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November 10, 2014

Mr. Nathan Moracco
Assistant Commissioner for Health Care
Minnesota Department of Human Services
540 Cedar Street
Elmer L. Anderson Human Services Building
St. Paul, MN 55155-3854

[Sent via email: nathan.moracco@state.mn.us]

Re: CY 2015 Rate Development for Basic Care, EW Add-on, and NF Add-on for MSHO and MSC+

Dear Mr. Moracco:

The attached report describes the development of the County Based Purchasing (CBP) and non-CBP Basic Care, Elderly Waiver (EW) Add-on, and Nursing Facility (NF) Add-on rates for the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) programs for the calendar year (CY) 2015 contract period.

This report reflects wording changes to the rate memo dated October 1, 2014 for the "Moving Home Minnesota" rates; however, no changes to the 2015 rates were made from those presented in that memo.

❖ ❖ ❖ ❖ ❖

Please let us know if you have any questions.

Sincerely,

Eric Goetsch

Eric P. Goetsch, FSA, MAAA
Principal and Consulting Actuary

EPG/kal

Attachment

Basic Care, Elderly Waiver Add-on, and Nursing Facility Add-on Rate Development for MSHO and MSC+ Calendar Year 2015

Prepared for:
Minnesota Department of Human Services

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I. EXECUTIVE SUMMARY

This report documents the development of the County Based Purchasing (CBP) and non-CBP Basic Care, Elderly Waiver (EW) Add-on, and Nursing Facility (NF) Add-on rates for the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) programs for the calendar year (CY) 2015 contract period. The report assumes the reader is familiar with the basic aspects of the MSHO and MSC+ programs, the population groups covered under the programs, the Minnesota Medicaid program, and managed care rating principles.

This report contains:

- A description of the information used to develop the CY 2015 Basic Care base rates and rate cell relativities, which will be used to determine the 2015 Basic Care capitation payments. The 2015 Basic Care rates were developed from 2013 health plan experience.
- A description of the information used to develop the CY 2015 EW Add-on base rates and risk factor weights, which will be used to determine the 2015 EW Add-on capitation payments. The 2015 EW Add-on rates were developed from 2013 health plan experience.
- A description of the information used to develop the CY 2015 NF Add-on base rates and rate cell relativities, which will be used to determine the 2015 NF Add-on capitation payments. The 2015 NF Add-on rates were developed from 2011 through 2013 health plan experience.

The structure of this report is intended to provide transparency of all the components of the CY 2015 Basic Care, EW Add-on, and NF Add-on rate developments.

Overall, using the August 2014 membership mix by rate cell, **the CY 2015 MSHO and MSC+ rates provide an estimated aggregate per member per month (PMPM) increase of 1.9% from the CY 2014 rates amended effective July 1, 2014**. The components of this increase are as follows:

- Using the August 2014 membership mix by rate cell, the **CY 2015 Basic Care base rates provide an estimated aggregate PMPM decrease of 0.5% from the 2014 Basic Care base rates amended effective July 1, 2014** and contribute -0.3% to the overall 1.9% increase in MSHO / MSC+ rates from 2014 to 2015. This increase reflects community Basic Care rates increasing 0.4% in aggregate and the institutional Basic Care rates decreasing 9.0% in aggregate. In addition, this increase reflects Metro Basic Care rates decreasing 5.8% in aggregate and non-Metro Basic Care rates increasing 9.5% in aggregate.

  Due to the demographic mix differences among plans, the increase or decrease in Basic Care rates PMPM from CY 2014 to CY 2015 will vary by plan. The overall Basic Care rate change of -0.5% consists of the following approximate multiplicative components:

  – 4.5% decrease due to the starting 2013 experience, as adjusted for benefit changes, being lower than projected in the prior year's rate development
  – 3.2% increase due to average Basic Care trend rates from 2014 to 2015
  – 2.5% increase due to the change in the projected impact of 2014 legislative changes and trend from the prior year's rate development
  – 0.5% increase due to the projected impact of 2015 legislative changes
  – 1.1% increase due to the reallocation of projected administrative costs between the Basic Care and EW rates
  – 3.1% decrease due to the rebasing of rate cell relativities for CY 2015, including normalizing them to 1.000 using the CY 2013 membership mix by rate cell

- Using the August 2014 membership mix by rate cell, **CY 2015 EW Add-on rates provide an estimated aggregate PMPM increase of 3.7% from the 2014 EW Add-on rates amended effective July 1, 2014** and contribute 1.4% to the overall 1.9% increase in MSHO / MSC+ rates from 2014 to 2015. This increase reflects Metro EW Add-on rates increasing 1.4% in aggregate and non-Metro EW Add-on rates increasing 5.9% in aggregate.

  Due to the demographic mix differences among plans, the increase or decrease in EW Add-on rates PMPM from CY 2014 to CY 2015 will vary by plan. The overall EW Add-on rate change of 3.7% consists of the following approximate multiplicative components:

  – 1.3% decrease due to the starting 2013 experience, as adjusted for benefit changes, being higher than projected in the prior year's rate development
  – 3.8% increase due to assumed trend from 2014 to 2015
  – 2.2% increase due to the change in the projected impact of 2014 legislative changes and trend from the prior year's rate development
  – 0.5% increase due to the projected impact of 2015 legislative changes
  – 3.2% decrease due to the reallocation of projected administrative costs between the Basic Care and EW rates
  – 0.8% increase due to the rebasing of risk factor weights for CY 2015, including normalizing them to 1.000 using the CY 2013 membership mix by risk factor group
  – 1.1% increase due to the nursing facility level of care requirement change's impact on the EW risk factors

- Using the August 2014 membership mix by rate cell, **CY 2015 NF Add-on rates provide an estimated aggregate PMPM increase of 13.8% from the 2014 NF Add-on rates amended effective July 1, 2014** and contribute 0.7% to the overall 1.9% increase in MSHO / MSC+ rates from 2014 to 2015. This increase reflects Metro NF Add-on rates decreasing 0.1% in aggregate and non-Metro NF Add-on rates increasing 25.9% in aggregate.

  Due to the demographic mix differences among plans, the increase or decrease in NF Add-on rates PMPM from CY 2014 to CY 2015 will vary by plan. The overall NF Add-on rate change of 13.8% consists of the following approximate multiplicative components:

  – 6.0% increase due to the initial rate
  – 1.9% increase due to the tail rate
  – 0.4% increase due to the elimination of the enrollment adjustment
  – 5.0% increase due to the rebasing of rate cell relativities for CY 2015, including normalizing them to 1.000 using the CY 2013 membership mix by rate cell

The impact of the potential implementation of ICD-10 was not reflected in the 2015 rate development. DHS's intention is to implement ICD-10 on a budget neutral basis should the effective date occur in 2015.

CAVEATS AND LIMITATIONS

This report is intended for use by the Minnesota Department of Human Services (DHS) as they negotiate a contract with the participating health plans to provide Basic Care, EW, and NF services to the MSHO and MSC+ population in CY 2015. The information contained in this report may not be suitable for other purposes or audiences. Our understanding is that DHS intends to distribute this report to the health plans participating in the MSHO and MSC+ programs, as well as to CMS to document the rate development.

Differences between the capitation rates and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected. These capitation rates may not be appropriate for all health plans. Any health plan considering participating in MSHO and MSC+ should consider their unique circumstances before deciding to contract under these rates.

We relied on data and information supplied to us by the health plans and DHS. While we did review the information for reasonableness, we did not audit or attempt any independent verification of such data. If this data is incomplete or inaccurate, then our conclusions will be incomplete or inaccurate.

This report was prepared specifically for DHS and the development of CY 2015 Basic Care, EW Add-on, and NF Add-on rates for the MSHO and MSC+ programs and may not be appropriate for other purposes. This report should only be viewed in its entirety. While we understand that the work product will be shared with the health plans, Milliman does not intend to benefit any third party and assumes no duty or liability to other parties who receive this work.

This report is a summary of the CY 2015 Basic Care, EW Add-on, and NF Add-on rate development and does not address all of the issues detailed in the CMS checklist. This report also does not contain an actuarial certification for the premium rates. This information will be provided in a separate report at a later date.

I, Eric P. Goetsch, FSA, am an Actuary for Milliman, a member of the American Academy of Actuaries and meet the Qualification Standards of the Academy to render the actuarial opinions contained herein. To the best of my knowledge and belief, this letter is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This letter and its exhibits are subject to the terms and conditions of the contract between Milliman and the State of Minnesota #67920 effective through June 30, 2015.

II. DEVELOPMENT OF CY 2015 SENIOR BASIC CARE RATES

CALENDAR YEAR 2013 HEALTH PLAN EXPERIENCE

The CY 2015 Basic Care rates are based on aggregate CY 2013 health plan experience for incurred claim costs and administrative costs. The CY 2013 health plan experience for Basic Care was separated into community and institutionalized subgroups to reflect the differences in mix of services by population. The rate development uses the experience provided by the health plans for members enrolled in the MSHO and MSC+ programs for their State Plan services (i.e., reported claim costs have been adjusted to exclude non-State Plan services as reported by the plans) and administrative expenses. Administrative expenses were adjusted to exclude non-allowable expenses, the 1.0% premium tax, and the 0.6% surcharge. The 2015 revenue associated with the premium tax and HMO surcharge are explicitly added to rates at the end of the rate development process, as described later in this report.

