 2022 RATES	EXPENDITURE CHANGE
Nursing Facility-Subtier A	$ 158.3	$ 167.4	$ 9.1
Nursing Facility-Subtier B	36.0	34.2	(1.8)
NFLOC – Waiver	85.4	64.0	(21.3)
Community Well	105.8	137.4	31.7
Total MI Health Link	**$ 385.5**	**$ 403.1**	**$ 17.7**
Total Federal	262.8	277.6	14.8
Total State	122.7	125.5	2.9

Notes:

1. Annualized expenditures were developed with projected enrollment.
2. State expenditures based on Federal Fiscal Year (FFY) 2022 and 2023 FMAPs of 65.48% and 64.71%, plus an additional 6.2%. IPA amounts are 100% state funded.
3. Amounts related to the Insurance Provider Assessment and QAS are included in the values listed in Table 2
4. 2022 aggregate expenditures reflect 12 months 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 2022 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 required by the three-way contract.

A. RATE DEVELOPMENT STANDARDS

i. Rate ranges

The capitation rates documented in this report are point estimates and do not represent a rate range.

ii. Annual basis

The actuarial certification contained in this report is effective for the capitation rates for the one-year rate period from January 1, 2022 through December 31, 2022.

iii. 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 C.F.R. § 438 that are effective for the CY 2022 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 2022 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 7, which coincides with calendar year 2022. 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, Demonstration Year 5 being CY 2020, and Demonstration Year 6 being CY 2021.

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, 2022 through December 31, 2022.

(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.

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.

(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 reflects a retroactive adjustment to the CY 2022 capitation rates back to January 1, 2022.

iv. 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.

v. Cross-subsidization of rate cell payment

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

vi. Effective dates

To the best of our knowledge, the effective dates of changes to the MI Health Link program are consistent with the assumptions used in the development of the certified CY 2022 capitation rates.

vii. 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.

viii. Capitation Rate Ranges

This section is not applicable because a single set of capitation rates by rate cell were developed for the CY 2022 rating period.

ix. State's responsibility with rate ranges

This section is not applicable because a single set of capitation rates by rate cell were developed for the CY 2022 rating period.

x. Generally accepted actuarial practices and principles

(a) Reasonable, appropriate, and attainable

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

(b) Outside the rate setting process

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

(c) Final contracted rates

The CY 2022 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.

xi. Rate certification for effective time periods

This actuarial certification is effective for the one-year rating period January 1, 2022 through December 31, 2022.

xii. Direct and indirect impacts of COVID-19

The MI Health Link program does not cover services related to COVID testing or vaccinations. Worsened by the COVID-19 pandemic, direct care workers experienced increased shortage of availability to provide the covered services. During CY 2020 and CY 2021, an increase in reimbursement through a hazard pay was appropriated to these providers to help address demand. The increased reimbursement level was continued to be incorporated for the CY 2022 rating period as documented in this certification report. No other direct or indirect costs were included and no risk corridors were in place for historical or future rating periods

xiii. 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 or up to 1% within the certified rate range
3. Risk adjustment, under a methodology described in the initial certification, changes the rates paid to the MCOs

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

B. APPROPRIATE DOCUMENTATION

i. Certification type

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

ii. Documentation of required elements

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

iii. 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.

iv. Capitation Rate Ranges

This section is not applicable because a single set of capitation rates by rate cell were developed for the CY 2022 rating period.

v. 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.

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

The methodology and assumptions were applied consistently across all populations.

vii. Different FMAP

All populations receive the regular state FMAP of 65.48% for FFY 2022 through September 2022, and the FFY 2023 FMAP of 64.71% for October through December 2022. We have assumed the 6.2% enhanced FMAP due to the public health emergency will be extended through CY 2022.

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

The previous rate certification applied to CY 2021 capitation rates. A comparison to the October to December 2021 rates is provided in Table 1.

ix. 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 the entirety of CY 2022, but will submit an amended report if that policy changes during the calendar year.

x. COVID-19 Approach

(a) Data used

For the base data summaries, calendar year 2019 experience was utilized and summarized in Appendix 2. Data through July 2021 was reviewed when selecting the prospective trend assumptions outlined in Appendix 3.

(b) Direct and indirect impacts of COVID-19

Based on our review of the encounter claims experience, the COVID-19 pandemic did not have a significant impact on service utilization. However, because of the pandemic, increased reimbursement for direct care workers was appropriated for the CY 2020 and 2021 rating periods. We have continued to include this adjustment for the CY 2022 capitation rate development

(c) Risk mitigations strategies used

No additional risk mitigation strategies have been incorporated into the program as a result of the COVID-19 pandemic

2. Data

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

A. RATE DEVELOPMENT STANDARDS

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

B. APPROPRIATE DOCUMENTATION

i. Requested data

As the actuary contracted by 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 2022 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 2022 MI Health Link capitation rate development:

- Encounter data for the MI Health Link population as submitted by the ICOs for January 1, 2019 through December 31, 2019 (base data year) and paid through July 2021
- Fee-for-service for the MI Health Link eligible population for January 1, 2019 through December 31, 2019 (base data year) and paid through September 2021
- Detailed fee-for-service and managed care enrollment data for January 1, 2019 through December 31, 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 2022
- Additional gross adjustment expenditure information outside the MMIS claims system
- Summary of known policy and program changes through state fiscal year 2022 (including changes to fee schedules and other payment rates)
- Monthly enrollment for the MI Health Link program

Appendix 2 illustrates the encounter base data summaries that provide the foundation for the calendar year 2022 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 CY 2019. The encounter and dee-for-service data used in our rate development process reflects adjudicated data through July 2021.

For the purposes of trend development and analyzing historical experience, we also reviewed encounter and enrollment experience dating back to state fiscal year 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

There were no sub-capitated claims identified in the historical encounter data for the MI Health Link program.

(b) Availability and quality of the data

(i) Steps taken to validate the data

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

The fee-for-service (FFS) data is provided by MDHHS. Milliman has many years of experience working with MDHHS's FFS data.

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

Completeness

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

- Encounter per member per month (PMPM) cost for high level service categories;
- Distribution of members by encounter-reported expenditures; and,
- Review of month to month activity across the program and rate cell.

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

The CY 2019 encounter data used in the development of the rates includes claims adjudicated and submitted to MDHHS through July 2021. Minor completion factors were applied to the base data in CY 2019.

Encounter data is summarized through the encounter quality initiative (EQI) process. Separate sets of summaries, by rate group, are prepared for each ICO. Each summary illustrates utilization, cost per service, and per member per month cost for the population, stratified by category of service. The format of each exhibit is similar to the base data exhibits that are provided in Appendix 2, allowing most data issues to be discovered before the annual capitation rate development process.

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

Accuracy

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

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

Consistency of data across data sources

As historical encounter data is the primary source of information used in the development of capitation rates effective January 1, 2022, it is important to assess the consistency of the encounter data with other sources of information. The main sources of comparison were the ICO-submitted EQI reports, in which each ICO submitted exposure and expenditure information that covered the time periods starting from January 2019. We utilized the EQI reported data to validate the encounter data being utilized for rate development was appropriate and consistent between the two sources of information.

We also reviewed the consistency of the monthly enrollment in eligibility and capitation payment files received by MDHHS was reconciled with publicly available values.

(ii) Actuary's assessment

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

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

• Selected data that were both appropriate and sufficiently current for the intended purpose: we used data that reflected the covered population and services under the contract;

• Reviewed the data for reasonability, consistency, and comprehensiveness: documented in the certification report;

• Disclosed any known limitations of the data: documented in the certification report; and,

• Placed reliance on the data supplied by MDHHS and its vendors: documented in the certification report.

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

(iii) Data concerns

We have not identified any material concerns with the quality or availability of the encounter 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

All populations enrolled in managed care during the rate period were included in the risk-based managed care delivery system in the CY 2019 base experience period. As such, expenditure data for populations enrolled in FFS during CY 2019 is not reflected in the base experience cost models used to develop the capitation rates.

(ii) Use of managed care encounter data

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

(d) Reliance on a data book

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

iii. Data adjustments

Capitation rates were developed from historical calendar year 2019 encounter data, paid through July 2021. 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 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

The capitation rates are based on state calendar year 2019 experience. Encounter data reflects claims paid and submitted to MDHHS through July 31, 2021 and includes eighteen months of claims run-out. Based on a review of historical completion patterns for claims in this program, minor completion adjustments were applied to the base experience period data.

(c) Errors found in the data

Following a review of the encounter data, duplicate encounters were identified and removed as part of the summarized base period 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 2022 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 reimbursement increase for personal care services relative to the individual rate reflected in the base data. For calendar year 2022, 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.

MDHHS has also increased reimbursement for direct care wage (DCW) services by $2.35 per hour for hazard pay in response to the COVID-19 pandemic. The $2.35 per hour increase was grossed up an additional 7.65% to account for the additional anticipated payments made by MDHHS for Federal Insurance Contributions Act (FICA) on employer related taxes.

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.

