Healthy Michigan – Medicaid Expansion Initial Rate Certification

State of Michigan

Department of Community Health

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I. BACKGROUND

Milliman, Inc. has been retained by the State of Michigan, Department of Community Health (MDCH) to provide actuarial and consulting services related to the development of actuarially sound capitation rates for the Medicaid expansion program in the State of Michigan, operating under the Alternative Benefit Plan referred to as Healthy Michigan. The rates illustrated in this report are for the April 1, 2014 through March 31, 2015 time period.

The actuarially sound capitation rates were developed using published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board, the Centers for Medicare and Medicaid Services (CMS), and federal regulations to ensure compliance with generally accepted actuarial practices and regulatory requirements. Specifically, the following were used as guidance:

- AAA health practice council practice note, published in August 2005 titled: *Actuarial Certification of Rates for Medicaid Managed Care Programs*.
- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been published as of the capitation rate certification date.
- CMS rate setting checklist for regional offices for capitated Medicaid managed care plans (Draft).
- Federal regulation 42 CFR 438.6(c).
- Throughout this document, the term "actuarially sound" is defined as follows:

  "Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates – including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income – provide for all reasonable, appropriate, and attainable costs, including health benefits; health benefit settlement expenses; marketing and administrative expenses; any government-mandated assessments, fees, and taxes; and the cost of capital."

This report provides the documentation of the actuarially sound capitation rates and has been developed to comply with the requirements outlined above.

II. EXECUTIVE SUMMARY

Effective April 1, 2014 the State of Michigan will be expanding its current Medicaid population to allow coverage of all individuals, regardless of family status, up to 138% of Federal Poverty Level (FPL). The expansion population will be operating under the Healthy Michigan plan, which has been approved by CMS under a Section 1115 waiver amendment to the current Adult Benefit Waiver (ABW) 1115 waiver. The Healthy Michigan plan is similar to the current Medicaid state plan, but will include additional coverage for certain services. The beneficiaries that will be covered under the eligibility requirements of the expansion will be maintained separately from those currently Medicaid eligible. It is the intention of MDCH to enroll all members into a managed care organization, although some fee-for-service coverage would be anticipated to occur.

The remainder of this report illustrates the development of the capitation rates and discusses the data sources, assumptions and general methodology utilized in the calculation of these rates. While all attempts to rate this population accurately will be made, Milliman anticipates that this rate setting will vary from the true cost of the covered individuals. Milliman will work with MDCH and the participating health plans to monitor utilization and cost on a timely basis to quickly detect variations in costs and assumptions factored into the capitation rates. Please note, the values illustrated in this letter do not reflect the supplemental physician fee increase for primary care physicians or the health insurer assessment fee as required under the Affordable Care Act (ACA). It is anticipated that these will be paid on a pass-through basis consistent with the current managed care program.

Table 1 illustrates the fully loaded capitation rates by rate cell at both the low and high end of the certified rate range.

Table 1
State of Michigan
Department of Community Health
Healthy Michigan Expansion
April 2014 – March 2015 Capitation Rates

	Projected Average Monthly Enrollment	Low Rate Range	High Rate Range
Males			
19-24 Years Old	26,895	$ 134.17	$ 144.51
25-34 Years Old	39,226	240.69	260.55
35-44 Years Old	35,504	356.87	387.09
45-54 Years Old	32,777	556.92	604.26
55-64 Years Old	30,051	645.25	700.72
Females			
19-24 Years Old	21,849	$ 292.41	$ 317.56
25-34 Years Old	33,210	372.62	404.68
35-44 Years Old	37,405	473.90	514.91
45-54 Years Old	34,807	592.84	644.53
55-64 Years Old	32,207	743.11	807.05
Maternity	500	$6,757.61	$6,793.57

Enclosure 1 provides the development of the capitation rates for both the low and high rate ranges. Enclosure 2 contains an actuarial certification regarding the actuarial soundness of the capitation rates. Enclosure 3 provides responses to the *2014 Managed Care Rate Setting Consultation Guide* provided by CMS for purposes of guidance in establishing capitation rates for Medicaid expansion populations.

III. DEVELOPMENT OF CAPITATION RATES

BASE DATA

As a majority of the expansion population that is anticipated to enroll in the Healthy Michigan plan is currently uninsured, there is a significant lack of historical experience upon which to develop the expansion population rates. For purposes of this rate setting and case mix distribution, Milliman has utilized the following data sources to assist in the creation of base claims cost experience:

- SFY 2011-2012 Adult TANF encounter and FFS experience specific to the state of Michigan
- State of Michigan Adult Benefit Waiver enrollment and reported expenditures
- American Community Survey data
- Internal Milliman databases

SFY 2011-2012 Adult TANF encounter data was summarized by the corresponding rate cells to establish a benchmark for the Healthy Michigan rates. As previously indicated, the majority of covered services will be consistent with those currently provided to Medicaid beneficiaries through the State plan, with certain services included in the managed care capitation rates that are not currently the responsibility of the health plans.

