Legislative Report

Program of All-inclusive Care for the Elderly (PACE) Actuarial Analysis

Manager Care Contracting and Rates/Aging Divisions

March, 1, 2024

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $60,000.

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I. Executive summary

This report was required as the result of legislation passed in 2023 that directed the Minnesota Department of Human Services (DHS) to complete an actuarial analysis of a potential Medicaid capitation rate that would be paid to potential entities participating in a Program of All-inclusive Care for the Elderly (PACE) program. The following actuarial analysis was completed by the actuarial firm, Milliman, the Department’s contract actuarial firm that completes rates development for the Medical Assistance and MinnesotaCare managed care programs. This report should help potential PACE entities determine interest in participating in a PACE program in Minnesota.

II. Legislation

Laws of Minnesota, 2023 Regular Session, Chapter 61, Article 2, Section 37: DIRECTION TO COMMISSIONER; FUTURE PACE IMPLEMENTATION FUNDING.

(a) The commissioner of human services shall work collaboratively with stakeholders to undertake an actuarial analysis of Medicaid costs for nursing home eligible beneficiaries for the purposes of establishing a monthly Medicaid capitation rate for the program of all-inclusive care for the elderly (PACE). The analysis must include all sources of state Medicaid expenditures for nursing home eligible beneficiaries, including but not limited to capitation payments to plans and additional state expenditures to skilled nursing facilities consistent with Code of Federal Regulations, chapter 42, part 447, and long-term care costs.

(b) The commissioner shall also estimate the administrative costs associated with implementing and monitoring PACE.

(c) The commissioner shall provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance on the actuarial analysis, proposed capitation rate, and estimated administrative costs by March 1, 2024. The commissioner shall recommend a financing mechanism and administrative framework by September 1, 2024.

(d) By September 1, 2024, the commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance on the commissioner's progress toward developing a recommended financing mechanism. For purposes of this section, the commissioner may issue or extend a request for proposal to an outside vendor.

III. Introduction

In 2005, the legislature authorized DHS to approve and implement a PACE program in Minnesota. The Centers for Medicare and Medicaid Services describe PACE as: "The Programs of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals provides PACE participants with coordinated care. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. Financing for the program is capped, which allows providers to deliver all services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service plans. PACE is a program under Medicare, and states can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit. The PACE program becomes the sole source of Medicaid and Medicare benefits for PACE participants."

After internal assessment and engagement with potential providers, an RFP was released in March 2011 to invite potential PACE entities to apply to participate in the program. DHS received no bidders for the RFP and PACE was not implemented in Minnesota. In recent years, providers of services for older adults have been interested in implementing PACE in Minnesota and worked to advance the legislation passed in 2023 requiring this actuarial analysis in addition to an analysis of program administration.

CMS establishes the guidelines for PACE rate development and indicates that PACE rates cannot exceed the amount that would otherwise have been paid, or "AWOP," if the participants were not enrolled under the PACE program. CMS also requires that states take under consideration the level of needed care, or frailty, of participants when setting rates. Since most seniors and adults with disabilities that would be eligible for PACE are enrolled in managed care plans, the rates described in the following report are built off the current capitation rates paid to managed care plans covering these populations. Those rates were then adjusted to account for program differences and to include any services not covered under managed care, notably PCA and disability waiver services for people ages 55-65.

This report meets the requirement to provide a PACE actuarial analysis by March 1, 2024. DHS will submit an additional report by September 1, 2024 with recommendations regarding an administrative framework and other considerations regarding implementation of a PACE program in Minnesota. The legislature should consider information from both reports before moving forward with decisions regarding PACE implementation.

IV. Actuarial Analysis

The actuarial analysis is found in the accompanying report developed by Milliman.

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February 23, 2024

Jeff Provance
Health Actuary, Director Minnesota Department of Human Services
540 Cedar Street
Elmer L. Anderson Human Services Building
St. Paul, MN 55155-3854
Sent via email: jeffrey.provance@state.mn.us

Re: Calendar Year 2024 PACE Capitation Rate Analysis

Dear Jeff:

Thank you for the opportunity to assist the Minnesota Department of Human Services (DHS) with this important project. Our report summarizes the development of the illustrative Calendar Year (CY) 2024 amount that would otherwise have been paid (AWOP) for a potential Program of All Inclusive Care for the Elderly (PACE) and the resulting CY 2024 capitation rate for a potential PACE program.

Jeff, please let us know if you would like to discuss further or have any other questions.

Sincerely,

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

Sarah A. Wunder, FSA, MAAA
Senior Consulting Actuary

MCC/SAW/mb

Attachment

MILLIMAN REPORT

Minnesota Department of Human Services

Illustrative Calendar Year 2024 Capitation Rates for a Potential PACE Program

February 23, 2024

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Appendix B – CY 2024 Capitation Rate Development for SNBC Report
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This report assumes that the reader is familiar with the State of Minnesota Public Programs, their benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the PACE program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

I. EXECUTIVE SUMMARY

Consistent with Laws of Minnesota, 2023 Regular Session, Chapter 61, Article 2, Section 37, the Minnesota Department of Human Services (DHS) retained Milliman, Inc. (Milliman) to "undertake an actuarial analysis of Medicaid costs for nursing home eligible beneficiaries for the purposes of establishing a monthly Medicaid capitation rate for the Program of All-inclusive Care for the Elderly (PACE)." This report summarizes the development of what calendar year (CY) 2024 capitation rates could be for a PACE program. The ultimate rate development methodology would need to be consistent with the approach outlined in the State Plan, should the State decide to implement a PACE program. However, the data and methodology in this report are consistent with accepted practices and current DHS expectations.

Please note, the Medicaid capitation rates calculated for CY 2024 are provided for illustrative purposes only according to one potential PACE capitation rate development methodology and are not intended to represent actual payment for services. If the State elects to move forward with implementation of a PACE program, a separate analysis would need to be conducted to develop the capitation rates for the PACE program based on the final program design and specifications. These capitation rates include consideration for the Medicaid portion of Basic Care, long term care (LTC) and nursing facility (NF) costs, but they do not incorporate the costs DHS would incur by administering the PACE program. They also do not account for Medicare covered costs or associated revenue.

We understand that this report and exhibits may be shared with the Legislature and other interested stakeholders. However, Milliman does not intend to benefit, or create a legal duty to, any third-party recipient of its work.

Our role is to develop illustrative CY 2024 PACE capitation rates and demonstrate that they are below the "Amount that Would Otherwise have been Paid" (AWOP) in lieu of a member enrolling in PACE. This requirement, along with other Medicaid payment requirements are outlined in 42 CFR 460.182. While these rates are not required to be certified as actuarially sound, Milliman still closely followed the at-risk rate development actuarial opinion guidance outlined by CMS and the Academy of Actuaries to ensure compliance with generally accepted actuarial practices and regulatory requirements, including the December 2015 PACE Medicaid Capitation Rate Setting Guide. Specific Actuarial Standards of Practice (ASOPs) we considered include:

- ASOP No. 1 – Introductory Actuarial Standard of Practice
- ASOP No. 5 – Incurred Health and Disability Claims
- ASOP No. 12 – Risk Classification
- ASOP No. 23 – Data Quality
- ASOP No. 25 – Credibility Procedures
- ASOP No. 41 – Actuarial Communications
- ASOP No. 42 – Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims
- ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 49 – Medicaid Managed Care Capitation Rate Development and Certification
- ASOP No. 56 – Modeling
- Other applicable standards of practice

A. ILLUSTRATIVE CY 2024 PACE RATE

The projected average illustrative CY 2024 capitation rate for the PACE program is $3,726.26 per member per month (PMPM). Total Federal and State projected annual costs would be approximately $4.5M for every 100 PACE enrollees. The PACE rates are prospective in nature and do not include any retrospective adjustments or incentives.

As seen in Exhibit 1, the actual capitation rates that would be paid to a PACE plan would vary by each member's rate cell, including geographical region, age, gender, and Medicare eligibility. The average is developed using the actual Fiscal Year (FY) 2022 enrollment for the Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC) Public Programs underlying the PACE rate development. If a PACE program is ultimately implemented, we recommend collapsing this structure into significantly fewer rate cells for credibility reasons and ease of administration, consistent with typical PACE rate structures nationally.

This report assumes that the reader is familiar with the State of Minnesota Public Programs, their benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the PACE program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

The AWOP in lieu of a member enrolling in PACE is the upper limit of the corresponding PACE capitation rate. The AWOP values in Exhibit 1 are developed from the mature managed care experience of the MSHO / MSC+ and Special Needs Basic Care programs and reflects adjustments in the capitation rate development to reflect specific characteristics of the PACE program. Since the AWOP reflects mature managed care experience, it is appropriate to contract at PACE capitation rate levels that do not assume additional managed care savings beyond those already underlying the AWOP calculated in this report.

B. NOTES ON REPORT STRUCTURE

This report outlines our assumed AWOP and capitation rate development data and methodologies. Section II provides background on the potential Minnesota PACE program. Portions of the MSHO / MSC+ and SNBC program enrollment comprise the population comparable to the PACE enrollment that is used to develop the starting AWOP in Section III and Exhibit 2. Please see the CY 2024 MSHO / MSC+ and SNBC capitation rate reports, which are included as Appendix A and Appendix B to this report, for full details of the service cost and non-benefit cost projection methodologies.

We then adjust the MSHO / MSC+ and SNBC capitation rate AWOPs to reflect the benefits covered by PACE, the estimated location of care mix (community versus NF / “institutional”) and other financial provisions in Section 4 and Exhibits 3 and 4 to develop the final AWOP rates. Adjustments to the final AWOP rates are made in Section V and Exhibits 5 and 6 to develop PACE capitation rates. Final illustrative capitation rates are confirmed to be below the AWOP rates in Exhibit 1.

C. DATA RELIANCE AND IMPORTANT CAVEATS

Milliman prepared this report for the specific purpose of developing illustrative CY 2024 AWOP and capitation rates for a potential PACE program. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of DHS. We understand this report will be shared with the Legislature and other interested parties. Milliman does not intend to benefit, or create a legal duty to, any third-party recipient of its work. This report should only be reviewed in its entirety.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate CY 2024 PACE AWOPs and PACE capitation rates. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice.

The models rely on data and information as input to the models. In addition to the data outlined in Appendices A and B, we used reports on FY 2022 costs of services for MSHO / MSC+ and SNBC individuals that were paid for on a fee-for-service (FFS) basis outside of managed care. We have relied upon this data and information provided by DHS for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose.

Differences between the capitation rates and actual PACE Organization experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. If a PACE program is established in Minnesota, it is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. These rates may not be appropriate for all PACE Organizations. Any organization considering participating in PACE should consider their unique circumstances before deciding to contract under these rates.

The authors of this report are actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This report assumes that the reader is familiar with the State of Minnesota Public Programs, their benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the PACE program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

II. BACKGROUND

PACE is a full-risk, fully-integrated Medicaid-Medicare managed care delivery system for the full range of LTC and acute and primary care services, which strives to foster people's independence and quality of life. PACE is a national model of care delivery for beneficiaries aged 55 and older. Participating organizations would have contracts with both the State of Minnesota and with CMS and receive monthly capitation payments from each entity for dually eligible beneficiaries.

Eligibility for PACE would be determined through existing Public Program and level of care eligibility determinations or the MNChoices member needs assessment process if the determinations are not yet complete. All members in this program will meet the Nursing Home Level of Care criteria. Enrollment in PACE is voluntary.

The AWOP rate for the PACE program reflects costs that would have been incurred by PACE enrollees under Minnesota Public Programs (after adjustment for benefit differences) if PACE were not in existence. The covered population and benefit set are very similar between Minnesota Public Programs and the PACE program. Therefore, consistent with DHS expectations, in this report we adjust the MSHO / MSC+ and SNBC capitation rates to reflect the specific characteristics of the PACE program and enrolled population.

We give consideration to the unique attributes of the PACE population for the following rate setting assumptions:

- Projected Medicare eligibility distribution
- Projected age group distribution
- Projected gender distribution
- Service area
- Population acuity, as measured by the assumed PACE population's location of care mix

The first four bullets in the previous list reflect the potential rate cells for PACE capitation rates, which are consistent with the rate cells used for MSHO / MSC+ and SNBC. Following are the populations forming the base rates for the PACE populations:

- Ages 55 to 64 – SNBC Community and Institutional rate cells
- Ages 65 and older – MSHO / MSC+ Community Elderly Waiver and Institutional rate cells

For final capitation rate development, we also exclude certain fiscal mechanisms from the Public Programs capitation rates that would not be applicable to a PACE program, including the premium tax, capitation withhold and a State Directed Payment.

This report assumes that the reader is familiar with the State of Minnesota Public Programs, their benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the PACE program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

III. STARTING AWOP DEVELOPMENT

This section of the report describes the development of the starting CY 2024 PACE AWOP. The starting, unadjusted AWOP is comprised of components of capitation rates for the MSHO / MSC+ and SNBC programs. The PACE rate cells generally follow the rate structure of these programs, though there are differences between the structure of the two programs and their components. For that reason, the PACE rate cells in this report are more granular than those of the underlying Public Programs. As a result, certain components of the AWOP development will not vary across rate cells, because they did not vary in the original MSHO / MSC+ or SNBC capitation rate development. If a PACE program is ultimately implemented, we recommend collapsing this structure into significantly fewer rate cells for credibility reasons and ease of administration, consistent with typical PACE rate structures nationally.

Table 1 outlines the components of each starting AWOP in Exhibit 2A (Community location of care rate cells) and Exhibit 2B (Institutional location of care rate cells) along with references to the corresponding exhibits in Appendices A and B of this report.

Table 1
Minnesota Department of Human Services
AWOP Component Value Sources

AWOP Component and Rate Cells	Appendix Reference
Basic Care Rates, Ages 55 to 64	Appendix B (SNBC rate report), Exhibit 2B, "Plan RA Rate - Withhold at Risk."
Basic Care Rates, Ages 65+	Appendix A (MSHO / MSC+ rate report), Exhibit 3A "Total Rates - After Withhold at Risk."
Elderly Waiver (EW) Rates, Ages 55 to 64	EW service costs are covered on an FFS basis outside of SNBC capitation and will be accounted for in Section IV. Therefore, the values in Exhibit 2 are $0.00.
EW Rates, Ages 65+	Appendix A, Exhibit 6A; EW rates vary by Activities of Daily Living (ADL) needs for MSHO / MSC+. Since the PACE program would not have rate cells varying by ADL needs, we build in the average rate using FY 2022 enrollment.
NF Add-on Rates, Ages 55 to 64	Appendix B, Exhibit 2B, "NF Add-on."
NF Add-on Rates, Ages 65+	Appendix A, Exhibit 9A.

Notes:

- Capitation rates are targeted to cover the first 100 days (SNBC) or 180 days (MSHO / MSC+) of NF costs before a member is moved to the FFS program. To financially incent community-based care in those managed care programs, the projected NF costs are distributed over projected C*ommunity* location of care member months. Therefore, NF Add-on payments are paid for members in Community rate cells and not Institutional rate cells in those programs. To be consistent with regulation, we develop the AWOP in the same manner.

- Individuals in Institutional rate cells are not eligible for EW services, so the EW add-on is not paid for Institutional rate cells.

- For CY 2024 MSHO / MSC+ and SNBC rate development we assume 0% of the capitation withhold ultimately at risk (0.25% of revenue) is expected to be earned back by the MCOs, consistent with historical experience. Therefore, we choose MSHO / MSC+ and SNBC capitation rates with the same assumption in the PACE AWOP development.

Please see Appendices A and B to this report for details around the data and methodology underlying the development of each of the components of the MSHO / MSC+ and SNBC capitation rates.

IV. PACE-SPECIFIC AWOP ADJUSTMENTS

A. COVERED SERVICE ADJUSTMENT

This section of the report describes adjustments made to the starting AWOP rates to address benefit coverage differences between Minnesota Public Programs and the PACE program.

For MSHO / MSC+ and SNBC members, some services are provided outside of managed care capitation. Some of these services are formally carved out of MCO responsibility under managed care. Other services may be provided via FFS simply due to timing reasons related to MCO enrollment. All of these services would be covered for PACE members. Therefore, DHS provided us with costs for the services covered outside of capitation for MSHO / MSC+ and SNBC members during FY 2022, consistent with the base data underlying capitation rate development for these programs. DHS confirmed that these were the only services with material costs for these populations that are covered outside of managed care capitation. We converted the costs to PMPM values using the FY 2022 enrollment from capitation rate development. We reviewed the resulting PMPM values for reasonability against costs for other covered populations and had no concerns.

Exhibits 3a and 3b add costs to each of the rate cells in Exhibits 2a and 2b for the following services covered outside of capitation for the MSHO / MSC+ and SNBC populations:

- FQHC – All rate cells
- Other State Plan services provided via FFS
  - PCA / Home Care Nursing – Primarily ages 55 to 64 only, since these services are carved out of SNBC
  - Public Health Nursing – All rate cells
  - Hospice – All rate cells
- Waiver services – Primarily ages 55 to 64 only, since these services are carved out of SNBC

The dates of service for the additional services were during FY 2022 with runout through late January 2024, so no claim completion adjustment was necessary. We trended costs to CY 2024 at the following annualized rates, consistent with capitation rate development:

- FQHC – 1.6%
- Other State Plan services – -3.0%
- Waiver services – 4.0%

Note, we have seen consistent negative trends in "Other State Plan services" (substantially all of which are PCA and home care nursing) for a number of years, coupled with higher trends for waiver services. We expect this reflects movement in service delivery from State Plan services to waiver services that meet similar member needs.

Additionally, since DHS receives pharmacy manufacturer rebates outside of capitation for MSHO / MSC+ and SNBC, but would not do so for a PACE program, Exhibits 3a and 3b also reduce AWOP pharmacy costs for this issue. DHS provided us average CY 2022 rebate percentages of 0% for Dual Eligibles and 58% for Medicaid Only Eligibles, which we believe to be reasonable. Using rebate collection data from DHS, we estimated CY 2022 pharmacy rebates PMPM by rate cell and trended to CY 2024 using annualized rates of 5.8% for ages 55 to 64 and 4.9% for ages 65+, consistent with MSHO / MSC+ and SNBC rate development.

Note, we have not adjusted AWOP Institutional costs for services received on an FFS basis after a member disenrolls from MSHO / MSC+ or SNBC. After discussion with DHS, we believe it is reasonable to assume that most or all members will disenroll from PACE during NF stays expected to be long-term at similar patterns to those seen under MSHO / MSC+ and SNBC. This is an important assumption that should be monitored and updated if a PACE program is started in Minnesota.

Exhibits 4a and 4b show the projected AWOP by location of care as the sum of Exhibits 2 and 3.

This report assumes that the reader is familiar with the State of Minnesota Public Programs, their benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the PACE program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

B. LOCATION OF CARE ADJUSTMENT

PACE programs typically have a different location of care mix (i.e., Community versus NF / Institutional) than the proxy populations underlying the AWOP development. To that end, we analyzed the institutional percentages of MSHO / MSC+ and SNBC (2% to 13%) and collected similar location of care information from PACE programs in several other states. As a result, and after discussion with DHS, we determined that an assumption of 95% Community / 5% Institutional location of care mix would be appropriate for this PACE rate development exercise. The second table in Exhibit 1 shows the resulting final AWOP blended 95% / 5% across Exhibits 4a and 4b.

This report assumes that the reader is familiar with the State of Minnesota Public Programs, their benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the PACE program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

V. PACE CAPITATION RATE DEVELOPMENT

Exhibits 5a and 5b show the adjustments made to the location of care-specific AWOPs in Exhibits 4a and 4b to develop the illustrative CY 2024 PACE capitation rates for each rate cell. We adjust each AWOP for the following issues in Table 2 to develop the final capitation rates:

Table 2
Minnesota Department of Human Services
AWOP Adjustment Formulas

AWOP Adjustment	Reference
We remove the portion of the AWOP rate associated with the 1% Premium Tax and 0.6% HMO surcharge applicable to Basic Care rates for MSHO / MSC+ and SNBC, since PACE organizations will not be subject to these taxes unless they are also licensed HMOs. We built the AWOP with non-County-Based Purchasing ("non-CBP") MCO rates, which enroll the vast majority of the proxy populations and are subject to the Premium Tax and HMO surcharge.	-1.6% of Exhibit 2A -1.6% of Exhibit 2B
We add back the portion of the AWOP rate associated with the 0.25% net withhold at risk for MSHO / MSC+ and SNBC, since PACE will not be subject to this withhold arrangement. The withhold does not apply to the EW and NF add-on portions of the capitation rates.	+0.25% / 0.9975 * 0.984 = 0.247% of Exhibit 2A, Basic Care Rates +0.25% / 0.9975 * 0.984 = 0.247% of Exhibit 2B, Basic Care Rates
We remove the portion of the AWOP rate associated with the Directed Payment for a Safety Net Hospital in Hennepin County and associated margin, since PACE will not be subject to this Directed Payment. This is only applicable to Non-Medicare rate cells since the rate cells for Medicare eligibles do not include the directed payment costs.	Appendix B (SNBC rate report), Exhibit 2A, - "Non-CBP Directed Payment for a Safety Net Hospital in Hennepin County" – "Margin for Directed Payment…" Appendix A (MSHO / MSC+ rate report), Exhibit 3A, - "Directed Payment for a Safety Net Hospital in Hennepin County" - "Margin for Directed Payment…"

Exhibits 6a and 6b show the illustrative total PACE capitation rates by location of care, combining Exhibits 4 and 5. The first table in Exhibit 1 shows the resulting final capitation rates after blending 95% Community / 5% Institutional across Exhibits 6a and 6b. These blended capitation values are what would be paid to PACE organizations and are less than the final AWOP amounts in the second table of Exhibit 1 to be in compliance with the rate requirements of 42 CFR 460.182.

Additional rate reductions from each AWOP are not necessary since the basis of the AWOP rates already reflects experience from mature managed care programs. Documentation of compliance with the December 2015 PACE Medicaid Rate Setting Guide is included as Appendix C. The PACE rates are prospective in nature and do not include any retrospective adjustments or incentives.

This report assumes that the reader is familiar with the State of Minnesota Public Programs, their benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the PACE program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

EXHIBITS

Exhibit 1
Calendar Year 2024 PACE Rate Development
Illustrative PACE AWOP and Capitation Rates

Final Capitation Rate Blended Total: $3,726.26

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$3,428.61	$3,728.75	$4,369.81	$5,247.46	$4,823.50	$6,258.41	$6,716.62	$7,139.21	$2,865.96	$3,806.33	$4,284.49	$4,855.47	$4,717.17	$6,294.63	$6,692.13	$7,111.69
North	$2,524.06	$3,019.66	$3,642.11	$4,449.45	$3,080.22	$6,353.84	$6,991.91	$7,867.08	$1,807.06	$3,143.70	$3,596.93	$4,382.96	$2,978.05	$6,315.07	$7,015.06	$7,890.46
South	$2,556.19	$3,019.66	$3,642.11	$4,449.45	$2,774.84	$6,353.84	$6,991.91	$7,867.08	$1,777.57	$3,143.70	$3,596.93	$4,382.96	$3,054.79	$6,315.07	$7,015.06	$7,890.46

Final AWOP Rate Blended Total: $3,805.29

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$3,437.67	$3,784.17	$4,434.91	$5,325.70	$5,097.04	$6,702.65	$7,167.04	$7,597.15	$2,875.02	$3,862.70	$4,348.49	$4,928.36	$4,990.71	$6,516.90	$6,920.59	$7,347.66
North	$2,532.34	$3,065.54	$3,698.24	$4,519.00	$3,152.48	$6,449.50	$7,096.05	$7,983.90	$1,815.35	$3,191.36	$3,652.38	$4,451.70	$3,050.31	$6,410.61	$7,119.07	$8,007.16
South	$2,565.00	$3,065.54	$3,698.24	$4,519.00	$2,840.67	$6,449.50	$7,096.05	$7,983.90	$1,786.38	$3,191.36	$3,652.38	$4,451.70	$3,120.62	$6,410.61	$7,119.07	$8,007.16

FY 2022 Member Months

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	32,753	19,188	19,487	9,996	28,916	3,236	1,495	382	40,813	36,407	44,588	27,145	34,437	5,377	2,476	691
North	18,113	8,442	6,394	3,602	12,171	238	82	48	24,798	14,722	17,293	16,170	13,866	511	216	47
South	11,971	5,490	5,159	3,219	5,628	98	58	47	16,565	10,619	11,928	11,852	7,363	282	166	65

Exhibit 2a
Calendar Year 2024 PACE Rate Development
Starting PACE AWOP Community Rate Cells

Basic Care Rates

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$649.61	$2,050.47	$2,282.85	$2,678.13	$2,620.56	$5,234.49	$5,234.49	$5,234.49	$649.61	$2,129.84	$2,196.69	$2,178.04	$2,620.56	$5,000.72	$5,000.72	$5,000.72
North	$588.93	$1,137.05	$1,048.80	$877.45	$2,258.32	$4,886.79	$4,886.79	$4,886.79	$588.93	$1,257.25	$1,031.94	$734.59	$2,258.32	$4,886.71	$4,886.71	$4,886.71
South	$629.17	$1,137.05	$1,048.80	$877.45	$2,120.09	$4,886.79	$4,886.79	$4,886.79	$629.17	$1,257.25	$1,031.94	$734.59	$2,120.09	$4,886.71	$4,886.71	$4,886.71

Elderly Waiver Rates

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$0.00	$1,800.24	$2,207.17	$2,701.57	$0.00	$1,800.24	$2,207.17	$2,701.57	$0.00	$1,800.24	$2,207.17	$2,701.57	$0.00	$1,800.24	$2,207.17	$2,701.57
North	$0.00	$1,927.81	$2,485.58	$3,320.07	$0.00	$1,927.81	$2,485.58	$3,320.07	$0.00	$1,927.81	$2,485.58	$3,320.07	$0.00	$1,927.81	$2,485.58	$3,320.07
South	$0.00	$1,927.81	$2,485.58	$3,320.07	$0.00	$1,927.81	$2,485.58	$3,320.07	$0.00	$1,927.81	$2,485.58	$3,320.07	$0.00	$1,927.81	$2,485.58	$3,320.07

Nursing Facility Add-On Rates

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$14.98	$81.21	$121.55	$161.00	$24.12	$49.64	$49.64	$49.64	$14.98	$73.70	$123.45	$237.20	$24.12	$45.76	$45.76	$45.76
North	$14.98	$97.67	$296.60	$496.38	$24.12	$58.20	$58.20	$58.20	$14.98	$110.24	$268.56	$567.14	$24.12	$59.92	$59.92	$59.92
South	$14.98	$97.67	$296.60	$496.38	$24.12	$58.20	$58.20	$58.20	$14.98	$110.24	$268.56	$567.14	$24.12	$59.92	$59.92	$59.92

Total Starting AWOP

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$664.59	$3,931.92	$4,611.56	$5,540.70	$2,644.68	$7,084.37	$7,491.29	$7,985.70	$664.59	$4,003.79	$4,527.30	$5,116.81	$2,644.68	$6,846.72	$7,253.65	$7,748.05
North	$603.91	$3,162.53	$3,830.99	$4,693.91	$2,282.44	$6,872.80	$7,430.56	$8,265.06	$603.91	$3,295.31	$3,786.08	$4,621.81	$2,282.44	$6,874.44	$7,432.21	$8,266.70
South	$644.15	$3,162.53	$3,830.99	$4,693.91	$2,144.21	$6,872.80	$7,430.56	$8,265.06	$644.15	$3,295.31	$3,786.08	$4,621.81	$2,144.21	$6,874.44	$7,432.21	$8,266.70

Exhibit 2a
Calendar Year 2024 PACE Rate Development
Starting PACE AWOP Institutional Rate Cells

Basic Care Rates

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$721.11	$671.51	$525.31	$442.21	$5,976.39	$3,866.41	$3,866.41	$3,866.41	$721.11	$735.56	$498.13	$317.53	$5,976.39	$3,866.41	$3,866.41	$3,866.41
North	$721.11	$696.88	$528.58	$373.68	$5,976.39	$3,454.73	$3,454.73	$3,454.73	$721.11	$760.05	$462.36	$310.45	$5,976.39	$3,454.73	$3,454.73	$3,454.73
South	$721.11	$696.88	$528.58	$373.68	$5,976.39	$3,454.73	$3,454.73	$3,454.73	$721.11	$760.05	$462.36	$310.45	$5,976.39	$3,454.73	$3,454.73	$3,454.73

Elderly Waiver Rates

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
North	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
South	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Nursing Facility Add-On Rates

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
North	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
South	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Total Starting AWOP

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$721.11	$671.51	$525.31	$442.21	$5,976.39	$3,866.41	$3,866.41	$3,866.41	$721.11	$735.56	$498.13	$317.53	$5,976.39	$3,866.41	$3,866.41	$3,866.41
North	$721.11	$696.88	$528.58	$373.68	$5,976.39	$3,454.73	$3,454.73	$3,454.73	$721.11	$760.05	$462.36	$310.45	$5,976.39	$3,454.73	$3,454.73	$3,454.73
South	$721.11	$696.88	$528.58	$373.68	$5,976.39	$3,454.73	$3,454.73	$3,454.73	$721.11	$760.05	$462.36	$310.45	$5,976.39	$3,454.73	$3,454.73	$3,454.73

Exhibit 3a
Calendar Year 2024 PACE Rate Development
PACE Specific AWOP Adjustments Community Rate Cells

FQHC

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$3.23	$2.60	$3.19	$1.26	$36.15	$26.22	$36.04	$19.64	$3.23	$3.31	$1.71	$0.80	$36.15	$27.03	$19.93	$18.64
North	$5.76	$3.73	$1.53	$1.11	$35.01	$9.69	$25.61	$43.27	$5.76	$3.03	$2.01	$1.18	$35.01	$9.50	$8.17	$12.28
South	$2.11	$3.73	$1.53	$1.11	$20.20	$9.69	$25.61	$43.27	$2.11	$3.03	$2.01	$1.18	$20.20	$9.50	$8.17	$12.28

Public Health Nursing / Hospice

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$0.21	$2.01	$14.38	$10.69	$1.05	$2.00	$0.00	$11.74	$1.35	$2.94	$7.05	$20.40	$1.08	$0.00	$0.00	$13.45
North	$1.38	$8.50	$12.14	$16.97	$1.71	$0.00	$0.00	$0.00	$4.46	$2.08	$8.69	$18.06	$4.24	$0.00	$0.00	$0.00
South	$3.43	$8.50	$12.14	$16.97	$0.05	$0.00	$0.00	$0.00	$2.14	$2.08	$8.69	$18.06	$3.51	$0.00	$0.00	$0.00

PCA/Home Care

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$548.96	$0.00	$0.00	$0.00	$667.90	$0.00	$0.00	$0.00	$621.36	$0.00	$0.00	$0.00	$1,009.62	$0.00	$0.00	$0.00
North	$147.95	$0.00	$0.00	$0.00	$159.87	$0.00	$0.00	$0.00	$194.71	$0.00	$0.00	$0.00	$347.63	$0.00	$0.00	$0.00
South	$92.98	$0.00	$0.00	$0.00	$199.98	$0.00	$0.00	$0.00	$150.81	$0.00	$0.00	$0.00	$476.86	$0.00	$0.00	$0.00

Waiver Services

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$2,333.80	$0.01	$0.13	$0.02	$2,067.37	$0.00	$0.00	$0.00	$1,664.49	$0.06	$0.00	$0.00	$1,587.32	$0.00	$0.00	$0.00
North	$1,848.14	$0.60	$0.08	$0.17	$883.42	$0.00	$0.00	$0.00	$1,045.57	$0.11	$0.04	$0.10	$677.64	$0.00	$0.00	$0.00
South	$1,899.66	$0.60	$0.08	$0.17	$743.53	$0.00	$0.00	$0.00	$1,003.94	$0.11	$0.04	$0.10	$730.43	$0.00	$0.00	$0.00

Pharmacy Rebates

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$0.00	$0.00	$0.00	$0.00	($379.09)	($246.18)	($178.15)	($204.60)	$0.00	$0.00	$0.00	$0.00	($349.49)	($203.17)	($180.01)	($248.17)
North	$0.00	$0.00	$0.00	$0.00	($356.40)	($264.32)	($165.33)	($84.03)	$0.00	$0.00	$0.00	$0.00	($465.15)	($301.79)	($115.06)	($26.03)
South	$0.00	$0.00	$0.00	$0.00	($435.00)	($264.32)	($165.33)	($84.03)	$0.00	$0.00	$0.00	$0.00	($417.53)	($301.79)	($115.06)	($26.03)

Exhibit 3b
Calendar Year 2024 PACE Rate Development
PACE Specific AWOP Adjustments   Institutional Rate Cells

FQHC

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$1.28	$1.11	$0.31	$0.22	$3.00	$0.00	$0.00	$0.00	$1.28	$0.81	$0.52	$0.15	$3.00	$1.62	$10.28	$0.00
North	$6.94	$1.09	$1.08	$1.46	$43.68	$52.26	$100.70	$8.27	$6.94	$2.33	$1.48	$0.55	$43.68	$19.79	$0.00	$13.27
South	$1.17	$1.09	$1.08	$1.46	$40.91	$52.26	$100.70	$8.27	$1.17	$2.33	$1.48	$0.55	$40.91	$19.79	$0.00	$13.27

Public Health Nursing / Hospice

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$188.18	$154.37	$203.35	$570.74	$226.69	$0.00	$0.00	$0.00	$202.21	$242.99	$282.30	$626.50	$210.26	$0.00	$0.00	$0.00
North	$248.92	$200.67	$383.76	$473.69	$192.21	$0.00	$0.00	$0.00	$242.48	$261.30	$436.60	$540.52	$700.93	$0.00	$0.00	$0.00
South	$53.54	$200.67	$383.76	$473.69	$75.99	$0.00	$0.00	$0.00	$343.22	$261.30	$436.60	$540.52	$365.91	$0.00	$0.00	$0.00

PCA/Home Care

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$12.32	$0.00	$0.00	$0.00	$15.90	$0.00	$0.00	$0.00	$20.64	$0.00	$0.00	$0.00	$32.58	$0.00	$0.00	$0.00
North	$6.93	$0.00	$0.00	$0.00	$2.92	$0.00	$0.00	$0.00	$0.64	$0.00	$0.00	$0.00	$37.37	$0.00	$0.00	$0.00
South	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.09	$0.00	$0.00	$0.00	$58.69	$0.00	$0.00	$0.00

Waiver Services

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$365.73	$62.12	$13.27	$0.00	$404.36	$0.00	$0.00	$0.00	$409.77	$82.68	$3.78	$0.91	$367.05	$0.00	$0.00	$0.00
North	$127.37	$80.28	$1.37	$0.22	$156.37	$0.00	$0.00	$0.00	$102.16	$93.35	$7.73	$0.70	$128.16	$0.00	$0.00	$0.00
South	$319.96	$80.28	$1.37	$0.22	$342.50	$0.00	$0.00	$0.00	$395.19	$93.35	$7.73	$0.70	$503.01	$0.00	$0.00	$0.00

Pharmacy Rebates

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$0.00	$0.00	$0.00	$0.00	($408.74)	($275.12)	($159.93)	($360.48)	$0.00	$0.00	$0.00	$0.00	($432.75)	($271.09)	($242.78)	($20.71)
North	$0.00	$0.00	$0.00	$0.00	($436.56)	($262.20)	($160.48)	($46.60)	$0.00	$0.00	$0.00	$0.00	($634.74)	($323.31)	($254.26)	($131.02)
South	$0.00	$0.00	$0.00	$0.00	($408.71)	($262.20)	($160.48)	($46.60)	$0.00	$0.00	$0.00	$0.00	($728.46)	($323.31)	($254.26)	($131.02)

Exhibit 4a
Calendar Year 2024 PACE Rate Development
Final AWOPs Community Rate Cells

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$3,550.78	$3,936.54	$4,629.26	$5,552.68	$5,038.06	$6,866.40	$7,349.18	$7,812.47	$2,955.02	$4,010.10	$4,536.06	$5,138.01	$4,929.35	$6,670.58	$7,093.57	$7,531.98
North	$2,607.14	$3,175.36	$3,844.74	$4,712.15	$3,006.03	$6,618.17	$7,290.84	$8,224.30	$1,854.40	$3,300.53	$3,796.81	$4,641.14	$2,881.81	$6,582.15	$7,325.32	$8,252.96
South	$2,642.33	$3,175.36	$3,844.74	$4,712.15	$2,672.96	$6,618.17	$7,290.84	$8,224.30	$1,803.15	$3,300.53	$3,796.81	$4,641.14	$2,957.68	$6,582.15	$7,325.32	$8,252.96

Exhibit 4b
Calendar Year 2024 PACE Rate Development
Final AWOPs   Institutional Rate Cells

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$1,288.63	$889.11	$742.24	$1,013.17	$6,217.59	$3,591.28	$3,706.48	$3,505.92	$1,355.01	$1,062.04	$784.72	$945.08	$6,156.53	$3,596.94	$3,633.91	$3,845.70
North	$1,111.27	$978.92	$914.79	$849.06	$5,935.01	$3,244.79	$3,394.95	$3,416.40	$1,073.33	$1,117.03	$908.16	$852.23	$6,251.78	$3,151.21	$3,200.47	$3,336.98
South	$1,095.79	$978.92	$914.79	$849.06	$6,027.08	$3,244.79	$3,394.95	$3,416.40	$1,467.78	$1,117.03	$908.16	$852.23	$6,216.44	$3,151.21	$3,200.47	$3,336.98

Exhibit 5a
Calendar Year 2024 PACE Rate Development
PACE Specific Capitation Adjustments Community Rate Cells

Remove 1.6% Premium Tax and MCO Assessment

Area	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	($10.63)	($62.91)	($73.79)	($88.65)	($42.31)	($113.35)	($119.86)	($127.77)	($10.63)	($64.06)	($72.44)	($81.87)	($42.31)	($109.55)	($116.06)	($123.97)
North	($9.66)	($50.60)	($61.30)	($75.10)	($36.52)	($109.96)	($118.89)	($132.24)	($9.66)	($52.72)	($60.58)	($73.95)	($36.52)	($109.99)	($118.92)	($132.27)
South	($10.31)	($50.60)	($61.30)	($75.10)	($34.31)	($109.96)	($118.89)	($132.24)	($10.31)	($52.72)	($60.58)	($73.95)	($34.31)	($109.99)	($118.92)	($132.27)

Add Back 0.25% Net Withhold at Risk

Area	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$1.60	$5.06	$5.63	$6.60	$6.46	$12.91	$12.91	$12.91	$1.60	$5.25	$5.42	$5.37	$6.46	$12.33	$12.33	$12.33
North	$1.45	$2.80	$2.59	$2.16	$5.57	$12.05	$12.05	$12.05	$1.45	$3.10	$2.54	$1.81	$5.57	$12.05	$12.05	$12.05
South	$1.55	$2.80	$2.59	$2.16	$5.23	$12.05	$12.05	$12.05	$1.55	$3.10	$2.54	$1.81	$5.23	$12.05	$12.05	$12.05

Remove Directed Payment for a Safety Net Hospital in Hennepin County and Associated Margin

Area	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$0.00	$0.00	$0.00	$0.00	($216.98)	($342.99)	($342.99)	($342.99)	$0.00	$0.00	$0.00	$0.00	($216.98)	($112.56)	($112.56)	($112.56)
North	$0.00	$0.00	$0.00	$0.00	($10.01)	($0.16)	($0.16)	($0.16)	$0.00	$0.00	$0.00	$0.00	($10.01)	$0.00	$0.00	$0.00
South	$0.00	$0.00	$0.00	$0.00	($5.11)	($0.16)	($0.16)	($0.16)	$0.00	$0.00	$0.00	$0.00	($5.11)	$0.00	$0.00	$0.00

Exhibit 5b
Calendar Year 2024 PACE Rate Development
PACE Specific Capitation Adjustments Institutional Rate Cells

Remove 1.6% Premium Tax and MCO Assessment

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	($11.54)	($10.74)	($8.40)	($7.08)	($95.62)	($61.86)	($61.86)	($61.86)	($11.54)	($11.77)	($7.97)	($5.08)	($95.62)	($61.86)	($61.86)	($61.86)
North	($11.54)	($11.15)	($8.46)	($5.98)	($95.62)	($55.28)	($55.28)	($55.28)	($11.54)	($12.16)	($7.40)	($4.97)	($95.62)	($55.28)	($55.28)	($55.28)
South	($11.54)	($11.15)	($8.46)	($5.98)	($95.62)	($55.28)	($55.28)	($55.28)	($11.54)	($12.16)	($7.40)	($4.97)	($95.62)	($55.28)	($55.28)	($55.28)

Add Back 0.25% Net Withhold at Risk

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$1.78	$1.66	$1.30	$1.09	$14.74	$9.54	$9.54	$9.54	$1.78	$1.81	$1.23	$0.78	$14.74	$9.54	$9.54	$9.54
North	$1.78	$1.72	$1.30	$0.92	$14.74	$8.52	$8.52	$8.52	$1.78	$1.87	$1.14	$0.77	$14.74	$8.52	$8.52	$8.52
South	$1.78	$1.72	$1.30	$0.92	$14.74	$8.52	$8.52	$8.52	$1.78	$1.87	$1.14	$0.77	$14.74	$8.52	$8.52	$8.52

Remove Directed Payment for a Safety Net Hospital in Hennepin County and Associated Margin

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +	55-64	65 - 74	75 - 84	85 +
Metro	$0.00	$0.00	$0.00	$0.00	($585.99)	($407.31)	($407.31)	($407.31)	$0.00	$0.00	$0.00	$0.00	($585.99)	($407.31)	($407.31)	($407.31)
North	$0.00	$0.00	$0.00	$0.00	($585.99)	($3.06)	($3.06)	($3.06)	$0.00	$0.00	$0.00	$0.00	($585.99)	($3.06)	($3.06)	($3.06)
South	$0.00	$0.00	$0.00	$0.00	($585.99)	($3.06)	($3.06)	($3.06)	$0.00	$0.00	$0.00	$0.00	($585.99)	($3.06)	($3.06)	($3.06)

Exhibit 6a
Calendar Year 2024 PACE Rate Development
Illustrative Capitation Rate   Community Rate Cells

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$3,541.75	$3,878.69	$4,561.11	$5,470.63	$4,785.22	$6,422.98	$6,899.24	$7,354.63	$2,945.99	$3,951.29	$4,469.04	$5,061.51	$4,676.52	$6,460.81	$6,877.28	$7,307.78
North	$2,598.93	$3,127.56	$3,786.03	$4,639.21	$2,965.07	$6,520.09	$7,183.85	$8,103.95	$1,846.19	$3,250.91	$3,738.78	$4,569.01	$2,840.84	$6,484.22	$7,218.45	$8,132.74
South	$2,633.57	$3,127.56	$3,786.03	$4,639.21	$2,638.77	$6,520.09	$7,183.85	$8,103.95	$1,794.39	$3,250.91	$3,738.78	$4,569.01	$2,923.49	$6,484.22	$7,218.45	$8,132.74

Exhibit 6b
Calendar Year 2024 PACE Rate Development
Illustrative Capitation Rate Institutional Rate Cells

	Males								Females							
	Medicare				Non-Medicare				Medicare				Non-Medicare			
Area	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**	**55-64**	**65 - 74**	**75 - 84**	**85 +**
Metro	$1,278.87	$880.02	$735.13	$1,007.18	$5,550.72	$3,131.65	$3,246.85	$3,046.29	$1,345.25	$1,052.09	$777.98	$940.78	$5,489.66	$3,137.30	$3,174.27	$3,386.06
North	$1,101.51	$969.49	$907.63	$844.00	$5,268.14	$3,194.98	$3,345.14	$3,366.59	$1,063.58	$1,106.74	$901.91	$848.03	$5,584.91	$3,101.40	$3,150.66	$3,287.17
South	$1,086.03	$969.49	$907.63	$844.00	$5,360.21	$3,194.98	$3,345.14	$3,366.59	$1,458.02	$1,106.74	$901.91	$848.03	$5,549.57	$3,101.40	$3,150.66	$3,287.17

APPENDIX A

CY 2024 Capitation Rate Development for MSHO and MSC+ Report

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September 29, 2023

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Elmer L. Anderson Human Services Building
St. Paul, MN 55155-3854
Sent via email: jeffrey.provance@state.mn.us

Re: Calendar Year 2024 Capitation Rate Development for MSHO and MSC+

Dear Jeff:

The Department of Human Services (DHS) retained Milliman to develop actuarially sound rates for the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) programs for the calendar year (CY) 2024 contract period. The attached report describes the development of actuarially sound CY 2024 Basic Care, Elderly Waiver (EW) Add-on, and Nursing Facility (NF) Add-on capitation rates. The rates in this report are based on July 2021 to June 2022 calendar year (FY 2022) health plan financial summaries, emerging health plan experience, FY 2022 encounter data, provider contracting changes expected to impact CY 2024, trends projecting the experience to CY 2024, and several adjustments for program changes passed through the 2023 legislative session.

We look forward to discussing these results with you.

Sincerely,

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

Briana Botros, FSA, MAAA
Consulting Actuary

MCC/BB/jf

Attachments

MILLIMAN REPORT

Minnesota Department of Human Services

Basic Care, Elderly Waiver Add-on, and Nursing Facility Add-On Rate Development for MSHO and MSC+ Calendar Year 2024

September 29, 2023

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

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Appendix H – Rate Setting Checklist
Appendix I – Responses to CMS Rate Setting Guide

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration, and other factors. This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

I. EXECUTIVE SUMMARY

This report documents the development of the County Based Purchasing (CBP) and non-CBP Basic Care, Elderly Waiver (EW) Add-on rates, and Nursing Facility (NF) Add-on rates for the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) programs for the calendar year (CY) 2024 contract period. The report assumes the reader is familiar with the basic aspects of the MSHO and MSC+ programs, the population groups covered under the programs, the Minnesota Medicaid program, and managed care rating principles.

The MSHO programs began in 1995 as a Fully Integrated Dual Eligible Special Needs Plan in which Medicaid, Medicare, and Long-Term Services and Support benefits are integrated into one benefit package. The MSC+ program began in 2009, replacing the Minnesota Senior Care program introduced in 2005. Both the MSHO and MSC+ programs provide coverage to low income adults at least 65 years of age. To be eligible for MSHO coverage, enrollees must also be eligible for Medicare Parts A and B and be enrolled in the health plan's Medicare Advantage Special Needs Plan (MA-SNP). The MSC+ program provides coverage to enrollees eligible for Medicare Parts A and B, as well as Non-Dually eligible seniors. These programs cover basic acute care and personal care services. Home and community-based services are provided through the EW Add-on and 180 days of nursing facility coverage is provided through the NF Add-on.

Eight health plans serve the MSHO and MSC+ populations in Minnesota. Three of the plans are County Based Purchasing (CBP) plans. The rate group specific rates provided in this report vary between CBP plans and non-CBP plans to account for CBP plans not being liable for the 1% premium tax and the 0.6% HMO surcharge. A portion of the MSHO enrollment is for plans operating as Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP).

The 87 counties in Minnesota are grouped into the metro (including Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties) and non-metro regions. These regions have not changed from the CY 2023 rate development.

The MSHO and MSC+ rate development includes the following three rate cells:

- Community – Non-Elderly Waiver
- Community – Elderly Waiver
- Institutional

Within each rate cell, the rate group structure differs between Basic Care, the EW Add-on, and the NF Add-on.

This report contains:

- A description of the information used to develop the CY 2024 Basic Care base rates and rate group relativities, which will be used to determine the CY 2024 Basic Care capitation payments. The CY 2024 Basic Care base rates were developed from fiscal year (FY) 2022 health plan experience. The CY 2024 Basic Care rate group relativities were developed using a blend of FY 2021 and FY 2022 health plan experience. Rates are adjusted for withholds.

- A description of the information used to develop the CY 2024 EW Add-on base rates and risk factor weights, which will be used to determine the CY 2024 EW Add-on capitation payments. The CY 2024 EW Add-on base rates were developed from FY 2022 health plan experience. The CY 2024 EW Add-on risk factor weights were developed using a blend of FY 2021 and FY 2022 health plan experience.

- A description of the information used to develop the CY 2024 NF Add-on base rates and rate group relativities, which will be used to determine the CY 2024 NF Add-on capitation payments. The CY 2024 NF Add-on base rates were developed from FY 2018 through FY 2022 health plan experience. The CY 2024 NF Add-on rate group relativities were developed using a blend of FY 2021 and FY 2022 health plan experience.