N+3 Removal Adjustment

Historically, MDHHS has implemented a 3-month delay in paying capitation rates for members who move from the Community Well population to a nursing facility. The orginal intent of this adjustment was to incentivize ICOs to keep members in a community setting, to the extent it was appropriate. The base data reflects significant nursing facility utilization for the Community Well population as a result of this policy. Following discussion with CMS, this N+3 process is being removed effective January 1, 2022. The impact of this adjustment represents a decrease to the Community Well population as a result of Nursing Facility utilizers anticipated to receive the Nursing Facility capitation rate instead. This adjustment has been documented in the cost models 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 2022 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 C.F.R § 438.4(b)(6) and are only based on services outlined in 42 C.F.R § 438.3(c)(1)(ii) and 438.3(e). The ICOs do not provide any in-lieu-of services.

ii. Benefit Cost Trend Assumptions

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

iii. In Lieu Of Services

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

iv. 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 encounter and enrollment data for members enrolled in the MI Health Link program for the noted demonstration regions. This data consisted of calendar year 2019 incurred experience that was submitted by the ICOs to the data warehouse and maintained by Optum. This information serves as the starting point of the base experience and is noted as unadjusted CY 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 encounter data. Appendix 2 contains actuarial models for services incurred during CY 2019 and paid through July 2021. 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 (July 1, 2019) to the midpoint of the CY 2022 rating period (July 1, 2022). 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 2022. These represented an increase to $1,556 for the Part A deductible and to $233 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:

- **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.
- **Direct-Care Worker (DCW) adjustment** MDHHS increased reimbursement for DCW services by $2.35 per hour for hazard pay in response to the COVID-19 pandemic. Based on historical experience, we determined that wage adjustment for DCW services would produce approximately a $35.4 million increase. This was calculated by increasing historical reimbursement rates by $2.35 per hour, with an additional gross adjustment of approximately 7.65% to cover employer related costs consistent with FICA. Appendix 3 documents the adjustment made to underlying base experience for the increased reimbursement amounts for DCW services

Step 4: Include PMPM adjustments for administrative costs and QAS payments

We have also included specific adjustments for administrative costs in the CY 2022 capitation rate development. The PMPM amounts vary by rating tier and reflect approximately a 1% load for the nursing facility tiers and 10% for the community well population. The administrative load for the nursing facility level of care (waiver tier) is based on administrative costs included in the MI Choice managed care waiver program.

In Appendix 4, we also reduce the prospective paid capitation rate by a rate cell specific QAS PMPM amount. The QAS adjustment was developed by weighting actual CY 2022 FFS QAS per diem rates by facility multiplied by the projected nursing home utilization for each rate cell from Appendix 2. This same amount is then added back when illustrating the fully loaded rate in Appendix 4. Section 4.D provides additional details of the QAS state directed payment.

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 a lower hourly rate compared to 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 encounter experience to establish the CY 2022 capitation rates. Historically, we have utilized fee-for-service data for the MI Health Link eligible population based on rate setting methodology prescribed by CMS for dual demonstration programs in absence of the demonstration. We did perform a separate rate development utilizing fee-for-service experience and communicated with CMS to ensure that capitation rates developed from encounter data was appropriate.

(c) Overpayments to providers

Consistent with 42 C.F.R. § 438.608(d), MDHHS outlines the program integrity guidelines and reporting requirements related to overpayments, recoveries, and refunds in the 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 (CY 2019) to the CY 2022 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 encounter trends was SFY 2017 through 2019 encounter data specific to the MI Health Link program.

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 encounter 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 C.F.R. § 438.3(c)(1)(ii). Results of the analysis indicate full compliance with MHPAEA for financial requirements and both quantitative and non-quantitative treatment limits with no remediation needed that would constitute a program adjustment. Based on the final results, we have not made any rating adjustments to accommodate parity compliance.

v. In Lieu of Services

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 2021 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 7 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 2022 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 7 of the MI Health Link program are consistent with those from Demonstration Year 6. 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 2022 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable.

(b) Capitation payments minus withhold

The CY 2022 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 was 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. STATE DIRECTED PAYMENTS

i. Rate Development Standards

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

- Uniform dollar increase for nursing facilities (QAS program).

(a) Description of Managed Care Plan Requirement

The add-on QAS payment amounts were originally developed based on the fee-for-service (FFS) model approved in the state plan. Prior to this rating period, ICOs were required to pay FFS rates to nursing facilities which included the QAS add-on amount. In order to maintain this portion of the nursing facility daily rate it is being transitioned to a directed payment.

Michigan also performs an annual calculation of the Medicare UPL for nursing facilities. The total payments for these services remain below the UPL. As such, the QAS payments are reasonable, equitable, and appropriate for these providers.

(b) Written Approval

MDHHS has received written approval for the QAS state directed payment delivery systems with the pre-print control name of MI_Fee_NF_New_20220101-20221231.

(c) Actuarial Standards

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

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

The payments within the various directed payment initiatives are done so on a retrospective basis to the ICOs.

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

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

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

PMPM estimates related to the state directed payments are included in Appendix 4 of this certification report.

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

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

(iv) Change from initial base rate certification

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

ii. Appropriate Documentation

(a) Description of Delivery System and Provider Payment Initiatives

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

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

CONTROL NAME	TYPE OF PAYMENT	BRIEF DESCRIPTION	RATE ADJUSTMENT OR SEPARATE PAYMENT TERM
MI_Fee_NF_New_20220101-20221231	Uniform percentage increase	Uniform dollar increase for nursing facilities for the rating period covering January 1,2022 through December 31, 2022.	Separate payment term

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

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

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

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

CONTROL NAME	AGGREGATE AMOUNT	PMPM MAGNITUDE	PREPRINT CONSISTENCY CONFIRMATION	SUBMIT REQUIRED DOCUMENTATION REQUIREMENT
MI_Fee_NF_New_20220101-20221231	$22.2 million	Listed by rate cell in Appendix 4	This state directed payment is consistent with the preprint.	MDHHS will provide required documentation following CY 2022 with actual amounts paid on a retrospective basis.

(b) Additional directed payments not addressed

Not applicable.

(c) Requirements regarding reimbursement rates

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

E. PASS-THROUGH PAYMENTS

i. Rate Development Standards

This section 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 2022 capitation rates.

(ii) Description of how Pass-Through payments will be paid

Not applicable.

(iii) Amount

Not applicable.

(iv) Programs

Not applicable/

(v) Providers receiving the payment

Not applicable.

(vi) Financing mechanism

Not applicable.

(b) Description of Aggregate Pass-Through Payments

(i) Amount

Not applicable.

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

Not applicable.

(c) Description of Hospital Pass-Through Payments

(i) Data, methodologies, and assumptions

Not applicable.

(ii) Aggregate amounts

Not applicable.

(ii) Trend adjustments

Not applicable.

(iii) Applicable percentage

Not applicable.

(iv) Directed payment arrangements

Not applicable.

(d) Calculations for transitioning states

Not applicable.

5. Projected non-benefit costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 C.F.R §438.5(e), the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to ICO operation of the MI Health Link program.

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

ii. PMPM versus percentage

The non-benefit cost was developed as a percentage of the capitation rate for the community well population and established as a PMPM amount for the remaining rate cells.

An additional component of the non-benefit expense is the insurance provider assessment (IPA) that is applicable to insurance providers in the State of Michigan. The IPA assesses a PMPM rate of $53.55 to each covered member month, by 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 2022 in Appendix 4 based on a complete 12 months' worth of payments over the calendar year.

The estimated IPA load of $30.53 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 2021 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.

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

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

Data

The primary data sources used in the development of the calendar year 2022 non-benefit costs are listed below:

- Historical non-benefit costs included in rate certifications for other managed care programs.
- Historical state administrative costs related to nursing facility members.

Assumptions and methodology

We incorporated PMPM adjustments for the Nursing Facility tier based on the state administrative costs associated with Nursing Facility members, a PMPM amount of $66.15. The Nursing Facility Level of Care tier included a PMPM amount of $132.30 consistent with the admin/operations expenses included in the SFY 2022 MI Choice capitation rates. The Community Well administrative load reflects a 10% adjustment.

(b) Material changes

The material adjustment is to include specific administrative loads for each of the MI Health Link rating tiers. These were historically not included in prior rate developments.

(c) Other material adjustments

There are no other material adjustments applicable to the non-benefit cost component of the capitation rate .

ii. Non-benefit costs, by cost category

In the development of the actuarially sound capitation rates, we have included a non-benefit cost allowance of 9.0% for administration costs and 1.0% for contribution to reserves, risk margin and cost of capital across the rate cells for the Community Well population. The administrative cost allowance was calculated as a percentage of the capitation rate prior to profit and applicable state taxes. Therefore, the capitation rate was determined by dividing the projected managed care claim cost by one minus the non-benefit cost allowance (e.g., 1 minus 10). The remaining rating tiers received PMPM amounts and did not have a specific split between administrative load and risk margin.

iii. Historical non-benefit costs

There were not specific non-benefit costs included in prior rate development periods.

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. RATE DEVELOPMENT STANDARDS

The MI Health Link capitation rates were developed based on a non-blended approach considering the long-term care setting that the beneficiaries are using.

C. APPROPRIATE DOCUMENTATION

i. Capitation Rate Structure

(a) Capitation Rate Structure

The MI Health Link rate structure for calendar year 2022 did not change from the 2015-2021 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. Data, Assumptions, and Methodology

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

iii. Non-benefit costs

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

iv. 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:

- Encounter data for the MI Health Link population for January 1, 2019 through December 31, 2019 (base data year) and paid through July 2021
- Detailed fee-for-service and managed care enrollment data for January 1, 2019 through December 31, 2019
- Additional gross adjustment expenditure information outside the MMIS claims system
- Summary of 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

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 2022 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, 2022. 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 2022.

