

# Calendar Year 2025 MI Health Link Medicaid Capitation Rate Certification

January 1, 2025 through December 31, 2025

State of Michigan Department of Health and Human Services

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## Introduction & Executive Summary

### BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of Michigan, Department of Health and Human Services (MDHHS) to provide actuarial and consulting services related to the development of actuarially sound capitation rates for the MI Health Link program to be effective January 1, 2025. The rates being certified as actuarially sound are to be effective from January 1, 2025 and remain in effect through December 31, 2025. MI Health Link is Michigan's demonstration managed care program for the dual eligible (Medicare-Medicaid) population.

This letter provides documentation for the development of the actuarially sound capitation rates for calendar year CY 2025. 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 2024-2025 Medicaid Managed Care Rate Development Guide, released by the Center for Medicare and Medicaid Services in January 2024 (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 C.F.R. § 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, 2025 through December 31, 2025. The capitation rates covered under this certification are documented in Appendix 3. 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 2024, the most recently certified capitation rates. Please note that the rates illustrated in Table 1 include amounts associated with the Insurance Provider Assessment (IPA) and Quality Assurance Supplement Payments (QAS), which will be paid on a retrospective basis. The estimated amounts for these items are documented in Appendix 3 with discussion of those amounts noted later in this report.

**TABLE 1: COMPARISON WITH CY2024 RATES (PMPM RATES)**

<b>RATE CELL</b>	<b>AVERAGE MONTHLY ENROLLMENT</b>	<b>CY 2024 Q4 RATES</b>	<b>CY 2025 RATES</b>	<b>% CHANGE</b>
<b>Nursing Facility – Subtier A</b>				
Over Age 65	1,740	\$ 7,899.45	\$ 8,300.68	5.1%
Under Age 65	270	7,245.83	7,454.54	2.9%
<b>Nursing Facility – Subtier B</b>				
Over Age 65	240	\$ 13,279.05	\$ 13,702.18	3.2%
Under Age 65	15	12,927.48	14,074.11	8.9%
<b>Nursing Facility LOC-Waiver</b>				
Over Age 65	1,185	\$ 2,393.23	\$ 2,789.52	16.6%
Under Age 65	1,035	2,522.96	2,982.21	18.2%
<b>Community Well</b>				
Over Age 65	15,555	\$ 393.39	\$ 483.30	22.9%
Under Age 65	13,020	372.27	446.45	19.9%
<b>Composite</b>	<b>33,060</b>	<b>\$1,073.67</b>	<b>\$1,200.19</b>	<b>11.8%</b>

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 2025.
3. Ultimate Nursing Facility rates are subject to end of year reconciliations that are unknown at the time of payment.

The projected CY 2025 enrollment estimates were developed based off July 2024 enrollment in the MI Health Link program.

**FISCAL IMPACT ESTIMATE**

The estimated fiscal impact of the CY 2025 MI Health Link rate changes documented in this report represents a \$50.2 million increase to aggregate expenditures. This amount is on a state and federal expenditure basis using the projected monthly enrollment for CY 2025 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 2025 capitation rates illustrated in Table 1. The federal expenditures illustrated in Table 2 are based on a combination of the Federal Fiscal Year (FFY) 2025 and FFY 2026 FMAPs of 65.13% and 65.30%.

**TABLE 2: COMPARISON WITH CY 2024 RATES (\$ MILLIONS)**

<b>POPULATION</b>	<b>AGGREGATE EXPENDITURES AT CY 2024 Q4 RATES</b>	<b>AGGREGATE EXPENDITURES AT CY 2025 RATES</b>	<b>EXPENDITURE CHANGE</b>
Nursing Facility-Subtier A	\$ 188.4	\$ 197.5	\$ 9.1
Nursing Facility-Subtier B	40.6	42.0	1.4
NFLOC – Waiver	65.4	76.7	11.3
Community Well	131.6	160.0	28.4
<b>Total MI Health Link</b>	<b>\$ 425.9</b>	<b>\$ 476.1</b>	<b>\$ 50.2</b>
Total Federal	269.7	302.4	32.7
Total State	156.2	173.7	17.5

Notes:

1. Annualized expenditures were developed with projected CY 2025 enrollment.
2. State expenditures based on a combination of the Federal Fiscal Years (FFY) 2025 and 2026 FMAPs of 65.13% and 65.30% to get 65.17%. 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. Ultimate payments made to Nursing Facilities are subject to end of year reconciliations that are unknown at the time of payment.