Consistent with CMS guidance, the rates are certified net of the portion of the withhold arrangement ultimately at risk, amounting to 0.25% of payments. This is the withhold return that is reasonably achievable. The rates net of the withhold at risk are shown in Exhibits 3A through 3B. Since the plan contract includes "loss limit" and payment timing provisions regarding the 8.0% nominal withhold, ultimately only 0.25% of payments are at risk. Based on historical withhold returns, we expect plans to receive 7.75% of the 8.0% nominal withhold. Please see "Section II. E - Withhold" below for additional discussion of the withhold.

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration, and other factors. This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

A. RATE CHANGES FROM CY 2023 TO CY 2024

Overall, the CY 2024 MSHO and MSC+ rates, across the three components outlined below, provide an estimated aggregate per member per month (PMPM) increase of 17.4% from the CY 2023 rates using the FY 2022 membership mix by rate group. The CY 2023 rates were presented in our report dated September 20, 2022. The rate change drivers are multiplicative factors, with the aggregate result calculated as the product of "one plus" each change driver. The components of this rate increase and their approximate impact are as follows:

- Using the FY 2022 membership mix by rate cell**, the estimated aggregate PMPM increase for the CY 2024 Basic Care base rates is 7.7% from the CY 2023 Basic Care base rates**. Basic Care accounts for 56% of the overall MSHO / MSC+ capitation rate and contributes a 4.7% increase to the overall 17.4% increase in MSHO / MSC+ rates from CY 2023 to CY 2024. This increase reflects community Basic Care rates increasing 7.8% in aggregate and the institutional Basic Care rates increasing 6.0% in aggregate. Table 1 documents the primary drivers of the rate change.

  Due to the demographic mix differences among plans, the Basic Care rate change will vary by plan. The overall Basic Care rate increase consists of the following approximate multiplicative components shown in Table 1:

Table 1
Minnesota Department of Human Services
Calendar Year 2024 MSHO and MSC+ Rate Development
Seniors Basic Care Rate Change Drivers

Component	Rate Change
Differences in Actual vs. Projected FY 2022 Costs	-0.2%
Differences in Trend Assumptions from FY 2022 to CY 2023	-2.0%
Non-Pharmacy Trend from CY 2023 to CY 2024	+1.4%
Pharmacy Trend from CY 2023 to CY 2024	+0.1%
Differences in Program Change Adjustments	+6.3%
Differences for Administrative Cost Load	+1.8%
Total excluding Directed Payment for a Safety Net Hospital in Hennepin County	**+7.5%**
Differences in Directed Payment for Safety Net Hospital in Hennepin County[1]	**+0.2%**
Total including Directed Payment for a Safety Net Hospital in Hennepin County	**+7.7%**

[1] The Directed Payment for a Safety Net Hospital in Hennepin County rate change is shown in aggregate across CBP and non-CBP plans; however, the rate adjustment only applies to non-CBP plans.

- Using the FY 2022 membership mix, **the estimated aggregate PMPM increase for the CY 2024 EW Add-on rates is 40.7% from the CY 2023 EW Add-on rates**. EW accounts for 39% of the overall MSHO / MSC+ capitation rate and contributes a 13.1% increase to the overall 17.4 increase in MSHO / MSC+ rates from 2023 to 2024.

  Due to the demographic mix differences among plans, the EW Add-on rate change from 2023 to 2024 will vary by plan. The overall EW Add-on rate change consists of the following approximate multiplicative components shown in Table 2:

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration, and other factors. This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

Table 2 Minnesota Department of Human Services Calendar Year 2024 MSHO and MSC+ Rate Development Elderly Waiver Rate Change Drivers	
Component	**Rate Change**
Differences in Actual vs. Projected FY 2022 Costs	+3.9%
Differences in Trend Assumptions from FY 2022 to CY 2023	+5.4%
Trend from CY 2023 to CY 2024	+6.8%
Differences in Program Change Adjustments	+20.3%
Total	**+40.7%**

- Using the FY 2022 membership mix by rate cell, **the estimated aggregate PMPM decrease for the CY 2024 NF Add-on rates is 6.8% from the CY 2023 NF Add-on rates**. NF accounts for 5% of the overall MSHO / MSC+ capitation rate and contributes a -0.5% change to the overall 17.4% increase in MSHO / MSC+ rates from 2023 to 2024.

  Due to the demographic mix differences among plans, the NF Add-on rate change from 2023 to 2024 will vary by plan. The overall NF Add-on increase consists of the following approximate multiplicative components shown in Table 3:

Table 3 Minnesota Department of Human Services Calendar Year 2024 MSHO and MSC+ Rate Development Nursing Facility Rate Change Drivers	
Component	**Rate Change**
Differences in Assumed Utilization[1]	-7.5%
Average Per Diem Increase	0.0%
Change in Tail Rate	-0.9%
Removal of Disenrollment Fee	+1.7%
Total	**-6.8%**

[1] Expressed as average NF days per community enrollee.

B. PROJECTED CY 2024 CAPITATION RATE COMPONENT BREAKDOWN

Table 4 summarizes the components of the CY 2024 MSHO / MSC+ capitation rate for non-CBP plans. This summary includes the EW Add-on and NF Add-on and is net of the withhold at risk of 0.25% applied only to Basic Care.

Table 4 Minnesota Department of Human Services Calendar Year 2024 MSHO and MSC+ Rate Development Projected Non CBP CY 2024 Components (as a % of Revenue) for Non CBP Plans	
Component	**Total**
Claims[1]	91.36%
Administration	4.79%
Care Coordination	1.01%
Margin[2]	1.24%
Premium Tax and HMO Surcharge	1.60%
Total[3]	**100.00%**

[1] Includes Directed Payment for a Safety Net Hospital in Hennepin County.
[2] Margin is net of the withhold at risk of 0.25%, applied only to Basic Care.
[3] Reflects EW Add-On and NF Add-On and reflects non-CBP plans.

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C. NOTES ON ACTUARIAL CERTIFICATION AND SUPPORTING DOCUMENTATION

Our role is to certify that the CY 2024 capitation rates produced by the rating methodology are actuarially sound to comply with Centers for Medicare and Medicaid Services (CMS) regulations. We developed actuarially sound capitation rates using published guidance from the American Academy of Actuaries (AAA), CMS, and federal regulations to ensure compliance with generally accepted actuarial practices and regulatory requirements. Specific Actuarial Standards of Practice (ASOPs) we considered include:

- *ASOP No. 1 – Introductory Actuarial Standard of Practice*
- *ASOP No. 5 – Incurred Health and Disability Claims*
- *ASOP No. 12 – Risk Classification*
- *ASOP No. 23 – Data Quality*
- *ASOP No. 25 – Credibility Procedures*
- *ASOP No. 41 – Actuarial Communications*
- *ASOP No. 42 – Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims*
- *ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies*
- *ASOP No. 49 – Medicaid Managed Care Capitation Rate Development and Certification*
- *ASOP No. 56 – Modeling*
- Other applicable standards of practice

The actuarial certification, CMS Rate Setting Checklist, and responses to the 2023-2024 CMS Rate Setting Guide are included as Appendices G through I.

D. COVID-19 CONSIDERATIONS IN CY 2024 RATE DEVELOPMENT

The COVID-19 pandemic and public health emergency (PHE) have impacted health care costs significantly since March 2020. The impact of the COVID-19 pandemic and PHE on CY 2024 capitation rates is difficult to predict due to the evolving nature of the pandemic. To develop our best estimates of future costs, we considered a wide array of potential impacts based on information from publicly available sources, internal Milliman research, and MCO feedback.

DHS and Milliman performed a substantial review of the FY 2022 and CY 2022 overall experience and determined no explicit adjustment was necessary to project emerging CY 2022 experience beyond existing trend assumptions.

We expect to review capitation rates with DHS during the contract period should beneficiary redetermination timing, and associated average population acuity, be materially different than what is projected in this report.

E. CAVEATS AND LIMITATIONS

This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the MSHO and MSC+ programs in CY 2024. The information contained in this report may not be suitable for other purposes or audiences. Milliman does not intend to benefit any third party and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate CY 2024 capitation rates for the MSHO and MSC+ programs. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. In preparing this analysis, we relied on data and information supplied to us by DHS and the MSHO and MSC+ health plans in the development of these rates. While we reviewed the information for reasonableness, we did not audit or attempt any independent verification of such data. If this data is incomplete or inaccurate, then our conclusions will be incomplete or inaccurate.

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

I, Michael C. Cook, FSA, MAAA, Principal and Consulting Actuary for Milliman, am a member of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinions contained herein. To the best of my knowledge and belief, this report is complete and accurate, and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration, and other factors. This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

II. DEVELOPMENT OF CY 2024 BASIC CARE RATES

A. FISCAL YEAR 2022 HEALTH PLAN BASIC CARE EXPERIENCE

Overview

The July 2021 to June 2022 (FY 2022) base period experience uses the following data sources provided by participating health plans:

- Encounter data for FY 2022 dates of service with claim runout through September 30, 2022. MCO-submitted encounter data is used to determine the composite base period service cost amounts for most services.
- Financial summaries containing claim costs associated with FY 2022 dates of service and claim runout through September 30, 2022.
- Financial data is used to determine the demographic distribution of service costs and includes some service costs not reported in the encounter data.

We utilize FY 2022 base period experience for Minnesota public programs rate development to allow for adequate time for data review and individual health plan contracting meetings ahead of expected submission to CMS for review in the fall of 2023. Based on a comparison of CY 2022 and FY 2022 service costs as reported by the health plans in the financial summaries, we did not see material differences between time periods outside of expected service cost trends applied later in rate development or the COVID-19 costs and other seasonal viruses. Therefore, we did not apply an additional base data adjustment to FY 2022 experience except for base data adjustments for AMP rebate cap removal and weight loss drugs. Please see Appendix A and Section II.C for additional discussions of trends used to project FY 2022 services costs to CY 2024 levels.

The FY 2022 base period experience used in the CY 2024 rate development was developed as follows:

- We summarized FY 2022 financial data by rate group, region, and service category, net of pharmacy rebates. This includes an adjustment for incurred but not paid (IBNP) amounts based on health-plan reported information in the financial summaries. Additionally, we moved expenses for non-benefit activities reported in the health plan service cost data to administrative costs and adjusted base data amounts to account for payments made outside the claims system for Basic Care services, and also allocated some amounts to non-Basic Care service categories by MCO based on financial data submissions.
- We applied an overall program-level adjustment to the FY 2022 financial data to reflect differences in health plan costs reported in the financial data and health plan costs reported in the encounter data. We rely heavily on supplemental health plan-provided information in Schedule XX of the financial summaries to determine the magnitude of this adjustment.
- Due to the removal of the Average Manufacturer's Price (AMP) rebate cap through the American Rescue Plan Act (ARPA), effective January 1, 2024, manufacturers can be required to pay rebates that exceed the sale price for a given drug. The current AMP rebate cap limits the amount manufacturers are required to pay state Medicaid programs when drug prices outpace inflation.

  Several manufacturers have responded by decreasing prices on insulin products, with potentially more to follow suit on insulin and non-insulin products in the coming months. We applied an adjustment to account for the known price changes to insulin products. We reviewed the total FY 2022 spend for insulin products for each of these manufacturers by program and rate cell and applied the price decrease to adjust our starting base period experience for Non-Duals. The estimated CY 2024 impact for this adjustment is expected to be a decrease of $1.3M for the Basic Care population. The overall cost adjustment is 0.9982 for Basic Care as shown in Exhibits 1A through 1D.

  We will review future significant preferred drug list (PDL) and pharmacy price changes driven by the AMP rebate cap removal throughout the remainder of 2023 and 2024 to determine whether additional rate adjustments are warranted.

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- We reviewed the PMPM costs associated with weight loss drugs (i.e., GLP-1 products) between FY 2022 and H1 2023 an explicit adjustment to reflect the emerging experience was necessary for Non-Duals for Wegovy, Ozempic, and Mounjaro. Such weight loss drugs costs were materially higher than the base period, but only modestly increased on a monthly basis during H1 2023. We therefore used modest utilization trend in projecting the $2.82 May 2023 PMPM amount to $2.98 PMPM in CY 2024.

  To incorporate the projected costs, we increased the base period experience ($0.92 PMPM) by the increase in weight loss drugs PMPM amounts between FY 2022 and the projected PMPM amounts. The estimated CY 2024 impact for this adjustment is an increase of $97K for the Seniors population The overall cost adjustment is 1.0001 for Seniors as shown in Exhibits 1A through 1D.

  We will review future significant experience changes in weight loss drugs throughout the remainder of 2023 and 2024 to determine whether additional rate adjustments are warranted.

The remainder of this section describes the financial data and financial-to-encounter adjustment in more detail.

The final FY 2022 base data is shown in the "FY 22 Experience PMPM" column of Exhibits 1A through 1C for each rate cell (Community Non-Elderly Waiver, Community Elderly Waiver, and Institutional) and summarized in Table 5. Cost differences by region, age, gender, and Medicare coverage are reflected in the rate group relativity factors described later in this section.

Table 5
Minnesota Department of Human Services
Calendar Year 2024 MSHO and MSC+ Rate Development
Seniors Basic Care Services
Fiscal Year 2022 Aggregate Health Plan Experience PMPM

	Cost Experience PMPM			
Component	**Community Non-EW**	**Community EW**	**Institutional**	**Composite**
Basic Care Services	$732.81	$1,366.10	$380.96	$925.72

Exhibit 1D contains the statewide FY 2022 PMPM health plan experience by service category in aggregate across all eight rate groups. Overall FY 2022 financial base period experience increased 2.4% from the FY 2021 experience used in CY 2023 rate development, including the impact of demographic and program changes.

Please note, the following related to the base period experience:

- The FY 2022 base period experience is net of non-state plan services.

- The data used in rate setting excludes retrospective member Medicaid eligibility, since plans are not responsible for claims costs for any retrospective eligibility periods. Therefore, no separate adjustment to rate development is needed for this issue.

- The base data is net of any claim recoveries and other third-party liability identified by the health plans. When recoveries are attributable to individual encounters, those encounters are generally adjusted and resubmitted to DHS. Otherwise, recoveries are allocated to the proper populations and categories of services in the health plan financial reporting and included in rate development to supplement the encounter data.

FY 2022 Financial Experience

The financial information reflects the health plans' best estimates of ultimate incurred claim costs for MSHO and MSC+ services provided in FY 2022. This data was provided at a rate group and service category level and includes three months of runout. It includes sub-capitated and fee-for-service (FFS) payments made by health plans, as well as IBNP amounts. IBNP amounts reported by health plans were 2.6% of overall submitted FFS claims, consistent with prior years. We relied on this data as given, and performed reasonableness tests where possible including the following:

- We reviewed comparisons included as part of the financial reporting template demonstrating internal consistency of certain reported data elements.

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- We reviewed the health plan reported IBNP estimates.
- We compared the July 2021 through December 2021 experience reported with the FY 2022 financial summaries to the same July 2021 through December 2021 experience reported in the prior CY 2021 financial summaries.
- We compared the July 2021 through December 2021 experience to the January 2022 through June 2022 experience.
- We worked collaboratively with the health plans to address data anomalies we encountered during our review.
- Plans provided CY 2022 financial data, split by half year. We reviewed the plan reconciliations of the CY 2022 financial data to the CY 2022 NAIC annual statement.

Plans identified costs for substituted in lieu of services (ILOS) separately. The expectation is any historical costs for ILOS will be applicable to similar covered services in the CY 2024 projection period. The ILOS in the base period that are not expected to continue in the CY 2024 projected period were cost effective relative to the services they replaced, but were of immaterial size, so we did not adjust rates for their anticipated termination. The overall CY 2024 ILOS cost percentage in the MSHO and MSC+ programs is projected to be less than 0.1% of total capitation payments (including directed payments); therefore, we made no further adjustment to validate cost-effectiveness beyond the plan contractual requirement. Federal regulation requires rate development to include special treatment for costs associated with stays in an Institution for Mental Diseases (IMD) for individuals between ages 21 and 64. The MSHO and MSC+ programs cover individuals ages 65 and over; therefore, no adjustment is necessary.

The FY 2022 financial experience includes reductions for pharmacy manufacturer rebates reported by the health plans.

Two of the current health plans have sub-capitated arrangements in the MSHO and MSC+ programs. In total, sub-capitated services represent about 0.4% of program service costs in the FY 2022 base period data. We reviewed the description of the sub-capitated arrangements to confirm if the arrangement is for covered services, since the arrangements are reported separately in the health plans' financial template submissions.

Encounter Data

Encounter data is submitted by the MCOs to the State through the State's MMIS system. This data is intended to be used as the base period experience used in rate setting. However, there are certain difficulties that preclude Milliman from using the encounter data directly; the most material issue being that encounter claims for members enrolled in the integrated Medicare-Medicaid MSHO program includes both Medicare and Medicaid liability. For this reason, we summarize our base data using the financial data described above and scale the aggregate financial data to amounts in the encounter data including adjustments to remove aggregate Medicare liability and other adjustments outlined below.

The FY 2022 encounter data is also used to develop certain program change adjustments as described later in this report.

We reviewed the FY 2022 encounter data and financial data using the separate Schedule XX reconciliations provided by health plans in the financial summary templates and the DHS Control Detail Report for the encounter summaries to determine the extent to which the encounter data could be used in the rate development. We initially reviewed the explanations provided in Schedule XX and interpreted each as either an adjustment to financial or encounter data. DHS reviewed Schedule XX and our interpretation of the health plans' explanations and worked together with health plans to determine the appropriateness of the adjustments.

As a result of the Schedule XX analyses, several adjustments were made to MCO-submitted encounter data. The following tables show the impact of material individual adjustments we made to the encounter data for FY 2022 (Table 6) to more accurately reflect actual MCO experience.

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Table 6 Minnesota Department of Human Services Calendar Year 2024 MSHO and MSC+ Rate Development Seniors Basic Care Services Encounter Data Adjustments FY 2022	
Adjustment to Encounter Data[1]	**% Impact**
Valid encounter claims not accepted by MMIS – Denial Code D300 (Pay-To provider ID not on DHS' provider files)	0.5%
Valid encounter claims not accepted by MMIS – Denial Code D412 (Treating provider ID not on DHS' provider files)	0.4%
Non-state plan services in encounter records	-0.3%
All Other Adjustments	0.0%
Total[2]	**0.6%**

[1] Only adjustments resulting in an absolute impact greater than +/- 0.1% are shown. Adjustments with less than or equal to +/- 0.1% impacts are grouped in 'All Other Adjustments.'
[2] Starting dollars exclude Medicare Liability for integrated products and federal reinsurance.

Additionally, we applied a 0.2% decrease to the starting encounter data to account for the difference between the Milliman and the DHS Control Detail Report for the encounter data summaries.

After accounting for all appropriate adjustments included in Schedule XX (excluding Medicare liability and including adjustments to financial data to improve the appropriateness of the comparison), the adjusted encounter data is on average less than 0.1% lower than the adjusted financial data for MSHO and MSC+, including Basic Care, EW Add-on, and NF Add-on costs. Therefore, we feel comfortable putting significant reliance on the encounter data in rate development.

We calculated a scaling factor, shown in Exhibit 1, as the ratio of FY 2022 adjusted PMPM encounter data costs to the FY 2022 PMPM financial costs included in the encounter data, consistent with those costs reconciled as part of the Schedule XX analysis, limited to exclude expenses reported outside the claims system. The final factor is dampened because we only apply the adjustment to FFS and sub-capitated financial costs, consistent with those costs reconciled as part of the Schedule XX analysis. Table 7 details the development of the adjustment factor shown in Exhibit 1.

Table 7 Minnesota Department of Human Services Calendar Year 2024 MSHO and MSC+ Rate Development Seniors Basic Care Services Financial to Encounter Scaling Factor	
[A] FY 2022 Financial Data PMPM – Unadjusted[1]	$1,367.79
[B] FY 2022 Encounter Data PMPM – Unadjusted	$1,348.35
[C] FY 2022 Encounter Data Adjustment Factor	1.0063
[D] FY 2022 Encounter Data PMPM – Adjusted ([B] x [C])	$1,356.81
[E] Financial-to-Encounter Scaling Factor – Preliminary ([D] / [A])	**0.9920**
[F] FFS / Sub-capitation Dampening Factor	0.9371
[G] Financial-to-Encounter Scaling Factor – Final ((1 – (1 – [E]) x [F])	**0.9925**

[1] Includes experience related to Basic Care, EW Add-on, and NF Add-on.

B. PROJECTING FY 2022 EXPERIENCE TO CY 2024 – PROGRAM CHANGES

This section describes the program change adjustments applied to the FY 2022 base period experience to project to the CY 2024 rate period. Exhibits 1A through 1D illustrate the adjustments applied by service category as described below, with Exhibit 1D illustrating the weighted composite impact of the projection factors across all three rate cells. For program changes which also affected the CY 2023 rate development we modified our previous analysis based on FY 2022 encounter data, plan data submissions, and / or DHS legislative fiscal notes where appropriate, to apply the adjustments for changes between FY 2022 and CY 2024. We discuss our approach in the listing below.

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Treatment of Institution for Mental Diseases (IMD) Costs

Effective July 5, 2016, Federal Medicaid regulation requires rate development to include special treatment for costs associated with stays in an IMD for individuals between ages 21 and 64. The MSHO and MSC+ programs only cover individuals 65 and over. Therefore, no adjustment is necessary.

Certified Community Behavioral Health Clinic (CCBHC)

Effective September 1, 2019, managed care plans were required to make prospective payment rates to each CCBHC. Effective January 1, 2023, six demonstration CCBHCs transitioned over to state plan authority and the managed care plans began paying the prospective payment rate using the state plan payment policy, however, the six demonstration clinics will be transitioning back to federal demonstration authority on July 1, 2023. There were no other changes in CCBHC demonstration enrollment status since FY 2022; therefore, we do not include an adjustment to the base data for CY 2024.

Community First Services and Supports (CFSS) Agency Provider

Per Laws 2021, Special Session 1, Chapter 7, Article 13, Sections 49, 51, 52, and 53 and effective January 1, 2022, the Minnesota legislature allows CFSS and Personal Care Assistance (PCA) support workers to be reimbursed for driving clients enrolled in Medical Assistance (MA) as an Instrumental Activity of Daily Living (IADL). The fiscal note provided by DHS assumes that 45% of qualifying adults will not be enrolled in other HCBS waivers and that spending will increase by 2% due to these additional services.

Based on the projected costs provided by DHS, the estimated CY 2024 state and federal budget impact for this legislative item is expected to be $1.5 million for the elderly population (based on the average of the FY 2024 and FY 2025 amounts from the fiscal note). The resulting overall PMPM increase applied to PCA costs was $1.68, $4.04, and $0.03 for Community Non-EW, Community EW, and Institutional rate cells, respectively.

Managed Care Contracts, Community First Services and Supports, Payment Rates (PCA Framework)

Per Laws 2021, Special Session 1, Chapter 7, Article 13, Sections 48, 49, and 55 and effective October 1, 2021, the Minnesota legislature establishes a PCA and CFSS rate framework, replacing the old PCA component values and CFSS values in FFS rate setting. The fiscal note provided by DHS assumes that of the total PCA / CFSS / CSG spending, 99% is attributable to base PCA rates, 0.6% to enhanced PCA rates, and 0.4% to qualified professional / worker training and development. Furthermore, the rate increase is 10.11% for each of FY 2024 and FY 2025 for the base PCA rates, 10.25% for each of FY 2024 and FY 2025 for the enhanced PCA rates, and 49.7% for each of FY 2024 and FY 2025 for qualified professional / worker training and development.

Based on the projected costs provided by DHS, the estimated CY 2024 state and federal budget impact for this legislative item is expected to be $9.1 million for the elderly population (based on the average of the FY 2024 and FY 2025 amounts from the fiscal note provided by DHS). The resulting overall PMPM increase applied to Basic Care PCA costs was $9.99, $24.04 and $0.18 for Community Non-EW, Community EW, and Institutional rate cells, respectively.

Dental Reimbursement and Critical Access Dental (CAD) Providers

Effective January 1, 2022, per Laws 2021, Special Session 1, Chapter 7, Article 1, Sections 22, 23, 28 and 29, the Minnesota legislature increased FFS dental payment rates by 98%, removed the community clinic dental Add-on, and required health plans and CBPs to reimburse dental providers at least equal to FFS rates. Furthermore, an additional 20% rate increase was applied to CAD providers.

To incorporate these payment increases into the rate process, we used the 2H 2021 encounter dental claims and repriced them to the 1H 2022 encounter data, which is reflective of the FFS dental reimbursement fee schedule and an additional 20% rate increase for all dental claims associated with a CAD provider.

Additionally, the State has established a performance benchmark for at least 55% of children and adults who were continuously enrolled for at least 11 months to receive at least one dental visit during the calendar year. Prior to the implementation of the performance benchmark, approximately 47% of members met this qualification. Therefore, we

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project an increase in the average dental utilization rate over the next three years of approximately 17%. We apply 2.5 years of this increase for CY 2024 (half of the base data already reflects increased reimbursement), resulting in an increase of roughly 14% to projected dental costs because of the expected increase in utilization.

The estimated CY 2024 state and federal budget impact for this legislative item is expected to be $3.9 million for the Basic Care population. The resulting overall PMPM increase applied to Basic Care Dental costs was $4.53, $5.22, and $3.60 for Community Non-EW, Community EW, and Institutional rate cells, respectively. The impact of these rate changes differ materially geographically. We accounted for the different impact on Metro and Non-Metro dental costs by adjusting the demographic rating factors shown in Exhibit 2. The adjustment shown in Exhibit 2 is budget neutral by rate cell.

Community First Services and Supports PCA and Enhanced PCA

Effective January 1, 2024, per Laws 2023, Chapter 61, Article 1, Sections 54, the Minnesota legislature increases rates for CFSS PCA, enhanced PCA, and qualified professional worker training and development.

The fiscal note provided by DHS assumes that of the total PCA / CFSS / CSG spending, 99% is attributable to base PCA rates, 0.6% to enhanced PCA rates, and 0.4% to qualified professional / worker training and development. Furthermore, the rate increase effective January 1, 2024 is 21.30% for the base PCA rates, 21.32% for the enhanced PCA rates, and 18.60% for qualified professional / worker training and development.

Based on the fiscal note information provided by DHS, the estimated CY 2024 state and federal budget impact for the PCA rate increases is expected to be $71.9M for the Seniors population. The resulting overall PMPM increase applied to Basic Care PCA costs was $66.00, $158.75 and $1.17 for Community Non-EW, Community EW, and Institutional rate cells, respectively.

Rate Increase for Home Care Services

Effective January 1, 2024, per Laws 2023, Chapter 61, Article 1, Section 68, the Minnesota legislature enacts a 14.99% rate increase for home health agencies and 25% rate increase for home care nursing.

The fiscal note provided by DHS estimates the FY 2024 and FY 2025 home health and home care nursing spend for managed care. Based on the fiscal note information provided by DHS, the estimated CY 2024 state and federal budget impact is expected to be $4.6M for Seniors. The resulting overall PMPM increases varying by rate group are included in the projection of CY 2024 costs for each rate group and in composite in Exhibits 1A through 1D.

Expansion of MA Adult Dental Benefits

Effective January 1, 2024, per Laws 2023, Chapter 70, Article 1, Section 11, the Minnesota legislature restores the comprehensive dental benefit for the adult population. The fiscal note provided by DHS assumes a 36.50% increase in dental costs for FY 2024 and FY 2025 due to this program change and a one-month delay in implementation.

Based on the fiscal note information provided by DHS, the estimated CY 2024 state and federal budget impact for the expansion of MA adult dental benefits is expected to be $4.6M for Seniors. The resulting overall PMPM increases varying by rate group are included in the projection of CY 2024 costs for each rate group and in composite in Exhibits 1A through 1D.

Rate increase for Outpatient Behavioral Health Services

Effective January 1, 2024, per Laws 2023, Chapter 70, Article 1, Section 35, the Minnesota legislature enacts a 3.0% rate increase for certain behavioral health services, with additional subsequent rate increases on an annual basis. The fiscal note provided by DHS assumes the rate increase will be applicable to approximately 8% of total managed care costs.

Based on the fiscal note information provided by DHS, the estimated CY 2024 state and federal budget impact for the 3% rate increase for outpatient behavioral health services is expected to be $2.0M for Seniors. The resulting overall PMPM increases varying by rate group are included in the projection of CY 2024 costs for each rate group and in composite in Exhibits 1A through 1D.

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Elimination of MA Cost-Sharing

Effective January 1, 2024, per Laws 2023, Chapter 70, Article 16, Section 12, the Minnesota legislature eliminates all cost-sharing for all covered services. The fiscal note provided by DHS assumes cost sharing accounts for 0.21% of MA payments for the elderly and disabled populations.

Based on the fiscal note information provided by DHS, the estimated CY 2024 state and federal budget impact is expected to be $1.6M for Seniors. The resulting overall PMPM increases varying by rate group are included in the projection of CY 2024 costs for each rate group and in composite in Exhibits 1A through 1D.

Program Changes with Aggregate Adjustments

Several items proposed as part of the 2019 through 2022 Minnesota Legislative session are individually expected to have either no or immaterial impact on managed care Basic Care costs. For the legislative items listed below, we reviewed the expected financial impact of all items in aggregate based on discussions with DHS, reviews of financial notes, and our understanding of the legislative items. We determined that the aggregate change for all items combined results in a 0.67% rate increase for the MSHO and MSC+ Basic Care programs. We included these combined changes as a PMPM adjustment to all service categories in Exhibits 1A through 1D, since we do not apply the adjustment at a service category level.

1. **Nonsurgical Treatment for Periodontal Disease**: Per Laws 2021, Special Session 1, Chapter 7, Article 1, Section 7 and effective January 1, 2022, the Minnesota legislature expanded MA coverage of dental services for adults to include coverage of nonsurgical treatment for periodontal disease in an office setting, including scaling and root planning once every two years for each quadrant and routine periodontal maintenance procedures.

2. **Co-Payment Limits for Brand Name Drugs**: Per Laws 2021, Special Session 1, Chapter 7, Article 1, Section 17 and effective January 1, 2022, the Minnesota legislature set the copayment at $1 per prescription for brand name multisource drugs listed on the preferred drug list.

3. **Crisis Stabilization Services Per Diem**: Per Laws 2021, Special Session 1, Chapter 7, Article 11, Section 16 and effective January 1, 2022, the Minnesota legislature requires the commissioner to establish a statewide per diem rate for residential crisis stabilization services provided to MA enrollees for settings that serve no more than four adult residents. The legislation outlines rate and payment requirements and requires providers to submit annual cost reports to inform the commissioner’s annual recalculation of the statewide per diem rate.

4. **90 Day Prescription Refills**: Per Laws 2021, Chapter 7, Article 1, Sections 8 and 11 and effective January 1, 2022, the Minnesota legislature allows a 90-day supply of a prescription drug to be dispensed under MA, if the drug appears on the 90-day supply list published by the commissioner and requires the list to be published on the DHS website.

5. **SUD Rate Enhancement (**Substance Use Disorder 1115 Demonstration Waiver): Per Laws 2021, Special Session 1, Chapter 7, Article 11, Sections 18 through 23 and effective January 1, 2022, the Minnesota legislature provides rate increases for Substance Use Disorder (SUD) providers from 15% to 25% for residential providers and from 10% to 20% for non-residential providers. To receive a rate increase, participating providers must meet demonstration project requirements and provide evidence of formal referral arrangements with providers delivering step-up or step-down levels of care.

6. **Home Health Services Inflationary Adjustments**: Per Laws 2021, Special Session 1, Chapter 7, Article 13, Section 11 and effective January 1, 2022, the Minnesota legislature provides an annual inflation adjustment to the medical assistance service rates for home health agency services, including skilled nursing, respiratory therapy, speech therapy, occupational therapy, physical therapy, and home health aide. The rates are increased 2.60% in FY 2023, 2.79% in FY 2024, and 2.96% in FY 2025.

7. **Home Care Nursing Services Inflationary Adjustments**: Per Laws 2021, Special Session 1, Chapter 7, Article 13, Section 12 and effective January 1, 2022, the Minnesota legislature provides an annual inflation adjustment to the medical assistance service rates for home care nursing services. Rates for home care nursing services will be based on the federal CMS Home Health Agency Market basket, from the forecasted

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midpoint of the prior rate year to the midpoint of the current rate year. The rates are increased 2.60% in FY 2023, 2.79% in FY 2024 and 2.96% in FY 2025, and an additional 30-day payment delay in FY 2025 has been included to accommodate the fact that Medicaid pays fee for service claims, retrospectively.

8. **Personal Care Assistant Hours Requirement**: Per Laws 2021, Special Session 1, Chapter 7, Article 13, Sections 13-14 and effective January 1, 2022, the Minnesota legislature reduces from 12 to 10 the required hours of service a person needs to qualify for an enhanced PCA service rate.

9. **Home Health 5% Rate Increase**: Per Laws 2021, Special Session 1, Chapter 7, Article 13, Section 74 and effective January 1, 2022, the Minnesota legislature provides a five percent rate increase for certain home care services, including home health services, home care nursing services, and respiratory therapy.

10. **Culturally Specific or Responsive; Disability Responsive Program; Provider Rate**: Per Laws 2021, Special Session 1, Chapter 7, Article 11, Sections 9-12 and effective January 1, 2022, the Minnesota legislature modified the definition of “culturally specific programs,” expanding it to include “culturally responsive programs” and adding a “disability responsive program” definition. Additionally, the legislature removed higher rates for certain Substance Use Disorder (SUD) treatment services and implemented a 5% rate increase for SUD treatment services provided by culturally specific programs, culturally responsive programs, or disability responsive programs.

11. **Critical Access Mental Health Minimum Fee Schedule**: Effective January 1, 2023, per Laws 2022, Chapter 99, Article 1, Section 24, health plans will be required to reimburse providers of critical access mental health services at rates at least as great as the FFS rates. The estimated CY 2024 impact for this legislative item is expected to be $0.3 million for the MSHO and MSC+ population.

12. **NEMT Rate Increase:** Effective January 1, 2024, per Laws 2023, Chapter 61, Article 3, Sections 5 and 8, the Minnesota legislature increased the base and mileage rates for NEMT services by 11.06%. Additionally, the commissioner will be required to adjust the rate paid per mile when the price of gasoline exceeds $3.00 per gallon, which will be evaluated on the first day of each quarter.

13. **Fuel Adjustor for NEMT and Ambulance Services:** Effective January 1, 2024, per Laws 2023, Chapter 61, Article 3, Section 6, the commissioner will be required to adjust the rate paid per mile for NEMT and ambulance services when the price of gasoline exceeds $3.00 per gallon, which will be evaluated on the first day of each quarter.

14. **PCA Transportation Definitions**: Per Laws 2023, Chapter 61, Article 1, Section 12 and effective January 1, 2024, the Minnesota legislature adjusted the definition of "instrumental activities of daily living" for PCA services to include driving recipients to medical appointments and to participate in the community.

15. **Inflationary Adjustment for Intensive Residential Treatment Services (IRTS), Residential Crisis Stabilization (RCS), Assertive Community Treatment (ACT), and Psychiatric Residential Treatment Facilities (PRTF):** Per Laws 2023, Chapter 70, Article 1, Sections 10, 28, 29 and effective January 1, 2024, the Minnesota legislature requires an annual inflationary adjustment to reimbursement rates for IRTS, RCS, ACT, and PRTF services. The inflationary adjustment will be applied on January 1 of each year using the CMS Medicare Economic Index (MEI) for IRTS, RCS, and ACT services, and the CMS Inpatient Psychiatric Facility Market Basket for PRTF services.

16. **MA Coverage of Seizure Detection Devices**: Per Laws 2023, Chapter 70, Article 1, Section 21 and effective January 1, 2024, the Minnesota legislature add seizure detection devices as a covered service under Medical Assistance and establishes a payment rate.

17. **MA Coverage of Tobacco**: Per Laws 2023, Chapter 70, Article 1, Section 23 and effective January 1, 2024, the Minnesota legislature allows for competitive bidding for Quitline services and establishes coverage of all USDA approved prescription and over-the-counter tobacco and nicotine cessation drugs. Prior authorization on these drugs would be prohibited.

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18. **MA Coverage of Recuperative Care Services**: Per Laws 2023, Chapter 70, Article 1, Section 25 and effective January 1, 2024, the Minnesota legislature adds recuperative care after an inpatient visit as a covered services under Medical Assistance for enrollees age 21 and over.

19. **Rate Increase for Family Planning Services**: Per Laws 2023, Chapter 70, Article 1, Section 37 and effective January 1, 2024, the Minnesota legislature increases payment rates for family planning and abortion services by 20%. This rate increase is not applicable to FQHCs, RHCs, or Individualized home supports (IHS).

20. **No-Cost Diagnostic Treatment for Services after a Mammogram**: Per Laws 2023, Chapter 70, Article 1, Section 39 and effective January 1, 2024, the Minnesota legislature eliminates cost sharing obligations for diagnostics and testing following a mammogram under Medical Assistance.

21. **Transition Costs for HSS Enrollees**: Per Laws 2023, Chapter 70, Article 11, Section 2 and effective January 1, 2024, the Minnesota legislature indefinitely extends payments for additional transitional services for individuals eligible for Housing Stabilization Services (HSS) who are also not on an HCBS waiver.

22. **Rate increase for Adult Day Treatment**: Per Laws 2023, Chapter 70, Article 9, Section 40 and effective January 1, 2024, the Minnesota legislature enacts a 50% rate increase for adult day treatment (ADT) services.

C. PROJECTING FY 2022 EXPERIENCE TO CY 2024 – MEDICAL AND PHARMACY TRENDS

This section describes the trends applied to the FY 2022 base data to project the experience to CY 2024. Table 8 contains the service category specific annualized utilization, unit cost, and PMPM cost trend assumptions used in the 2024 rate development.

- The composite FY 2022 to CY 2024 aggregate non-pharmacy PMPM annual is 1.6% in total and between 1.4% and 2.8% among the various rate cells, as applied in Exhibits 1A through 1D. Table 8 illustrates the average annual trend applied to FY 2022 experience to project CY 2024 service costs.

- The composite FY 2022 to CY 2024 aggregate pharmacy PMPM annual trend is 4.9%.

These trends reflect recent MSHO and MSC+ aggregate medical and pharmacy PMPM experience trends:

Table 8
Minnesota Department of Human Services
Calendar Year 2024 MSHO and MSC+ Rate Development
Basic Care Services Trend by Service Category
Annual Trend Assumptions from FY 2022 to CY 2024

Category of Service	Utilization	Unit Cost	PMPM
Hospital Inpatient	0.5%	1.5%	2.0%
Hospital Outpatient	3.2%	1.3%	4.6%
Hospital Outpatient Crossover	3.2%	3.0%	6.3%
Physician	1.6%	0.0%	1.6%
Physician Crossover	1.6%	-0.5%	1.1%
Part A Crossover			2.8%
PCA			1.0%
Home Health			-3.0%
Dental			1.2%
Other			2.0%
Composite (Excluding Pharmacy)			**1.6%**
Pharmacy	-1.4%	6.4%	4.9%
Composite (Including Pharmacy)			**1.7%**

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Data Sources

At a high-level, we develop best estimate trend values to project the FY 2022 base claim cost to CY 2024 and applied them at the service category level. We considered several data sources in the development of trends, such as:

- CY 2017 to CY 2019 and CY 2021 to CY 2022 aggregate Basic Care non-pharmacy experience, normalized for changes in program adjustments, provider contracting, and rate group mix (shown in Appendix A). Note, program adjustment and rate group mix normalization are generally performed in aggregate, so results at the category of service level should be viewed with caution. **Appendix A also includes experience trends for CY 2019 through CY 2021 for illustration purposes even though they are not considered in projecting FY 2022 claims for non-PCA services to CY 2024.**

- Historical pharmacy program experience through December 2022.

- Historical and anticipated changes in provider contracting levels.

- FY 2022 financial and encounter data experience.

- CY 2022 financial experience.

These trends are meant to reflect cost impacts not already specifically accounted for in the program changes mentioned in the prior section of this report.

General Methodology

Our general approach to trend development for most categories of service is to consider anticipated future changes in provider reimbursement and pharmacy unit costs, along with historical pre-pandemic utilization / service mix trends. We develop utilization / service mix trends reflecting historical utilization / service mix trends for MSHO and MSC+. We reviewed these utilization / service mix trends against experience and assumptions from other state Medicaid programs. We utilize this approach because it is frequently difficult to directly measure changes in utilization for services other than inpatient hospital and pharmacy due to differences over time or between plans in counting utilization "units."

The medical unit cost trend assumptions reflect our best estimates of anticipated changes in provider contracting levels based on conversations with DHS and information provided by the health plans. The health plans provided annual historical and projected provider contracting average unit cost changes for inpatient and outpatient services for CY 2021 through CY 2024 by program and region. The pharmacy unit cost trend assumptions reflect our best estimates of anticipated changes in pharmacy unit costs from FY 2022 to CY 2024, including the impact of the state set PDL.

Managed care plans have multiple mechanisms available to influence trend rates, including increasing care management activities and negotiating provider reimbursement including contracting structures that incent more efficient delivery of care. Each health plan may focus on different mechanisms to realize the trends seen in recent years. We expect health plans will continue to place different emphases on various cost containment exercises. Each mechanism impacts utilization and unit cost trends differently, and the resulting utilization and unit cost trend impacts for a particular health plan may not match assumptions used in this report.

Historical Non-Pharmacy Program Experience

MSHO / MSC+ overall aggregate PMPM medical (excluding pharmacy) annualized cost experience trends, after normalizing for program, provider contracting, and demographic changes, were 1.3% from CY 2017 to CY 2018, 2.4% from CY 2018 to CY 2019, and -2.9% from CY 2021 to CY 2022 for an average annual trend of 0.2%, as shown in Appendix A. Appendix A also includes experience trends for CY 2019 through CY 2021 for illustration purposes even though they are not considered in projecting FY 2022 claims for non-PCA services to CY 2024.

The historical program trends demonstrate significant volatility at the service category levels, which may be driven by changes in data reporting methodologies. Given this, the program-level trends assumed in the CY 2024 rate development were prospectively selected considering the overall PMPM cost trends but did not directly rely on historical program experience for most service categories. We will continue to monitor historical experience in future years and incorporate historical experience into future trend assumptions, as appropriate.

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Annual Non-Pharmacy Service Utilization and Mix Trends

We set the annual utilization and mix trend assumptions used for the Hospital Inpatient (0.5%), Hospital Outpatient and Outpatient Crossover (3.2%), and Physician and Physician Crossover (1.6%) trend categories consistent with internal Milliman research used to develop baseline trend assumptions for Milliman's 2024 Medicare Advantage bid development work serving a similar population and Medicare cost sharing amounts. The Milliman standard trends are developed by first beginning with CMS published trend projections for Medicare by major type of service. Milliman reviews the assumptions and environment surrounding the CMS trends and adjusts for high-level expectations, engaging with CMS experts to understand complexities and to establish the reasonableness of alternative assumptions.

Table 8 documents the annual trend applied from FY 2022 experience to CY 2024 by service category. This results in an average annual utilization trend of 1.2%.

Annual Non-Pharmacy Service Unit Cost Trends

DHS understands health plans generally modify their provider reimbursement levels similarly to changes in FFS levels, unless constrained by legislation, for services other than hospital. This does not imply that health plan reimbursement is equal to FFS reimbursement.

For that reason, we utilize non-hospital provider reimbursement trends between FY 2022 and CY 2024 equal to those expected for FFS reimbursement. For inpatient and outpatient hospital services, we incorporate expectations in contracting levels based on provider contracting information provided by the health plans. We project unit cost trends based on a variety of sources and considerations expected to impact costs from FY 2022 and CY 2024.

- **Hospital Inpatient** – DHS understands that plan hospital reimbursement levels and structure vary significantly across plans. While reimbursement is generally established considering FFS reimbursement, it has not tracked along with changes in FFS reimbursement over time. Reported actual or expected contracting levels for FY 2022 through CY 2024 were positive. As a result, we set the unit cost trend equal to 1.5% relative to FY 2022 reimbursement levels.

- **Hospital Outpatient** – We reviewed historical trends between outpatient drug and non-drug costs and observed significantly higher trends in outpatient drug costs. Therefore, we increased annual outpatient unit costs trends to account for these higher drug trends. To do this, we calculated the historical total outpatient drug claims trend from CY 2018 to CY 2022. We relied on industry benchmarks to further increase this trend by 0.7% to account for high cost and gene therapies expected to be launched. We then estimated the historical unit cost outpatient drug claims trend from CY 2018 to CY 2022 by removing the utilization trend (using the estimated historical average annual utilization trend for CY 2024 rate development). Based on this analysis, we applied annual trends of 4.6% for the outpatient drug costs, which make up 8.6% of the outpatient costs. We applied annual unit cost trends of 1.0% for the outpatient non-drug costs based on provider contracting levels for FY 2021 through CY 2024. This results in a combined annual unit cost trend for outpatient hospital services of 1.3%.

- **Physician** – We set trend for physician and other medical at 0.0% since there are no known material anticipated changes in FFS provider reimbursement other than changes explicitly adjusted due to program changes.

- **Outpatient and Physician Crossover** – We applied an annual trend of 3.0% for Outpatient Crossover and - 0.5% for Physician Crossover. These trends assumed 15% of Medicare Part B claims (hospital outpatient and physician claims) for Dual Eligible members paid by Medicaid are for the Part B deductible and the remaining 85% is for Part B coinsurance. We assumed an annual PMPM trend 0.0% to the Part B deductible based on actual change of -3.0% from 2022 to 2023 and an assumed increase of 3.0% from 2023 to 2024. For the Part B coinsurance, we used annual trends of 3.7% for Outpatient Crossover and -0.9% for Physician Crossover, consistent with internal Milliman research used to develop baseline trend assumptions for Milliman's 2024 Medicare Advantage bid development.

Annual Non-Pharmacy PMPM Cost Trends for Other Services

- **Part A Crossover** – Medicaid liability for Part A cost sharing was reported directly by health plans. The annualized trend rate for Part A cost sharing of 2.8% was based on the estimated change in the Medicare Part A deductible from CY 2022 to CY 2023.

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- **Personal Care Assistants** – Based on a review of personal care assistant trends in recent years, we assumed a 1.0% annual PMPM trend. This trend includes consideration of the continued shift of service utilization from PCA to Elderly Waiver utilization.
- **Home Health** – Home health PMPM trends have been negative over the last several years, so we assumed a -3.0% annual home health PMPM trend.
- **Dental** – Historical experience for this service category has been too volatile for the Seniors population to be used directly in determining trend. Therefore, we set the dental PMPM cost trend equal to 1.2%, similar to the trend used in the PMAP and MinnesotaCare CY 2024 capitation rate development.
- **Other** – Service cost trends for services bucketed into the "other" category have shown material variability during the years based on our trend analysis, including years of negative trend and years of positive trend. We set the trend for this service at 2.0%.

Pharmacy PMPM Trends

The pharmacy trends developed in this section are applied from FY 2022 to CY 2024, including the impact of the state single PDL.

We analyzed July 2021 through December 2022 pharmacy experience for the eligible population and developed utilization and cost summaries by traditional and specialty drug types and population. We developed cost projections through CY 2022 using those summaries, considering annual script utilization per 1,000 and average script cost changes for traditional and specialty drugs. The CY 2023 and CY 2024 trends were developed using marketplace intelligence including major pipeline drug launches, blockbuster biosimilar and generic launches, expanded indications, expanded treatable population, as well as consideration of the PDL and state drug mix. Unit cost and utilization trends inputs were developed by therapeutic class and population (adults, children, high needs, expansion, and Duals).

Based on these results, we projected an annual unit cost trend of 6.4% and annual utilization trend of -1.4% for the Non-Dual population. The utilization trends are impacted by the shift towards 90-day supply scripts and the negative utilization trends observed from FY 2022 to CY 2022. Projected utilization trends for CY 2023 and CY 2024 are positive. This annual utilization trend includes an adjustment from FY 2022 to CY 2022 based on actual 2022 experience and then relatively flat trend projections through CY 2024. Appendix B shows the assumptions by drug type. Historical Medicaid liability for the Dual population is generally low and has been too volatile to be used directly in determining trend; therefore, we set the pharmacy trends equal to the values assumed for the Non-Dual population. We estimate the impact of changes to the state PDL list will increase trends by 0.9%.

We will monitor changes to the state PDL list and future product launches with DHS during the contract period to determine if changes are materially different than what is projected in this report.