Though we did not perform a detailed, systematic review of the experience reported by the health plans, we compared the Seniors experience as reported and used for the rate development to Minnesota statutory filings and Medicare Advantage bid forms from the plans and found them to be consistent. Therefore, no adjustments to the base experience were required.

Table 1 contains the statewide aggregate 2013 PMPM health plan experience used for the community and institutionalized subgroups. Table 2 contains the category-of-service detail underlying the 2013 Basic Care experience for each subgroup.

Table 1
2015 MSHO and MSC+ Rate Development
Basic Care Services and Administrative Costs
Calendar Year 2013 Aggregate Health Plan Experience PMPM

	Cost Experience PMPM		
Component	**Community**	**Institutionalized**	**Composite**
Basic Care Services	$765.51	$250.67	$638.46
Administrative Costs	52.17	17.08	43.51
Total	**$817.68**	**$267.75**	**$681.97**

DEVELOPMENT OF CALENDAR YEAR 2015 BASIC CARE BASE RATES

The following adjustments were made to the aggregate CY 2013 Basic Care health plan experience to develop the CY 2015 Basic Care rates.

Trend

The annual trend rate for claim costs provides for projected changes in utilization, provider reimbursement rates, and mix of services, assuming no unusual changes in provider networks. The annual PMPM trends by service category are provided in Table 2 of this report.

Utilization Trend for Inpatient, Outpatient, and Physician

- **Inpatient** – Utilization trends are based on internal Milliman research. These are consistent with the trends used in Milliman's 2015 Medicare Advantage bid development and reflect the utilization patterns of a standard Medicare population. Annual utilization trend is set to -2.0%.

- **Outpatient** – Utilization trends are based on internal Milliman research. These are consistent with the trends used in Milliman's 2015 Medicare Advantage bid development and reflect the utilization patterns of a standard Medicare population. Annual outpatient utilization trend is set to 2.5%.

- **Physician and All Other** – Utilization trends are based on internal Milliman research. These are consistent with the trends used in Milliman's 2015 Medicare Advantage bid development and reflect the utilization patterns of a standard Medicare population. Annual physician utilization trend is set to 1.0%.

Charge Trend for Inpatient, Outpatient, and Physician

- **Inpatient** – We set the annual unit cost trend equal to 1.0% based on typical medical trends for inpatient unit costs. Milliman's internal Medicare research indicates some shift to higher cost services for an over 65 population, so we set annual mix trend at 0.5%, consistent with the trends used in Milliman's 2015 Medicare Advantage bid development. The resulting annual inpatient charge trend is 1.5%.

- **Outpatient** – According to DHS, outpatient, non-critical hospital rates are increased for Medicare changes. Critical access hospitals are small rural hospitals and increase with cost, but are a small percentage of total. Therefore, we set the annual unit cost at 2.0% which is consistent with Milliman's internal Medicare research. Milliman's internal Medicare research also indicates lower unit cost inpatient hospital admissions shifting to the outpatient setting, so we included a 1.0% mix trend consistent with the trends used in Milliman's 2015 Medicare Advantage bid development. The resulting annual outpatient charge trend is 3.0%.

- **Physician and All Other** – Physician costs are tied to the RBRVS fee schedule structure and the Minnesota conversion factor is not projected to change from 2013 to 2015; therefore, we assumed 0.0% unit cost trend for physician services. Milliman's internal Medicare research shows some shift to higher cost services for the standard Medicare population, so we included mix trends of 1.0%, consistent with the trends used in Milliman's 2015 Medicare Advantage bid development. The resulting annual physician and all other charge trend is 1.0%. We considered changes in the cost of Methadone Transportation services when determining this trend assumption.

Cost Trend for Other Services

- **Non-Medicare-Covered Drugs** – Non-Medicare-covered drug trends are based on an analysis of historical non-Medicare-covered drug costs as provided by the health plans. Annual non-Medicare-covered drug PMPM trend was set at 1.0%.

- **Part A Cost Sharing** – The trend rate for Part A cost sharing reflects Milliman's estimate of the trend in the Part A deductible. Annual Part A cost sharing PMPM trend was set at 2.7%.

- Medicare utilization and mix and Medicaid payment levels, based on internal Milliman research and are a blend of the total cost PMPM trend for outpatient and physician services. Annual Part B cost sharing PMPM trend was set at 3.2%.

- **Dental** – Medicaid payment rates for dental services are not expected to change materially from 2013 to 2015 and utilization rates are expected to increase slightly. Therefore, we applied a 1.0% annual dental PMPM trend.

- **Home Health** – Home health PMPM trends have been flat to negative over the last two years, so we assume no home health PMPM trend.

- **Personal Care Assistants** – Based on a review of personal care assistant trends over the last three years, we assumed a 5.0% annual PMPM trend.

- **Nursing Facility Relocation Targeted Case Management, Mental Health Targeted Case Management, and Administrative Expenses** – Trends for these costs are set consistent with inflation, as we do not expect utilization or mix to impact these costs. Annual nursing facility relocation targeted case management, mental health targeted case management, and administrative expense trends were set at 1.5%.

Table 2
2015 MSHO and MSC+ Rate Development
Basic Care Services
Annual Trend Assumptions from 2013 to 2015

	2013 Cost PMPM		Annual Trend Rate		2015 Cost PMPM	
Item	**Comm**	**Instit**	**Comm**	**Instit**	**Comm**	**Instit**
Drug Costs						
Medicare cost sharing	$0	$0	0.00%	0.00%	$0	$0
Non-Medicare-covered drugs	13.88	15.28	1.00%	1.00%	14.16	15.59
Part C Cost Sharing						
Medicare Part A cost sharing	33.42	30.41	2.70%	2.70%	35.25	32.07
Medicare Part B cost sharing	117.03	106.72	3.23%	3.23%	124.73	113.74
Other Medicaid-Covered Costs						
Hospital Inpatient	13.71	2.27	-0.50%	-0.50%	13.57	2.25
Hospital Outpatient	10.00	1.60	5.60%	5.60%	11.16	1.79
Physician	33.22	9.05	2.01%	2.01%	34.56	9.42
Dental	13.43	9.37	1.00%	1.00%	13.70	9.56
Home Health	65.01	1.74	0.00%	0.00%	65.01	1.74
Personal Care Assistants	345.02	3.05	5.00%	5.00%	380.38	3.36
NF Reloc. TCM and MH TCM	5.95	1.84	1.50%	1.50%	6.13	1.89
All other Non-Medicare	114.84	69.33	2.01%	2.01%	119.50	72.15
Total Medicaid-Covered Costs						
Total	$765.51	$250.67	3.38%	2.54%	$818.15	$263.56

The Table service categories are the same service categories used in the 2014 rate development. Table 3 contains a mapping of service categories from the 2015 rate development data request to the Table 2 categories.

Table 3
2015 MSHO and MSC+ Rate Development
Mapping of Service Categories from 2015 Rate Development Data Request to Table 2 Categories

2015 Rate Development Data Request Service Category	Table 2 Service Category
Inpatient	Hospital Inpatient
Inpatient Crossover	Medicare Part A cost sharing
Outpatient (Non-ER)	Hospital Outpatient
ER Outpatient	Hospital Outpatient
Outpatient Crossover	Medicare Part B cost sharing
Primary Care: Office Visit	Physician
Primary Care: Other than Office Visit	Physician
Specialty Care: Office Visit	Physician
Specialty Care: Other than Office Visit	Physician
Mental Health Professional	Physician
ER Physician	Physician
Dental	Dental
Pharmacy	Non-Medicare-covered drugs covered by Medicaid
Pharmacy Crossover	Non-Medicare-covered drugs covered by Medicaid
Mental Health/Substance Abuse Non-Facility	All other Non-Medicare services
Mental Health TCM	NF Relocation TCM and MH TCM
Non-MH TCM	NF Relocation TCM and MH TCM
Transportation	All other Non-Medicare services
Home Health	Home Health
Vision	All other Non-Medicare services
Family Planning	All other Non-Medicare services
Medical Supplies/DME/Prosthetics	All other Non-Medicare services
Specialized Therapy	All other Non-Medicare services
PCA	Personal Care Assistants
Health Care Home	Physician
Care Coordination (State Plan expenses only)	Physician
Elderly Waiver Services	Elderly Waiver Costs
Nursing Facility	NF Add on-Medicaid costs including Medicaid covered coinsurance
Other Medical	All other Non-Medicare services
Pharmacy Rebates	Prescription Drug Rebates
NF Relocation TCM and MH TCM	NF Relocation TCM and MH TCM

LEGISLATIVE ADJUSTMENTS

2013 Legislative and Benefit Adjustments

Rate Restoration for PCA, Home Health, and Home Care Nursing Services

Article 7, Section 51 reduced reimbursement rates for personal care services, home health services, and home care nursing services by 1.5% effective on July 1, 2011. The 2013 Minnesota Legislature reduced the rate reduction from 1.5% to 1% effective July 1, 2013 for continuing care providers unless otherwise noted. This rate change is referred to as the 0.5% rate restore.