## Section I. Medicaid managed care rates

### 1. General information

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

The capitation rates provided under this certification are “actuarially sound” for purposes of 42 C.F.R. § 438.4(a), according to the following criteria:

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

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 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 2025 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 C.F.R. § 438.4(a), the term “actuarially sound” will be defined as in ASOP 49:

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

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, 2025 through December 31, 2025.

### 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 2025 managed care program rating period.

#### (b) Certified capitation rates for each rate cell

The certified capitation rates by rate cell are illustrated in Appendix 3. The rates within this report represent the capitation rates prior to application of the area factors, which are additionally illustrated in Appendix 3. 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 2025 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 10, which coincides with calendar year 2025. Demonstration Year 1 comprised of the partial year 2015 and the complete calendar year 2016 time periods with each subsequent calendar year representing another demonstration year.

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

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

The program pays secondary to Medicare for Medicare covered services.

Table 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, 2025 through December 31, 2025.

**(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 for comparison purposes in establishing 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
- Certain delivery system and provider payment initiatives

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

#### (vi) Retroactive adjustment to capitation rates

This rate certification report does not include a retroactive adjustment to the CY 2025 capitation rates.

### 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 2025 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 C.F.R. § 438.8, of at least 85% for the rate year.

## viii. Capitation Rate Ranges

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

## 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 2025 rating periods.

## 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 2025 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 3.

## xi. Rate certification for effective time periods

This actuarial certification is effective for the one-year rating period January 1, 2025 through December 31, 2025.

## 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 (DCW) experienced increased shortage of availability to provide the covered services. Since CY 2020, an increase in reimbursement through a DCW wage increase was appropriated to these providers to help address demand. The increased reimbursement level was continued to be incorporated for the CY 2025 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. Further, no explicit acuity adjustments were made to account for the PHE unwinding.

## 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 2025 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 capitation rates were developed in a manner consistent with 42 CFR 438.4(b)(1), including that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and that these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs.

### vii. Different FMAP

All populations receive the regular state FFY 2025 FMAP of 65.13% for nine months and the regular FFY 2026 FMAPs of 65.30% for the remaining three months.

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

The previous rate certification applied to the CY 2024 capitation rates with amended rates effective as of October 1, 2024. A comparison to the October to December 2024 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.

### x. COVID-19 Approach

#### (a) Data used

For the base data summaries, calendar year 2023 experience was utilized and summarized in Appendix 2.. As previously noted, we did not make any specific adjustments for the PHE caused by COVID-19 outside of the DCW wage adjustment that is continuing into CY 2025. The CY 2023 data represents the most appropriate source of information for rate development when considering the impact the PHE may have had on the MI Health Link program.

#### (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 starting with the CY 2020 rating period. We have continued to include the higher reimbursement as part of the CY 2025 capitation rate development. CY 2025 enrollment was projected past on post-PHE enrollment.

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

There are no COVID-19 related costs included in the capitation rates for CY 2025. Costs associated with COVID-19 testing, vaccine administration, beneficiary vaccine incentives, and other treatments are not covered under the MHL program because they are funded completely by Medicare

**(d) 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 2023 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 2025 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 2025 MI Health Link capitation rate development:

- Encounter data for the MI Health Link population as submitted by the ICOs for January 1, 2023 through December 31, 2023 (base data year) and paid through September 2024
- Managed care enrollment data for January 1, 2023 through December 31, 2023
- 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 2025
- Additional gross adjustment expenditure information outside the MMIS claims system
- Summary of known policy and program changes through calendar year 2025 (including changes to fee schedules and other payment rates)
- Monthly enrollment for the MI Health Link program
- Information reported from DCW providers from the CY 2025 MHL DCW Provider Survey

Appendix 2 illustrates the encounter base data summaries that provide the foundation for the calendar year 2025 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 2023. The encounter data used in our rate development process reflects adjudicated data through September 2024.

For the purposes of trend development and analyzing historical experience, we also reviewed encounter and enrollment experience dating back to state fiscal year 2021. 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.