D. RATE GROUP RELATIVITIES

The Basic Care medical cost rate group relativities in Exhibits 2A, 2B, and 2C were developed separately using FY 2021 and FY 2022 medical costs from the health plan experience, as follows:

- We developed initial medical cost rate group relativities for each year by comparing the difference between age, gender, Medicare coverage, and region-specific Basic Care medical costs and total Basic Care medical costs for the given year separately for the Community Non-EW, Community EW, and Institutional rate cells. The region-specific costs were calculated for the Metro and Non-Metro regions. Metro is defined as Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties. All other counties are considered Non-Metro.
- We normalized the initial rate group relativities for each year of experience, such that they separately composite to 1.000 using the FY 2022 distribution of members by age, gender, Medicare coverage, and region, separately for the Community Non-EW, Community EW, and Institutional rate groups.

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The normalized rate group relativities were blended using 50% weight for each year.

By definition, all of the rate group relativities composite to 1.000 using the FY 2022 distribution of eligibles by rate group separately for each rate cell. As the rate group mix changes over time beyond FY 2021, the rate group relativities may not composite to 1.000. This aggregate mix change was considered when determining the appropriateness of the trend factors used to develop CY 2024 base rates and will continue to be considered when determining the appropriateness of trends in the future.

We further adjust these demographic factors to account for the varying impact of dental fee schedule changes. This is discussed in the Program Changes with Aggregate Adjustments section above.

The rate group relativities will be applied to the CY 2024 Basic Care medical cost base rates to calculate the final CY 2024 Basic Care medical cost rate for each enrollee.

E. CY 2024 BASIC CARE BASE RATE DEVELOPMENT

Exhibits 3A-1 through 3A-3 (non-CBP) and 3B-1 through 3B-3 (CBP) contain the CY 2024 Basic Care rates for each rate group. The CY 2024 Basic Care capitation revenue for each health plan will be determined by the CY 2024 Basic Care rates for each rate group, adjusted for withhold and the plan-specific membership mix by rate group. Table 9 summarizes these results:

Table 9
Minnesota Department of Human Services
Calendar Year 2024 MSHO and MSC+ Rate Development
CY 2024 PMPM Capitation Rate by Component

Component	Community Non-Elderly Waiver	Community Elderly Waiver	Institutionalized	Composite
Service Costs	$870.90	$1,642.60	$424.95	$1,103.53
Administration Cost	$79.99	$171.15	$53.50	$111.18
Care Coordination	$31.36	$14.35	$21.38	$23.43
Directed Payment for a Safety Net Hospital in Hennepin County (Non-CBP)	$11.01	$10.29	$3.88	$9.77
Premium Tax, HMO Surcharge, and Margin (Non-CBP)	$30.51	$56.47	$15.47	$38.59
Margin (CBP)	$13.74	$25.58	$6.99	$16.18
Non-County Based Purchasing Rates	**$1,023.77**	**$1,894.87**	**$519.18**	**$1,286.51**
County Based Purchasing Rates	**$996.00**	**$1,853.69**	**$506.82**	**$1,254.32**

The projected portion of rates associated with medical expenses exceeds 85% for all rate cells. In addition, the projected portion of each individual health plan's contracted rate also exceeds 85%.

The remainder of this section describes the components of the CY 2024 base rates.

Service Costs by Service Category

Exhibits 1A through 1C contain actuarial cost models showing the distribution of PMPM costs by service category for the three rate groups, including the impact of trend and program changes from FY 2022 to CY 2024. Exhibit 1D shows the composite values of Exhibits 1A through 1C.

The capitation rates are based on historical health plan experience. Any health plan efficiencies and impacts of network adequacy / access to care are inherent in this data; therefore, no adjustments for these items were applied in the development of the capitation rates.

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Administration and Basic Care Coordination Costs

In order to develop administrative and case management costs, we reviewed program experience from plan reported financial summaries for CY 2022, including care coordination costs. We included $0.90 PMPM to account for the Electronic Visit Verification (EVV) requirements for PCA and Home Health Care services, consistent with actual contracting terms and historical authorization levels.

The CY 2022 health plan non-medical MSHO / MSC+ cost experience, reported in plan financial data submissions with exclusions for unallowable expenses, EVV Add-on, the 1.0% premium tax, and the 0.6% surcharge, was allocated into fixed administration, variable administration, and care coordination components.

The 2024 revenue associated with the premium tax and HMO surcharge are explicitly added to rates at the end of the rate development process, as described later in this report.

Administration Costs Development

The total CY 2022 allowable administration costs were $101.96 PMPM. This PMPM is materially higher than historical costs, because one MCO significantly changed their cost allocation methodology between MSHO / MSC+ and other Minnesota Public Programs. The administration costs were trended to 2024 using a 4.0% annualized trend rate, which is comparable to recent Employment Cost Index calculations published by the Bureau of Labor Statistics. This considers the high levels of inflation and wage growth seen in early 2023 at 4.5% trend for CY 2022 to CY 2023 and the expectation of a return closer to the historical average in 2024 at 3.5% trend from CY 2023 to CY 2024.

The fixed administration costs were assumed to be 30% of the total, while variable administration costs were assumed to be 70%, comparable to historical plan reporting. Each rate cell receives 1) the fixed administration load along with 2) the variable administration load adjusted to reflect the rate cell medical cost relative to overall average medical cost across all rate cells. Note, for the EW rate cells, only half of the EW costs were used when calculating the variable administration allocation for the EW rate cells to reflect the assumption that variable administration costs will vary less by rate cell than the medical costs.

Care Coordination Development

The care coordination costs, which were reported separately by the health plans, were $21.66 PMPM for CY 2022. The care coordination costs were trended to 2024 using the same trend assumptions as administrative costs. MCOs submitted average care coordination costs by population to reflect the varying required levels of care coordination. This relationship was used to allocate the $21.66 PMPM to each population.

We also applied an adjustment factor to vary the care coordination costs for Dual eligibles vs. Non-Dual eligibles based on the historical differences in care coordination costs between MSHO and MSC+ enrollees as reported in plan financial data submissions. This resulted in a ratio of 0.77 and 3.80 for Dual eligibles and Non-Dual eligibles, respectively, on a PMPM basis.

Note, aggregate projected administrative costs across the Minnesota Public Programs will be evaluated at a future date if these costs exceed the limit on administrative costs under Minnesota Statutes § 256B.69, subdivision 5i.

Legislated Premium Tax and HMO Surcharge

The non-CBP MSHO and MSC+ CY 2024 Basic Care rates include an allowance for the legislated premium tax of 1% and HMO surcharge of 0.6%. The CBP CY 2023 Basic Care rates do not include the premium tax adjustment or HMO surcharge.

Margin

The target margin is set at 1.38% of revenue for both MSHO and MSC+ programs. This amount, along with the premium tax and HMO surcharge discussed above, is developed and shown at the rate group level in Exhibits 3A and 3B, for non-CBP and CBP plans, respectively. Since we do not anticipate any material portion of the 0.25% withhold at risk to be returned to plans, the net target margin is 1.13% of revenue.

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The target net margin consists of two components:

- Risk margin and general cost of capital: 1.0% net margin
- Capitation delay cost of capital: 0.13% net margin

Risk Margin and General Cost of Capital

The CY 2024 rate development includes a 1.0% net profit margin for risk margin and general cost of capital. Considerations informing this assumption include the generally consistent profitability of Minnesota Public Programs health plan operations, historical investment income realized on supporting capital, and the continued market interest in growing Medicaid blocks of business that target similar margin levels.

Capitation Delay Cost of Capital

One or two months of Minnesota Public Programs capitation payments to health plans are delayed each calendar year, depending on the program. In CY 2024, the June capitation rate payment will be delayed until July for MSHO and MSC+. In addition, a material portion of the annual plan payments is delayed until the next calendar year due to withhold arrangements. This reduces the amount of investment income earned by health plans on retained capital.

We estimate the impact of these delayed payments on health plans' investment income to be about 0.13% for MSHO and MSC+, assuming an annualized investment return of 1.5%, comparable to reported historical returns. Therefore, the CY 2024 rate development includes a net profit margin of 0.13% for the cost of capital associated with payment delays.

Withhold

Nominal withholds of 8.0% for MSHO and MSC+, 5.0% of which is based on performance, are required by Minnesota law to be removed from plan payments. However, the ultimate amount at risk to health plans is only 0.25% of capitation because the plan contracts will include a "loss limit" and payment timing provisions. The remainder of the nominal withhold is required to be returned to health plans and ultimately only impacts the cash flow between DHS and the plans.

Health plan financials in recent years indicate that plans are adequately capitalized, which includes the impact of withhold timing delays. There are no changes to the capitation payment timing patterns in 2024 that would drive changes in health plan retained capital levels. Therefore, we have no concerns that this withhold payment delay affects the fiscal stability of the organizations.

Based on our review of the withhold return metrics and the ultimate amount at risk to health plans, we believe little to none of the 0.25% will be paid back to plans. Therefore, final plan payments, assuming none of the 0.25% at-risk withhold is returned, will be subject to the actuarial certification.

APPLICABLE DIRECTED PAYMENT ARRANGEMENTS

The following directed payment arrangements apply to the Seniors program for CY 2024. Additional documentation of these arrangements is included in Appendix I.

- Directed Payment for a Safety Net Hospital in Hennepin County (see description below)
- Inclusion of Care Coordination Services in a BHH (see description below)
- CCBHC (see description below)
- Managed Long-term Supports and Services (MLTSS) Minimum Fee Schedule (see description below)
- Substance Use Disorder 1115 Demonstration Waiver (see Section II)
- Dental Services (see Section II)
- Culturally / Disability Responsive Substance Use Disorder (SUD) (see Section II)
- Critical Access Mental Health Minimum Fee Schedule (see Section II)
- Rate Increase for Outpatient Behavioral Health Services (see Section II)
- Fuel Adjustor for NEMT and Ambulance Services (see Section II)
- Rate Increase for Adult Day Treatment (see Section II)

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Directed Payment for a Safety Net Hospital in Hennepin County

In accordance with MN State Statute 256B.1973 and effective January 1, 2022, Minnesota implemented a payment arrangement that is a state-directed fee schedule in which a uniform fee schedule is to be applied to each claim submitted by eligible providers to a participating health plan. Eligible providers are non-state government teaching hospitals with high medical assistance utilization and a level 1 trauma center, as well as the hospital's affiliated billing professionals, ambulance services, and clinics. The uniform fee schedule adjustment is calculated as the estimated difference between the average commercial rate (ACR) of the top five contracted payers for services rendered by the eligible provider and the average amount paid for those services by the participating health plan.

This adjustment applies only to Non-CBP health plans; CBP health plans are excluded from this arrangement as these plans do not serve regions which this hospital system primarily services and historical utilization data for these plans is not credible. In addition, this adjustment only applies to the Non-Dual population since Medicare payments for Dual members make administration of the program prohibitively difficult.

Inpatient, Ambulance, Anesthesia, and Physician (effective January 1, 2022)

We summarized the CY 2022 supplemental payment amounts reported by each participating health plan in the financial summaries by health plan, region, rate cell, and applicable service category. We then estimated the corresponding base payment amounts based on the payment information provided by the safety net hospital system in Hennepin County.

The CY 2022 information was trended to CY 2024 as follows:

1. The CY 2022 base payments PMPM were trended for two years using the annual category of service-specific utilization and unit cost trends consistent with the CY 2024 rate development to project from CY 2022 payment amounts for this hospital system in absence of the directed payment arrangements. There are no material program changes that impact the services subject to the directed payment.

2. The total CY 2022 payments PMPM, including directed payments, were trended from CY 2022 to CY 2024 using the annual utilization trend consistent with the CY 2024 rate development and CY 2022 to 2023 commercial unit cost increases for each category of service as provided by the hospital system and applied for two years. These values ranged from 4.8% to 5.0%. We validated the reasonability of these commercial unit cost increases with trend information from the Milliman *Commercial Health Cost Guidelines*™ *(HCGs)*.

The CY 2024 supplemental PMPM payment is calculated as the difference between items 1 and 2 above. This amount is calculated separately for each combination of participating health plan, program, rate cell, and region.

Outpatient (effective January 1, 2023)

Outpatient services were added to the directed payment arrangement in CY 2023; therefore, we do not have CY 2022 supplemental payment amounts reported by the participating health plans for this service category. To calculate the CY 2024 supplemental payment amounts, we trended the estimated CY 2023 PMPM payment amounts from the CY 2023 rate development for one year using a similar approach as outlined below.

1. The CY 2023 base payments PMPM were trended for one year using the annual category of service-specific utilization and unit cost trends consistent with the CY 2024 rate development. There are no material program changes that impact the services subject to the directed payment.

2. The total CY 2023 payments, including supplemental payments, were trended one year by the annual utilization trend consistent with the CY 2024 rate development and unit cost increase provided by the hospital system of 5.1%. We validated the reasonability of the commercial unit cost increase with trend information from the Milliman *HCGs.*

The CY 2024 supplemental payment PMPM is calculated as the difference between items 1 and 2 above. This amount is calculated separately for each combination of participating health plan, program, rate cell, and region.

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Exhibit 3 contains the average directed payment PMPM Add-on across all health plans by rate cell, region, age, gender, and Medicare coverage. The plan-specific PMPM Add-ons will be provided separate from this report, and will include the final directed payment PMPM separately for each health plan.

Inclusion of Care Coordination Services in a Behavioral Health Home

Per the Patient Protection and Affordable Care Act of 2010, an optional health home benefit was created so that states could better coordinate care for Medicaid enrollees with chronic conditions. Behavioral Health Homes (BHH) is Minnesota's Medical Assistance (MA) benefit that satisfies this federal benefit and is a Medicaid covered benefit effective July 1, 2016 as part of the 2015 legislative session, Chapter 71, Article 11, section 31. The BHH model supports members with serious mental illness and covers the following components of health home services:

- Comprehensive care management
- Care coordination
- Health promotion and wellness
- Comprehensive transitional care
- Patient and family support
- Referral to community and social support services

Managed care organizations are required to reimburse BHH providers at a minimum of the FFS rate. The impact of this is considered to be fully phased into the base data, therefore, no explicit adjustment was made for this directed payment.

Certified Community Behavioral Health Clinic (CCBHC)

Effective September 1, 2019, managed care plans were required to make the prospective payment rates for each CCBHC. Previously, these payments were paid by DHS. Additionally, the MCOs are responsible for payment of CCBHC claims at each CCBHC's prospective payment system (PPS) rate or greater. The impact of this considered to be fully phased into the base data, therefore no explicit adjustment was made for this directed payment.

MLTSS Minimum Fee Schedule

MCOs are required to reimburse providers of Elderly Waiver, Home Care and other MLTSS at least equal to FFS rates. This is a longstanding arrangement, and the impacts of this directed payment are fully reflected in the rate setting base data. No additional adjustment in rate development is required.

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III. DEVELOPMENT OF CY 2024 ELDERLY WAIVER ADD-ON RATES

A. FISCAL YEAR 2022 BASE PERIOD HEALTH PLAN EW EXPERIENCE

The CY 2024 EW Add-on rates are based on aggregate FY 2022 incurred health plan experience, both for EW and case management services, including health plan-provided estimates of IBNP claims as of September 30, 2022. The rate development uses the experience provided by the health plans for EW eligibles enrolled in the MSHO and MSC+ programs for their State Plan services. Table 10 contains the statewide aggregate FY 2022 PMPM health plan experience for these two main service subgroups, including the costs for EW services provided to new EW eligibles in the first month prior to their enrollment in the Community EW rate cell. Appendix D contains the category of service detail underlying the FY 2022 EW experience:

Table 10
Minnesota Department of Human Services
Calendar Year 2024 MSHO and MSC+ Rate Development
Elderly Waiver and Case Management Services
FY 2022 Aggregate Health Plan Experience PMPM
Including EW Services Cost for New EW Eligibles

Component	PMPM
Elderly Waiver Services	$1,433.56
EW Case Management Services	$97.76
Total	**$1,531.32**

B. PROGRAM CHANGES

Home Delivered Meals

Per Minnesota Statutes, section 256B.0915, subdivision 16(l) and effective July 1, 2022, the Minnesota Legislature authorized a 6.12% rate increase for Home Delivered Meals, based on changes in the NF dietary per diem.

The estimated CY 2024 state and federal budget impact for this legislative item is expected to be $404,821. The resulting overall increase is 0.10%.

Personal Care Assistant Hours Requirement

Per Laws 2021, Special Session 1, Chapter 7, Article 13, Sections 13 to 14 and effective January 1, 2022, the Minnesota legislature reduces the required hours of service a person needs to qualify for an enhanced PCA service rate from 12 to 10. We anticipate an impact on projected EW service costs of less than 0.01%.

Customized Living Rate Floor

Per Laws 2021, Special Session 1, Chapter 7, Article 13, Sections 61 to 62 and effective July 1, 2022, the Minnesota legislature establishes a rate floor for EW customized living services provided in assisted living facilities with a census of at least 80% EW participants. The fiscal note provided by DHS assumes 1.4% of Customized Living spending is impacted by the rate floor, the average rate increase in the rate floor is 64% and is followed by an annual increase of 7.84% starting in FY 2024 and 5.21% in FY 2025 with an additional 30 day payment delay in the first year to accommodate the fact that Medicaid pays FFS claims retrospectively.

The estimated CY 2024 state and federal budget impact for this legislative item is expected to be $3,395,716 for the EW population in managed care. The resulting overall PMPM increase applied to EW costs is $10.94.

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EW 3.15% Rate Increase

Per Laws 2021, Special Session 1, Chapter 7, Article 13, Sections 63-64 and effective January 1, 2022, the Minnesota legislature applies a 3.15% rate increase to all residential and non-residential services. The fiscal note provided by DHS assumes 22% of spending is for non-residential services and 62% is for residential services, and 16% of services are not subject to the rate increase.

The estimated CY 2024 state and federal budget impact for this legislative item is expected to be $7.8 million for the EW population. The resulting overall PMPM increase applied to EW costs is $24.97.

Additional EW Rate Increases

Per Laws 2023, Chapter 61, Article 2, Sections 4-5, 13-34, 40, 43 and effective January 1, 2024, the Minnesota legislature applies average rate increases of 38.23% and increases budgets by 80.96% across Elderly Waiver Services.

The estimated CY 2024 state and federal budget impact for this legislative item is expected to be $119.1 million for the EW population. The resulting overall PMPM increase applied to EW costs is $383.89.

Community First Services and Supports (CFSS) Agency Provider Requirements

Per Laws 2021, Special Session 1, Chapter 7, Article 13, Sections 49, 51, 52, and 53 and effective January 1, 2022, the Minnesota legislature allows CFSS and PCA support workers to be reimbursed for driving clients enrolled in MA as an Instrumental Activity of Daily Living (IADL). We anticipate an impact on projected EW service costs of less than 0.01%.

Managed Care Contracts, Community First Services and Supports, Payment Rates (PCA Framework)

Per Laws 2021, Special Session 1, Chapter 7, Article 13, Sections 48, 49, and 55 and effective October 1, 2021, the Minnesota legislature establishes a PCA and CFSS rate framework, replacing the old PCA component values and CFSS values in FFS rate setting. The fiscal note provided by DHS assumes that of the total PCA / CFSS / CSG spending, 99% is attributable to base PCA rates, 0.6% to enhanced PCA rates, and 0.4% to qualified professional / worker training and development. Furthermore, the rate increase is 10.11% for each FY 2024 and FY 2025 for the base PCA rates, 10.25% for each FY 2024 and FY 2025 for the enhanced PCA rates, and 49.7% for each FY 2024 and FY 2025 for qualified professional / worker training and development.

Based on the projected costs provided by DHS, the estimated CY 2024 state and federal budget impact for this legislative item is expected to be $112,070 for the EW population (based on the average of the FY 2024 and FY 2025 amounts from the fiscal note provided by DHS). The resulting overall PMPM increase applied to EW PCA costs was $0.36.

Rate Increase for Direct Support Services Workforce

Per Laws 2021, Special Session 1, Chapter 7, Article 13, Sections 72 to 73 and effective October 1, 2021, the Minnesota legislature enacts a 1.58% rate increase to Consumer Directed Community Supports (CDCS) services, with a subsequent rate increase of 0.81% effective July 1, 2022.

Per Laws 2023, Chapter 61, Article 2, Sections 4-5, 13-34, 40, 43 and effective January 1, 2024, the Minnesota legislature increased budgets by 80.96% and enacted an additional 38.23% rate increase for CDCS services.

The estimated CY 2024 state and federal budget impact for these legislative items is expected to be $5.5 million for the EW population. The resulting overall PMPM increase applied to EW costs was $17.87.

Statewide Customized Living Non-24 Hour Services Limit

Effective January 1, 2023, the limit for Customized Living Non-24 hour services is determined on a statewide basis and will not vary by geography. We anticipate an impact on projected EW service costs of 0.05%.

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Community First Services and Supports PCA and Enhanced PCA

Effective January 1, 2024, per Laws 2023, Chapter 61, Article 1, Sections 54, the Minnesota legislature increases rates for CFSS PCA, enhanced PCA, and qualified professional worker training and development.

The fiscal note provided by DHS assumes that of the total PCA / CFSS / CSG spending, 99% is attributable to base PCA rates, 0.6% to enhanced PCA rates, and 0.4% to qualified professional / worker training and development. Furthermore, the rate increase effective January 1, 2024 is 21.30% for the base PCA rates, 21.32% for the enhanced PCA rates, and 18.60% for qualified professional / worker training and development.

Based on the projected costs provided by DHS, the estimated CY 2024 state and federal budget impact for this legislative item is expected to be $881,559 for the EW population. The resulting overall PMPM increase applied to EW PCA costs was $2.84.

C. PROJECTING FY 2022 EXPERIENCE TO CY 2024 – TREND

An annual PMPM trend of 7.0% was used to project EW plan experience from FY 2022 to the CY 2024 rating period based on consideration of emerging CY 2022 experience and a substantial review of FY 2017 through FY 2022 EW managed care experience for the EW population, as illustrated in Appendix E**.** This trend considers the continued shift of services from PCA to Elderly Waiver utilization.

Additionally, Case Management costs were trended based on recent Employment Cost Index calculations published by the Bureau of Labor Statistics. This considers the high levels of inflation and wage growth seen in early 2022 at 4.5% trend for CY 2022 to CY 2023 and the expectation of a return to the historical average in 2023 at 3.5% trend from CY 2023 to CY 2024.

D. PROJECTING FY 2022 EXPERIENCE TO CY 2024 – OTHER ADJUSTMENTS

Adjustment for Administration Requirements

The projected 2024 administration costs for the MSHO and MSC+ programs were included in full in the 2024 Basic Care rates, adjusted by rate group based on the overall average costs of that rate group, including Basic Care, EW, and NF costs. Therefore, no administration costs were added to the EW Add-on rates for 2024.

Margin

The target margin was set at 1.38% of revenue for MSHO and MSC+ EW Add-on rates, consistent with the margin for the basic care component of the rates.

Legislated Premium Tax and HMO Surcharge

The non-CBP MSHO and MSC+ CY 2024 EW Add-on rates were increased to include a provision for the legislated premium tax of 1% and HMO surcharge of 0.6%. The CBP 2024 EW Add-on rates do not include the premium tax adjustment or HMO surcharge.

E. CY 2024 EW ADD-ON BASE RATE DEVELOPMENT

DHS will issue a single monthly PMPM payment to each health plan in 2024, for which the health plan must provide the EW benefits set forth in the contract for all EW eligible recipients. The amount of the monthly payment will be equal to the product of the CY 2024 projected service costs multiplied by the EW-specific risk score plus case management. We include an explicit load for margin, legislated premium tax, and HMO surcharge. The projected service costs and case management amounts are shown in Exhibit 4. The risk adjustment algorithm is described below.

Calendar Year 2024 EW Risk Factors

The EW Add-on risk factors in Exhibit 5 were developed using FY 2021 and FY 2022 EW service costs from the health plan experience, as follows:

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- We developed initial risk factors for each year by comparing the difference between age, activities of daily living (ADL), and region-specific EW service costs and total EW service costs for the given year. The region-specific costs were calculated for the Metro and Non-Metro regions. Metro is defined as Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties. All other counties are considered Non-Metro.

- We normalized the initial risk factors for each year of experience, such that they separately composite to 1.000 using the FY 2022 distribution of eligibles by age, ADL, and region.

- The normalized risk factors for each year were blended using 50% weight for each year.

Exhibits 6A (non-CBP) and 6B (CBP) show the implied CY 2024 EW Add-on rates for each combination of risk factors.

By definition, all of the risk factors composite to 1.000 using the FY 2022 distribution of eligibles. As the region, ADL, and age mix changes over time beyond FY 2022, the risk factors may not composite to 1.000. This aggregate mix change was considered when determining the appropriateness of the trend factors used to develop CY 2024 base rates and will continue to be considered when determining the appropriateness of trends in the future.

Composite risk scores for each health plan will be set based on health plan enrollment as of August 2023. The health plan-specific capitation rates reflecting these composite risk scores are subject to this certification.

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IV. DEVELOPMENT OF CY 2024 NURSING FACILITY ADD-ON RATES

This section of the report documents the development of the Nursing Facility (NF) Add-on capitation rates. The capitation rates are paid for each non-institutionalized member to cover average projected costs for nursing facility services for which the health plans are ultimately liable. This includes the first 180 days of coverage. After this time period, the member remains in the Institutional rate cell, but nursing facility services are provided on an FFS basis.

A. NURSING FACILITY FREQUENCY AND AVERAGE LENGTH-OF-STAY ASSUMPTION

The frequency of admission and average length of stay (ALOS) assumptions were determined based on a study of historical NF utilization patterns for MSHO and MSC+ members enrolled during FY 2022. This study relied on the living arrangement identified on DHS eligibility files. MSHO / MSC+ enrollees were limited to those members not currently institutionalized (i.e., Community EW and Community Non-EW members). A nursing facility admission was recorded when the living arrangement field indicated that the member was now institutionalized. If an individual was discharged from the facility (as evidenced by a change in living arrangement), but readmitted within six months, the readmission was not counted as a new admission. An individual's length of stay (LOS) is calculated as the number of days between an admission and discharge, including days from subsequent readmissions that are not counted as a separate admit. This LOS is capped at 180 days, to reflect the benefit period covered under the NF Add-on. The assumptions used for the 2024 rate development are:

- **Frequency of NF admissions of 6.7% annually** – The frequency of admission in Appendix F is expressed as the expected admissions per eligible per month (0.558%) and reflects the most recent three-year averages of admission data derived from the study detailed above. This is a decrease from the frequency assumption used in prior certifications, consistent with the decrease in admission rates observed in this population over the period of our study. Note, the admission frequencies reflected in Table 11 are those admissions for which there was some Medicaid liability, since DHS has no financial responsibility for admissions with only Medicare-covered days.

- **Medicaid ALOS of 78 days** – The ALOS in Appendix F is calculated over a 180-day benefit period, which is the maximum nursing facility benefit for the MSHO and MSC+ programs. The benefit excludes days that would occur beyond 180 days and days outside of the contract period. All skilled nursing facility days qualifying for Medicare-only payment count toward the benefit and the 180-day length-of-stay maximum. However, the Medicare-only days are not included in the assumed Medicaid average length of stay of 78 days underlying Table 11, as DHS has no financial responsibility for Medicare-only days. This is based on the most recent three-year average of admission data derived from the study detailed above. The ALOS within the contract year depends on the pattern of enrollment by month. The projected CY 2024 ALOS of 59.7 days (from Appendix F) within the CY 2024 contract period is based on monthly enrollment projections provided by DHS through December 2024. The projected enrollment was developed using the previous year enrollment, trends in previous years, program enrollment planning (for example, mailings to go out), and any program changes or likely program migration.

The frequency of admissions and ALOS assumptions used for the 2024 rate development results in estimated 2024 nursing facility days per community enrollee of 4.7 Historical utilization experience is shown in Table 11:

Table 11
Minnesota Department of Human Services
Calendar Year 2024 MSHO and MSC+ Rate Development
Nursing Facility Services
Average NF Per Community Enrollee by Year

Year	Average NF Days per Community Enrollee
FY 2018	7.1
FY 2019	6.3
CY 2019	5.5
FY 2021	5.4
FY 2022	4.7

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An adjustment is made later in the rate setting process to account for the difference in the frequency and ALOS between rate groups.

B. NURSING FACILITY CHARGE PER DAY ASSUMPTION

The first step in developing the CY 2024 assumed average charge per day uses nursing facility MA FFS charge per day data from the Reports and Forecasts Division at DHS, including actual MA nursing facility charges from 2022 and charge projections for 2023 and beyond. Table 12 contains the fiscal year projection data used to estimate the CY 2024 FFS charge per day:

Table 12
Minnesota Department of Human Services
Calendar Year 2024 MSHO and MSC+ Rate Development
Nursing Facility Services
FFS Nursing Facility Charge Per Day Estimates
Based on Data from DHS Reports and Forecasting Division

Fiscal Year	Estimated Charge per Day
2024	$364.70
2025	$383.43

Using the FY 2024 and FY 2025 MA covered days, the weighted average of these two fiscal year estimates results in a projected FFS nursing facility MA charge per day of $374.03 for CY 2024 [$374.03 = ($364.70 x 3,820,740 + $383.43 x 3,788,959) / (3,820,740 + 3,788,959)].

We then adjusted this FFS amount to reflect the average MCO per diem relationship to FFS. Historical MCO per diems have been lower than the average FFS per diems because a larger portion of the days covered under managed care (that is, the first 180 days) have partial Medicare coverage. Because of volatility of the relationship between average MCO reported per diems and FFS over time, we averaged several years of experience to arrive at a relationship of 0.8998 and phase in 50% of this impact for CY 2024 and plan to fully reflect this impact in CY 2025. This is equivalent to a projected CY 2024 MCO per diem of $336.56 as shown in Appendix F.

There are no material program changes impacting projected CY 2024 NF costs through the 2023 legislative session.

C. NURSING FACILITY ADD-ON RATE CALCULATION

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

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

The calculation of the initial rate, as well as subsequent adjustments, is outlined in Exhibit 7A for non-CBP plans and Exhibit 7B for CBP plans.

Section A of Exhibits 7A and 7B shows the calculation of the initial rate of $112.09 PMPM for CY 2024.

Section B of Exhibits 7A and 7B contains the calculation of the tail rate. The tail rate is equal to the expected nursing facility costs for days in CY 2024 from admissions occurring in CY 2023 divided by projected community eligible months in CY 2024. The tail rate for CY 2024 is $33.47 PMPM.

Section C of Exhibit 7A contains an initial MSHO / MSC+ non-CBP base rate for CY 2024 of $145.56 PMPM. We then increased the initial base rate by 1.6% for the legislated premium tax of 1% and the HMO surcharge of 0.6% and by 1.38% for the contribution to surplus. The final MSHO / MSC+ non-CBP base rate for CY 2024 is $150.03 PMPM.

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Rates for CBP entities are excluded from the 1% premium tax and HMO surcharge. Section C of Exhibit 7B contains an initial MSHO / MSC+ CBP base rate for CY 2024 of $145.56 PMPM. The initial base rate was increased 1.38% for the contribution to surplus. The final MSHO / MSC+ CBP base rate for CY 2024 is $147.60 PMPM.

Calendar Year 2024 NF Rate Group Relativities

The NF Add-on rate group relativities in Exhibit 8 were developed separately using FY 2021 and FY 2022 medical costs from the health plan experience, as follows:

- We developed initial medical cost rate group relativities for each year by comparing the difference between age, gender, and region-specific NF costs and total NF costs for the given year. The region-specific costs were calculated for the Metro and Non-Metro regions. Metro is defined as Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington Counties. All other counties are considered Non-Metro.

- We normalized the initial rate group relativities for each year of experience, such that they separately composite to 1.000 using the FY 2022 distribution of eligibles by age, gender, and region.

- We blended the normalized rate group relativities for each year using 50% weight for each year.

By definition, all of the rate group relativities composite to 1.000 using the FY 2022 distribution of eligibles by age, gender, region, and Dual / Non-Dual. As the age, gender, Dual / Non-Dual, and region mix changes over time beyond FY 2022, the rate group relativities may not composite to 1.000. This aggregate mix change was considered when determining the appropriateness of the trend factors used to develop CY 2024 base rates and will continue to be considered when determining the appropriateness of trends in the future.

Exhibit 9A (MSHO / MSC+ non-CBP) and Exhibit 9B (MSHO / MSC+ CBP) contain the CY 2024 180-day NF Add-on rates by age, gender, and region for Dual eligible and Medicaid-only enrollees using the CY 2024 NF Add-on base rates in Exhibit 7 and the rate group relativities contained in Exhibit 8.

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EXHIBITS 1 THROUGH 3

BASIC CARE EXHIBITS

(Provided in Excel)

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Exhibit 1A
Calendar Year 2024 MSHO and MSC+ Rate Development
Development of CY 2024 Per Member Per Month Projected Costs
Community Non Elderly Waiver

Member Months: **367,705**

Service Category	Trend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	FY22 Experience PMPM	AMP Rebate Cap Base Period Adjustment	Weight Loss Drug	PMPM Trend	Elimination of MA Cost-Sharing	Community First Services and Supports PCA and Enhanced PCA	Community First Services and Supports (CFSS)	Managed Care Contracts, Community First Services and Supports, Payment Rates (PCA Framework)	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Hospital Inpatient	$13,107,617	0.992	$35.38			1.051	1.002								$37.25
Inpatient Crossover	Part A Crossover	10,098,098	0.992	27.26			1.072	1.002								29.29
Outpatient (Non-ER)	Hospital Outpatient	8,177,825	0.992	22.07			1.119	1.002							1.142	28.27
ER Outpatient	Hospital Outpatient	758,120	0.992	2.05			1.119	1.002								2.29
Outpatient Crossover	Hospital Outpatient Cr	19,392,431	0.992	52.34			1.166	1.002								61.17
Physician - Primary Care	Physician	10,581,571	0.992	28.56			1.042	1.002								29.81
Physician - Specialty Care	Physician	2,622,445	0.992	7.08			1.042	1.002								7.39
Physician Crossover	Physician Crossover	19,784,812	0.992	53.40			1.029	1.002								55.05
Dental	Dental	6,575,240	0.992	17.75			1.029	1.002				1.248		1.335		30.47
Mental F ealth/Substance Abuse Facility - Inpatient	Other	857,387	0.992	2.31			1.051	1.002								2.44
Mental F ealth/Substance Abuse Facility - Outpatient	Other	936,888	0.992	2.53			1.051	1.002								2.66
Mental F ealth/Substance Abuse Non-Facility	Other	9,989,634	0.992	26.96			1.051	1.002								28.39
Mental F ealth TCM	Other	3,169,820	0.992	8.56			1.051	1.002								9.01
Transportation	Other	8,748,968	0.992	23.61			1.051	1.002								24.87
PCA	PCA	121,961,641	0.992	329.19			1.025	1.002	1.195	1.004	1.025					415.86
Health Care Home (HCH)	Other	32,711	0.992	0.09			1.051	1.002								0.09
Home Health	Home Health	7,657,989	0.992	20.67			0.927	1.002					1.209			23.22
Hospice	Other	415,876	0.992	1.12			1.051	1.002								1.18
Hearing	Other	1,055,599	0.992	2.85			1.051	1.002								3.00
Vision	Other	1,420,990	0.992	3.84			1.051	1.002								4.04
Family Planning	Other	428	0.992	0.00			1.051	1.002								0.00
Medical Supplies/DME/Prosthetics	Other	6,460,812	0.992	17.44			1.051	1.002								18.36
Specialized Therapy	Other	530,855	0.992	1.43			1.051	1.002								1.51
Relocation Service Coordination (RSC)	Other	202,378	0.992	0.55			1.051	1.002								0.58
Other Medical	Other	1,662,593	0.992	4.49			1.051	1.002								4.73
Alternative to HCH	Other	2,525,243	0.992	6.82			1.051	1.002								7.18
Behavioral Health Home (BHH)	Other	252,227	0.992	0.68			1.051	1.002								0.72
Certified Community Behavioral Health Clinics (CCBHC)	Other	496,439	0.992	1.34			1.051	1.002								1.41
Pharmacy	Pharmacy	13,851,805	0.992	37.39	0.940	1.004	1.127	1.002								39.82
Pharmacy Rebates	Pharmacy	(57,536)	1.000	-0.16			1.127	1.002								-0.18
Non-State Plan Expenses		(1,768,070)	0.992	-4.77			1.000	1.000								-4.77
Other Program Adjustments																5.79
Total Medicaid-Covered Costs		**$271,502,837**	**0.992**	**$732.81**	**0.997**	**1.000**	**1.048**	**1.002**	**1.086**	**1.002**	**1.012**	**1.005**	**1.005**	**1.009**	**1.004**	**$870.90**

Exhibit 1B
Calendar Year 2024 MSHO and MSC+ Rate Development
Development of CY 2024 Per Member Per Month Projected Costs
Community Elderly Waiver

Member Months: **296,566**

Service Category	Trend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	FY22 Experience PMPM	AMP Rebate Cap Base Period Adjustment	Weight Loss Drug	PMPM Trend	Elimination of MA Cost-Sharing	Community First Services and Supports PCA and Enhanced PCA	Community First Services and Supports (CFSS)	Managed Care Contracts, Community First Services and Supports, Payment Rates (PCA Framework)	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Hospital Inpatient	$8,244,190	0.992	$27.59			1.051	1.002								$29.05
Inpatient Crossover	Part A Crossover	13,698,956	0.992	45.84			1.072	1.002								49.26
Outpatient (Non-ER)	Hospital Outpatient	3,415,483	0.992	11.43			1.119	1.002							1.142	14.64
ER Outpatient	Hospital Outpatient	369,171	0.992	1.24			1.119	1.002								1.39
Outpatient Crossover	Hospital Outpatient Cr	20,336,889	0.992	68.06			1.166	1.002								79.54
Physician - Primary Care	Physician	12,908,548	0.992	43.20			1.042	1.002								45.09
Physician - Specialty Care	Physician	2,090,793	0.992	7.00			1.042	1.002								7.30
Physician Crossover	Physician Crossover	23,983,752	0.992	80.26			1.029	1.002								82.74
Dental	Dental	5,089,981	0.992	17.03			1.029	1.002				1.297		1.335		30.40
Mental Health/Substance Abuse Facility - Inpatient	Other	338,672	0.992	1.13			1.051	1.002								1.19
Mental Health/Substance Abuse Facility - Outpatient	Other	576,088	0.992	1.93			1.051	1.002								2.03
Mental Health/Substance Abuse Non-Facility	Other	22,395,760	0.992	74.95			1.051	1.002								78.92
Mental Health TCM	Other	2,104,862	0.992	7.04			1.051	1.002								7.42
Transportation	Other	13,196,595	0.992	44.16			1.051	1.002								46.50
PCA	PCA	236,609,606	0.992	791.83			1.025	1.002	1.195	1.004	1.025					1,000.32
Health Care Home (HCH)	Other	64,093	0.992	0.21			1.051	1.002								0.23
Home Health	Home Health	15,880,755	0.992	53.15			0.927	1.002					1.209			59.71
Hospice	Other	349,174	0.992	1.17			1.051	1.002								1.23
Hearing	Other	1,350,460	0.992	4.52			1.051	1.002								4.76
Vision	Other	1,209,878	0.992	4.05			1.051	1.002								4.26
Family Planning	Other	113	0.992	0.00			1.051	1.002								0.00
Medical Supplies/DME/Prosthetics	Other	12,537,991	0.992	41.96			1.051	1.002								44.18
Specialized Therapy	Other	335,142	0.992	1.12			1.051	1.002								1.18
Relocation Service Coordination (RSC)	Other	322,567	0.992	1.08			1.051	1.002								1.14
Other Medical	Other	823,941	0.992	2.76			1.051	1.002								2.90
Alternative to HCH	Other	2,369,400	0.992	7.93			1.051	1.002								8.35
Behavioral Health Home (BHH)	Other	247,694	0.992	0.83			1.051	1.002								0.87
Certified Community Behavioral Health Clinics (CCBHC)	Other	497,170	0.992	1.66			1.051	1.002								1.75
Pharmacy	Pharmacy	8,512,615	0.992	28.49	0.956	1.004	1.127	1.002								30.87
Pharmacy Rebates	Pharmacy	(24,413)	1.000	-0.08			1.127	1.002								-0.09
Non-State Plan Expenses		(1,625,379)	0.992	-5.44			1.000	1.000								-5.44
Other Program Adjustments																10.90
Total Medicaid-Covered Costs		**$408,210,544**	**0.992**	**$1,366.10**	**0.999**	**1.000**	**1.038**	**1.002**	**1.112**	**1.003**	**1.015**	**1.003**	**1.006**	**1.005**	**1.001**	**$1,642.60**

Exhibit 1C
Calendar Year 2024 MSHO and MSC+ Rate Development
Development of CY 2024 Per Member Per Month Projected Costs
Institutional

Member Months: **109,535**

Service Category	Trend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	FY22 Experience PMPM	AMP Rebate Cap Base Period Adjustment	Weight Loss Drug	PMPM Trend	Elimination of MA Cost-Sharing	Community First Services and Supports PCA and Enhanced PCA	Community First Services and Supports (CFSS)	Managed Care Contracts, Community First Services and Supports, Payment Rates (PCA Framework)	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Hospital Inpatient	$1,614,873	0.992	$14.63			1.051	1.002								$15.41
Inpatient Crossover	Part A Crossover	4,564,437	0.992	41.36			1.072	1.002								44.44
Outpatient (Non-ER)	Hospital Outpatient	734,406	0.992	6.65			1.119	1.002							1.142	8.52
ER Outpatient	Hospital Outpatient	79,094	0.992	0.72			1.119	1.002								0.80
Outpatient Crossover	Hospital Outpatient Cr	7,827,950	0.992	70.93			1.166	1.002								82.89
Physician - Primary Care	Physician	720,622	0.992	6.53			1.042	1.002								6.82
Physician - Specialty Care	Physician	395,573	0.992	3.58			1.042	1.002								3.74
Physician Crossover	Physician Crossover	9,706,351	0.992	87.95			1.029	1.002								90.66
Dental	Dental	1,677,936	0.992	15.20			1.029	1.002				1.230		1.335		25.73
Mental F ealth/Substance Abuse Facility - Inpatient	Other	158,384	0.992	1.44			1.051	1.002								1.51
Mental F ealth/Substance Abuse Facility - Outpatient	Other	33,432	0.992	0.30			1.051	1.002								0.32
Mental F ealth/Substance Abuse Non-Facility	Other	229,122	0.992	2.08			1.051	1.002								2.19
Mental F ealth TCM	Other	433,909	0.992	3.93			1.051	1.002								4.14
Transportation	Other	5,546,712	0.992	50.26			1.051	1.002								52.92
PCA	PCA	645,500	0.992	5.85			1.025	1.002	1.195	1.004	1.025					7.39
Health Care Home (HCH)	Other	19,328	0.992	0.18			1.051	1.002								0.18
Home Health	Home Health	242,162	0.992	2.19			0.927	1.002					1.209			2.47
Hospice	Other	264,628	0.992	2.40			1.051	1.002								2.52
Hearing	Other	457,039	0.992	4.14			1.051	1.002								4.36
Vision	Other	275,022	0.992	2.49			1.051	1.002								2.62
Family Planning	Other	0	0.992	0.00			1.051	1.002								0.00
Medical Supplies/DME/Prosthetics	Other	2,387,648	0.992	21.63			1.051	1.002								22.78
Specialized Therapy	Other	11,983	0.992	0.11			1.051	1.002								0.11
Relocation Service Coordination (RSC)	Other	1,248,773	0.992	11.31			1.051	1.002								11.91
Other Medical	Other	436,178	0.992	3.95			1.051	1.002								4.16
Alternative to HCH	Other	718,887	0.992	6.51			1.051	1.002								6.86
Behavioral Health Home (BHH)	Other	14,333	0.992	0.13			1.051	1.002								0.14
Certified Community Behavioral Health Clinics (CCBHC)	Other	54,625	0.992	0.49			1.051	1.002								0.52
Pharmacy	Pharmacy	2,116,608	0.992	19.18	0.973	1.004	1.127	1.002								21.16
Pharmacy Rebates	Pharmacy	(3,077)	1.000	-0.03			1.127	1.002								-0.03
Non-State Plan Expenses		(567,697)	0.992	-5.14			1.000	1.000								-5.14
Other Program Adjustments																2.84
Total Medicaid-Covered Costs		**$42,044,741**	**0.992**	**$380.96**	**0.999**	**1.000**	**1.073**	**1.002**	**1.003**	**1.000**	**1.000**	**1.009**	**1.001**	**1.016**	**1.003**	**$424.95**

Exhibit 1D
Calendar Year 2024 MSHO and MSC+ Rate Development
Development of CY 2024 Per Member Per Month Projected Costs
Total

Member Months: 773,806

Service Category	Trend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	FY22 Experience PMPM	AMP Rebate Cap Base Period Adjustment	Weight Loss Drug	PMPM Trend	Elimination of MA Cost-Sharing	Community First Services and Supports PCA and Enhanced PCA	Community First Services and Supports (CFSS)	Managed Care Contracts, Community First Services and Supports, Payment Rates (PCA Framework)	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Hospital Inpatient	$22,966,681	0.992	$29.46			1.051	1.002								$31.01
Inpatient Crossover	Part A Crossover	28,361,492	0.992	36.38			1.072	1.002								39.08
Outpatient (Non-ER)	Hospital Outpatient	12,327,713	0.992	15.81			1.119	1.002							1.142	20.25
ER Outpatient	Hospital Outpatient	1,206,385	0.992	1.55			1.119	1.002								1.74
Outpatient Crossover	Hospital Outpatient C	47,557,270	0.992	61.00			1.166	1.002								71.29
Physician - Primary Care	Physician	24,210,741	0.992	31.05			1.042	1.002								32.41
Physician - Specialty Care	Physician	5,108,812	0.992	6.55			1.042	1.002								6.84
Physician Crossover	Physician Crossover	53,474,915	0.992	68.59			1.029	1.002								70.70
Dental	Dental	13,343,157	0.992	17.11			1.029	1.002				1.264		1.335		29.77
Mental Health/Substance Abuse Facility - Inpatient	Other	1,354,443	0.992	1.74			1.051	1.002								1.83
Mental Health/Substance Abuse Facility - Outpatient	Other	1,546,408	0.992	1.98			1.051	1.002								2.09
Mental Health/Substance Abuse Non-Facility	Other	32,614,515	0.992	41.83			1.051	1.002								44.05
Mental Health TCM	Other	5,708,591	0.992	7.32			1.051	1.002								7.71
Transportation	Other	27,492,275	0.992	35.26			1.051	1.002								37.13
PCA	PCA	359,216,747	0.992	460.73			1.025	1.002	1.195	1.004	1.025					582.04
Health Care Home (HCH)	Other	116,132	0.992	0.15			1.051	1.002								0.16
Home Health	Home Health	23,780,906	0.992	30.50			0.927	1.002					1.209			34.27
Hospice	Other	1,029,678	0.992	1.32			1.051	1.002								1.39
Hearing	Other	2,863,099	0.992	3.67			1.051	1.002								3.87
Vision	Other	2,905,889	0.992	3.73			1.051	1.002								3.92
Family Planning	Other	540	0.992	0.00			1.051	1.002								0.00
Medical Supplies/DME/Prosthetics	Other	21,386,451	0.992	27.43			1.051	1.002								28.88
Specialized Therapy	Other	877,979	0.992	1.13			1.051	1.002								1.19
Relocation Service Coordination (RSC)	Other	1,773,718	0.992	2.27			1.051	1.002								2.40
Other Medical	Other	2,922,711	0.992	3.75			1.051	1.002								3.95
Alternative to HCH	Other	5,613,530	0.992	7.20			1.051	1.002								7.58
Behavioral Health Home (BHH)	Other	514,253	0.992	0.66			1.051	1.002								0.69
Certified Community Behavioral Health Clinics (CCBHC)	Other	1,048,234	0.992	1.34			1.051	1.002								1.42
Pharmacy	Pharmacy	24,481,028	0.992	31.40	0.948	1.004	1.127	1.002								33.75
Pharmacy Rebates	Pharmacy	(85,026)	1.000	-0.11			1.127	1.002								-0.12
Non-State Plan Expenses		(3,961,146)	0.992	-5.08			1.000	1.000								-5.08
Other Program Adjustments																7.33
Total Medicaid-Covered Costs		**$721,758,121**	**0.992**	**$925.72**	**0.998**	**1.000**	**1.044**	**1.002**	**1.096**	**1.002**	**1.013**	**1.004**	**1.005**	**1.007**	**1.002**	**$1,103.53**

xhibit 2A

Ca ar Year 2024 and MSC+ nt

Basi oup Relativiti i graphic Group

Area	Gender	Age				Normalized FY 2022 Cost Relativities	Metro / Non-Metro Dental Adjustment	Final CY 2024 Rate Cell Relativities
Metro	Female	65 - 74	$709.34	$701.14	0.9769	0.9404	1.0000	0.9587
Metro	Female	75 - 84	900.53	828.35	1.2402	1.1111	1.0000	1.1757
Metro	Female	85 +	1,845.62	1,642.79	2.5417	2.2035	1.0000	2.3727
Metro	Female	Non-MC[2]	2,399.01	2,255.34	2.4982	3.0251	1.0000	2.7617
Metro	Male	65 - 74	637.35	601.73	0.8777	0.8071	1.0000	0.8424
Metro	Male	75 - 84	785.98	738.94	1.0824	0.9911	1.0000	1.0368
Metro	Male	85 +	1,452.56	1,252.93	2.0004	1.6806	1.0000	1.8405
Metro	Male	Non-MC[2]	2,399.01	2,255.34	2.4982	3.0251	1.0000	2.7617
Non - Metro	Female	65 - 74	435.88	419.81	0.6003	0.5631	0.9999	0.5816
Non - Metro	Female	75 - 84	452.34	441.44	0.6229	0.5921	0.9999	0.6075
Non - Metro	Female	85 +	584.39	569.02	0.8048	0.7632	0.9999	0.7840
Non - Metro	Female	Non-MC[2]	2,399.01	2,255.34	2.4982	3.0251	0.9999	2.7614
Non - Metro	Male	65 - 74	415.43	375.40	0.5721	0.5035	0.9999	0.5378
Non - Metro	Male	75 - 84	430.88	477.27	0.5934	0.6402	0.9999	0.6167
Non - Metro	Male	85 +	592.21	526.40	0.8156	0.7061	0.9999	0.7608
Non - Metro	Male	Non-MC[2]	2,399.01	2,255.34	2.4982	3.0251	0.9999	2.7614
Total			**$774.85**	**$745.54**	**1.0000**	**1.0000**		**1.0000**

[1] Prior to the financial to encounter adjustment and removal of non-state plan services.