The 2013 experience data reflects a 1.5% rate reduction for 1/1/2013 through 6/30/2013 and a 1.0% rate reduction for 7/1/2013 through 12/31/2013. The average impact reflected in the 2013 experience is 1.25% (6/12 * 0.015 + 6/12 * 0.01). The rate reduction required for the 2015 rating period is 1%, resulting in a 0.25% rate restore applied for the 2015 rate development. The aggregate factors applied to the community rates and the institutional rates for this adjustment are 1.0013 and 1.0000, respectively, based on the cost of personal care services, home health services, and home care nursing services as a percentage of total 2013 costs.

Capitation Ratable Reduction and Sunsetting of Fee Reductions

Based on Minnesota legislative statutes 256B.76 and 256B.766, effective September 1, 2011, FFS provider fee reductions for various providers were implemented, as outlined in Table 4. These fee reductions sunset on July 1, 2013.

Table 4
2015 MSHO and MSC+ Rate Development
Provider Fee Reductions
Effective September 1, 2011 – July 1, 2013
By Provider Type

Provider Type	Reduction
Outpatient Hospital	5%
Physician and Professional Services	3%
Basic Care Services	3%
Dental Services	3%

As the items are sunsetting in July 2013, a half year of the reinstated increases should be reflected in the 2015 rates. DHS' understanding is that the majority of health plans' non-inpatient fee schedules track closely over time to changes in the FFS fee schedules. Therefore, we are including these changes in the capitation rate development.

The aggregate factors applied to the community rates and the institutional rates for this adjustment are 1.0147 and 1.0144, respectively, based on the cost of these services as a percentage of total 2013 costs.

Inpatient Hospital Fee Sunsetting

Based on Minnesota legislative statute 256.969, the total payment for FFS admissions occurring on or after September 1, 2011, through October 31, 2014, made to hospitals for inpatient services before third-party liability and spend down, is reduced 10% from the current statutory rates. Facilities defined under subdivision 16, long-term hospitals as determined under the Medicare program, children's hospitals

whose patients are predominantly under 18 years of age, and payments under managed care are excluded.

DHS believes that plan inpatient reimbursement levels and structure vary significantly across plans. While reimbursement is generally established giving consideration to FFS rates, it does not tend to track along with changes in FFS reimbursement over time. Additionally, the reduction in inpatient hospital fees was an adjustment that was made after the base rate is calculated and, therefore, would not be included in any published hospital base rates that are tied to FFS. Therefore, no adjustment was made to the 2015 rates for this legislative change. Instead, we are including unit cost trend as consideration for increasing inpatient hospital contracting levels.

PCP Rate Increase Due to the Affordable Care Act

Section 1902 (a)(13) of the Affordable Care Act (ACA) requires Medicaid primary care providers (PCPs) to be paid at 100% of the Medicare fee schedule for specific evaluation and management (E&M) services from January 2013 through December 2014. The PCPs are defined as family medicine, general internal medicine, and pediatric medicine providers; other providers will get no increase to their payment. The specific E&M Healthcare Common Procedure Coding System (HCPCS) codes paid at the higher level are 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474 or their successors.

Although this item was effective 1/1/2013, the costs associated with enhanced PCP payments for these E&M services were not reflected in the 2013 financial summary submissions that were submitted to Milliman since a lump sum payment was made after 2013 for the enhanced PCP payments. Therefore, no adjustment was made to the 2015 rates to reflect these enhanced payments.

Mental Health Services: Expansion in Provider Provision

Based on Minnesota legislative statute 256B.0625, subdivision 42 new mental health providers are allowed to provide an existing service reimbursed under the current rate development effective July 1, 2013. DHS determined that this impact has no material net impact on managed care; therefore, no adjustment was made to the 2015 rates for this legislative change.

Mental Health Services: Expansion in Covered Consultants

Based on Minnesota legislative statute 256B.0625, subdivision 48, Psychologist and Advance Practice Registered Nurse (APRNs) certified in psychiatric mental health were added as covered consultants effective July 1, 2013. DHS determined that this impact has no material net impact on managed care; therefore, no adjustment was made to the 2015 rates for this legislative change.

Additional Preventive Dental

Minnesota legislative statutes 256B.0625, subdivision 9(e) made several changes to dental coverage for adults effective July 1, 2013, including:

- Coverage for up to four dental prophylaxis visits per year, in accordance with an appropriate individualized treatment plan.
- Oral or IV sedation when medically necessary.
- Behavior management for behavioral challenges.

- House calls or extended care facility calls for onsite delivery of covered services provided in certain institutional settings (defined as nursing facilities, skilled nursing facilities, boarding care homes, Institutions for Mental Diseases (IMDs), Intermediate Care Facilities for People with Developmental Disabilities (ICF / DDs), hospices, and hospital swing beds) when accompanied by another covered service. In addition, billing criteria was expanded to allow practitioners to bill individually for each resident seen on the same day rather than one visit per location per day.

The aggregate factors applied to the community rates and the institutional rates for this adjustment are 1.0013 and 1.0035, respectively, based on encounter data provided by DHS. These factors reflect that the second half of the 2013 base experience included costs for these services.

Family Planning Services

Based on statute 256B.674, rates paid to Community Health Clinics for family planning services were increased by 20% effective July 1, 2013. Due to the low utilization of family planning by the senior population, no adjustment was made for the 2015 rates for this legislative change.

2014 Legislative and Benefit Adjustments

Dental Services Rate Increase

Based on statute 256B.76, subdivision 2, payment rates for dental services will be increased 5% effective January 1, 2014. The aggregate factors applied to the community rates and the institutional rates for this adjustment are 1.0008 and 1.0025, respectively, based on the cost of dental services as a percentage of total 2013 costs.

Dental Managed Care Prior Authorization

Based on Minnesota legislative law chapter 291, article 9, section 1, and amendment to statue 256B.0625, subdivision 9, effective July 1, 2014, prior authorizations on dental house calls, behavioral management, and oral or IV sedation are prohibited.

We calculated the 2013 plan liability for dental procedure codes related to these services using the encounter data. Based on the relative magnitude of these costs, it was determined that these changes had no material impact on managed care capitation rates. Therefore, no adjustment was made to the 2015 rates for this legislative change.

Home and Community Based Services 1% Rate Increase Effective April 1, 2014

Based on Section 60 of Article 2: Contingent Reform 2020; Redesigning Home and Community-Based Services, reimbursement rates, grants, allocation, individual limits, and rate limits shall be increased by 1% for the rate period beginning April 1, 2014. A 1% increase for personal care services, home health services, and home care nursing payments was applied to the 2015 rates. Adjustment factors were calculated for the 2015 rate development based on service category mix of the 2013 experience for each population. The aggregate factors applied to the community rates and the institutional rates for this adjustment are 1.0054 and 1.0002, respectively, based on the cost of personal care services, home health services, and home care nursing services as a percentage of total 2013 costs.

Home and Community Based Services 5% Rate Increase Effective July 1, 2014

Based on the 2014 Session Laws of Minnesota, chapter 312, article 27 sections 71 and 75, the legislature authorized a 5.0% rate increase effective July 1, 2014 for continuing care providers. A 5% increase for personal care services, home health services, and home care nursing payments was applied to the 2015 rates. Adjustment factors were calculated for the 2015 rate development based on service category mix of the 2013 experience for each population. The aggregate factors applied to the community rates and the institutional rates for this adjustment are 1.0272 and 1.0010, respectively, based on the cost of personal care services, home health services, and home care nursing services as a percentage of total 2013 costs.

The adjustment for EW-related home and community based services is made in the EW section later in this report.

Vaccine Replacement and Changes

Vaccine coverage is changing for adults with vaccine replacements, vaccine administration rate changes, and vaccine exclusions effective January 1, 2014. This adjustment only applies to non-duals within the MSHO and MSC+ programs since Medicare covers the cost of vaccines for dual eligibles. Since non-duals are only approximately 4.0% of the total MSHO and MSC+ population, the impact of this legislative change would be minimal and, therefore, no adjustment was made to the 2015 rates for this legislative change.

DME Exemptions from the Payment Rate Established by Medicare

Medicaid rates for DME are linked by State law to Medicare rates. However, CMS approved new competitive bids in some metropolitan counties and zip codes for DME equipment which have lowered current Medicare rates. The legislature has approved a temporary extension of existing Medicaid rates for Medicaid DME items affected by this change. Therefore, we will not adjust 2015 rates and will wait to see what happens legislatively, amending rates in 2015 if necessary.

Decreases in FFS payments for DME, Prosthetics, and Orthotics

Based on Minnesota legislative statutes 256B.766, effective July 1, 2014, a 0.33% FFS payment reduction for DME / Prosthetics / Orthotics was implemented. This fee reduction sunsets on July 1, 2015.

Because the PMPM increases from this change were minimal, no adjustment was made to the 2015 rates for this legislative change.