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

March 8, 2022
Date

Appendix 2: CY 2022 Cost Models

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 7 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: ICO-Nursing Subtier A-65+ | **Calendar Year 2019 Base Experience** | **Trended/Adjusted to CY 2022**

Member Months: 15,560 Category of Service	Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	N+3 Removal Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	809.8	$ 182.07	$ 12.29	$ 0.00	$ 0.00	$ 0.18	$ 1.31	$ 0.00	822.0	$ 201.20	$ 13.78
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	13.1	1,801.57	1.97	-	-	0.03	0.21	-	13.3	1,988.10	2.21
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	30.8	154.00	0.40	-	-	0.01	0.04	-	31.2	169.77	0.44
Subtotal Inpatient Hospital			**$ 14.65**								**$ 16.43**
Outpatient Hospital											
Outpatient Emergency Room	91.8	$ 140.53	$ 1.07	$ 0.00	$ 0.00	$ 0.08	$ 0.02	$ 0.00	99.1	$ 143.01	$ 1.18
Outpatient Surgery	13.1	173.53	0.19	-	-	0.01	0.01	-	14.1	177.82	0.21
Outpatient Radiology	40.1	43.81	0.15	-	-	0.01	0.00	-	43.5	44.14	0.16
Outpatient Pathology/Lab	435.7	2.56	0.09	-	-	0.01	0.00	-	476.9	2.61	0.10
Outpatient Pharmacy	174.3	40.27	0.58	-	-	0.05	0.01	-	188.6	40.60	0.64
Outpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	11,088.4	23.22	21.46	0.05	-	1.66	0.35	-	11,971.9	23.57	23.51
Subtotal Outpatient Hospital			**$ 23.55**								**$ 25.81**
Professional											
Inpatient and Outpatient Surgery	893.1	$ 18.75	$ 1.40	$ 0.00	$ 0.00	$ 0.01	$ 0.04	$ 0.00	901.4	$ 19.31	$ 1.45
Anesthesia	57.1	23.79	0.11	-	-	-	0.01	-	57.1	24.85	0.12
Inpatient Visits	1,718.3	41.06	5.88	0.01	-	0.05	0.16	-	1,735.8	42.18	6.10
MH/SA	276.9	23.97	0.55	-	-	0.00	0.02	-	278.7	24.83	0.58
Emergency Room	228.3	39.95	0.76	-	-	0.01	0.02	-	230.7	41.09	0.79
Office/Home Visits/Consults	349.4	39.59	1.15	0.00	-	0.01	0.03	-	353.1	40.65	1.20
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	915.4	4.20	0.32	-	-	-	0.01	-	915.4	4.38	0.33
Radiology	804.4	14.43	0.97	-	-	0.01	0.03	-	812.7	14.86	1.01
Office Administered Drugs	192.8	87.06	1.40	0.01	-	0.01	0.04	-	194.9	89.46	1.45
Physical Exams	5.4	22.44	0.01	-	-	-	-	-	5.4	22.44	0.01
Therapy	60.9	7.96	0.04	-	-	-	0.00	-	60.9	8.33	0.04
Vision	287.7	28.03	0.67	-	-	0.01	0.02	-	291.2	28.69	0.70
Other Professional	991.0	21.88	1.81	0.01	-	0.01	0.05	-	1,000.6	22.49	1.88
Subtotal Professional			**$ 15.07**								**$ 15.65**
Pharmacy											
Pharmacy	2,508.0	$ 7.88	$ 1.65	$ 0.00	$ 0.00	$ 0.01	$ 0.02	$ 0.00	2,527.9	$ 7.97	$ 1.68
Subtotal Pharmacy			**$ 1.65**								**$ 1.68**
Ancillary											
Emergency Transportation	173.5	$ 114.32	$ 1.65	$ 0.00	$ 0.00	$ 0.02	$ 0.04	$ 0.00	175.3	$ 116.81	$ 1.71
Non-Emergency Transportation	156.6	45.69	0.60	-	-	0.01	0.01	-	158.8	46.62	0.62
DME/Prosthetics	864.5	49.89	3.59	0.01	-	0.03	0.08	-	873.7	50.98	3.71
Dental	809.8	73.64	4.97	0.01	-	0.04	0.11	-	818.1	75.29	5.13
Other Ancillary	1.5	1,453.34	0.19	-	-	0.00	0.00	-	1.6	1,482.70	0.19
Subtotal Ancillary			**$ 11.00**								**$ 11.36**
LTSS											
Hospice	12,654.8	$ 243.77	$ 257.07	$ 1.28	$ 0.00	$ 3.90	$ 16.05	$ 0.00	12,909.7	$ 258.69	$ 278.30
Nursing Home	317,076.1	207.47	5,482.01	27.41	1.08	83.07	342.37	-	323,528.8	220.17	5,935.94
HCBS	1,257.1	55.51	5.82	0.03	-	0.09	0.36	1.83	1,282.3	75.99	8.12
Subtotal LTSS			**$ 5,744.89**								**$ 6,222.36**
Total Medical Costs			**$ 5,810.80**								**$ 6,293.29**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 7 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: ICO-Nursing Subtier A-Under | **Calendar Year 2019 Base Experience** | **Trended/Adjusted to CY 2022**

Member Months: 2,564 Category of Service	Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	N+3 Removal Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	1,750.4	$ 213.20	$ 31.10	$ 0.00	$ 0.00	$ 0.47	$ 3.32	$ 0.00	1,776.7	$ 235.63	$ 34.89
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	28.1	-	-	-	-	-	-	-	-	-	-
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	1,937.6	481.16	77.69	-	-	1.17	8.29	-	1,966.8	531.71	87.15
Subtotal Inpatient Hospital			**$ 108.79**								**$ 122.03**
Outpatient Hospital											
Outpatient Emergency Room	121.7	$ 121.51	$ 1.23	$ 0.00	$ 0.00	$ 0.10	$ 0.02	$ 0.00	131.4	$ 123.25	$ 1.35
Outpatient Surgery	18.7	174.00	0.27	-	-	0.02	0.00	-	20.2	176.61	0.30
Outpatient Radiology	18.7	66.03	0.10	-	-	0.01	0.00	-	20.0	67.17	0.11
Outpatient Pathology/Lab	159.1	5.28	0.07	-	-	0.00	-	-	165.8	5.28	0.07
Outpatient Pharmacy	421.2	76.95	2.70	0.01	-	0.21	0.05	-	454.3	78.24	2.96
Outpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	15,449.3	26.34	33.91	0.08	-	2.61	0.56	-	16,677.6	26.74	37.17
Subtotal Outpatient Hospital			**$ 38.29**								**$ 41.96**
Professional											
Inpatient and Outpatient Surgery	683.3	$ 16.45	$ 0.94	$ 0.00	$ 0.00	$ 0.01	$ 0.02	$ 0.00	691.2	$ 16.84	$ 0.97
Anesthesia	154.4	24.62	0.32	-	-	-	0.01	-	154.4	25.47	0.33
Inpatient Visits	1,333.9	41.88	4.66	0.01	-	0.03	0.13	-	1,347.5	43.06	4.83
MH/SA	1,151.3	24.60	2.36	0.01	-	0.01	0.07	-	1,161.2	25.29	2.45
Emergency Room	599.1	33.60	1.68	0.01	-	0.01	0.05	-	604.9	34.54	1.74
Office/Home Visits/Consults	524.2	33.86	1.48	0.00	-	0.01	0.05	-	528.5	34.94	1.54
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	982.8	4.00	0.33	-	-	-	0.02	-	982.8	4.19	0.34
Radiology	1,020.3	10.34	0.88	-	-	0.01	0.02	-	1,031.9	10.63	0.91
Office Administered Drugs	159.1	61.28	0.81	0.00	-	0.00	0.02	-	160.3	62.87	0.84
Physical Exams	9.4	-	-	-	-	-	-	-	-	-	-
Therapy	84.2	-	-	-	-	-	-	-	-	-	-
Vision	341.7	28.39	0.81	-	-	0.01	0.02	-	346.1	29.15	0.84
Other Professional	1,273.0	13.48	1.43	-	-	0.02	0.04	-	1,288.9	13.84	1.49
Subtotal Professional			**$ 15.68**								**$ 16.28**
Pharmacy											
Pharmacy	2,817.5	$ 9.18	$ 2.16	$ 0.01	$ 0.00	$ 0.02	$ 0.01	$ 0.00	2,847.2	$ 9.24	$ 2.19
Subtotal Pharmacy			**$ 2.16**								**$ 2.19**
Ancillary											
Emergency Transportation	299.5	$ 85.91	$ 2.14	$ 0.01	$ 0.00	$ 0.01	$ 0.05	$ 0.00	302.4	$ 88.02	$ 2.22
Non-Emergency Transportation	1,628.7	41.64	5.65	0.01	-	0.04	0.12	-	1,645.5	42.55	5.83
DME/Prosthetics	2,691.1	45.78	10.27	0.03	-	0.08	0.23	-	2,718.7	46.81	10.61
Dental	1,076.4	60.62	5.44	0.01	-	0.04	0.13	-	1,087.1	62.02	5.62
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 23.50**								**$ 24.28**
LTSS											
Hospice	11,391.6	$ 233.42	$ 221.59	$ 1.11	$ 0.00	$ 3.36	$ 13.84	$ 0.00	11,621.1	$ 247.71	$ 239.89
Nursing Home	302,508.6	215.16	5,424.08	27.12	(59.20)	81.29	335.01	-	305,253.2	228.33	5,808.30
HCBS	4,951.6	39.88	16.45	0.08	-	0.25	1.02	5.16	5,051.8	54.58	22.98
Subtotal LTSS			**$ 5,662.12**								**$ 6,071.16**
Total Medical Costs			**$ 5,850.54**								**$ 6,277.92**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 7 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: ICO-Nursing Subtier B-65+ | **Calendar Year 2019 Base Experience** | **Trended/Adjusted to CY 2022**