**(v) Exceptions**

No exception to base data requirements has been requested by the state or granted by CMS due to the COVID-19 public health emergency.

**(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.

**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 2023 encounter data used in the development of the rates includes claims adjudicated and submitted to MDHHS through September 2024. Minor completion factors were applied to the CY 2023 base data.

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, 2025, 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 2023. 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**

Review of the encounter data in comparison to ICO-submitted EQI reports showed a discrepancy in one ICO's reported HCBS expenditures. A minor adjustment was applied as part of the completion adjustment to align with the EQI reports. We have not identified any other material concerns with the quality or availability of the encounter data. The only general 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 2023 base experience period. As such, expenditure data for populations enrolled in FFS during CY 2023 is not reflected in the base experience cost models used to develop the capitation rates.

**(ii) Use of managed care encounter data**

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

**(d) Reliance on a data book**

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

**iii. Data adjustments**

Capitation rates were developed from historical calendar year 2023 encounter data, paid through September 2024. 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.

As described in the previous data validation section, the encounter data is compared to the EQI health plan reported information. Minor adjustments to the base experience were incorporated to better align the base data with the plan reported amounts.

**(b) Completion adjustment**

The capitation rates are based on calendar year 2023 experience. Encounter data reflects claims paid and submitted to MDHHS through September 30, 2024 and includes nine 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 2025 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.

***DCW Wage Increase***

Reflected in the CY 2023 base data, expenses reported for DCW services included the increased hourly rates of \$2.64 per hour for hazard pay in response to the COVID-19 pandemic. Effective for the CY 2025 rating period, this adjustment was increased to \$3.84 per hour, which includes additional allocation to cover employer related costs. Please note that this is being referred to as a wage increase and is no longer a hazard pay adjustment during the PHE. Appendix 2 documents the initial adjustment to remove amounts reflected in the base data. Appendix 3 documents the subsequent adjustment to add funding back in at the higher hourly rate and allowing additional funding for indirect and overtime. The total amount of funding included in the capitation rates for the DCW wage increase for the CY 2025 rating period is approximately \$38.8 million.

## **Dental Adjustment**

Effective April 1, 2023, MDHHS implemented policy changes to redesign the adult dental services. These changes included increased reimbursement rates for providers, improved access and provider participation, reduced administrative burdens for providers, and expanding the benefit package to ensure robust coverage across Medicaid-covered populations. The CY 2025 capitation rates have been adjusted to include an additional \$3.3 million to fund the cost of providing coverage for these expanded services. A review of the MI Health Link encounter data indicates that the current reimbursement level is at or above the proposed fee schedule increase. Therefore, the dental adjustment is limited to the expanded services and has been documented in the cost models in Appendix 2.

## **Minimum Wage and Earned Sick Time**

On February 21, 2025, two laws went into effect in Michigan:

- The state increased the minimum hourly wage rate from \$10.33 per hour to \$12.48<sup>1</sup>
- Michigan Earned Sick Time Act (ESTA)<sup>2</sup> required employers to provide all eligible non-exempt employees with an accrual of one hour of sick time per thirty hours worked up to a specified limit that will roll over to the following year.

In the first quarter of calendar year 2025, MDHHS requested us to conduct a survey to collect information regarding the impact both state law changes would have on providers relative to the current compensation practices. It is important to note the interaction of the minimum wage and the historical direct care worker (DCW) wage increase policy. In SFY 2025, the capitation rates include a wage increase of \$3.40 (or \$3.84 with employer related expenditures) per hour for DCW services. In this survey, we included the following instructions based on our conversations with MDHHS:

*The Minimum Wage Increase worksheet captures the effect of Michigan's minimum wage increase across your organization. The minimum wage update is effective February 21, 2025, with yearly increases thereafter. The wages reported on this tab should be the amount paid to the worker, or the worker's regular wage and the \$3.40 per hour direct care work base wage increase and otherwise consistent with Provider L Letter 24-59.*

We collected and analyzed the provider survey data to support an estimated impact of both state law changes. Based on this analysis, we estimated a \$13.4 million impact due to the minimum wage and \$3.4 million impact due to the ESTA for the February 1, 2025, to December 31, 2025 time period (i.e., an 11 month impact).