The targeted effective date of the Medicaid expansion is April 1, 2014. The capitation rates illustrated in this report are for a 12-month rating period. Due to the uniqueness of the population, Milliman will work with MDCH to monitor the costs of the population and potentially update rates as necessary. Milliman will collect all available experience through September 30, 2014 for the Healthy Michigan population and analyze the need to update rates that will be made retroactively effective to October 1, 2014. MDCH and Milliman will be requesting that the health plans submit all enrollment and claim experience for the six-month time period from April 1, 2014 to September 30, 2014. The information to be submitted by the health plans will be due October 31, 2014. Milliman will analyze the submitted experience and adjust the capitation rates as necessary. Milliman will work with MDCH and CMS to adjust the capitation rates to reflect the emerging experience of the population being served and ensure actuarial sound rates for the entirety of the twelve-month rating period.

Milliman recognizes that the data sources utilized in the development of the base experience may not reflect the true cost profile of the projected expansion population; therefore, several utilization and cost adjustments have been applied.

RATE DEVELOPMENT

The following provides the rating components that are included in the capitation rates.

Base Claims Components

The current managed care payment rates for the Adult TANF population reflect current payment on most services that will be covered by the Alternative Benefit Plan at reimbursement levels that are anticipated to be consistent with reimbursement levels for services provided to the expansion population. Milliman has summarized historical encounter claims information that was the basis of the State Fiscal Year (SFY) 2014 Adult TANF capitation rates.

For purposes of the Healthy Michigan plan, rate cells that differ from those currently in the Adult TANF population will be established. Milliman has created rate cells that differ by age and gender with splits for 19-24, 25-34, 35-44, 45-54, and 55-64. The historical data was summarized by the applicable Healthy Michigan rate cells and trended forward to October 1, 2014, the midpoint of the initial rating period. Table 2 illustrates the annual trend rates by category of service and on a composite basis that were applied to the historical encounter experience.

Table 2 State of Michigan Department of Community Health Summary of Annual Trend Rates by Service Category	
Service Category	**Trend Rate**
Inpatient Hospital	0.5%
Outpatient Hospital	2.0%
Physician	3.5%
Pharmacy	4.5%
Other Ancillary	3.5%
Composite Trend	2.8%

The application of the trend values illustrated in Table 2 reflect the projected cost of services included in the SFY 2011-2012 encounter experience at managed care utilization levels. Further adjustments are applied to reflect the absence of historical care management on this population.

Consistent with the capitation payments made in the current Medicaid managed care program in the State of Michigan, adjustments were made to the base costs to reflect hospital and physician reimbursement arrangements. These adjustments are included as part of the base claims cost component reflected in Enclosure 1.

Additional Services

Additional adjustments were made to the base experience to reflect services that were not included in the historical experience, but are a covered service under the Healthy Michigan Plan. These adjustments include costs for the following services:

- Non-Emergency Medical Transportation (NEMT) – The cost of NEMT services is not reported in the base encounter data and is included at a rate based upon information utilized in the calculation of SFY 2014 Adult TANF capitation rates.
- Adult Chiropractic and Vision services – Coverage for Adult chiropractic and vision services were reinstated during SFY 2013 and are not reported in the base encounter data. Cost estimates applied to the rate development were based upon information utilized in the calculation of the SFY 2014 Adult TANF capitation rates.
- Hearing Aids – The coverage of hearing aids is a new benefit for the Healthy Michigan population. The estimated cost for this benefit is based on utilization for similar benefits in other state Medicaid programs.
- Habilitative services – An adjustment was made to reflect the impact of adding habilitative services for the Healthy Michigan population.
- Expanded Behavioral Health – The set of mild-to-moderate mental health services that will be covered by the managed care health plans will be expanded as a result of transitioning the Adult Benefit Waiver population. An adjustment was applied to historical behavioral health experience to reflect the anticipated increase in utilization of these services.

Copays and Contributions

Under the Healthy Michigan Act, all members are required to pay a set of standard copays along with contributions equal to 2% of income for those above 100% FPL. Based on discussions with MDCH, cost sharing requirements can be reduced for members that comply with physician prescribed healthy behaviors. As the cost-sharing requirements under this plan do not begin until six months following enrollment, Milliman has incorporated an approximate 0.4% reduction to the base claims costs to reflect the eventual collection of the member payments. The reduction percentage was calculated based on the estimated portion of the population above 100% FPL, only requiring contributions for 6 months in the first rating period, and the assumption that not all members required to make payments will ultimately remit these contributions.