Member Months: 2,248 Category of Service	Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	N+3 Removal Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	133.5	$ 778.17	$ 8.65	$ 0.00	$ 0.00	$ 0.13	$ 0.92	$ 0.00	135.4	$ 860.06	$ 9.71
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	10.7	680.04	0.61	-	-	0.01	0.07	-	10.8	754.56	0.68
Subtotal Inpatient Hospital			**$ 9.26**								**$ 10.39**
Outpatient Hospital											
Outpatient Emergency Room	256.2	$ 105.35	$ 2.25	$ 0.01	$ 0.00	$ 0.17	$ 0.04	$ 0.00	276.3	$ 107.18	$ 2.47
Outpatient Surgery	21.4	61.39	0.11	-	-	0.01	-	-	23.0	61.39	0.12
Outpatient Radiology	234.9	56.67	1.11	-	-	0.09	0.02	-	254.4	57.46	1.22
Outpatient Pathology/Lab	16.0	-	-	-	-	-	-	-	-	-	-
Outpatient Pharmacy	42.7	23.61	0.08	-	-	0.01	-	-	47.0	23.61	0.09
Outpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	944.8	32.21	2.54	0.01	-	0.19	0.04	-	1,020.4	32.69	2.78
Subtotal Outpatient Hospital			**$ 6.09**								**$ 6.68**
Professional											
Inpatient and Outpatient Surgery	277.6	$ 24.00	$ 0.56	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.00	278.8	$ 24.73	$ 0.57
Anesthesia	5.3	-	-	-	-	-	-	-	-	-	-
Inpatient Visits	1,847.0	33.82	5.21	0.01	-	0.05	0.14	-	1,866.8	34.72	5.40
MH/SA	-	-	-	-	-	-	-	-	-	-	-
Emergency Room	133.5	49.99	0.56	0.00	-	0.00	0.02	-	134.2	51.46	0.58
Office/Home Visits/Consults	672.6	34.94	1.96	0.01	-	0.01	0.06	-	678.4	36.04	2.04
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	32.0	11.28	0.03	-	-	-	-	-	32.0	11.28	0.03
Radiology	843.4	15.68	1.10	0.00	-	0.01	0.03	-	852.2	16.17	1.15
Office Administered Drugs	69.4	273.18	1.58	-	-	0.02	0.04	-	70.1	280.37	1.64
Physical Exams	-	-	-	-	-	-	-	-	-	-	-
Therapy	-	-	-	-	-	-	-	-	-	-	-
Vision	250.9	40.38	0.84	0.00	-	0.01	0.02	-	253.5	41.36	0.87
Other Professional	811.4	34.98	2.37	0.01	-	0.02	0.07	-	820.1	35.96	2.46
Subtotal Professional			**$ 14.20**								**$ 14.74**
Pharmacy											
Pharmacy	4,115.7	$ 7.34	$ 2.52	$ 0.01	$ 0.00	$ 0.02	$ 0.02	$ 0.00	4,159.7	$ 7.40	$ 2.56
Subtotal Pharmacy			**$ 2.52**								**$ 2.56**
Ancillary											
Emergency Transportation	32.0	$ 172.26	$ 0.46	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	32.2	$ 177.04	$ 0.48
Non-Emergency Transportation	-	-	-	-	-	-	-	-	-	-	-
DME/Prosthetics	661.9	41.44	2.29	0.01	-	0.01	0.05	-	667.2	42.43	2.36
Dental	1,158.4	87.86	8.48	0.02	-	0.07	0.19	-	1,170.3	89.80	8.76
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 11.23**								**$ 11.59**
LTSS											
Hospice	1,206.4	$ 373.87	$ 37.59	$ 0.19	$ 0.00	$ 0.57	$ 2.35	$ 0.00	1,230.6	$ 396.82	$ 40.69
Nursing Home	351,533.8	298.08	8,732.01	43.66	(128.03)	130.37	537.28	-	353,385.6	316.32	9,315.29
HCBS	475.1	28.87	1.14	0.01	-	0.02	0.07	0.36	485.6	39.46	1.60
Subtotal LTSS			**$ 8,770.74**								**$ 9,357.58**
Total Medical Costs			**$ 8,814.03**								**$ 9,403.54**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 7 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: ICO-Nursing Subtier B-Under — **Calendar Year 2019 Base Experience** — **Trended/Adjusted to CY 2022**

Member Months: 111 Category of Service	Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	N+3 Removal Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	432.4	$ 241.65	$ 8.71	$ 0.00	$ 0.00	$ 0.13	$ 0.93	$ 0.00	438.9	$ 267.15	$ 9.77
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 8.71**								**$ 9.77**
Outpatient Hospital											
Outpatient Emergency Room	1,189.2	$ 59.40	$ 5.89	$ 0.02	$ 0.00	$ 0.45	$ 0.10	$ 0.00	1,284.2	$ 60.31	$ 6.45
Outpatient Surgery	-	-	-	-	-	-	-	-	-	-	-
Outpatient Radiology	-	-	-	-	-	-	-	-	-	-	-
Outpatient Pathology/Lab	-	-	-	-	-	-	-	-	-	-	-
Outpatient Pharmacy	-	-	-	-	-	-	-	-	-	-	-
Outpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	216.2	7.65	0.14	-	-	0.01	0.01	-	228.9	8.08	0.15
Subtotal Outpatient Hospital			**$ 6.02**								**$ 6.61**
Professional											
Inpatient and Outpatient Surgery	324.3	$ 18.67	$ 0.50	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	327.6	$ 19.17	$ 0.52
Anesthesia	-	-	-	-	-	-	-	-	-	-	-
Inpatient Visits	2,054.1	37.93	6.49	0.02	-	0.05	0.18	-	2,074.0	38.98	6.74
MH/SA	108.1	-	-	-	-	-	-	-	-	-	-
Emergency Room	-	-	-	-	-	-	-	-	-	-	-
Office/Home Visits/Consults	973.0	36.30	2.94	0.01	-	0.02	0.08	-	983.7	37.29	3.06
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	-	-	-	-	-	-	-	-	-	-	-
Radiology	1,081.1	15.14	1.36	0.00	-	0.01	0.04	-	1,091.1	15.58	1.42
Office Administered Drugs	-	-	-	-	-	-	-	-	-	-	-
Physical Exams	-	-	-	-	-	-	-	-	-	-	-
Therapy	-	-	-	-	-	-	-	-	-	-	-
Vision	324.3	30.74	0.83	-	-	0.01	0.03	-	327.5	31.72	0.87
Other Professional	648.6	14.70	0.79	0.00	-	0.00	0.02	-	652.6	15.13	0.82
Subtotal Professional			**$ 12.93**								**$ 13.42**
Pharmacy											
Pharmacy	3,675.7	$ 5.70	$ 1.75	$ 0.00	$ 0.00	$ 0.02	$ 0.01	$ 0.00	3,713.8	$ 5.73	$ 1.77
Subtotal Pharmacy			**$ 1.75**								**$ 1.77**
Ancillary											
Emergency Transportation	-	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	-	$ 0.00	$ 0.00
Non-Emergency Transportation	-	-	-	-	-	-	-	-	-	-	-
DME/Prosthetics	216.2	23.85	0.43	-	-	0.01	0.01	-	220.3	24.29	0.45
Dental	1,297.3	42.97	4.65	0.01	-	0.04	0.10	-	1,311.6	43.89	4.80
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 5.07**								**$ 5.24**
LTSS											
Hospice	-	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	-	$ 0.00	$ 0.00
Nursing Home	347,567.6	297.99	8,631.04	43.16	(333.55)	125.73	518.21	-	340,937.0	316.23	8,984.60
HCBS	648.6	18.30	0.99	0.01	-	0.01	0.06	0.31	659.3	25.09	1.38
Subtotal LTSS			**$ 8,632.03**								**$ 8,985.98**
Total Medical Costs			**$ 8,666.51**								**$ 9,022.79**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 7 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: ICO-NF Level of Care-65+ | **Calendar Year 2019 Base Experience** | **Trended/Adjusted to CY 2022**