FFS Inpatient Rebasing to APR-DRG

Effective November 1, 2014, FFS inpatient payments will be based on APR-DRG payments, except long term and critical access hospitals. Critical access hospitals will be paid on a cost-based methodology. The rebasing of rates associated with moving to the new grouper must be budget neutral. In addition, CMS began enforcing hospital specific DSH limits which may impact the rates at which high volume MA hospitals can be paid. Similar to the sunset of the 10% reduction in inpatient rates, DHS believes that plan inpatient reimbursement levels and structure vary significantly across plans. While reimbursement is generally established giving consideration to FFS rates, it does not tend to track along with changes in FFS reimbursement over time. In addition, this would only apply for non-dual experience and non-duals are only approximately 4.0% of the total MSHO and MSC+ population. Therefore, no adjustment was made to the 2015 rates for this legislative change.

Community First Service and Supports Program Integrity and Policy Changes

Based on Minnesota legislative statute 256B.85, CFSS is replacing PCA services as of July 1, 2014 or upon federal approval. Because of the uncertainty of the effective date and the magnitude of the impact, an adjustment for this change may be reconsidered at a later date.

2015 Legislative and Benefit Adjustments

Increased Community PCA Utilization Due to the Change of NF Level of Care (LOC) Requirement

Based on statutes 2012, section 256B.0911, effective January 1, 2015, the determination of the need for NF level of care will change such that a percentage of the community EW individuals will lose their EW eligibility. DHS estimated this percentage to be approximately 13%. We estimated these individuals will most likely increase their utilization of PCA services as a result of losing EW eligibility, and we assumed an increase in utilization of 15% based on an analysis of the PCA costs for the EW population versus the non-EW population.

This change will take effect over the course of the 2015. We estimated that, on average, the 13% of the population that will lose their EW eligibility will do so for half of the year. With the PCA costs for the community EW population losing its eligibility equal to $362 PMPM, PCA costs PMPM for this population would increase $3.53 ($3.53 = $362 x 15% x (13% x ½). This increase in PCA for the population losing EW eligibility is blended into the overall community rate, resulting in rates being increased by a factor of 1.0024. Please note that this increase also reflects that a similar percentage of new enrollees who would have previously been eligible for EW services will not be eligible due to the new NF level of care requirements.

Chiropractic Services

As of April 7, 2014 and pursuant to Minnesota legislative statutes 256B.0625, sub. 8e, plans are required to allow members up to 24 medically necessary chiropractic visits per year unless prior authorization of a greater number of visits is obtained.

To determine the impact of this change, we analyzed those people in the 2013 encounter data reaching the 12 chiropractic visit limit and assumed that they would use the average number of visits for those over 12 visits. Because the PMPM increases from this change were minimal, no adjustment was made to the 2015 rates for this legislative change.

Adult Rehabilitative Mental Health Service

Based on statute 256B.761, coverage policy and rates are being restructured for Rehabilitative Mental Health Services (ARMHS), effective January 1, 2015. We assume that this benefit will only apply to adults ages 16 through 50; therefore, no adjustment was made to the 2015 rates for this legislative change.

Direct Payment of Claims to FQHC/RHC Providers

Based on Minnesota legislative statutes 256B.0625, subdivisions 30, effective January 1, 2015, DHS is required to pay FQHC and RHC claims directly to providers for non-dual members. For services provided recipients in managed care, DHS may opt to receive claims directly from the provider or receive them from the managed care organization.

Since non-duals are only approximately 4.0% of the total MSHO and MSC+ population, the impact of this legislative change would be minimal and, therefore, no adjustment was made to the 2015 rates to reflect the reduced payments associated with this legislative change.

Court Order Early Intervention Services

Based on Minnesota legislative statutes 256B.0624, subdivisions 5, 6, and 10, effective January 1, 2015, the definition behind "mental health crisis assessment," "mental health mobile crisis intervention services," and "mental health crisis stabilization services" has changed. It requires mobile crisis intervention staff to be experienced in engagement strategies and work with families to ensure service linkage is being received so the team can offer to assist the recipient in developing an advanced directive.

Per discussions with DHS, there is expected to be no fiscal impact for the addition of this service because this is the responsibility of the mobile crisis team and is not expected to have a material impact on health plan costs. Therefore, no adjustment was made to the 2015 rates for this legislative change.

Increases FFS payments for DME, Prosthetics, and Orthotics

Based on Minnesota legislative statutes 256B.766, subdivision 40, effective July 1, 2015, a 3% FFS payment increase for DME / Prosthetics / Orthotics will be implemented.

DHS expects that this law will be revised and may result in an effective date sometime later than July 1, 2015 or an alternative adjustment to the payment rate. If the law takes effect on July 1, 2015, we will review the impact to determine if an adjustment needs to be made to the rates to incorporate it.

Home and Community Based Services 1% Rate Increase Effective July 1, 2015

Based on Minnesota legislative law chapter 312, article 27, sections 56-57, amendments to statutes 256B.439, subdivisions 1 and 7, effective July 1, 2015 all HCBS providers will receive a 1% quality add on increase to payment rates based on the provider's quality score. Based on the assumption that the quality scores for all provider's will qualify, the aggregate factors applied to the community rates and the institutional rates for this adjustment are 1.0027 and 1.0001, respectively, based on the cost of personal care services, home health services, and home care nursing services as a percentage of total 2013 costs.

OTHER NON-LEGISLATIVE ADJUSTMENTS APPLIED TO CY 2015 RATES

Provision for Contribution to Surplus

The target contribution to surplus was set at 0.75% of revenue for MSHO and MSC+ Basic Care rates.

Legislated Premium Tax and HMO Surcharge

The non-CBP MSHO and MSC+ CY 2014 Basic Care rates were increased to include a provision for the legislated premium tax of 1% and HMO surcharge of 0.6%, resulting in an adjustment factor of 1.0163 being applied to the rates (1.0163 = 1 / (1 – 0.01 – 0.006)). The CBP 2014 Basic Care rates do not include the premium tax adjustment or HMO surcharge.

Withhold

A withhold of 8.0%, of which 5.0% is tied to performance, is required by Minnesota law to be removed from MSHO and MSC+ Basic Care payments to health plans. However, the ultimate amount at risk to health plans is only 0.25% of capitation because the plan contract includes "loss limit" provisions. The

remainder of the withhold is required to be returned to health plans and ultimately only impacts the cash flow of DHS and the health plans. The plans are adequately capitalized and we have no concerns that this payment delay affects the fiscal stability of the organizations. Final health plan payments, assuming none of the 0.25% at-risk withhold is returned, are subject to the actuarial certification.

Calendar Year 2015 Base Rates

Table 5 contains the development of the MSHO / MSC+ Basic Care base rates for CY 2015.

Table 5
2015 MSHO and MSC+ Rate Development
Basic Care Services
2015 Base Rates

Component / Adjustment	Community	Institutional	Composite
CY 2013 Basic Care Health Plan Experience PMPM	**$765.51**	**$250.67**	**$638.46**
Trend 2013 to 2015	1.0688	1.0514	1.0671
Estimated CY 2015 Prior to Benefit Changes	**$818.15**	**$263.56**	**$681.30**
2013 ADJUSTMENTS			
Rate Restoration to Payment Rates for PCA, HH, and HCN	1.0013	1.0000	1.0012
Capitation Ratable Reduction and Sunsetting of Fee Reductions	1.0147	1.0144	1.0147
Additional Preventive Dental Benefits	1.0013	1.0035	1.0015
2014 ADJUSTMENTS			
Dental Services Rate Increase	1.0008	1.0024	1.0009
HCBS 1% Rate Increase Effective April 1, 2014	1.0054	1.0002	1.0049
HCBS 5% Rate Increase Effective July 1, 2014	1.0272	1.0010	1.0247
2015 ADJUSTMENTS			
Increase in Community PCA Utilization due to NF LOC Requirement	1.0024	1.0000	1.0022
HCBS 5% Rate Increase Effective July 1, 2015	1.0027	1.0001	1.0024
Estimated CY 2015 After Benefit Changes	**$864.64**	**$269.27**	**$717.71**
Administrative Costs			
CY 2013 Health Plan Experience PMPM	**$52.17**	**$17.08**	**$43.51**
Trend 2013 to 2015	1.0302	1.0302	1.0302
Estimated CY 2015	**$53.75**	**$17.60**	**$44.83**
OTHER NON LEGISLATIVE ADJUSTMENTS			
Provision for Contribution to Surplus	1.0076	1.0076	1.0076
Legislated Premium Tax (not applied to CBP rates)	1.0163	1.0163	1.0163
CY 2015 Base Rates	**$940.37**	**$293.73**	**$780.79**
CY 2015 Base Rates for CBP	**$925.32**	**$289.04**	**$768.30**

DEVELOPMENT OF CALENDAR YEAR 2015 BASIC CARE RATE CELL RELATIVITIES

The rate cell relativities were developed using 2013 claim costs adjusted for benefit and legislative changes through 2015. They will be applied to the CY 2015 Basic Care base rates to calculate the final CY 2015 Basic Care rate for each enrollee.

Rate Cell Relativities

The Basic Care rate cell relativities in Table 6 were developed as follows:

- We developed initial 2015 rate cell relativities by comparing the difference between age, gender, and area-specific Basic Care costs and total Basic Care costs from CY 2013 health plan experience, separately for the community and institutional populations. The area-specific costs were calculated for the Metro and Non-Metro areas. Metro is defined as combination of the Hennepin, Ramsey, Core Metro, and Carver regions established in 2004. Non-Metro is defined as the combination of the Olmsted, Greater Metro, North East, North Central, South West, and South East regions established in 2004.