[2] Non-MC PMPM represents the composite Community Non-EW PMPM for all non-dual eligible members.

xhibit 2B

Ca ar Year 2024 and MSC+ nt

Basi oup Relativiti i graphic Group

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Area	Gender	Age				Normalized FY 2022 Cost Relativities	Metro / Non-Metro Dental Adjustment	Final CY 2024 Rate Cell Relativities
Metro	Female	65 - 74		$1,569.91				
Metro	Female	75 - 84	1,510.47	1,639.05	1.1848	1.1804	1.0000	1.1826
Metro	Female	85 +	1,499.49	1,613.27	1.1762	1.1618	1.0000	1.1690
Metro	Female	Non-MC[2]	3,599.15	3,992.73	2.4811	2.8754	1.0000	2.6783
Metro	Male	65 - 74	1,417.20	1,514.20	1.1116	1.0905	1.0000	1.1011
Metro	Male	75 - 84	1,597.92	1,679.21	1.2534	1.2093	1.0000	1.2314
Metro	Male	85 +	1,871.88	1,998.47	1.4683	1.4392	1.0000	1.4538
Metro	Male	Non-MC[2]	3,599.15	3,992.73	2.4811	2.8754	1.0000	2.6783
Non - Metro	Female	65 - 74	852.07	882.47	0.6683	0.6355	0.9999	0.6519
Non - Metro	Female	75 - 84	671.16	713.97	0.5264	0.5142	0.9999	0.5203
Non - Metro	Female	85 +	445.82	470.36	0.3497	0.3387	0.9999	0.3442
Non - Metro	Female	Non-MC[2]	3,599.15	3,992.73	2.4811	2.8754	0.9999	2.6780
Non - Metro	Male	65 - 74	775.69	777.86	0.6084	0.5602	0.9999	0.5842
Non - Metro	Male	75 - 84	711.33	694.62	0.5580	0.5002	0.9999	0.5290
Non - Metro	Male	85 +	553.59	582.55	0.4342	0.4195	0.9999	0.4268
Non - Metro	Male	Non-MC[2]	3,599.15	3,992.73	2.4811	2.8754	0.9999	2.6780
Total			**$1,271.86**					**1.0000**

[1] Prior to the financial to encounter adjustment and removal of non-state plan services.

[2] Non-MC PMPM represents the composite Community Non-EW PMPM for all non-dual eligible members.

Exhibit 2A
Calendar Year 2024 MSHO and MSC+ Rate Development
Basic Care Rate Group Relativities for Geographic Area and Demographic Group
Community Non-Elderly Waiver Rate Cell

Area	Gender	Age Group			Normalized FY 2021 Cost Relativities	Normalized FY 2022 Cost Relativities	Metro / Non-Metro Dental Adjustment	Final CY 2024 Rate Cell Relativities
Metro	Female	65 - 74	$560.89	$562.61	1.5228	1.4494	1.0003	1.4865
Metro	Female	75 - 84	357.99	373.76	0.9719	0.9629	1.0003	0.9677
Metro	Female	85 +	212.97	220.29	0.5782	0.5675	1.0003	0.5730
Metro	Female	Non-MC[2]	2,943.21	2,905.25	7.0009	7.4843	1.0003	7.2449
Metro	Male	65 - 74	488.61	530.16	1.3265	1.3658	1.0003	1.3466
Metro	Male	75 - 84	391.07	385.01	1.0617	0.9918	1.0003	1.0271
Metro	Male	85 +	288.40	352.26	0.7830	0.9075	1.0003	0.8455
Metro	Male	Non-MC[2]	2,943.21	2,905.25	7.0009	7.4843	1.0003	7.2449
Non - Metro	Female	65 - 74	559.86	605.90	1.5200	1.5609	0.9997	1.5400
Non - Metro	Female	75 - 84	322.26	351.14	0.8749	0.9046	0.9997	0.8895
Non - Metro	Female	85 +	208.07	213.70	0.5649	0.5505	0.9997	0.5576
Non - Metro	Female	Non-MC[2]	2,943.21	2,905.25	7.0009	7.4843	0.9997	7.2408
Non - Metro	Male	65 - 74	505.02	556.51	1.3711	1.4336	0.9997	1.4020
Non - Metro	Male	75 - 84	393.98	387.93	1.0696	0.9994	0.9997	1.0342
Non - Metro	Male	85 +	265.23	260.76	0.7201	0.6718	0.9997	0.6957
Non - Metro	Male	Non-MC[2]	2,943.21	2,905.25	7.0009	7.4843	0.9997	7.2408
Total			**$363.03**	**$388.18**	**1.0000**	**1.0000**		**1.0000**

[1] Prior to the financial to encounter adjustment and removal of non-state plan services.
[2] Non-MC PMPM represents the composite Community Non-EW PMPM for all non-dual eligible members.

Exhibit 3A 1
Calendar Year 2024 MSHO and MSC+ Rate Development
Community Non Elderly Waiver Rate Cell
Non County Based Purchasing Rates

FY 2022 Membership

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	57,447	11,511	2,606	12,211	72,535	19,398	5,282	17,073
Non - Metro	43,441	8,168	1,864	3,517	54,673	15,063	4,646	3,866

Base Rates

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$733.69	$902.96	$1,602.93	$2,405.18	$834.93	$1,023.88	$2,066.37	$2,405.18
Non - Metro	468.35	537.11	662.54	2,404.92	506.55	529.05	682.75	2,404.92

Administrative Cost & Care Coordination

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$94.22	$104.10	$139.10	$260.14	$98.68	$109.92	$164.58	$259.96
Non - Metro	82.40	94.81	109.95	260.52	84.79	93.14	114.16	260.60

Premium Tax, HMO Surcharge, and Margin

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$25.43	$30.93	$53.51	$81.87	$28.68	$34.83	$68.52	$81.86
Non - Metro	16.92	19.41	23.73	81.87	18.16	19.11	24.48	81.87

Directed Payment for a Safety Net Hospital in Hennepin County

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$0.00	$0.00	$0.00	$171.12	$0.00	$0.00	$0.00	$92.48
Non - Metro	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.40

Premium Tax and HMO Surcharge for Directed Payment for a Safety Net Hospital in Hennepin County

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$0.00	$0.00	$0.00	$2.82	$0.00	$0.00	$0.00	$1.53
Non - Metro	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01

Margin for Directed Payment for a Safety Net Hospital in Hennepin County

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$0.00	$0.00	$0.00	$2.43	$0.00	$0.00	$0.00	$1.32
Non - Metro	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01

Total Rates - Prior to Withhold

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$853.34	$1,038.00	$1,795.54	$2,923.56	$962.28	$1,168.63	$2,299.47	$2,842.33
Non - Metro	567.67	651.33	796.21	2,747.31	609.50	641.30	821.39	2,747.80

Withhold

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$68.27	$83.04	$143.64	$233.88	$76.98	$93.49	$183.96	$227.39
Non - Metro	45.41	52.11	63.70	219.78	48.76	51.30	65.71	219.82

Total Rates - After Withhold

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$785.07	$954.96	$1,651.90	$2,689.68	$885.30	$1,075.14	$2,115.51	$2,614.94
Non - Metro	522.25	599.23	732.52	2,527.52	560.74	590.00	755.68	2,527.98

Withhold at Risk

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$2.13	$2.60	$4.49	$7.31	$2.41	$2.92	$5.75	$7.11
Non - Metro	1.42	1.63	1.99	6.87	1.52	1.60	2.05	6.87

Total Rates - After Withhold at Risk

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$851.21	$1,035.41	$1,791.05	$2,916.25	$959.88	$1,165.71	$2,293.72	$2,835.22
Non - Metro	566.25	649.71	794.22	2,740.44	607.98	639.70	819.33	2,740.93

Exhibit 3A 2
Calendar Year 2024 MSHO and MSC+ Rate Development
Community Elderly Waiver Rate Cell
Non County Based Purchasing Rates

FY 2022 Membership

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	19,827	20,260	10,372	5,359	37,947	46,467	27,978	8,969
Non - Metro	11,917	9,516	5,513	534	21,349	23,583	21,996	1,166

Base Rates

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	$1,808.61	$2,022.63	$2,387.96	$4,399.40	$1,882.65	$1,942.54	$1,920.22	$4,399.40
Non - Metro	959.68	869.00	701.11	4,398.87	1,070.75	854.57	565.34	4,398.87

Administrative Cost & Care Coordination

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	$185.74	$197.74	$216.87	$353.65	$188.90	$194.03	$198.20	$353.47
Non - Metro	146.25	151.10	152.33	354.02	152.09	149.12	149.14	354.10

Premium Tax, HMO Surcharge, and Margin

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	$61.26	$68.20	$80.01	$145.99	$63.63	$65.63	$65.07	$145.99
Non - Metro	33.97	31.33	26.21	145.99	37.56	30.83	21.95	145.99

Directed Payment for a Safety Net Hospital in Hennepin County

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	$0.00	$0.00	$0.00	$338.18	$0.00	$0.00	$0.00	$110.98
Non - Metro	0.00	0.00	0.00	0.16	0.00	0.00	0.00	0.00

Premium Tax and HMO Surcharge for Directed Payment for a Safety Net Hospital in Hennepin County

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	$0.00	$0.00	$0.00	$5.58	$0.00	$0.00	$0.00	$1.83
Non - Metro	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Margin for Directed Payment for a Safety Net Hospital in Hennepin County

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	$0.00	$0.00	$0.00	$4.81	$0.00	$0.00	$0.00	$1.58
Non - Metro	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Total Rates - Prior to Withhold

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	$2,055.60	$2,288.57	$2,684.84	$5,247.61	$2,135.18	$2,202.19	$2,183.49	$5,013.25
Non - Metro	1,139.90	1,051.43	879.65	4,899.04	1,260.40	1,034.52	736.43	4,898.96

Withhold

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	$164.45	$183.09	$214.79	$419.81	$170.81	$176.18	$174.68	$401.06
Non - Metro	91.19	84.11	70.37	391.92	100.83	82.76	58.91	391.92

Total Rates - After Withhold

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	$1,891.16	$2,105.48	$2,470.05	$4,827.80	$1,964.36	$2,026.02	$2,008.81	$4,612.19
Non - Metro	1,048.71	967.32	809.28	4,507.11	1,159.57	951.76	677.52	4,507.04

Withhold at Risk

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	$5.14	$5.72	$6.71	$13.12	$5.34	$5.51	$5.46	$12.53
Non - Metro	2.85	2.63	2.20	12.25	3.15	2.59	1.84	12.25

Total Rates - After Withhold at Risk

	Males				Females			
Area	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**	**65 - 74**	**75 - 84**	**85 +**	**Non-MC**
Metro	$2,050.47	$2,282.85	$2,678.13	$5,234.49	$2,129.84	$2,196.69	$2,178.04	$5,000.72
Non - Metro	1,137.05	1,048.80	877.45	4,886.79	1,257.25	1,031.94	734.59	4,886.71

Exhibit 3A 3
Calendar Year 2024 MSHO and MSC+ Rate Development
Institutional Rate Cell
Non County Based Purchasing Rates

FY 2022 Membership

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	7,050	4,805	2,844	436	7,145	8,894	11,317	473
Non - Metro	4,575	5,894	4,694	84	5,739	9,776	20,348	181

Base Rates

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$572.21	$436.46	$359.28	$3,078.68	$631.69	$411.21	$243.51	$3,078.68
Non - Metro	595.77	439.49	295.65	3,076.93	654.43	378.00	236.94	3,076.93

Administrative Cost & Care Coordination

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$80.91	$74.48	$70.82	$280.31	$83.73	$73.28	$65.33	$280.31
Non - Metro	82.03	74.62	67.80	280.23	84.81	71.71	65.02	280.23

Premium Tax, HMO Surcharge, and Margin

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$20.06	$15.69	$13.21	$103.17	$21.97	$14.88	$9.49	$103.17
Non - Metro	20.82	15.79	11.16	103.12	22.71	13.81	9.27	103.12

Directed Payment for a Safety Net Hospital in Hennepin County

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$0.00	$0.00	$0.00	$401.60	$0.00	$0.00	$0.00	$401.60
Non - Metro	0.00	0.00	0.00	3.01	0.00	0.00	0.00	3.01

Premium Tax and HMO Surcharge for Directed Payment for a Safety Net Hospital in Hennepin County

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$0.00	$0.00	$0.00	$6.62	$0.00	$0.00	$0.00	$6.62
Non - Metro	0.00	0.00	0.00	0.05	0.00	0.00	0.00	0.05

Margin for Directed Payment for a Safety Net Hospital in Hennepin County

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$0.00	$0.00	$0.00	$5.71	$0.00	$0.00	$0.00	$5.71
Non - Metro	0.00	0.00	0.00	0.04	0.00	0.00	0.00	0.04

Total Rates - Prior to Withhold

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$673.19	$526.63	$443.32	$3,876.10	$737.40	$499.37	$318.32	$3,876.10
Non - Metro	698.62	529.90	374.61	3,463.39	761.95	463.52	311.23	3,463.39

Withhold

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$53.86	$42.13	$35.47	$310.09	$58.99	$39.95	$25.47	$310.09
Non - Metro	55.89	42.39	29.97	277.07	60.96	37.08	24.90	277.07

Total Rates - After Withhold

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$619.34	$484.50	$407.85	$3,566.01	$678.41	$459.42	$292.86	$3,566.01
Non - Metro	642.73	487.51	344.65	3,186.32	700.99	426.44	286.33	3,186.32

Withhold at Risk

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$1.68	$1.32	$1.11	$9.69	$1.84	$1.25	$0.80	$9.69
Non - Metro	1.75	1.32	0.94	8.66	1.90	1.16	0.78	8.66

Total Rates - After Withhold at Risk

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$671.51	$525.31	$442.21	$3,866.41	$735.56	$498.13	$317.53	$3,866.41
Non - Metro	696.88	528.58	373.68	3,454.73	760.05	462.36	310.45	3,454.73

EXHIBITS 4 THROUGH 6

EW ADD-ON EXHIBITS

(Provided in Excel)

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration, and other factors. This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

Exhibit 4
Calendar Year 2024 MSHO and MSC+ Rate Development
Elderly Waiver and Case Management Services
Calendar Year 2024 Base Rates

Component / Adjustment	FY 2022 Elderly Waiver Services	CY 2022 Case Management
Aggregate EW Health Plan Experience PMPM	**$1,433.56**	**$97.76**
Trend Adjustments		
Trend FY 2022 to CY 2022	1.0344	1.0000
Trend CY 2022 to CY 2023	1.0700	1.0450
Trend CY 2023 to CY 2024	1.0700	1.0350
Program Adjustments		
Home Delivered Meals Rate Increase	1.0010	1.0000
Personal Care Assistant Hour Requirement	1.0000	1.0000
Customized Living Rate Floor	1.0064	1.0000
EW 3.15% Rate Increase	1.0147	1.0000
CFSS Agency Provider Requirements	1.0001	1.0000
PCA Framework	1.0002	1.0000
CDCS Rate Increase	1.0105	1.0000
Statewide Customized Living Limits	1.0005	1.0000
Community First Services and Supports PCA and Enhanced PCA	1.0017	1.0000
Additional EW Rate Increases	1.2261	1.0000
Other Non Program Adjustments		
HMO Surcharge / Legislated Premium Tax (not applied to CBP rates)	1.60%	1.60%
Provision for Contribution to Surplus	1.38%	1.38%
CY 2024 Base Rates for non-CBP	**$2,221.77**	**$108.98**
CY 2024 Base Rates for CBP	**$2,185.72**	**$107.21**

Exhibit 5
Calendar Year 2024 MSHO and MSC+ Rate Development
Elderly Waiver Services
Risk Factors

Age Group	Metro Indicator	ADL Group	Normalized Risk Factors from FY 2021 Experience	Normalized Risk Factors from FY 2022 Experience	Final/Blended CY 2024 Risk Factors
65 – 74	Metro	0 to 3 ADLs	0.652	0.692	0.672
75 – 84	Metro	0 to 3 ADLs	0.786	0.846	0.816
85 +	Metro	0 to 3 ADLs	0.871	0.936	0.903
65 – 74	Metro	4 to 6 ADLs	0.885	0.936	0.910
75 – 84	Metro	4 to 6 ADLs	1.105	1.185	1.145
85 +	Metro	4 to 6 ADLs	1.390	1.422	1.406
65 – 74	Metro	7 to 8 ADLs	0.797	0.831	0.814
75 – 84	Metro	7 to 8 ADLs	0.975	0.978	0.977
85 +	Metro	7 to 8 ADLs	1.264	1.247	1.256
65 – 74	Non-Metro	0 to 3 ADLs	0.556	0.529	0.542
75 – 84	Non-Metro	0 to 3 ADLs	0.624	0.619	0.622
85 +	Non-Metro	0 to 3 ADLs	0.800	0.778	0.789
65 – 74	Non-Metro	4 to 6 ADLs	1.434	1.398	1.416
75 – 84	Non-Metro	4 to 6 ADLs	1.749	1.662	1.706
85 +	Non-Metro	4 to 6 ADLs	2.004	1.888	1.946
65 – 74	Non-Metro	7 to 8 ADLs	1.836	1.745	1.790
75 – 84	Non-Metro	7 to 8 ADLs	2.440	2.152	2.296
85 +	Non-Metro	7 to 8 ADLs	2.822	2.561	2.691

Exhibit 6A
Calendar Year 2024 MSHO and MSC+ Rate Development
Elderly Waiver Add on Rates
Non County Based Purchasing

	0 to 3 ADLs			4 to 6 ADLs			7 to 8 ADLs		
Area	**65 - 74**	**75 - 84**	**85 +**	**65 - 74**	**75 - 84**	**85 +**	**65 - 74**	**75 - 84**	**85 +**
Metro	$1,602.53	$1,922.27	$2,115.85	$2,131.47	$2,653.10	$3,233.27	$1,917.44	$2,278.98	$2,898.66
Non-Metro	1,314.06	1,489.82	1,861.80	3,254.75	3,898.21	4,432.24	4,086.24	5,210.53	6,088.53

Exhibit 6B
Calendar Year 2024 MSHO and MSC+ Rate Development
Elderly Waiver Add on Rates
County Based Purchasing

	0 to 3 ADLs			4 to 6 ADLs			7 to 8 ADLs		
Area	**65 - 74**	**75 - 84**	**85 +**	**65 - 74**	**75 - 84**	**85 +**	**65 - 74**	**75 - 84**	**85 +**
Non-Metro	$1,292.75	$1,465.64	$1,831.60	$3,201.95	$3,834.97	$4,360.33	$4,019.94	$5,126.00	$5,989.75

EXHIBITS 7 THROUGH 9

NF ADD-ON EXHIBITS

(Provided in Excel)

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration, and other factors. This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

Exhibit 7A
Calendar Year 2024 MSHO and MSC+ Rate Development
Minnesota Senior Health Options and Minnesota Senior Care Plus Programs
180 Day Nursing Facility Add On Rate Calculation
CY 2024 Non County Based Capitation Payment Rates

Rate Component	CY 2023	CY 2024
Section A		
Monthly Claim Frequency [App. E (3)]	0.625%	0.558%
(x) Medicaid Length of Stay 1 [App. E (7) to (8)]	59.0	59.7
(x) Charge per Day 1 [App. E (2)]	$336.70	$336.56
= Initial Rate (A) = [App. E (3)] x [App. E (7) to (8)] x [App. E (2)]	$124.06	$112.09
Section B		
NF Dollars for Prior Year Admits (B)	$27,081,599	$30,083,885
(/) Eligible Months [App. E (4)]	792,552	898,843
= Tail Rate (C) = (B) / [App. E (4)]	$34.17	$33.47
Section C		
Initial Base Rate (D) = (A)+(C)	$158.23	$145.56
Disenrollment Fee Adjustment (E)	0.983	1.000
Projected Costs (F) = (D) * (E)	$155.54	$145.56
Legislated Premium Tax Adjustment (G)	$2.57	$2.40
Margin (H)	$2.21	$2.07
Final Base Rate (I) = (F) + (G) + (H)	$160.32	$150.03

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

Exhibit 7B
Calendar Year 2024 MSHO and MSC+ Rate Development
Minnesota Senior Health Options and Minnesota Senior Care Plus Programs
180 Day Nursing Facility Add On Rate Calculation
CY 2024 County Based Capitation Payment Rates

Rate Component	CY 2023	CY 2024
Section A		
Monthly Claim Frequency [App. E (3)]	0.625%	0.558%
(x) Medicaid Length of Stay 1 [App. E (7) to (8)]	59.0	59.7
(x) Charge per Day 1 [App. E (2)]	$336.70	$336.56
= Initial Rate (A) = [App. E (3)] x [App. E (7) to (8)] x [App. E (2)]	$124.06	$112.09
Section B		
NF Dollars for Prior Year Admits (B)	$27,081,599	$30,083,885
(/) Eligible Months [App. E (4)]	792,552	898,843
= Tail Rate (C) = (B) / [App. E (4)]	$34.17	$33.47
Section C		
Initial Base Rate (D) = (A)+(C)	$158.23	$145.56
Disenrollment Fee Adjustment (E)	0.983	1.000
Projected Costs (F) = (D) * (E)	$155.54	$145.56
Margin (G)	$2.18	$2.04
Final Base Rate (H) = (F) + (G)	$157.72	$147.60

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

Exhibit 8
CY 2024 MSHO and MSC+ Rate Development
NF Add on Rate Group Relativities for Geographic Area and Demographic Group

Area	Gender	Age Group	Medicare Status	Normalized FY 2021 Cost Relativities	Normalized FY 2022 Cost Relativities	Final CY 2024 Rate Relativities
Metro	Male	65 – 74	Dual	0.610	0.473	0.541
Metro	Male	75 – 84	Dual	0.764	0.856	0.810
Metro	Male	85 +	Dual	0.931	1.216	1.073
Metro	Female	65 – 74	Dual	0.429	0.553	0.491
Metro	Female	75 – 84	Dual	0.813	0.833	0.823
Metro	Female	85 +	Dual	1.667	1.495	1.581
Non-Metro	Male	65 – 74	Dual	0.743	0.559	0.651
Non-Metro	Male	75 – 84	Dual	1.856	2.098	1.977
Non-Metro	Male	85 +	Dual	3.440	3.178	3.309
Non-Metro	Female	65 – 74	Dual	0.746	0.724	0.735
Non-Metro	Female	75 – 84	Dual	1.748	1.832	1.790
Non-Metro	Female	85 +	Dual	3.723	3.838	3.780
Metro	Male	All	Non-Dual	0.416	0.246	0.331
Non-Metro	Male	All	Non-Dual	0.280	0.496	0.388
Metro	Female	All	Non-Dual	0.275	0.335	0.305
Non-Metro	Female	All	Non-Dual	0.478	0.321	0.399

Exhibit 9A
Calendar Year 2024 MSHO and MSC+ Rate Development
Nursing Facility Add On Rates (PMPM)
180 Day Benefit Period
Non County Based Purchasing Rates

	Males				Females			
Area	**65-74**	**75-84**	**85+**	**Non-MC**	**65-74**	**75-84**	**85+**	**Non-MC**
Metro	$81.21	$121.55	$161.00	$49.64	$73.70	$123.45	$237.20	$45.76
Non Metro	97.67	296.60	496.38	58.20	110.24	268.56	567.14	59.92

Exhibit 9B
Calendar Year 2024 MSHO and MSC+ Rate Development
Nursing Facility Add On Rates (PMPM)
180 Day Benefit Period
County Based Purchasing Rates

	Males				Females			
Area	**65-74**	**75-84**	**85+**	**Non-MC**	**65-74**	**75-84**	**85+**	**Non-MC**
Non Metro	$96.08	$291.79	$488.33	$57.25	$108.45	$264.21	$557.94	$58.95

APPENDIX A

Basic Care Trend Study

(Provided in Excel)

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Append x A
Ca endar Year 2024 MSHO and MSC+ Rate Deve opment
Sen ors Bas c Care Serv ces
Per Annum H stor ca Trends CY 2017 to CY 2022
Broad Serv ce Categor es*

Category of Service	CY 2017 Reported PMPM	CY 2017 Provider Contracting Adjustment	CY 2017 Impact of Program Adjustments	CY 2017 Impact of Demographics	CY 2017 Adjusted PMPM	CY 2018 Reported PMPM*	CY 2018 Provider Contracting Adjustment	CY 2018 Impact of Program Adjustments	CY 2018 Impact of Demographics	CY 2018 Adjusted PMPM
Hospital Inpatient	$22.05	0.997	1.000	1.008	$22.15	$19.11	1.024	1.000	1.016	$19.88
Part A Crossover	$33.23	0.997	1.000	1.008	$33.38	$34.36	1.024	1.000	1.016	$35.75
Hospital Outpatient	$12.89	0.997	1.000	1.008	$12.95	$12.19	0.997	1.000	1.016	$12.34
Outpatient Crossover	$50.76	0.997	1.000	1.008	$51.01	$53.70	0.997	1.000	1.016	$54.36
Physician	$36.77	1.000	1.000	1.008	$37.06	$33.27	1.000	1.000	1.016	$33.79
Physician Crossover	$70.11	1.000	1.000	1.008	$70.66	$68.14	1.000	1.000	1.016	$69.20
Dental	$12.88	1.000	1.000	1.008	$12.98	$14.19	1.000	0.989	1.016	$14.26
Home Health	$45.96	1.000	1.000	1.008	$46.32	$44.44	1.000	1.000	1.016	$45.14
Personal Care Assistants	$385.22	1.000	1.002	1.008	$389.10	$411.34	1.000	1.012	1.016	$422.99
Other	$113.55	1.000	1.000	1.008	$114.44	$109.72	1.000	1.000	1.016	$111.43
Composite	**$783.43**	**1.000**	**1.001**	**1.008**	**$790.05**	**$800.47**	**1.001**	**1.006**	**1.016**	**$819.14**
Pharmacy	$22.60	1.000	1.000	1.008	$22.78	$21.09	1.000	1.000	1.016	$21.42

Category of Service	CY 2019 Reported PMPM	CY 2019 Provider Contracting Adjustment	CY 2019 Impact of Program Adjustments	CY 2019 Impact of Demographics	CY 2019 Adjusted PMPM	CY 2020 Reported PMPM	CY 2020 Provider Contracting Adjustment	CY 2020 Impact of Program Adjustments	CY 2020 Impact of Demographics	CY 2020 Adjusted PMPM
Hospital Inpatient	$22.71	1.006	0.999	1.015	$23.16	$29.78	1.002	1.000	1.020	$30.43
Part A Crossover	$33.92	1.006	1.000	1.015	$34.64	$35.58	1.002	1.000	1.020	$36.35
Hospital Outpatient	$12.21	1.002	0.999	1.015	$12.41	$12.03	1.001	1.000	1.020	$12.27
Outpatient Crossover	$57.35	1.002	1.000	1.015	$58.32	$56.86	1.001	1.000	1.020	$58.03
Physician	$35.87	1.000	0.998	1.015	$36.36	$30.05	1.000	1.031	1.020	$31.61
Physician Crossover	$68.00	1.000	1.000	1.015	$69.03	$62.77	1.000	1.031	1.020	$66.01
Dental	$14.68	1.000	0.998	1.015	$14.87	$9.68	1.000	1.000	1.020	$9.88
Home Health	$42.83	1.000	1.000	1.015	$43.48	$39.70	1.000	1.000	1.020	$40.50
Personal Care Assistants	$431.96	1.000	1.012	1.015	$443.83	$458.09	1.000	1.020	1.020	$476.80
Other	$118.94	1.000	1.000	1.015	$120.70	$126.40	1.000	1.008	1.020	$129.91
Composite	**$838.46**	**1.001**	**1.006**	**1.015**	**$856.79**	**$860.94**	**1.000**	**1.015**	**1.020**	**$891.80**
Pharmacy	$23.53	1.000	0.998	1.015	$23.84	$27.91	1.000	1.000	1.020	$28.47

Category of Service	CY 2021 Reported PMPM	CY 2021 Provider Contracting Adjustment	CY 2021 Impact of Program Adjustments	CY 2021 Impact of Demographics	CY 2021 Adjusted PMPM	CY 2022 Reported PMPM
Hospital Inpatient	$27.27	1.008	1.000	1.001	$27.51	$28.58
Part A Crossover	$34.52	1.008	1.000	1.001	$34.82	$36.84
Hospital Outpatient	$15.81	1.000	1.000	1.001	$15.84	$17.97
Outpatient Crossover	$65.88	1.000	1.000	1.001	$65.97	$59.45
Physician	$34.86	1.000	1.000	1.001	$34.90	$39.04
Physician Crossover	$68.63	1.000	1.000	1.001	$68.71	$70.49
Dental	$14.39	1.000	1.436	1.001	$20.67	$19.14
Home Health	$33.26	1.000	1.000	1.001	$33.30	$28.16
Personal Care Assistants	$460.32	1.000	1.066	1.001	$491.14	$462.78
Other	$132.20	1.000	1.000	1.001	$132.34	$136.17
Composite	**$887.16**	**1.001**	**1.041**	**1.001**	**$925.21**	**$898.63**
Pharmacy	$29.75	1.000	1.000	1.001	$29.78	$32.16

Category of Service	Annualized Trend Rates** CY 2017 - CY 2018	CY 2018 - CY 2019	CY 2019 - CY 2020	CY2020 - CY2021	CY2021 - CY2022
Hospital Inpatient	-13.7%	14.2%	28.6%	-10.4%	3.9%
Part A Crossover	2.9%	-5.1%	2.7%	-5.0%	5.8%
Hospital Outpatient	-5.9%	-1.0%	-3.1%	28.8%	13.5%
Outpatient Crossover	5.3%	5.5%	-2.5%	13.5%	-9.9%
Physician	-10.2%	6.2%	-17.3%	10.3%	11.9%
Physician Crossover	-3.6%	-1.7%	-9.1%	4.0%	2.6%
Dental	9.3%	2.9%	-34.9%	45.6%	-7.4%
Home Health	-4.0%	-5.1%	-8.7%	-17.9%	-15.4%
Personal Care Assistants	5.7%	2.1%	3.2%	-3.5%	-5.8%
Other	-4.1%	6.7%	4.7%	1.8%	2.9%
Composite	**1.3%**	**2.4%**	**0.5%**	**-0.5%**	**-2.9%**
Pharmacy	-7.4%	9.9%	17.0%	4.5%	8.0%

**Data is based on financial summaries, excluding BHH and CCBHC service costs.*
***Annualized Trend Rates are the reported PMPM for the latter year divided by the adjusted PMPM for the prior year and annualized as applicable.*

APPENDIX B

Pharmacy Trend Study

(Provided in Excel)

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Appendix B.1
Calendar Year 2024 MSHO and MSC+ Rate Development
PMPM Trends

Category	FY 2022	CY 2022	CY 2023	CY 2024	Annualized Trend
Traditional	$ 223.17	$ 221.85	$ 232.15	$ 244.04	
Annualized Trend		-1.2%	4.6%	5.1%	**3.6%**
Specialty	$ 75.82	$ 79.51	$ 87.51	$ 92.77	
Annualized Trend		10.0%	10.1%	6.0%	**8.4%**
Total	$ 298.99	$ 301.35	$ 319.66	$ 336.81	
Annualized Trend		1.6%	6.1%	5.4%	**4.9%**

Appendix B.2
Calendar Year 2024 MSHO and MSC+ Rate Development
Utilization/1000 Trends

Category	FY 2022	CY 2022	CY 2023	CY 2024	Annualized Trend
Traditional	47,057.3	44,827.4	45,004.6	45,367.2	
Annualized Trend		-9.3%	0.4%	0.8%	**-1.5%**
Specialty	290.4	284.7	297.1	302.9	
Annualized Trend		-3.8%	4.3%	1.9%	**1.7%**
Total	47,347.7	45,112.1	45,301.7	45,670.0	
Annualized Trend		-9.2%	0.4%	0.8%	**-1.4%**

Appendix B.3
Calendar Year 2024 MSHO and MSC+ Rate Development
Cost/Rx Trends

Category	FY 2022	CY 2022	CY 2023	CY 2024	Annualized Trend
Traditional	$ 62.26	$ 65.51	$ 68.50	$ 71.63	
Annualized Trend		10.7%	4.6%	4.6%	**5.8%**
Specialty	$ 2,266.63	$ 2,386.76	$ 2,535.20	$ 2,615.56	
Annualized Trend		10.9%	6.2%	3.2%	**5.9%**
Total	$ 75.78	$ 80.16	$ 84.68	$ 88.50	
Annualized Trend		11.9%	5.6%	4.5%	**6.4%**

APPENDIX C

Summary of CY 2024

Administration and Care Coordination Costs

(Provided in Excel)

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Appendix C
Calendar Year 2024 MSHO and MSC+ Rate Development
Breakdown of Admin Components
Including Margin and Premium Tax

Community Non - Elderly Waiver Rate Cell

Fixed Administration

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$33.35	$33.35	$33.35	$33.35	$33.35	$33.35	$33.35	$33.35
Non-Metro	33.35	33.35	33.35	33.35	33.35	33.35	33.35	33.35

Variable Administration

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$38.52	$48.40	$83.40	$116.31	$42.97	$54.22	$108.88	$116.14
Non-Metro	26.70	39.11	54.24	116.69	29.09	37.44	58.46	116.77

Care Coordination

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$22.35	$22.35	$22.35	$110.47	$22.35	$22.35	$22.35	$110.47
Non-Metro	22.35	22.35	22.35	110.47	22.35	22.35	22.35	110.47

Total

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$94.22	$104.10	$139.10	$260.14	$98.68	$109.92	$164.58	$259.96
Non-Metro	82.40	94.81	109.95	260.52	84.79	93.14	114.16	260.60

Community Elderly Waiver Rate Cell

Fixed Administration

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$33.35	$33.35	$33.35	$33.35	$33.35	$33.35	$33.35	$33.35
Non-Metro	33.35	33.35	33.35	33.35	33.35	33.35	33.35	33.35

Variable Administration

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$140.58	$152.58	$171.72	$261.96	$143.74	$148.87	$153.05	$261.78
Non-Metro	101.09	105.94	107.17	262.33	106.93	103.97	103.99	262.41

Care Coordination

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$11.80	$11.80	$11.80	$58.34	$11.80	$11.80	$11.80	$58.34
Non-Metro	11.80	11.80	11.80	58.34	11.80	11.80	11.80	58.34

Total

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$185.74	$197.74	$216.87	$353.65	$188.90	$194.03	$198.20	$353.47
Non-Metro	146.25	151.10	152.33	354.02	152.09	149.12	149.14	354.10

Institutional Rate Cell

Fixed Administration

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$33.35	$33.35	$33.35	$33.35	$33.35	$33.35	$33.35	$33.35
Non-Metro	33.35	33.35	33.35	33.35	33.35	33.35	33.35	33.35

Variable Administration

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$27.13	$20.69	$17.03	$145.96	$29.95	$19.50	$11.54	$145.96
Non-Metro	28.25	20.84	14.02	145.88	31.03	17.92	11.23	145.88

Care Coordination

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$20.43	$20.43	$20.43	$101.00	$20.43	$20.43	$20.43	$101.00
Non-Metro	20.43	20.43	20.43	101.00	20.43	20.43	20.43	101.00

Total

Area	Males				Females			
	65 - 74	75 - 84	85 +	Non-MC	65 - 74	75 - 84	85 +	Non-MC
Metro	$80.91	$74.48	$70.82	$280.31	$83.73	$73.28	$65.33	$280.31
Non-Metro	82.03	74.62	67.80	280.23	84.81	71.71	65.02	280.23

APPENDIX D

FY 2022 Aggregate Health Plan EW Experience

PMPM by Service Category

(Provided in Excel)

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Appendix D
Calendar Year 2024 MSHO and MSC+ Rate Development
Elderly Waiver and Case Management Services
FY 2022 Aggregate Health Plan Experience PMPM by Category of Service

Elderly Waiver Services	**FY 2022 Cost PMPM**
Adult Companion, Remote	$0.00
Adult Day	182.48
Adult Day Bath	0.04
Adult Day FADS License	0.50
Assessment of Environmental Accessibility Adaptations - Vehicle	0.01
Family Caregiver Training and Education, Remote	0.00
Family Caregiver Coaching and Counseling, Remote	0.00
Family Caregiver/Family Memory Care, Remote	0.00
CDCS Background Checks	0.01
CDCS Consumer Directed Community Supports	0.95
CDCS Mandatory Case Mgt	0.28
Chore Services	2.85
Companion Services, Adult	1.24
Customized Living	69.21
Customized Living 24 Hr	787.82
Env. Mod and Provision (claims only)	2.13
Environment Accessibility Adaptations - Vehicle Installation	0.05
Environmental Accessibility Adaptations / Home Install	6.20
Environmental Accessibility Adaptations/Home Assessments	0.13
Extended Home Health Aide (eff. March 2009)	0.88
Extended Personal Care 1:1	12.86
Extended Shared Personal Care 1:2	0.00
Extended Shared Personal Care 1:3	0.00
Family Caregiver Coaching and Counseling (including assessment)	0.01
Family Caregiver Training and Education	0.01
Family Caregiver/ Family Memory Care	0.00
Foster Care, Corporate	3.46
Foster Care, Family	30.41
Home Delivered Meals	21.56
Homemaker Services - Home Management	7.60
Homemaker Services - Personal Cares/ADL Assistance	3.47
Homemaker Services/Cleaning	99.27
Homemaker/Home Mgmt, Remote	0.00
Individual Community Living Support - in-person	37.03
Individual Community Living Support - remote	0.08
LPN Complex Extended	0.00
LPN Regular Extended 1:1	0.00
LPN Shared Extended 1:2	0.00
PERS Installation and Testing	0.29
PERS Monthly Service Fee	9.72
PERS Purchase	0.18
Personal Assistance (claims only)	29.34
Personal Care Assistance (PCA) Complex, 1:1 Ratio, Extended	0.21
Personal Care Assistance (PCA) Complex, 1:2 Ratio, Extended	0.00
Personal Care Assistance (PCA) Complex, 1:3 Ratio, Extended	0.00
Post-Discharge Case Consultation and Collaboration, Home Care Training Family	0.00
Post-Discharge Case Consultation and Collaboration, Home Care Training. Non-Family	0.00
Respite not-in-home per diem (out of home)	0.06
Respite Svcs, In-home, remote	0.00
Respite, in home	0.88
Respite, out of home	0.00
RN Complex Extended	0.10
RN Regular Extended 1:1	0.00
RN Regular Extended 1:2	0.00
Self-Directed Support (claims only)	6.02
Specialized Supplies and Equipment	6.37
Support Planner/ Flexible Case Management (claims only)	0.58
Transitional Services	0.25
Transitional Services, Remote	0.00
Transportation, commercial/non commercial, mileage	0.32
Transportation, Extended	76.28
Treatment and Training (claims only)	0.73
Unknown 99	1.39
Incurred but not Reported Claims	30.26
Total Elderly Waiver Services	**$1,433.56**
CY 2022 Total Care Coordination / Case Management Services Costs PMPM	**$97.76**
Total	**$1,531.32**

APPENDIX E

Elderly Waiver Trend Study

(Provided in Excel)

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Appendix E
Calendar Year 2024 MSHO and MSC+ Rate Development
Elderly Waiver Add on Rates
Historical Trend Analysis

	FY 2017	FY 2018	FY 2019	CY 2019**	FY 2020**	FY 2021**	FY 2022***
Claim Costs - Customized Living	$650.46	$677.32	$715.01	$740.79	$768.45	$812.23	$857.03
Claim Costs - Other*	$455.83	$483.30	$482.28	$508.21	$463.80	$472.18	$576.53
Claim Costs - Total	$1,106.29	$1,160.62	$1,197.30	$1,249.01	$1,232.25	$1,284.41	$1,433.56
Program Adjustments	1.047	1.024	1.006	1.000	1.001	1.019	1.018
Demographic Factor	0.994	0.992	0.992	0.999	1.001	1.001	1.000
Normalized Costs	$1,150.61	$1,179.31	$1,194.74	$1,247.95	$1,233.94	$1,310.57	$1,458.79
Annualized Trend		0.87%	1.53%	9.29%	-2.50%	4.09%	9.38%

**Includes IBNR for all services.*
***Annualized Trend Rates are calculated as the latter year 'Claim Costs - Total' row divided by the 'Normalized Costs' for the prior year and annualized as applicable.*
****Removes the 5% increase for PCA temporary workforce effective April 1, 2022 through June 30, 2022.*

APPENDIX F

180 Day NF Add-On Rate Calculation for January 2024 through December 2024

(Provided in Excel)

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Appendix F
Calendar Year 2024 MSHO and MSC+ Rate Development
Preliminary 180 Day Nursing Facility Add On Rate Calculation
CY 2024 Capitation Payment Rates
Total Eligible Population

	CY 2023	CY 2024
NF Add-On (1)	$160.32	$150.03
Per Diem (2)	$336.70	$336.56
Monthly Freq (3)	0.625%	0.558%

					Average NF Days for Admissions in Month by Contract Period		**NF Dollars for Admissions in Month by Contract Period**
		(4)	(5) = (1) x (4)	(6) = (3) x (4)	(7)	(8)	(9) = (2) x (6) x (8)
Year	Month	Monthly Enrollment	Total NF Add-On Paid to Health Plans	Admissions	CY 2023	CY 2024	CY 2024
2023 Contract Period							
2023	January	62,602	$10,036,208	391.3	77.0	0.0	$0
	February	63,180	10,128,872	394.9	77.0	0.0	0
	March	63,703	10,212,718	398.1	77.0	0.0	0
	April	64,334	10,313,847	402.1	77.0	0.0	0
	May	64,976	10,416,725	406.1	77.0	0.0	0
	June	65,628	10,521,384	410.2	77.0	0.0	0
	July	66,292	10,627,860	414.3	71.6	5.4	746,683
	August	66,968	10,736,186	418.6	61.3	15.7	2,216,153
	September	67,656	10,846,397	422.8	50.1	26.9	3,832,766
	October	68,355	10,958,530	427.2	37.9	39.1	5,616,627
	November	69,067	11,072,622	431.7	24.3	52.7	7,653,674
	December	69,791	11,188,710	436.2	8.8	68.2	10,017,981
Total 2023 Contract Period		792,552	$127,060,058	4,953.4	59.0	18.0	$30,083,885
2024 Contract Period							
2024	January	70,528	$10,581,298	393.8		78.0	$10,337,380
	February	71,277	10,693,780	398.0		78.0	10,447,270
	March	72,040	10,808,240	402.2		78.0	10,559,091
	April	72,817	10,924,715	406.6		78.0	10,672,881
	May	73,607	11,043,243	411.0		78.0	10,788,677
	June	74,411	11,163,866	415.5		78.0	10,906,519
	July	75,229	11,286,623	420.0		72.6	10,259,660
	August	76,062	11,411,555	424.7		62.1	8,870,706
	September	76,909	11,538,704	429.4		50.7	7,329,930
	October	77,772	11,668,113	434.2		38.4	5,616,275
	November	78,650	11,799,826	439.1		24.6	3,640,771
	December	79,543	11,933,888	444.1		8.9	1,326,383
Total 2024 Contract Period		898,843	$134,853,851	5,018.5		59.7	$100,755,543
Grand Total							$130,839,428

APPENDIX G

Actuarial Certification

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration, and other factors. This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

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Michael Cook, FSA, MAAA
Principal and Consulting Actuary

michael.cook@milliman.com

September 29, 2023

Minnesota Department of Human Services
Capitated Contracts Ratesetting
Actuarial Certification
Minnesota Senior Health Options / Minnesota Senior Care Plus

I, Michael Cook, am associated with the firm of Milliman, Inc. I am a member of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I have been retained by the Minnesota Department of Human Services (DHS) to perform an actuarial certification of the Basic Care, Nursing Facility add-on, and Elderly Waiver add-on capitation rates for the period of January 1, 2024 through December 31, 2024 for the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) programs. This certification does not cover the Medicare Advantage capitation rates from CMS, which are components of the overall capitation rate paid through the MSHO program. The health plans participating in MSHO / MSC+ should consider all sources of capitation when evaluating the program.

I reviewed the actuarial assumptions and actuarial methods used to develop the Basic Care, Nursing Facility add-on, and Elderly Waiver add-on payment rates for the period of January 1, 2024 through December 31, 2024 for MSHO / MSC+. I reviewed the calculated capitation rates and am familiar with the following regulation and guidance:

- The requirements of 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7
- CMS "Appendix A, PAHP, PIHP, and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Rate setting dated November 10, 2014"
- 2023 to 2024 Medicaid Managed Care Rate Development Guide
- Actuarial Standard of Practice 49 – Medicaid Managed Care Capitation Rate Development and Certification

The payment rates, methodology, data, and assumptions used to calculate the January 1, 2024 through December 31, 2024 rates are documented in our report to DHS, of which this certification is a part.

In making my opinion, I relied on the accuracy of the data and information provided by DHS and the health plans with which they contract. The report referenced above includes a description of the data and information upon which I relied. A copy of the reliance letter received from DHS is attached and constitutes part of this opinion. I performed no independent verification as to the accuracy or completeness of this data and information. I reviewed the data for reasonableness and consistency with prior years and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary.

In my opinion, the payment rates identified above are actuarially sound, as defined in 42 CFR §438.4, including that they:

Have been developed in accordance with generally accepted actuarial principles and practices and Actuarial Standards of Practice.

1. Are appropriate for the populations to be covered and the services furnished.
2. Meet the relevant actuarial requirements of 42 CFR §438.4(b).

Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs might differ from these projections and will be dependent on each contracted health plan's situation and experience. These capitation rates may not be appropriate for all health plans. Any health plan considering participating in MSHO / MSC+ should consider their unique circumstances before deciding to contract under these rates.

This certification is intended solely for the use of DHS and the federal agencies to which this certification must be submitted. This certification should not be relied upon by other parties. This Opinion assumes the reader is familiar with the Minnesota Medicaid program, MSHO / MSC+, Minnesota's home and community based waivers, Medicaid eligibility rules, and actuarial rating techniques. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the results.

Michael Cook
Member, American Academy of Actuaries

Date: September 29, 2023

September 29, 2023

Michael Cook, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
17335 Golf Parkway
Suite 100
Brookfield, WI 53045

Re: Data Reliance for Actuarial Certification of January 1, 2024 through December 31, 2024 for PMAP, SNBC, MSHO, and MSC+ Capitation Rates

Dear Michael:

I, Jeff Provance, Health Actuary, Director, hereby affirm that the listings and summaries prepared and submitted to Milliman, Inc. for the development of the January 1, 2024 through December 31, 2024 Prepaid Medical Assistance Program (PMAP), Special Needs BasicCare (SNBC), Minnesota Senior Health Options (MSHO), and Minnesota Senior Care Plus (MSC+) capitation rates were prepared under my direction, and to the best of my knowledge and belief, are accurate and complete. These listings and summaries include:

1. Data files containing financial information by capitated plan, detailed service category, program and sub-program, geographic indicators, and demographic indicators for calendar year (CY) 2016 through CY 2022 paid through second quarter (Q2) 2023.