Member Months: 10,491 Category of Service	Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	N+3 Removal Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	903.6	$ 223.33	$ 16.82	$ 0.00	$ 0.00	$ 0.25	$ 1.80	$ 0.00	917.1	$ 246.83	$ 18.86
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	36.6	-	-	-	-	-	-	-	-	-	-
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	84.6	351.01	2.48	-	-	0.04	0.27	-	85.9	388.32	2.78
Subtotal Inpatient Hospital			**$ 19.29**								**$ 21.64**
Outpatient Hospital											
Outpatient Emergency Room	250.5	$ 137.26	$ 2.87	$ 0.01	$ 0.00	$ 0.22	$ 0.05	$ 0.00	270.6	$ 139.30	$ 3.14
Outpatient Surgery	48.0	202.03	0.81	-	-	0.07	0.01	-	52.1	204.95	0.89
Outpatient Radiology	116.7	52.30	0.51	-	-	0.04	0.01	-	125.2	53.20	0.55
Outpatient Pathology/Lab	297.4	3.42	0.08	-	-	0.01	0.00	-	330.4	3.46	0.10
Outpatient Pharmacy	221.9	84.70	1.57	0.00	-	0.13	0.02	-	239.9	85.80	1.72
Outpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	2,752.1	48.16	11.04	0.03	-	0.85	0.18	-	2,971.3	48.86	12.10
Subtotal Outpatient Hospital			**$ 16.88**								**$ 18.50**
Professional											
Inpatient and Outpatient Surgery	368.3	$ 41.38	$ 1.27	$ 0.00	$ 0.00	$ 0.01	$ 0.04	$ 0.00	371.7	$ 42.60	$ 1.32
Anesthesia	125.8	44.06	0.46	-	-	0.01	0.01	-	127.8	44.85	0.48
Inpatient Visits	147.6	66.82	0.82	-	-	0.01	0.02	-	149.2	68.70	0.85
MH/SA	264.2	1.76	0.04	-	-	-	-	-	264.2	1.76	0.04
Emergency Room	344.3	35.25	1.01	-	-	0.01	0.03	-	347.2	36.26	1.05
Office/Home Visits/Consults	1,532.7	45.14	5.77	0.01	-	0.05	0.16	-	1,548.2	46.41	5.99
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	821.3	11.48	0.79	-	-	0.01	0.02	-	831.1	11.77	0.82
Radiology	614.2	13.54	0.69	-	-	0.01	0.02	-	622.2	13.91	0.72
Office Administered Drugs	926.5	105.36	8.13	0.02	-	0.06	0.23	-	935.5	108.27	8.44
Physical Exams	96.1	55.92	0.45	-	-	0.00	0.01	-	96.4	57.53	0.46
Therapy	108.7	19.76	0.18	-	-	0.00	0.00	-	109.4	20.15	0.18
Vision	310.0	41.96	1.08	-	-	0.01	0.03	-	312.8	43.08	1.12
Other Professional	6,684.6	57.03	31.77	0.08	-	0.24	0.88	-	6,752.3	58.59	32.97
Subtotal Professional			**$ 52.46**								**$ 54.44**
Pharmacy											
Pharmacy	11,043.8	$ 8.07	$ 7.42	$ 0.02	$ 0.00	$ 0.05	$ 0.06	$ 0.00	11,152.4	$ 8.13	$ 7.56
Subtotal Pharmacy			**$ 7.42**								**$ 7.56**
Ancillary											
Emergency Transportation	163.6	$ 103.59	$ 1.41	$ 0.00	$ 0.00	$ 0.01	$ 0.03	$ 0.00	165.1	$ 105.93	$ 1.46
Non-Emergency Transportation	13,285.7	46.51	51.49	0.13	-	0.39	1.18	-	13,419.5	47.56	53.19
DME/Prosthetics	13,032.9	43.53	47.27	0.12	-	0.36	1.08	-	13,164.6	44.51	48.83
Dental	1,179.3	108.93	10.71	0.02	-	0.08	0.24	-	1,191.2	111.39	11.06
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 110.88**								**$ 114.53**
LTSS											
Hospice	68.6	$ 266.17	$ 1.52	$ 0.01	$ 0.00	$ 0.02	$ 0.09	$ 0.00	69.9	$ 282.43	$ 1.65
Nursing Home	5,555.6	171.82	79.55	0.40	(65.87)	0.21	0.87	-	997.9	182.34	15.16
HCBS	280,595.9	51.39	1,201.59	6.01	-	18.21	75.02	377.25	286,250.8	70.35	1,678.08
Subtotal LTSS			**$ 1,282.66**								**$ 1,694.89**
Total Medical Costs			**$ 1,489.60**								**$ 1,911.56**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 7 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: ICO-NF Level of Care-Under 6 — **Calendar Year 2019 Base Experience** — **Trended/Adjusted to CY 2022**

Member Months: 11,728 Category of Service	Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	N+3 Removal Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	788.9	$ 378.41	$ 24.88	$ 0.00	$ 0.00	$ 0.37	$ 2.66	$ 0.00	800.8	$ 418.20	$ 27.91
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	56.3	24.89	0.12	-	-	0.00	0.01	-	57.1	27.49	0.13
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	61.4	229.06	1.17	-	-	0.02	0.12	-	62.4	252.97	1.32
Subtotal Inpatient Hospital			**$ 26.17**								**$ 29.35**
Outpatient Hospital											
Outpatient Emergency Room	198.5	$ 125.81	$ 2.08	$ 0.01	$ 0.00	$ 0.16	$ 0.03	$ 0.00	214.5	$ 127.52	$ 2.28
Outpatient Surgery	50.1	412.56	1.72	0.01	-	0.13	0.02	-	54.2	417.91	1.89
Outpatient Radiology	90.0	37.11	0.28	-	-	0.02	0.00	-	97.1	37.33	0.30
Outpatient Pathology/Lab	161.7	19.83	0.27	-	-	0.02	0.01	-	174.4	20.28	0.29
Outpatient Pharmacy	567.9	22.35	1.06	0.00	-	0.09	0.02	-	613.8	22.67	1.16
Outpatient MH/SA	3.1	25.59	0.01	-	-	-	-	-	3.1	25.59	0.01
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	5,624.5	54.84	25.70	0.06	-	1.98	0.42	-	6,071.5	55.67	28.17
Subtotal Outpatient Hospital			**$ 31.12**								**$ 34.10**
Professional											
Inpatient and Outpatient Surgery	347.9	$ 67.34	$ 1.95	$ 0.00	$ 0.00	$ 0.02	$ 0.06	$ 0.00	351.3	$ 69.29	$ 2.03
Anesthesia	132.0	47.21	0.52	-	-	0.01	0.01	-	134.0	48.16	0.54
Inpatient Visits	115.6	56.91	0.55	-	-	0.01	0.02	-	117.3	58.52	0.57
MH/SA	327.4	5.80	0.16	-	-	0.00	0.00	-	331.1	5.87	0.16
Emergency Room	402.1	33.41	1.12	-	-	0.01	0.04	-	405.1	34.52	1.17
Office/Home Visits/Consults	1,771.1	37.45	5.53	0.01	-	0.05	0.15	-	1,789.3	38.47	5.74
Maternity	2.0	7.97	0.00	-	-	-	-	-	2.0	7.97	0.00
Pathology/Lab	886.1	13.01	0.96	-	-	0.01	0.03	-	895.3	13.38	1.00
Radiology	548.4	13.16	0.60	-	-	0.01	0.01	-	557.2	13.39	0.62
Office Administered Drugs	1,068.2	61.89	5.51	0.01	-	0.04	0.16	-	1,078.8	63.63	5.72
Physical Exams	143.2	58.63	0.70	-	-	0.01	0.01	-	145.3	59.79	0.72
Therapy	83.9	29.92	0.21	-	-	-	0.01	-	83.9	31.14	0.22
Vision	415.4	39.36	1.36	0.00	-	0.01	0.04	-	418.7	40.47	1.41
Other Professional	7,450.9	65.29	40.54	0.10	-	0.30	1.14	-	7,525.2	67.11	42.08
Subtotal Professional			**$ 59.71**								**$ 61.98**
Pharmacy											
Pharmacy	10,049.8	$ 9.88	$ 8.27	$ 0.02	$ 0.00	$ 0.06	$ 0.06	$ 0.00	10,150.8	$ 9.95	$ 8.42
Subtotal Pharmacy			**$ 8.27**								**$ 8.42**
Ancillary											
Emergency Transportation	98.2	$ 96.99	$ 0.79	$ 0.00	$ 0.00	$ 0.01	$ 0.02	$ 0.00	99.6	$ 99.04	$ 0.82
Non-Emergency Transportation	20,924.3	52.30	91.19	0.23	-	0.68	2.09	-	21,134.1	53.49	94.20
DME/Prosthetics	12,484.0	43.08	44.82	0.11	-	0.34	1.02	-	12,609.8	44.05	46.29
Dental	1,812.1	77.43	11.69	0.03	-	0.09	0.26	-	1,830.5	79.16	12.08
Other Ancillary	-	-	-	-	-	-	-	-	-	-	-
Subtotal Ancillary			**$ 148.49**								**$ 153.38**
LTSS											
Hospice	-	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	-	$ 0.00	$ 0.00
Nursing Home	1,006.8	177.72	14.91	0.07	(11.78)	0.05	0.20	-	219.6	188.75	3.45
HCBS	302,844.5	52.03	1,313.15	6.56	-	19.90	81.99	412.26	308,947.3	71.23	1,833.87
Subtotal LTSS			**$ 1,328.06**								**$ 1,837.32**
Total Medical Costs			**$ 1,601.82**								**$ 2,124.56**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 7 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: ICO-Community Well-65+ | **Calendar Year 2019 Base Experience** | **Trended/Adjusted to CY 2022**