- We developed blended 2015 rate cell relativities by blending the initial 2015 rate cell relativities and the 2014 rate cell relatives both with 50% weight.

- We normalized the blended 2015 rate cell relativities such that they composite to 1.000 using the CY 2013 distribution of eligibles by age, gender, and area, separately for the community and institutional populations. These final 2015 rate cell relativities are contained in Table 6.

Table 6
CY 2015 MSHO and MSC+ Rate Development
Basic Care Rate Cell Relativities for Geographic Area and Demographic Group
Community and Institutional Populations

Area	Gender	Age Group	Community Relativity	Institutionalized Relativity
Metro	Female	65 - 74	0.9857	1.6075
Metro	Female	75 - 84	1.2013	1.1449
Metro	Female	85 +	1.3982	0.8349
Metro	Female	Non-MC	2.1510	5.5774
Metro	Male	65 - 74	0.8928	1.6347
Metro	Male	75 - 84	1.2145	1.3304
Metro	Male	85 +	1.4334	1.0096
Metro	Male	Non-MC	2.2089	5.5774
Non-Metro	Female	65 - 74	0.6463	1.4009
Non-Metro	Female	75 - 84	0.7984	0.9643
Non-Metro	Female	85 +	0.9673	0.7243
Non-Metro	Female	Non-MC	1.4088	3.6939
Non-Metro	Male	65 - 74	0.5845	1.3250
Non-Metro	Male	75 - 84	0.7914	1.0798
Non-Metro	Male	85 +	0.9291	0.8720
Non-Metro	Male	Non-MC	1.4442	3.6939

By definition, all of the demographic factors composite to 1.000 using the CY 2013 distribution of eligibles by age, gender, and area, separately for the community and institutional populations. As the age, gender, and area mix changes over time, the demographic factors may not composite to 1.000. This aggregate demographic factor change was considered when determining the appropriateness of the trend factors used to develop CY 2015 base rates and will continue to be considered when determining the appropriateness of trends in the future.

CALENDAR YEAR 2015 BASIC CARE RATES

Exhibits 1A (non-CBP) and 1B (CBP) contain the CY 2015 Basic Care rates for each rate cell prior to the withhold reduction. Exhibits 1C (non-CBP) and 1D (CBP) contain the CY 2015 Basic Care rates for each rate cell after withhold. The CY 2015 Basic Care capitation revenue for each health plan will be determined by the CY 2015 Basic Care rates for each rate cell, adjusted for withhold and the plan-specific membership mix by geographic area and demographic group rate cells.

III. DEVELOPMENT OF CY 2015 ELDERY WAIVER ADD-ON RATES

CALENDAR YEAR 2013 HEALTH PLAN EW EXPERIENCE

The CY 2015 EW Add-on rates are based on aggregate CY 2013 health plan experience; both for EW and care coordination / case management (CC / CM) services. The rate development uses the experience provided by the health plans for EW eligibles enrolled in the MSHO and MSC+ programs for their State Plan services. Table 7 contains the statewide aggregate 2013 PMPM health plan experience for these two main service subgroups, including the costs for EW services provided to new EW eligibles in the first month prior to their being in Rate Cell B. Appendix B contains the category-of-service detail underlying the 2013 EW experience.

Table 7
2015 MSHO and MSC+ Rate Development
Elderly Waiver and Care Coordination / Case Management Services
Calendar Year 2013 Aggregate Health Plan Experience PMPM
Including EW Services Cost for New EW Eligibles
In First Month Prior to Rate Cell B

Component	PMPM
Elderly Waiver Services	$1,005.41
Care Coordination / Case Management Services	98.24
Total	**$1,103.65**

DEVELOPMENT OF CALENDAR YEAR 2015 EW ADD-ON BASE RATES

The following adjustments were made to the aggregate CY 2013 EW health plan experience to develop the CY 2015 EW Add-on base rates.

Trend

An annual PMPM trend of 4.0% was used to project the CY 2013 EW plan experience to the CY 2015 rating period based on recent EW managed care experience and DHS projections for the EW population. Consistent with the Basic Care rate development, annual care coordination and case management trends were set at 1.5%.

LEGISLATIVE ADJUSTMENTS TO 2013 TRENDED BASE COSTS FOR CY 2015 RATES

Adjustment for Limits on Long Term Care Rates [Article 7, Section 51, Paragraph (a)]

Legislation effective July 1, 2011 required a 1.5% decrease in rates through June 30, 2013 and a 1.0% decrease beginning July 1, 2013 for EW services except customized living services, PERS, specialized supplies and equipment, and modifications/adaptations. This rate change is referred to as the 0.5% rate restore.

The 1.5% rate reduction is reflected in the 1/1/2013 through 6/30/2013 experience and the 1.0% rate reduction is reflected in the 7/1/2013 through 12/31/2013 experience for an average impact on 2013 experience of 1.25% (6/12 x 1.5% + 6/12 x 1.0%). The rate reduction required for the 2015 rating period is 1.0%, resulting in a 0.25% rate restore applied for the 2015 rate development. Customized living services, PERS, specialized supplies and equipment, and modifications / adaptations represent 65% of

the cost of EW services; therefore, the resulting adjustment factor for the EW services portion of the rates is 1.0009 (1.0009 = 1 + [0.25% x (100% – 65%)]). The adjustment factor for the care coordination / case management services portion of the rates is 1.0025 (1.0025 = 1 + 0.25%).

Home and Community Based Services 1% Rate Increase Effective April 1, 2014

Based on Section 60 of Article 2: Contingent Reform 2020; Redesigning Home and Community-Based Services, reimbursement rates, grants, allocation, individual limits, and rate limits shall be increased by 1% effective April 1, 2014. A 1.0100 factor was applied to the 2015 EW Add-on rate development for this legislative change.

Home and Community Based Services 5% Rate Increase Effective July 1, 2014

Based on the 2014 Session Laws of Minnesota, chapter 312, article 27 sections 71 and 75, the legislature authorized a 5.0% rate increase effective July 1, 2014 for continuing care providers. A 1.0500 factor was applied to the 2015 EW Add-on rate development for this legislative change.

Home and Community Based Services 5% Rate Increase Effective July 1, 2014

Based on Minnesota legislative law chapter 312, article 27, sections 56-57, amendments to statutes 256B.439, subdivisions 1 and 7, effective July 1, 2015 all HCBS providers will receive a 1% quality add on increase to payment rates based on the provider's quality score. Based on the assumption that the quality scores for all provider's will qualify, the 2015 EW Add-on rate was adjusted by a factor of 1.0050 to reflect the 1% increase for the second half of 2015.

OTHER NON-LEGISLATIVE ADJUSTMENTS APPLIED TO CY 2015 RATES

Adjustment for Administration Requirements

The projected 2015 administration costs for the MSHO and MSC+ programs were included in full in the 2015 Basic Care rates. Therefore no administration costs were added to the EW Add-on rates for 2015.

Legislated Premium Tax and HMO Surcharge

The non-CBP MSHO and MSC+ CY 2015 EW Add-on rates were increased to include a provision for the legislated premium tax of 1% and HMO surcharge of 0.6%, resulting in an adjustment factor of 1.0163 being applied to the rates (1.0163 = 1 / (1 – 0.01 – 0.006)). The CBP 2015 EW Add-on rates do not include the premium tax adjustment or HMO surcharge.

Calendar Year 2015 Base Rates

Table 8 contains the development of the MSHO / MSC+ EW base rates for CY 2015. Please note that the "Moving Home Minnesota" rates are consistent with the Elderly Waiver rates for 2015. In future years, these rates may vary as emerging experience becomes available.

Table 8 2015 MSHO and MSC+ Rate Development Elderly Waiver and Care Coordination / Case Management Services 2015 Base Rates		
Component / Adjustment	**Elderly Waiver Services**	**Care Coordination / Case Management**
Aggregate CY 2013 EW Health Plan Experience PMPM	**$1,005.41**	**$98.24**
2013 ADJUSTMENTS		
Adjustment for Limits on Long Term Care Rates (effective 7/1/2013)	1.0009	1.0025
2014 ADJUSTMENTS		
Trend 2013 to 2014	1.0400	1.0150
HCBS 1% Rate Increase (effective 4/1/2014)	1.0100	1.0100
HCBS 5% Rate Increase (effective 7/1/2014)	1.0500	1.0500
2015 ADJUSTMENTS		
Trend 2014 to 2015	1.0400	1.0150
HCBS 1% Rate Increase (effective 7/1/2015)	1.0050	1.0050
OTHER NON LEGISLATIVE ADJUSTMENTS		
Legislated Premium Tax (not applied to CBP rates)	1.0163	1.0163
CY 2015 Base Rates for non-CBP	**$1,178.89**	**$109.89**
CY 2015 Base Rates for CBP	**$1,160.03**	**$108.13**

DEVELOPMENT OF CALENDAR YEAR 2015 EW RISK FACTORS

The risk factors in Table 9 were developed as follows:

- We developed initial 2015 risk factor by comparing the difference between age, ADL, and area-specific EW costs and total EW costs from CY 2013 health plan experience, using 2013 EW demographic data provided by DHS.
- We developed blended 2015 risk factors by blending the initial 2015 risk factors and the 2014 risk factors both with 50% weight.
- We normalized the blended 2015 risk factors such that they composite to 1.000 using the CY 2013 distribution of eligibles by age, ADL, and area. These final 2015 risk factors are contained in Table 9.

