MI Health Link – Calendar Year 2016 Medicaid Capitation Rate Development

January 1, 2016 through December 31, 2016

State of Michigan

Department of Health and Human Services

Prepared for:
Penny Rutledge
Director, Actuarial Division

Prepared by:
Robert M. Damler
FSA, MAAA
Principal & Consulting Actuary

Christopher Pettit
FSA, MAAA
Principal & Consulting Actuary

111 Monument Circle
Suite 601
Indianapolis, IN 46204-5128
USA

Tel +1 317 639-1000
Fax +1 317 639-1001

milliman.com

May 3, 2016

Table of Contents

INTRODUCTION

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 MI Health Link to be effective January 1, 2016. These rates will be in effect through the remainder of calendar year 2016. MI Health Link is Michigan's managed care program for the dual eligible (Medicare-Medicaid) population.

This letter provides documentation for the development of the actuarially sound capitation rates for calendar year 2016. 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 2016 Managed Care Rate Setting Consultation Guide (2016 guide), released by CMS in September 2015. Section 3 of the 2016 guide is not applicable to this certification, since the covered services do not include rates for new adult groups (Section 3).

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, 2016 through December 31, 2016. During calendar year 2016, it is anticipated that hospice beneficiaries will be allowed to remain in the program. This will be a change from calendar year 2015 and requires an update to the three-way contract between CMS, MDHHS and the Integrated Care Organizations (ICOs). Thus, we have illustrated rates prior to this change as well as once the change has been approved. The rates in Table 1 are illustrated on a gross basis prior to adjustment for any amounts that are expected to be paid by the beneficiary and recouped by the nursing facilities. The rates in Table 1 reflect the mandatory 1% savings assumption prescribed by CMS and the state. The percentage change reflects a blend of the "without hospice" and "with hospice" rates.

Table 1 State of Michigan Department of Health and Human Services MI Health Link Capitation Rates by Rate Cell Effective January 1, 2016 Comparison with CY 2015 Rates (PMPM Rates)					
Rate Cell	**Estimated CY2016 Average Monthly Enrollment**	**CY2015**	**CY 2016 Without Hospice**	**CY2016 with Hospice**	**% Change**
Nursing Facility – Subtier A					
Over Age 65	1,646	$5,907.38	$6,033.24	$6,006.08	1.9%
Under Age 65	218	$4,845.02	$5,209.22	$5,207.17	7.5%
Nursing Facility – Subtier B					
Over Age 65	196	$8,503.68	$9,128.71	$9,158.64	7.5%
Under Age 65	13	$8,710.76	$9,243.52	$9,254.62	6.2%
Nursing Facility LOC-Waiver					
Over Age 65	78	$2,059.64	$2,229.41	$2,229.41	8.2%
Under Age 65	57	$3,139.47	$2,771.22	$2,771.22	(11.7%)
Community Residents					
Over Age 65	12,696	$160.66	$141.93	$141.93	(11.7%)
Under Age 65	18,557	$120.71	$121.08	$121.08	0.3%

Notes:
1. Values shown are on a gross basis prior to reduction for patient pay amounts and withhold.
2. Distribution of enrollment by age based on base experience distribution applied to actual enrollment

FISCAL IMPACT ESTIMATE

The estimated fiscal impact of the 2016 MI Health Link rate changes on a state and federal expenditures basis is $1.9 million based upon the projected monthly enrollment for calendar year 2016. Development of estimated total expenditures, as well as federal only expenditures, under the current calendar year 2015 contracted capitation rates and the enclosed 2016 capitation rates, is illustrated on a rate cell basis in Table 2 based on the Federal Fiscal Year 2016 FMAP of 65.60%.

Table 2 compares the estimated state and federal expenditures under the current contracted capitation rates to the January 2016 contracted capitation rates, based on estimated average monthly enrollment for calendar year 2016. For illustration purposes we have assumed that the “with hospice” rates will be in effect for 6 months of the calendar year.

Table 2 State of Michigan Department of Health and Human Services MI Health Link Rates Effective January 1, 2016 Comparison with Previous Rates (Aggregate Expenditures $ Millions)			
Population	**Aggregate Expenditures at Current Rates**	**Aggregate Expenditures at January Rates**	**Expenditure Change**
Nursing Facility-Subtier A	$ 129.4	$ 132.5	$ 3.1
Nursing Facility-Subtier B	21.4	22.9	1.5
NFLOC - Waiver	4.1	4.0	(0.1)
Community Well	51.4	48.6	(2.7)
Total MI Health Link	**$206.2**	**$208.0**	**$1.9**
Total Federal	**135.2**	**136.5**	**1.2**
Total State	**70.9**	**71.6**	**0.7**

Notes:
1. Aggregate expenditures were developed based on projected monthly enrollment.
2. State expenditures based on Federal Fiscal Year 2016 FMAP of 65.60%
3. Values are rounded.

RATE CHANGE SUMMARY

Table 3 illustrates the changes from the CY 2015 capitation rates to the CY 2016 capitation rates by major category.

Table 3
State of Michigan
Department of Health and Human Services
MI Health Link
Rates Effective January 1, 2016
Capitation Rate Change Impact Summary

	Nursing Facility-Subtier A		Nursing Facility-Subtier B		NFLOC-Waiver		Community Well	
Rating Impact Factor	**Over 65**	**Under 65**	**Over 65**	**Under 65**	**Over 65**	**Under 65**	**Over 65**	**Under 65**
Previous Capitation	$ 5,907.38	$ 4,845.02	$ 8,503.68	$ 8,710.76	$ 2,059.64	$ 3,139.47	$ 160.66	$ 120.71
Rebasing and Trend[1]	125.86	364.20	625.03	532.76	3.51	(13.97)	(12.45)	2.53
Capitation Rate Updates[2]	N/A	N/A	N/A	N/A	166.26	(354.28)	0.49	0.61
Selection Factor[3]	N/A	N/A	N/A	N/A	N/A	N/A	(8.54)	(5.85)
Blending Cost Mix[4]	N/A	N/A	N/A	N/A	N/A	N/A	1.77	3.09
CY 2016 Capitation without Hospice	**$ 6,033.24**	**$ 5,209.22**	**$ 9,128.71**	**$ 9,243.52**	**$ 2,229.41**	**$ 2,771.22**	**$ 141.93**	**$ 121.08**
Hospice Coverage	$ (27.16)	$ (2.05)	$ 29.93	$ 11.10	$ 0.00	$ 0.00	$ 0.00	$ 0.00
CY 2016 Capitation with Hospice	**$ 6,006.08**	**$ 5,207.17**	**$ 9,158.64**	**$ 9,254.62**	**$ 2,229.41**	**$ 2,771.22**	**$ 141.93**	**$ 121.08**

[1] Rebasing and trend change reflects update to SFY 2014 base data along with completion and trend adjustments to CY 2016 midpoint

[2] Reflects impact of updates to MIChoice and Duals Lite capitation rates for SFY 2016

[3] Reflects impact of update to Community Well selection factor

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

SECTION I. MANAGED CARE RATES

1. GENERAL INFORMATION

This section provides information listed under the General Information section of the 2016 Managed Care Rate Setting Consultation Guide (2016 guide), Section I.

The capitation rates provided with this certification are "actuarially sound" for purposes of 42 CFR 438.6(c), according to the following criteria:

- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and,
- The capitation rates meet the requirements of 42 CFR 438.6(c).

Assessment of actuarial soundness under 42 CFR 438.6, in the context of MI Health Link, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration.

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Federal regulation 42 CFR §438.6(c).
- *2016 Medicaid Managed Care Rate Development Guide* published by CMS on September 23, 2015.
- Throughout this document, the term "actuarially sound" will be defined 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."

A. ANNUAL BASIS

The actuarial certification contained in this report is effective for the capitation rates for the one year rate period from January 1, 2016 through December 31, 2016.

B. DOCUMENTATION

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.

C. 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.

D. REQUIRED ELEMENTS

i. Actuarial certification

The actuarial certification, signed by Robert Damler, FSA, MAAA, is in Appendix 1. Mr. Damler meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, that certify that the final rates meet the standards in 42 CFR §438.6(c).

ii. Certified rates

The certified capitation rates by rate cell are illustrated in Appendix 3. These rates represent the contracted capitation rates to be paid to the integrated care organizations (ICOs) on a gross basis prior to reduction for projected patient pay amounts that will be recouped by the nursing facilities.

iii. Capitation rates for each rate cell

The capitation rates included in Appendix 3 are provided on a rate cell basis. The Nursing Facility capitation rates were 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.

iv. Program information

(a) Managed care program

MDHHS, along with CMS and the MI Health Link ICOs, provides benefits for fully dual eligibles under the MI Health Link program within targeted geographic areas. This letter provides the documentation and certification of the calendar year 2016 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. Demonstration Year 1 is comprised of the partial year 2015 and the complete calendar year 2016 time periods.

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

(b) Rating period

This actuarial certification is effective for the one-year rating period January 1, 2016 through December 31, 2016.

(c) Covered populations

Target Population

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

Excluded Populations

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

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

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

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

Nursing Facility Population

This population includes individuals residing in a nursing facility who meet the state definition of nursing home level of care and who are not enrolled in a waiver. Milliman identified the population in the capitation rate-setting process by using fields in the MDHHS eligibility data that denote Medicaid individuals as meeting the nursing home level of care criteria and reside in a nursing facility. The capitation rate for this rate cell was developed based on projected gross nursing facility rates. On an individual basis, MDHHS will deduct the actual patient pay liability amount from the nursing facility capitation rate shown in Table 1 and pay the net capitation rate to the ICOs. The nursing facility population is divided into subtiers, split by individuals residing in a privately owned (Subtier A) versus a publicly owned (Subtier B) nursing facility.

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

Nursing Facility Level of Care-Waiver Population

This population includes individuals who meet the state definition of nursing home level of care, but do not reside in a nursing facility. Eligible individuals must not be enrolled in the State's MIChoice program. Milliman utilized current MIChoice enrollee experience in the rate-setting process to determine the capitation rates for this population. The development of the rates is a combination of SFY 2016 MIChoice capitation payments and historical fee-for-service costs for services that are not identified as a waiver service. The development of these rates is illustrated in Appendix 3.

Community Residents Population

This population includes all other qualifying individuals who were not previously categorized. This population is comprised of eligible individuals who are neither institutionalized nor participating in a 1915(c) waiver program. The development of the capitation rates for this population is a blend of historical fee-for-service experience and the capitation rates for the Duals Lite program. As certain services are not covered under the Duals Lite capitation rate, fee-for-service costs related to Duals Lite enrollees are also included in the development of this rate. These costs are illustrated separately from fee-for-service experience on non-HMO enrollees in Appendix 3.

(d) 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.

(e) Covered services

Appendix 5 provides a listing of the services covered under the MI Health Link program. Beneficiaries who reside in a hospice facility are currently excluded from the program, but will be allowed to stay in the program once the contract change has been approved. However, beneficiaries will not be allowed to enroll from a hospice setting, but rather transition to hospice during enrollment.

Detailed benefit coverage information for all benefits can be found in the provider agreements.

2. DATA

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

A. DESCRIPTION OF THE DATA

i. Description of the data

(a) Types of data

The following experience served as the primary data sources for the calendar year 2016 MI Health Link capitation rate development:

- Fee-for-service data for the MI Health Link eligible population for October 1, 2013 through September 30, 2014 (base data year) and paid through February 2015
- Detailed fee-for-service and managed care enrollment data for October 1, 2013 through September 30, 2014
- Managed care capitation rates paid to the health plans serving enrollees in the Duals Lite and MIChoice managed care programs for SFY 2016
- Additional gross adjustment expenditure information outside the MMIS claims system
- Summary of policy and program changes through state fiscal year 2015 (including changes to fee schedules and other payment rates)
- Monthly enrollment for the MI Health Link program through February 2016

Appendix 2 illustrates the fee-for-service base data summaries that provide the foundation for the calendar year 2016 MI Health Link capitation rate development. The information is stratified by rate cell and category of service.

(b) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during state fiscal year 2014 (October 1, 2013 to September 30, 2014). The fee-for-service data used in our rate development process reflects adjudicated data through February 2015.

For the purposes of trend development and analyzing historical experience, we also reviewed fee-for-service and enrollment experience from state fiscal years 2012 and 2013. We utilized enrollment through February 2016 for purposes of emerging population enrollment patterns.

(c) Data sources

The historical fee-for-service data experience used for this certification was provided by MDHHS. This data is maintained and pulled by Optum. Additional off-system costs were provided by MDHHS.

(d) Sub-capitation

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

ii. Availability and quality of the data

(a) Steps taken to validate the data

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

Completeness

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

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

Accuracy

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

Consistency across data sources

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

(b) Actuary's assessment

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

The fee-for-service data represents the most appropriate data to be used for developing the actuarially sound capitation rates for the CY 2016 MI Health Link program.

(c) Data concerns

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

iii. Use of encounter and fee-for-service data

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

iv. Use of managed care encounter data

Encounter data was not used for this certification. The encounter data is not of sufficient quantity or quality to be relied upon for the development of actuarially sound capitation rates. The program began in March 2015 and the encounter data has not been reported to MDHHS. We did utilize the SFY 2016 capitation rates for the Duals Lite and MIChoice programs for purposes of establishing the Community and Waiver tier rates. These rates were based on encounter data, but no updates to these rates were made for purposes of the MI Health Link rate development. Additionally, as these rates are intended to be projections of costs "in absence of the demonstration" encounter data would not be applicable.

v. 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 fee-for-service claims data and enrollment for all covered services and populations.