Member Months: 176,096 Category of Service	Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	N+3 Removal Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	393.5	$ 196.70	$ 6.45	$ 0.00	$ 0.00	$ 0.10	$ 0.69	$ 0.00	399.6	$ 217.33	$ 7.24
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	37.1	907.30	2.80	-	-	0.04	0.30	-	37.6	1,003.49	3.15
Inpatient Maternity Delivery	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	25.5	274.62	0.58	-	-	0.01	0.07	-	25.9	305.07	0.66
Subtotal Inpatient Hospital			**$ 9.84**								**$ 11.04**
Outpatient Hospital											
Outpatient Emergency Room	103.8	$ 99.80	$ 0.86	$ 0.00	$ 0.00	$ 0.07	$ 0.01	$ 0.00	112.4	$ 100.98	$ 0.95
Outpatient Surgery	31.6	189.59	0.50	-	-	0.04	0.01	-	34.1	192.44	0.55
Outpatient Radiology	134.5	42.54	0.48	-	-	0.04	0.01	-	144.9	43.21	0.52
Outpatient Pathology/Lab	214.2	8.36	0.15	-	-	0.01	-	-	232.6	8.36	0.16
Outpatient Pharmacy	182.3	25.37	0.39	-	-	0.03	0.01	-	196.5	25.89	0.42
Outpatient MH/SA	0.7	30.53	0.00	-	-	-	-	-	0.7	30.53	0.00
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	1,337.3	39.24	4.37	0.01	-	0.34	0.07	-	1,443.4	39.84	4.79
Subtotal Outpatient Hospital			**$ 6.75**								**$ 7.40**
Professional											
Inpatient and Outpatient Surgery	307.2	$ 54.15	$ 1.39	$ 0.00	$ 0.00	$ 0.02	$ 0.04	$ 0.00	311.0	$ 55.60	$ 1.44
Anesthesia	90.4	50.73	0.38	-	-	0.01	0.01	-	92.0	51.66	0.40
Inpatient Visits	109.3	56.02	0.51	-	-	0.01	0.01	-	111.2	57.10	0.53
MH/SA	177.3	8.30	0.12	-	-	-	0.00	-	177.3	8.43	0.12
Emergency Room	270.2	35.55	0.80	-	-	0.01	0.02	-	272.6	36.49	0.83
Office/Home Visits/Consults	1,563.0	39.26	5.11	0.01	-	0.04	0.14	-	1,578.9	40.32	5.31
Maternity	-	-	-	-	-	-	-	-	-	-	-
Pathology/Lab	581.6	7.16	0.35	-	-	-	0.01	-	581.6	7.41	0.36
Radiology	516.4	13.47	0.58	-	-	0.01	0.01	-	525.3	13.72	0.60
Office Administered Drugs	649.4	54.21	2.93	0.01	-	0.02	0.08	-	655.7	55.76	3.05
Physical Exams	90.8	31.80	0.24	-	-	-	0.01	-	90.8	33.12	0.25
Therapy	96.2	21.34	0.17	-	-	-	0.01	-	96.2	22.59	0.18
Vision	347.1	40.57	1.17	0.00	-	0.01	0.04	-	350.3	41.79	1.22
Other Professional	2,161.7	33.73	6.08	0.01	-	0.05	0.17	-	2,183.2	34.67	6.31
Subtotal Professional			**$ 19.84**								**$ 20.59**
Pharmacy											
Pharmacy	6,063.2	$ 9.37	$ 4.73	$ 0.01	$ 0.00	$ 0.04	$ 0.03	$ 0.00	6,127.0	$ 9.43	$ 4.82
Subtotal Pharmacy			**$ 4.73**								**$ 4.82**
Ancillary											
Emergency Transportation	44.6	$ 108.91	$ 0.40	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	44.9	$ 111.58	$ 0.42
Non-Emergency Transportation	2,613.9	36.61	7.97	0.02	-	0.06	0.19	-	2,639.2	37.45	8.24
DME/Prosthetics	2,774.1	35.19	8.13	0.02	-	0.06	0.19	-	2,801.3	35.99	8.40
Dental	1,173.0	98.36	9.61	0.02	-	0.07	0.22	-	1,184.4	100.62	9.93
Other Ancillary	1.2	1,995.12	0.20	-	-	0.00	0.00	-	1.2	2,032.08	0.21
Subtotal Ancillary			**$ 26.33**								**$ 27.20**
LTSS											
Hospice	151.0	$ 239.15	$ 3.01	$ 0.01	$ 0.00	$ 0.05	$ 0.19	$ 0.00	154.2	$ 253.69	$ 3.26
Nursing Home	3,351.7	204.64	57.16	0.29	(51.63)	0.09	0.36	-	345.9	217.11	6.26
HCBS	28,225.9	53.39	125.58	0.63	-	1.90	7.84	39.43	28,794.1	73.09	175.38
Subtotal LTSS			**$ 185.75**								**$ 184.90**
Total Medical Costs			**$ 253.24**								**$ 255.94**

State of Michigan Department of Health and Human Services
Integrated Care Dual Demonstration
Demonstration Year 7 Rate Development
Projected Base Experience

Region: All Demo Regions
Rate Cell: ICO-Community Well-Under 6 | **Calendar Year 2019 Base Experience** | **Trended/Adjusted to CY 2022**

Member Months: 212,086 Category of Service	Utilization per 1,000	Cost per Service	PMPM	Completion Adjustment	N+3 Removal Adjustment	Utilization Trend Adjustment	Cost Trend Adjustment	Minimum Wage Adjustment	Annual Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital											
Inpatient Medical/Surgical/Non-Delivery	272.5	$ 220.18	$ 5.00	$ 0.00	$ 0.00	$ 0.08	$ 0.53	$ 0.00	276.8	$ 243.18	$ 5.61
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	230.8	567.41	10.92	-	-	0.17	1.16	-	234.4	626.99	12.25
Inpatient Maternity Delivery	1.9	348.89	0.05	-	-	-	0.01	-	1.9	396.06	0.06
Other Inpatient	16.7	508.50	0.71	-	-	0.01	0.08	-	16.9	562.47	0.79
Subtotal Inpatient Hospital			**$ 16.68**								**$ 18.71**
Outpatient Hospital											
Outpatient Emergency Room	155.8	$ 90.32	$ 1.17	$ 0.00	$ 0.00	$ 0.09	$ 0.02	$ 0.00	168.4	$ 91.46	$ 1.28
Outpatient Surgery	28.5	242.17	0.57	-	-	0.05	0.01	-	30.9	245.02	0.63
Outpatient Radiology	99.1	39.07	0.32	-	-	0.03	0.01	-	107.0	39.76	0.35
Outpatient Pathology/Lab	243.6	8.60	0.17	-	-	0.02	-	-	264.9	8.60	0.19
Outpatient Pharmacy	174.5	39.00	0.57	-	-	0.05	0.01	-	188.9	39.56	0.62
Outpatient MH/SA	6.3	69.66	0.04	-	-	-	0.01	-	6.3	79.22	0.04
Outpatient Maternity	-	-	-	-	-	-	-	-	-	-	-
Other Outpatient	1,774.5	48.47	7.17	0.02	-	0.55	0.12	-	1,915.3	49.23	7.86
Subtotal Outpatient Hospital			**$ 10.01**								**$ 10.98**
Professional											
Inpatient and Outpatient Surgery	258.1	$ 51.95	$ 1.12	$ 0.00	$ 0.00	$ 0.01	$ 0.03	$ 0.00	260.4	$ 53.48	$ 1.16
Anesthesia	64.3	54.40	0.29	-	-	-	0.01	-	64.3	56.48	0.30
Inpatient Visits	80.1	50.95	0.34	-	-	-	0.01	-	80.1	53.19	0.35
MH/SA	400.0	15.67	0.52	-	-	0.00	0.02	-	402.1	16.17	0.54
Emergency Room	396.1	33.18	1.10	-	-	0.01	0.03	-	400.2	34.07	1.14
Office/Home Visits/Consults	1,770.7	36.12	5.33	0.01	-	0.04	0.15	-	1,788.4	37.14	5.53
Maternity	7.1	97.82	0.06	-	-	-	-	-	7.1	97.82	0.06
Pathology/Lab	674.6	8.83	0.50	-	-	0.00	0.02	-	678.2	9.18	0.52
Radiology	489.7	13.01	0.53	-	-	0.01	0.01	-	498.9	13.25	0.55
Office Administered Drugs	655.5	55.20	3.02	0.01	-	0.02	0.08	-	662.3	56.68	3.13
Physical Exams	156.6	43.17	0.56	-	-	0.00	0.02	-	158.0	44.40	0.58
Therapy	119.4	19.14	0.19	-	-	-	0.01	-	119.4	19.76	0.20
Vision	329.2	42.03	1.15	0.00	-	0.01	0.03	-	332.8	43.10	1.20
Other Professional	1,715.4	38.93	5.57	0.02	-	0.04	0.15	-	1,733.2	40.00	5.78
Subtotal Professional			**$ 20.27**								**$ 21.04**
Pharmacy											
Pharmacy	4,926.7	$ 12.04	$ 4.94	$ 0.02	$ 0.00	$ 0.04	$ 0.04	$ 0.00	4,976.5	$ 12.14	$ 5.03
Subtotal Pharmacy			**$ 4.94**								**$ 5.03**
Ancillary											
Emergency Transportation	47.4	$ 106.60	$ 0.42	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	47.7	$ 109.12	$ 0.43
Non-Emergency Transportation	3,427.5	41.44	11.84	0.03	-	0.09	0.27	-	3,462.0	42.38	12.23
DME/Prosthetics	2,690.5	32.07	7.19	0.02	-	0.06	0.17	-	2,717.4	32.82	7.43
Dental	1,877.9	76.28	11.94	0.03	-	0.09	0.27	-	1,896.7	78.02	12.33
Other Ancillary	0.3	1,327.34	0.03	-	-	-	-	-	0.3	1,327.34	0.03
Subtotal Ancillary			**$ 31.42**								**$ 32.45**
LTSS											
Hospice	31.6	$ 226.90	$ 0.60	$ 0.00	$ 0.00	$ 0.01	$ 0.04	$ 0.00	32.3	$ 240.59	$ 0.65
Nursing Home	642.4	194.47	10.41	0.05	(8.50)	0.03	0.12	-	122.8	206.23	2.11
HCBS	29,587.9	49.82	122.83	0.61	-	1.86	7.67	38.56	30,184.0	68.20	171.54
Subtotal LTSS			**$ 133.84**								**$ 174.30**
Total Medical Costs			**$ 217.16**								**$ 262.52**