Table 9 Calendar Year 2015 MSHO and MSC+ Rate Development Elderly Waiver Services Risk Factors			
Age Group	**Metro Indicator**	**ADL Group**	**Risk Factor**
65 – 74	Metro	0 to 3 ADLs	0.631
75 – 84	Metro	0 to 3 ADLs	0.696
85 +	Metro	0 to 3 ADLs	0.833
65 – 74	Metro	4 to 6 ADLs	0.992
75 – 84	Metro	4 to 6 ADLs	1.130
85 +	Metro	4 to 6 ADLs	1.398
65 – 74	Metro	7 to 8 ADLs	1.245
75 – 84	Metro	7 to 8 ADLs	1.416
85 +	Metro	7 to 8 ADLs	1.845
65 – 74	Non-Metro	0 to 3 ADLs	0.607
75 – 84	Non-Metro	0 to 3 ADLs	0.676
85 +	Non-Metro	0 to 3 ADLs	0.841
65 – 74	Non-Metro	4 to 6 ADLs	1.388
75 – 84	Non-Metro	4 to 6 ADLs	1.589
85 +	Non-Metro	4 to 6 ADLs	1.849
65 – 74	Non-Metro	7 to 8 ADLs	2.031
75 – 84	Non-Metro	7 to 8 ADLs	2.332
85 +	Non-Metro	7 to 8 ADLs	2.720

By definition, all of the risk factors composite to 1.000 using the CY 2013 distribution of eligibles by area, ADL, and age. As the area, ADL, and age mix changes over time, the risk factors may not composite to 1.000. This aggregate risk factor change was considered when determining the appropriateness of the trend factors used to develop CY 2015 base rates and will continue to be considered when determining the appropriateness of trends in the future. The overall EW risk factors for each plan will be recalculated annually and will reflect the mix of each plan's membership by county at the beginning of the contract year.

After initially normalizing the EW risk scores to 1.000 using the CY 2013 distribution of eligibles by area, ADL, and age, the 0 to 3 ADL factors were increased due to the EW eligibility changes effective in 2015. Per guidance from DHS, approximately 13% of the community EW individuals will lose their EW eligibility, and we projected these will be individuals currently needing assistance with 0 or 1 ADL. The 0 to 3 ADLs factor was increased by 1.3% for Metro recipients and 4.5% for Non-Metro recipients to account for the fact that we will have relatively more 2 and 3 ADL members in the 0 to 3 ADL group by the end of the year. These factors were derived from an analysis in which we determined the relative risk factor for those individuals needing assistance with 0, 1, 2, or 3 ADLs. The risk factors in Table 9 include this adjustment to the 0 to 3 ADL factor.

CALENDAR YEAR 2015 FINAL EW ADD-ON RATES

Exhibits 2A (non-CBP) and 2B (CBP) contain the CY 2015 EW Add-on rates for each rate cell. The CY 2015 EW Add-on capitation revenue for each health plan will be determined by the CY 2015 EW Add-on rates for each rate cell and the plan-specific membership mix by area, ADL, and age group rate cells. The CY 2015 EW Add-on rates for each rate cell in Exhibits 2A and 2B are the sum of the following:

- The EW Services 2015 base rate multiplied by the plan-specific annual risk factors for area, ADL, and age.
- The EW CC / CM 2015 base rate.

IV. DEVELOPMENT OF CY 2015 NURSING FACILITY ADD-ON RATES

FREQUENCY AND AVERAGE LENGTH-OF-STAY ASSUMPTION

The frequency of admission and average length of stay (ALOS) assumptions were determined based on MSHO and MSC+ admission data provided by the health plans for years 2011 through 2013. The final assumptions used for the 2015 rate development are:

- **Frequency of nursing facility admissions of 13.5% annually** – The frequency of admission in Appendix B is expressed as the expected admissions per eligible per month (1.125%). Please note that the admission frequencies reflected in Table 10 are those admissions for which there was some Medicaid liability, since DHS has no financial responsibility for admissions with only Medicare-covered days.

- **Medicaid average length of stay of 53 days** – The ALOS in Appendix B is calculated over a 180-day benefit period, which is the maximum nursing facility benefit for the MSHO and MSC+ programs. The benefit excludes days that would occur beyond 180 days and days outside of the contract period. All skilled nursing facility days that qualify for Medicare-only payment count toward the benefit and the 180-day length-of-stay maximum. However, the Medicare-only days are not included in the assumed Medicaid average length of stay of 53 days reflected in Table 10 as DHS has no financial responsibility for Medicare-only days. The ALOS within the contract year depends on the pattern of enrollment by month. The projected CY 2015 ALOS of 41.1 days (from Appendix B) within the CY 2015 contract period is based on monthly enrollment projections provided by DHS through December 2015.

The average nursing facility days per community enrollee (which equals the product of admission frequency and ALOS) for the combined MSHO and MSC+ population decreased from 2011 through 2013. The frequency of admissions and ALOS assumptions used for the 2015 rate development, which results in estimated 2015 nursing facility days per community enrollee of 7.2, are consistent with the trend in average days per community enrollee in Table 10. In addition, the resulting initial NF base rate of $112.41 (see Appendix C) is consistent with the trend in nursing facility costs per community enrollee per month in Table 10.

Table 10
2015 MSHO and MSC+ Rate Development
Nursing Facility Services
Average NF Days and Medicaid Costs Per Community Enrollee by Calendar Year

Calendar Year	Average NF Days per Community Enrollee	NF Medicaid Costs per Community Enrollee per Month
2011	10.7	$129.72
2012	9.7	120.98
2013	7.9	114.22

An adjustment is made later in the rate setting process to account for the difference in the frequency and ALOS between Metro and the Non-Metro Counties and between age / gender combinations.

CHARGE PER DAY ASSUMPTION

The CY 2015 average charge per day was developed using nursing facility MA charge per day projections from the Reports and Forecasts Division at DHS, which include the impact of known legislative changes on charge per day. Table 11 contains the fiscal year projection data that was used to estimate the CY 2015 charge per day.

Table 11
2015 MSHO and MSC+ Rate Development
Nursing Facility Services
Nursing Facility Charge Per Day Estimates
Based on Data from DHS Reports and Forecasting Division

Fiscal Year	Estimated Charge per Day
2015	$186.03
2016	192.21

The weighted average of these two fiscal year estimates results in a projected nursing facility MA charge per day of $189.06 for CY 2015, which is used in Appendices B and C to develop the 2015 NF add-on rates.

180-DAY NURSING FACILITY ADD-ON RATE CALCULATION

The 180-day NF Add-on initial rate is calculated by the following formula:

Initial Rate	=	Adjusted Monthly Frequency of Nursing Facility Admissions
	x	Average Length of Stay within the contract period
	x	Average Charge per Day

The calculation of the initial rate as well as subsequent adjustments is outlined in Appendix C1 for non-CBP plans and Appendix C2 for CBP plans.

Section A of Appendices C1 and C2 shows the calculation of the initial rate of $87.44 PMPM for CY 2015.

Section B of Appendices C1 and C2 contain the calculation of the tail rate. The tail rate is equal to the expected nursing facility costs for days in CY 2015 from admissions occurring in CY 2014 divided by projected community eligible months in CY 2015. The tail rate for CY 2015 is $24.97 PMPM.

Section C of Appendix C contains an initial MSHO / MSC+ base rate for CY 2015 of $112.41 PMPM. The initial base rate was decreased 1.7% for the elimination of disenrollment fees and increased 1.63% for the legislated premium tax of 1% and the HMO surcharge of 0.6% (1.0163 = 1 / (1 - 0.01 -0.006)). The final MSHO / MSC+ base rate for CY 2015 is $112.30 PMPM.

Rates for CBP entities are excluded from the 1% premium tax. Section C of Appendix C2 contains an initial CBP base rate for CY 2015 of $112.41 PMPM. The initial base rate has been decreased by 1.7% for the elimination of disenrollment fees. The final CBP base rate for CY 2015 is $110.50 PMPM.

Section D of Appendix C1 (MSHO / MSC+ non-CBP) and Appendix C2 (MSHO / MSC+ CBP) contains aggregate 180-day NF Add-on rates specific to enrollees eligible for both Medicaid and Medicare versus Medicaid-only enrollees. The adjustment to calculate these rates reflects differences in frequency and ALOS for Medicare versus Non-Medicare enrollees based on health plan experience. The aggregate Medicare and Non-Medicare rates equal the overall 180-day NF Add-on rates times the corresponding Medicare and Non-Medicare adjustment.

Rate Cell Relativities

The NF Add-on rate cell relativities in Table 12 were developed as follows:

- We developed initial 2015 rate cell relativities by compared the difference between age, gender, area, and dual/non-dual-specific nursing facility costs and total nursing facility costs from CY 2010 through CY 2013 health plan experience. The area-specific costs were calculated for the Metro and Non-Metro areas. Metro is defined as combination of the Hennepin, Ramsey, Core Metro, and Carver regions established in 2004. Non-Metro is defined as the combination of the Olmsted, Greater Metro, North East, North Central, South West, and South East regions established in 2004.