B. DATA ADJUSTMENTS

Capitation rates were developed from historical state fiscal year 2014 fee-for-service data, paid through February 2015. As shown in Appendix 2, the primary base data year adjustments include completion, trend, reimbursement, and other program adjustments.

i. Credibility adjustment

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

ii. Completion adjustment

Historical fee-for-service claims experience was run through an internal Milliman claims reserving system to estimate completion factors. Separate sets of factors were developed for each demonstration tier and category of service. Milliman combined the nursing facility subtiers for purposes of the completion factor analysis. The development of the completion factors for SFY 2014 experience was based on a traditional triangle methodology utilizing paid data through February 2015. Average adjustments were applied to SFY 2014 experience to account for the runout applicable to each of the experience periods. Applied completion factors are illustrated in Appendix 2.

iii. Errors found in the data

No known specific errors were found in the data.

iv. 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 2016 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.

Based on a review of the specific policy and program changes that have occurred across other Medicaid populations in the State of Michigan, it was determined that no specific changes materially impact the services covered by the MI Health Link program. Included in this is the swtich to APR-DRG reimbursement effective October 1, 2015. We evaluated the payment methodology change to APR-DRG for the MI Health Link program and found the impact to be immaterial. This is primarily a result of the Medicare primary benefit and the Medicare benefit design

Although certain reimbursement changes have occurred, these are accounted for in the base data and consideration of future trend. Policy and program changes that were noted in the CY 2015 MI Health Link capitation rate development were for time periods prior to the base data utilized in the CY 2016 rate development process. Thus, the base data would include these adjustments.

v. Exclusion of payments or services from the data

The only services that have been excluded from the data are for beneficiaries in a hospice setting (who are otherwise eligible for the program) for the rates prior to the hospice change and any services and enrollment related to individuals noted under 1.D.iv.c. Both associated enrollment and services were removed for these beneficiaries.

3. PROJECTED BENEFIT COST AND TRENDS

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

A. DEVELOPMENT OF PROJECTED BENEFIT COSTS

i. Description of the data, assumptions, and methodologies

The adjusted fee-for-service base data year described in the previous section reflects benefits and program requirements as of the end of the data period (September 30, 2014). Additional adjustments were made for completion and trend to the midpoint of the effective period of the capitation rates. Development of the projected benefit cost stratified by population group, region, and category of service is provided in Appendix 2.

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

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

- **Date of Service** – The base data utilized for rate development was limited to SFY 2014.
- **Category of Service** – Claim line detail provided by MDHHS was used to summarize the expenditure data for the base data summaries. Milliman internal software was used to group services using detailed procedure and diagnosis code information for all service categories with the exception of institutional claims. For these expenditures, procedure code and MDHHS-specific information was used to categorize the expenditure data. Service category lines are contained within the appropriate provider types outlined below.
- **Provider Type** – Expenditures were stratified by provider type. The provider type includes nursing facility, inpatient hospital, outpatient hospital, prescription drugs, other ancillary services, and physician services. The following provides additional information regarding the provider type.
    - Nursing facility services include daily costs for members residing in a nursing facility. The Nursing Facility cost per day includes gross adjustment payments made by MDHHS to all nursing facilities for Quality Assurance Supplement (QAS) payments and Certified Public Expenditures on county-owned facilities.
    - Inpatient hospital services include all services performed and billed on the hospital facility claim, including any outpatient services that may have occurred in conjunction with that inpatient admission. This would include emergency room services that may have been incurred if the individual was admitted to the hospital.
        - Hospital Inpatient services were split between general and psychiatric services based on the DRG on the claim. Utilization rates have been shown for the number of admissions, length of stay, and days.
    - Outpatient hospital services include all services performed and billed on the hospital facility claim that were not associated with an inpatient admission. These services were split between general and hospice service based on the procedure and revenue codes on the claim.
    - Prescription drug claims were identified by the invoice type H, noted on the claim.
    - Ancillary services were stratified using HCPCS code and MDHHS code information. Utilization for other ancillary services represents the number of units billed on each individual claim.
        - A separate line item was included for services that are covered under the 1915c waiver. Please note that for the Nursing Facility Level of Care-Waiver tier, waiver services in the

historical fee-for-service actuarial models are removed as the MIChoice capitation rates were used to represent the expected cost of these services for this population.

- Home help service cost includes all gross adjustment payments made by MDHHS for Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax (FUTA) payments.

- Physician services were stratified by CPT-4 code for the majority of service categories. Milliman performed additional stratifications for physician services by CPT-4 code to provide details regarding the services provided. Utilization represents the count of claim lines associated with each individual claim number.

Actuarial Models

Each actuarial model illustrates annual utilization rates per 1,000, average cost per unit, and per member per month (PMPM) claims cost developed using fee-for-service data. Appendix 2 contains actuarial models for services incurred during SFY 2014 and paid through February 2015. Additional factors are reflected to illustrate the adjustments applied to the calendar year 2016 base data. The following provides a brief description of each of the data fields.

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

- **Average Length of Stay** – This value represents the average number of days a member stayed in a nursing facility each month or the average number of days per inpatient hospital admission.

- **Annual Utilization Per 1,000** – This value represents the annual utilization rates per 1,000 member months by type of service. The value was calculated by dividing the total utilization for each service category by the member months in the corresponding period and multiplying by 12 times 1,000.

- **Cost per Service –** This value represents the net paid amount per unit of service, which represents the paid amount divided by total utilization. The supplemental nursing facility patient pay amount is reflected below the base data cost model on a per member per month (PMPM) basis.

- **Member Months –** This value represents the number of enrollee months in each rate cell during each experience period. Each enrollee was assumed to be eligible for the entire month.

- **PMPM –** The PMPM value represents the net claim cost for each type of service. The value was calculated by multiplying the annual utilization per 1,000 times the average cost per unit and dividing by the product of 12 times 1,000.

(a) Prospective Program Changes

No specific adjustments were made for prospective program changes. The secondary set of rates reflect the inclusion of hospice beneficiaries, but only for those who are enrolled in the MI Health Link program and move to the hospice setting. While case mix and reimbursement changes have occurred, these are accounted for in our development of prospective trend.

(b) Managed care efficiency adjustments

No adjustments were applied to the fee-for-service base data to reflect managed care efficiency adjustments. As CY 2016 is still part of demonstration year 1, expected savings from the integration of Medicare and Medicaid services for the MI Health Link program are explicitly reflected as the 1% integrated care joint savings percentage referenced in the development of the rates in Appendix 3.

(c) Covered population changes

A separate set of rates was developed for when the hospice benefit change is approved in the contract. This will only be for beneficiaries who move into a hospice setting after already being enrolled in the MI Health Link program. Beneficiaries who reside in a hospice setting on a fee-for-service basis will not be allowed to enroll in the MI Health Link program.

Prospective risk selection factors were applied to the base data in order to reflect the voluntary and opt-out nature of MI Health Link. These selection factors were developed using claims probability distributions (CPDs) by population and applying penetration assumptions by cost category, which reflects a more favorable mix of enrollment than the current fee-for-service experience. Evaluation of the CPDs showed that the risk selection is applicable only to the Community population, because the majority of service cost for the Nursing Facility and waiver populations is determined by the nursing facility and waiver services.

Based on assumed participation of hospice enrollees, a selection factor was developed under the “with hospice” set of rates. Based on historical fee-for-service experience, the percentage of the Nursing Facility population was approximately 4.8% hospice beneficiaries for the Over 65 population and 2.4% for Under 65. We have assumed that only 1% of those who enroll in the MI Health Link program will eventually move to a hospice setting. This adjustment results in an adjustment factor of 1.004 for the Over 65 nursing facility rate cells and a 1.001 adjustment for the Under 65 nursing facility rate cells.

During the calendar year 2015 rate setting process, assumptions were made regarding community resident enrollment percentages with varying penetration levels based on members’ annual cost and types of services that were utilized. The composite selection factor that was estimated for the Community population assumed to participate in MI Health Link was approximately 0.818 for the Over Age 65 population and 0.812 for the Under Age 65 population in CY 2015 rates. We performed a review of these selection factors based on an analysis of SFY 2014 experience for all eligible Community residents and those which enrolled in the MI Health Link program through February 2016. The results of this analysis indicated that the emerging adjustment was 0.702 for the Over 65 and 0.709 for the Under 65 populations. We have assigned 50% credibility to the updated selection factors and are applying adjustment factors of 0.760 for both the Over 65 and 0 Under 65 population in the CY 2016 rate setting process. This adjustment is applied to the total PMPM cost after application of trend, program and rating period adjustments only for the fee-for-service component of the Community rate. It is assumed that the Duals Lite component of the Community rate already reflects the selection inherent in the base experience. The comparison of the Community Tier and related selection factor analysis is included as Appendix 7 of this report.

(d) Data smoothing

Regional rating factors were developed and utilized as a data smoothing technique for region and population combinations. For example, regional and population group cost relativities were developed from the combined data for all Community populations. The regional and population group cost relativities will be utilized to establish final payment to the ICOs in CY 2016. The regional factors are illustrated in Appendix 3.

ii. Material changes to the data, assumptions, and methodologies

No material changes have been made to the data outside of items previously indicated.

B. PROJECTED BENEFIT COST TRENDS

i. Description of the data, assumptions, and methodologies

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (SFY 2014) to the CY 2016 rating period of this certification. We evaluated prospective trend rates using MDHHS, as well as external data sources.

Milliman developed trend rate assumptions for the populations and services covered under the MI Health Link program based on claims experience data from October 1, 2011 through September 30, 2014. Utilization, cost per unit, and PMPM costs were summarized for the experience period by incurred month, rate cell, and medical service category. Trend rate assumptions were developed based on a review of regression modeling results, Medicare market basket forecasts, and actuarial judgment. Separate trend rates were developed by demonstration tier and medical service category. Separate trend adjustments were developed for utilization and cost per service. Cost per unit trend rates are reflective of both changes in the unit cost of a given medical service and changes in the mix or intensity of services over time within a given medical service category.

Appendix 6 provides the assumed utilization and cost trends that were applied to the base period data in the development of the capitation rates for the MI Health Link program.

(a) Data

The primary source of data used in the development of historical fee-for-service trends was SFY 2012 through 2014 fee-for-service data specific to the MI Health Link eligible population.

External data sources that were referenced 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. These other sources included previously utilized MI Health Link rate development trend rates, MDHHS budgetary forecasting assumptions, and trend rates utilized in other state demonstration programs.

(b) 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.

(c) 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 data trend projections due to anomalies observed in the historical trend data and patterns that we do not expect to continue over the long-term. We referred to the sources

listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in the MI Health Link population, and shifting population mix.

Explicit adjustments were made outside of trend to reflect all recent or planned changes in reimbursement from the base period to the rating period.

ii. Benefit cost trend components

Appendix 6 provides the trend rates by population and category of service. These trends include both utilization and cost per service components.

iii. Variation

We developed trends by population and 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 identified in the section above.

iv. 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 explicitly rely on the historical fee-for-serve 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 MI Health Link population, and shifting population mix.

We made adjustments to the trends derived from historical experience in cases where the resulting trends did not appear reasonably sustainable, or were not within reasonable 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 additional sources and actuarial judgement to develop prospective trend.

v. Any other adjustments

(a) Impact of managed care

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

(b) Trend changes other than utilization and unit cost

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

C. IN LIEU OF SERVICES

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

D. RETROSPECTIVE ELIGIBILITY PERIODS

i. Health plan responsibility

ICOs are not responsible for periods of retrospective eligibility as those time periods are covered on a fee-for-service basis. Therefore, no adjustments have been made to account for retrospective eligibility.

ii. Enrollment treatment

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

iii. Adjustments

No changes have been made to the rates to reflect retrospective eligibility.

E. FINAL PROJECTED BENEFIT COSTS

Final projected benefit costs are documented by population and rate cell in Appendix 3.

F. IMPACT OF MATERIAL CHANGES

This section relates to material changes to covered benefits or services since the previous rate certification, which was for the CY 2015 rating period.

i. Change to covered benefits

The only material benefit change from the prior rate setting is the coverage of hospice beneficiaries for those who move into a hospice setting during active enrollment in the MI Health Link program. This change has been previously discussed.

ii. Change to payment requirements

There were no material changes related to payment requirements.

iii. Change to waiver requirements

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

iv. Change due to litigation

There were no material changes due to litigation.

G. DOCUMENTATION OF MATERIAL CHANGES

We have documented any material changes earlier in the document.

4. PASS-THROUGH PAYMENTS

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

5. PROJECTED NON-BENEFIT COSTS

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

Certain non-benefit expenses are included in the development of the Duals Lite and MIChoice population capitation rates that are utilized in the development of the Community and Waiver rates. A small change was made to the Duals Lite rate to remove the portion of the rate associated with use tax as ICOs will not be responsible for paying the use tax on applicable capitation rates. No other changes were made to those rates under the CY 2016 MI Health Link rate development process.

A. DATA, ASSUMPTIONS AND METHODOLOGIES

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 3.

B. NON-BENEFIT COSTS, BY COST CATEGORY

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 3.

C. PMPM VERSUS PERCENTAGE

This section is not applicable because there was no specific allowance for non-benefit costs in the development of the rates illustrated in Appendix 3.