2. Data files containing enrollment information by capitated plan, program and sub-program, geographic indicators, and demographic indicators for CY 2016 through first half (H1) 2023.

3. Summaries of managed care Elderly Waiver (EW) claim experience data from CY 2016 through FY 2022 and enrollment from CY 2016 through August 2023. This information was provided by combinations of age, area, and Activities of Daily Living (ADL) usage.

4. Data files containing capitated plan encounter data from CY 2016 through CY 2022 paid through H1 2023.

5. Plan-reconciliations of financial and encounter data and DHS Control Detail report.

6. Data files containing actual monthly enrollment in total by enrollment category through August 2023, and projected monthly enrollment through December 2024 for the PMAP, MSHO, MSC+, and SNBC programs.

7. Data files containing managed care nursing facility admission and length of stay experience from CY 2016 to CY 2022.

8. Projected 2024 average nursing facility charge per day supplied by the Reports and Forecasting division of Minnesota DHS.

9. A summary of legislative and program changes impacting CY 2024 contracts through the 2023 legislative session and relevant fiscal notes and impact estimates.

10. Results of analyses performed by DHS regarding the fiscal impact of legislative changes (i.e., fiscal notes and other ad hoc analyses).

11. Projected settlement amounts for the Integrated Hospital Payment (IHP) program.

12. Required percentage adjustments for capitated plan surcharges, legislated premium taxes, withhold arrangements, and payment delays.

13. Required per-member per-month (PMPM) adjustments for pass-through arrangements.

14. Summary of historical and projected provider contracting changes.

15. Notification of changes to the Prescription Drug List (PDL) effective through September 15, 2023.

16. Summary of Hennepin County Medical Center supplemental payments and contracting trends.

17. Summary of Institution for Mental Disease (IMD) and Substance Use Disorder (SUD) providers.

18. Additional detail regarding MCO-reported CY 2022 administrative costs and expectations for 2024, as well as CY 2024 Medicare Bid Pricing Tools (BPTs) provided by the MCOs.

19. Expectations related to EVV impacts.

20. Expectations related to CY 2024 COVID-19 impacts.

21. Expectations related to GLP-1 drugs and weight loss management.

22. Expected timing of disenrollment due to end of the Public Health Emergency (PHE).

23. Expected CY 2024 directed payment preprints submitted to CMS.

24. Any other items provided to Milliman by DHS to support the 2024 rate development not mentioned above.

I affirm the above information and any other related data submitted to Milliman, Inc. are, to the best of my knowledge and belief, accurately stated.

Jeffrey T Provance
Name

9/18/2023
Date

APPENDIX H

Rate Setting Checklist

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration, and other factors. This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

APPENDIX H

RATE SETTING CHECKLIST

This section of the report lists each item in the November 10, 2014 CMS checklist and discusses how DHS addresses each issue and / or directs the reader to other parts of this report. CMS uses the rate setting checklist to review and approve a state's Medicaid capitation rates.

AA.1.0 – Overview of Rates Being Paid Under the Contract

The CY 2024 Minnesota Senior Health Options and Minnesota Senior Care Plus (MSHO / MSC+) Basic Care, Elderly Waiver (EW) add-on, and Nursing Facility (NF) add-on capitation rates are developed using FY 2022 Minnesota Medicaid managed care organization (MCO) financial summary data and FY 2022 encounter data for the MCO eligible population along with other information. DHS sets rates by region and rate cell.

Please refer to the *Executive Summary* of this rate report for background on the program and more details around the rate development.

AA.1.1 – Actuarial Certification

The actuarial certification of the CY 2024 capitation rates is included as Appendix G. The MSHO / MSC+ Basic Care, Elderly Waiver (EW) add-on, and Nursing Facility (NF) add-on capitation rates have been developed in accordance with generally accepted actuarial principles and practices and are appropriate for the populations to be covered and the services to be furnished under the contract.

AA.1.2 – Projection of Expenditures

Not required under current regulation.

AA.1.3 – Risk Contracts

The Minnesota MSHO / MSC+ program, including the Basic Care, EW add-on, and NF-add on payments meet the criteria of a risk contract.

AA.1.4 – Modifications

The CY 2024 rates documented in this report are the initial capitation rates for the CY 2024 Minnesota MSHO and MSC+ managed care contracts.

Note: There is no AA.1.5 on the Rate Setting Checklist

AA.1.6 – Limit on Payment to Other Providers

Any provider rate enhancement is built into the capitation rates and is addressed in the rate memo.

AA.1.7 – Risk and Profit

Targeted margin is considered as part of final rate development.

AA.1.8 – Family Planning Enhanced Match

DHS does not claim enhanced match for family planning services for the population covered under this program.

AA.1.9 – Indian Health Service (IHS) Facility Enhanced Match

DHS does not claim enhanced match for Indian Health Services for the population covered under this program.

AA.1.10 – Newly Eligible Enhanced Match

The MSHO / MSC+ Basic Care, EW add-on, and NF add-on programs previously covered the newly-eligible Medicaid population. Therefore, none of the recipients are eligible for the enhanced Federal match under Section 1905(y).

APPENDIX H

RATE SETTING CHECKLIST

AA.1.11 – Retroactive Adjustments

The rates documented in this rate report are the capitation rates for the CY 2024 MSHO / MSC+ managed care contracts. The Basic Care, EW add-on, and NF add-on payments do not contain any retroactive adjustments.

AA.2.0 – Based Only Upon Services Covered Under the State Plan

The CY 2024 rate methodology relies on FY 2022 MCO financial summary data and encounter data as the primary data source. Only State Plan, cost effective in lieu of services, and waiver services that are covered under the MSHO / MSC+ contract have been included in the rate development.

Please refer to Section II.A of the rate report for more details.

AA.2.1 – Provided Under the Contract to Medicaid-Eligible Individuals

The capitation rate development methodology relies on data that includes only those eligible and currently enrolled in the MSHO / MSC+ program and does not include experience for individuals not eligible to enroll in the program.

AA.2.2 – Data Sources

The CY 2024 capitation rates are developed using Minnesota Medicaid MSHO / MSC+ Basic Care, EW add-on, and NF add-on MCO financial summary, encounter, and eligibility data for FY 2022 for the MCO eligible population as the primary data source.

Please refer to Section II.A of the rate report for more details.

AA.3.0 – Adjustments to Base Year Data

All adjustments to the base year data are discussed in Sections II, III, and IV of this report. In addition, each item in the checklist is addressed in items AA.3.1 to AA.3.17 below.

AA.3.1 – Benefit Differences

The base data used to calculate the capitation rates has been adjusted to only include services covered under the Medicaid MCO program contract, as outlined in Section II.A of the rate report.

The following sections outline legislative or program changes implemented between the base period year and the contract period.

- Basic Care – *Section II.B*
- EW add-on – *Section III.B*
- NF add-on – *Section IV*

AA.3.2 – Administrative Cost Allowance Calculations

The MCO capitation rates include explicit administrative allowances calculation, as described in Section II.E of the rate report.

AA.3.3 – Special Populations' Adjustments

The capitation rates methodology does not include an adjustment for special populations as the base MCO encounter data used to calculate the capitation rates is consistent with the Minnesota MSHO and MSC+ program populations.

AA.3.4 – Eligibility Adjustments

The base MCO financial summary data and encounter data only reflect experience for time periods where members were enrolled in a MSHO / MSC+ MCO.

APPENDIX H

RATE SETTING CHECKLIST

AA.3.5 – Third Party Liability (TPL)

The managed care organizations are responsible for the collection of any TPL recoveries. The base MCO encounter summary data is reported net of TPL recoveries; therefore, no adjustment was necessary.

AA.3.6 – Indian Health Care Provider Payments

The state pays IHCPs directly through FFS; the services are carved-out of the MCO contracts and these claims do not appear in the MCO encounters

AA.3.7 – DSH Payments

DSH payments are not included in the capitation rates.

AA.3.8 – FQHC and RHC Reimbursement

FQHC and RHC encounter claims and settlements are not included in the capitation rates for all non-dual MSHO / MSC+ populations.

AA.3.9 – Graduate Medical Education (GME)

GME payments are not included in the capitation rates.

AA.3.10 – Copayments, Coinsurance, and Deductibles in Capitated Rates

Enrollees who are not dually eligible for Medicare pay copayments according to the contract. There are no coinsurance requirements. The family deductible is tracked by the MCO and reported; there are no other deductibles. Effective 1/1/2024, all cost-sharing for covered services in the Minnesota MSHO and MSC+ program will be eliminated. The adjustment for the increase to the state liability is documented in Section II.B.

The MSHO program integrates Medicare and Medicaid primary, acute, drugs, home care, long term care waiver services, and the first 180 days of care in a nursing facility. MSHO plans provide all Medicare services including Part D drugs and Medicare cost-sharing. The Medicaid share of the cost-sharing payments is reflected in the experience data.

AA.3.11 – Medical Cost / Trend Inflation

Trend rates from FY 2022 to CY 2024 were developed by program and type of service for MSHO / MSC+ Basic Care, EW add-on, and NF add-on eligible services and individuals using historical MCO financial summary data from January 2017 to December 2022 and actuarial judgment. Please see the following sections for more details on the trend development.

- Basic Care – Section II.C
- EW add-on – Section III.C
- NF add-on – Section IV

AA.3.12 – Utilization Adjustments

Please see Section II.C for more details on the utilization trend development.

AA.3.13 – Utilization and Cost Assumptions

The capitation rates use actuarially sound rate cell relativities to adjust the rates for each participating MCO in a particular region in order to reflect the acuity of enrolled members. Acuity adjustments were applied independently from the unit cost and utilization trend adjustments.

AA.3.14 – Post-Eligibility Treatment of Income (PETI)

Capitation rates are developed net of patient liability. Base MCOs' financial summary data are net of patient liability, so no adjustment to the data is necessary for this issue.

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RATE SETTING CHECKLIST

AA.3.15 – Incomplete Data Adjustment

The FY 2022 financial summary data was provided with limited months of runout. Plans provided IBNR amounts as part of the submission to include in the base data development. These amounts were reviewed for reasonableness and included as part of the base data. See Section II.A for additional details.

AA.3.16 – Primary Care Rate Enhancement

Not applicable

AA.3.17 – Health Homes

The cost of health care homes is included in the MSHO / MSC+ rates.

AA.4.0 – Establish Rate Category Groupings

The rate category groupings are described in the following sections of the rate memo:

- Basic Care – Section II.D
- EW add-on – Section III.E
- NF add-on – Section IV.C

The rates for each rate category are included in Exhibit 3 (Basic Care), Exhibit 6 (EW Add-on), and Exhibit 9 (NF Add-on).

AA.4.1 – Eligibility Categories

There are three eligibility categories for MSHO / MSC+; Community Non-EW, Community EW, and Institutional.

AA.4.2 – Age

Those ages 65 and over are eligible for enrollment in the MSHO / MSC+ programs.

AA.4.3 – Gender

Gender is used for rate category groupings for the Basic Care and NF add-on rates, but not the EW add-on rates.

AA.4.4 – Locality / Region

Geographic regions are defined in Section II.D of the rate report.

AA.4.5 – Risk Adjustments

Risk adjustment is used for the EW Add-on rates and the process is described in Section III.E of the rate report. This adjustment is performed prospectively and the actuarial certification includes this adjustment.

AA.5.0 – Data Smoothing

We did not perform any data smoothing.

AA.5.1 – Cost-Neutral Data Smoothing Adjustment

We did not perform any data smoothing.

AA.5.2 – Data Distortion Assessment

Our review of the base MCO financial summary and encounter data did not detect any material distortions or outliers.

APPENDIX H

RATE SETTING CHECKLIST

AA.5.3 – Data Smoothing Techniques

We determined that a data smoothing mechanism resulting from data distortions was not required.

AA.5.4 – Risk Adjustments

Risk adjustment is used for the EW Add-on rates and the process is described in Section III.E of the rate report.

AA.6.0 – Stop Loss, Reinsurance, or Risk Sharing Arrangements

Not applicable.

AA.6.1 – Commercial Reinsurance

DHS does not require entities to purchase commercial reinsurance.

AA.6.2 – Stop-Loss Program

Not applicable.

AA.6.3 – Risk Corridor Program

Not applicable.

AA.7.0 – Incentive Arrangements

There are no incentive arrangements in the programs.

Capitation rates are certified as actuarially sound net of the portion of funds withheld from capitation that is not reasonably expected to be returned to the MCOs (0.25%).

AA.7.1 – Electronic Health Records (EHR) Incentive Payments

DHS has not implemented incentive payments related to EHRs for the contract period.

APPENDIX I

Responses to CMS Rate Setting Guide

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration, and other factors. This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the MSHO and MSC+ programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

APPENDIX I

RESPONSES TO 2023 THROUGH 2024 MANAGED CARE RATE SETTING GUIDE

SECTION I. MEDICAID MANAGED CARE RATES

1. GENERAL INFORMATION

A. Rate Development Standards

i. The CY 2024 capitation rates do not include a rate range.

ii. The rate certification included in Appendix G is for the January 2024 through December 2024 (CY 2024) contract period.

iii. The rate certification includes all of the items required in the rate development guide.

a. The rate certification is included in Appendix G.

b. The final capitation rates are shown in Exhibit 3 (Basic Care), Exhibit 6 (EW Add-on), and Exhibit 9 (NF Add-on).

The Exhibit 6 EW Add-on rates are risk adjusted for each health plan. The plan-specific rate sheets, provided separately from this report, include the final certified EW Add-on rate.

c. The descriptions of MSHO and MSC+ programs can be found in Section I of the report –

The MSHO programs began in 1995 as a Fully Integrated Dual Eligible Special Needs Plan in which Medicaid, Medicare, and Long Term Services and Support benefits are integrated into one benefit package. The MSC+ program began in 2009, replacing the Minnesota Senior Care program introduced in 2005. Both the MSHO and MSC+ *programs provide coverage to low income adults at least 65 years of age. To be eligible for MSHO coverage, enrollees must also be eligible for Medicare Parts A and B and be enrolled in the health plan's Medicare Advantage Special Needs Plan (MA-SNP). The MSC+ program provides coverage to enrollees eligible for Medicare Parts A and B, as well as Non-Dually eligible seniors. These programs cover basic acute care and personal care services. Home and community-based services are provided through the EW Add-on and 180 days of nursing facility coverage is provided through the NF Add-on.*

Eight health plans serve the MSHO and MSC+ populations in Minnesota. Three of the plans are County Based Purchasing (CBP) plans. A portion of the MSHO enrollment is for plans operating as Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP).

The following directed payment arrangements apply to the Seniors program for CY 2024. Additional documentation of these arrangements is included below in Section I.4.D of this rate setting guide.

- Inclusion of Care Coordination Services in a BHH minimum fee schedule
- CCBHC minimum fee schedule
- Substance Use Disorder 1115 Demonstration Waiver minimum fee schedule
- Directed Payment for a Safety Net Hospital in Hennepin County
- Dental Services minimum fee schedule
- Culturally / disability responsive SUD minimum fee schedule
- Managed long-term services and supports minimum fee schedule
- Critical Access Mental Health Minimum Fee Schedule
- Rate Increase for Outpatient Behavioral Health Services
- Fuel Adjustor for NEMT and Ambulance Services
- Rate Increase for Adult Day Treatment

iv. Rate differences by rate cell are not based on federal financial participation rates.

v. Rate cells do not cross-subsidize other rate cells.

APPENDIX I

RESPONSES TO 2023 THROUGH 2024 MANAGED CARE RATE SETTING GUIDE

vi. The assumptions used to develop the capitation rates are consistent with the effective dates of all changes to the MSHO and MSC+ programs from the fiscal year (FY) 2022 base period to CY 2024.

vii. The target MLR within the CY 2024 rates is 91.23% on a statewide basis for the MSHO and MSC+ programs using FY 2022 base period membership. As such, the capitation rates are developed such that MCOs can reasonably achieve an MLR of greater than 85%.

viii. The CY 2024 capitation rates do not include a rate range.

ix. The CY 2024 capitation rates do not include a rate range.

x. The rate setting report includes documentation showing that the CY 2024 rates were developed using generally accepted actuarial practices and principles.

   a. All adjustment to the capitation rates reflect reasonable, appropriate, and attainable costs.

   b. No adjustments to the rates are performed outside of the initial rate setting process beyond those outlined in Sections II-IV of the report.

   c. The final contracted rates in each cell match the capitation rates in the certification.

xi. The rate certification covers the CY 2024 time period.

xii. Section I.D. includes documentation of the COVID-19 and related unwinding considerations in the CY 2024 rate development.

xiii. The MSHO and MSC+ rate certification is consistent with CMS procedures.

B. Appropriate Documentation

i. The actuary is certifying CY 2024 capitation rates.

ii. We believe this report properly documents all the elements included in the rate certification and provides CMS enough detail to determine that regulation standards are met. Please see this report for the following details:

   a. Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources.

   b. Assumptions made, including any basis or justification for the assumption.

   c. Methods for analyzing data and developing assumptions and adjustments.

iii. The actuarial certification includes specific rates for each rate cell. Please see this report for support for the specific assumptions that underlie each certified rate. The assumptions used in rate development do not differ by managed care organization.

iv. The CY 2024 capitation rates do not include a rate range.

v. We detail within our responses in this guide the section of our report where each item described in the 2023-2024 Medicaid Managed Care Rate Development Guide can be found.

vi. All differences in the assumptions, methodologies, and factors used to develop capitation rates for covered populations comply with 42 C.F.R. § 438.4(b)(1), are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and do not vary with the rate of FFP associated with the covered populations.

vii. All services covered for the MSHO and MSC+ populations are subject to the same Federal Medical Assistance Percentage (FMAP).

APPENDIX I

RESPONSES TO 2023 THROUGH 2024 MANAGED CARE RATE SETTING GUIDE

viii. Relative to the previous rating period:

a. See Tables 1 to 3 for a rate comparison of CY 2024 capitation rates to CY 2023 capitation rates. See Section I for additional information regarding this rate change.

b. The CY 2024 capitation rates do not include any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.

c. There were no de minimis adjustments made to the actuarially sound CY 2023 capitation rates.

ix. There are no anticipated amendments to this rate certification at this time. We expect to review capitation rates with DHS during the contract period should beneficiary redetermination timing, and associated average population acuity, be materially different than what is projected in this report.

x. Section I.D. includes documentation of the COVID-19 and related unwinding considerations in the CY 2024 rate development. After reviewing FY 2022 experience, we believe the environment has stabilized enough to eliminate a risk mechanism. This is consistent with our use of FY 2022 for base data.

2. DATA

A. Rate Development Standards

i. The MSHO and MSC+ rate development process follows CMS rate development standards related to base data.

a. Service data sources are included in Sections II.A, III.A, and IV. DHS has provided encounter and FFS data for CY 2017 through Q2 2023 to the state's actuaries for this rate development. Managed care plans and DHS have provided detailed financial reporting data for CY 2017 through Q2 2023 to the State's actuaries for this and prior year rate development.

b. Sections II.A, III.A, and IV include documentation of the FY 2022 base data period used to develop the CY 2024 MSHO and MSC+ capitation rates.

c. Base data is specific to the population and services expected to be covered by the MSHO and MSC+ program during the CY 2024 rate period.

d. The CY 2024 rate calculation uses FY 2022 base data, which is within the CMS three year requirement.

B. Appropriate Documentation

i. Sections II.A, III.A, and IV include documentation of the base data used for MSHO and MSC+ rate development. DHS provided detailed financial reporting data for CY 2017 through Q2 2023 and FFS and encounter data for CY 2017 through Q2 2023 to the state's actuaries for this year's rate development.

ii. Sections II.A, III.A, and IV thoroughly describe the base data used to calculate the CY 2024 MSHO and MSC+ rates.

a. The CY 2024 capitation rates for the MSHO and MSC+ programs are developed using FY 2022 encounter data, financial data, FFS data, and other information. The financial data is the primary source of base data for sub-capitated services.

b. DHS and Milliman went through an extensive data validation process to review all capitated plan data included in the CY 2024 rate setting methodology. DHS internally reviews encounter data submissions and notifies plans of corrections necessary to allow for records to be accepted. Milliman reviewed the encounter and financial data. We provided data summaries to all participating capitated plans and requested feedback on these summaries, asked pertinent questions, and revised and adjusted the base data accordingly based on plan responses.

The capitated plan financial data, encounter data, and FFS data, are all of very high quality and appropriate for use in rate development.

c. All base data is specific to the populations that will be covered under the CY 2024 MSHO and MSC+ capitation rates.

d. The rate documentation methodology does not use a data book separate from what is shown in the report.

iii. Sections II-IV thoroughly documents all adjustments made to the base data.

3. PROJECTED BENEFIT COSTS AND TRENDS

A. Rate Development Standards

i. Final capitation rates are based only upon services described in 42 CFR §438.3(c)(1)(ii) and 438.3(e).

ii. This report includes a detailed discussion on the methodology used to develop benefit utilization and unit cost trends.

a. Basic Care – Section II.C
b. EW add-on – Section III.C
c. NF add-on – Section IV

iii. Section II.A discusses costs for in lieu of services or settings (ILOS). The ILOS services were required to be cost-effective relative to the covered service.

iv. The projected ILOS Cost Percentage is less than 0.1% as described in Section II.A.

v. IMD services are not applicable, as the MSHO and MSC+ programs cover individuals age 65 and over.

B. Appropriate Documentation

i. Final projected benefit costs are shown in Exhibit 1 (Basic Care), Exhibit 4 (EW Add-on), and Appendix F (NF Add-on).

ii. Sections II.B-E (Basic Care), III.B-E (EW Add-on) and IV (NF Add-on) of this report document the development of projected benefit costs from the base period data to CY 2024. The health plans reported $1.9 million for MSHO and MSC+ in overpayments to providers in FY 2022. The base period costs used in rate development are net of these overpayments.

iii. Section II.C (Basic Care), III.C (EW Add-on), and IV (NF Add-on) of this report includes a detailed discussion on the methodology used to develop benefit utilization and unit cost trends.

iv. No adjustments for the Mental Health Parity and Addiction Equity Act were made as part of rate development.

v. The ILOS that will be provided during 2024 are outlined below. The projected ILOS Cost Percentage is less than 0.1%. We projected this percentage based on reviewing the estimated CY 2024 ILOS amounts of $57 thousand compared to the total estimated capitation amount of $993.7 million.

a. Traditional Healing: This ILOS service will provide culturally and linguistically competent healthcare services in the Indigenous communities and address health equity.

b. Unattended Sleep Study: This ILOS will offer unattended sleep studies in the home, in lieu of the lab setting. A sleep study is a non-invasive test that tracks what happens to a person’s body while they sleep.

c. Health and Wellness Benefit Classes: This ILOS will offer members access to a multitude of health and wellness programs regarding living well, getting fit and reducing falls, including things such as pain management, nutrition, exercise, medication usage, dealing with emotions, and communicating with doctors. Classes will be held both in person and online.

vi. Retrospective eligibility periods are excluded from the Basic Care program and all rate calculations.

vii. Exhibits 1 and 4 quantify the impact of program changes implemented for CY 2024.

viii. Exhibits 1 and 4 quantify the impact of program changes implemented for CY 2024.

4. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT

A. Incentive Arrangements

The MSHO and MSC+ programs do not include an incentive arrangement.

B. Withhold Arrangements

Nominal withholds of 8.0% for MSHO and MSC+, 5% of which is based on performance, are required by Minnesota law to be removed from plan payments. However, the ultimate amount at risk to health plans is only 0.25% of capitation, because the plan contracts will include "loss limit" and payment timing provisions. The remainder of the nominal withhold is required to be returned to health plans and ultimately only impacts the cash flow of DHS and the plans. The plans are adequately capitalized, and we have no concerns that this payment delay affects the fiscal stability of the organizations. Based on our review of the withhold return metrics and the ultimate amount at risk to health plans, we believe a minimal amount of the 0.25% will be paid back to plans. Therefore, final plan payments, assuming none of the 0.25% at-risk withhold is returned, will also be subject to the actuarial certification.

C. Risk Sharing Mechanisms

The MSHO and MSC+ programs do not include risk sharing mechanisms.

D. State Directed Payments

Please see Tables 1 and 2 below for the requested information regarding the state directed payments.

Table 1
State Directed Payments

Control name of the state directed payment	Type of payment	Brief description	Is the payment included as a rate adjustment or separate payment term?
Minimum fee schedule for Behavioral Health Homes (BHH)	Minimum fee schedule (using Medicaid State plan approved rates)	The MCO shall pay a certified BHH provider at least the ongoing standard care BHH rate established in the STATE's fee schedule for each month after the completion of the six month BHH care engagement rate.	Rate Adjustment (base data reflects the long-standing minimum fee schedule arrangement).
Minimum fee schedule for Certified Community Behavioral Health Clinics (CCBHC)	Minimum fee schedule (using Medicaid State plan approved rates)	I addition to billed claims from CCBHCs, the MCO shall be responsible for a supplemental CCBHC payment as directed by the STATE. Additionally, the MCO shall be responsible for payment of CCBHC claims at each CCBHC's prospective	Rate Adjustment (base data reflects the long-standing minimum fee schedule arrangement).

APPENDIX I

RESPONSES TO 2023 THROUGH 2024 MANAGED CARE RATE SETTING GUIDE

Table 1
State Directed Payments

Control name of the state directed payment	Type of payment	Brief description	Is the payment included as a rate adjustment or separate payment term?
		payment system (PPS) rate or greater as directed by the STATE.	
Minimum fee schedule for Substance Use Disorder (SUD) 1115 Demonstration Waiver services	Minimum fee schedule (using Medicaid State plan approved rates)	MCOs must reimburse Providers an amount that is at least equal to the FFS base rate payment for the SUD services described in Minnesota Statutes, §256B.0759, subd. 4, (b) and (c).	Rate Adjustment
Directed Payment for a Safety Net Hospital in Hennepin County	Specific fee schedule	In accordance with MN State Statute 256B.1973, effective January 1, 2022 or upon federal approval, Minnesota implemented a payment arrangement that is a state-directed fee schedule in which a uniform payment adjustment factor is to be applied to each claim submitted by eligible providers to a participating health plan. Eligible providers under this section are non-state government teaching hospitals with high medical assistance utilization and a level 1 trauma center and the hospital's affiliated billing professionals, ambulance services, and clinics. Hennepin County Medical Center qualifies as an eligible provider. The uniform payment adjustment equals the estimated difference between the average commercial rate of the top five contracted payers for services rendered by the eligible provider and the amounts paid for those services by MCOs.	Rate Adjustment
Minimum fee schedule for Dental Services	Minimum fee schedule (using Medicaid State plan approved rates)	MCOs are required to reimburse dental providers at least equal to FFS rates. Critical Access Dental (CAD) providers receive an additional 20% rate increase.	Rate Adjustment
Minimum fee schedule for Culturally / disability responsive SUD services	Minimum fee schedule (using Medicaid State plan approved rates)	The definition of "culturally specific programs" was expanded to include "culturally responsive programs" and "disability responsive program." A 5% rate increase for SUD treatment services provided by culturally specific programs, culturally responsive programs, or disability responsive programs is required.	Rate Adjustment
Minimum fee scheduled for MLTSS	Minimum fee schedule	MCOs are required to reimburse providers of Elderly Waiver and Home Care Services at least equal to FFS rates.	Rate Adjustment (base data reflects the long-standing minimum fee schedule arrangement).

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RESPONSES TO 2023 THROUGH 2024 MANAGED CARE RATE SETTING GUIDE

Table 1 State Directed Payments			
Control name of the state directed payment	**Type of payment**	**Brief description**	**Is the payment included as a rate adjustment or separate payment term?**
		MCOs are required to establish contracts with providers that are not less than the State-established rate.	
Minimum fee schedule for Critical Access Mental Health	Minimum fee schedule (using Medicaid State plan approved rates)	Effective January 1, 2023, MCOs will be required to reimburse providers of critical access mental health services at rates at least equal to FFS rates.	Rate Adjustment
Rate Increase for Outpatient Behavioral Health Services	Uniform Percentage Increase	Effective January 1, 2024, payment rates for treatment are increased by 3%. In January of each year starting in 2025, rates are also increased by the expected change in the CPI for medical Care Services.	Rate Adjustment
Fuel Adjustor for NEMT and Ambulance Services	Uniform Percentage Increase	Effective January 1, 2024, the commissioner will be required to adjust the rate paid per mile for NEMT and ambulance services when the price of gasoline exceeds $3.00 per gallon, which will be evaluated on the first day of each quarter.	Rate Adjustment
Rate Increase for Adult Day Treatment	Uniform Percentage Increase	Effective January 1, 2024, the Minnesota legislature enacts a 50% rate increase for adult day treatment (ADT) services	Rate Adjustment

DHS will submit 438.6(c) preprints to CMS for 2024 for the Directed Payment for a Safety Net Hospital in Hennepin County. The 2024 preprint for the Directed Payment for a Safety Net Hospital in Hennepin County is consistent with the approved 2022 preprint and the 2023 preprint now in CMS review.

Table 2 includes the details for these state directed payment incorporated as rate adjustments:

Table 2 State Directed Payments Rate Adjustment					
Control name of the state directed payment	**Rate cells affected**	**Impact**	**Description of the adjustment**	**Confirmation the rates are consistent with the preprint**	**For maximum fee schedules, provide the information requested**
Minimum fee schedule for Behavioral Health Homes (BHH)	All rate cells	N/A – included in base data.	The minimum fee schedule is a long-standing arrangement which was in effect during the base data period. Please refer to Section II.E. of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Minimum fee schedule for Certified	All rate cells	N/A – included in base data.	The minimum fee schedule is a long-standing arrangement which was in effect during the base data period.	Preapproval not required	N/A

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Table 2
State Directed Payments   Rate Adjustment

Control name of the state directed payment	Rate cells affected	Impact	Description of the adjustment	Confirmation the rates are consistent with the preprint	For maximum fee schedules, provide the information requested
Community Behavioral Health Clinics (CCBHC)			Please refer to Section II.E. of the CY 2024 rate certification for additional information.		
Minimum fee schedule for Substance Use Disorder (SUD) 1115 Demonstration Waiver services	All rate cells	Please refer to Exhibit 1 ("Other Legislative Adjustments") of the CY 2024 rate certification for the impact by rate cell.	Implemented as program adjustment in Exhibit 1. Please refer to Section II.B. of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Directed Payment for a Safety Net Hospital in Hennepin County	All rate cells	Please refer to Exhibit 3 of the CY 2024 rate certification for the impact by rate cell.	Implemented as a PMPM add-on in Exhibit 3. Please refer to Section II.E. of the CY 2024 rate certification for additional information.	Rates are consistent with preprint	N/A
Minimum fee schedule for Dental Services	All rate cells	Please refer to Exhibit 1 of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section II.B. of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Minimum fee schedule for Culturally / Disability responsive SUD services	All rate cells	Please refer to Exhibit 1 ("Other Program Adjustments") of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section II.B. of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Minimum fee schedule for MLTSS	All rate cells	N/A – included in base data.	The minimum fee schedule is a long-standing arrangement which was in effect during the base data period.	Preapproval not required	N/A
Minimum fee schedule for Critical Access Mental Health	All rate cells	Please refer to Exhibit 1 ("Other Program Adjustments") of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section II.B. of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Rate increase for Outpatient Behavioral Health Services	All rate cells	Please refer to Exhibit 1 of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section II.B. of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Fuel Adjustor for Ambulance and NEMT	All rate cells	Please refer to Exhibit 1 of the CY 2024 rate certification for the	Implemented as a program adjustment in Exhibit 1.	Preapproval not required	N/A

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RESPONSES TO 2023 THROUGH 2024 MANAGED CARE RATE SETTING GUIDE

Table 2 State Directed Payments Rate Adjustment					
Control name of the state directed payment	**Rate cells affected**	**Impact**	**Description of the adjustment**	**Confirmation the rates are consistent with the preprint**	**For maximum fee schedules, provide the information requested**
Services		impact by rate cell.	Please refer to Section II.B. of the CY 2024 rate certification for additional information.		
Rate Increase for Adult Day Treatment	All rate cells	Please refer to Exhibit 1 (Impact for Program Adjustment) of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section II.B. of the CY 2024 rate certification for additional information.	Preapproval not required	N/A

E. Pass-Through Payments

Not applicable.

5. PROJECTED NON-BENEFIT COSTS

A. Rate Development Standards

i. Please refer to Section II.E for a description of the data and methodology used to develop the projected non-benefit costs included in the capitation rates.

ii. The non-benefit costs included in the CY 2024 capitation rates are developed as a projected PMPM load. The targeted margin is applied as a percentage of the total rate for each eligibility category. The administrative costs are developed as a blend of 30% fixed / 70% variable administrative costs when applied to the eligibility category. The final PMPM administrative load is reviewed for reasonableness compared to national benchmarks. Please see Section II.E for additional detail on how the administrative component is calculated.

B. Appropriate Documentation

i. Please refer to Section II.E for a description of the data and methodology used to develop the projected non-benefit costs included in the capitation rates.

ii. The administrative and targeted margin components of the non-benefit costs are separately identified in the report.

iii. Historical non-benefit cost information includes care coordination and administrative expenses for integrated products allocated to Medicare. These historical costs serve as the basis for the projected administrative load.

a. CY 2018 administrative expenses PMPM were $195.51 for MSHO and $148.64 for MSC+.

b. CY 2019 administrative expenses PMPM were $210.04 for MSHO and $157.81 for MSC+.

c. CY 2020 administrative expenses PMPM were $215.85for MSHO and $155.30 for MSC+.

APPENDIX I

RESPONSES TO 2023 THROUGH 2024 MANAGED CARE RATE SETTING GUIDE

6. RISK ADJUSTMENT

A. Rate Development Standards

Risk adjustment is used for the EW Add-on rates, and the process is described in Section III.E. The plan-specific rate sheets, provided separate from this report, will include the EW Add-on risk scores by plan based on health plan enrollment as of August 2023.

B. Appropriate Documentation

Risk adjustment is used for the EW Add-on rates, and the process is described in Section III.E. No significant updates were made to this methodology since the CY 2023 certification. The calculation of this adjustment is performed as part of this certification.

7. ACUITY ADJUSTMENTS

A. Rate Development Standards

i. There were no acuity adjustments made to the initial CY 2024 capitation rates. We expect to review capitation rates with DHS during the contract period should beneficiary redetermination timing, and associated average population acuity, be materially different than what is projected in this report.

B. Appropriate Documentation

i. There were no acuity adjustments made to the initial CY 2024 capitation rates.

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

This section addresses the various requirements related to the capitation rate development for the EW Add-on and NF Add-on. A description of each program follows:

ELDERLY WAIVER ADD-ON

DHS works to help seniors continue living in their homes and independently in the community for as long as possible. DHS develops policy and administers state and federal programs that provide home and community-based services, caregiver support, and alternative housing arrangements. The EW Add-on rates cover the costs of providing those services for those enrollees who qualify for them.

Section III of the rate report contains a full description of the rate development for the EW Add-on rates, including a description of the base data, trends, program adjustments, and final EW Add-on rate calculation.

NURSING FACILITY ADD-ON

The MSHO and MSC+ programs provide coverage for the first 180 days of care in a nursing facility for enrollees who enter a nursing facility after enrollment. The NF Add-on payment is made for MSHO and MSC+ enrollees who live in the community as a pre-payment for the costs that will be incurred once an enrollee is admitted to a nursing facility. Once admitted, the MCO no longer receives the NF Add-on payment for that enrollee and only receives the Basic Care portion of the rate.

Section IV of the rate report contains a full description of the rate development for the NF Add-on rates, including a description of the base data, trends, charge per day assumptions, program adjustments, and final NF Add-on rate calculation.

1. Managed Long-Term Services and Supports

A. For EW Add-on and NF Add-on, the guidance above in Section I regarding the required standards for rate development and CMS's expectations for appropriate documentation required in the rate certification is also applicable.

APPENDIX I

RESPONSES TO 2023 THROUGH 2024 MANAGED CARE RATE SETTING GUIDE

B. Rate Development Standards
   Please refer to Section III (Elderly Waiver Add-on) and Section IV (Nursing Facility Add-on) for a description of the rate setting approaches.

C. Appropriate Documentation

   i. Please refer to Section III (Elderly Waiver Add-on) and Section IV (Nursing Facility Add-on) for a description of the rate cells and rating categories used for each program.

   ii. Administrative costs associated with these programs are included by eligibility category as part of the Basic Care rate development. Please refer to Section II.E for details.

   iii. Please refer to Section III (Elderly Waiver Add-on) and Section IV (Nursing Facility Add-on) for a description of the data sources used to develop the assumptions used for rate setting.

SECTION III. NEW ADULT POPULATION CAPITATION RATES

This section does not apply to the MSHO and MSC+ programs.

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APPENDIX B

CY 2024 Capitation Rate Development for SNBC Report

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September 19, 2023

Jeff Provance
Health Actuary, Director
Minnesota Department of Human Services
540 Cedar Street
Elmer L. Anderson Human Services Building
St. Paul, MN 55155-3854
Sent via email: jeffrey.provance@state.mn.us

Re: Calendar Year 2024 Capitation Rate Development for SNBC

Dear Jeff:

The Department of Human Services (DHS) retained Milliman to develop actuarially sound rates for the Special Needs BasicCare (SNBC) program for the calendar year (CY) 2024 contract period. The attached report discusses the development of the actuarially sound CY 2024 capitation rates. The rates in this report are based on July 2021 to June 2022 (FY 2022) health plan financial summaries, emerging health plan experience, FY 2022 encounter data, provider contracting changes expected to impact CY 2024, trends projecting the experience to CY 2024, and adjustments for program changes passed through the 2023 legislative session.

We expect to review capitation rates during the contract period should beneficiary redetermination timing, and associated average population acuity, be materially different than what is projected in this report.

We look forward to discussing these results with you.

Sincerely,

Briana Botros, FSA, MAAA
Consulting Actuary

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

BB/MCC/zk

Attachments

MILLIMAN REPORT

Minnesota Department of Human Services

Special Needs BasicCare Rate Development For Calendar Year 2024

September 19, 2023

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

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I. EXECUTIVE SUMMARY

This report documents the development of the calendar year (CY) 2024 base rate for the Special Needs BasicCare (SNBC) program. The report assumes the reader is familiar with the basic aspects of the SNBC program, population groups consisting of people with disabilities to be covered under the program, the Minnesota Medicaid program, and managed care rating principles.

The SNBC program began in 2008 and provides coverage to adults with disabilities ages 18 to 64 who voluntarily choose to enroll. This program provides coverage for the following:

- Basic acute care services, such as emergency room, hospital, preventative care services, and behavioral health services
- Access to a care coordinator or navigator to help enrollees get health care and support services
- Home health services, including skilled nurse visit, home health aide and home care therapies
- 100 days of nursing facility coverage, through the SNBC Nursing Facility Add-On

Personal care assistance, home care nursing, and home and community-based waiver services are provided to SNBC enrollees on a fee-for-service (FFS) basis.

Seven health plans serve the SNBC population in Minnesota. Two of the plans are County Based Purchasing (CBP) plans, while an additional plan, Hennepin Health, is owned and operated by Hennepin County, but does not receive the “CBP” designation. These three plans are referred to as County Owned and Operated Plans, or “COO” plans. The rates provided in this report vary between CBP plans and non-CBP plans to account for CBP plans not being liable for the 1% premium tax and the 0.6% HMO surcharge. A portion of the includes SNBC enrollment is for plans operating as Fully integrated Dual Eligible Special Needs Plans (FIDE-SNP).

The 87 counties covered by managed care plans in Minnesota are grouped into three regions, which are defined in Appendix A. The assigned regions for each county have not changed from the CY 2023 rate development.

The SNBC rate development includes eight total rate groups, including the following information:

- Medicare coverage – Dual Eligible, Non-Dual Eligible
- Rate cell – Institutional, Community
- Region (Community only) – Metro, Non-Metro North, Non-Metro South

This report contains a description of the information used to develop the CY 2024 SNBC base rates, including the Nursing Facility Add-On, which will be used to determine the CY 2024 BasicCare capitation payments. The 2024 SNBC capitation rates were developed from fiscal year (FY) 2022 (July 2021 through June 2022) health plan experience. The BasicCare capitation rates are risk adjusted and include a withhold arrangement.

Consistent with CMS guidance, the rates are certified net of the portion of the withhold arrangement ultimately at risk, amounting to 0.25% of payments. This is the withhold return that is reasonably achievable. The rates net of the withhold at risk are shown in Exhibit 2. Since the plan contract includes “loss limit” and payment timing provisions regarding the 8.0% nominal withhold, ultimately only 0.25% of payments are at risk. Based on historical withhold returns, we expect plans to receive 7.75% of the 8.0% nominal withhold. Please see “Section V, G - Withhold” below for additional discussion of the withhold.

A. RATE CHANGES FROM CY 2023 TO CY 2024

Overall, the aggregate CY 2024 SNBC rates reflect an approximate 3.7% aggregate per member per month (PMPM) increase over the corresponding CY 2023 SNBC rates using the FY 2022 membership distribution across rate groups. The CY 2023 rates were presented in our report dated September 20, 2022. The rate change drivers are multiplicative factors, with the aggregate result calculated as the product of “one plus” each change driver. Table 1 below documents the primary drivers of this rate change. This rate change reflects Community Metro rates

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration, and other factors. This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the SNBC program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

increasing 4.6% in aggregate; Community Non-Metro rates increasing 2.2% in aggregate; and Institutional rates increasing 4.9% in aggregate. The differences in rate changes by rate group is primarily driven by differences in the base data used in each year's rate development, composite service cost trends that differ due to the mix of services, and the regional impact of program adjustments and directed payment arrangements.

Due to risk adjustment and varying population mixes, the rate change will vary for each plan.

Table 1
Minnesota Department of Human Services
Calendar Year 2024 Special Needs BasicCare Rate Development
Special Needs BasicCare Rate Change Drivers

Component	Rate Change
Differences in Actual vs. Projected FY 2022 Costs	-0.1%
Differences in Trend Assumptions from FY 2022 to CY 2023	+1.5%
Differences in Acuity Adjustment from FY 2022 to CY 2023	-0.4%
Acuity Adjustment from CY 2023 to CY 2024	+0.7%
Non-Pharmacy Trend from CY 2023 to CY 2024	+1.5%
Pharmacy Trend from CY 2023 to CY 2024	+0.9%
Differences in Program Change Adjustments	+0.6%
Difference due to NF Add-On Rate	-0.2%
Differences in Administrative Cost Load	-1.0%
Total excluding Directed Payment for a Safety Net Hospital in Hennepin County	**+3.6%**
Differences in Directed Payment for Safety Net Hospital in Hennepin County[1]	+0.1%
Total excluding Directed Payment for a Safety Net Hospital in Hennepin County	**+3.7%**

[1]The Directed Payment for a Safety Net Hospital in Hennepin County rate change is shown in aggregate across CBP and non-CBP plans; however, the rate adjustment only applies to non-CBP plans.

B. PROJECTED CY 2024 CAPITATION RATE COMPONENT BREAKDOWN

Table 2 summarizes the components of the CY 2024 SNBC capitation rate for non-CBP plans. This summary includes the NF Add-On and is net of the withhold at risk of 0.25%, applied only to BasicCare.

Table 2
Minnesota Department of Human Services
Calendar Year 2024 Special Needs BasicCare Rate Development
Projected Non CBP CY 2024 Components (as a % of Revenue) for Non CBP Plans[1]

Component	Total
Claims[2]	90.46%
Administration and Case Management	6.78%
Margin[3]	1.15%
Premium Tax and HMO Surcharge	1.60%
Total	**100.00%**

[1] Includes NF Add-On.
[2] Includes Directed Payment for a Safety Net Hospital in Hennepin County.
[3] Margin is net of the withhold at risk of 0.25%.

C. NOTES ON ACTUARIAL CERTIFICATION AND SUPPORTING DOCUMENTATION

Our role is to certify that the CY 2024 capitation rates produced by the rating methodology are actuarially sound to comply with Centers for Medicare and Medicaid Services (CMS) regulations. We developed actuarially sound capitation rates using published guidance from the American Academy of Actuaries (AAA), CMS, and federal regulations to ensure compliance with generally accepted actuarial practices and regulatory requirements. Specific Actuarial Standards of Practice (ASOPs) we considered include:

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration, and other factors. This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the SNBC program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

- *ASOP No. 1 – Introductory Actuarial Standard of Practice*
- *ASOP No. 5 – Incurred Health and Disability Claims*
- *ASOP No. 12 – Risk Classification*
- *ASOP No. 23 – Data Quality*
- *ASOP No. 25 – Credibility Procedures*
- *ASOP No. 41 – Actuarial Communications*
- *ASOP No. 42 – Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims*
- *ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies*
- *ASOP No. 49 – Medicaid Managed Care Capitation Rate Development and Certification*
- *ASOP No. 56 – Modeling*
- Other applicable standards of practice

The actuarial certification, CMS Rate Setting Checklist, and responses to the 2023-2024 CMS Rate Setting Guide are included as Appendices H through J.

D. COVID-19 CONSIDERATIONS IN CY 2024 RATE DEVELOPMENT

The COVID-19 pandemic and public health emergency (PHE) have impacted health care costs significantly since March 2020. The impact of the COVID-19 pandemic and PHE on CY 2024 capitation rates is difficult to predict due to the evolving nature of the pandemic. To develop our best estimates of future costs, we considered a wide array of potential impacts based on information from publicly available sources, internal Milliman research, and MCO feedback.

DHS and Milliman performed a substantial review of the CY 2018 to CY 2022 overall experience and determined no explicit adjustment was necessary to project 2024 cost beyond existing trend assumptions and an adjustment for the difference between base period and CY 2022 COVID-19 costs and other seasonal viruses described in Section II.A.

Medicaid enrollment is projected to decrease starting July 2023 and running through June 2024 as member eligibility determinations restart. This change in enrollment is anticipated to impact the average acuity of beneficiaries. We include acuity adjustments in this rate development. This report includes an assumption related to the magnitude of the membership decrease. **We expect to review capitation rates with DHS during the contract period should beneficiary redetermination timing, and associated average population acuity, be materially different than what is projected in this report.**

E. CAVEATS AND LIMITATIONS

This report is intended for use by DHS to execute and have approved a contract to provide most basic care State plan services to people covered by the SNBC program in CY 2024. The information contained in this report may not be suitable for other purposes or audiences. Milliman does not intend to benefit any third party and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety and in conjunction with the contract.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate CY 2024 capitation rates for the SNBC program. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. In preparing this analysis, we relied on data and information supplied to us by DHS and the SNBC health plans in the development of these rates. While we did review the information for reasonableness, we did not audit or attempt any independent verification of such data. If this data is incomplete or inaccurate, then our conclusions will be incomplete or inaccurate.

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

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

II. FISCAL YEAR 2022 BASE EXPERIENCE

A. OVERVIEW

The July 2021 to June 2022 (FY 2022) base period experience uses the following two data sources provided by participating health plans:

- Encounter data for FY 2022 dates of service with claim runout through September 30, 2022. MCO-submitted encounter data is used to determine the composite base period service cost amounts for most services.
- Financial summaries containing claim costs associated with FY 2022 dates of service and claim runout through September 30, 2022.
- Financial data is used to determine the demographic distribution of service costs and includes some service costs not reported in the encounter data.

We utilize FY 2022 base period experience for Minnesota public programs rate development to allow for adequate time for data review and individual health plan contracting meetings ahead of expected submission to CMS for review in the fall of 2023. Based on a comparison of CY 2022 and FY 2022 service costs as reported by the health plans in the financial summaries, we did not see material differences between time periods outside of expected service cost trends applied later in rate development and the COVID-19 costs and other seasonal viruses described below. Therefore, we applied a base data adjustment to adjust for emerging CY 2022 experience for the costs associated with COVID-19, influenza, and RSV between FY 2022 and CY 2022 for Non-Duals, as well as base data adjustments for AMP rebate cap removal and weight loss drugs. Please see Appendix D and Section IV for additional discussions of trends used to project FY 2022 service costs to projected CY 2024 levels.