Morbidity Adjustment

A morbidity adjustment has been applied to the base claims cost to encompass two items: an increase for the absence of care management on the anticipated population and the populations' expected ultimate morbidity. Milliman has developed low and high rate ranges based upon the variance of these assumptions.

Milliman reviewed the ultimate morbidity of expansion populations in other states along with studies regarding the relation of morbidity to income level. Based upon our review, the ultimate morbidity of the Healthy Michigan population could be lower than that of the current TANF Adult Medicaid population. Thus, a rate decrease would be considered to reflect the ultimate morbidity. However, when coupled with the lack of managed care, the morbidity adjustment has been set at an approximate 5% increase for the low end of the rate range.

As the expected morbidity of this population is not known, Milliman recognizes that a certain portion of the population may reflect a morbidity profile more consistent with a Disabled population. Due to the wide variance that could be observed with an uninsured population, Milliman established the high end of the rate range utilizing a morbidity adjustment of approximately 15%.

Pent-Up Demand

Based on studies of offering coverage to previously uninsured beneficiaries, there is an anticipated increased demand of services at the outset of a new program. The occurrence of pent-up demand typically appears in the first-year of enrollment as a spike in demand for previously uninsured individuals that will trend back to ultimate levels. This adjustment is for services that new beneficiaries may not have previously received due to inability to obtain their coverage. Milliman has applied an approximate 10% increase for the first year rates as the enrollment in the expansion population continues to grow to ultimate levels. The adjustment percentage is based on a review of historical experience from expansion in other states, including that of the Healthy Indiana Plan.

Administrative Load (Non-benefit component)

In the development of the capitation rates, Milliman has included an administration load of approximately 9.8% of the total medical capitation rate. Milliman recognizes that the Healthy Michigan law that was passed by State Legislature includes a series of additional administrative functions that are not currently required to be performed by the managed care health plans. Therefore, Milliman has increased the administrative load that is currently utilized in the MHP capitation rates. This rate load is applied to all medical benefit claim cost components and subsequent adjustments. Milliman anticipates that the morbidity and pent-up demand adjustments will decrease over time, thereby reducing the administrative load component of these rates. The additional dollars included in the administrative load for this initial rating period reflect costs related to implementation of the program and benefits.

Claims Tax

In addition to the administrative load, the capitation rates for all services were increased to reflect the Claims Tax of 1.0%. The claims tax assessment is not applied to the administrative load component of the capitation rates. The claims tax assessment will be determined as a percentage of the claim cost component of the capitation rate.

OTHER RATE DEVELOPMENT

Maternity

Maternity services that will be provided under the Medicaid expansion population will encompass the set of services that are offered to Pregnant Women under the current Medical Assistance program. A separate Maternity Case Rate payment will be made for pregnant women enrolled in the Healthy Michigan plan. The case rate payment is equal to the current MHP Maternity Case Rate payment, adjusted for trend. As the current capitation rates for TANF adults do not include costs related to maternity services, Milliman has not made any adjustments to the base data to reflect the impact of maternity services.

Dental

The current capitation rates for TANF adults do not include costs related to dental services. Based on discussions with MDCH, dental services will be included as part of the capitation rate for the Healthy Michigan plan. Utilizing ***Milliman Dental Cost Guidelines*** a base set of services was established for the Healthy Michigan enrolled members. The current TANF adult population does receive dental services on a fee-for-service basis. With an expansion to cover a significant number of adults, MDCH wanted to target reimbursement at a higher value than current levels. Therefore, Milliman has applied fee schedule information that is approximately two times the current State of Michigan Medicaid dental fee screens. This fee schedule is consistent with fees paid in other Medicaid managed care dental networks in the State of Michigan. This adjustment to the fee screens is to accommodate the projected cost of dental services at a reimbursement level higher than Medicaid.

Similar to the concept of pent-up demand for medical services, Milliman anticipates a higher demand for dental services in the first year. An additional 15% adjustment was applied to the dental costs to reflect pent-up demand. As the dental component of the capitation rate is separately calculated, a 10% administrative load and the 1% claims tax was applied to calculate the fully loaded dental rate. Table 3 illustrates the development of the dental capitation rate for each rate cell. Based on historical experience, the dental rates do not vary by gender.