D. HEALTH INSURER FEE

i. Whether the fee is incorporated in the rates

There is no allocation in the rate development for purposes of the Health Insurer Fee (HIF). As these rates are to be developed “in absence of the demonstration,” no HIF would be applicable under a fee-for-service arrangement. The only consideration for HIF in the MI Health Link rates would be attributed to the Duals Lite capitation portion of the rate documented in the development of the Community tier in Appendix 3.

ii. Fee year or data year

To the extent HIF expenses are provided for the Duals Lite component of the rate, it will be calculated based on the fee year. Potential amended calendar year 2016 rates will be based on the 2016 HIF attributable to the 2015 data year.

iii. Determination of fee impact to rates

The calculation of the fee for each ICO that will be subject to payment by the state will be based on the final Form 8963 premium amounts reported by the insurer, aggregate HIF premium base, final IRS invoices provided to the health plans subject to the HIF, Form 8963 premium amounts attributable to MDHHS, fee year HIF tax percentage, and adjustments for premium revenue based on benefits described in 26 CFR 57.2(h)(2)(ix) such as nursing home and home health care. Final fee amounts are adjusted for applicable fees and taxes that are applied to MDHHS capitation rate revenue associated with the Duals Lite component of the Community rate. The CY 2016 capitation rates will be amended based on the 2016 HIF attributable to the 2015 data year. We anticipate amending the rates, if necessary, in the last quarter of calendar year 2016.

iv. Identification of long-term care benefits

As a majority of the services provided under the MI Health Link program are operated on a fee-for-service basis, the impact of the HIF is anticipated to be minimal.

6. RATE RANGE DEVELOPMENT

This section is not applicable because rate ranges were not established for the MI Health Link program.

7. RISK MITIGATION AND RELATED CONTRACTUAL PROVISIONS

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

A. DESCRIPTION OF RISK MITIGATION

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 is a risk corridor established for gains/losses. The following provides a summary of the risk corridor applicable to the MI Health Link program:

1. Between 0.0% and 3.0% gain/loss, the ICO will bear 100% of the risk/reward.
2. For the increment greater than 3.0% up to 9.0% gain/loss, the ICO will bear 50.0% of the risk/reward; the state and CMS will share the other 50.0%.
3. Greater than 9.0% gain/loss, the ICO will bear 100% of the risk/reward.

All medical and administrative costs will be subject to the risk corridor with ICOs required to submit a certified financial statement as developed by the state. The Medicare risk sharing liability is 2% of the risk-adjusted Medicare baseline as described in the MOU between the state and CMS.

A 1% withhold is applied to all capitation rates. The rates being paid to the ICOs without the withhold are also actuarially sound. The amounts being withheld from payments to the plans can be earned back based upon metrics that consistent with cost and utilization assumptions included in the rate development process

B. RISK ADJUSTMENT MODEL AND METHODOLOGY

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

C. ADDRESS COST NEUTRALITY

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

D. OTHER RISK SHARING ARRANGEMENTS

No other risk sharing arrangements exist for the covered populations.

E. MEDICAL LOSS RATIO

i. Description

Beginning Demonstration Year 2, each ICO will be required annually to meet a minimum medical loss ratio (MMLR) threshold which regulates the minimum amount (as a percentage of the gross joint Medicare and Medicaid payments) that must be used for expenses either directly related to medical claims or those which are related to the care and quality of enrollees. This will be established at 85%. However, this is not applicable for CY 2016 as CY 2017 would be demonstration year 2.

ii. Financial consequences

Currently there are no financial consequences for having a medical loss ratio below the 85% in demonstration year 1.

F. 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.

G. INCENTIVES AND WITHHOLDS

i. Incentives

There are currently no incentives in the health plan contracts.

ii. Withholds

Withholds constitute 1% of the certified rates. The details of the quality metrics can be found in the 3-way contract.

iii. Estimate of percent to be returned

The MI Health Link program is new and the estimated amount of withhold return is uncertain.

iv. Effect on the capitation rates

The rates are certified as actuarially sound with or without withhold measures.

8. OTHER RATE DEVELOPMENT CONSIDERATIONS

A. DIFFERENT FMAP

None of the MI Health Link population groups are eligible for an FMAP higher than the regular FMAP of 65.60%.

B. ACTUARIALLY ACCEPTED PRACTICES AND PRINCIPLES

i. Reasonable, appropriate, and attainable

In our judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To our knowledge, there are no reasonable, appropriate, and attainable costs that have not been included in the certification with the exception of HIF related expenses that are not to be included as part of this rate development.

ii. Outside the rate setting process

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

iii. Rates within ranges

The rates to be paid will be consistent with the rates as documented in this report. A rate range was not developed.

9. PROCEDURES FOR RATE CERTIFICATION AND CONTRACT AMENDMENTS

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

1. The hospice benefit change which has been accounted for in this rate certification.
2. A contract amendment that does not affect the rates.
3. Risk adjustment, under a methodology described in the initial certification, changes the rates paid to the ICOs

In case 2 listed above, a contract amendment must still be submitted to CMS.

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

1. MANAGED LONG-TERM SERVICES AND SUPPORTS

A. COMPLETION OF SECTION I.

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

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

B. MLTSS RATE STRUCTURE

(a) Capitation Rate Structure

The MI Health Link rate structure for calendar year 2016 did not change from the 2015 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.

Nursing Facility

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

Transition Rules

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

NFLOC-Waiver

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

(b) Methodology

The structure, rationale, and payment methodology are discussed in (a) above.

C. MANAGED CARE EFFECT

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

D. NON-BENEFIT COST

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

E. EXPERIENCE AND ASSUMPTIONS

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

SECTION III. NEW ADULT GROUP CAPITATION RATES

Section III of the 2016 guidance is not applicable to the MI Health Link program as these are not new adult groups.

LIMITATIONS AND QUALIFICATIONS

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved June 30, 2015.

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

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

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

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

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

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

APPENDIX 1: ACTUARIAL CERTIFICATION

State of Michigan
Department of Health and Human Services
Calendar Year 2016 Capitation Rates
MI Health Link Program
Actuarial Certification

I, Robert Damler, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Michigan and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.6(c), according to the following criteria:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and,
- the capitation rates meet the requirements of 42 CFR 438.6(c).

Assessment of actuarial soundness under 42 CFR 438.6, in the context of MI Health Link, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration.

For the purposes of this certification "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 2016.

The capitation rates are considered actuarially sound even if the withhold rate is fully held due to a plan not meeting the contract requirements.

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

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

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

Robert Damler, FSA
Member, American Academy of Actuaries

May 3, 2016
Date

APPENDIX 2: BASE DATA ACTUARIAL MODELS

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Nursing Facility - Tier 1 (including Hospice)
Subtier Private Facilities / HLTCU
Age 65+

Total Member Months **102,703**

	Fiscal Year 2014								Trended/Adjusted to CY 2016		
Type of Service	**Annual Admits Per 1,000**	**Average Length of Stay**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**	**Completion Adjustment**	**Trend Factor Util**	**Trend Factor Cost**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**
Nursing Facility											
Nursing Facility	10,798.0	25.3	272,912.9	$ 205.53	$ 4,674.38	1.007	1.010	1.010	281,029.9	$ 210.19	$ 4,922.47
Inpatient Hospital											
General	41.0	8.5	348.1	$ 426.25	$ 12.36	1.110	0.980	1.020	369.2	$ 445.67	$ 13.71
Psychiatric	3.3	20.0	65.4	621.60	3.39	1.110	0.980	1.020	69.4	649.93	3.76
Subtotal	44.3	9.3	413.5	$ 457.16	$ 15.75				438.6	$ 477.99	$ 17.47
Outpatient Hospital											
General			547.5	$ 45.87	$ 2.09	1.011	1.015	1.005	572.5	$ 46.39	$ 2.21
Hospice			668.3	4,323.14	240.78	1.011	1.015	1.005	698.9	4,371.92	254.62
Subtotal			1,215.9	$ 2,397.01	$ 242.87				1,271.4	$ 2,424.07	$ 256.83
Prescription Drugs					$ 1.22	1.001	0.975	0.990			$ 1.13
Other Ancillaries											
Transportation			48.1	201.76	0.81	1.027	1.015	0.995	51.1	$ 199.50	$ 0.85
DME/Prosthetics/Orthotics			1,344.0	55.34	6.20	1.027	1.015	0.995	1,427.7	54.72	6.51
Waiver Services			37.2	6.74	0.02	1.027	1.015	0.995	39.5	6.67	0.02
Other Ancillary			1,616.9	32.50	4.38	1.027	1.015	0.995	1,717.5	32.14	4.60
Home Help			138.5	427.39	4.93	1.027	1.015	0.995	147.1	422.59	5.18
Subtotal			3,184.6	$ 61.57	$ 16.34				3,382.9	$ 60.88	$ 17.16
Physician											
Private Duty Nursing/Home H			1.1	$ 1,126.10	$ 0.10	1.027	1.015	0.995	1.1	$ 1,113.47	$ 0.10
Phys Visits Office/Consult			320.3	20.62	0.55	1.027	1.015	0.995	340.2	20.39	0.58
Phys Visit Other			11,631.8	20.78	20.14	1.027	1.015	0.995	12,355.9	20.54	21.15
Surgery/Anesthesia			9.2	28.89	0.02	1.027	1.015	0.995	9.8	28.57	0.02
Lab/Pathology			492.1	6.40	0.26	1.027	1.015	0.995	522.8	6.33	0.28
Surgery			433.5	14.46	0.52	1.027	1.015	0.995	460.5	14.30	0.55
Vision/Hearing			219.3	22.42	0.41	1.027	1.015	0.995	233.0	22.17	0.43
Therapeutic Inj.			59.5	41.55	0.21	1.027	1.015	0.995	63.2	41.08	0.22
Other			398.3	6.46	0.21	1.027	1.015	0.995	423.1	6.39	0.23
Subtotal			13,565.1	$ 19.84	$ 22.43				14,409.5	$ 19.61	$ 23.55
Total Claims/Benefit Cost					$ 4,972.99						$ 5,238.62
Supplemental SNF Copayments					$ 782.07	1.007	1.010	1.010			$ 805.33
Total Adjusted Gross Cost					**$5,755.06**						**$6,043.95**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Nursing Facility - Tier 1 (including Hospice)
Subtier Private Facilities / HLTCU
Age Under 65

Total Member Months **14,875**

	Fiscal Year 2014								Trended/Adjusted to CY 2016		
Type of Service	**Annual Admits Per 1,000**	**Average Length of Stay**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**	**Completion Adjustment**	**Trend Factor Util**	**Trend Factor Cost**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**
Nursing Facility											
Nursing Facility	9,752.5	23.1	225,577.4	$ 220.60	$ 4,146.83	1.007	1.010	1.010	232,286.5	$ 225.59	$ 4,366.79
Inpatient Hospital											
General	135.5	14.0	1,899.0	$ 521.49	$ 82.53	1.110	0.980	1.020	2,014.3	$ 545.25	$ 91.53
Psychiatric	6.5	26.6	171.8	594.96	8.52	1.110	0.980	1.020	182.3	622.07	9.45
Subtotal	142.0	14.6	2,070.9	$ 527.59	$ 91.05				2,196.6	$ 551.62	$ 100.97
Outpatient Hospital											
General			1,749.0	$ 71.07	$ 10.36	1.011	1.015	1.005	1,828.9	$ 71.87	$ 10.95
Hospice			343.7	4,134.17	118.40	1.011	1.015	1.005	359.4	4,180.83	125.20
Subtotal			2,092.6	$ 738.33	$ 128.76				2,188.2	$ 746.66	$ 136.16
Prescription Drugs					$ 3.11	1.001	0.975	0.990			$ 2.88
Other Ancillaries											
Transportation			134.7	214.72	2.41	1.027	1.015	0.995	143.1	$ 212.32	$ 2.53
DME/Prosthetics/Orthotics			2,679.9	60.13	13.43	1.027	1.015	0.995	2,846.8	59.45	14.10
Waiver Services			93.6	5.86	0.05	1.027	1.015	0.995	99.4	5.80	0.05
Other Ancillary			2,116.0	27.88	4.92	1.027	1.015	0.995	2,247.8	27.57	5.16
Home Help			470.3	454.97	17.83	1.027	1.015	0.995	499.6	449.87	18.73
Subtotal			5,494.6	$ 84.37	$ 38.63				5,836.6	$ 83.43	$ 40.58
Physician											
Private Duty Nursing/Home Health			9.7	$ 110.37	$ 0.09	1.027	1.015	0.995	10.3	$ 109.13	$ 0.09
Phys Visits Office/Consult			975.3	20.88	1.70	1.027	1.015	0.995	1,036.0	20.65	1.78
Phys Visit Other			24,021.8	20.74	41.51	1.027	1.015	0.995	25,517.1	20.50	43.59
Surgery/Anesthesia			27.4	30.47	0.07	1.027	1.015	0.995	29.1	30.13	0.07
Lab/Pathology			1,069.7	7.15	0.64	1.027	1.015	0.995	1,136.3	7.07	0.67
Surgery			813.2	16.44	1.11	1.027	1.015	0.995	863.8	16.25	1.17
Vision/Hearing			270.3	22.73	0.51	1.027	1.015	0.995	287.1	22.47	0.54
Therapeutic Inj.			198.5	41.04	0.68	1.027	1.015	0.995	210.8	40.58	0.71
Other			830.9	7.78	0.54	1.027	1.015	0.995	882.7	7.69	0.57
Subtotal			28,216.7	$ 19.92	$ 46.85				29,973.2	$ 19.70	$ 49.20
Total Claims/Benefit Cost					$ 4,455.22						$ 4,696.58
Supplemental SNF Copayments					$ 540.76	1.007	1.010	1.010			$ 556.85
Total Adjusted Gross Cost					**$4,995.98**						**$5,253.43**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Nursing Facility - Tier 1 (including Hospice)
Subtier County Owned Facilities
Age 65+