At this time, there is no adjustment included for the minimum wage or ESTA in this rate certification while the Michigan State Legislature considers a bill to provide the supplemental budget to fund the impact of these state law changes and MDHHS current policies. Given there is insufficient funding to support both the state law changes and MDHHS current DCW policies, MDHHS has indicated they will adjust their current DCW policies to be budget neutral considering both state law changes effective February 1, 2025 if the supplemental is not approved. We will reevaluate the capitation rates before the end of the fiscal year and make appropriate adjustments based on policy or legislative/budget developments that deviate from our budget neutral assumption.

### **(e) Exclusion of payments or services from the data**

No specific payments were excluded from the rate development.

<sup>1</sup> <https://www.legislature.mi.gov/documents/2025-2026/publicact/htm/2025-PA-0001.htm>

<sup>2</sup> <https://legislature.mi.gov/documents/2025-2026/publicact/pdf/2025-PA-0002.pdf>

### 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 2023 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 2023 experience in Appendix 2.

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 2023 and paid through September 2024. 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, 2023) to the midpoint of the CY 2025 rating period (July 1, 2025). We have included one-time specific adjustments to the Inpatient Hospital (approximately 3.0% increase) and Professional (approximately 0.25% 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 2025. These represented an increase to \$1,676 for the Part A deductible and to \$257 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 4.

### ***Step 3: Adjust for additional payments and reimbursement changes***

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 3.
- **Direct-Care Worker (DCW) adjustment** MDHHS increased reimbursement for DCW services to \$3.84 per hour effective for the CY 2025 rating period. 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 2025 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 similar administrative costs included in the MI Choice managed care waiver program.

In Appendix 3, we increase the capitation rate by a rate cell specific QAS PMPM amount to illustrate the fully loaded rate. The QAS adjustment was developed by weighting actual CY 2025 QAS per diem rates by facility multiplied by the projected nursing home utilization for each rate cell from Appendix 2. 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 3, 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. We have not identified a need to regionally adjust rates for the Subtier B or Waiver tiers and have noted these as 1.0 in the table below.

The following table documents the developed regional adjustment factors by demonstration region and population. Separate regional adjustments were not developed for Over/Under 65 rate cells.

**TABLE 4: REGIONAL ADJUSTMENT FACTORS (ON ICO EFFECTIVE RATE)**

DEMONSTRATION REGION	NURSING FACILITY - SUBTIER A	NURSING FACILITY - SUBTIER B	WAIVER (NF LEVEL OF CARE)	COMMUNITY WELL
Region 1	0.9595	1.0000	1.0000	0.9275
Region 4	1.0059	1.0000	1.0000	0.9658
Region 7	1.0012	1.0000	1.0000	0.9769
Region 9	1.0194	1.0000	1.0000	1.0542

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

The primary change from the prior year rate-setting is re-basing the capitation rate development with CY 2023 base experience. All material assumptions are documented in this rate certification report and the overall methodology utilized to develop the capitation rates is consistent with the prior rate-setting analysis.

**(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 2023) to the CY 2025 rating period of this certification. We evaluated prospective trend rates using historical experience for the Michigan Medicaid managed care program, as well as external data sources.

**(a) Required elements**

**(i) Data**

The primary source of data used in the development of historical encounter trends was SFY 2021 through 2023 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 4 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 Nursing Facility fee schedule per diem rate.

## **(b) Benefit cost trend components**

Separate utilization and cost per unit trend components were developed and illustrated in Appendix 4 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.

**(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 2024 rating period.

**(a) Change to covered benefits**

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

**(b) Recoveries of overpayments**

To the best of our knowledge, all information related to any payment recoveries 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 10 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 2025 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 10 of the MI Health Link program are consistent with those from Demonstration Year 9. As of the timing of this report, the calculations of the withhold for Demonstration Year 9 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 2025 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable based on the amounts included in the development of the capitation rates.

**(b) Capitation payments minus withhold**

The CY 2025 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable, and the capitation rates are certified as actuarially sound.

**C. RISK SHARING MECHANISMS****i. Rate Development Standards**

This section provides documentation of the risk-sharing mechanisms in the 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%. Starting with Demonstration Year 8, the target MLR was increased to 88%.