Table 3
State of Michigan
Department of Community Health
Healthy Michigan Expansion
Dental Component of Capitation Rates

Rate Cell	Base Claims Cost	Pent-Up Demand	Adminstrative Load	Claims Tax	Fully Loaded Dental Rate
19-24 Years Old	$ 14.13	$ 2.12	$ 1.62	$ 0.16	$ 18.04
25-34 Years Old	15.03	2.25	1.73	0.17	19.19
35-44 Years Old	15.69	2.35	1.80	0.18	20.03
45-54 Years Old	18.22	2.73	2.10	0.21	23.26
55-64 Years Old	21.56	3.23	2.48	0.25	27.52

Health Insurance Assessment Fee

The health insurance assessment fee required under the Affordable Care Act (ACA) is not applicable to all carriers and is only known in an aggregate amount on a national basis. The assessment fee in 2014 is $8 billion on a national basis. The fee will be apportioned to the specified health insurance carriers following submission of health insurance premium information for calendar year 2013. The health insurance assessment fee will be due by September 30, 2014 for CY 2013. As the expansion population did not exist in CY 2013, the impact of this fee is not reflected in the PMPM costs for the initial rate setting. Subsequent rate developments will include amounts for the Health Insurer Assessment fee.

GEOGRAPHIC ADJUSTMENT

Under the current State plan, MDCH has separated the state into 10 geographic regions. Regional area factors are applied to the TANF population based on regional morbidity differences observed in the base encounter experience. The regional area factors are budget neutral on a composite basis. For the current TANF population, Milliman utilizes a blending of two different area factor calculations: morbidity adjustments based on diagnosis code information and average relative cost by geographic region. The morbidity adjustment is given a two-thirds weight with the average relative cost receiving a one-third weight. Due to the absence of historical experience for the Healthy Michigan population, Milliman has assumed a standard 1.0 morbidity for all regions in the calculation of the area factors for the Healthy Michigan capitation rates. The relative average cost portion of the area factor is consistent with those utilized in the area factor development for the current TANF population.

The area factors were calculated by applying a two-thirds weight to the morbidity factor and one-third weight to the relative average cost. The factors were normalized to a 1.0 on a statewide basis utilizing projected enrollment by geographic region. Table 4 illustrates the area factors to be applied to each region. The Relative Cost Factor column in Table 4 is consistent with cost adjustments illustrated in Enclosure 7 of Milliman's August 24, 2012 rate certification letter for the current State plan.

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Table 4 State of Michigan Department of Community Health Regional Area Factors				
Geographic Area	Projected Enrollment Distribution	Morbidity Factor	Relative Cost Factor	Area Factor
Region 1	30.0%	1.0000	1.0336	1.0070
Region 2	7.0%	1.0000	1.0244	1.0039
Region 3	9.0%	1.0000	1.0038	0.9971
Region 4	15.5%	1.0000	0.9782	0.9886
Region 5	4.5%	1.0000	0.9927	0.9934
Region 6	5.5%	1.0000	0.9955	0.9944
Region 7	5.5%	1.0000	1.0065	0.9980
Region 8	4.0%	1.0000	0.9747	0.9875
Region 9	10.0%	1.0000	1.0267	1.0047
Region 10	9.0%	1.0000	1.0260	1.0045
Composite	100.0%	1.0000	1.0125	1.0000

IV. RISK MITIGATION

Due to the unusual level of uncertainty with the Healthy Michigan expansion population, MDCH intends to apply a risk mitigation strategy for a period of time. The risk mitigation strategy will aid health plans in covering these newly insured beneficiaries and help to stabilize experience during the outset of the program. Several options exist for helping to manage the inherent risk of an unknown population, and have been widely used in other states.

Following a meeting with the health plans and a review of the plans' responses on preferred risk mitigation strategies, Milliman and MDCH are proposing a combination of risk corridor with shared savings/losses be established for the Healthy Michigan population. This risk corridor will not apply to the administrative load for either the medical or dental components.

The risk corridor method allows health plans to operate as normal with the understanding that if the beneficiaries that enroll have a higher morbidity profile than the rates initially projected, a safety net has been created to ensure that the health plan will not bear the entire cost. The shared savings/losses that would accompany this strategy allows the plans to distribute additional risk or reward for managing the care of their respective population, with the knowledge that the State will provide assistance for a pre-determined range. The risk corridor will be established as a percentage of the medical costs incurred, including care management services as defined in the NAIC medical loss ratio calculation. The pre-determined range is as follows:

- +/- 3% of the claim cost component will be the full risk of the health plans
- +/- 3%-8% of the claim cost component will be 75% to the plan and 25% to the state
- +/- 8%-12% of the claim cost component will be 50% to the plan and 50% to the state
- +/- 12%-15% of the claim cost component will be 25% to the plan and 75% to the state
- +/- 15% of the claim cost component will be the full risk of the health plans.

Milliman recognizes that the proposed risk corridor percentages do not provide additional risk sharing beyond the 15% threshold. Milliman believes that the potential rate adjustment at October 1, 2014 will provide further support if the certified rate varies from the actual experience.