Appendix 3: Case Mix Exhibit

State of Michigan Department of Health and Human Services
MI Health Link
CY 2022 Capitation Rate Development
Enrollment Case Mix Exhibit

	Projected Benefit Expense			
	Region 1	**Region 4**	**Region 7**	**Region 9**
Nursing Subtier A-65+	$ 6,089.27	$ 5,950.36	$ 6,401.52	$ 6,487.58
Nursing Subtier A-Under 65	5,741.70	5,107.25	6,571.13	6,402.72
Nursing Subtier B-65+	9,466.84	9,058.73	4,038.24	10,693.41
Nursing Subtier B-Under 65	9,059.61	7,968.55	5,235.14	11,561.73
NF Level of Care-65+	1,929.17	2,301.38	1,834.97	2,024.17
NF Level of Care-Under 65	1,513.53	2,817.01	2,006.05	1,940.83
Community Well-65+	174.48	265.23	269.18	246.75
Community Well-Under 65	149.59	239.38	311.69	219.80
	Base Period ICO Enrollment			
	Region 1	**Region 4**	**Region 7**	**Region 9**
Nursing Subtier A-65+	1,893	2,966	7,853	2,848
Nursing Subtier A-Under 65	163	376	1,632	393
Nursing Subtier B-65+	1,889	332	6	21
Nursing Subtier B-Under 65	90	14	1	6
NF Level of Care-65+	611	1,065	7,498	1,317
NF Level of Care-Under 65	382	2,074	7,678	1,594
Community Well-65+	17,185	33,579	99,867	25,465
Community Well-Under 65	25,500	56,447	106,048	24,091
	Projected ICO Enrollment			
	Region 1	**Region 4**	**Region 7**	**Region 9**
Nursing Subtier A-65+	1,917	3,385	10,485	3,292
Nursing Subtier A-Under 65	262	510	2,290	717
Nursing Subtier B-65+	2,466	465	-	129
Nursing Subtier B-Under 65	144	36	-	-
NF Level of Care-65+	934	1,833	9,130	1,963
NF Level of Care-Under 65	457	2,733	10,124	1,986
Community Well-65+	19,523	35,015	119,182	33,101
Community Well-Under 65	26,479	54,600	114,708	27,953
	Composite Base Benefit Expense			**Case Mix**
	Base Period Enroll	**Projected Enroll**		**Adjustment**
Nursing Subtier A-65+	$ 6,293.29	$ 6,304.95		1.0019
Nursing Subtier A-Under 65	6,277.92	6,283.98		1.0010
Nursing Subtier B-65+	9,403.54	9,456.60		1.0056
Nursing Subtier B-Under 65	9,022.79	8,841.40		0.9799
NF Level of Care-65+	1,911.56	1,929.80		1.0095
NF Level of Care-Under 65	2,124.56	2,127.70		1.0015
Community Well-65+	255.94	255.98		1.0002
Community Well-Under 65	262.52	263.38		1.0033

Appendix 4: CY 2022 Capitation Rate Development

State of Michigan Department of Health and Human Services
MI Health Link CY 2022 Capitation Rate Development
Demonstration Year 7 Rate Development

Region: Statewide	Projected Exposure	Base Benefit Expense	Patient Pay Expense	Administrative Costs	Remove QAS	Proposed Effective Rate	Prior Effective Rate	% Change	Estimated IPA PMPM	QAS PMPM	Proposed Rate	Current Rate	% Change
Nursing Subtier A													
Over 65	19,080	$ 6,304.95	$ 955.62	$ 66.15	$ (1,040.49)	$ 6,286.23	$ 7,008.97	(10.3%)	$ 30.53	$ 1,040.49	$ 7,357.25	$ 7,045.77	4.4%
Under 65	3,780	6,283.98	774.45	66.15	(925.74)	6,198.83	6,276.53	(1.2%)	30.53	925.74	7,155.11	6,313.33	13.3%
Subtotal Nursing Subtier A	**22,860**	**$ 6,301.49**	**$ 925.66**	**$ 66.15**	**$ (1,021.52)**	**$ 6,271.78**	**$ 6,887.86**	**(8.9%)**	**$ 30.53**	**$ 983.21**	**$ 7,323.83**	**$ 6,924.66**	**5.8%**
Nursing Subtier B													
Over 65	3,060	$ 9,456.60	$ 1,034.68	$ 66.15	$ (1,457.38)	$ 9,100.06	$ 11,084.41	(17.9%)	$ 30.53	$ 1,457.38	$ 10,587.97	$ 11,121.20	(4.8%)
Under 65	180	8,841.40	1,098.56	66.15	(1,416.29)	8,589.82	10,847.20	(20.8%)	30.53	1,416.29	10,036.65	10,884.05	(7.8%)
Subtotal Nursing Subtier B	**3,240**	**$ 9,422.42**	**$ 1,038.23**	**$ 66.15**	**$ (1,455.09)**	**$ 9,071.71**	**$ 11,071.23**	**(18.1%)**	**$ 30.53**	**$ 1,437.53**	**$ 10,557.34**	**$ 11,108.03**	**(5.0%)**
NF Level of Care													
Over 65	13,860	$ 1,929.80	$ 0.00	$ 132.30	$ (3.35)	$ 2,058.75	$ 2,607.01	(21.0%)	$ 30.53	$ 3.35	$ 2,092.64	$ 2,643.80	(20.8%)
Under 65	15,300	2,127.70	-	132.30	(0.72)	2,259.28	3,149.79	(28.3%)	30.53	0.72	2,290.53	3,186.48	(28.1%)
Subtotal NF Level of Care	**29,160**	**$ 2,033.63**	**$ 0.00**	**$ 132.30**	**$ (1.97)**	**$ 2,163.96**	**$ 2,891.80**	**(25.2%)**	**$ 30.53**	**$ 1.97**	**$ 2,196.47**	**$ 2,928.54**	**(25.0%)**
Community Well													
Over 65	206,820	$ 255.98	$ 0.00	$ 28.44	$ (1.18)	$ 283.25	$ 225.34	25.7%	$ 30.53	$ 1.18	$ 314.96	$ 262.14	20.1%
Under 65	223,740	263.38	-	29.26	(0.38)	292.27	193.63	50.9%	30.53	0.38	323.18	230.43	40.3%
Subtotal Community Well	**430,560**	**$ 259.83**	**$ 0.00**	**$ 28.87**	**$ (0.76)**	**$ 287.93**	**$ 208.86**	**37.9%**	**$ 30.53**	**$ 0.77**	**$ 319.23**	**$ 245.66**	**29.9%**
Total	**485,820**			**$ 37.08**	**$ (58.57)**	**$ 740.68**	**$ 756.62**	**(2.1%)**	**$ 30.53**	**$ 58.57**	**$ 829.78**	**$ 793.41**	**4.6%**

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	98.5%	100.0%	100.0%	96.1%
Region 4	98.6%	100.0%	100.0%	99.0%
Region 7	100.6%	100.0%	100.0%	99.1%
Region 9	100.7%	100.0%	100.0%	102.3%