Total Member Months **8,313**

	Fiscal Year 2014								Trended/Adjusted to CY 2016			
Type of Service	**Annual Admits Per 1,000**	**Average Length of Stay**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**	**Completion Adjustment**	**Trend Factor Util**	**Trend Factor Cost**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**
Nursing Facility											
Nursing Facility	11,932.2	28.2	336,004.3	$ 276.91	$ 7,753.48	1.007	1.010	1.010	345,997.7	$ 283.18	$ 8,164.97
Inpatient Hospital											
General	31.8	2.6	83.7	$ 419.75	$ 2.93	1.110	0.980	1.020	88.8	$ 438.87	$ 3.25
Psychiatric	-	-	-	-	-	1.110	0.980	1.020	-	-	-
Subtotal	31.8	2.6	83.7	$ 419.75	$ 2.93				88.8	$ 438.87	$ 3.25
Outpatient Hospital											
General			658.2	$ 48.89	$ 2.68	1.011	1.015	1.005	688.3	$ 49.44	$ 2.84
Hospice			41.9	2,150.09	7.50	1.011	1.015	1.005	43.8	2,174.35	7.93
Subtotal			700.1	$ 174.53	$ 10.18				732.1	$ 176.48	$ 10.77
Prescription Drugs					$ 2.05	1.001	0.975	0.990			$ 1.90
Other Ancillaries											
Transportation			8.7	171.30	0.12	1.027	1.015	0.995	9.2	$ 169.38	$ 0.13
DME/Prosthetics/Orthotics			398.4	71.88	2.39	1.027	1.015	0.995	423.2	71.07	2.51
Waiver Services			1.4	4.00	0.00	1.027	1.015	0.995	1.5	3.96	0.00
Other Ancillary			1,280.4	24.78	2.64	1.027	1.015	0.995	1,360.1	24.50	2.78
Home Help			15.9	419.10	0.55	1.027	1.015	0.995	16.9	414.40	0.58
Subtotal			1,704.8	$ 40.19	$ 5.71				1,810.9	$ 39.73	$ 6.00
Physician											
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	1.027	1.015	0.995	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			170.3	22.76	0.32	1.027	1.015	0.995	180.9	22.51	0.34
Phys Visit Other			4,220.9	22.75	8.00	1.027	1.015	0.995	4,483.6	22.50	8.41
Surgery/Anesthesia			1.4	38.96	0.00	1.027	1.015	0.995	1.5	38.52	0.00
Lab/Pathology			189.1	9.57	0.15	1.027	1.015	0.995	200.9	9.46	0.16
Surgery			244.0	15.98	0.32	1.027	1.015	0.995	259.1	15.80	0.34
Vision/Hearing			209.3	31.92	0.56	1.027	1.015	0.995	222.3	31.56	0.58
Therapeutic Inj.			39.0	31.32	0.10	1.027	1.015	0.995	41.4	30.97	0.11
Other			197.8	6.80	0.11	1.027	1.015	0.995	210.1	6.72	0.12
Subtotal			5,271.7	$ 21.80	$ 9.58				5,599.9	$ 21.56	$ 10.06
Total Claims/Benefit Cost					$ 7,783.93						$ 8,196.94
Supplemental SNF Copayments					$ 990.01	1.007	1.010	1.010			$ 1,019.45
Total Adjusted Gross Cost					**$8,773.94**						**$9,216.39**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Nursing Facility - Tier 1 (including Hospice)
Subtier County Owned Facilities
Age Under 65

Total Member Months **825**

	Fiscal Year 2014								Trended/Adjusted to CY 2016		
Type of Service	**Annual Admits Per 1,000**	**Average Length of Stay**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**	**Completion Adjustment**	**Trend Factor Util**	**Trend Factor Cost**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**
Nursing Facility											
Nursing Facility	11,854.5	28.0	332,058.2	$ 290.63	$ 8,042.20	1.007	1.010	1.010	341,934.2	$ 297.21	$ 8,468.86
Inpatient Hospital											
General	43.6	4.0	174.5	$ 193.49	$ 2.81	1.110	0.980	1.020	185.1	$ 202.31	$ 3.12
Psychiatric	-	-	-	-	-	1.110	0.980	1.020	-	-	-
Subtotal	43.6	4.0	174.5	$ 193.49	$ 2.81				185.1	$ 202.31	$ 3.12
Outpatient Hospital											
General			770.9	$ 70.74	$ 4.54	1.011	1.015	1.005	806.1	$ 71.54	$ 4.81
Hospice			43.6	804.60	2.93	1.011	1.015	1.005	45.6	813.68	3.09
Subtotal			814.5	$ 110.05	$ 7.47				851.8	$ 111.30	$ 7.90
Prescription Drugs					$ 1.39	1.001	0.975	0.990			$ 1.28
Other Ancillaries											
Transportation			189.1	235.39	3.71	1.027	1.015	0.995	200.9	$ 232.75	$ 3.90
DME/Prosthetics/Orthotics			930.9	117.80	9.14	1.027	1.015	0.995	988.9	116.47	9.60
Waiver Services			14.5	4.00	0.00	1.027	1.015	0.995	15.5	3.96	0.01
Other Ancillary			2,385.5	15.51	3.08	1.027	1.015	0.995	2,534.0	15.33	3.24
Home Help			87.3	72.89	0.53	1.027	1.015	0.995	92.7	72.08	0.56
Subtotal			3,607.3	$ 54.77	$ 16.46				3,831.8	$ 54.15	$ 17.29
Physician											
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	1.027	1.015	0.995	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			349.1	28.98	0.84	1.027	1.015	0.995	370.8	28.65	0.89
Phys Visit Other			11,403.6	20.49	19.48	1.027	1.015	0.995	12,113.5	20.26	20.45
Surgery/Anesthesia			-	-	-	1.027	1.015	0.995	-	-	-
Lab/Pathology			523.6	10.46	0.46	1.027	1.015	0.995	556.2	10.34	0.48
Surgery			276.4	13.67	0.31	1.027	1.015	0.995	293.6	13.51	0.33
Vision/Hearing			363.6	23.88	0.72	1.027	1.015	0.995	386.3	23.61	0.76
Therapeutic Inj.			29.1	184.49	0.45	1.027	1.015	0.995	30.9	182.42	0.47
Other			130.9	5.28	0.06	1.027	1.015	0.995	139.1	5.22	0.06
Subtotal			13,076.4	$ 20.48	$ 22.32				13,890.4	$ 20.25	$ 23.44
Total Claims/Benefit Cost					$ 8,092.65						$ 8,521.89
Supplemental SNF Copayments					$ 791.41	1.007	1.010	1.010			$ 814.95
Total Adjusted Gross Cost					**$8,884.06**						**$9,336.84**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Nursing Facility - Tier 1 (excluding Hospice)
Subtier Private Facilities / HLTCU
Age 65+

Total Member Months **97,394**

	Fiscal Year 2014								Trended/Adjusted to CY 2016			
Type of Service	**Annual Admits Per 1,000**	**Average Length of Stay**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**	**Completion Adjustment**	**Trend Factor Util**	**Trend Factor Cost**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**
Nursing Facility											
Nursing Facility	11,307.6	25.4	286,767.9	$ 205.60	$ 4,913.38	1.007	1.010	1.010	295,296.9	$ 210.26	$ 5,174.09
Inpatient Hospital											
General	41.8	8.6	358.8	$ 427.18	$ 12.77	1.110	0.980	1.020	380.6	$ 446.65	$ 14.17
Psychiatric	3.4	20.0	69.0	621.60	3.57	1.110	0.980	1.020	73.2	649.93	3.96
Subtotal	45.2	9.5	427.8	$ 458.54	$ 16.35				453.8	$ 479.44	$ 18.13
Outpatient Hospital											
General			567.4	$ 46.03	$ 2.18	1.011	1.015	1.005	593.3	$ 46.55	$ 2.30
Hospice			44.7	3,411.53	12.72	1.011	1.015	1.005	46.8	3,450.03	13.45
Subtotal			612.1	$ 291.94	$ 14.89				640.1	$ 295.24	$ 15.75
Prescription Drugs					$ 1.26	1.001	0.975	0.990			$ 1.16
Other Ancillaries											
Transportation			50.0	202.88	0.85	1.027	1.015	0.995	53.1	$ 200.61	$ 0.89
DME/Prosthetics/Orthotics			1,331.7	57.32	6.36	1.027	1.015	0.995	1,414.6	56.68	6.68
Waiver Services			31.4	5.44	0.01	1.027	1.015	0.995	33.4	5.38	0.01
Other Ancillary			1,645.6	32.52	4.46	1.027	1.015	0.995	1,748.0	32.15	4.68
Home Help			143.0	425.85	5.08	1.027	1.015	0.995	152.0	421.08	5.33
Subtotal			3,201.8	$ 62.81	$ 16.76				3,401.1	$ 62.10	$ 17.60
Physician											
Private Duty Nursing/Home Health			1.1	$ 1,126.10	$ 0.10	1.027	1.015	0.995	1.2	$ 1,113.47	$ 0.11
Phys Visits Office/Consult			331.6	20.68	0.57	1.027	1.015	0.995	352.2	20.45	0.60
Phys Visit Other			11,718.8	20.75	20.27	1.027	1.015	0.995	12,448.3	20.52	21.29
Surgery/Anesthesia			9.6	28.82	0.02	1.027	1.015	0.995	10.2	28.50	0.02
Lab/Pathology			499.0	6.42	0.27	1.027	1.015	0.995	530.1	6.35	0.28
Surgery			442.0	14.54	0.54	1.027	1.015	0.995	469.5	14.37	0.56
Vision/Hearing			223.0	22.45	0.42	1.027	1.015	0.995	236.9	22.20	0.44
Therapeutic Inj.			61.7	39.80	0.20	1.027	1.015	0.995	65.6	39.35	0.22
Other			409.3	6.52	0.22	1.027	1.015	0.995	434.8	6.45	0.23
Subtotal			13,696.1	$ 19.81	$ 22.61				14,548.7	$ 19.59	$ 23.75
Total Claims/Benefit Cost					$ 4,985.24						$ 5,250.48
Supplemental SNF Copayments					$ 819.33	1.007	1.010	1.010			$ 843.70
Total Adjusted Gross Cost					**$5,804.57**						**$6,094.18**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Nursing Facility - Tier 1 (excluding Hospice)
Subtier Private Facilities / HLTCU
Age Under 65

Total Member Months **14,502**

	Fiscal Year 2014								Trended/Adjusted to CY 2016		
Type of Service	**Annual Admits Per 1,000**	**Average Length of Stay**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**	**Completion Adjustment**	**Trend Factor Util**	**Trend Factor Cost**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**
Nursing Facility											
Nursing Facility	9,976.0	23.2	231,025.2	$ 220.63	$ 4,247.65	1.007	1.010	1.010	237,896.4	$ 225.63	$ 4,473.05
Inpatient Hospital											
General	137.4	14.2	1,944.6	$ 521.69	$ 84.54	1.110	0.980	1.020	2,062.6	$ 545.46	$ 93.76
Psychiatric	6.6	26.6	176.3	594.96	8.74	1.110	0.980	1.020	187.0	622.07	9.69
Subtotal	144.0	14.7	2,120.8	$ 527.78	$ 93.28				2,249.6	$ 551.83	$ 103.45
Outpatient Hospital											
General			1,786.5	$ 71.28	$ 10.61	1.011	1.015	1.005	1,868.1	$ 72.09	$ 11.22
Hospice			40.5	3,212.68	10.86	1.011	1.015	1.005	42.4	3,248.93	11.48
Subtotal			1,827.1	$ 141.00	$ 21.47				1,910.5	$ 142.59	$ 22.70
Prescription Drugs					$ 3.18	1.001	0.975	0.990			$ 2.94
Other Ancillaries											
Transportation			138.2	214.72	2.47	1.027	1.015	0.995	146.8	$ 212.32	$ 2.60
DME/Prosthetics/Orthotics			2,681.0	61.20	13.67	1.027	1.015	0.995	2,847.9	60.52	14.36
Waiver Services			93.5	5.83	0.05	1.027	1.015	0.995	99.3	5.76	0.05
Other Ancillary			2,148.9	27.93	5.00	1.027	1.015	0.995	2,282.7	27.62	5.25
Home Help			475.0	456.59	18.07	1.027	1.015	0.995	504.5	451.47	18.98
Subtotal			5,536.6	$ 85.10	$ 39.27				5,881.3	$ 84.15	$ 41.24
Physician											
Private Duty Nursing/Home Health			9.9	$ 110.37	$ 0.09	1.027	1.015	0.995	10.6	$ 109.13	$ 0.10
Phys Visits Office/Consult			991.3	20.89	1.73	1.027	1.015	0.995	1,053.0	20.65	1.81
Phys Visit Other			24,046.3	20.73	41.55	1.027	1.015	0.995	25,543.2	20.50	43.64
Surgery/Anesthesia			28.1	30.47	0.07	1.027	1.015	0.995	29.9	30.13	0.08
Lab/Pathology			1,072.4	7.22	0.65	1.027	1.015	0.995	1,139.2	7.14	0.68
Surgery			825.8	16.43	1.13	1.027	1.015	0.995	877.2	16.25	1.19
Vision/Hearing			274.7	22.60	0.52	1.027	1.015	0.995	291.8	22.34	0.54
Therapeutic Inj.			203.6	41.04	0.70	1.027	1.015	0.995	216.2	40.58	0.73
Other			845.7	7.76	0.55	1.027	1.015	0.995	898.3	7.67	0.57
Subtotal			28,297.9	$ 19.92	$ 46.97				30,059.4	$ 19.69	$ 49.33
Total Claims/Benefit Cost					$ 4,451.81						$ 4,692.71
Supplemental SNF Copayments					$ 552.69	1.007	1.010	1.010			$ 569.13
Total Adjusted Gross Cost					**$5,004.50**						**$5,261.84**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Nursing Facility - Tier 1 (excluding Hospice)
Subtier County Owned Facilities
Age 65+