The timeline for risk mitigation will depend upon the level of data that is available to assess the population and verify the rate setting process. Milliman anticipates that this will take at least 2 years following the rollout of the program until ultimate enrollment levels have been reached. The proposed strategy will need to be effectively monitored to ensure that the population is being properly managed and that controls are in place to limit over-utilization.

V. CAPITATION RATE IMPACT

Table 5 illustrates the estimated impact of the proposed capitation rates for both the low and high rate ranges. The enrollment values shown reflect projected average monthly enrollment during the first year of the Healthy Michigan plan. For purposes of this rate projection, expenditures related to maternity case rate payments has not been included. As the federal match on these rates is 100%, the expenditures reflect all Federal dollars.

Table 5
State of Michigan
Department of Community Health
April 2014 – March 2015 Projected Expenditures
Healthy Michigan Expansion
{Dollars shown in Millions}

	Projected Average Monthly Enrollment	Low Rate Range	High Rate Range
Males			
19-24 Years Old	26,895	$ 43.3	$ 46.6
25-34 Years Old	39,226	113.3	122.6
35-44 Years Old	35,504	152.0	164.9
45-54 Years Old	32,777	219.1	237.7
55-64 Years Old	30,051	232.7	252.7
Females			
19-24 Years Old	21,849	$76.7	$83.3
25-34 Years Old	33,210	148.5	161.3
35-44 Years Old	37,405	212.7	231.1
45-54 Years Old	34,807	247.6	269.2
55-64 Years Old	32,207	287.2	311.9
Maternity Deliveries	500	$ 40.5	$ 40.8
Total Expenditures	323,931	$1,773.6	$1,922.0

Note: 1. Values have been rounded.
2.Total projected average monthly enrollment does not included maternity deliveries.
3. Expected average monthly deliveries assumes no deliveries in first 6 months due to program enrollment, with 1,000 per month for second 6 months.

Enclosure 1 provides the development of the capitation rates by rate cell.

VI. DATA RELIANCE

We have relied upon the following information provided by MDCH to develop the actuarially sound capitation rates for the April 1, 2014 to March 31, 2015 time period:

1. Data and information provided for the SFY 2014 actuarially sound capitation rate development, as documented in correspondence provided by Milliman on September 11, 2013; and

2. Information related to the Healthy Michigan Section 1115 waiver amendment approved by CMS.

We have relied upon MDCH for the accuracy of the information provided. We performed no independent audit or review of the data and information. The capitation rates provided in this letter will change to the extent that there are material errors in the information that was provided. We have also utilized other external sources of information for purposes of rate development, including American Community Survey data and ***Milliman Health Cost Guidelines.***

VII. LIMITATIONS AND QUALIFICATIONS

The services provided for this project were performed under the signed contract between Milliman and MDCH approved October 21, 2010.

The information contained in this letter, including the enclosures, has been prepared for the State of Michigan, Department of Community Health 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 MDCH 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 MDCH and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

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

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.

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Enclosure 1

Michigan Department of Community Health
Health Plan Capitation Rate Development
Statewide

Fiscal Year: 2014

Expansion Population Proposed Rates - Low Rates

Population	Average Year 1 Enrollment	Trended Base Claims Cost	Cost-sharing Adjustment	Base Claims Adjustment	Adjusted Base Claims Cost	Non-Emergency Transportation	Adult Chiro	Adult Vision	Hearing Aids	Habilitative Services	Admin/ Profit/ Surplus	Claims Tax	Proposed Medical Capitation Rate	Proposed Dental Capitation Rate
TANF/L Male														
19 - 24 Years	26,895	$87.03	($0.34)	$13.50	$100.19	$2.52	$0.16	$0.81	$0.05	$0.17	$11.19	$1.04	$116.13	$18.04
25 - 34 Years	39,226	168.90	(0.66)	25.87	194.11	2.52	0.16	0.81	0.10	0.33	21.49	1.98	221.50	19.19
35 - 44 Years	35,504	258.79	(1.00)	38.68	296.47	2.52	0.16	0.81	0.20	1.00	32.67	3.01	336.84	20.03
45 - 54 Years	32,777	412.85	(1.57)	60.11	471.39	2.52	0.16	0.81	0.40	2.36	51.24	4.78	533.66	23.26
55 - 64 Years	30,051	476.98	(1.84)	69.39	544.53	2.52	0.16	0.81	0.50	3.68	60.01	5.52	617.73	27.52
TANF/L Female														
19 - 24 Years	21,849	$209.34	($0.84)	$32.32	$240.82	$2.52	$0.16	$0.81	$0.05	$0.42	$27.14	$2.45	$274.37	$18.04
25 - 34 Years	33,210	270.99	(1.06)	41.57	311.50	2.52	0.16	0.81	0.10	0.53	34.65	3.16	353.43	19.19
35 - 44 Years	37,405	348.62	(1.36)	53.10	400.36	2.52	0.16	0.81	0.20	1.36	44.41	4.05	453.87	20.03
45 - 54 Years	34,807	437.53	(1.72)	66.21	502.02	2.52	0.16	0.81	0.40	2.57	56.02	5.08	569.58	23.26
55 - 64 Years	32,207	553.20	(2.12)	80.61	631.69	2.52	0.16	0.81	0.50	4.25	69.26	6.40	715.59	27.52
Composite	323,931	$326.24	($1.27)	$48.72	$373.69	$2.52	$0.16	$0.81	$0.25	$1.68	$41.28	$3.79	$424.19	$21.66