Appendix 5: Trend Analysis

State of Michigan, Department of Health and Human Services
MI Health Link CY 2022 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*
1/1/2018	38,225	509.6	2,974.2	5,305.8	18,328.3	15,769.3
2/1/2018	38,725	432.9	2,420.1	5,344.7	18,313.4	15,038.5
3/1/2018	38,910	429.6	2,240.1	5,421.1	18,193.1	14,878.8
4/1/2018	38,151	429.6	2,111.1	5,497.6	18,171.9	14,878.8
5/1/2018	39,182	429.6	1,980.6	5,622.0	18,171.2	14,878.8
6/1/2018	38,423	429.6	1,946.4	5,648.8	18,171.2	14,824.8
7/1/2018	37,928	426.4	1,934.6	5,648.8	18,171.2	14,721.3
8/1/2018	37,383	426.4	1,934.6	5,648.8	18,171.2	14,824.8
9/1/2018	36,819	432.9	1,934.6	5,648.8	18,191.8	14,932.8
10/1/2018	36,282	444.3	1,934.6	5,665.8	18,312.7	15,252.1
11/1/2018	35,672	475.5	1,946.4	5,673.5	18,312.7	15,305.5
12/1/2018	35,495	489.4	2,111.1	5,695.3	18,312.7	16,306.4
1/1/2019	35,045	514.3	2,218.6	5,717.1	18,312.7	16,306.4
2/1/2019	35,038	541.7	2,413.0	5,717.1	18,289.5	16,306.4
3/1/2019	34,383	555.1	2,648.8	5,707.3	18,289.5	16,306.4
4/1/2019	33,987	560.2	2,831.6	5,707.3	18,289.5	16,023.5
5/1/2019	33,689	560.2	2,904.6	5,707.3	18,326.7	15,951.8
6/1/2019	35,960	573.2	2,930.9	5,707.3	18,326.7	15,951.8
7/1/2019	35,153	573.2	2,930.9	5,707.3	18,326.7	15,951.8
8/1/2019	36,914	573.2	2,957.1	5,768.4	18,326.7	15,951.8
9/1/2019	37,501	573.2	2,957.1	5,768.4	18,326.7	15,880.2
10/1/2019	37,525	573.2	2,930.9	5,720.9	18,326.7	15,669.8
11/1/2019	37,747	571.8	2,894.4	5,697.6	18,358.7	15,508.7
12/1/2019	37,940	561.9	2,957.1	5,697.6	18,358.7	14,735.4
1/1/2020	36,948	552.0	2,981.3	5,720.9	18,358.7	14,575.4
2/1/2020	37,639	523.8	3,010.5	5,724.4	18,358.7	14,476.7
3/1/2020	37,048	518.7	3,252.0	5,744.1	18,642.4	14,476.7
4/1/2020	37,790	513.6	3,300.2	5,759.4	18,642.4	14,476.7
5/1/2020	37,845	485.4	3,425.3	5,759.4	18,717.5	14,476.7
6/1/2020	38,062	474.9	3,672.4	5,774.7	18,711.8	14,538.1
7/1/2020	38,610	474.9	3,705.4	5,774.7	18,711.8	14,589.9
8/1/2020	39,298	474.9	3,738.5	5,759.4	18,711.8	14,589.9
9/1/2020	39,435	474.9	3,766.4	5,759.4	18,711.8	14,641.8
10/1/2020	39,717	474.9	3,834.1	5,759.4	18,912.5	15,055.1
11/1/2020	40,153	485.4	3,941.5	5,739.7	19,018.7	15,361.9
12/1/2020	40,139	533.0	5,124.7	5,704.6	19,065.7	16,814.5
Low Estimate		**1.15%**	**14.69%**	**1.01%**	**0.85%**	**(2.21%)**
High Estimate		**7.65%**	**26.46%**	**2.29%**	**1.73%**	**0.82%**
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 2022 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*
1/1/2018	38,225	$ 463.08	$ 79.65	$ 7.13	$ 207.38	$ 51.20
2/1/2018	38,725	372.32	64.54	8.25	211.11	48.28
3/1/2018	38,910	345.90	69.58	9.04	213.72	46.11
4/1/2018	38,151	344.16	69.64	9.04	213.97	45.90
5/1/2018	39,182	342.41	66.81	10.15	215.19	45.68
6/1/2018	38,423	327.60	50.09	10.68	215.90	44.25
7/1/2018	37,928	324.69	49.08	11.41	216.61	44.45
8/1/2018	37,383	302.61	49.08	11.43	216.69	44.14
9/1/2018	36,819	298.13	49.08	11.44	216.45	43.82
10/1/2018	36,282	290.42	49.08	11.91	215.02	43.01
11/1/2018	35,672	291.20	48.78	12.01	215.02	44.41
12/1/2018	35,495	292.28	46.18	11.98	215.02	42.36
1/1/2019	35,045	297.46	46.07	11.95	215.02	42.36
2/1/2019	35,038	300.83	42.72	11.95	217.56	42.36
3/1/2019	34,383	298.65	40.95	11.93	218.69	42.36
4/1/2019	33,987	295.91	40.36	11.82	218.69	40.97
5/1/2019	33,689	300.96	39.80	11.33	219.37	41.16
6/1/2019	35,960	299.40	40.97	11.03	219.85	41.16
7/1/2019	35,153	324.14	41.02	10.62	220.61	41.16
8/1/2019	36,914	348.54	40.71	10.18	221.25	41.16
9/1/2019	37,501	350.69	41.52	9.85	221.25	40.82
10/1/2019	37,525	350.69	42.40	8.90	221.63	41.30
11/1/2019	37,747	324.95	43.45	8.11	222.27	40.30
12/1/2019	37,940	310.30	42.93	7.81	222.29	41.00
1/1/2020	36,948	313.42	43.12	7.44	222.59	41.45
2/1/2020	37,639	327.66	43.35	7.11	222.88	41.73
3/1/2020	37,048	312.71	40.30	7.00	222.26	41.94
4/1/2020	37,790	297.46	45.67	6.98	223.28	41.71
5/1/2020	37,845	294.92	44.44	6.98	224.16	41.50
6/1/2020	38,062	301.39	41.45	6.96	224.23	41.32
7/1/2020	38,610	301.39	41.08	6.96	224.23	41.18
8/1/2020	39,298	301.39	40.71	7.06	224.23	41.18
9/1/2020	39,435	301.39	41.28	7.08	224.23	41.24
10/1/2020	39,717	323.71	41.19	7.08	224.04	40.47
11/1/2020	40,153	316.76	40.07	7.12	225.78	39.66
12/1/2020	40,139	288.48	30.82	7.21	226.95	36.17
Low Estimate		**(9.06%)**	**(41.07%)**	**(32.33%)**	**1.54%**	**(8.61%)**
High Estimate		**(1.43%)**	**(13.46%)**	**(9.22%)**	**2.86%**	**(3.90%)**
Selected Trend		**0.50%**	**0.50%**	**0.25%**	**2.00%**	**0.75%**

State of Michigan, Department of Health and Human Services
MI Health Link CY 2022 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*
1/1/2018	38,225	$ 19.66	$ 19.74	$ 3.15	$ 316.75	$ 67.29
2/1/2018	38,725	13.43	13.02	3.68	322.17	60.51
3/1/2018	38,910	12.38	12.99	4.08	324.01	57.17
4/1/2018	38,151	12.32	12.25	4.14	324.01	56.91
5/1/2018	39,182	12.26	11.03	4.76	325.86	56.64
6/1/2018	38,423	11.73	8.12	5.03	326.93	54.66
7/1/2018	37,928	11.54	7.91	5.37	328.01	54.53
8/1/2018	37,383	10.75	7.91	5.38	328.13	54.53
9/1/2018	36,819	10.75	7.91	5.39	328.13	54.53
10/1/2018	36,282	10.75	7.91	5.62	328.13	54.66
11/1/2018	35,672	11.54	7.91	5.68	328.13	56.64
12/1/2018	35,495	11.92	8.12	5.68	328.13	57.57
1/1/2019	35,045	12.75	8.52	5.69	328.13	57.57
2/1/2019	35,038	13.58	8.59	5.69	331.59	57.57
3/1/2019	34,383	13.82	9.04	5.68	333.31	57.57
4/1/2019	33,987	13.82	9.52	5.62	333.31	54.71
5/1/2019	33,689	14.05	9.63	5.39	335.03	54.71
6/1/2019	35,960	14.30	10.01	5.25	335.76	54.71
7/1/2019	35,153	15.48	10.02	5.05	336.93	54.71
8/1/2019	36,914	16.65	10.03	4.89	337.89	54.71
9/1/2019	37,501	16.75	10.23	4.74	337.89	54.02
10/1/2019	37,525	16.75	10.36	4.24	338.49	53.92
11/1/2019	37,747	15.48	10.48	3.85	340.04	52.09
12/1/2019	37,940	14.53	10.58	3.71	340.08	50.34
1/1/2020	36,948	14.42	10.71	3.55	340.53	50.34
2/1/2020	37,639	14.30	10.88	3.39	340.98	50.34
3/1/2020	37,048	13.52	10.92	3.35	345.29	50.60
4/1/2020	37,790	12.73	12.56	3.35	346.87	50.32
5/1/2020	37,845	11.93	12.68	3.35	349.64	50.06
6/1/2020	38,062	11.93	12.68	3.35	349.64	50.06
7/1/2020	38,610	11.93	12.68	3.35	349.64	50.06
8/1/2020	39,298	11.93	12.68	3.39	349.64	50.06
9/1/2020	39,435	11.93	12.96	3.40	349.64	50.32
10/1/2020	39,717	12.81	13.16	3.40	353.09	50.77
11/1/2020	40,153	12.81	13.16	3.41	357.84	50.77
12/1/2020	40,139	12.81	13.16	3.43	360.57	50.68
Low Estimate		**(5.03%)**	**(1.17%)**	**(29.35%)**	**2.44%**	**(9.72%)**
High Estimate		**4.80%**	**12.16%**	**(7.48%)**	**4.43%**	**(4.41%)**
Selected Trend		**1.00%**	**3.00%**	**0.50%**	**2.50%**	**1.00%**

Appendix 6: Covered Services

State of Michigan, Department of Health and Human Services
MI Health Link CY 2022 Capitation Rate Development
List of Covered Services

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

*Must meet level of care requirements

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