The FY 2022 base period experience used in the CY 2024 rate development was developed as follows:

- We summarized FY 2022 financial data by rate group and service category, net of pharmacy rebates. This includes an adjustment for incurred but not paid (IBNP) amounts based on health-plan reported information in the financial summaries. Additionally, we moved expenses for non-benefit activities reported in the health plan service cost data to administrative costs and adjusted base data amounts to account for payments made outside the claims system for BasicCare services, and also allocated some amounts to non-BasicCare service categories by MCOs based on financial data submissions.
- We applied an overall program-level adjustment to the FY 2022 financial data to reflect differences in health plan costs reported in the financial data and health plan costs reported in the encounter data. We rely heavily on the health plan-provided information in Schedule XX of the financial summaries to determine the magnitude of this adjustment.
- We applied an adjustment to remove the estimated impact of the gross savings and provider settlements resulting from the Integrated Health Partnerships (IHP) program.
- We applied an adjustment to remove the claims and days associated with the Institution for Mental Diseases (IMD) stays.
- We reviewed the PMPM costs associated with COVID-19, influenza, and RSV between FY 2022 and CY 2022 and an explicit adjustment to reflect the emerging CY 2022 information was necessary for Non-Duals. Such virus-related costs were especially high in the second half of 2021, which we have not seen historically and do not expect to continue in 2024.
- We reduced the base period experience by the decrease in COVID-19 PMPM amounts between FY 2022 and CY 2022 PMPM amounts, which is then partially offset by the increase in influenza and RSV costs experienced for the same time frame. The estimated CY 2024 impact for this adjustment is a decrease of $3.7M for the SNBC population The overall cost adjustment is 0.9958 for SNBC as shown in Exhibits 1-1 through 1-9.

- Due to the removal of the Average Manufacturer's Price (AMP) rebate cap through the American Rescue Plan Act (ARPA), effective January 1, 2024, manufacturers can be required to pay rebates that exceed the sale price for a given drug. The current AMP rebate cap limits the amount manufacturers are required to pay state Medicaid programs when drug prices outpace inflation.

  Several manufacturers have responded by decreasing prices on insulin products, with potentially more to follow suit on insulin and non-insulin products in the coming months. We applied an adjustment to account for the known price changes to insulin products. We reviewed the total FY 2022 spend for insulin products for each of these manufacturers by program and rate cell and applied the price decrease to adjust our starting base period experience for Non-Duals. The estimated CY 2024 impact for this adjustment is expected to be a decrease of $8.6M for the SNBC population. The overall cost adjustment is 0.9903 for SNBC as shown in Exhibits 1-1 through 1-9.

  We will review future significant preferred drug list (PDL) and pharmacy price changes driven by the AMP rebate cap removal throughout the remainder of 2023 and 2024 to determine whether additional rate adjustments are warranted.

- We reviewed the PMPM costs associated with weight loss drugs (i.e., GLP-1 products) between FY 2022 and H1 2023 which indicated an explicit adjustment to reflect the emerging experience was necessary for Non-Duals for Wegovy, Ozempic, and Mounjaro. Such weight loss drugs costs continued to increase significantly on a monthly basis through H1 2023. We trend the $11.80 May 2023 PMPM amount to $17.91 PMPM in CY 2024 expecting that the monthly percentage increases during H1 2023 will slow down throughout the remainder of 2023 and 2024.

  To incorporate the projected costs, we increased the base period experience ($2.30 PMPM) by the increase in weight loss drugs PMPM amounts between FY 2022 and the projected PMPM amounts. The estimated CY 2024 impact for this adjustment is an increase of $4.5M for the SNBC population The overall cost adjustment is 1.0049 for SNBC as shown in Exhibits 1-1 through 1-9.

  We will review future significant experience changes in weight loss drugs throughout the remainder of 2023 and 2024 to determine whether additional rate adjustments are warranted.

We describe the financial data and financial-encounter adjustment factor in more detail in Sections II.B and II.C, respectively. We provide details regarding the IHP and IMD adjustments as part of the program changes in Section III.

The final FY 2022 base data is shown in the "FY22 Experience PMPM" column of Exhibits 1-1 through 1-8. SNBC has eight rate groups that are combinations of:

- **Medicare Coverage:** Medicaid only or Medicaid and Medicare (Dual eligible). Dual eligible enrollees must be enrolled in both Parts A and B of Medicare.

- **Institutional Status:** Population categories of Institutionalized (NF / ICF) or Community (all other population categories). There are separate institutional base rates for Dual eligible enrollees and non-Dual-eligible enrollees, but those two base rates are not further separated by county of residence.

- **County of Residence:** For the Community population only, we further split rates by the Metro, Non-Metro North, and Non-Metro South regions. Appendix A contains the county definitions for each rate region.

Exhibit 1-9 contains the statewide aggregate FY 2022 PMPM health plan experience by service category across all eight rate groups. Overall, financial base period experience increased 3.3% from the FY 2021 experience used in CY 2023 rate development, including the impact of demographic and program changes.

Note the following related to the base period experience:

- The FY 2022 base period experience is net of non-state plan services.

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- The data used in rate setting excludes retrospective member Medicaid eligibility, since the effective date of enrollment in managed care is always after the date when the enrollment data is entered on DHS's Medicaid Management Information System. Therefore, no separate adjustment to rate development is needed for this issue.

- The base data is net of any claim recoveries and other third-party liability identified by the health plans. When recoveries are attributable to individual encounters, those encounters are generally adjusted and resubmitted to DHS. Otherwise, recoveries are allocated to the proper populations and categories of services in the health plan financial reporting and included in rate development to supplement to the encounter data.

B. FY 2022 FINANCIAL EXPERIENCE

The financial information reflects the health plans' best estimates of ultimate incurred claim costs for SNBC services provided in FY 2022. This data was provided at the rate group and service category level and includes three months of runout. It includes sub-capitated and FFS payments made by health plans, as well as settlement allocations and IBNP amounts. IBNP amounts reported by health plans were 2.1% of overall submitted FFS claims, consistent with prior years. We relied on this data as given, and performed reasonableness tests where possible, including the following:

- We reviewed comparisons included as part of the financial reporting template demonstrating internal consistency of certain reported data elements.

- We reviewed health plan-reported IBNP estimates.

- We compared the July 2021 through December 2021 experience reported with the FY 2022 financial summaries to the same July 2021 through December 2021 experience reported in the prior CY 2021 financial summaries.

- We compared the July 2021 through December 2021 experience to the January 2022 through June 2022 experience.

- We worked collaboratively with the health plans to address data anomalies we encountered during our review.

- Plans provided CY 2022 financial data, split by half year. We reviewed the plan reconciliations of the CY 2022 financial data to the CY 2022 NAIC annual statement.

Plans identified costs for substituted in lieu of services (ILOS) separately. The expectation is any historical costs for ILOS will be applicable to similar covered services in the CY 2024 projection period. The ILOS in the base period that are not expected to continue in the CY 2024 projected period were cost effective relative to the services they replaced, but were of immaterial size, so we did not adjust rates for their anticipated termination. The overall CY 2024 ILOS cost percentage in the SNBC program is projected to be less than 0.1% of total capitation payments (including directed payments); therefore, we made no further adjustment to validate cost-effectiveness beyond the plan contractual requirement. Furthermore, the expectation is any historical costs for in lieu of services, except for Institution for Mental Diseases (IMD) services, which are discussed later in this report, will be applicable to similar covered services in the CY 2024 projection period.

The FY 2022 financial experience includes reductions for pharmacy manufacturer rebates reported by the health plans.

The claim payment amounts in the FY 2022 financial summary data, as reported by the plans, reflect the estimated impact of the gross savings and provider settlements resulting from the IHP program.

Three of the current health plans have sub-capitated arrangements in the SNBC program. In total, sub-capitated services represent about 0.1% of program non-subcapitated service costs in the FY 2022 base period data. We reviewed the description of the sub-capitated arrangement to determine if the arrangement is for covered services, since those arrangements are reported separately on the health plans' financial template submissions.

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C. FY 2022 ENCOUNTER DATA

Encounter data is submitted by the MCOs to the State through the State's MMIS system. This data is intended to be used as the base period experience used in rate setting. However, there are certain difficulties that preclude Milliman from using the encounter data directly, the most material issue being that encounter claims for members enrolled in the integrated Medicare-Medicaid product includes both Medicare and Medicaid liability. For this reason, we state our base data using the financial data described above and scale the aggregate financial data to amounts in the encounter data, including adjustments for removal of aggregate Medicare liability and other adjustments outlined below.

The FY 2022 encounter data is also used to develop member-level risk scores and certain program change adjustments as described later in this report.

We reviewed the FY 2022 encounter data and financial data using the Schedule XX reconciliations provided by health plans in the financial summary template and the DHS Control Detail Report encounter summaries to determine the extent to which the encounter data could be used in the rate development. We initially reviewed the explanations provided in Schedule XX and interpreted each as either an adjustment to financial or encounter data. DHS reviewed Schedule XX and our interpretation of the health plans' explanations and worked together with health plans to determine the appropriateness of the adjustments.

As a result of the Schedule XX analyses, several adjustments were made to MCO-submitted encounter data. The following table shows the impact of the material individual adjustments we made to the encounter data for FY 2022 (Table 3) in order to more accurately quantify actual MCO experience.

Table 3
Minnesota Department of Human Services
Calendar Year 2024 Special Needs BasicCare Rate Development
Special Needs BasicCare Services
Encounter Data Adjustments FY 2022

Adjustment to Encounter Data[1]	% Impact
Valid encounter claims not accepted by MMIS - Denial Code D300 (Pay-To provider ID not on DHS' provider file)	0.2%
Valid encounter claims not accepted by MMIS - Denial Code D412 (Treating provider ID not on DHS' provider file)	0.2%
Claims not yet submitted or reprocessed after warrant date	1.6%
Non State plan services in encounter records	-0.6%
All other adjustments	0.0%
Total[2]	**1.4%**

[1] Only adjustments resulting in an absolute impact greater than +/- 0.1% are shown. Adjustments with less than or equal to +/- 0.1% impacts are grouped in 'All Other Adjustments.'
[2] Starting dollars exclude Medicare Liability for integrated products.

Additionally, we applied a 0.1% decrease to the starting encounter data for SNBC to account for the difference between the Milliman and the DHS Control Detail Report encounter data summaries.

After accounting for all appropriate adjustments included in Schedule XX (excluding Medicare liability and including adjustments to financial data to improve the appropriateness of the comparison), the adjusted encounter data is on average 0.1% higher than the adjusted financial data for SNBC. Therefore, we feel comfortable significant reliance on the encounter data in rate development.

We calculate a scaling factor, shown in Exhibit 1, as the ratio of FY 2022 adjusted PMPM encounter data costs to the FY 2022 PMPM financial costs, limited to exclude expenses reported outside the claims system. The final factor is dampened because we only apply the adjustment to FFS and sub-capitated financial costs, consistent with those costs reconciled as part of the Schedule XX analysis. Table 4 below details the development of the adjustment factor shown in Exhibit 1.

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Table 4 Minnesota Department of Human Services Calendar Year 2024 Special Needs BasicCare Rate Development Special Needs BasicCare Services Financial to Encounter Scaling Factor	
[A] FY 2022 Financial Data PMPM – Unadjusted[1]	$995.12
[B] FY 2022 Encounter Data PMPM – Unadjusted	$979.55
[C] FY 2022 Encounter Data Adjustment Factor	1.0139
[D] FY 2022 Encounter Data PMPM – Adjusted ([B] x [C])	$993.16
[E] Financial-to-Encounter Scaling Factor – Preliminary ([D] / [A])	**0.9980**
[F] FFS / Sub-capitation Dampening Factor	0.9466
[G] Financial-to-Encounter Scaling Factor – Final (1 – (1 – [E]) x [F])	**0.9981**

[1] Includes experience related to BasicCare and NF Add-On.

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III. PROGRAM CHANGES

This section describes the program change adjustments applied to the FY 2022 base period experience to adjust to the CY 2024 projection period. Exhibits 1-1 through 1-9 illustrate the adjustments applied by service category for each change described below. For program changes which also affected the CY 2023 rate development, we modified our previous analyses using FY 2022 encounter data, plan data submissions, and / or DHS legislative fiscal notes to apply the adjustments for changes between FY 2022 and CY 2024. We discuss our approach in the listing below.

A. PROGRAM CHANGES WITH SPECIFIC ADJUSTMENTS

Consideration for Integrated Health Partnership Arrangements

Minnesota has implemented accountable care organizations (ACO), through IHPs, which include Non-Dual members attributed from the FFS and managed care delivery systems. Therefore, participating SNBC health plans share savings realized with the ACOs for attributed members under managed care when service costs are lower than prospective targets. The CY 2024 rate development includes projection factors effectively 1) removing IHP settlements from the FY 2022 base experience and 2) adding projections of IHP payments for IHPs whose savings are reflected in the base period and whose targets are not rebased for the CY 2024 contract period for each target "base year." Other projected IHP payments during the contract period represent situations where we expect plans to realize total net savings equal in magnitude to the IHP payments. To incorporate the incremental differences, we applied an adjustment of 0.9988 to SNBC Non-Dual rate cells, and we show a column with the adjustments applied to the FY 22 Blended Experience PMPM by service category in Exhibits 1-1 through 1-9. Please refer to Appendix B for quantification of the aggregate impact of this adjustment.

Treatment of Institution for Mental Diseases (IMD) Costs

Federal Medicaid regulation requires rate development to include special treatment for costs associated with stays in an IMD for individuals between ages 21 and 64. When developing the rates, the following steps were taken to comply with the regulation for IMD stays of more than 15 days during a calendar month:

- All claims and enrollment days associated with the IMD stays were removed
- All other remaining costs and enrollment days (non-IMD) in the month were not removed

For all other IMD stays (15 days and less during a calendar month), we repriced IMD costs at the average cost per day of an equivalent inpatient hospital psychiatric stay. Based on an FFS provider reimbursement analysis provided by DHS, the average per diem cost of an equivalent inpatient hospital psychiatric stay is estimated to be $1,267.25.

As a result of the Substance Use Disorder (SUD) 1115 Demonstration Waiver, the state is anticipated to be eligible to receive federal funding for 65% of SUD-related IMD stays in CY 2024. Furthermore, based on discussions with DHS, we assumed that 90% of IMD stays are SUD-related. Therefore, we reduced the number of member months and claims that we were previously excluding through the IMD adjustment by approximately 59% (65% * 90%).

The overall inpatient cost adjustment is 0.9974 for SNBC. The overall non-inpatient cost adjustment is 0.9995. Appendix C details these adjustments, and we show a column with the adjustments applied to the FY 2022 Blended Experience PMPM by service category in Exhibits 1-1 through 1-9.

Certified Community Behavioral Health Clinic (CCBHC)

Effective September 1, 2019, managed care plans were required to make prospective payment rates to each CCBHC. Effective January 1, 2023, six demonstration CCBHCs transitioned over to state plan authority and the managed care plans began paying the prospective payment rate using the state plan payment policy, however, the six demonstration clinics will be transitioning back to federal demonstration authority on July 1, 2023. There were no other changes in CCBHC demonstration enrollment status since FY 2022; therefore, we do not include an adjustment to the base data for CY 2024.

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Dental Reimbursement and Critical Access Dental (CAD) Providers

Effective January 1, 2022, per Laws 2021, Special Session 1, Chapter 7, Article 1, Sections 22, 23, 28 and 29, the Minnesota legislature increased FFS dental payment increased dental payment rates by 98%, removed the community clinic dental Add-On, and required health plans and CBPs to reimburse dental providers at least equal to FFS rates. Furthermore, an additional 20% rate increase was applied to CAD providers.

To incorporate these payment increases into the rate process, we used the 2H 2021 encounter dental claims and repriced them to the 1H 2022 encounter data, which is reflective of the FFS dental reimbursement fee schedule and an additional 20% rate increase for all dental claims associated with a CAD provider.

Additionally, the State has established a performance benchmark for at least 55% of children and adults who were continuously enrolled for at least 11 months to receive at least one dental visit during the calendar year. Prior to the implementation of the performance benchmark, approximately 47% of members met this qualification. Therefore, we project an increase in the average dental utilization rate over the next three years of approximately 17%. We apply 2.5 years of this trend to CY 2024 (half of the base data already reflects increased reimbursement), resulting in an increase of roughly 14% to projected dental costs because of the expected increase in utilization.

The estimated CY 2024 state and federal budget impact for this legislative item is expected to be $4.1M million for the SNBC population. The resulting overall PMPM increase applied to BasicCare Dental costs and varying by rate group are included in the projection of CY 2024 costs for each rate group and in composite in Exhibits 1-1 through 1-9.

Rate Increase for Home Care Services and EIDBI

Effective January 1, 2024, per Laws 2023, Chapter 61, Article 1, Sections 68 and 72, the Minnesota legislature enacts a 14.99% rate increase for home health agencies and 14.99% rate increase for Early Intensive Developmental and Behavioral Intervention (EIDBI) services.

The fiscal note provided by DHS estimates the FY 2024 and FY 2025 home health and EIDBI spend for managed care. As EIDBI services primarily applies to children age two to age six, this legislative item will have limited impact on the SNBC program. Based on the fiscal note information provided by DHS, the estimated CY 2024 state and federal budget impact is expected to be $2.2M for SNBC. The resulting overall PMPM increases varying by rate group are included in the projection of CY 2024 costs for each rate group and in composite in Exhibits 1-1 through 1-9

Expansion of MA Adult Dental Benefits

Effective January 1, 2024, per Laws 2023, Chapter 70, Article 1, Section 11, the Minnesota legislature restores the comprehensive dental benefit for the adult population. The fiscal note provided by DHS assumes a 36.50% increase in dental costs for FY 2024 and FY 2025 due to this program change and a one-month delay in implementation.

Based on the fiscal note information provided by DHS, the estimated CY 2024 state and federal budget impact for the expansion of MA adult dental benefits is expected to be $5.1M for SNBC. The resulting overall PMPM increases varying by rate group are included in the projection of CY 2024 costs for each rate group and in composite in Exhibits 1-1 through 1-9.

Rate increase for Outpatient Behavioral Health Services

Effective January 1, 2024, per Laws 2023, Chapter 70, Article 1, Section 35, the Minnesota legislature enacts a 3.0% rate increase for certain behavioral health services, with additional subsequent rate increases on an annual basis. The fiscal note provided by DHS assumes the rate increase will be applicable to approximately 8% of total managed care costs.

Based on the fiscal note information provided by DHS, the estimated CY 2024 state and federal budget impact for the 3% rate increase for outpatient behavioral health services is expected to be $2.5M for SNBC. The resulting overall PMPM increases varying by rate group are included in the projection of CY 2024 costs for each rate group and in composite in Exhibits 1-1 through 1-9.

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Elimination of MA Cost-Sharing

Effective January 1, 2024, per Laws 2023, Chapter 70, Article 16, Section 12, the Minnesota legislature eliminates cost-sharing for all covered services. The fiscal note provided by DHS assumes cost sharing accounts for 0.21% of MA payments for the elderly and disabled populations.

Based on the fiscal note information provided by DHS, the estimated CY 2024 state and federal budget impact is expected to be $2.1M for SNBC. The resulting overall PMPM increases varying by rate group are included in the projection of CY 2024 costs for each rate group and in composite in Exhibits 1-1 through 1-9.

B. PROGRAM CHANGES WITH AGGREGATE ADJUSTMENTS

Several items proposed as part of the 2019 through 2023 Minnesota Legislative session are individually expected to have either no or minimal impact on managed care costs. For the program changes listed below, we reviewed the expected financial impact of all items in aggregate based on discussions with DHS, reviews of financial notes, and our understanding of the legislative items. We determined that the aggregate change for all items combined results in a $7.65 PMPM, or 0.59%, rate increase for the SNBC program. We included these combined changes as a PMPM adjustment to all service categories in Exhibits 1-1 through 1-9, since we do not apply the adjustment at a service category level.

1. **Nonsurgical Treatment for Periodontal Disease**: Per Laws 2021, Special Session 1, Chapter 7, Article 1, Section 7 and effective January 1, 2022, the Minnesota legislature expanded Medical Assistance (MA) coverage of dental services for adults to include coverage of nonsurgical treatment for periodontal disease in an office setting, including scaling and root planning once every two years for each quadrant and routine periodontal maintenance procedures.

2. **Co-Payment Limits for Brand Name Drugs**: Per Laws 2021, Special Session 1, Chapter 1, Article 1, Section 17 and effective January 1, 2022, the Minnesota legislature set the copayment at $1 per prescription for brand name multisource drugs listed on the preferred drug list.

3. **Crisis Stabilization Services Per Diem**: Per Laws 2021, Special Session 1, Chapter 7, Article 11, Section 16 and effective January 1, 2022, the Minnesota legislature requires the commissioner to establish a statewide per diem rate for residential crisis stabilization services provided to MA enrollees for settings that serve no more than four adult residents. The legislation outlines rate and payment requirements and requires providers to submit annual cost reports to inform the commissioner's annual recalculation of the statewide per diem rate.

4. **Youth Assertive Community Treatment (Youth ACT) / Intensive Rehabilitative Mental Health Services (IRMHS)**: Youth Assertive Community Treatment (Youth ACT) / Intensive Rehabilitative Mental Health Services (IRMHS) is an intensive, comprehensive, and non-residential rehabilitative mental health service. Services are delivered using a multidisciplinary team approach and are available 24 hours a day, 7 days per week. Youth ACT / IRMHS teams work intensively with youth with severe mental health or co-occurring mental health and substance use issues to assist them with remaining in their community while reducing the need for residential or inpatient placements. Per Laws 2021, Special Session 1, Chapter 7, Article 11, Sections 29, 30, and 31 and effective January 1, 2022, the Minnesota legislature expands the population eligible from ages 16 to 20, to ages 8 to 25.

5. **90 Day Prescription Refills:** Per Laws 2021, Chapter 7, Article 1, Sections 8 and 11 and effective January 1, 2022, the Minnesota legislature allows a 90-day supply of a prescription drug to be dispensed under MA, if the drug appears on the 90-day supply list published by the commissioner and requires the list to be published on the DHS website.

6. **SUD Rate Enhancement (**Substance Use Disorder 1115 Demonstration Waiver): Per Laws 2021, Special Session 1, Chapter 7, Article 11, Sections 18 through 23 and effective January 1, 2022, the Minnesota legislature provides rate increases for Substance Use Disorder (SUD) providers from 15% to 25% for residential providers and from 10% to 20% for non-residential providers. To receive a rate increase, participating providers must meet demonstration project requirements and provide evidence of formal referral arrangements with providers delivering step-up or step-down levels of care.

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7. **Home Health Services Inflationary Adjustments**: Per Laws 2021, Special Session 1, Chapter 7, Article 13, Section 11 and effective January 1, 2022, the Minnesota legislature provides an annual inflation adjustment to the medical assistance service rates for home health agency services, including skilled nursing, respiratory therapy, speech therapy, occupational therapy, physical therapy, and home health aide. The rates are increased 2.60% in FY 2023, 2.79% in FY 2024, and 2.96% in FY 2025.

8. **Home Health 5% Rate Increase**: Per Laws 2021, Special Session 1, Chapter 7, Article 13, Section 74 and effective January 1, 2022, the Minnesota legislature provides a 5% rate increase for certain home care services, including home health services, home care nursing services, and respiratory therapy.

9. **Culturally Specific or Responsive; Disability Responsive Program; Provider Rate**: Per Laws 2021, Special Session 1, Chapter 7, Article 11, Sections 9-12 and effective January 1, 2022, the Minnesota legislature modified the definition of "culturally specific programs," expanding it to include "culturally responsive programs" and adding a "disability responsive program" definition. Additionally, the legislature removed higher rates for certain Substance Use Disorder (SUD) treatment services and implemented a 5% rate increase for SUD treatment services provided by culturally specific programs, culturally responsive programs, or disability responsive programs.

10. **Critical Access Mental Health Minimum Fee Schedule**: Effective January 1, 2023, per Laws 2022, Chapter 99, Article 1, Section 24, health plans will be required to reimburse providers of critical access mental health services at rates at least as great as the FFS rates. The estimated CY 2024 impact for this legislative item is expected to be $1.2 million for the SNBC population.

11. **Separate Reimbursement for Long-Acting Reversible Contraceptives (LARCs)**: Per Laws 2023, Chapter 70, Article 1, Section 7 and effective January 1, 2024, the Minnesota legislature requires reimbursement of LARCs outside of the DRG when placed immediately postpartum.

12. **NEMT Rate Increase:** Effective January 1, 2024, per Laws 2023, Chapter 61, Article 3, Sections 5 and 8, the Minnesota legislature increased the base and mileage rates for NEMT services by 11.06%. Additionally, the commissioner will be required to adjust the rate paid per mile when the price of gasoline exceeds $3.00 per gallon, which will be evaluated on the first day of each quarter.

13. **Fuel Adjustor for NEMT and Ambulance Services:** Effective January 1, 2024, per Laws 2023, Chapter 61, Article 3, Section 6, the commissioner will be required to adjust the rate paid per mile for NEMT and ambulance services when the price of gasoline exceeds $3.00 per gallon, which will be evaluated on the first day of each quarter.

14. **Inflationary Adjustment for Intensive Residential Treatment Services (IRTS), Residential Crisis Stabilization (RCS), Assertive Community Treatment (ACT), and Psychiatric Residential Treatment Facilities (PRTF):** Per Laws 2023, Chapter 70, Article 1, Sections 10, 28, 29 and effective January 1, 2024, the Minnesota legislature requires an annual inflationary adjustment to reimbursement rates for IRTS, RCS, ACT, and PRTF services. The inflationary adjustment will be applied on January 1 of each year using the CMS Medicare Economic Index (MEI) for IRTS, RCS, and ACT services, and the CMS Inpatient Psychiatric Facility Market Basket for PRTF services.

15. **MA Coverage of Seizure Detection Devices**: Per Laws 2023, Chapter 70, Article 1, Section 21 and effective January 1, 2024, the Minnesota legislature add seizure detection devices as a covered service under Medical Assistance and establishes a payment rate.

16. **MA Coverage of Tobacco**: Per Laws 2023, Chapter 70, Article 1, Section 23 and effective January 1, 2024, the Minnesota legislature allows for competitive bidding for Quitline services and establishes coverage of all USDA approved prescription and over-the-counter tobacco and nicotine cessation drugs. Prior authorization on these drugs would be prohibited.

17. **MA Coverage of Recuperative Care Services**: Per Laws 2023, Chapter 70, Article 1, Section 25 and effective January 1, 2024, the Minnesota legislature adds recuperative care after an inpatient visit as a covered services under Medical Assistance for enrollees age 21 and over.

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18. **Rate Increase for Family Planning Services**: Per Laws 2023, Chapter 70, Article 1, Section 37 and effective January 1, 2024, the Minnesota legislature increases payment rates for family planning and abortion services by 20%. This rate increase is not applicable to FQHCs, RHCs, or Individualized home supports (IHS).

19. **No-Cost Diagnostic Treatment for Services after a Mammogram**: Per Laws 2023, Chapter 70, Article 1, Section 39 and effective January 1, 2024, the Minnesota legislature eliminates cost sharing obligations for diagnostics and testing following a mammogram under Medical Assistance.

20. **Transition Costs for HSS Enrollees**: Per Laws 2023, Chapter 70, Article 11, Section 2 and effective January 1, 2024, the Minnesota legislature indefinitely extends payments for additional transitional services for individuals eligible for Housing Stabilization Services (HSS) who are also not on an HCBS waiver.

21. **Rate increase for Adult Day Treatment**: Per Laws 2023, Chapter 70, Article 9, Section 40 and effective January 1, 2024, the Minnesota legislature enacts a 50% rate increase for adult day treatment (ADT) services.

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IV. PROJECTING FY 2022 EXPERIENCE TO CY 2024 – MEDICAL AND PHARMACY TRENDS

This section describes the trends applied to the FY 2022 base data to project the experience to CY 2024. Appendix E contains the service category specific annualized utilization, unit cost, and PMPM cost trend assumptions used in the 2024 rate development.

- The composite FY 2022 to CY 2024 aggregate non-pharmacy PMPM annual trend is 3.3%. This varies between 2.8% and 3.7% among the various rate groups based on the distribution of service costs, as illustrated in Exhibits 1-1 through 1-9. Appendix E illustrates the average annual trend applied to FY 2022 experience to project CY 2024 service costs.

- The composite FY 2022 to CY 2024 aggregate pharmacy PMPM annual trend is 5.8%.

These trends are reflective of recent SNBC aggregate medical and pharmacy PMPM experience trends.

A. DATA SOURCES

At a high level, we develop best estimate trend values to project the FY 2022 base claim cost to CY 2024 and applied them at the service category level. We considered several data sources in the development of trends, such as:

- CY 2017 to CY 2019 and CY 2021 to CY 2022 aggregate BasicCare non-pharmacy experience, normalized for changes in program adjustments, provider contracting, and rate group mix (shown in Appendix D). Please note, program adjustment and rate group mix normalization are generally performed in aggregate, so results at the category of service level should be viewed with caution. Appendix D also includes experience trends for CY 2019 through CY 2021 for illustration purposes. This trend demonstrates the significant impact to SNBC service costs from the COVID-19 pandemic. We do not expect that these service cost changes will be reflective of service cost trends after the pandemic and they are not considered in the development of projecting FY 2022 experience to CY 2024.

- Historical pharmacy program experience through December 2022.

- Historical and anticipated changes in provider contracting levels.

- FY 2022 financial and encounter data experience.

- CY 2022 financial experience.

These trends are meant to reflect cost impacts not already specifically accounted for in the program changes mentioned in the prior section of this report.

B. GENERAL METHODOLOGY

Our general approach to trend development for most categories of service is to consider anticipated future changes in provider reimbursement, pharmacy unit costs, and acuity along with historical pre-pandemic utilization / service mix trends. We develop utilization / service mix trends reflecting historical utilization / service mix trends for SNBC. We reviewed these utilization / service mix trends against experience and assumptions from other state Medicaid programs. We utilize this approach, because it is frequently difficult to directly measure changes in utilization for services other than inpatient hospital and pharmacy due to differences over time or between plans in counting utilization "units."

The medical unit cost trend assumptions reflect our best estimates of anticipated changes in provider contracting levels based on conversations with DHS and information provided by the health plans. The health plans provided annual historical and projected provider contracting average unit cost changes for inpatient and outpatient services for CY 2021 through CY 2024 by program and region. The pharmacy unit cost trend assumptions reflect our best estimates of anticipated changes in pharmacy unit costs from FY 2022 to CY 2024, including the impact of the state set PDL.

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Managed care plans have multiple mechanisms available to influence trend rates, including increasing care management activities and negotiating provider reimbursement including structures that incent more efficient delivery of care. Each health plan may have focused on different mechanisms to realize the trends seen in recent years. We expect health plans will continue to place different emphases on various cost containment exercises. Each mechanism impacts utilization and unit cost trends differently, and the resulting utilization and unit cost trend impacts may not match assumptions used in this report.

Acuity Trends

Trends in average member acuity are based on expected membership changes between the base and contract periods. We maintain a model that develops a relationship between historical enrollment levels and risk scores that is then applied in rate development through an additional acuity trend component. The acuity trend add-on is included in the trend factors in Appendix E. The PMPM trend for pharmacy has been less volatile with changes in enrollment, so we do not apply the acuity change to pharmacy costs.

We developed acuity adjustments for the Non-Dual SNBC population reflecting expected changes in acuity between FY 2022 and CY 2024 as follows:

- Step 1: We analyzed historical Non-Dual SNBC experience, including October 2018 to October 2022 enrollment and January 2018 through June 2022 diagnosis experience, which demonstrated enrollment increases (decreases) consistently resulted in acuity decreases (increases). We developed a regression analysis for each program predicting the relationship between enrollment changes and acuity changes using this historical experience. We reviewed historical experience for the Dual population and did not observe a strong enough relationship between Medicaid liability and membership changes to be used in determining a regression analysis; therefore, we do not include an acuity change factor for the Dual population. The resulting regression equation is as follows:

  $$\textit{SNBC: Acuity Change Factor} = \textit{Membership Change Factor}^{-0.118}$$

- Step 2: Enrollment by month was projected by DHS for each program, starting with actual reported enrollment. through August 2023. During the Department of Health and Human Services (HHS) PHE, the Families First Coronavirus Response Act (FFCRA) imposed a moratorium on eligibility redetermination for most individuals enrolled in Medicaid, which led to elevated Medicaid enrollment levels. With this continuous enrollment condition ending on March 31, 2023 per the Consolidated Appropriations Act 2023, states must, over time, return to normal eligibility and enrollment operations. States now have up to 12 months to initiate, and 14 months to complete, a renewal for all individuals enrolled in Medicaid. Minnesota DHS will begin normal eligibility redeterminations in July 2023. This change in enrollment is anticipated to impact the average acuity of beneficiaries. We projected enrollment changes based on monthly enrollment projection forecasts provided by DHS assuming the maintenance of eligibility ends in July 2023 with disenrollment occurring in July 2023 to June 2024 for SNBC. These monthly enrollment trend projections reflect both typical historical levels of enrollment changes and impacts of the enrollment unwind.

  These projections resulted in a 3.6% decrease in enrollment for SNBC Non-Dual from FY 2022 to CY 2024.

- Step 3: We applied the regression formulas calculated in Step 1 to the projected enrollment changes calculated in Step 2 to determine the projected changes in acuity.

  We projected a 0.5% increase in acuity for SNBC Non-Dual from FY 2022 to CY 2024.

We expect to review capitation rates with DHS during the contract period should beneficiary redetermination timing, and associated average population acuity, be materially different than projected in this report.

C. HISTORICAL NON-PHARMACY PROGRAM EXPERIENCE

SNBC overall aggregate medical (excluding pharmacy) PMPM cost experience trends, after normalizing for changes in program adjustments, provider contracting, and rate group mix, were 4.4% from CY 2017 to CY 2018, 1.5% from CY 2018 to CY 2019, and 3.6% from CY 2021 to CY 2022, as shown in Appendix D, for an average annual trend of

3.2%. Appendix D also includes experience trends for CY 2019 through CY 2021 for illustration purposes even though they are not considered in projecting FY 2022 experience to CY 2024.

The historical program trends demonstrate significant volatility at the service category levels, which may be driven by changes in data reporting methodologies and differences in reporting between plans. Given this, the program-level trends assumed in the CY 2024 rate development were prospectively selected considering the overall PMPM cost trends, but did not directly rely on historical program experience for specific service categories. We will continue to monitor historical experience in future years and incorporate historical experience into future trend assumptions, as appropriate.

D. ANNUAL NON-PHARMACY SERVICE UTILIZATION AND MIX TRENDS

We developed the utilization and mix trends in Appendix E, considering historical PMPM program experience (normalized for changes in program adjustments, provider contracting, and rate group mix) and utilization experience for different types of services in similar Medicaid programs.

We set the utilization trends for Dual eligible members for the Hospital Inpatient (0.5%), Hospital Outpatient and Outpatient Crossover (3.2%), and Physician and Physician Crossover (1.6%) consistent with internal Milliman research used to develop baseline trend assumptions for Milliman's 2024 Medicare Advantage bid development work. The Milliman standard trends are developed beginning with CMS published trend projections for Medicare by major type of service. Milliman then reviews the assumptions and environment surrounding the CMS trends and adjusts for high-level expectations, engaging with CMS experts to understand complexities and to establish the reasonableness of alternative assumptions.

Utilization trends for Non-Duals are initially set equal to trend levels assumed in CY 2024 PMAP capitation rate development because of significant SNBC trend volatility at the service category level. These trends are adjusted uniformly, such that the aggregate non-pharmacy utilization trend across all service categories is appropriate given recent SNBC program experience.

This results in an average annual utilization trend of 2.6%**, which also includes acuity adjustments for Non-Duals equal to a 0.5% increase (or 0.2% annualized increase).** Appendix E documents the annual trend applied from FY 2022 experience to CY 2024 by service category.

E. ANNUAL NON-PHARMACY UNIT COST TRENDS

DHS understands health plans generally modify their provider reimbursement levels similarly to changes in FFS levels, unless constrained by legislation, for services other than hospital. This does not imply that health plan reimbursement is equal to FFS reimbursement.

For that reason, we utilize non-hospital provider reimbursement trends between FY 2022 and CY 2024 equal to those expected for FFS reimbursement. For inpatient and outpatient hospital services, we incorporate expectations in contracting levels based on provider contracting information provided by the health plans. We project unit cost trends based on a variety of sources and considerations expected to impact costs from FY 2022 to CY 2024.

- **Hospital Inpatient**: DHS understands plan hospital reimbursement levels and structure vary significantly across plans. While reimbursement is generally established considering FFS rates, it has not tracked along with changes in FFS reimbursement over time. Reported actual or expected contracting levels for FY 2022 through CY 2024 were positive. As a result, we set the annual unit cost trend equal to 1.5% relative to FY 2022 reimbursement levels.

- **Hospital Outpatient**: We reviewed historical trends between outpatient drug and non-drug costs and observed significantly higher trends in outpatient drug costs. Therefore, we increased annual outpatient unit costs trends to account for these higher drug trends. To do this, we calculated the historical total outpatient drug claims trend from CY 2018 to CY 2022. We relied on industry benchmarks to further increase this trend by 0.7% to account for high cost and gene therapies expected to be launched. We then estimated the historical unit cost outpatient drug claims trend from CY 2018 to CY 2022 by removing the utilization trend (using the estimated historical average annual utilization trend for CY 2024 rate development). Based on this analysis, we applied annual trends of 4.6% for the outpatient drug costs, which make up 8.6% of the outpatient costs.

We applied annual unit cost trends of 1.0% for the outpatient non-drug costs based on provider contracting levels for FY 2022 compared to projected CY 2024. This results in a combined annual unit cost trend for outpatient hospital services of 1.3%.

- **Physician and Other Medical**: We set trend for physician and other medical at 0.0% since there are no material anticipated changes in FFS provider reimbursement from FY 2022 to CY 2024 other than changes explicitly adjusted due to program changes for Duals. For certain Non-Duals Ambulatory, dental and NEMT services, we include an additional 0.5% adjustment for CY 2022 through CY 2024 to account for current pressures from workforce challenges and inflation in negotiating 2024 provider contracts. In this adjustment we include service types that do not receive reimbursement derived from actual costs of care, such as FQHCs, and have not received substantial rate increases in recent years, such and long-term services and supports. These remaining services make up 65% of the Physician and Other Medical categories of service for a net unit cost trend of 0.3%.

- **Outpatient and Physician Crossover:** We applied an annual trend of 3.0% for Outpatient Crossover and -0.5% for Physician Crossover. These trends assumed 15% of Medicare Part B claims (hospital outpatient and physician claims) for Dual Eligible members paid by Medicaid are for the Part B deductible and the remaining 85% is for Part B coinsurance. We assumed an annual PMPM trend 0.0% to the Part B deductible based on actual change of -3.0% from 2022 to 2023 and an assumed increase of 3.0% from 2023 to 2024. For the Part B coinsurance, we used annual trends of 3.7% for Outpatient Crossover and -0.9% for Physician Crossover, consistent with internal Milliman research used to develop baseline trend assumptions for Milliman's 2024 Medicare Advantage bid development.

- **Inpatient Crossover:** For inpatient crossover claims, the annual trend of 2.8% was based on the change in the Medicare Part A deductible from CY 2022 ($1,556) to CY 2023 ($1,600).

F. PHARMACY PMPM TRENDS

The pharmacy trends developed in this section are applied from FY 2022 to CY 2024, including the impact of the state single PDL.

We analyzed July 2021 through December 2022 pharmacy experience for the eligible population and developed utilization and cost summaries by traditional and specialty drug types and population. We developed cost projections through CY 2022 using those summaries, considering annual script utilization per 1,000 and average script cost changes for traditional and specialty drugs. The CY 2023 and CY 2024 trends were developed using marketplace intelligence including major pipeline drug launches, blockbuster biosimilar and generic launches, expanded indications, expanded treatable population, as well as consideration of the PDL and state drug mix. Unit cost and utilization trends inputs were developed by therapeutic class and population (adults, children, high needs, expansion, and Duals).

Based on these results, we project an annual unit cost trend of 6.2% and annual utilization trend of -0.5% for the Non-Dual population. The utilization trends are impacted by the shift towards 90-day supply scripts and the negative utilization trends observed from FY 2022 to CY 2022. Projected utilization trends for CY 2023 and CY 2024 are positive. Appendix F shows the assumptions by drug type. Historical experience for the Dual population has been too volatile to be used directly in determining trend; therefore, we set the pharmacy trends equal to the values assumed for the Non-Dual population. We estimate the impact of changes to the state PDL list to increase trends by 1.4%.

We will monitor changes to the state PDL list and future product launches with DHS during the contract period to determine if changes are materially different than what is projected in this report.

V. CY 2024 BASE RATE DEVELOPMENT

As in past years, DHS will issue a single monthly payment by rate group to each health plan in 2024 for which the health plan must provide the SNBC benefits set forth in the contract for all enrolled persons. The amount of the monthly payment will be equal to the product of the CY 2024 base rates, including projected service costs, administrative costs, and margin, multiplied by the SNBC-specific risk scores developed using plan-specific membership. The projected portion of rates associated with medical expenses exceeds 85% in composite. In addition, the projected portion of each individual health plan's contracted rate also exceeds 85%.

The remainder of this section describes the components of the CY 2024 base rates.

A. SERVICE COSTS BY SERVICE CATEGORY

Exhibits 1-1 through 1-8 contain actuarial cost models showing the distribution of PMPM costs by service category for the eight rate groups, including the impact of trend and program changes from FY 2022 to CY 2024. Exhibit 1-9 shows the composite values of Exhibits 1-1 through 1-8.

The capitation rates are based on historical health plan experience.

B. ADMINISTRATION COSTS

In order to develop administrative and case management costs, we reviewed program experience reported on plan reported financial summaries from CY 2022, including care coordination costs. We included $0.27 PMPM to account for the Electronic Visit Verification (EVV) requirements for Home Health Care services, consistent with actual contracting terms and historical utilization levels.

The CY 2022 health plan non-medical SNBC cost experience, reported in plan financial data submissions and excluding unallowable expenses, the 1.0% premium tax, and the 0.6% surcharge, was allocated into fixed administration, variable administration, and care coordination components.

The 2024 revenue associated with the premium tax and HMO surcharge are explicitly added to rates at the end of the rate development process, as described later in this report.

Administration Costs Development

The total CY 2022 allowable administration costs were $96.08 PMPM. This PMPM is materially lower than historical costs, because one MCO significantly changed their cost allocation methodology between SNBC and other Minnesota Public Programs. The administration costs were trended to 2024 using a 4.0% annualized trend rate, which is comparable to recent Employment Cost Index calculations published by the Bureau of Labor Statistics. This considers the high levels of inflation and wage growth seen in early 2023 at 4.5% trend for CY 2022 to CY 2023 and the expectation of a return to the historical average in 2024 at 3.5% trend from CY 2023 to CY 2024.

The fixed administration costs were assumed to be 30% of the total, while variable administration costs were assumed to be 70%, comparable to historical plan reporting. Each rate cell receives 1) the fixed administration load along with 2) the variable administration load adjusted to reflect the rate cell medical cost relative to overall average medical cost across all rate cells.

Note, aggregate projected administrative costs across the Minnesota Public Programs will be evaluated at a future date if these costs exceed the limit on administrative costs under Minnesota Statutes § 256B.69, subdivision 5i.

C. LEGISLATED PREMIUM TAX AND HMO SURCHARGE

The CY 2024 SNBC rates include an allowance for the legislated premium tax of 1% and HMO surcharge of 0.6%. These allowances are developed and shown at the rate group and region level in Exhibit 2A. Final base rates for the CBP plans do not include the premium tax adjustment or the HMO surcharge.

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D. MARGIN

The target margin is set at 1.40% of revenue for the SNBC program. This amount is developed and shown at the rate group and region level in Exhibit 2A. Since we do not anticipate any material portion of the 0.25% withhold at risk to be returned to plans, the net target margin is 1.15% of revenue.

The target net margin consists of two components:

- Risk margin and general cost of capital: 1.0% net margin
- Capitation delay cost of capital: 0.15% net margin

Risk Margin and General Cost of Capital

The CY 2024 rate development includes a 1.0% net profit margin for risk margin and general cost of capital. Considerations informing this assumption include the generally consistent profitability of Minnesota Public Programs health plan operations, historical investment income realized on supporting capital, and the continued market interest in growing Medicaid blocks of business that target similar margin levels.

Capitation Delay Cost of Capital

One or two months of Minnesota Public Programs capitation payments to health plans are delayed each calendar year, depending on the program. In CY 2024, the May and June capitation rate payment will be delayed until July for SNBC. In addition, a material portion of the annual plan payments is delayed until the next calendar year due to the withhold arrangements. This reduces the amount of investment income earned by health plans on retained capital.

We estimate the impact of these delayed payments on health plans' investment income to be about 0.15% for SNBC, assuming an annualized investment return of 1.5%, comparable to reported historical returns. Therefore, the CY 2024 rate development includes a net profit margin of 0.15% for the cost of capital associated with payment delays.

E. RISK ADJUSTMENT

Similar to CY 2023 rates, the CY 2024 rates will be risk-adjusted using the Chronic Illness and Disability Payment System (CDPS+Rx) risk adjuster. CDPS+Rx utilizes medical diagnoses and pharmacy utilization to develop estimates of the relative disease burdens of Medicaid populations. Each beneficiary will be assigned a risk score based on their managed care and FFS medical diagnoses and pharmacy utilization, which will continue to be associated with the beneficiary, regardless of their enrolled health plan. Risk adjustment will be budget neutral to the program in total. Appendix G provides detail on the risk adjustment algorithm we will follow.

F. APPLICABLE DIRECTED PAYMENT ARRANGEMENTS

The following directed payment arrangements apply to the SNBC program for CY 2024. Additional documentation of these arrangements is included in Appendix J.

- Directed Payment for a Safety Net Hospital in Hennepin County (see description below)
- Inclusion of Care Coordination Services in a BHH (see description below)
- CCBHC (see description below)
- Managed Long-Term Supports and Services (MLTSS) Minimum Fee Schedule (see description below)
- IHP (see Section III)
- Substance Use Disorder 1115 Demonstration Waiver (see Section III)
- Dental Services (see Section III)
- Culturally / Disability Responsive Substance Use Disorder (SUD) (see Section III)
- Critical Access Mental Health Minimum Fee Schedule (see Section III)
- Rate Increase for Outpatient Behavioral Health Services (see Section III)
- Separate Reimbursement for Long-Acting Reversible Contraceptives (LARCs) (see Section III)
- Fuel Adjustor for NEMT and Ambulance Services (see Section III)
- Rate Increase for Adult Day Treatment (see Section III)

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Directed Payment for a Safety Net Hospital in Hennepin County

In accordance with MN State Statute 256B.1973 and effective January 1, 2022, Minnesota implemented a payment arrangement that is a state-directed fee schedule in which a uniform fee schedule is to be applied to each claim submitted by eligible providers to a participating health plan. Eligible providers are non-state government teaching hospitals with high medical assistance utilization and a level 1 trauma center, as well as the hospital's affiliated billing professionals, ambulance services, and clinics. The uniform fee schedule adjustment is calculated as the estimated difference between the average commercial rate (ACR) of the top five contracted payers for services rendered by the eligible provider and the average amount paid for those services by the participating health plan. This adjustment applies only to Non-CBP health plans; CBP health plans are excluded from this arrangement as these plans do not serve regions which this hospital system primarily services and historical utilization data for these plans is not credible. In addition, this adjustment only applies to the Non-Dual population since Medicare payments for Dual members make administration of the program prohibitively difficult.

Inpatient, Ambulance, Anesthesia, and Physician (effective January 1, 2022)

We summarized the CY 2022 supplemental payment amounts reported by each participating health plan in the financial summaries by health plan, region, rate cell, and applicable service category. We then estimated the corresponding base payment amounts based on the payment information provided by the safety net hospital system in Hennepin County.

The CY 2022 information was trended to CY 2024 as follows:

1. The CY 2022 base payments PMPM were trended for two years using the annual category of service-specific utilization and unit cost trends consistent with the CY 2024 rate development to project from CY 2022 payment amounts for this hospital system in absence of the directed payment arrangements. There are no material program changes that impact the services subject to the directed payment.

2. The total CY 2022 payments PMPM, including directed payments, were trended from CY 2022 to CY 2024 using the annual utilization trend consistent with the CY 2024 rate development and CY 2022 to 2023 commercial unit cost increases for each category of service as provided by the hospital system and applied for two years. These values ranged from 4.8% to 5.0%. We validated the reasonability of these commercial unit cost increases with trend information from the Milliman *Commercial Health Cost Guidelines™ (HCGs).*

The CY 2024 supplemental PMPM payment is calculated as the difference between items 1 and 2 above. This amount is calculated separately for each combination of participating health plan, program, rate cell, and region.