Expansion Population Proposed Rates - High Rates

Population	Average Year 1 Enrollment	Trended Base Claims Cost	Cost-sharing Adjustment	Base Claims Adjustment	Adjusted Base Claims Cost	Non-Emergency Transportation	Adult Chiro	Adult Vision	Hearing Aids	Habilitative Services	Admin/ Profit/ Surplus	Claims Tax	Proposed Medical Capitation Rate	Proposed Dental Capitation Rate
TANF/L Male														
19 - 24 Years	26,895	$87.03	($0.34)	$22.52	$109.21	$2.52	$0.16	$0.81	$0.05	$0.17	$12.42	$1.13	$126.47	$18.04
25 - 34 Years	39,226	168.90	(0.66)	43.20	211.44	2.52	0.16	0.81	0.10	0.33	23.85	2.15	241.36	19.19
35 - 44 Years	35,504	258.79	(1.00)	65.04	322.83	2.52	0.16	0.81	0.20	1.00	36.26	3.28	367.06	20.03
45 - 54 Years	32,777	412.85	(1.57)	101.41	512.69	2.52	0.16	0.81	0.40	2.36	56.87	5.19	581.00	23.26
55 - 64 Years	30,051	476.98	(1.84)	117.77	592.91	2.52	0.16	0.81	0.50	3.68	66.61	6.01	673.20	27.52
TANF/L Female														
19 - 24 Years	21,849	$209.34	($0.84)	$54.26	$262.76	$2.52	$0.16	$0.81	$0.05	$0.42	$30.13	$2.67	$299.52	$18.04
25 - 34 Years	33,210	270.99	(1.06)	69.54	339.47	2.52	0.16	0.81	0.10	0.53	38.46	3.44	385.49	19.19
35 - 44 Years	37,405	348.62	(1.36)	88.87	436.13	2.52	0.16	0.81	0.20	1.36	49.29	4.41	494.88	20.03
45 - 54 Years	34,807	437.53	(1.72)	111.30	547.11	2.52	0.16	0.81	0.40	2.57	62.16	5.54	621.27	23.26
55 - 64 Years	32,207	553.20	(2.12)	136.39	687.47	2.52	0.16	0.81	0.50	4.25	76.86	6.96	779.53	27.52
Composite	323,931	$326.24	($1.27)	$81.99	$406.96	$2.52	$0.16	$0.81	$0.25	$1.68	$45.82	$4.13	$462.33	$21.66

Maternity Case Rate	SFY 2014 Certified Rate	Trend to October 1, 2014	Proposed Capitation Rate
Low Rate	$6,732.81	$24.80	$6,757.61
High Rate	$6,768.64	$24.93	$6,793.57

Enclosure 2

STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH

Healthy Michigan Medicaid Expansion

Capitation Rates Effective April 1, 2014 through March 31, 2015

Actuarial Certification

I, Robert M. Damler, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I was retained by the State of Michigan, Department of Community Health to perform an actuarial review and certification regarding the development of the capitation rates to be effective for the twelve month time period from April 1, 2014 through March 31, 2015 for the Healthy Michigan plan. The capitation rates developed for this time period are for a new managed care program and were developed using historical encounter experience for a similar population. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion.

I reviewed the historical claims experience for reasonableness and consistency. I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

The capitation rates provided with this certification are effective for the one-year rating period beginning April 1, 2014 through March 31, 2015.

The capitation rates provided with this certification meet the requirements defined in 42 CFR 438.6(c), including:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the populations to be covered, and the services to be furnished under the contract; and,

For the purposes of this certification "actuarial soundness" is defined as follows:

> Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates – including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income – provide for all reasonable, appropriate, and attainable costs, including health benefits; health benefit settlement expenses; marketing and administrative expenses; any government-mandated assessments, fees, and taxes; and the cost of capital.