- We developed blended 2015 rate cell relativities by blending the initial 2015 rate cell relativities and the 2014 rate cell relatives both with 50% weight.

- We normalized the blended 2015 rate cell relativities such that they composite to 1.000 using the CY 2013 distribution of eligibles by age, gender, area, and dual/non-dual. These final 2015 rate cell relativities are contained in Table 12.

Table 12
CY 2015 MSHO and MSC+ Rate Development
NF Add-on Rate Cell Relativities for Geographic Area and Demographic Group

Area	Gender	Age Group	Relativity
Metro	Male	65 – 74	0.385
Metro	Male	75 – 84	0.804
Metro	Male	85 +	1.812
Metro	Female	65 – 74	0.293
Metro	Female	75 – 84	0.672
Metro	Female	85 +	1.593
Non-Metro	Male	65 – 74	0.632
Non-Metro	Male	75 – 84	1.465
Non-Metro	Male	85 +	3.343
Non-Metro	Female	65 – 74	0.487
Non-Metro	Female	75 – 84	1.222
Non-Metro	Female	85 +	2.592
		Dual	1.030
		Non-Dual	0.440

By definition, all of the demographic factors composite to 1.000 using the CY 2013 distribution of eligibles by age, gender, area, and dual/non-dual. As the age, gender, and area mix changes over time, the demographic factors may not composite to 1.000. This aggregate demographic factor change was considered when determining the appropriateness of the trend factors used to develop CY 2015 base rates and will continue to be considered when determining the appropriateness of trends in the future.

Exhibit 3A (MSHO / MSC+ non-CBP) and Exhibit 3B (MSHO / MSC+ CBP) contain the CY 2015 180-day NF Add-on rates by age, gender and region for dual eligible and Medicaid-only enrollees using the CY 2015 NF Add-on base rate and the rate cell relativities contained in Table 12.

V. HEALTH INSURER FEE

We provided a letter to DHS dated May 16, 2014 regarding our recommended methodology to calculate the amount to reimburse plans for the health insurer fee. The recommended approach is repeated below.

We recommend that DHS process the capitation rate adjustments for the health insurer fee outside of the monthly capitation rate payment system in the form of one annual payment to Medicaid health plans for two items related to the health insurer fee:

- The actual health insurer fee amount (allocated across lines of business by revenue), and
- The income tax impact related to the health insurer fee (allocated across lines of business by revenue).

All payments will be increased for consideration of the 1% premium tax and 0.6% HMO surcharge if applicable to a particular health plan.

Health Insurer Fee Amount

According to the final IRS regulations, each health insurer is required to report its net premiums written to the IRS annually by April 15 of the fee year. The IRS will then send each insurer a notice of preliminary fee calculation each fee year that will include the insurer's allocated fee, net premiums written for health insurance of United States health risks, net premiums written taken into account, and aggregate net premiums written taken into account for all insurers. The regulations provide that the IRS will send each covered entity its final fee calculation for a fee year no later than August 31 of that fee year, and that the covered entity must pay the fee by September 30 by electronic funds transfer.

Related Income Tax Amount

Since the ACA health insurer fee is not deductible for corporate income tax purposes, DHS should consider an allowance to cover the federal income tax impact on the additional revenue added to Medicaid managed care payments to cover the ACA health insurer fee. The health insurer fee should be grossed up by the marginal corporate tax income rate for each plan. Using the following assumptions:

- K = Federal Income Tax % = 35%
- L = State Income Tax % = 9.8%
- M = Premium Tax % = 1.6%

The total capitation rate adjustment to insurers would be based on the following formula:

Total $ Adjustment = HIF / (1 – K – L *(1 – K)) * 1 / (1 – M) = 1.7333 * HIF

These assumptions used in the example above should be confirmed for each plan's situation.

Revenue not Subject to the HIF

As part of the HIF, the Internal Revenue Service Regulations (November 29, 2013) state that the HIF is not applicable to *"benefits for long-term care, nursing home care, home health care, community-based care."*

As such, we provide Table 13 below that provide the percentage of overall services for MSHO and MSC+ by rate cell (including pharmacy), that are attributable long-term care (LTC) services. This data was compiled using the 2013 Encounter Summary data that was provided to Milliman and accounts for membership migration, trend, and program changes.

Table 13
CY 2015 MSHO and MSC+ Rate Development
Medical PMPM Attributable to LTC

Rate Component	Percentage
Basic Care Rates	49.4%
EW Add-On Rates	100.0%
NF Add-On Rates	100.0%

These percentages can be applied to the 2015 premium rate to determine the portion of the rate that is considered LTC services. We defined LTC services as any costs under the following service headings:

- Adult Day Care
- Assisted Living Services
- Elderly Waiver Services
- Extended home care Nursing
- Home Health Services
- ICF-DD
- Inpatient Long Term Hospital
- LTC Consultation-Pre-admission Screening
- Nursing Facility Level I
- Nursing Facility Level II
- Personal Care Services
- Home care Nursing
- Respite Care

We encourage DHS to solicit an official legal opinion on the appropriate services to consider in this calculation.

Exhibit 1
Seniors Basic Care Rates for January 2015 through December 2015

Exhibit 2
Elderly Waiver (EW) Add-on Rates for January 2015 through December 2015

Exhibit 3
180 Day Nursing Facility (NF) Add-on Rates for January 2015 through December 2015

Exhibit 1A
Calendar Year 2015 MSHO and MSC+ Rate Development
Basic Care Rates
Non-County Based Purchasing Rates
Prior to Withhold Adjustment

Community Population

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$839.59	$1,142.10	$1,347.96	$2,077.22	$926.90	$1,129.67	$1,314.78	$2,022.77
Non-Metro	549.64	744.19	873.66	1,358.04	607.78	750.83	909.62	1,324.80

Institutional Population

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$480.17	$390.78	$296.54	$1,638.26	$472.17	$336.30	$245.25	$1,638.26
Non-Metro	389.21	317.18	256.14	1,085.01	411.49	283.25	212.75	1,085.01

Exhibit 1B
Calendar Year 2015 MSHO and MSC+ Rate Development
Basic Care Rates
County Based Purchasing Rates
Prior to Withhold Adjustment

Community Population

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Non-Metro	$540.84	$732.28	$859.68	$1,336.31	$598.06	$738.82	$895.06	$1,303.60

Institutional Population

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Non-Metro	$382.98	$312.10	$252.04	$1,067.65	$404.91	$278.72	$209.35	$1,067.65

Exhibit 1C
Calendar Year 2015 MSHO and MSC+ Rate Development
Basic Care Rates
Non-County Based Purchasing Rates
After Withhold Adjustment

Community Population

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$772.42	$1,050.73	$1,240.13	$1,911.05	$852.74	$1,039.30	$1,209.60	$1,860.95
Non-Metro	505.67	684.65	803.77	1,249.40	559.16	690.76	836.85	1,218.81

Institutional Population

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$441.76	$359.52	$272.82	$1,507.20	$434.40	$309.39	$225.63	$1,507.20
Non-Metro	358.07	291.80	235.65	998.21	378.57	260.59	195.73	998.21

Exhibit 1D
Calendar Year 2015 MSHO and MSC+ Rate Development
Basic Care Rates
County Based Purchasing Rates
After Withhold Adjustment

Community Population

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Non-Metro	$497.58	$673.70	$790.91	$1,229.41	$550.21	$679.71	$823.46	$1,199.31

Institutional Population

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Non-Metro	$352.35	$287.14	$231.88	$982.24	$372.52	$256.42	$192.60	$982.24

Exhibit 2A
Calendar Year 2015 MSHO and MSC+ Rate Development
Elderly Waiver Add-on Rates
Non-County Based Purchasing

	0 to 3 ADLs			4 to 6 ADLs			7 to 8 ADLs		
Area	**65 - 74**	**75 - 84**	**85 +**	**65 - 74**	**75 - 84**	**85 +**	**65 - 74**	**75 - 84**	**85 +**
Metro	$854.18	$930.42	$1,091.34	$1,278.83	$1,442.34	$1,758.12	$1,577.43	$1,779.59	$2,285.32
Non-Metro	$825.21	$906.29	$1,101.69	$1,746.09	$1,983.58	$2,290.00	$2,503.79	$2,859.01	$3,316.99

Exhibit 2B
Calendar Year 2015 MSHO and MSC+ Rate Development
Elderly Waiver Add-on Rates
County Based Purchasing

Area	0 to 3 ADLs			4 to 6 ADLs			7 to 8 ADLs		
	65 - 74	75 - 84	85 +	65 - 74	75 - 84	85 +	65 - 74	75 - 84	85 +
Non-Metro	$812.00	$891.79	$1,084.07	$1,718.15	$1,951.85	$2,253.36	$2,463.73	$2,813.27	$3,263.92

Exhibit 3

Calendar Year 2015 MSHO and MSC+ Rate Development
Nursing Facility Add-On Rates
180 Day Benefit Period
Non-County Based Purchasing Rates