Outpatient (effective January 1, 2023)

Outpatient services were added to the directed payment arrangement in CY 2023; therefore, we do not have CY 2022 supplemental payment amounts reported by the participating health plans for this service category. To calculate the CY 2024 supplemental payment amounts, we trended the estimated CY 2023 PMPM payment amounts from the CY 2023 rate development for one year using a similar approach as outlined below.

1. The CY 2023 base payments PMPM were trended for one year using the annual category of service-specific utilization and unit cost trends consistent with the CY 2024 rate development. There are no material program changes that impact the services subject to the directed payment.

2. The total CY 2023 payments, including supplemental payments, were trended one year by the annual utilization trend consistent with the CY 2024 rate development and unit cost increase provided by the hospital system of 5.1%. We validated the reasonability of the commercial unit cost increase with trend information from the Milliman *HCGs*.

The CY 2024 supplemental payment PMPM is calculated as the difference between items 1 and 2 above. This amount is calculated separately for each combination of participating health plan, program, rate cell, and region.

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Exhibit 2 contains the total average directed payment PMPM Add-On across all health plans by rate cell, region, and Medicare coverage. The plan-specific PMPM Add-Ons will be provided separate from this report, and will include the final directed payment PMPM separately for each health plan.

Inclusion of Care Coordination Services in a Behavioral Health Home

Per the Patient Protection and Affordable Care Act of 2010, an optional health home benefit was created so that states could better coordinate care for Medicaid enrollees with chronic conditions. Behavioral Health Homes (BHH) is Minnesota's Medical Assistance (MA) benefit that satisfies this federal benefit and is a Medicaid covered benefit effective July 1, 2016 as part of the 2015 legislative session, Chapter 71, Article 11, section 31. The BHH model supports members with serious mental illness and covers the following components of health home services:

- Comprehensive care management
- Care coordination
- Health promotion and wellness
- Comprehensive transitional care
- Patient and family support
- Referral to community and social support services

Managed care organizations are required to reimburse BHH providers at a minimum of the FFS rate. The impact of this is considered to be fully phased into the base data, therefore no explicit adjustment was made for this directed payment.

Certified Community Behavioral Health Clinic (CCBHC)

Effective September 1, 2019, managed care plans were required to make the prospective payment rates for each CCBHC. Previously, these payments were paid by DHS. Additionally, the MCOs are responsible for payment of CCBHC claims at each CCBHC's prospective payment system (PPS) rate or greater. The impact of this is considered to be fully phased into the base data, therefore no explicit adjustment was made for this directed payment.

MLTSS Minimum Fee Schedule

MCOs are required to reimburse providers of Home Care and other MLTSS at least equal to FFS rates. This is a longstanding arrangement, and the impacts of this directed payment are fully reflected in the rate setting base data. No additional adjustment in rate development is required.

G. WITHHOLD

A nominal withhold of 8.0%, 5.0% of which is based on performance, is required by Minnesota law to be removed from plan payments. However, the plan contracts include a "loss limit" and payment timing provisions, such that the ultimate amount at risk to health plans is only 0.25% of payments. The remainder of the nominal withhold is required to be returned to health plans and ultimately only impacts the cash flow between DHS and the plans.

Health plan financials in recent years indicate plans are adequately capitalized, which includes the impact of withhold timing delays. There are no changes to the payment timing patterns in CY 2024 that would drive changes in health plan retained capital levels. Therefore, we have no concerns that this withhold payment delay affects the financial stability of the organizations.

Based on our review of the withhold return metrics and the ultimate amount at risk to health plans, we believe little to none of the 0.25% will be paid back to plans. Therefore, final plan payments, assuming none of the 0.25% at-risk withhold is returned, will be subject to the actuarial certification.

H. CAPITATION RATE COMPONENTS

Exhibit 2A contains the components required to develop the CY 2024 capitation rates for each combination of:

- Medicare coverage: Dual Eligible, Non-Dual Eligible
- Rate cell: Institutional, Community
- Region (Community only): Metro, Non-Metro North, Non-Metro South

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There are separate institutional base rates for Dual eligible and Non-Dual eligibles, but those two base rates are not further separated by region.

Exhibits 2B and 2C contain templates of the spreadsheets that will be used by DHS to develop CY 2024 capitation rates for non-CBP and CBP plans, respectively. The 1.000 risk factors in Exhibits 2B and 2C, for acute services, are for illustrative purposes only. They are not intended to reflect the risk scores of any particular plan for CY 2024.

Our certification of the 2024 rates includes the application of the risk-adjustment methodology described in Section E and Appendix G.

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VI. SNBC NURSING FACILITY ADD-ON RATE

This section of the report documents the development of the SNBC Nursing Facility (NF) Add-On capitation rate. The capitation rate is paid for each non-institutionalized member to cover average projected costs for nursing facility services for which the health plans are ultimately liable. This includes the first 100 days of coverage. After this time period, the member remains in the Institutional rate cell, but nursing facility services are provided on a FFS basis.

A. NURSING FACILITY FREQUENCY AND AVERAGE LENGTH-OF-STAY ASSUMPTION

The frequency of admission and average length of stay (ALOS) assumptions were determined based on a study of historical NF utilization patterns for SNBC members enrolled during FY 2022. This study relied on the living arrangement identified on DHS eligibility files. SNBC enrollees were limited to those members not currently institutionalized. A nursing facility admission was recorded when the living arrangement field indicated that the member was now institutionalized. If an individual was discharged from the facility (as evidenced by a change in living arrangement), but readmitted within six months, the readmission was not counted as a new admission. An individual's length of stay (LOS) is calculated as the number of days between an admission and discharge, including days from subsequent readmissions that are not counted as a separate admit. This LOS is capped at 100 days, to reflect the benefit period covered under the NF Add-On. The assumptions used for the 2024 rate development are:

- **Frequency of NF admissions of 1.6% annually**: The frequency of admission in Exhibit 3A is expressed as the expected admissions per eligible per month (0.133%) and reflects the most recent three-year averages of admission data derived from the study detailed above. Note, the admission frequencies shown in Table 5 are those admissions for which there was some Medicaid liability, since DHS has no financial responsibility for admissions with only Medicare-covered days.

- **Medicaid ALOS of 41 days**: The ALOS in Exhibit 3A is calculated over a 100-day benefit period, which is the maximum nursing facility benefit for the SNBC program. The benefit excludes days that would occur beyond 100 days and days outside of the contract period. All skilled nursing facility days qualifying for Medicare-only payment count toward the benefit and the 100-day length-of-stay maximum. However, the Medicare-only days are not included in the assumed Medicaid ALOS of 41 days reflected in Table 5, as DHS has no financial responsibility for Medicare-only days. This is based on the most recent three-year average of admission data derived from the study detailed above. The ALOS within the contract year depends on the pattern of enrollment by month. The projected CY 2024 ALOS of 35.5 days (from Exhibit 3A) within the CY 2024 contract period is based on monthly enrollment projections provided by DHS through December 2024. The projected enrollment was developed using the previous year enrollment, trends in previous years, program enrollment planning (for example, mailings to go out), and any program changes or likely program migration.

The frequency of admissions and ALOS assumptions used for the 2024 rate development, which results in estimated 2024 nursing facility days per community enrollee of 0.66, are reasonable with the average days per community enrollee in Table 5.

Table 5
Minnesota Department of Human Services
CY 2024 Special Needs BasicCare Rate Development
Nursing Facility Services
Average NF Days Per Community Enrollee

Year	Average NF Days per Community Enrollee
FY 2018	0.85
FY 2019	0.88
CY 2019	0.70
FY 2021	0.73
FY 2022	0.59

An adjustment is made later in the rate setting process to account for the difference in the frequency and ALOS between Dual eligible and Non-Dual eligible enrollees.

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B. NURSING FACILITY CHARGE PER DAY ASSUMPTION

The first step in developing the CY 2024 assumed average charge per day uses nursing facility MA FFS charge per day data from the Reports and Forecasts Division at DHS, including actual MA nursing facility charges from 2022 and charge projections for 2023 and beyond. Table 6 contains the fiscal year projection data used to estimate the CY 2024 FFS charge per day:

Table 6
Minnesota Department of Human Services
CY 2024 Special Needs BasicCare Rate Development
Nursing Facility Services
Nursing Facility Charge Per Day Estimates
Based on Data from DHS Reports and Forecasting Division

Fiscal Year	Estimated Charge per Day
2024	$364.70
2025	$383.43

Using the FY 2024 and FY 2025 MA covered days, the weighted average of these two fiscal year estimates results in a projected nursing facility MA charge per day of $374.03 for CY 2024 [$374.03 = ($364.70 x 3,820,740 + $383.43 x 3,788.959) / (3,820,740 + 3,788,959)], Historical analyses performed by the Reports and Forecasts Division at DHS indicate the average charge per day for an under 65 population is 1.4% lower than the overall charge per day. This resulted in an estimated SNBC charge per day of $368.79 ($374.03 x 0.9860).

We then adjusted this FFS amount to reflect the average MCO per diem relationship to FFS. Historical MCO per diems have been lower than the average FFS per diems because a larger portion of the days covered under managed care (that is, the first 180 days) have partial Medicare coverage. Because of volatility of the relationship between average MCO reported per diems and FFS over time, we averaged several years of experience to arrive at a relationship of 0.820 and phased in 50% of this impact for CY 2024 and plan to fully reflect this impact in CY 2025. This is equivalent to a projected CY 2024 MCO per diem of $335.66 as shown in Exhibit 3A.

There are no material program changes impacting projected CY 2024 NF costs through the 2023 legislative session.

C. NF ADD-ON RATE CALCULATION

The 100-day NF Add-On initial rate is calculated by the following formula:

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

The calculation of the initial rate, as well as subsequent adjustments, is outlined in Exhibit 3B for non-CBP plans and Exhibit 3C for CBP plans.

Section A of Exhibits 3B and 3C shows the calculation of the initial rate of $15.88 PMPM for CY 2024.

Section B of Exhibits 3B and 3C contains the calculation of the tail rate. The tail rate is equal to the expected nursing facility costs for days in CY 2024 from admissions occurring in CY 2023 divided by projected community eligible months in CY 2024. The tail rate for CY 2024 is $2.86 PMPM.

Section C of Exhibit 3B contains an initial SNBC non-CBP base rate for CY 2024 of $18.74 PMPM. We then increased the initial base rate by 1.60%, for the legislated premium tax of 1% and the HMO surcharge of 0.6%, and by 1.40% for the contribution to surplus. The final SNBC non-CBP base rate for CY 2024 is $19.32 PMPM.

Rates for CBP entities are excluded from the 1% premium tax and 0.6% HMO surcharge. Section C of Exhibit 3B contains an initial SNBC CBP base rate for CY 2024 of $18.74 PMPM. The initial base rate was increased 1.40% for the contribution to surplus. The final SNBC CBP base rate for CY 2024 is $19.01 PMPM.

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Section C of Exhibits 3B and 3C also contains the NF Add-On rates specific to enrollees eligible for both Medicare and Medicaid vs. Medicaid-only enrollees. The adjustment to calculate these rates reflects differences in frequency and ALOS for Dual eligible vs. Medicaid-only eligible based on FY 2022 health plan experience. The FY 2022 relativities, by Medicare and non-Medicare, were normalized to 1.000 using the FY 2022 distribution. The Nursing Facility amounts paid in FY 2022 were summarized for the total ($11.28 PMPM), Medicare ($8.75 PMPM), and non-Medicare ($14.08 PMPM) populations. The adjustments were calculated using these relativities:

Medicare = $8.75 / $11.28 = 0.776 and non-Medicare = $14.08 / $11.28= 1.248.

The aggregate Dual eligible and Medicaid-only rates equal the overall NF Add-On rates, multiplied by these Dual eligible and Medicaid-only adjustments.

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EXHIBITS

(Provided in Excel)

Exhib t 1 1
Special Needs Bas cCare
Deve opment of CY 2024 Per Member Per Month Projected Costs
Rate Group: Dua Elig bles, Al Regions, Inst tut onal

Member Months: **10,445**

Service Category	Trend Category	Blend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	IHP Adjustment Factor	IMD Adjustment Factor	Seasonal Virus and COVID-19 Base Period Adjustment	AMP Cap Base Period Adjustment	Weight Loss Drugs	FY22 Experience PMPM	PMPM Trend	Elimination of MA Cost Sharing	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate Increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Inpatient	Medical	$ 135,699	0.9981	1.0000	0.9907	1.0000	1.0000	1.0000	$12.85	1.0507	1.0021					$13.53
Inpatient Crossover	Inpatient Crossover	Medical	855,211	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	81.72	1.0722	1.0021					87.81
Outpatient (Non-ER)	Outpatient	Medical	73,743	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	7.05	1.1191	1.0021				1.0297	8.14
ER Outpatient	Outpatient	Medical	2,626	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.25	1.1191	1.0021					0.28
Outpatient Crossover	Outpatient Crossove	Medical	745,524	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	71.24	1.1662	1.0021					83.26
Physician - Primary Care	Physician	Medical	116,129	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	11.10	1.0417	1.0021					11.58
Physician - Specialty Care	Physician	Medical	30,191	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	2.89	1.0417	1.0021					3.01
Physician Crossover	Physician Crossover	Medical	1,438,363	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	137.45	1.0287	1.0021					141.69
Dental	Dental	Dental	151,548	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	14.48	1.0764	1.0021	1.1789		1.3345		24.58
Mental Health/Substance Abuse Facility - Inpatient	Other	Medical	7,207	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.69	1.0764	1.0021					0.74
Mental Health/Substance Abuse Facility - Outpatient	Other	Medical	50,868	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	4.86	1.0764	1.0021					5.24
Mental Health/Substance Abuse Non-Facility	Other	Medical	220,345	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	21.06	1.0764	1.0021					22.71
Mental Health TCM	Other	Medical	128,076	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	12.24	1.0764	1.0021					13.20
Transportation	Other	Medical	1,037,463	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	99.14	1.0764	1.0021					106.94
Health Care Home (HCH)	Other	Medical	154	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.01	1.0764	1.0021					0.02
Home Health	Other	Home Health	32,567	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	3.11	1.0764	1.0021		1.1499			3.86
Hospice	Other	Medical	9,400	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.90	1.0764	1.0021					0.97
Hearing	Other	Medical	14,973	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	1.43	1.0764	1.0021					1.54
Vision	Other	Medical	29,590	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	2.83	1.0764	1.0021					3.05
Family Planning	Other	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0764	1.0021					0.00
Medical Supplies/DME/Prosthetics	Other	Medical	712,645	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	68.10	1.0764	1.0021					73.46
Specialized Therapy	Other	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0764	1.0021					0.00
Relocation Service Coordination (RSC)	Other	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0764	1.0021					0.00
Other Medical	Other	Medical	32,722	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	3.13	1.0764	1.0021					3.37
Pharmacy	Pharmacy	Pharmacy	130,534	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	12.47	1.1501	1.0021					14.38
Pharmacy Rebates	Pharmacy	Pharmacy	-	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.1501	1.0021					0.00
Behavioral Health Home (BHH)	N/A	Medical	9,685	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.93	1.0000	1.0021					0.93
Certified Community Behavioral Health Clinics (CCBHC)	N/A	Medical	26,851	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	2.57	1.0000	1.0021					2.57
Non-State Plan Services	N/A	N/A	(28,906)	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	(2.76)	1.0000	1.0000					(2.76)
Impact for Other Program Adjustments																	3.70
Total Base Rate			**$ 5,963,208**	**0.9981**	**1.0000**	**0.9998**	**1.0000**	**1.0000**	**1.0000**	**$569.72**	**1.0762**	**1.0021**	**1.0045**	**1.0008**	**1.0100**	**1.0004**	**$627.81**
Non-CBP NF Add-On																	**$0.00**
CBP NF Add-On																	**$0.00**

Exhib t 1 2
Special Needs Bas cCare
Deve opment of CY 2024 Per Member Per Month Projected Costs
Rate Group: Dua Elig bles, Metro Count es, Commun ty

Member Months: **198,108**

Service Category	Trend Category	Blend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	IHP Adjustment Factor	IMD Adjustment Factor	Seasonal Virus and COVID-19 Base Period Adjustment	AMP Cap Base Period Adjustment	Weight Loss Drugs	FY22 Experience PMPM	PMPM Trend	Elimination of MA Cost Sharing	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate Increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Inpatient	Medical	$ 1,363,484	0.9981	1.0000	0.9907	1.0000	1.0000	1.0000	$6.81	1.0507	1.0021					$7.17
Inpatient Crossover	Inpatient Crossover	Medical	6,657,693	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	33.54	1.0722	1.0021					36.04
Outpatient (Non-ER)	Outpatient	Medical	1,434,048	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	7.23	1.1191	1.0021				1.0297	8.34
ER Outpatient	Outpatient	Medical	110,242	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.56	1.1191	1.0021					0.62
Outpatient Crossover	Outpatient Crossove	Medical	7,680,234	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	38.70	1.1662	1.0021					45.22
Physician - Primary Care	Physician	Medical	3,526,993	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	17.77	1.0417	1.0021					18.55
Physician - Specialty Care	Physician	Medical	293,955	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	1.48	1.0417	1.0021					1.55
Physician Crossover	Physician Crossover	Medical	18,848,537	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	94.96	1.0287	1.0021					97.90
Dental	Dental	Dental	3,924,871	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	19.77	1.0764	1.0021	1.3274		1.3345		37.79
Mental Health/Substance Abuse Facility - Inpatient	Other	Medical	1,616,685	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	8.15	1.0764	1.0021					8.79
Mental Health/Substance Abuse Facility - Outpatient	Other	Medical	3,037,114	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	15.30	1.0764	1.0021					16.51
Mental Health/Substance Abuse Non-Facility	Other	Medical	22,213,306	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	111.92	1.0764	1.0021					120.73
Mental Health TCM	Other	Medical	8,514,356	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	42.90	1.0764	1.0021					46.27
Transportation	Other	Medical	6,398,255	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	32.24	1.0764	1.0021					34.77
Health Care Home (HCH)	Other	Medical	16,960	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.09	1.0764	1.0021					0.09
Home Health	Other	Home Health	3,641,381	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	18.35	1.0764	1.0021		1.1499			22.76
Hospice	Other	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0764	1.0021					0.00
Hearing	Other	Medical	199,501	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	1.01	1.0764	1.0021					1.08
Vision	Other	Medical	717,503	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	3.61	1.0764	1.0021					3.90
Family Planning	Other	Medical	5,242	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.03	1.0764	1.0021					0.03
Medical Supplies/DME/Prosthetics	Other	Medical	4,733,376	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	23.85	1.0764	1.0021					25.73
Specialized Therapy	Other	Medical	2,269,427	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	11.43	1.0764	1.0021					12.33
Relocation Service Coordination (RSC)	Other	Medical	37,345	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.19	1.0764	1.0021					0.20
Other Medical	Other	Medical	559,363	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	2.82	1.0764	1.0021					3.04
Pharmacy	Pharmacy	Pharmacy	1,369,020	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	6.90	1.1501	1.0021					7.95
Pharmacy Rebates	Pharmacy	Pharmacy	(1,188)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	(0.01)	1.1501	1.0021					(0.01)
Behavioral Health Home (BHH)	N/A	Medical	723,503	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	3.65	1.0000	1.0021					3.65
Certified Community Behavioral Health Clinics (CCBHC)	N/A	Medical	931,762	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	4.69	1.0000	1.0021					4.70
Non-State Plan Services	N/A	N/A	(486,418)	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	(2.45)	1.0000	1.0000					(2.45)
Impact for Other Program Adjustments																	3.34
Total Base Rate			**############ ####**	**0.9981**	**1.0000**	**0.9999**	**1.0000**	**1.0000**	**1.0000**	**$505.46**	**1.0732**	**1.0021**	**1.0128**	**1.0054**	**1.0171**	**1.0004**	**$566.59**
Non-CBP NF Add-On																	**$14.98**
CBP NF Add-On																	**$14.74**

Exhib t 1 3
Spec al Needs BasicCare
Deve opment of CY 2024 Per Member Per Month Pro ected Costs
Rate Group: Dual Elig bles, Non Metro North Count es, Commun ty

Member Months: **114,646**

Service Category	Trend Category	Blend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	IHP Adjustment Factor	IMD Adjustment Factor	Seasonal Virus and COVID-19 Base Period Adjustment	AMP Cap Base Period Adjustment	Weight Loss Drugs	FY22 Experience PMPM	PMPM Trend	Elimination of MA Cost Sharing	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate Increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Inpatient	Medical	$ 697,722	0.9981	1.0000	0.9907	1.0000	1.0000	1.0000	$6.02	1.0507	1.0021					$6.34
Inpatient Crossover	Inpatient Crossover	Medical	3,746,717	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	32.62	1.0722	1.0021					35.05
Outpatient (Non-ER)	Outpatient	Medical	377,573	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	3.29	1.1191	1.0021				1.0297	3.80
ER Outpatient	Outpatient	Medical	4,430	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.04	1.1191	1.0021					0.04
Outpatient Crossover	Outpatient Crossove	Medical	6,646,787	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	57.87	1.1662	1.0021					67.63
Physician - Primary Care	Physician	Medical	1,540,904	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	13.42	1.0417	1.0021					14.00
Physician - Specialty Care	Physician	Medical	202,775	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	1.77	1.0417	1.0021					1.84
Physician Crossover	Physician Crossover	Medical	10,692,933	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	93.09	1.0287	1.0021					95.97
Dental	Dental	Dental	2,121,130	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	18.47	1.0764	1.0021	1.2436		1.3345		33.06
Mental Health/Substance Abuse Facility - Inpatient	Other	Medical	1,166,423	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	10.16	1.0764	1.0021					10.95
Mental Health/Substance Abuse Facility - Outpatient	Other	Medical	758,036	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	6.60	1.0764	1.0021					7.12
Mental Health/Substance Abuse Non-Facility	Other	Medical	9,507,276	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	82.77	1.0764	1.0021					89.29
Mental Health TCM	Other	Medical	3,919,610	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	34.12	1.0764	1.0021					36.81
Transportation	Other	Medical	4,589,100	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	39.95	1.0764	1.0021					43.10
Health Care Home (HCH)	Other	Medical	91	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0764	1.0021					0.00
Home Health	Other	Home Health	2,130,621	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	18.55	1.0764	1.0021		1.1499			23.01
Hospice	Other	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0764	1.0021					0.00
Hearing	Other	Medical	128,905	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	1.12	1.0764	1.0021					1.21
Vision	Other	Medical	454,247	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	3.95	1.0764	1.0021					4.27
Family Planning	Other	Medical	2,773	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.02	1.0764	1.0021					0.03
Medical Supplies/DME/Prosthetics	Other	Medical	1,806,248	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	15.73	1.0764	1.0021					16.96
Specialized Therapy	Other	Medical	48,349	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.42	1.0764	1.0021					0.45
Relocation Service Coordination (RSC)	Other	Medical	26,039	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.23	1.0764	1.0021					0.24
Other Medical	Other	Medical	159,005	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	1.38	1.0764	1.0021					1.49
Pharmacy	Pharmacy	Pharmacy	1,005,575	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	8.75	1.1501	1.0021					10.09
Pharmacy Rebates	Pharmacy	Pharmacy	(1,757)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	(0.02)	1.1501	1.0021					(0.02)
Behavioral Health Home (BHH)	N/A	Medical	374,895	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	3.26	1.0000	1.0021					3.27
Certified Community Behavioral Health Clinics (CCBHC)	N/A	Medical	472,933	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	4.12	1.0000	1.0021					4.13
Non-State Plan Services	N/A	N/A	(253,669)	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	(2.21)	1.0000	1.0000					(2.21)
Impact for Other Program Adjustments																	3.01
Total Base Rate			**$ 52,325,673**	**0.9981**	**1.0000**	**0.9999**	**1.0000**	**1.0000**	**1.0000**	**$455.50**	**1.0771**	**1.0021**	**1.0099**	**1.0060**	**1.0166**	**1.0002**	**$510.93**

Non-CBP NF Add-On	**$14.98**
CBP NF Add-On	**$14.74**

Exhib t 1 4
Spec al Needs BasicCare
Deve opment of CY 2024 Per Member Per Month Pro ected Costs
Rate Group: Dual Elig bles, Non Metro South Counties Community

Member Months: **77,897**

Service Category	Trend Category	Blend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	IHP Adjustment Factor	IMD Adjustment Factor	Seasonal Virus and COVID-19 Base Period Adjustment	AMP Cap Base Period Adjustment	Weight Loss Drugs	FY22 Experience PMPM	PMPM Trend	Elimination of MA Cost Sharing	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate Increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Inpatient	Medical	$ 590,751	0.9981	1.0000	0.9907	1.0000	1.0000	1.0000	$7.50	1.0507	1.0021					$7.90
Inpatient Crossover	Inpatient Crossover	Medical	2,508,024	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	32.14	1.0722	1.0021					34.53
Outpatient (Non-ER)	Outpatient	Medical	430,738	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	5.52	1.1191	1.0021				1.0297	6.37
ER Outpatient	Outpatient	Medical	4,660	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.06	1.1191	1.0021					0.07
Outpatient Crossover	Outpatient Crossove	Medical	3,831,620	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	49.10	1.1662	1.0021					57.38
Physician - Primary Care	Physician	Medical	1,205,728	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	15.45	1.0417	1.0021					16.13
Physician - Specialty Care	Physician	Medical	91,928	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	1.18	1.0417	1.0021					1.23
Physician Crossover	Physician Crossover	Medical	5,665,963	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	72.60	1.0287	1.0021					74.84
Dental	Dental	Dental	1,581,402	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	20.26	1.0764	1.0021	1.2412		1.3345		36.21
Mental Health/Substance Abuse Facility - Inpatient	Other	Medical	938,920	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	12.03	1.0764	1.0021					12.98
Mental Health/Substance Abuse Facility - Outpatient	Other	Medical	712,302	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	9.13	1.0764	1.0021					9.85
Mental Health/Substance Abuse Non-Facility	Other	Medical	9,116,067	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	116.81	1.0764	1.0021					126.00
Mental Health TCM	Other	Medical	3,780,027	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	48.43	1.0764	1.0021					52.25
Transportation	Other	Medical	2,721,746	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	34.87	1.0764	1.0021					37.62
Health Care Home (HCH)	Other	Medical	834	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.01	1.0764	1.0021					0.01
Home Health	Other	Home Health	1,875,660	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	24.03	1.0764	1.0021		1.1499			29.81
Hospice	Other	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0764	1.0021					0.00
Hearing	Other	Medical	73,950	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.95	1.0764	1.0021					1.02
Vision	Other	Medical	365,631	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	4.68	1.0764	1.0021					5.05
Family Planning	Other	Medical	664	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.01	1.0764	1.0021					0.01
Medical Supplies/DME/Prosthetics	Other	Medical	1,136,547	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	14.56	1.0764	1.0021					15.71
Specialized Therapy	Other	Medical	4,306	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.06	1.0764	1.0021					0.06
Relocation Service Coordination (RSC)	Other	Medical	18,570	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.24	1.0764	1.0021					0.26
Other Medical	Other	Medical	437,364	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	5.60	1.0764	1.0021					6.05
Pharmacy	Pharmacy	Pharmacy	583,677	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	7.48	1.1501	1.0021					8.62
Pharmacy Rebates	Pharmacy	Pharmacy	-	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.1501	1.0021					0.00
Behavioral Health Home (BHH)	N/A	Medical	166,114	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	2.13	1.0000	1.0021					2.13
Certified Community Behavioral Health Clinics (CCBHC)	N/A	Medical	478,108	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	6.13	1.0000	1.0021					6.14
Non-State Plan Services	N/A	N/A	(184,877)	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	(2.37)	1.0000	1.0000					(2.37)
Impact for Other Program Adjustments																	3.23
Total Base Rate			**$ 38,136,424**	**0.9981**	**1.0000**	**0.9998**	**1.0000**	**1.0000**	**1.0000**	**$488.59**	**1.0772**	**1.0021**	**1.0100**	**1.0073**	**1.0169**	**1.0003**	**$549.07**

Non-CBP NF Add-On	**$14.98**
CBP NF Add-On	**$14.74**

Exhib t 1 5
Special Needs Bas cCare
Deve opment of CY 2024 Per Member Per Month Projected Costs
Rate Group: Non Dua Elig bles, A Reg ons Institut ona

Member Months: **3,971**

Service Category	Trend Category	Blend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	IHP Adjustment Factor	IMD Adjustment Factor	Seasonal Virus and COVID-19 Base Period Adjustment	AMP Cap Base Period Adjustment	Weight Loss Drugs	FY22 Experience PMPM	PMPM Trend	Elimination of MA Cost Sharing	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate Increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Inpatient	Medical	$ 6,961,707	0.9981	0.9988	0.9907	0.9940	1.0000	1.0000	$1,721.09	1.0534	1.0021					$1,816.77
Inpatient Crossover	Inpatient Crossover	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0776	1.0021					0.00
Outpatient (Non-ER)	Outpatient	Medical	1,771,597	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	442.08	1.1531	1.0021				1.0297	526.03
ER Outpatient	Outpatient	Medical	232,490	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	58.02	1.1531	1.0021					67.04
Outpatient Crossover	Outpatient Crossove	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.1720	1.0021					0.00
Physician - Primary Care	Physician	Medical	2,056,588	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	513.20	1.0905	1.0021					560.85
Physician - Specialty Care	Physician	Medical	914,010	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	228.08	1.0905	1.0021					249.26
Physician Crossover	Physician Crossover	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0338	1.0021					0.00
Dental	Dental	Dental	45,461	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	11.34	1.0905	1.0021	1.2991		1.3345		21.49
Mental Health/Substance Abuse Facility - Inpatient	Other	Medical	110,874	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	27.67	1.0905	1.0021					30.24
Mental Health/Substance Abuse Facility - Outpatient	Other	Medical	83,107	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	20.74	1.0905	1.0021					22.66
Mental Health/Substance Abuse Non-Facility	Other	Medical	324,387	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	81.43	1.0905	1.0021					89.00
Mental Health TCM	Other	Medical	52,812	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	13.18	1.0905	1.0021					14.40
Transportation	Other	Medical	951,793	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	237.51	1.0905	1.0021					259.56
Health Care Home (HCH)	Other	Medical	864	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	0.22	1.0905	1.0021					0.24
Home Health	Other	Home Health	57,972	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	14.47	1.0905	1.0021		1.1499			18.18
Hospice	Other	Medical	747,648	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	186.57	1.0905	1.0021					203.89
Hearing	Other	Medical	10,064	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	2.53	1.0905	1.0021					2.76
Vision	Other	Medical	19,575	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	4.88	1.0905	1.0021					5.34
Family Planning	Other	Medical	751	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	0.19	1.0905	1.0021					0.20
Medical Supplies/DME/Prosthetics	Other	Medical	1,008,531	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	251.67	1.0905	1.0021					275.04
Specialized Therapy	Other	Medical	-	0.9981	1.0000	1.0000	0.9940	1.0000	1.0000	0.00	1.0905	1.0021					0.00
Relocation Service Coordination (RSC)	Other	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0905	1.0021					0.00
Other Medical	Other	Medical	24,639	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	6.15	1.0905	1.0021					6.72
Pharmacy	Pharmacy	Pharmacy	2,832,491	0.9981	0.9988	1.0000	0.9940	0.8954	1.0181	644.38	1.1501	1.0021					742.66
Pharmacy Rebates	Pharmacy	Pharmacy	(2,350)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	(0.59)	1.1501	1.0021					(0.68)
Behavioral Health Home (BHH)	N/A	Medical	4,216	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	1.06	1.0000	1.0021					1.06
Certified Community Behavioral Health Clinics (CCBHC)	N/A	Medical	29,796	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	7.48	1.0000	1.0021					7.50
Non-State Plan Services	N/A	N/A	(85,872)	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	(21.58)	1.0000	1.0000					(21.58)
Impact for Other Program Adjustments																	29.02
Total Base Rate			**$ 18,153,151**	**0.9981**	**0.9988**	**0.9964**	**0.9941**	**0.9836**	**1.0026**	**$4,451.76**	**1.0921**	**1.0021**	**1.0008**	**1.0005**	**1.0011**	**1.0031**	**$4,927.65**

Non-CBP NF Add-On	**$0.00**
CBP NF Add-On	**$0.00**

Exhib t 1 6
Special Needs Bas cCare
Deve opment of CY 2024 Per Member Per Month Projected Costs
Rate Group: Non Dua Elig bles, Metro Counties, Community

Member Months: **212,808**

Service Category	Trend Category	Blend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	IHP Adjustment Factor	IMD Adjustment Factor	Seasonal Virus and COVID-19 Base Period Adjustment	AMP Cap Base Period Adjustment	Weight Loss Drugs	FY22 Experience PMPM	PMPM Trend	Elimination of MA Cost Sharing	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate Increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Inpatient	Medical	$ 85,141,378	0.9981	0.9988	0.9907	0.9940	1.0000	1.0000	$392.77	1.0534	1.0021					$414.61
Inpatient Crossover	Inpatient Crossover	Medical	35,567	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	0.17	1.0776	1.0021					0.18
Outpatient (Non-ER)	Outpatient	Medical	39,166,745	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	182.38	1.1531	1.0021				1.0297	217.01
ER Outpatient	Outpatient	Medical	6,207,788	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	28.91	1.1531	1.0021					33.40
Outpatient Crossover	Outpatient Crossove	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.1720	1.0021					0.00
Physician - Primary Care	Physician	Medical	50,674,947	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	235.96	1.0905	1.0021					257.87
Physician - Specialty Care	Physician	Medical	8,188,588	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	38.13	1.0905	1.0021					41.67
Physician Crossover	Physician Crossover	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0338	1.0021					0.00
Dental	Dental	Dental	3,541,697	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	16.49	1.0905	1.0021	1.3038		1.3345		31.36
Mental Health/Substance Abuse Facility - Inpatient	Other	Medical	23,648,837	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	110.12	1.0905	1.0021					120.34
Mental Health/Substance Abuse Facility - Outpatient	Other	Medical	7,012,363	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	32.65	1.0905	1.0021					35.68
Mental Health/Substance Abuse Non-Facility	Other	Medical	42,831,517	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	200.64	1.0905	1.0021					219.27
Mental Health TCM	Other	Medical	9,383,123	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	43.69	1.0905	1.0021					47.75
Transportation	Other	Medical	16,816,382	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	78.30	1.0905	1.0021					85.57
Health Care Home (HCH)	Other	Medical	96,877	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	0.45	1.0905	1.0021					0.50
Home Health	Other	Home Health	3,374,252	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	15.71	1.0905	1.0021		1.1499			19.75
Hospice	Other	Medical	737,989	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	3.44	1.0905	1.0021					3.76
Hearing	Other	Medical	311,385	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	1.46	1.0905	1.0021					1.59
Vision	Other	Medical	846,392	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	3.94	1.0905	1.0021					4.31
Family Planning	Other	Medical	208,195	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	0.97	1.0905	1.0021					1.06
Medical Supplies/DME/Prosthetics	Other	Medical	16,158,958	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	75.24	1.0905	1.0021					82.23
Specialized Therapy	Other	Medical	1,821,722	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	8.48	1.0905	1.0021					9.27
Relocation Service Coordination (RSC)	Other	Medical	33,124	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	0.16	1.0905	1.0021					0.17
Other Medical	Other	Medical	1,649,537	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	7.68	1.0905	1.0021					8.39
Pharmacy	Pharmacy	Pharmacy	101,501,463	0.9981	0.9988	1.0000	0.9940	0.9515	1.0259	461.36	1.1501	1.0021					531.73
Pharmacy Rebates	Pharmacy	Pharmacy	(124,898)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	(0.59)	1.1501	1.0021					(0.68)
Behavioral Health Home (BHH)	N/A	Medical	922,081	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	4.32	1.0000	1.0021					4.33
Certified Community Behavioral Health Clinics (CCBHC)	N/A	Medical	1,423,639	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	6.67	1.0000	1.0021					6.68
Non-State Plan Services	N/A	N/A	(2,005,557)	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	(9.41)	1.0000	1.0000					(9.41)
Impact for Other Program Adjustments																	12.85
Total Base Rate			**############ ####**	**0.9981**	**0.9988**	**0.9981**	**0.9946**	**0.9883**	**1.0060**	**$1,940.11**	**1.1039**	**1.0021**	**1.0026**	**1.0012**	**1.0036**	**1.0029**	**$2,181.24**

Non-CBP NF Add-On	**$24.12**
CBP NF Add-On	**$23.73**

Exhib t 1 7
Spec al Needs BasicCare
Deve opment of CY 2024 Per Member Per Month Projected Costs
Rate Group: Non Dual Elig bles, Non Metro North Counties Community

Member Months: **93,878**

Service Category	Trend Category	Blend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	IHP Adjustment Factor	IMD Adjustment Factor	Seasonal Virus and COVID-19 Base Period Adjustment	AMP Cap Base Period Adjustment	Weight Loss Drugs	FY22 Experience PMPM	PMPM Trend	Elimination of MA Cost Sharing	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate Increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Inpatient	Medical	$ 31,688,974	0.9981	0.9988	0.9907	0.9940	1.0000	1.0000	$331.39	1.0534	1.0021					$349.81
Inpatient Crossover	Inpatient Crossover	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0776	1.0021					0.00
Outpatient (Non-ER)	Outpatient	Medical	18,904,339	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	199.54	1.1531	1.0021				1.0297	237.43
ER Outpatient	Outpatient	Medical	3,495,616	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	36.90	1.1531	1.0021					42.64
Outpatient Crossover	Outpatient Crossove	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.1720	1.0021					0.00
Physician - Primary Care	Physician	Medical	20,786,407	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	219.41	1.0905	1.0021					239.78
Physician - Specialty Care	Physician	Medical	3,998,935	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	42.21	1.0905	1.0021					46.13
Physician Crossover	Physician Crossover	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0338	1.0021					0.00
Dental	Dental	Dental	1,738,451	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	18.35	1.0905	1.0021	1.2599		1.3345		33.72
Mental Health/Substance Abuse Facility - Inpatient	Other	Medical	9,118,877	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	96.25	1.0905	1.0021					105.19
Mental Health/Substance Abuse Facility - Outpatient	Other	Medical	2,373,070	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	25.05	1.0905	1.0021					27.37
Mental Health/Substance Abuse Non-Facility	Other	Medical	13,060,203	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	138.69	1.0905	1.0021					151.56
Mental Health TCM	Other	Medical	3,311,679	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	34.96	1.0905	1.0021					38.20
Transportation	Other	Medical	7,207,284	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	76.08	1.0905	1.0021					83.14
Health Care Home (HCH)	Other	Medical	10,504	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	0.11	1.0905	1.0021					0.12
Home Health	Other	Home Health	1,538,256	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	16.24	1.0905	1.0021		1.1499			20.40
Hospice	Other	Medical	336,189	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	3.55	1.0905	1.0021					3.88
Hearing	Other	Medical	99,934	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	1.06	1.0905	1.0021					1.16
Vision	Other	Medical	420,147	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	4.43	1.0905	1.0021					4.85
Family Planning	Other	Medical	74,660	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	0.79	1.0905	1.0021					0.86
Medical Supplies/DME/Prosthetics	Other	Medical	6,144,057	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	64.85	1.0905	1.0021					70.87
Specialized Therapy	Other	Medical	20,186	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	0.21	1.0905	1.0021					0.23
Relocation Service Coordination (RSC)	Other	Medical	22,090	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	0.23	1.0905	1.0021					0.26
Other Medical	Other	Medical	271,982	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	2.87	1.0905	1.0021					3.14
Pharmacy	Pharmacy	Pharmacy	47,883,676	0.9981	0.9988	1.0000	0.9940	0.9515	1.0259	493.38	1.1501	1.0021					568.63
Pharmacy Rebates	Pharmacy	Pharmacy	(36,697)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	(0.39)	1.1501	1.0021					(0.45)
Behavioral Health Home (BHH)	N/A	Medical	420,595	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	4.47	1.0000	1.0021					4.48
Certified Community Behavioral Health Clinics (CCBHC)	N/A	Medical	580,672	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	6.17	1.0000	1.0021					6.18
Non-State Plan Services	N/A	N/A	(824,499)	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	(8.77)	1.0000	1.0000					(8.77)
Impact for Other Program Adjustments																	12.03
Total Base Rate			**############ ####**	**0.9981**	**0.9988**	**0.9983**	**0.9945**	**0.9865**	**1.0069**	**$1,808.02**	**1.1081**	**1.0021**	**1.0026**	**1.0013**	**1.0042**	**1.0034**	**$2,042.85**
Non-CBP NF Add-On																	**$24.12**
CBP NF Add-On																	**$23.73**

Exh bit 1 8
Spec al Needs BasicCare
Deve opment of CY 2024 Per Member Per Month Projected Costs
Rate Group: Non Dual E gib es, Non Metro South Counties Commun ty

Member Months: **46,266**

Service Category	Trend Category	Blend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	IHP Adjustment Factor	IMD Adjustment Factor	Seasonal Virus and COVID-19 Base Period Adjustment	AMP Cap Base Period Adjustment	Weight Loss Drugs	FY22 Experience PMPM	PMPM Trend	Elimination of MA Cost Sharing	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate Increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Inpatient	Medical	$ 11,930,086	0.9981	0.9988	0.9907	0.9940	1.0000	1.0000	$253.15	1.0534	1.0021					$267.22
Inpatient Crossover	Inpatient Crossover	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0776	1.0021					0.00
Outpatient (Non-ER)	Outpatient	Medical	10,189,191	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	218.23	1.1531	1.0021				1.0297	259.67
ER Outpatient	Outpatient	Medical	403,624	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	8.64	1.1531	1.0021					9.99
Outpatient Crossover	Outpatient Crossove	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.1720	1.0021					0.00
Physician - Primary Care	Physician	Medical	11,630,917	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	249.11	1.0905	1.0021					272.24
Physician - Specialty Care	Physician	Medical	1,021,397	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	21.88	1.0905	1.0021					23.91
Physician Crossover	Physician Crossover	Medical	-	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	0.00	1.0338	1.0021					0.00
Dental	Dental	Dental	840,075	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	17.99	1.0905	1.0021	1.2000		1.3345		31.49
Mental Health/Substance Abuse Facility - Inpatient	Other	Medical	3,336,140	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	71.45	1.0905	1.0021					78.09
Mental Health/Substance Abuse Facility - Outpatient	Other	Medical	799,170	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	17.12	1.0905	1.0021					18.71
Mental Health/Substance Abuse Non-Facility	Other	Medical	6,069,548	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	130.78	1.0905	1.0021					142.92
Mental Health TCM	Other	Medical	2,264,675	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	48.50	1.0905	1.0021					53.01
Transportation	Other	Medical	2,897,327	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	62.05	1.0905	1.0021					67.82
Health Care Home (HCH)	Other	Medical	3,308	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	0.07	1.0905	1.0021					0.08
Home Health	Other	Home Health	1,108,247	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	23.74	1.0905	1.0021		1.1499			29.83
Hospice	Other	Medical	209,844	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	4.49	1.0905	1.0021					4.91
Hearing	Other	Medical	44,702	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	0.96	1.0905	1.0021					1.05
Vision	Other	Medical	255,854	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	5.48	1.0905	1.0021					5.99
Family Planning	Other	Medical	10,802	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	0.23	1.0905	1.0021					0.25
Medical Supplies/DME/Prosthetics	Other	Medical	3,229,946	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	69.18	1.0905	1.0021					75.60
Specialized Therapy	Other	Medical	2,664	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	0.06	1.0905	1.0021					0.06
Relocation Service Coordination (RSC)	Other	Medical	7,039	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	0.15	1.0905	1.0021					0.17
Other Medical	Other	Medical	804,176	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	17.22	1.0905	1.0021					18.82
Pharmacy	Pharmacy	Pharmacy	22,747,209	0.9981	0.9988	1.0000	0.9940	0.9515	1.0259	475.58	1.1501	1.0021					548.11
Pharmacy Rebates	Pharmacy	Pharmacy	(14,949)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	(0.32)	1.1501	1.0021					(0.37)
Behavioral Health Home (BHH)	N/A	Medical	124,370	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	2.68	1.0000	1.0021					2.69
Certified Community Behavioral Health Clinics (CCBHC)	N/A	Medical	368,212	0.9981	0.9988	1.0000	1.0000	1.0000	1.0000	7.93	1.0000	1.0021					7.95
Non-State Plan Services	N/A	N/A	(381,642)	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	(8.23)	1.0000	1.0000					(8.23)
Impact for Other Program Adjustments																	11.33
Total Base Rate			**$ 79,901,936**	**0.9981**	**0.9988**	**0.9986**	**0.9945**	**0.9862**	**1.0071**	**$1,698.13**	**1.1099**	**1.0021**	**1.0021**	**1.0021**	**1.0042**	**1.0039**	**$1,923.29**
Non-CBP NF Add-On																	**$24.12**
CBP NF Add-On																	**$23.73**

Exhib t 1 9
Special Needs Bas cCare
Deve opment of CY 2024 Per Member Per Month Projected Costs
Rate Group: Composite

Member Months: **758,019**

Service Category	Trend Category	Blend Category	FY22 Financial Experience Dollars	Financial-Encounter Adjustment Factor	IHP Adjustment Factor	IMD Adjustment Factor	Seasonal Virus and COVID-19 Base Period Adjustment	AMP Cap Base Period Adjustment	Weight Loss Drugs	FY22 Experience PMPM	PMPM Trend	Elimination of MA Cost Sharing	Dental Reimbursement and Critical Access Dental (CAD) Providers	Rate Increase for Home Care Services	Expansion of the MA Adult Dental Benefit	Outpatient Behavioral Health Rate Increase.	Total
Inpatient	Inpatient	Medical	$ 138,509,802	0.9981	0.9988	0.9907	0.9941	1.0000	1.0000	$179.41	1.0533	1.0021					$189.38
Inpatient Crossover	Inpatient Crossover	Medical	13,803,212	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	18.18	1.0722	1.0021					19.53
Outpatient (Non-ER)	Outpatient	Medical	72,347,974	0.9981	0.9988	1.0000	0.9942	1.0000	1.0000	94.60	1.1520	1.0021				1.0297	112.45
ER Outpatient	Outpatient	Medical	10,461,476	0.9981	0.9988	1.0000	0.9941	1.0000	1.0000	13.68	1.1527	1.0021					15.80
Outpatient Crossover	Outpatient Crossove	Medical	18,904,165	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	24.89	1.1662	1.0021					29.09
Physician - Primary Care	Physician	Medical	91,538,613	0.9981	0.9988	1.0000	0.9944	1.0000	1.0000	119.72	1.0871	1.0021					130.43
Physician - Specialty Care	Physician	Medical	14,741,779	0.9981	0.9988	1.0000	0.9943	1.0000	1.0000	19.28	1.0885	1.0021					21.03
Physician Crossover	Physician Crossover	Medical	36,645,796	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	48.25	1.0287	1.0021					49.74
Dental	Dental	Dental	13,944,635	0.9981	0.9995	1.0000	0.9974	1.0000	1.0000	18.30	1.0826	1.0021	1.2811		1.3345		33.95
Mental Health/Substance Abuse Facility - Inpatient	Other	Medical	39,943,963	0.9981	0.9989	1.0000	0.9946	1.0000	1.0000	52.25	1.0892	1.0021					57.03
Mental Health/Substance Abuse Facility - Outpatient	Other	Medical	14,826,029	0.9981	0.9991	1.0000	0.9959	1.0000	1.0000	19.42	1.0862	1.0021					21.14
Mental Health/Substance Abuse Non-Facility	Other	Medical	103,342,648	0.9981	0.9993	1.0000	1.0000	1.0000	1.0000	135.97	1.0849	1.0021					147.84
Mental Health TCM	Other	Medical	31,354,358	0.9981	0.9994	1.0000	0.9971	1.0000	1.0000	41.14	1.0832	1.0021					44.66
Transportation	Other	Medical	42,619,350	0.9981	0.9992	1.0000	0.9961	1.0000	1.0000	55.85	1.0856	1.0021					60.77
Health Care Home (HCH)	Other	Medical	129,594	0.9981	0.9989	1.0000	1.0000	1.0000	1.0000	0.17	1.0886	1.0021					0.19
Home Health	Other	Home Health	13,758,956	0.9981	0.9995	1.0000	0.9974	1.0000	1.0000	18.06	1.0826	1.0021		1.1499			22.53
Hospice	Other	Medical	2,041,070	0.9981	0.9988	1.0000	0.9940	1.0000	1.0000	2.67	1.0905	1.0021					2.92
Hearing	Other	Medical	883,415	0.9981	0.9993	1.0000	1.0000	1.0000	1.0000	1.16	1.0839	1.0021					1.26
Vision	Other	Medical	3,108,940	0.9981	0.9994	1.0000	0.9970	1.0000	1.0000	4.08	1.0834	1.0021					4.43
Family Planning	Other	Medical	303,086	0.9981	0.9988	1.0000	0.9942	1.0000	1.0000	0.40	1.0901	1.0021					0.43
Medical Supplies/DME/Prosthetics	Other	Medical	34,930,309	0.9981	0.9991	1.0000	0.9955	1.0000	1.0000	45.74	1.0871	1.0021					49.83
Specialized Therapy	Other	Medical	4,166,655	0.9981	0.9995	1.0000	0.9974	1.0000	1.0000	5.47	1.0827	1.0021					5.93
Relocation Service Coordination (RSC)	Other	Medical	144,207	0.9981	0.9995	1.0000	1.0000	1.0000	1.0000	0.19	1.0825	1.0021					0.21
Other Medical	Other	Medical	3,938,788	0.9981	0.9991	1.0000	0.9958	1.0000	1.0000	5.16	1.0863	1.0021					5.62
Pharmacy	Pharmacy	Pharmacy	178,053,644	0.9981	0.9988	1.0000	0.9941	0.9515	1.0253	227.10	1.1501	1.0021					261.73
Pharmacy Rebates	Pharmacy	Pharmacy	(181,839)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	(0.24)	1.1501	1.0021					(0.28)
Behavioral Health Home (BHH)	N/A	Medical	2,745,459	0.9981	0.9993	1.0000	1.0000	1.0000	1.0000	3.61	1.0000	1.0021					3.62
Certified Community Behavioral Health Clinics (CCBHC)	N/A	Medical	4,311,974	0.9981	0.9993	1.0000	1.0000	1.0000	1.0000	5.67	1.0000	1.0021					5.69
Non-State Plan Services	N/A	N/A	(4,251,441)	0.9981	1.0000	1.0000	1.0000	1.0000	1.0000	(5.60)	1.0000	1.0000					(5.60)
Impact for Other Program Adjustments																	7.65
Total Base Rate			**############ ####**	**0.9981**	**0.9990**	**0.9985**	**0.9958**	**0.9903**	**1.0049**	**$1,154.61**	**1.0985**	**1.0021**	**1.0044**	**1.0023**	**1.0067**	**1.0025**	**$1,299.00**
Non-CBP NF Add-On																	**$18.95**
CBP NF Add-On																	**$18.64**

Exhibit 2A
Calendar Year 2024 Special Needs BasicCare Rate Development
Development of CY 2024 Base Rate Per Member Per Month (PMPM)

			BasicCare Rate Components				NF Add-on Rate Components		Directed Payment Rate Components				Composite Capitation Rates	
			A	B	C	D	E	F	G	H	I	J	K	L
													(A+B+C+D+E+G+H+I)	(A+B+C+F+J)
Population			**Base Rate**	**Admin Rate**	**Margin**	**Premium Tax & HMO Surcharge**	**Non-CBP NF Add-on [1]**	**CBP NF Add-on [2]**	**Non-CBP Directed Payment for a Safety Net Hospital in Hennepin County**	**Margin for Non-CBP Directed Payment for a Safety Net Hospital in Hennepin County**	**Premium Tax & HMO Surcharge for Non-CBP Directed Payment for a Safety Net Hospital in Hennepin County**	**CBP Directed Payment for a Safety Net Hospital in Hennepin County [2]**	**Average 1.0 Risk Score Rate for Non-CBP Plans [1]**	**Average 1.0 Risk Score Rate for CBP Plans [2]**
Duals	Institutional	All Regions	$627.81	$73.42	$10.12	$11.57	N/A	N/A	$0.00	$0.00	$0.00	$0.00	$722.92	$711.35
	Community	Metro	566.59	65.11	9.12	10.42	$14.98	$14.74	0.00	0.00	0.00	0.00	666.22	655.56
		Non-Metro North	510.93	61.76	8.27	9.45	14.98	14.74	0.00	0.00	0.00	0.00	605.38	595.70
		Non-Metro South	549.07	62.75	8.83	10.09	14.98	14.74	0.00	0.00	0.00	0.00	645.72	635.39
Non-Duals	Institutional	All Regions	4,927.65	306.33	75.54	86.33	N/A	N/A	577.65	8.34	9.53	0.00	5,991.36	5,309.52
	Community	Metro	2,181.24	153.17	33.69	38.51	$24.12	$23.73	213.90	3.09	3.53	0.00	2,651.25	2,391.83
		Non-Metro North	2,042.85	143.34	31.55	36.06	24.12	23.73	9.87	0.14	0.16	0.00	2,288.10	2,241.46
		Non-Metro South	1,923.29	133.31	29.68	33.92	24.12	23.73	5.04	0.07	0.08	0.00	2,149.53	2,110.01

[1] Includes 1.0% premium tax and 0.6% HMO surcharge.
[2] Does not include 1.0% premium tax nor 0.6% HMO surcharge.