This certification is intended for the State of Michigan and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this Opinion, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Robert M. Damler, FSA
Member, American Academy of Actuaries

March 5, 2014
Date

Enclosure 3

2014 Managed Care Rate Setting Consultation Guide
September 4, 2013

Effective January 1, 2014 the Affordable Care Act (ACA) allows states to expand Medicaid eligibility to adults up to 138% of the federal poverty level based on Modified Adjusted Gross Income (hereinafter referred to as the new adult group). The new adult group is required to receive benefits established using an Alternative Benefit Plan (ABP). If a State intends to use health plans to deliver benefits to the new adult group, the State will need to incorporate this eligibility group into its managed care rate development process. Enactment of the ACA has not changed the requirement that States must comply with title 42 CFR 438.6 and 438.60 in the development of managed care rates that are based on appropriate assumptions and methodologies.

CMS and States share the goal of developing managed care rates that accurately reflect the costs and risks of this eligibility group and any Alternative Benefit Plans included in the managed care arrangement. Because the new adult group, and especially any expansion population included in this eligibility group, may present increased uncertainty regarding utilization and cost of health care services, CMS expects that States will submit 2014 rate setting documentation such that cost and utilization assumptions and trends, risk mitigation strategies and ABP pricing approaches are clearly specified and transparent. To assist States in this effort, CMS has developed a set of critical elements that should be considered as part of the rate development process and an associated set of questions that should be addressed in writing and submitted by States as part of their 2014 rate setting packages. These elements were developed after consultation with federal actuaries and States that have experience in both managed care and in serving expansion populations, including childless adults.

The critical elements of 2014 rate-setting include the following:

1. States should research and analyze projected costs and utilization using appropriate studies and data, as available, improve the accuracy of the rates as much as possible.

Response: Milliman and MDCH have performed considerable research in establishing a benchmark for the utilization and costs for the Healthy Michigan population. We have utilized experience from the current Medicaid program, data for the limited expansion under the Adult Benefit Waiver, and other state expansions.

2. States should closely monitor the actual utilization and costs of the new adult group to quickly detect any significant variation from the assumptions that they factored into the managed care rates. States can take different approaches to mitigate this risk, including but not limited to setting risk corridors; establishing minimum and maximum medical loss ratios; and updating rates to reflect actual experience more often than currently done. CMS will also consider other approaches that States deem necessary and appropriate to address variation from rate-setting assumptions.

Response: Milliman and MDCH will work together to monitor the emerging experience for the Healthy Michigan population and make changes as deemed necessary. We have established methods for submitting encounter data. We have proposed an interim rate adjustment at six months in the rating period, if the data supports a need to revise.

3. States should use the same assumptions to build the non-benefit component of the capitated rate for the new adult group as they use for current enrollees. Differential assumptions applied solely to the new adult group will be considered by CMS when supported by sufficient justification in the rating period.

Response: The non-benefit component of these rates apply a percentage load slightly higher than for current Medicaid enrollees based upon the increased administrative functions required under the Healthy Michigan Act. These include the Healthy Michigan patient account and initial member enrollment requirements.

4. The rate review package should contain adequate actuarial documentation to support the assumptions and methodologies utilized in the Alternative Benefit Package pricing. The actuary should provide sufficient documentation as described by the Actuarial Standards of Practice.

Response: Milliman believes that the information included in this document provides sufficient documentation of the development of the capitation rates for the Healthy Michigan plan. The documentation meets the requirements established by the Actuarial Standards Board of the American Academy of Actuaries.

Questions

Utilization and Cost Data Sources and Assumptions

1. Please describe the data sources that the State intends to use for rate development for the new adult group.
   a) Will the State will be able to use its own encounter data and cost data when developing rates for the new adult group?
   Response: Milliman has utilized historical experience from the currently enrolled Adult TANF population with adjustments to reflect the morbidity of the targeted population. Milliman believes this source of data to be the most reasonable source of information based on consistency between covered benefits, reimbursement levels and membership demographics.

   b) What are the State-specific data sources that are being considered when developing rates? Are there national studies that have been determined relevant?
   Response: In conjunction with state-specific data sources, Milliman has also reviewed expansion population experience from other states along with studies regarding the coverage by income level in the Medicaid program.

   c) Are there any other data sources being considered when developing rates for the new adult group?
   Response: Milliman has reviewed other data sources for purposes of developing adjustments factors and establishing membership projections by demographics. Other data sources include the MEPS data and ACS data.

   d) What utilization assumptions did the State use?
   Response: The baseline utilization was developed from the managed care encounter experience for the TANF adult population. Adjustments have been made to the historical experience to reflect utilization adjustments for the absence of managed care and pent-up demand. These adjustments have been detailed in this document.

   e) If the State is using available existing data sources what, if any, adjustments to the base year utilization and cost data is being made to account for differences between that data and actual expected new adult group demographics?
   Response: The adjustment factors along with additional benefit coverages have been identified and detailed in this document.