January 2015 to December 2015 Contract Period

Medicare Population

Area	Males			Females		
	65-74	75-84	85+	65-74	75-84	85+
Metro	$44.55	$92.98	$209.63	$33.94	$77.72	$184.30
Non Metro	$73.15	$169.47	$386.84	$56.29	$141.40	$299.90

Non-Medicare Population

Area	Males			Females		
	65-74	75-84	85+	65-74	75-84	85+
Metro	$19.00	$39.67	$89.43	$14.48	$33.16	$78.62
Non Metro	$31.21	$72.30	$165.03	$24.01	$60.32	$127.94

Exhibit 3

Calendar Year 2015 MSHO and MSC+ Rate Development
Nursing Facility Add-On Rates
180 Day Benefit Period
County Based Purchasing Rates

January 2015 to December 2015 Contract Period

Medicare Population

Area	Males			Females		
	65-74	75-84	85+	65-74	75-84	85+
Non Metro	$71.98	$166.76	$380.64	$55.39	$139.13	$295.09

Non-Medicare Population

Area	Males			Females		
	65-74	75-84	85+	65-74	75-84	85+
Non Metro	$30.71	$71.14	$162.38	$23.63	$59.35	$125.89

Appendix A
CY 2013 Aggregate Health Plan Elderly Waiver Experience PMPM by Category of Service

Appendix B and C
180 Day Nursing Facility Add-on Rate Calculation for January 2015 through December 2015

Appendix A
Calendar Year 2015 MSHO and MSC+ Rate Development
Elderly Waiver and Care Coordination / Case Management Services
CY 2013 Aggregate Health Plan Experience PMPM by Category of Service

Elderly Waiver Services [1]	2013 Cost PMPM
Adult Day Care	$101.89
Adult Day Care Bath	$0.17
Adult Day Care FADS License	$0.95
Caregiver Training and Education	$0.01
CDCS Background checks	$0.00
CDCS Consumer Directed Community Supports	$4.40
CDCS Mandatory Case Mgt	$0.22
Chore Services	$2.14
Companion Care, Adult	$2.22
Customized Living	$66.96
Customized Living 24 Hr	$556.57
Env. Mod and Provision (claims only)	$0.48
Extended Home Health Aide	$1.74
Extended Medical Supplies and Equipment	$6.53
Extended Personal Care 1:1	$7.50
Extended Shared Personal Care 1:3	$0.01
Extended Shared Personal Care 1:2	$0.00
Flexible Case Management (claims only)	$0.09
Foster Care, Corporate	$4.86
Foster Care, family	$41.39
Home Delivered Meals	$24.62
Homemaker Services	$107.72
Homemaker services, Per Diem	$2.43
LPN Complex Extended	$0.21
LPN Regular Extended 1:1	$0.11
LPN Shared Extended 1:2	$0.00
Modifications/Adaptations	$2.01
Personal Assistance (claims only)	$7.27
Residential Care	$1.29
Respite not-in-home per diem	$0.32
Respite, in home	$0.88
Respite, out of home	$0.01
RN Complex Extended	$1.06
RN Regular Extended 1:1	$0.03
RN Regular Extended 1:2	$0.00
Self-Directed Support (claims only)	$1.83
Transitional Services	$0.32
Transportation, Extended	$31.83
Transportion, non commercial, mileage	$0.75
Treatment and Training (claims only)	$0.32
PERS Purchase	$0.14
PERS Installation and Testing	$0.19
PERS Monthly Service Fee	$8.73
Caregiver Assessment	$0.00
Unknown 99 [2]	$2.89
Incurred but not Reported Claims	$12.32
Total Elderly Waiver Services	**$1,005.41**
Care Coordination / Case Management Services [3]	
Case Management	$72.60
Case Management, Paraprofessional	$1.33
Other Care Management	$24.31
Total Care Coordination / Case Management Services Costs PMPM	**$98.24**
Total	**$1,103.65**

[1] Includes 2013 Elderly Waiver service costs for Blue Plus, Itasca Medical Plan, Health Partners, Medica, PrimeWest Health System, South Country Health Alliance, and UCare Minnesota.

[2] Includes 2013 Elderly Waiver services costs paid by DHS that were submitted with missing/incorrect procedure codes.

[3] Includes 2013 Medicaid care coordination and case management costs for Blue Plus, Itasca Medical Plan, Health Partners, Medica, PrimeWest Health System, South Country Health Alliance, and UCare Minnesota.

Appendix B
Calendar Year 2015 MSHO and MSC+ Rate Development
180 Day Nursing Facility Add-On Rate Calculation for January 2015 Through December 2015
Projected Enrollment after August 2014

	2014 Contract Period	2015 Contract Period
NF Add-On Per Diem		$112.30
		$189.06
Monthly Freq	1.1250%	1.1250%

Year	Month	Monthly Enrollment	Paid to Health Plans	Admissions	NF Days for Admissions in Month by Contract Period *		Health Plan Payments to NF for Admissions in Month for 2015 Contract Period
					2014 Contract Period	2015 Contract Period	
2014 Contract Period							
2014	January	37,507		422.0	53.0	0.0	$0
	February	37,468		421.5	53.0	0.0	0
	March	37,423		421.0	53.0	0.0	0
	April	37,384		420.6	53.0	0.0	0
	May	37,404		420.8	53.0	0.0	0
	June	37,385		420.6	53.0	0.0	0
	July	37,298		419.6	49.6	3.4	268,993
	August	36,985		416.1	42.4	10.6	831,992
	September	37,634		423.4	34.7	18.3	1,467,340
	October	37,669		423.8	26.3	26.7	2,141,684
	November	37,705		424.2	16.8	36.2	2,899,990
	December	37,740		424.6	6.1	46.9	3,767,439
Total 2014 Contract Period		449,603		5,058.0	41.1	11.9	$11,377,438
2015 Contract Period							
2015	January	37,776	$4,242,273	425.0		53.0	$4,258,405
	February	37,812	4,246,328	425.4		53.0	4,262,474
	March	37,845	4,249,990	425.8		53.0	4,266,150
	April	37,881	4,254,044	426.2		53.0	4,270,220
	May	37,916	4,257,967	426.6		53.0	4,274,158
	June	37,952	4,262,022	427.0		53.0	4,278,228
	July	37,987	4,265,945	427.4		49.6	4,008,205
	August	38,023	4,270,000	427.8		42.4	3,430,890
	September	38,059	4,274,054	428.2		34.7	2,806,392
	October	38,094	4,277,977	428.6		26.3	2,128,393
	November	38,130	4,282,032	429.0		16.8	1,365,631
	December	38,165	4,285,955	429.4		6.1	492,380
Total 2015 Contract Period		455,642	$51,168,586	5,126.0		41.1	$39,841,527
Grand Total							$51,218,965

Appendix C.1
Calendar Year 2015 MSHO and MSC+ Rate Development
180 Day Nursing Facility Add-On Rate Calculation
Contract Period January 2015 to December 2015
Non-County Based Purchasing Rates

Rate Component	2014	2015
Section A		
Monthly Claim Frequency	0.006403	0.011250
(x) Medicaid Length of Stay *	70.64	41.11
(x) Charge per Day *	$178.87	$189.06
= Initial Rate (1)	$80.90	$87.44
Section B		
2015 NF $ for 2014 Contract Period Admits	$10,443,707	$11,377,438
(/) 2015 Eligible Months	455,838	455,642
= Tail Rate (2)	$22.91	$24.97
Section C		
Initial Base Rate = (1)+(2)	$103.34	$112.41
Disenrollment Fee Adjustment	0.9830	0.9830
Legislated Premium Tax Adjustment	1.0163	1.0163
Final Base Rate	$103.24	$112.30
Section D		
(x) Medicare Adjustment	1.000	1.030
(x) Non Medicare Adjustment	0.669	0.440
= Aggregate Medicare Rate	$103.24	$115.70
= Aggregate Non-Medicare Rate	$69.07	$49.36

* The ALOS and charge per day exclude days that are 100% covered by Medicare.

Appendix C.2
Calendar Year 2015 MSHO and MSC+ Rate Development
180 Day Nursing Facility Add-On Rate Calculation
Contract Period January 2015 to December 2015
County Based Purchasing Rates

Rate Component	2013	2014
Section A		
Monthly Claim Frequency	0.006403	0.011250
(x) Medicaid Length of Stay *	70.64	41.11
(x) Charge per Day *	$178.87	$189.06
= Initial Rate (1)	$80.90	$87.44
Section B		
2015 NF $ for 2014 Contract Period Admits	$10,443,707	$11,377,438
(/) 2015 Eligible Months	455,838	455,642
= Tail Rate (2)	$22.91	$24.97
Section C		
Initial Base Rate = (1)+(2)	$103.34	$112.41
Disenrollment Fee Adjustment	0.9830	0.9830
Final Base Rate	$101.59	$110.50
Section D		
(x) Medicare Adjustment	1.000	1.030
(x) Non Medicare Adjustment	0.6690	0.440
= Aggregate Medicare Rate	$101.59	$113.84
= Aggregate Non-Medicare Rate	$67.96	$48.57

* The ALOS and charge per day exclude days that are 100% covered by Medicare.