Total Member Months **8,288**

	Fiscal Year 2014								Trended/Adjusted to CY 2016			
Type of Service	**Annual Admits Per 1,000**	**Average Length of Stay**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**	**Completion Adjustment**	**Trend Factor Util**	**Trend Factor Cost**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**
Nursing Facility											
Nursing Facility	11,931.9	28.2	336,444.5	$ 276.95	$ 7,764.77	1.007	1.010	1.010	346,451.0	$ 283.22	$ 8,176.82
Inpatient Hospital											
General	30.4	2.5	76.7	$ 455.21	$ 2.91	1.110	0.980	1.020	81.4	$ 475.95	$ 3.23
Psychiatric	-	-	-	-	-	1.110	0.980	1.020	-	-	-
Subtotal	30.4	2.5	76.7	$ 455.21	$ 2.91				81.4	$ 475.95	$ 3.23
Outpatient Hospital											
General			660.2	$ 48.89	$ 2.69	1.011	1.015	1.005	690.4	$ 49.44	$ 2.84
Hospice			5.8	1,059.33	0.51	1.011	1.015	1.005	6.1	1,071.29	0.54
Subtotal			666.0	$ 57.68	$ 3.20				696.5	$ 58.33	$ 3.39
Prescription Drugs					$ 2.06	1.001	0.975	0.990			$ 1.90
Other Ancillaries											
Transportation			8.7	171.30	0.12	1.027	1.015	0.995	9.2	$ 169.38	$ 0.13
DME/Prosthetics/Orthotics			398.2	71.76	2.38	1.027	1.015	0.995	423.0	70.96	2.50
Waiver Services			1.4	4.00	0.00	1.027	1.015	0.995	1.5	3.96	0.00
Other Ancillary			1,284.3	24.78	2.65	1.027	1.015	0.995	1,364.2	24.50	2.79
Home Help			15.9	419.10	0.56	1.027	1.015	0.995	16.9	414.40	0.58
Subtotal			1,708.5	$ 40.13	$ 5.71				1,814.9	$ 39.68	$ 6.00
Physician											
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	1.027	1.015	0.995	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			170.8	22.76	0.32	1.027	1.015	0.995	181.5	22.51	0.34
Phys Visit Other			4,191.6	22.77	7.95	1.027	1.015	0.995	4,452.5	22.52	8.36
Surgery/Anesthesia			1.4	38.96	0.00	1.027	1.015	0.995	1.5	38.52	0.00
Lab/Pathology			189.7	9.57	0.15	1.027	1.015	0.995	201.5	9.46	0.16
Surgery			244.7	15.98	0.33	1.027	1.015	0.995	259.9	15.80	0.34
Vision/Hearing			208.5	31.92	0.55	1.027	1.015	0.995	221.5	31.56	0.58
Therapeutic Inj.			39.1	31.32	0.10	1.027	1.015	0.995	41.5	30.97	0.11
Other			198.4	6.80	0.11	1.027	1.015	0.995	210.7	6.72	0.12
Subtotal			5,244.2	$ 21.80	$ 9.53				5,570.7	$ 21.56	$ 10.01
Total Claims/Benefit Cost					$ 7,788.18						$ 8,201.35
Supplemental SNF Copayments					$ 990.12	1.007	1.010	1.010			$ 1,019.57
Total Adjusted Gross Cost					**$8,778.30**						**$9,220.92**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Nursing Facility - Tier 1 (excluding Hospice)
Subtier County Owned Facilities
Age Under 65

Total Member Months **822**

	Fiscal Year 2014								Trended/Adjusted to CY 2016		
Type of Service	**Annual Admits Per 1,000**	**Average Length of Stay**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**	**Completion Adjustment**	**Trend Factor Util**	**Trend Factor Cost**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**
Nursing Facility											
Nursing Facility	11,854.0	28.0	332,219.0	$ 290.59	$ 8,044.91	1.007	1.010	1.010	342,099.8	$ 297.17	$ 8,471.82
Inpatient Hospital											
General	43.8	4.0	175.2	$ 193.49	$ 2.82	1.110	0.980	1.020	185.8	$ 202.31	$ 3.13
Psychiatric	-	-	-	-	-	1.110	0.980	1.020	-	-	-
Subtotal	43.8	4.0	175.2	$ 193.49	$ 2.82				185.8	$ 202.31	$ 3.13
Outpatient Hospital											
General			759.1	$ 66.22	$ 4.19	1.011	1.015	1.005	793.8	$ 66.96	$ 4.43
Hospice			-	-	-	1.011	1.015	1.005	-	-	-
Subtotal			759.1	$ 66.22	$ 4.19				793.8	$ 66.96	$ 4.43
Prescription Drugs					$ 1.39	1.001	0.975	0.990			$ 1.28
Other Ancillaries											
Transportation			189.8	235.39	3.72	1.027	1.015	0.995	201.6	$ 232.75	$ 3.91
DME/Prosthetics/Orthotics			934.3	117.80	9.17	1.027	1.015	0.995	992.5	116.47	9.63
Waiver Services			14.6	4.00	0.00	1.027	1.015	0.995	15.5	3.96	0.01
Other Ancillary			2,394.2	15.51	3.09	1.027	1.015	0.995	2,543.2	15.33	3.25
Home Help			87.6	72.89	0.53	1.027	1.015	0.995	93.0	72.08	0.56
Subtotal			3,620.4	$ 54.77	$ 16.52				3,845.8	$ 54.15	$ 17.36
Physician											
Private Duty Nursing/Home Health			-	$ 0.00	$ 0.00	1.027	1.015	0.995	-	$ 0.00	$ 0.00
Phys Visits Office/Consult			350.4	28.98	0.85	1.027	1.015	0.995	372.2	28.65	0.89
Phys Visit Other			11,416.1	20.50	19.51	1.027	1.015	0.995	12,126.7	20.27	20.48
Surgery/Anesthesia			-	-	-	1.027	1.015	0.995	-	-	-
Lab/Pathology			525.5	10.46	0.46	1.027	1.015	0.995	558.3	10.34	0.48
Surgery			277.4	13.67	0.32	1.027	1.015	0.995	294.6	13.51	0.33
Vision/Hearing			365.0	23.88	0.73	1.027	1.015	0.995	387.7	23.61	0.76
Therapeutic Inj.			29.2	184.49	0.45	1.027	1.015	0.995	31.0	182.42	0.47
Other			131.4	5.28	0.06	1.027	1.015	0.995	139.6	5.22	0.06
Subtotal			13,094.9	$ 20.49	$ 22.36				13,910.1	$ 20.26	$ 23.48
Total Claims/Benefit Cost					$ 8,092.20						$ 8,521.49
Supplemental SNF Copayments					$ 791.85	1.007	1.010	1.010			$ 815.40
Total Adjusted Gross Cost					**$8,884.05**						**$9,336.89**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Waiver - Tier 2
Subtier All
Age 65+

Total Member Months **24,903**

Type of Service	Fiscal Year 2014 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Trended/Adjusted to CY 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility											
Nursing Facility	59.8	16.0	958.4	$ 213.61	$ 17.06	1.017	0.995	1.005	963.7	$ 216.02	$ 17.35
Inpatient Hospital											
General	37.1	6.6	245.8	$ 240.88	$ 4.93	1.108	1.005	0.995	275.4	$ 238.18	$ 5.47
Psychiatric	-	-	-	-	-	1.108	1.005	0.995	-	-	-
Subtotal	37.1	6.6	245.8	$ 240.88	$ 4.93				275.4	$ 238.18	$ 5.47
Outpatient Hospital											
General			520.4	$ 66.82	$ 2.90	1.021	1.020	1.010	555.6	$ 68.33	$ 3.16
Hospice			3.9	2,629.21	0.84	1.021	1.020	1.010	4.1	2,688.74	0.92
Subtotal			524.3	$ 85.66	$ 3.74				559.7	$ 87.62	$ 4.09
Prescription Drugs					$ 3.78	1.000	0.990	0.990			$ 3.61
Other Ancillaries											
Transportation			35.2	87.77	0.26	1.012	1.010	1.015	36.4	$ 90.76	$ 0.28
DME/Prosthetics/Orthotics			22,167.9	24.33	44.95	1.012	1.010	1.015	22,940.4	25.16	48.10
Waiver Services			-	-	-	1.012	1.010	1.015	-	-	-
Other Ancillary			1,063.0	34.98	3.10	1.012	1.010	1.015	1,100.0	36.18	3.32
Home Help			50.1	451.94	1.89	1.012	1.010	1.015	51.9	467.33	2.02
Subtotal			23,316.2	$ 25.83	$ 50.19				24,128.7	$ 26.71	$ 53.71
Physician											
Private Duty Nursing/Home H			39.0	$ 148.06	$ 0.48	1.012	1.010	1.015	40.4	$ 153.10	$ 0.52
Phys Visits Office/Consult			2,859.4	24.24	5.78	1.012	1.010	1.015	2,959.1	25.07	6.18
Phys Visit Other			3,267.1	22.33	6.08	1.012	1.010	1.015	3,380.9	23.10	6.51
Surgery/Anesthesia			4.3	27.33	0.01	1.012	1.010	1.015	4.5	28.26	0.01
Lab/Pathology			822.6	6.08	0.42	1.012	1.010	1.015	851.2	6.29	0.45
Surgery			433.7	17.42	0.63	1.012	1.010	1.015	448.8	18.02	0.67
Vision/Hearing			115.7	25.84	0.25	1.012	1.010	1.015	119.7	26.72	0.27
Therapeutic Inj.			535.8	28.30	1.26	1.012	1.010	1.015	554.5	29.27	1.35
Other			767.1	7.80	0.50	1.012	1.010	1.015	793.9	8.06	0.53
Subtotal			8,844.7	$ 20.90	$ 15.41				9,152.9	$ 21.62	$ 16.49
Total Claims/Benefit Cost					$ 95.11						$ 100.71
Supplemental SNF Copayments					$ 0.00	1.017	0.995	1.005			$ 0.00
Total Adjusted Gross Cost					**$95.11**						**$100.71**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Waiver - Tier 2
Subtier All
Age Under 65

Total Member Months **9,579**

Type of Service	Fiscal Year 2014 Annual Admits Per 1,000	Fiscal Year 2014 Average Length of Stay	Fiscal Year 2014 Annual Utilization Per 1,000	Fiscal Year 2014 Cost Per Service	Fiscal Year 2014 PMPM	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Trended/Adjusted to CY 2016 Annual Utilization Per 1,000	Trended/Adjusted to CY 2016 Cost Per Service	Trended/Adjusted to CY 2016 PMPM
Nursing Facility											
Nursing Facility	52.6	15.8	833.1	$ 244.80	$ 16.99	1.017	0.995	1.005	837.7	$ 247.56	$ 17.28
Inpatient Hospital											
General	57.6	6.8	390.9	$ 165.63	$ 5.39	1.108	1.005	0.995	438.0	$ 163.77	$ 5.98
Psychiatric	-	-	-	-	-	1.108	1.005	0.995	-	-	-
Subtotal	57.6	6.8	390.9	$ 165.63	$ 5.39				438.0	$ 163.77	$ 5.98
Outpatient Hospital											
General			1,132.5	$ 67.90	$ 6.41	1.021	1.020	1.010	1,209.1	$ 69.44	$ 7.00
Hospice			1.3	820.84	0.09	1.021	1.020	1.010	1.3	839.42	0.09
Subtotal			1,133.7	$ 68.73	$ 6.49				1,210.4	$ 70.29	$ 7.09
Prescription Drugs					$ 3.25	1.000	0.990	0.990			$ 3.10
Other Ancillaries											
Transportation			100.2	124.42	1.04	1.012	1.010	1.015	103.7	$ 128.66	$ 1.11
DME/Prosthetics/Orthotics			23,929.9	24.31	48.47	1.012	1.010	1.015	24,763.7	25.14	51.88
Waiver Services			-	-	-	1.012	1.010	1.015	-	-	-
Other Ancillary			1,906.7	27.25	4.33	1.012	1.010	1.015	1,973.1	28.18	4.63
Home Help			57.6	344.73	1.66	1.012	1.010	1.015	59.6	356.47	1.77
Subtotal			25,994.4	$ 25.62	$ 55.50				26,900.1	$ 26.50	$ 59.40
Physician											
Private Duty Nursing/Home H			120.3	$ 131.27	$ 1.32	1.012	1.010	1.015	124.5	$ 135.75	$ 1.41
Phys Visits Office/Consult			3,780.8	23.30	7.34	1.012	1.010	1.015	3,912.5	24.09	7.85
Phys Visit Other			4,171.6	22.18	7.71	1.012	1.010	1.015	4,317.0	22.94	8.25
Surgery/Anesthesia			12.5	60.66	0.06	1.012	1.010	1.015	13.0	62.72	0.07
Lab/Pathology			1,002.2	10.77	0.90	1.012	1.010	1.015	1,037.1	11.13	0.96
Surgery			721.6	17.33	1.04	1.012	1.010	1.015	746.7	17.92	1.12
Vision/Hearing			111.5	23.00	0.21	1.012	1.010	1.015	115.4	23.79	0.23
Therapeutic Inj.			1,125.0	25.24	2.37	1.012	1.010	1.015	1,164.2	26.10	2.53
Other			979.6	10.87	0.89	1.012	1.010	1.015	1,013.8	11.24	0.95
Subtotal			12,025.1	$ 21.79	$ 21.84				12,444.1	$ 22.54	$ 23.37
Total Claims/Benefit Cost					$ 109.47						$ 116.21
Supplemental SNF Copayments					$ 0.00	1.017	0.995	1.005			$ 0.00
Total Adjusted Gross Cost					**$109.47**						**$116.21**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Community Well - Tier 3
Subtier All
Age 65+