2. If the State expects that MCOs will have to pay higher rates to providers in order to build or maintain an adequate network to meet the needs of their expanded membership, please provide specifics of the assumptions made and how those higher rates are reflected in the cost assumptions. If these assumptions will apply only to rates for the new adult group and not to rates developed for current enrollees, please clearly disclose this approach and provide supporting narrative documenting why those higher fees will be isolated only to the provision of services to the new adult group.

Response: Reimbursement levels for medical services in these capitation rates are consistent with those for currently enrolled members. In the course of the dental rate development, fees that are higher than the current FFS Adult dental Medicaid program were utilized. These fees are consistent, however, with other managed care dental networks in the State of Michigan. As the Healthy Michigan population will be maintained separately from the currently enrolled members, the fees will be specific to the expansion population.

3. Please describe what data sources the State intends to use to monitor the rates for the new adult group. Will the state collect actual encounter data submitted by MCOs along with the associated cost data that has been appropriately scrubbed and audited?

Response: Actual encounter data reported by the health plan, along with enrollment figures provided by Medicaid will be utilized to monitor the costs of this program.

Risk Mitigation Strategies

1. What risk mitigation arrangements does the state expect to use to reflect the unusual level of uncertainty associated with the new adult group? Please describe both the method to be used and the parameters for the arrangement. If using a medical loss ratio, describe how the State defines medical expenses as well as administrative expenses for purpose of calculating the MLR.

Response: The risk mitigation strategy to be utilized for this program will be a risk corridor with shared savings. The details of this strategy are detailed in this document.

2. How will the State review to effectively monitor and manage these arrangements properly? Identify specific data to be reviewed, frequency of review, etc.

Response: Based on discussions with MDCH and the health plans, we anticipate that reviews will take place on either a semi-annual or annual basis. Reported encounter data and financial information will be reviewed with a specific amount of runout to allow completion prior to performing the reviews. We anticipate an initial review of the data will occur in November 2014 and will focus on reported information for the first six months of the program.

3. If retrospective mitigation strategies are used, how long will it take after the end of the contract year to determine the outcome of the mitigation arrangements?

Response: The anticipated timeline for calculating the shared savings portion of the experience will occur 6 months following the end of the rating period. As indicated, we also expect an interim adjustment may occur during the first contract year.

Development of Non-benefit Component of Capitated Rate

1. Please describe how the state will develop the non-benefit component of the rate (such as administrative costs, profits, reserves, etc.), including the assumptions used to build this part of the rate.

Response: The non-benefit component of the rate was developed consistent with the non-benefit component utilized in the current enrollee managed care capitation rates. A portion of the component is for administrative functions, with other percentages allotted for profit, contingency, margin, and contribution to surplus.

2. How do these compare to the current non- benefit component of the rates for current enrollees?

Response: The non-benefit component of these rates is slightly higher than the percentage utilized in the development of the rates for currently enrolled members.

3. If different, describe the justification for any differences.

Response: The non-benefit component of these rates apply a percentage load slightly higher than for current Medicaid enrollees based upon the increased administrative functions required under the Healthy Michigan Act. These include the health account, assistance with initial health screenings, and other enrollment functions associated with newly covered lives.

Alternative Benefit Plans Pricing (ABP)

1. How does the State anticipate pricing Alternative Benefit Plans (ABP)?
   a) If an ABP is intended to closely resemble the State's Medicaid State plan, please identify the key differences between current rate setting benefit assumptions and the ABP. In particular, please specifically identify the impacts of any substituted services (e.g. personal care for chiropractic).
   Response: The ABP utilized for the expansion population is generally consistent with the set of covered services under the current State plan. Additional benefits have been detailed in this document.

   b) If an ABP is intended to closely resemble a commercial standard, please identify the key differences in benefits and the cost and/or utilization assumptions between the ABP and the current rate-setting benefit assumptions.
   Response: The ABP is not intended to closely resemble a commercial standard.

   c) If an ABP will include additional services or have different limitations on MH/SUD services to be consistent with MHPAEA, please identify the different cost and/or utilization assumptions that will be used for these services in the ABP.
   Response: The ABP does not include additional service or have different limitations on MH/SUD services from the current State plan.

2. Please identify if any of the new adult group will be included in current rate cells/ranges, and provide justification for their inclusion.

Response: the expansion population covered under the ABP will not be included with any current rate cells. The expansion populations will be paid under their own rate structure.