***Financial consequences***

If an ICO has an MLR below the target of 88%, the ICO will remit 50% of the difference between its MLR and 88%. 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 1.5% 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).
- HCBS Direct Care Worker premium pay (DCW)

**(a) Description of Managed Care Plan Requirement**

QAS: 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.

DCW: MDHHS requires the ICOs to participate in a state directed initiative to reimburse direct care workers at a higher hourly rate to ensure access to Medicaid beneficiaries.

**(b) Written Approval**

MDHHS has submitted and awaiting written approval for the QAS state directed payment delivery systems with the pre-print control name of MI\_Fee\_NF\_Renewal\_20250101-20251231.

MDHHS is awaiting written approval for the DCW state directed payment delivery systems for CY 2025.

**(c) Actuarial Standards**

Payments for the QAS and DCW 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 QAS payments within the various directed payment initiatives are done so on a retrospective basis to the ICOs. The DCW payments are included in the development of the monthly base capitation rates paid to the managed care health plans.

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

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

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

PMPM estimates related to the state directed payments are included in Appendix 3 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_Renewal_20250101-20251231	Uniform dollar increase	See description below.	Separate payment term
MI_Fee_HCBS2_Renewal_20250101-20251231 (pending approval)	Uniform dollar increase	See description below.	Rate Adjustment

- **QAS.** Uniform dollar increase for nursing facilities for the rating period covering January 1, 2025 through December 31, 2025
- **Direct care worker premium program.** The Direct Care Worker (DCW) program was developed to ensure continued access by Medicaid beneficiaries to home and community-based services. The program was introduced as a hazard pay in response to the COVID-19 pandemic but has continued post-PHE due to direct care worker shortages. Effective October 2021, this program was transitioned to a state directed payment.

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

The DCW payment arrangements will be incorporated through a rate adjustment applied in the development of the monthly base capitation rates paid to plans.

CONTROL NAME	RATE CELLS AFFECTED	AGGREGATE AMOUNT	PMPM MAGNITUDE	PREPRINT CONSISTENCY CONFIRMATION
MI_Fee_HCBS2_Renewal_20250101-20251231 (pending approval)	All rate cells	\$38.8 million	Listed by rate cell in Appendix 3	This state directed payment is consistent with the preprint.

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

The QAS 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_Renewal_20250101-20251231	\$34.1 million	Listed by rate cell in Appendix 3	This state directed payment is consistent with the preprint.	MDHHS will provide required documentation following CY 2025 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 2025 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 2025 in Appendix 3 based on a complete 12 months' worth of payments over the calendar year.

The estimated IPA load of \$30.53 reflected in Appendix 3 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 2024 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 2025 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 \$91.58. The Nursing Facility Level of Care tier included a PMPM amount of \$183.15 consistent with the admin/operations expenses included in the SFY 2025 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

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.

### 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.

## 7. Acuity Adjustments

This section provides information on any acuity adjustments included in the rate development.

### A. RATE DEVELOPMENT STANDARDS

#### i. Overview

No acuity adjustments were applied in the development of the CY 2025 MI Health Link capitation rates.

### B. APPROPRIATE DOCUMENTATION

#### i. Description

##### (a) Uncertainty

Not applicable.

##### (b) Acuity adjustment model

Not applicable.

##### (c) Data utilized

Not applicable.

##### (d) Potential interactions

Not applicable.

##### (e) Frequency

Not applicable.

##### (f) Application to capitation rates

Not applicable.

##### (g) Documentation

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 2025 did not change from the 2015-2024 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 Health Link program as these are not new adult groups.

## Limitations

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

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

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 actuarially 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, 2023 through December 31, 2023 (base data year) and paid through September 2024
- Additional gross adjustment expenditure information outside the MMIS claims system
- Summary of policy and program changes through state fiscal year 2025 (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 2025 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 retained 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, 2025. 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 C.F.R. § 438.4(a), according to the following criteria:

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

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

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

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of Michigan. The "actuarially sound" capitation rates that are associated with this certification are effective for calendar year 2025.

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.



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

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June 30, 2025  
Date

## Appendix 2: CY 2025 Cost Models

## Appendix 3: CY 2025 Capitation Rate Development

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## Appendix 4: Trend Analysis

## Appendix 5: Covered Services



Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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