Total Member Months **349,088**

Type of Service	Fiscal Year 2014 Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Trended/Adjusted to CY 2016 Annual Utilization Per 1,000	Cost Per Service	PMPM
Nursing Facility											
Nursing Facility	28.2	24.7	695.6	$ 168.57	$ 9.77	1.007	0.975	0.990	661.6	$ 164.80	$ 9.09
Inpatient Hospital											
General	25.4	7.5	190.1	$ 321.58	$ 5.09	1.089	1.015	0.995	214.1	$ 317.97	$ 5.67
Psychiatric	2.1	26.4	55.3	750.85	3.46	1.089	1.015	0.995	62.3	742.43	3.85
Subtotal	27.5	8.9	245.4	$ 418.28	$ 8.55				276.4	$ 413.59	$ 9.53
Outpatient Hospital											
General			413.7	$ 63.83	$ 2.20	1.012	1.020	1.005	437.9	$ 64.55	$ 2.36
Hospice			2.2	4,547.48	0.83	1.012	1.020	1.005	2.3	4,598.80	0.89
Subtotal			415.9	$ 87.55	$ 3.03				440.2	$ 88.55	$ 3.25
Prescription Drugs					$ 2.56	1.003	1.005	0.995			$ 2.57
Other Ancillaries											
Transportation			10.7	108.71	0.10	1.011	1.020	1.025	11.3	$ 114.92	$ 0.11
DME/Prosthetics/Orthotics			5,253.9	18.41	8.06	1.011	1.020	1.025	5,551.4	19.46	9.00
Waiver Services			299.1	5.67	0.14	1.011	1.020	1.025	316.1	6.00	0.16
Other Ancillary			1,575.9	30.86	4.05	1.011	1.020	1.025	1,665.1	32.62	4.53
Home Help			3,157.0	423.34	111.37	1.011	1.020	1.025	3,335.7	447.52	124.40
Subtotal			10,296.6	$ 144.19	$ 123.72				10,879.5	$ 152.43	$ 138.20
Physician											
Private Duty Nursing/Home H			11.0	$ 125.39	$ 0.11	1.011	1.020	1.025	11.6	$ 132.55	$ 0.13
Phys Visits Office/Consult			3,063.1	22.41	5.72	1.011	1.020	1.025	3,236.5	23.69	6.39
Phys Visit Other			2,499.8	22.97	4.79	1.011	1.020	1.025	2,641.4	24.29	5.35
Surgery/Anesthesia			13.3	29.36	0.03	1.011	1.020	1.025	14.1	31.03	0.04
Lab/Pathology			1,508.2	6.90	0.87	1.011	1.020	1.025	1,593.6	7.30	0.97
Surgery			553.3	13.99	0.65	1.011	1.020	1.025	584.7	14.79	0.72
Vision/Hearing			185.8	26.24	0.41	1.011	1.020	1.025	196.3	27.74	0.45
Therapeutic Inj.			1,043.0	29.78	2.59	1.011	1.020	1.025	1,102.0	31.48	2.89
Other			1,186.6	8.47	0.84	1.011	1.020	1.025	1,253.7	8.95	0.94
Subtotal			10,064.1	$ 19.08	$ 16.00				10,633.9	$ 20.17	$ 17.87
Total Claims/Benefit Cost					$ 163.64						$ 180.50
Supplemental SNF Copayments					$ 0.00	1.007	0.975	0.990			$ 0.00
Total Adjusted Gross Cost					**$163.64**						**$180.50**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Community Well - Tier 3
Subtier All
Age Under 65

Total Member Months **472,592**

Type of Service	Fiscal Year 2014 Annual Admits Per 1,000	Fiscal Year 2014 Average Length of Stay	Fiscal Year 2014 Annual Utilization Per 1,000	Fiscal Year 2014 Cost Per Service	Fiscal Year 2014 PMPM	Completion Adjustment	Trend Factor Util	Trend Factor Cost	Trended/Adjusted to CY 2016 Annual Utilization Per 1,000	Trended/Adjusted to CY 2016 Cost Per Service	Trended/Adjusted to CY 2016 PMPM
Nursing Facility											
Nursing Facility	5.7	22.6	129.7	$ 163.95	$ 1.77	1.007	0.975	0.990	123.4	$ 160.28	$ 1.65
Inpatient Hospital											
General	22.6	7.6	172.1	$ 353.05	$ 5.06	1.089	1.015	0.995	193.9	$ 349.09	$ 5.64
Psychiatric	-	-	-	-	-	1.089	1.015	0.995	-	-	-
Subtotal	22.6	7.6	172.1	$ 353.05	$ 5.06				193.9	$ 349.09	$ 5.64
Outpatient Hospital											
General			567.4	$ 72.41	$ 3.42	1.012	1.020	1.005	600.6	$ 73.23	$ 3.67
Hospice			0.1	3,918.30	0.02	1.012	1.020	1.005	0.1	3,962.52	0.03
Subtotal			567.5	$ 72.93	$ 3.45				600.7	$ 73.75	$ 3.69
Prescription Drugs					$ 3.53	1.003	1.005	0.995			$ 3.54
Other Ancillaries											
Transportation			11.1	117.26	0.11	1.011	1.020	1.025	11.8	$ 123.96	$ 0.12
DME/Prosthetics/Orthotics			3,938.4	19.12	6.27	1.011	1.020	1.025	4,161.4	20.21	7.01
Waiver Services			293.0	7.29	0.18	1.011	1.020	1.025	309.5	7.71	0.20
Other Ancillary			2,359.1	26.17	5.14	1.011	1.020	1.025	2,492.7	27.66	5.75
Home Help			2,498.0	433.97	90.34	1.011	1.020	1.025	2,639.4	458.77	100.91
Subtotal			9,099.6	$ 134.57	$ 102.04				9,614.7	$ 142.26	$ 113.98
Physician											
Private Duty Nursing/Home H			26.0	$ 159.26	$ 0.35	1.011	1.020	1.025	27.5	$ 168.36	$ 0.39
Phys Visits Office/Consult			2,949.4	22.16	5.45	1.011	1.020	1.025	3,116.4	23.43	6.08
Phys Visit Other			2,053.0	22.67	3.88	1.011	1.020	1.025	2,169.2	23.96	4.33
Surgery/Anesthesia			14.2	26.53	0.03	1.011	1.020	1.025	15.0	28.04	0.04
Lab/Pathology			1,281.8	7.95	0.85	1.011	1.020	1.025	1,354.4	8.41	0.95
Surgery			573.2	13.30	0.64	1.011	1.020	1.025	605.7	14.06	0.71
Vision/Hearing			144.2	28.91	0.35	1.011	1.020	1.025	152.4	30.56	0.39
Therapeutic Inj.			1,052.0	26.26	2.30	1.011	1.020	1.025	1,111.5	27.76	2.57
Other			1,005.9	12.23	1.03	1.011	1.020	1.025	1,062.8	12.93	1.15
Subtotal			9,099.8	$ 19.60	$ 14.86				9,615.0	$ 20.72	$ 16.60
Total Claims/Benefit Cost					$ 130.72						$ 145.10
Supplemental SNF Copayments					$ 0.00	1.007	0.975	0.990			$ 0.00
Total Adjusted Gross Cost					**$130.72**						**$145.10**

State of Michigan
Department of Health and Human Services
MI Health Link
Paid through February 2015

Region All
Population Community Well - Tier 3 (HMO Enrollee FFS Experience
Subtier All

Over 65 Rate Cell

Total Member Months		109,775								
	Fiscal Year 2014						**Trended/Adjusted to CY 2016**			
	Annual Utilization Per 1,000	**Cost Per Service**	**PMPM**	**Completion Adjustment**	**Trend Factor Util**	**Trend Factor Cost**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**
Home Help	2,642.0	$ 334.26	$ 73.59	1.011	1.020	1.025	2,791.6	$ 353.35	$ 82.20
Other Services	1,108.0	46.23	4.27	1.011	1.020	1.025	1,170.7	48.88	4.77
Total Benefit Cost	3,750.0	$ 249.16	$ 77.86				3,962.3	$ 263.39	$ 86.97

Under 65 Rate Cell

Total Member Months		187,472								
	Fiscal Year 2014						**Trended/Adjusted to CY 2016**			
	Annual Utilization Per 1,000	**Cost Per Service**	**PMPM**	**Completion Adjustment**	**Trend Factor Util**	**Trend Factor Cost**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**
Home Help	2,080.2	$ 345.97	$ 59.97	1.011	1.020	1.025	2,198.0	$ 365.73	$ 66.99
Other Services	2,339.1	43.78	8.53	1.011	1.020	1.025	2,471.5	46.28	9.53
Total Benefit Cost	4,419.3	$ 186.02	$ 68.51				4,669.5	$ 196.65	$ 76.52

APPENDIX 3: 2016 CAPITATION RATE DEVELOPMENT

State of Michigan
Department of Health and Human Services
MI Health Link
Calendar Year 2016 Rate Development - Excludes Hospice

Nursing Facility - Subtier A	Base FFS Experience	Selection Factor	Savings Percentage	Proposed Rate	Current Rate	Percent Change
Over 65	$6,094.18	1.000	0.010	$6,033.24	$5,907.38	2.1%
Under 65	$5,261.84	1.000	0.010	$5,209.22	$4,845.02	7.5%

Nursing Facility - Subtier B	Base FFS Experience	Selection Factor	Savings Percentage	Proposed Rate	Current Rate	Percent Change
Over 65	$9,220.92	1.000	0.010	$9,128.71	$8,503.68	7.4%
Under 65	$9,336.89	1.000	0.010	$9,243.52	$8,710.76	6.1%

Waiver C (NF Level of Care)	Base FFS Experience	MIChoice Capitation	Fully Loaded Cost	Selection Factor	Savings Percentage	Proposed Rate	Current Rate	Percent Change
Over 65	$100.71	$2,151.22	$2,251.93	1.000	0.010	$2,229.41	$2,059.64	8.2%
Under 65	$116.21	$2,683.00	$2,799.21	1.000	0.010	$2,771.22	$3,139.47	(11.7%)

Community Well	Base FFS Experience	Selection Factor	Total FFS Cost	Percent of FFS
Over 65	$180.50	0.760	$137.20	76.1%
Under 65	$145.10	0.760	$110.33	71.6%

	Duals Lite Capitation	Duals Lite FFS Cost	Total HMO Cost	Percent of MCO	Blended Cost	Savings Percentage	Proposed Rate	Current Rate	Percent Change
Over 65	$75.99	$86.97	$162.96	23.9%	$143.36	0.010	$141.93	$160.66	(11.7%)
Under 65	$75.99	$76.52	$152.51	28.4%	$122.31	0.010	$121.08	$120.71	0.3%

Regional Adjustment Factors (on Proposed Rate)

	Nursing Facility - Subtier A	Nursing Facility - Subtier B	Waiver (NF Level of Care)	Community Well
Region 1	97.9%	97.6%	99.3%	94.0%
Region 4	101.4%	104.1%	100.1%	100.5%
Region 7	99.0%	0.0%	100.0%	101.8%
Region 9	102.7%	103.4%	101.1%	96.7%

State of Michigan
Department of Health and Human Services
MI Health Link
Calendar Year 2016 Rate Development - Includes Hospice

Nursing Facility - Subtier A	Base FFS Experience	Selection Factor	Savings Percentage	Proposed Rate	Current Rate	Percent Change
Over 65	$6,043.95	1.004	0.010	$6,006.08	$5,907.38	1.7%
Under 65	$5,253.43	1.001	0.010	$5,207.17	$4,845.02	7.5%

Nursing Facility - Subtier B	Base FFS Experience	Selection Factor	Savings Percentage	Proposed Rate	Current Rate	Percent Change
Over 65	$9,216.39	1.004	0.010	$9,158.64	$8,503.68	7.7%
Under 65	$9,336.84	1.001	0.010	$9,254.62	$8,710.76	6.2%

Waiver C (NF Level of Care)	Base FFS Experience	MIChoice Capitation	Fully Loaded Cost	Selection Factor	Savings Percentage	Proposed Rate	Current Rate	Percent Change
Over 65	$100.71	$2,151.22	$2,251.93	1.000	0.010	$2,229.41	$2,059.64	8.2%
Under 65	$116.21	$2,683.00	$2,799.21	1.000	0.010	$2,771.22	$3,139.47	(11.7%)

Community Well	Base FFS Experience	Selection Factor	Total FFS Cost	Percent of FFS
Over 65	$180.50	0.760	$137.20	76.1%
Under 65	$145.10	0.760	$110.33	71.6%

	Duals Lite Capitation	Duals Lite FFS Cost	Total HMO Cost	Percent of MCO	Blended Cost	Savings Percentage	Proposed Rate	Current Rate	Percent Change
Over 65	$75.99	$86.97	$162.96	23.9%	$143.36	0.010	$141.93	$160.66	(11.7%)
Under 65	$75.99	$76.52	$152.51	28.4%	$122.31	0.010	$121.08	$120.71	0.3%

Regional Adjustment Factors (on Proposed Rate)

	Nursing Facility - Subtier A	Nursing Facility - Subtier B	Waiver (NF Level of Care)	Community Well
Region 1	97.9%	97.6%	99.3%	94.0%
Region 4	101.4%	104.1%	100.1%	100.5%
Region 7	99.0%	0.0%	100.0%	101.8%
Region 9	102.7%	103.4%	101.1%	96.7%

APPENDIX 4: PROJECTED ENROLLMENT

State of Michigan
Department of Health and Human Services
MI Health Link
Projected Enrollment

Rate Group	Region	Members as of September 2015	Members as of December 2015	Members as of February 2016	Projected Enrollment
Nursing Facility-Subtier A	Upper Peninsula	257	219	227	227
Nursing Facility-Subtier B	Upper Peninsula	176	151	159	159
NFLOC-Waiver	Upper Peninsula	8	12	15	15
Community	Upper Peninsula	3,557	3,355	3,315	3,315
Nursing Facility-Subtier A	SW Michigan	464	363	365	365
Nursing Facility-Subtier B	SW Michigan	63	52	49	49
NFLOC-Waiver	SW Michigan	-	2	8	8
Community	SW Michigan	8,087	7,449	7,345	7,345
Nursing Facility-Subtier A	Wayne	1,465	1,184	1,016	1,016
Nursing Facility-Subtier B	Wayne	-	-	-	-
NFLOC-Waiver	Wayne	5	28	98	98
Community	Wayne	21,581	17,560	16,822	16,822
Nursing Facility-Subtier A	Macomb	397	301	256	256
Nursing Facility-Subtier B	Macomb	4	1	1	1
NFLOC-Waiver	Macomb	1	3	14	14
Community	Macomb	5,468	4,037	3,771	3,771
Nursing Facility-Subtier A	Total	2,583	2,067	1,864	1,864
Nursing Facility-Subtier B	Total	243	204	209	209
NFLOC-Waiver	Total	14	45	135	135
Community	Total	38,693	32,401	31,253	31,253

APPENDIX 5: COVERED SERVICES

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

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

*Must meet level of care requirements

APPENDIX 6: PROSPECTIVE TREND RATES

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

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Physician	All Claims
1/15/2015	10,256	23,264.44	93.14	117.11	235.13	1,612.57	25,322.39
12/15/2014	10,356	23,108.55	74.58	109.27	234.21	1,612.09	25,138.69
11/15/2014	10,389	22,826.42	60.73	106.65	230.38	1,551.93	24,776.10
10/15/2014	10,502	22,815.36	55.49	105.96	231.05	1,542.96	24,750.82
9/15/2014	10,548	22,591.23	55.35	103.45	228.59	1,518.63	24,497.26
8/15/2014	10,647	22,615.47	52.99	103.82	228.79	1,521.55	24,522.62
7/15/2014	10,814	25,063.51	52.19	115.05	262.13	1,673.54	27,166.42
6/15/2014	10,783	28,409.14	55.17	133.87	306.83	2,028.11	30,933.12
5/15/2014	10,739	32,122.89	59.03	148.41	354.65	2,206.64	34,891.62
4/15/2014	10,772	35,542.31	61.40	164.39	398.09	2,376.09	38,542.28
3/15/2014	10,755	39,377.38	70.18	182.26	447.58	2,567.30	42,644.71
2/15/2014	10,719	39,243.74	108.37	182.44	451.01	2,495.02	42,480.58
1/15/2014	10,748	36,735.20	150.36	173.68	423.81	2,295.63	39,778.69
12/15/2013	10,793	33,285.45	191.04	156.00	388.49	1,886.95	35,907.93
11/15/2013	10,649	29,506.85	227.90	143.01	349.76	1,677.73	31,905.24
10/15/2013	10,823	25,961.90	280.83	128.09	316.30	1,481.67	28,168.79
9/15/2013	10,662	21,993.90	324.39	113.64	277.16	1,246.06	23,955.15
8/15/2013	10,618	22,055.04	336.55	114.56	283.82	1,261.30	24,051.27
7/15/2013	10,715	21,575.15	343.05	114.98	284.58	1,269.14	23,586.90
6/15/2013	10,601	21,532.85	350.23	120.18	289.09	1,365.26	23,657.61
5/15/2013	10,704	21,683.32	355.82	119.55	329.69	1,227.14	23,715.52
4/15/2013	10,682	21,592.66	375.82	119.57	368.01	1,068.69	23,524.76
3/15/2013	10,696	21,713.72	429.39	119.30	410.36	913.05	23,585.83
2/15/2013	10,761	21,628.96	465.32	118.74	446.55	756.86	23,416.43
12 month regression		71.2%	(90.8%)	47.0%	39.6%	120.5%	70.3%
24 month regression		7.0%	(72.8%)	(3.2%)	(21.3%)	34.8%	6.8%
Selected Trend		1.0%	(2.0%)	1.5%	(2.5%)	1.5%	
2015 Util/1000	41,503	23,492.99	107.63	124.50	234.63	1,623.66	25,583.41
2014 Util/1000	128,790	30,996.30	62.78	142.92	338.24	2,043.71	33,583.95
2013 Util/1000	128,967	21,852.72	377.30	116.49	344.28	1,078.26	23,769.05

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

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Physician	All Claims
1/15/2015	2,987	85.27	25.10	67.28	480.13	2,939.26	3,597.02
12/15/2014	2,997	84.07	23.88	56.98	468.05	2,887.42	3,520.41
11/15/2014	3,006	87.96	22.23	55.75	467.50	2,842.31	3,475.75
10/15/2014	3,034	82.19	18.89	57.15	473.77	2,870.80	3,502.80
9/15/2014	3,011	79.77	21.27	58.52	477.17	2,860.67	3,497.40
8/15/2014	2,989	81.28	25.30	59.29	477.75	2,841.06	3,484.68
7/15/2014	2,955	81.69	33.00	63.45	553.25	3,187.64	3,919.03
6/15/2014	2,916	93.24	43.03	78.45	635.39	3,697.08	4,547.19
5/15/2014	2,878	113.58	42.99	82.92	710.73	4,055.98	5,006.20
4/15/2014	2,854	127.93	41.67	86.02	777.99	4,387.89	5,421.50
3/15/2014	2,821	130.74	48.13	91.82	860.31	4,796.10	5,927.11
2/15/2014	2,798	119.71	43.29	88.02	857.68	4,721.39	5,830.10
1/15/2014	2,802	119.94	38.01	83.42	790.81	4,328.59	5,360.77
12/15/2013	2,807	110.47	27.60	66.87	725.63	3,790.19	4,720.77
11/15/2013	2,812	88.74	26.17	63.22	663.90	3,416.14	4,258.17
10/15/2013	2,839	85.18	28.56	59.01	615.00	3,059.88	3,847.63
9/15/2013	2,945	81.65	22.22	55.52	553.39	2,648.86	3,361.65
8/15/2013	2,927	89.21	24.37	58.08	577.57	2,693.87	3,443.09
7/15/2013	2,866	84.85	23.19	60.41	586.51	2,735.03	3,490.00
6/15/2013	2,814	95.79	27.71	73.08	603.58	2,886.36	3,686.51
5/15/2013	2,801	92.45	28.58	73.51	629.36	2,842.05	3,665.95
4/15/2013	2,747	90.57	27.32	74.90	650.04	2,791.19	3,634.02
3/15/2013	2,707	86.89	34.03	72.86	674.83	2,735.08	3,603.69
2/15/2013	2,670	90.64	30.57	72.78	684.62	2,664.53	3,543.14
12 month regression		48.8%	138.8%	69.4%	37.9%	79.0%	71.5%
24 month regression		(1.7%)	(4.8%)	(5.8%)	(14.5%)	7.1%	2.9%
Selected Trend		(0.5%)	0.5%	2.0%	(1.0%)	1.0%	
2015 Util/1000	12,024	83.20	28.69	71.37	484.29	2,970.12	3,637.67
2014 Util/1000	34,482	104.72	34.42	74.82	664.72	3,808.07	4,686.75
2013 Util/1000	33,144	84.19	27.94	63.92	612.18	2,690.60	3,478.81

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

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Physician	All Claims
1/15/2015	67,295	14.97	30.39	47.07	470.52	1,413.85	1,976.80
12/15/2014	67,234	16.90	24.91	36.18	468.37	1,392.41	1,938.77
11/15/2014	67,109	19.04	21.10	35.14	460.10	1,373.05	1,908.42
10/15/2014	67,257	20.98	18.98	35.36	464.10	1,375.63	1,915.05
9/15/2014	67,559	22.82	18.35	36.39	461.38	1,352.28	1,891.23
8/15/2014	67,827	25.08	17.82	37.90	461.74	1,348.04	1,890.56
7/15/2014	67,886	30.58	18.03	46.07	529.29	1,508.90	2,132.88
6/15/2014	68,088	39.75	20.31	63.83	603.55	1,789.01	2,516.45
5/15/2014	68,418	46.63	22.94	68.42	680.26	1,926.07	2,744.33
4/15/2014	68,317	57.65	23.81	71.78	750.04	2,074.53	2,977.81
3/15/2014	68,452	70.06	25.71	76.33	828.90	2,264.63	3,265.63
2/15/2014	68,396	74.15	24.49	75.39	828.45	2,235.72	3,238.20
1/15/2014	68,765	76.25	24.56	68.41	779.35	2,059.09	3,007.66
12/15/2013	69,036	75.69	22.79	52.14	724.09	1,762.36	2,637.08
11/15/2013	69,193	77.78	20.55	48.70	663.77	1,614.03	2,424.83
10/15/2013	69,743	76.88	19.89	46.23	616.12	1,460.35	2,219.48
9/15/2013	69,089	74.72	18.29	42.99	560.65	1,261.14	1,957.77
8/15/2013	69,434	81.53	20.05	44.71	583.13	1,275.55	2,004.96
7/15/2013	69,791	86.24	20.41	48.05	585.83	1,290.85	2,031.36
6/15/2013	70,060	93.76	22.15	61.06	597.88	1,392.34	2,167.18
5/15/2013	70,460	100.42	22.94	59.97	617.10	1,314.56	2,114.99
4/15/2013	70,757	105.10	23.91	58.45	627.82	1,239.60	2,054.87
3/15/2013	70,414	111.71	25.01	56.93	643.67	1,175.55	2,012.87
2/15/2013	70,601	117.52	25.22	54.74	647.96	1,087.82	1,933.26
12 month regression		(48.8%)	22.8%	84.8%	28.5%	80.8%	59.0%
24 month regression		(65.7%)	(2.1%)	(15.7%)	(14.7%)	11.8%	(0.1%)
Selected Trend		(2.5%)	1.5%	2.0%	0.5%	2.0%	
2015 Util/1000	268,895	12.70	35.39	53.25	477.43	1,440.90	2,019.67
2014 Util/1000	821,680	46.60	22.05	56.49	646.37	1,811.51	2,583.02
2013 Util/1000	846,062	93.36	21.68	50.02	602.50	1,218.00	1,985.55

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

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Physician	All Claims
1/15/2015	10,256	$165.88	$315.85	$1,828.29	$5.68	$23.75	$163.58
12/15/2014	10,356	165.02	362.96	1,897.03	5.64	21.82	162.47
11/15/2014	10,389	164.02	405.94	1,906.17	5.58	22.01	161.75
10/15/2014	10,502	163.05	452.46	1,934.39	5.85	22.11	161.03
9/15/2014	10,548	162.08	377.88	1,979.75	5.76	22.43	160.13
8/15/2014	10,647	162.22	405.60	2,021.83	5.88	23.04	160.53
7/15/2014	10,814	161.12	478.09	1,997.59	6.00	23.74	159.54
6/15/2014	10,783	160.78	500.86	1,959.33	6.38	26.22	158.81
5/15/2014	10,739	161.14	511.63	2,019.57	6.57	26.36	159.54
4/15/2014	10,772	161.34	540.30	2,015.17	6.61	26.75	159.95
3/15/2014	10,755	161.55	521.68	2,031.17	6.57	26.79	160.39
2/15/2014	10,719	161.17	397.17	2,019.31	6.59	27.12	160.24
1/15/2014	10,748	161.50	329.54	2,028.51	6.76	27.60	160.91
12/15/2013	10,793	161.45	297.09	2,078.96	6.80	27.43	161.79
11/15/2013	10,649	160.81	272.25	2,029.65	7.06	29.03	161.36
10/15/2013	10,823	160.12	255.43	2,032.79	7.34	30.24	161.04
9/15/2013	10,662	159.10	241.68	1,968.51	8.05	32.38	160.47
8/15/2013	10,618	159.23	240.53	1,994.19	8.60	33.21	160.72
7/15/2013	10,715	158.77	239.12	1,973.54	9.05	33.52	160.24
6/15/2013	10,601	158.75	237.51	1,907.38	9.46	32.99	159.72
5/15/2013	10,704	159.02	236.02	1,963.03	8.97	33.72	160.70
4/15/2013	10,682	158.83	224.80	1,982.53	8.64	34.98	161.18
3/15/2013	10,696	159.03	216.77	2,011.99	7.98	37.09	162.10
2/15/2013	10,761	158.00	218.54	2,000.16	7.53	40.00	161.86
12 month regression		1.7%	189.9%	0.7%	(29.8%)	(25.2%)	(1.0%)
24 month regression		2.0%	51.6%	(1.9%)	(22.9%)	(25.7%)	0.1%
Selected Trend		1.0%	2.0%	0.5%	(1.0%)	(0.5%)	
2015 CPS	41,503	$167.61	$416.88	$1,802.11	$5.77	$25.12	$165.51
2014 CPS	128,790	$161.80	$457.59	$2,007.32	$6.14	$24.38	$160.69
2013 CPS	128,967	$159.04	$232.13	$1,999.16	$8.23	$37.92	$161.28

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

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Physician	All Claims
1/15/2015	2,987	$215.47	$231.04	$78.06	$6.65	$24.43	$29.03
12/15/2014	2,997	219.82	210.33	82.95	7.23	23.23	28.03
11/15/2014	3,006	220.70	224.27	79.88	7.75	23.04	28.18
10/15/2014	3,034	230.49	250.13	80.86	7.09	22.93	27.83
9/15/2014	3,011	238.17	217.86	81.69	7.70	22.86	27.87
8/15/2014	2,989	227.80	135.04	88.56	7.69	23.11	27.70
7/15/2014	2,955	224.63	209.81	81.66	7.43	23.70	28.10
6/15/2014	2,916	209.84	181.77	69.03	7.03	25.36	28.81
5/15/2014	2,878	203.50	196.19	72.61	6.73	25.32	28.97
4/15/2014	2,854	193.54	201.97	77.38	6.64	25.38	28.84
3/15/2014	2,821	195.87	195.99	72.40	6.59	25.26	28.43
2/15/2014	2,798	205.66	213.24	66.87	6.68	25.15	28.16
1/15/2014	2,802	195.11	146.68	69.35	7.21	24.93	27.68
12/15/2013	2,807	191.09	168.36	77.46	7.82	23.58	26.69
11/15/2013	2,812	188.13	191.56	78.03	8.81	23.30	26.32
10/15/2013	2,839	183.59	206.92	68.23	10.39	23.09	26.67
9/15/2013	2,945	176.17	247.50	60.92	10.99	22.98	26.84
8/15/2013	2,927	175.74	253.65	65.34	12.02	23.09	27.54
7/15/2013	2,866	188.87	273.61	64.92	13.18	23.02	27.79
6/15/2013	2,814	187.16	261.39	61.32	14.08	23.87	29.03
5/15/2013	2,801	189.77	302.22	56.31	13.21	24.28	29.36
4/15/2013	2,747	185.16	314.07	55.54	12.30	24.55	29.17
3/15/2013	2,707	182.39	347.12	58.29	12.14	24.77	29.93
2/15/2013	2,670	175.81	382.23	58.74	10.97	25.02	29.94
12 month regression		17.0%	(29.5%)	13.5%	(54.7%)	15.0%	8.4%
24 month regression		14.9%	(22.1%)	22.6%	(31.4%)	(1.1%)	(1.1%)
Selected Trend		0.5%	(0.5%)	1.0%	(1.0%)	1.5%	
2015 CPS	12,024	$218.50	$242.26	$88.63	$5.94	$25.24	$29.27
2014 CPS	34,482	$225.27	$218.00	$79.78	$7.22	$23.93	$28.06
2013 CPS	33,144	$183.89	$289.11	$60.48	$11.68	$23.78	$28.39

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

Incurred Month	Member Months	Nursing Facility	Inpatient	Outpatient	Pharmacy	Physician	All Claims
1/15/2015	67,295	$168.37	$229.76	$76.43	$6.03	$20.27	$22.56
12/15/2014	67,234	164.92	274.95	83.41	6.18	18.48	21.29
11/15/2014	67,109	165.38	307.73	84.50	6.31	18.60	21.51
10/15/2014	67,257	162.83	325.44	87.46	6.53	18.81	21.71
9/15/2014	67,559	162.56	339.77	87.21	6.73	19.08	22.22
8/15/2014	67,827	165.61	362.86	85.95	6.77	19.46	22.87
7/15/2014	67,886	166.22	370.59	79.34	6.77	20.47	23.39
6/15/2014	68,088	166.43	348.91	69.64	6.67	22.72	24.97
5/15/2014	68,418	167.15	354.25	70.82	6.68	22.49	25.01
4/15/2014	68,317	168.26	367.53	73.00	6.65	22.18	25.08
3/15/2014	68,452	170.21	386.17	73.66	6.72	21.86	25.28
2/15/2014	68,396	170.31	386.97	72.94	7.01	21.63	25.25
1/15/2014	68,765	170.99	379.76	74.94	8.29	21.13	25.75
12/15/2013	69,036	171.99	393.90	84.16	10.02	19.03	25.47
11/15/2013	69,193	171.61	398.99	82.02	11.91	18.84	26.34
10/15/2013	69,743	171.20	409.27	76.76	14.19	18.82	27.51
9/15/2013	69,089	169.78	393.83	73.76	17.10	18.81	28.79
8/15/2013	69,434	168.00	383.70	73.76	18.54	19.33	30.00
7/15/2013	69,791	167.28	386.11	70.40	18.97	19.81	30.70
6/15/2013	70,060	165.79	419.88	62.12	19.44	21.28	32.25
5/15/2013	70,460	165.44	437.50	63.59	17.72	21.71	33.07
4/15/2013	70,757	165.50	417.57	64.94	15.91	22.03	33.32
3/15/2013	70,414	165.18	406.34	66.47	13.96	22.31	33.59
2/15/2013	70,601	165.15	415.33	67.57	12.08	22.27	33.95
12 month regression		(0.9%)	(10.8%)	(5.0%)	(74.8%)	24.9%	(20.3%)
24 month regression		(0.5%)	(18.7%)	13.6%	(48.2%)	(4.5%)	(22.5%)
Selected Trend		(1.0%)	(0.5%)	0.5%	(0.5%)	2.5%	
2015 CPS	268,895	$175.18	$212.09	$76.39	$5.86	$21.10	$23.06
2014 CPS	821,680	$165.94	$368.50	$82.61	$6.71	$20.29	$24.24
2013 CPS	846,062	$167.53	$398.39	$73.74	$15.53	$20.29	$31.24

APPENDIX 7: SELECTION FACTOR ANALYSIS

State of Michigan
Department of Health and Human Services
MI Health Link - Selection Factor Analysis
Paid through February 2015

Region All
Population Community Well - Tier 3
Subtier All
Age Under 65

	Composite					Enrolled				
	Fiscal Year 2014									
	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Cost Per Service	PMPM
Total Member Months			**472,592**					**189,879**		
Type of Service										
Nursing Facility										
Nursing Facility	5.7	22.6	129.7	$ 163.95	$ 1.77	3.3	22.3	73.3	$ 164.61	$ 1.00
Inpatient Hospital										
General	22.6	7.6	172.1	$ 353.05	$ 5.06	56.3	1.7	94.1	$ 350.47	$ 2.75
Psychiatric										
Subtotal	22.6	7.6	172.1	$ 353.05	$ 5.06	56.3	1.7	94.1	$ 350.47	$ 2.75
Outpatient Hospital										
General			567.4	$ 72.41	$ 3.42			536.9	$ 70.77	$ 3.17
Hospice			0.1	3,918.30	0.02			-	-	-
Subtotal			567.5	$ 72.93	$ 3.45			536.9	$ 70.77	$ 3.17
Prescription Drugs			4,870.7	$ 8.70	$ 3.53			4,258.0	$ 7.18	$ 2.55
Other Ancillaries										
Transportation			11.1	117.26	0.11			7.5	$ 94.97	$ 0.06
DME/Prosthetics/Orthotics			3,938.4	19.12	6.27			3,131.0	18.84	4.92
Waiver Services			293.0	7.29	0.18			230.6	6.97	0.13
Other Ancillary			2,359.1	26.17	5.14			2,240.4	25.98	4.85
Home Help			2,498.0	433.97	90.34			1,765.3	413.17	60.78
Subtotal			9,099.6	$ 134.57	$ 102.04			7,374.7	$ 115.10	$ 70.74
Physician										
Private Duty Nursing/Home Health			26.0	$ 159.26	$ 0.35			22.0	$ 156.17	$ 0.29
Phys Visits Office/Consult			2,949.4	22.16	5.45			2,592.3	22.98	4.97
Phys Visit Other			2,053.0	22.67	3.88			1,394.3	22.77	2.65
Surgery/Anesthesia			14.2	26.53	0.03			11.1	23.34	0.02
Lab/Pathology			1,281.8	7.95	0.85			1,088.5	7.77	0.71
Surgery			573.2	13.30	0.64			468.6	13.78	0.54
Vision/Hearing			144.2	28.91	0.35			145.0	29.75	0.36
Therapeutic Inj.			1,052.0	26.26	2.30			856.5	27.40	1.96
Other			1,005.9	12.23	1.03			854.8	13.43	0.96
Subtotal			9,099.8	$ 19.60	$ 14.86			7,432.9	$ 20.07	$ 12.43
Total Claims/Benefit Cost					$ 130.72					$ 92.64
									Emerging Selection Adjustment	0.709
									CY 2015 Selection Adjustment	0.812
									Proposed Selection Adjustment for CY 2016	0.760

State of Michigan
Department of Health and Human Services
MI Health Link - Selection Factor Analysis
Paid through February 2015

Region All
Population Community Well - Tier 3
Subtier All
Age 65+

	Composite					Enrolled				
	Fiscal Year 2014									
Total Member Months	**349,088**					**138,972**				
Type of Service	**Annual Admits Per 1,000**	**Average Length of Stay**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**	**Annual Admits Per 1,000**	**Average Length of Stay**	**Annual Utilization Per 1,000**	**Cost Per Service**	**PMPM**
Nursing Facility										
Nursing Facility	28.2	24.7	695.6	$ 168.57	$ 9.77	12.1	24.4	295.1	$ 170.62	$ 4.20
Inpatient Hospital										
General	25.4	7.5	190.1	$ 321.58	$ 5.09	63.8	1.1	69.8	$ 245.56	$ 1.43
Psychiatric										
Subtotal	27.5	8.9	245.4	$ 418.28	$ 8.55	69.1	1.7	115.2	$ 480.68	$ 4.61
Outpatient Hospital										
General			413.7	$ 63.83	$ 2.20			372.2	$ 66.81	$ 2.07
Hospice			2.2	4,547.48	0.83			0.5	4,199.79	0.18
Subtotal			415.9	$ 87.55	$ 3.03			372.7	$ 72.56	$ 2.25
Prescription Drugs			6,275.9	$ 4.89	$ 2.56			5,945.5	$ 4.50	$ 2.23
Other Ancillaries										
Transportation			10.7	108.71	0.10			8.0	$ 103.26	$ 0.07
DME/Prosthetics/Orthotics			5,253.9	18.41	8.06			4,071.8	17.03	5.78
Waiver Services			299.1	5.67	0.14			224.5	5.77	0.11
Other Ancillary			1,575.9	30.86	4.05			1,578.1	29.33	3.86
Home Help			3,157.0	423.34	111.37			2,344.8	405.12	79.16
Subtotal			10,296.6	$ 144.19	$ 123.72			8,227.3	$ 129.77	$ 88.97
Physician										
Private Duty Nursing/Home Health			11.0	$ 125.39	$ 0.11			7.9	$ 162.03	$ 0.11
Phys Visits Office/Consult			3,063.1	22.41	5.72			2,934.5	23.09	5.65
Phys Visit Other			2,499.8	22.97	4.79			1,402.0	23.07	2.70
Surgery/Anesthesia			13.3	29.36	0.03			10.9	28.10	0.03
Lab/Pathology			1,508.2	6.90	0.87			1,383.8	7.17	0.83
Surgery			553.3	13.99	0.65			499.3	13.25	0.55
Vision/Hearing			185.8	26.24	0.41			196.7	27.00	0.44
Therapeutic Inj.			1,043.0	29.78	2.59			875.6	20.86	1.52
Other			1,186.6	8.47	0.84			1,142.8	8.71	0.83
Subtotal			10,064.1	$ 19.08	$ 16.00			8,453.4	$ 17.95	$ 12.65
Total Claims/Benefit Cost					$ 163.64					$ 114.91
									Emerging Selection Adjustment	0.702
									CY 2015 Selection Adjustment	0.818
									Proposed Selection Adjustment for CY 2016	0.760