Exhibit 2B
Calendar Year 2024 Special Needs BasicCare Rate Development
CY 2024 Capitation Payment Rates
Non CBP Plans

Rate Regions			Risk Adjustment Base Rate [1]	Plan Acute Risk Factor [2]	Plan RA Rate [1], [2]	Directed Payment for a Safety Net Hospital in Hennepin County [1]	Plan RA Rate - Withhold [1], [2]	NF Add-on [1]	Plan Reimbursement Amount [1], [2]	Plan RA Rate - Withhold at Risk [1], [2], [3]	Certified Plan Reimbursement Amount [1], [2], [3]
			1	2	3	4	5	6	7	8	9
			Exh 2A (A + B + C + D)		(1 x 2)	Exh 2A (G + H + I)	(3 + 4) x 0.92	Exh 2A (E)	(5 + 6)	(3 + 4) x 0.9975	(6 + 8)
All Regions	**Institutionalized**	**Dual**	$722.92	1.0000	$722.92	$0.00	$665.08	N/A	$665.08	$721.11	$721.11
		Non-Dual	5,395.85	1.0000	5,395.85	595.51	5,512.05	N/A	5,512.05	5,976.39	5,976.39
Metro	**Non-Institutionalized**	**Dual**	651.24	1.0000	651.24	0.00	599.14	$14.98	614.12	649.61	664.59
		Non-Dual	2,406.61	1.0000	2,406.61	220.51	2,416.96	24.12	2,441.08	2,620.56	2,644.68
Non-Metro North	**Non-Institutionalized**	**Dual**	590.40	1.0000	590.40	0.00	543.17	14.98	558.15	588.93	603.91
		Non-Dual	2,253.80	1.0000	2,253.80	10.18	2,082.86	24.12	2,106.98	2,258.32	2,282.44
Non-Metro South	**Non-Institutionalized**	**Dual**	630.74	1.0000	630.74	0.00	580.28	14.98	595.26	629.17	644.15
		Non-Dual	2,120.21	1.0000	2,120.21	5.20	1,955.37	24.12	1,979.49	2,120.09	2,144.21

[1] Includes 1.0% premium tax and 0.6% HMO surcharge.
[2] The plan risk factor and risk adjusted rates will change every six months.
[3] Plan withhold ultimately at risk is 0.25%.

Exhibit 2C
Calendar Year 2024 Special Needs BasicCare Rate Development
CY 2024 Capitation Payment Rates
CBP Plans

Rate Regions			Risk Adjustment Base Rate [1]	Plan Acute Risk Factor [2]	Plan RA Rate [1], [2]	Directed Payment for a Safety Net Hospital in Hennepin County [1]	Plan RA Rate - Withhold [1], [2]	NF Add-on [1]	Plan Reimbursement Amount [1], [2]	Plan RA Rate - Withhold at Risk [1], [2], [3]	Certified Plan Reimbursement Amount [1], [2], [3]
			1	2	3	4	5	6	7	8	9
			Exh 2A (A + B + C)		(1 x 2)	Exh 2A (J)	(3 + 4) x 0.92	Exh 2A (F)	(5 + 6)	(3 + 4) x 0.9975	(6 + 8)
All Regions	Institutionalized	Dual	$711.35	1.0000	$711.35	$0.00	$654.44	N/A	$654.44	$709.57	$709.57
		Non-Dual	5,309.52	1.0000	5,309.52	0.00	4,884.76	N/A	4,884.76	5,296.24	5,296.24
Non-Metro North	Non-Institutionalized	Dual	580.96	1.0000	580.96	0.00	534.48	$14.74	549.22	579.50	594.24
		Non-Dual	2,217.74	1.0000	2,217.74	0.00	2,040.32	23.73	2,064.05	2,212.19	2,235.92
Non-Metro South	Non-Institutionalized	Dual	620.65	1.0000	620.65	0.00	571.00	14.74	585.74	619.10	633.84
		Non-Dual	2,086.29	1.0000	2,086.29	0.00	1,919.38	23.73	1,943.11	2,081.07	2,104.80

[1] Does not include 1.0% premium tax nor 0.6% HMO surcharge.
[2] The plan risk factor and risk adjusted rates will change every six months.
[3] Plan withhold ultimately at risk is 0.25%.

Exhibit 3A
Special Needs BasicCare
100 Day Nursing Facility Add On Rate Calculation
CY 2024 Capitation Payment Rates
Total Eligible Population

	CY 2023	CY 2024
NF Add-On (1)	$22.33	$19.32
Per Diem (2)	$330.78	$335.66
Monthly Freq (3)	0.167%	0.133%

Year	Month	(4) Monthly Enrollment	(5) = (1) x (4) Total NF Add-On Paid to Health Plans	(6) = (3) x (4) Admissions	Average NF Days for Admissions in Month by Contract Period (7) CY 2023	(8) CY 2024	NF Dollars for Admissions in Month by Contract Period (9) = (2) x (6) x (8) CY 2024
2023 Contract Period							
2023	January	66,395	$1,482,594	110.7	40.0	0.0	$0
	February	66,704	1,489,493	111.2	40.0	0.0	0
	March	66,910	1,494,093	111.5	40.0	0.0	0
	April	67,197	1,500,498	112.0	40.0	0.0	0
	May	67,485	1,506,933	112.5	40.0	0.0	0
	June	67,775	1,513,399	113.0	40.0	0.0	0
	July	68,065	1,519,895	113.4	40.0	0.0	0
	August	68,358	1,526,422	113.9	40.0	0.0	0
	September	68,651	1,532,980	114.4	40.0	0.0	0
	October	68,947	1,539,569	114.9	30.3	9.7	373,810
	November	69,243	1,546,189	115.4	19.4	20.6	796,883
	December	69,541	1,552,841	115.9	7.0	33.0	1,283,875
Total 2023 Contract Period		815,271	$18,204,907	1,358.8	34.6	5.4	$2,454,568
2024 Contract Period							
2024	January	69,840	$1,349,283	93.1		41.0	$1,281,527
	February	70,141	1,355,093	93.5		41.0	1,287,045
	March	70,443	1,360,930	93.9		41.0	1,292,589
	April	70,747	1,366,795	94.3		41.0	1,298,159
	May	71,052	1,372,687	94.7		41.0	1,303,756
	June	71,358	1,378,607	95.1		41.0	1,309,379
	July	71,666	1,384,556	95.6		41.0	1,315,029
	August	71,975	1,390,533	96.0		41.0	1,320,705
	September	72,286	1,396,538	96.4		41.0	1,326,409
	October	72,598	1,402,571	96.8		31.1	1,009,380
	November	72,912	1,408,633	97.2		19.9	649,827
	December	73,227	1,414,724	97.6		7.2	235,094
Total 2024 Contract Period		858,245	$16,580,949	1,144.3		35.5	$13,628,898
Grand Total							$16,083,466

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Exhibit 3B
Special Needs BasicCare
100 Day Nursing Facility Add On Rate Calculation
CY 2024 Non County Based Capitation Payment Rates

Rate Component		CY 2023	CY 2024
Section A			
Monthly Claim Frequency [Exh. 3A (3)]		0.167%	0.133%
(x) Truncated Medicaid Length of Stay [Exh. 3A (7) to (8)]		34.6	35.5
(x) Charge per Day [Exh. 3A (2)]		$330.78	$335.66
= Initial Rate (A) = [Exh. 3A (3)] x [Exh. 3A (7) to (8)] x [Exh. 3A (2)]		$19.09	$15.88
Section B			
NF Dollars for Prior Year Admits (B)		$2,399,901	$2,454,568
(/) Eligible Months [Exh. 3A (4)]		815,271	858,245
= Tail Rate (C) = (B) / [Exh. 3A (4)]		$2.94	$2.86
Section C			
Initial Base Rate (D) = (A) + (C)		$22.03	$18.74
Disenrollment Fee Adjustment (E)		0.983	1.000
Projected Costs (F) = (D) * (E)		$21.66	$18.74
Legislated Premium Tax Adjustment (G)		$0.36	$0.31
Margin (H)		$0.31	$0.27
Final Base Rate (I) = (F) + (G) + (H)		$22.33	$19.32
Non-Dual			$24.12
Dual			$14.98

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Exhibit 3C
Special Needs BasicCare
100 Day Nursing Facility Add On Rate Calculation
CY 2024 County Based Capitation Payment Rates

Rate Component		CY 2023	CY 2024
Section A			
Monthly Claim Frequency [Exh. 3A (3)]		0.167%	0.133%
(x) Truncated Medicaid Length of Stay [Exh. 3A (7) to (8)]		34.6	35.5
(x) Charge per Day [Exh. 3A (2)]		$330.78	$335.66
= Initial Rate (A) = [Exh. 3A (3)] x [Exh. 3A (7) to (8)] x [Exh. 3A (2)]		$19.09	$15.88
Section B			
NF Dollars for Prior Year Admits (B)		$2,399,901	$2,454,568
(/) Eligible Months [Exh. 3A (4)]		815,271	858,245
= Tail Rate (C) = (B) / [Exh. 3A (4)]		$2.94	$2.86
Section C			
Initial Base Rate (D) = (A) + (C)		$22.03	$18.74
Disenrollment Fee Adjustment (E)		0.983	1.000
Projected Costs (F) = (D) * (E)		$21.66	$18.74
Margin (G)		$0.31	$0.27
Final Base Rate (H) = (F) + (G)		$21.97	$19.01
Non-Dual			$23.73
Dual			$14.74

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APPENDICES

APPENDIX A

Rate Region County Definitions

(Provided in Excel)

Appendix A
Calendar Year 2024 Special Needs BasicCare Rate Development
Rate Region County Definitions

County Code	County Name	Final Rate Region
001	AITKIN	Non-Metro, North
002	ANOKA	Metro
003	BECKER	Non-Metro, North
004	BELTRAMI	Non-Metro, North
005	BENTON	Non-Metro, North
006	BIG STONE	Non-Metro, South
007	BLUE EARTH	Non-Metro, South
008	BROWN	Non-Metro, South
009	CARLTON	Non-Metro, North
010	CARVER	Metro
011	CASS	Non-Metro, North
012	CHIPPEWA	Non-Metro, South
013	CHISAGO	Non-Metro, North
014	CLAY	Non-Metro, North
015	CLEARWATER	Non-Metro, North
016	COOK	Non-Metro, North
017	COTTONWOOD	Non-Metro, South
018	CROW WING	Non-Metro, North
019	DAKOTA	Metro
020	DODGE	Non-Metro, South
021	DOUGLAS	Non-Metro, South
022	FARIBAULT	Non-Metro, South
023	FILLMORE	Non-Metro, South
024	FREEBORN	Non-Metro, South
025	GOODHUE	Non-Metro, South
026	GRANT	Non-Metro, South
027	HENNEPIN	Metro
028	HOUSTON	Non-Metro, South
029	HUBBARD	Non-Metro, North
030	ISANTI	Non-Metro, North
031	ITASCA	Non-Metro, North
032	JACKSON	Non-Metro, South
033	KANABEC	Non-Metro, North
034	KANDIYOHI	Non-Metro, South
035	KITTSON	Non-Metro, North
036	KOOCHICHING	Non-Metro, North
037	LAC QUI PARLE	Non-Metro, South
038	LAKE	Non-Metro, North
039	LAKE OF THE WOODS	Non-Metro, North
040	LE SUEUR	Non-Metro, South
041	LINCOLN	Non-Metro, South
042	LYON	Non-Metro, South
043	MCLEOD	Non-Metro, South
044	MAHNOMEN	Non-Metro, North
045	MARSHALL	Non-Metro, North
046	MARTIN	Non-Metro, South
047	MEEKER	Non-Metro, South
048	MILLE LACS	Non-Metro, North
049	MORRISON	Non-Metro, North
050	MOWER	Non-Metro, South
051	MURRAY	Non-Metro, South
052	NICOLLET	Non-Metro, South
053	NOBLES	Non-Metro, South
054	NORMAN	Non-Metro, North
055	OLMSTED	Non-Metro, South
056	OTTER TAIL	Non-Metro, North
057	PENNINGTON	Non-Metro, North
058	PINE	Non-Metro, North
059	PIPESTONE	Non-Metro, South
060	POLK	Non-Metro, North
061	POPE	Non-Metro, South
062	RAMSEY	Metro
063	RED LAKE	Non-Metro, North
064	REDWOOD	Non-Metro, South
065	RENVILLE	Non-Metro, South
066	RICE	Non-Metro, South
067	ROCK	Non-Metro, South
068	ROSEAU	Non-Metro, North
069	ST. LOUIS	Non-Metro, North
070	SCOTT	Metro
071	SHERBURNE	Non-Metro, North
072	SIBLEY	Non-Metro, South
073	STEARNS	Non-Metro, North
074	STEELE	Non-Metro, South
075	STEVENS	Non-Metro, South
076	SWIFT	Non-Metro, South
077	TODD	Non-Metro, North
078	TRAVERSE	Non-Metro, South
079	WABASHA	Non-Metro, South
080	WADENA	Non-Metro, North
081	WASECA	Non-Metro, South
082	WASHINGTON	Metro
083	WATONWAN	Non-Metro, South
084	WILKIN	Non-Metro, North
085	WINONA	Non-Metro, South
086	WRIGHT	Non-Metro, North
087	YELLOW MEDICINE	Non-Metro, South

APPENDIX B

Integrated Health Partnership Arrangements

(Provided in Excel)

Appendix B
Calendar Year 2024 Minnesota Public Programs Capitation Rate Development
Special Needs BasicCare
Integrated Health Partnership Arrangements

All Programs

	IHP Costs Removed from Base Period	IHP Costs Projected for CY 2024	Net IHP Cost Adjustment
IHPs Resetting Targets for 2022	-$20,133,204	$1,019,927	-$19,113,278
IHPs Resetting Targets for 2024			
IHPs Resetting Targets for 2023			
Total	**-$20,133,204**	**$1,019,927**	**-$19,113,278**

PMAP

	IHP Costs Removed from Base Period	IHP Costs Projected for CY 2024	Net IHP Cost Adjustment
IHPs Resetting Targets for 2022	-$16,293,475	$898,185	-$15,395,291
IHPs Resetting Targets for 2024			
IHPs Resetting Targets for 2023			
Total	**-$16,293,475**	**$898,185**	**-$15,395,291**

MinnesotaCare

	IHP Costs Removed from Base Period	IHP Costs Projected for CY 2024	Net IHP Cost Adjustment
IHPs Resetting Targets for 2022	-$2,822,324	$56,314	-$2,766,010
IHPs Resetting Targets for 2024			
IHPs Resetting Targets for 2023			
Total	**-$2,822,324**	**$56,314**	**-$2,766,010**

SNBC

	IHP Costs Removed from Base Period	IHP Costs Projected for CY 2024	Net IHP Cost Adjustment
IHPs Resetting Targets for 2022	-$1,017,405	$65,428	-$951,977
IHPs Resetting Targets for 2024			
IHPs Resetting Targets for 2023			
Total	**-$1,017,405**	**$65,428**	**-$951,977**

APPENDIX C

Institution for Mental Diseases (IMD) Adjustment

(Provided in Excel)

Appendix C
Calendar Year 2024 Special Needs BasicCare Rate Development
Capitation Rate Impact of Institutions for Mental Diseases (IMD) Legislative Adjustment

Measure of IMD Impact	All Programs
Excluded IMD Days	97,884
Excluded IMD Dollars	$32,074,738
Excluded Non-IMD Dollars	$6,345,383
Excluded Total Dollars	$38,420,121
Short Term IMD Days	20,837
Short Term IMD Actual Dollars	$10,523,876
Short Term IMD Repriced Dollars	$34,687,116
Short Term IMD Repriced Dollars Trended	$34,687,116
Excluded MMs	3,218
IP Factor	
Base Period Claims, IP	$1,221,145,804
Base Period MMs	12,155,038
Excluded Claims, IP	$3,283,271
Excluded MMs	1,335
Starting PMPM	$100.46
Ending PMPM	$100.21
IP Factor	**0.9974**
Non IP Factor	
Base Period Claims, Non IP	$4,463,985,059
Base Period MMs	12,155,038
Excluded Claims, Non IP	$2,633,334
Excluded MMs	1,335
Starting PMPM	$367.25
Ending PMPM	$367.08
Non IP Factor	**0.9995**

APPENDIX D

Trend Study

(Provided in Excel)

Append x D
Ca endar Year 2024 Spec a Needs Bas cCare Ra e Deve opmen
Per Annum H s or ca Trends CY 2017 o CY 2022
Broad Serv ce Ca egor es Overa Popu a on [1,2]

Category of Service	CY 2017 Reported PMPM	CY 2017 Provider Contracting Adjustment	CY 2017 Impact of Program Changes	CY 2017 Impact of Demographics	CY 2017 Adjusted PMPM
Hospital Inpatient	$242.03	1.000	1.000	1.005	$243.20
Hospital Outpatient	138.37	1.000	1.000	1.005	139.04
Physician	275.46	1.000	1.000	1.005	276.77
Dental	15.80	1.000	1.000	1.005	15.87
Home Health	24.19	1.000	1.000	1.005	24.31
Other	151.14	1.000	1.000	1.005	151.87
Composite without Pharmacy	**$846.99**	**1.000**	**1.000**	**1.005**	**$851.07**
Pharmacy	$197.98	1.000	1.000	1.005	$198.93

Category of Service	CY 2018 Reported PMPM	CY 2018 Provider Contracting Adjustment	CY 2018 Impact of Program Changes	CY 2018 Impact of Demographics	CY 2018 Impact of Admin Amounts in Service Costs	CY 2018 Adjusted PMPM
Hospital Inpatient	$249.68	1.005	1.000	1.002	1.000	$251.51
Hospital Outpatient	153.49	0.994	1.000	1.002	1.000	152.89
Physician	286.90	1.000	1.000	1.002	1.000	287.53
Dental	17.51	1.000	0.976	1.002	1.000	17.13
Home Health	22.73	1.000	1.000	1.002	1.000	22.78
Other	158.14	1.000	1.000	1.002	1.000	158.49
Composite without Pharmacy	**$888.46**	**1.000**	**1.000**	**1.002**	**1.000**	**$890.32**
Pharmacy	$196.61	1.000	1.000	1.002	1.000	$197.04

Category of Service	CY 2019 Reported PMPM	CY 2019 Provider Contracting Adjustment	CY 2019 Impact of Program Changes	CY 2019 Impact of Demographics	CY 2019 Adjusted PMPM	CY 2020 Reported PMPM	CY 2020 Provider Contracting Adjustment	CY 2020 Impact of Program Changes	CY 2020 Impact of Demographics	CY 2020 Adjusted PMPM
Hospital Inpatient	$242.35	1.010	0.999	1.005	$245.60	$244.79	1.019	1.000	1.001	$249.67
Hospital Outpatient	158.90	1.005	0.999	1.005	160.30	149.23	1.012	1.000	1.001	151.17
Physician	303.81	1.000	0.999	1.005	304.95	291.81	1.000	1.031	1.001	301.09
Dental	17.68	1.000	0.998	1.005	17.72	12.88	1.000	1.000	1.001	12.89
Home Health	21.72	1.000	1.000	1.005	21.82	21.52	1.000	1.000	1.001	21.54
Other	159.30	1.000	1.000	1.005	159.99	149.75	1.000	1.000	1.001	149.89
Composite without Pharmacy	**$903.75**	**1.004**	**0.999**	**1.005**	**$910.39**	**$869.98**	**1.007**	**1.010**	**1.001**	**$886.24**
Pharmacy	$195.20	1.000	0.998	1.005	$195.71	$222.76	1.000	1.000	1.001	$222.96

Category of Service	CY 2021 Reported PMPM	CY 2021 Provider Contracting Adjustment	CY 2021 Impact of Program Changes	CY 2021 Impact of Demographics	CY 2021 Adjusted PMPM	CY 2022 Reported PMPM	Annualized Trend Rates[3] CY 2017 - CY 2018	CY 2018 - CY 2019	CY 2019 - CY 2020	CY 2020 - CY 2021	CY 2021 - CY 2022
Hospital Inpatient	$245.73	1.015	1.000	0.994	$247.94	$257.93	2.67%	-3.64%	-0.33%	-1.58%	4.03%
Hospital Outpatient	154.92	1.018	1.000	0.994	156.81	158.40	10.39%	3.93%	-6.91%	2.48%	1.02%
Physician	321.46	1.000	1.000	0.994	319.62	337.38	3.66%	5.66%	-4.31%	6.77%	5.56%
Dental	15.61	1.000	1.455	0.994	22.59	21.31	10.31%	3.18%	-27.34%	21.14%	-5.69%
Home Health	19.01	1.000	1.000	0.994	18.90	17.83	-6.50%	-4.67%	-1.36%	-11.76%	-5.67%
Other	157.16	1.000	1.000	0.994	156.26	162.84	4.13%	0.51%	-6.40%	4.85%	4.21%
Composite without Pharmacy	**$913.89**	**1.007**	**1.008**	**0.994**	**$922.11**	**$955.69**	**4.39%**	**1.51%**	**-4.44%**	**3.12%**	**3.64%**
Pharmacy	$231.15	1.000	1.000	0.994	$229.82	$245.79	-1.17%	-0.93%	13.82%	3.67%	6.95%

[1] Reported service costs do not include Behavioral Health Home (BHH) or Certified Community Behavioral Health Clinics (CCBHC).
[2] No adjustments are made here to remove administrative costs reported as pharmacy costs in MCO financial reporting. Final base rates will be adjusted accordingly.
[3] Annualized Trend Rates are the reported PMPM for the latter year divided by the adjusted PMPM for the prior year and annualized as applicable.

APPENDIX E

Trend Assumptions

(Provided in Excel)

Appendix E
Calendar Year 2024 Special Needs BasicCare Rate Development
Benefit Specific Annual Trend Assumptions

	Dual Trend Rates			Non-Dual Trend Rates		
Service Category	**Utilization / Mix**	**Unit Cost**	**Total Cost**	**Utilization / Mix***	**Unit Cost****	**Total Cost**
Inpatient	0.5%	1.5%	2.0%	0.6%	1.5%	2.1%
Inpatient Crossover	0.0%	2.8%	2.8%	0.2%	2.8%	3.0%
Outpatient	3.2%	1.3%	4.6%	4.5%	1.3%	5.9%
Outpatient Crossover	3.2%	3.0%	6.3%	3.4%	3.0%	6.6%
Physician	1.6%	0.0%	1.6%	3.2%	0.3%	3.5%
Physician Crossover	1.6%	-0.5%	1.1%	1.8%	-0.5%	1.3%
Dental	3.0%	0.0%	3.0%	3.2%	0.3%	3.5%
Other	3.0%	0.0%	3.0%	3.2%	0.3%	3.5%
Composite (Excluding Pharmacy)			**2.9%**			**3.5%**
Pharmacy	-0.5%	6.2%	5.8%	-0.5%	6.2%	5.8%
Composite (Including Pharmacy)			**2.9%**			**4.1%**

**Non-Dual population includes acuity adjustments equal to a 0.5% increase (or 0.2% annualized increase).*

***Non-Dual Physician, Dental, and Other Medical categories of service include an additional 0.3% annualized increase to account foradditional pressures from workforce challenges and inflation in negotiating 2024 provider contracts.*

APPENDIX F

Pharmacy Trends

(Provided in Excel)

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Appendix F 1
Calendar Year 2024 Special Needs BasicCare Rate Development SNBC Non Dual
PMPM Trends

Category	FY 2022	CY 2022	CY 2023	CY 2024	Annualized Trend
Traditional	$367.26	$368.30	$384.06	$402.86	
Annualized Trend		0.6%	4.3%	4.9%	**3.8%**
Specialty	$127.71	$143.78	$155.55	$166.40	
Annualized Trend		26.8%	8.2%	7.0%	**11.2%**
Total	$494.97	$512.08	$539.60	$569.26	
Annualized Trend		7.0%	5.4%	5.5%	**5.8%**

Appendix F 2
Calendar Year 2024 Special Needs BasicCare Rate Development SNBC Non Dual
Utilization/1000 Trends

Category	FY 2022	CY 2022	CY 2023	CY 2024	Annualized Trend
Traditional	$54,606.47	$52,931.57	$53,335.06	$53,925.14	
Annualized Trend		-6.0%	0.8%	1.1%	**-0.5%**
Specialty	$338.24	$353.66	$368.71	$379.54	
Annualized Trend		9.3%	4.3%	2.9%	**4.7%**
Total	$54,944.71	$53,285.23	$53,703.77	$54,304.68	
Annualized Trend		-5.9%	0.8%	1.1%	**-0.5%**

Appendix F 3
Calendar Year 2024 Special Needs BasicCare Rate Development SNBC Non Dual
Cost/Rx Trends

Category	FY 2022	CY 2022	CY 2023	CY 2024	Annualized Trend
Traditional	$90.51	$94.96	$98.74	$102.88	
Annualized Trend		10.1%	4.0%	4.2%	**5.3%**
Specialty	$2,947.62	$3,163.71	$3,278.35	$3,381.24	
Annualized Trend		15.2%	3.6%	3.1%	**5.6%**
Total	$108.10	$115.32	$120.57	$125.79	
Annualized Trend		13.8%	4.6%	4.3%	**6.2%**

APPENDIX G

2024 SNBC Risk Adjustment Methodology

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APPENDIX G

2024 SNBC RISK ADJUSTMENT METHODOLOGY

This section of the report outlines the methodology for the development of the disease cost weights, member risk scores, and overall health plan risk scores by which the SNBC base rates will be risk adjusted.

OVERVIEW OF RISK ADJUSTMENT METHODOLOGY

Capitation rates paid to the plans for non-dual eligible individuals will be risk-adjusted using the Chronic Illness and Disability Payment System (CDPS+Rx) version 6.5 risk adjuster. CDPS+Rx utilizes medical diagnoses and pharmacy utilization to develop estimates of the relative disease burdens of Medicaid populations. Each beneficiary enrolled in the SNBC program during the enrollment month used to develop risk scores will be assigned a prospective risk score based on their managed care and fee-for-service (FFS) medical and pharmacy utilization using data during the assessment period.

Due to differences in reporting of pharmacy data for dual eligible members between integrated and non-integrated plans, the capitation rates paid to plans for dual eligible individuals will be risk-adjusted using the CDPS version 6.5 risk adjuster, which utilizes medical diagnoses to develop estimates of the relative disease burdens of Medicaid populations, but excludes pharmacy utilization information. Any references to CDPS + Rx in the report should be considered CDPS + Rx for the non-dual eligible individuals and CDPS for the dual eligible individuals. Separate cost weights were developed for the dual eligible and non-dual eligible populations.

A health plan's final capitation rate for each of the eight SNBC rate groups (which are combinations of dual / non-dual, community / institutional, and region indicators) will be determined based upon the following formula:

Rate Group Capitation Rate = Rate Group Base Rate x Plan Rate Group Risk Score

The plan rate group risk score will be the rate group risk score for each health plan divided by a normalization factor equal to the overall average rate group risk scores for all health plans. This normalization adjustment is required to ensure a 1.000 aggregate rate group risk score for the SNBC population as a whole, thereby ensuring a budget neutral risk-adjustment process. Risk scores will be calculated twice during calendar year (CY) 2024. Details regarding the enrollment month and assessment periods used to calculate plan rate group risk scores will be provided in the 2024 Risk Score Calculation section of this appendix.

COST WEIGHT DEVELOPMENT

Separate prospective cost weights were developed for non-dual eligible and dual eligible individuals for purposes of calculating individual risk scores for each eligible member in the SNBC program. Appendices F1 (non-dual eligible) and F2 (dual eligible) contain the SNBC demographic (including waiver status) and disease cost weights. The additive disease cost weights reflect the relative cost of providing care to individuals with particular medical conditions. In addition, for the portion of claim costs not explainable by the CDPS + Rx condition groupings, additive age / gender relativities were also developed, consistent with the CDPS + Rx standard methodology.

We utilized fiscal year (FY) 2021 diagnoses from plan encounter data and other FFS enrollee claim records to identify member diagnoses that trigger CDPS + Rx conditions. These conditions and member demographic information were then utilized to create cost weights to best predict relative FY 2022 encounter data paid amounts. This process only considered information for individuals who were both enrolled in the SNBC program in FY 2022 for six or more months and had medical or pharmacy utilization in FY 2021. The methodology below explains the details of the process using the FY 2021 diagnoses and FY 2022 paid amounts to develop the cost weights.

Methodology

We developed SNBC specific cost weights for the demographic and disease categories defined in the combined CDPS + Rx risk adjuster version 6.5, developed by the University of California – San Diego that is frequently used to risk adjust Medicaid populations. The initial structure of the model was kept the same as the standard CDPS + Rx model, which assigns a starting demographic risk score for each eligible member reflecting their age and gender. We added additional risk weights to the model to adjust for the specific costs of members with three or more months of Targeted Case Management (TCM) claims, the developmental disabilities (DD) waiver population, and the Community Alternatives for Disabled Individuals (CADI) waiver population. After adding the new risk weights, the intercept for each model was 0. A member is assigned to disease categories based upon their prescription drug history (non-dual eligible only) and ICD-10 diagnosis codes (dual eligible and non-dual eligible). Cost weights were developed separately for the dual eligible and non-dual eligible populations.

APPENDIX G

2024 SNBC RISK ADJUSTMENT METHODOLOGY

We developed cost weights for the demographic and disease categories defined in CDPS + Rx by performing a prospective regression analysis on statewide FY 2021 and FY 2022 health plan encounter and FFS claims data. All managed care encounter and FFS eligibility information and diagnoses (up to 25 codes of UB-04 forms and 12 codes on CMS-1500 forms) from FY 2021 were utilized to predict SNBC encounter paid amounts for FY 2022.

We reviewed the initial results of the model and made the following adjustments to the standard CDPS + Rx condition categories:

- Certain condition categories, or certain severity levels within a particular condition category, proved to be poor predictors of future costs for this population and were removed from the model. Such categories include "Pregnancy, complete" and "Pregnancy, incomplete," which have historically been removed from the model, in addition to various categories from either the non-dual model, dual model, or both. Categories that we determined to be poor predictors of future costs generally had a cost weight very close to or equal to zero and / or they had a p-value that was not statistically significant. CDPS + Rx condition categories that were removed are denoted by "n/a" in Appendices F1.B and F2.B. Additionally, after reviewing feedback from health plans and considering the predictive model performance of all variables in the risk model, we added the following cost weight variables to the risk model this year to help more accurately spread revenue across health plans:

  - Mental Health Targeted Case Management (TCM): Individuals with costs associated with these services are identified as FY 2022 members with three or more months with at least one TCM claim in FY 2021.

  - CADI (Community Alternatives for Disabled Individuals) Waiver.

- Several categories representing different severity levels within a particular disease type were combined to increase the credibility of the results.

- We reviewed the pharmacy data for dual eligible members between integrated and non-integrated plans and determined that the MRX categories were resulting in significantly more diagnoses for the individuals in the integrated plans over the non-integrated plans. We are unable to split the data for the integrated plans by Medicare or Medicaid costs to adjust for these differences. Therefore, the MRX categories were excluded from the dual eligible model.

The following are several technical details concerning the data utilized in cost weight development:

- The starting data set includes complete Medicaid eligibility information, whether members were enrolled in SNBC, FFS, or other public programs (e.g., PMAP, MNCare). It also includes all plan encounters and other member claims not paid by health plans.

- Member age is calculated as of January 1, 2022. We calculated one age per recipient because CDPS + Rx regression analysis is performed at a recipient level. Additionally, assigning an age at each month has a minimal effect on the actual results.

- Recipients that changed Medicare eligibility status during FY 2022 had their FY 2021 claims experience split between the dual eligible and non-dual eligible models. All FY 2021 diagnoses for these recipients were included in both models.

- The data set was adjusted to remove recipients with no medical or pharmacy utilization in FY 2021 and individuals enrolled in the SNBC program for less than six member months in FY 2022.

- Select laboratory and radiology diagnostic claims were not utilized for identifying condition diagnoses. These claims often include "rule-out" diagnoses, which are diagnosis codes for conditions the patient is suspected as having, but which have not been confirmed to be present. However, costs for these services were retained for use in the regression. The full list of excluded laboratory and radiology diagnostic codes are shown in Appendix G3.

- Similarly, claims identified as medical supplies or durable medical equipment (DME) were not utilized for identifying condition diagnoses. Because these claims are often submitted by non-clinician healthcare professionals, they are generally not considered a credible indicator of the presence of a disease.

APPENDIX G

2024 SNBC RISK ADJUSTMENT METHODOLOGY

R-Squared

R-squared measures the variability in a data set that is accounted for by the statistical model. R-squared values for regression models vary from 0% to 100%, with 100% indicating a model that explains all the variation in a particular data set. The regression models calibrated to non-dual eligible and dual eligible experience and eligibility have R-squared measures of 21% and 16%, respectively. These values are on par with typical prospective model predictive powers for a Medicaid population, including the prospective model for people with disabilities created by the University of California – San Diego. These values are also in line with predictive powers for risk models for similar populations and population sizes that Milliman has created for other state agencies.

2024 RISK SCORE CALCULATION

Risk scores for January 2024 through June 2024 will be based on SNBC enrollment as of October 2023, while risk scores for July 2024 through December 2024 will be based on SNBC enrollment as of April 2024. Each member enrolled in the SNBC program during the respective enrollment month with any FFS claim or managed care encounter data will be assigned a risk score based on the following information:

- Demographic information (including rate group and waiver program enrollment) in the enrollment month
- Medical diagnoses (non-dual and dual eligible) and pharmacy utilization (non-dual eligible only) based on managed care encounter and FFS claims data
- The cost weights used to calculate the risk scores are included in Appendix G1 (non-dual eligible) and Appendix G2 (dual eligible)

Table 1 below provides a summary of the effective months, enrollment month, and assessment period for each of these calculations.

Table 1
2024 Special Needs BasicCare Rate Development
2024 Risk Score Timeline

Effective Months	Assessment Period	Enrollment Period for Calculation	Calculation Date
January 2024 to June 2024	July 2022 to June 2023	October 2023	November 2023
July 2024 to December 2024	January 2023 to December 2023	April 2024	May 2024

Individuals enrolled in the SNBC program as of the enrollment month that have no FFS claim or managed care encounter data associated with the individual during the assessment period (i.e., new enrollees) will receive the average plan rate group risk score for that individual.

We will calculate eight risk scores for each plan, consistent with the eight SNBC rate groups. A plan's rate group risk score will be the rate group risk score for each health plan divided by a normalization factor equal to the overall average rate group risk scores for all health plans. This normalization is required to ensure a 1.00 aggregate rate group risk score for the SNBC population as a whole, thereby making the risk-adjustment process budget neutral.

The normalized risk scores aggregated by MCO, program, and rate cell will be set no lower than 0.900 and no higher than 1.100 for institutional rate cells only. This step will limit the impact that the low-credibility institutional rate cells may have on a health plan's revenue, while still reflecting members' acuity. This step is budget neutral to the state and to the health plans.

APPENDIX H

Actuarial Certification

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September 19, 2023

Minnesota Department of Human Services
Capitated Contracts Ratesetting
Actuarial Certification
Special Needs BasicCare

I, Michael Cook, am associated with the firm of Milliman, Inc. I am a member of the American Academy of Actuaries, and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I have been retained by the Minnesota Department of Human Services (DHS) to perform an actuarial certification of the capitation rates for the rating period of January 1, 2024 through December 31, 2024 for the Special Needs BasicCare (SNBC) program. This certification does not cover the Medicare Advantage capitation rates from CMS, which are components of the overall capitation rate paid through the SNBC program. The health plans participating in SNBC should consider all sources of capitation when evaluating the program.

I reviewed the actuarial assumptions and actuarial methods used to develop payment rates for the period of January 1, 2024 through December 31, 2024 for SNBC. I reviewed the calculated capitation rates and am familiar with the following regulation and guidance:

- The requirements of 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7
- CMS "Appendix A, PAHP, PIHP, and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting dated November 10, 2014"
- 2023 to 2024 Medicaid Managed Care Rate Development Guide
- Actuarial Standard of Practice 49 – Medicaid Managed Care Capitation Rate Development and Certification

The payment rates, methodology, data, and assumptions used to calculate the January 1, 2024 through December 31, 2024 rates are documented in our report to DHS, which is attached to this certification.

In making my opinion, I relied on the accuracy of the data and information provided by DHS and the health plans with which they contract. The report referenced above includes a description of the data and information upon which I relied. A copy of the reliance letter received from DHS is attached and constitutes part of this opinion. I performed no independent verification as to the accuracy or completeness of this data and information. I reviewed the data for reasonableness and consistency with prior years and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary.

In my opinion, the payment rates identified above are actuarially sound, as defined in 42 CFR 438.4, including that they:

1. Have been developed in accordance with generally accepted actuarial principles and practices and Actuarial Standards of Practice.

2. Are appropriate for the populations to be covered and the services furnished.

3. Meet the relevant actuarial requirements of 42 CFR 438.4(b).

Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will differ from these projections and will be dependent on each contracted health plan's situation and experience. These capitation rates may not be appropriate for all health plans. Any health plan considering participating in SNBC should consider their unique circumstances before deciding to contract under these rates.

This certification is intended solely for the use of DHS and the federal agencies to which this certification must be submitted. This certification should not be relied upon by other parties. This Opinion assumes the reader is familiar with the Minnesota Medicaid program, SNBC, Medicaid eligibility rules, and actuarial rating techniques. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the results.

Michael Cook
Member, American Academy of Actuaries

Date: September 19, 2023

APPENDIX I

Rate Setting Checklist

APPENDIX I

RATE SETTING CHECKLIST

This section of the report lists each item in the November 10, 2014 CMS checklist and discusses how DHS addresses each issue and / or directs the reader to other parts of this report. CMS uses the rate setting checklist to review and approve a state's Medicaid capitation rates.

AA.1.0 – Overview of Rates Being Paid Under the Contract

The CY 2024 Special Needs BasicCare (SNBC) and Nursing Facility (NF) add-on capitation rates are developed using FY 2022 Minnesota Medicaid managed care organization (MCO) financial summary data and FY 2022 encounter data for the MCO eligible population, along with other information. DHS sets rates by region and rate cell that vary by MCO for 2024.

Please refer to the *Executive Summary* of this rate report for background on the program and more details around the rate development.

AA.1.1 – Actuarial Certification

The actuarial certification of the CY 2024 capitation rates is included as Appendix H. The SNBC and NF add-on capitation rates have been developed in accordance with generally accepted actuarial principles and practices and are appropriate for the populations to be covered and the services to be furnished under the contract.

AA.1.2 – Projection of Expenditures

Not required under current regulation.

AA.1.3 – Risk Contracts

The Minnesota SNBC program including the basic care and NF-add on payments meet the criteria of a risk contract.

AA.1.4 – Modifications

The CY 2024 rates documented in this report are the initial capitation rates for the CY 2024 SNBC contracts.

Note: There is no AA.1.5 on the Rate Setting Checklist

AA.1.6 – Limit on Payment to Other Providers

Any provider rate enhancement is built into the capitation rates and is addressed in the rate memo.

AA.1.7 – Risk and Profit

Targeted margin is considered as part of final rate development.

AA.1.8 – Family Planning Enhanced Match

DHS does not claim enhanced match for family planning services for the population covered under this program.

AA.1.9 – Indian Health Service (IHS) Facility Enhanced Match

DHS does not claim enhanced match for Indian Health Services for the population covered under this program.

AA.1.10 – Newly Eligible Enhanced Match

The SNBC and NF add-on programs previously covered the newly eligible Medicaid population. Therefore, none of the recipients are eligible for the enhanced Federal match under Section 1905(y).

AA.1.11 – Retroactive Adjustments

The rates documented in this rate report are the capitation rates for the CY 2024 SNBC managed care contracts. The basic care and NF add-on payments do not contain any retroactive adjustments.

APPENDIX I

RATE SETTING CHECKLIST

AA.2.0 – Based Only Upon Services Covered Under the State Plan

The CY 2024 rate methodology relies on FY 2022 MCO financial summary data and encounter data as the primary data source. Only State Plan, cost effective in lieu of services, and waiver services covered under the SNBC contract have been included in the rate development. IMD stays and applicable member months were accounted for based on the regulations.

Please refer to Section II of the rate report for more details.

AA.2.1 – Provided Under the Contract to Medicaid-Eligible Individuals

The capitation rate development methodology relies on data that includes only those eligible and currently enrolled in the SNBC program and does not include experience for individuals not eligible to enroll in the program.

AA.2.2 – Data Sources

The CY 2024 capitation rates are developed using Minnesota Medicaid SNBC and NF add-on MCO financial summary, encounter, and eligibility data for FY 2022 for the MCO eligible population as the primary data source.

Please refer to Section II of the rate report for more details.

AA.3.0 – Adjustments to Base Year Data

All adjustments to the base year data are discussed in Sections II to VI of this report. In addition, each item in the checklist is addressed in items AA.3.1 to AA.3.17 below.

AA.3.1 – Benefit Differences

The base data used to calculate the capitation rates has been adjusted to only include services covered under the Medicaid MCO program contract, as outlined in Section II of the rate report.

The following sections outline legislative or program changes implemented between the base period year and the contract period.

- Basic Care – Section III
- NF add-on – Section VI

AA.3.2 – Administrative Cost Allowance Calculations

The MCO capitation rates include explicit administrative allowances calculation, as described in Section V.B of the rate report.

AA.3.3 – Special Populations' Adjustments

The capitation rates methodology does not include an adjustment for special populations, as the base MCO encounter data used to calculate the capitation rates is consistent with the Minnesota SNBC program population.

AA.3.4 – Eligibility Adjustments

The base MCO financial summary and encounter data only reflect experience for time periods where members were enrolled in a SNBC MCO.

AA.3.5 – Third Party Liability (TPL)

The managed care organizations are responsible for the collection of any TPL recoveries. The MCO encounter data is reported net of TPL recoveries; therefore, no adjustment was necessary.

APPENDIX I

RATE SETTING CHECKLIST

AA.3.6 – Indian Health Care Provider Payments

The state pays IHCPs directly through FFS; the services are carved-out of the MCO contracts and these claims do not appear in the MCO encounters

AA.3.7 – DSH Payments

DSH payments are not included in the capitation rates.

AA.3.8 – FQHC and RHC Reimbursement

FQHC and RHC encounter claims and settlements are not included in the capitation rates for all non-dual SNBC populations.

AA.3.9 – Graduate Medical Education (GME)

GME payments are not included in the capitation rates.

AA.3.10 – Copayments, Coinsurance, and Deductibles in Capitated Rates

The MCOs waive all Medicaid cost-sharing for community enrollees according to the contract. Therefore, there are no coinsurance or deductible requirements. Effective 1/1/2024, all cost-sharing for covered services in the SNBC program will be eliminated. The adjustment for the increase to the state liability is documented in Section II.A.

The Minnesota SNBC SNP program integrates Medicare and Medicaid primary, acute, drugs, home care, and the first 100 days of care in a nursing facility. The Medicaid share of the Medicare cost-sharing payments are reflected in the experience data.

AA.3.11 – Medical Cost / Trend Inflation

Trend rates from FY 2022 to CY 2024 were developed by program and type of service for SNBC and NF add-on eligible services and individuals using historical MCO financial summary data from January 2018 to December 2022 and actuarial judgment. Please see the following sections for more details on the trend development.

- Basic Care – Section IV
- NF add-on – Section VI

AA.3.12 – Utilization Adjustments

Please see Section IV for more details on the utilization trend development.

AA.3.13 – Utilization and Cost Assumptions

The capitation rates use an actuarially sound risk adjustment model to adjust the rates for each participating MCO in a particular region in order to reflect the acuity of enrolled members. Acuity adjustments were applied independently from the unit cost and utilization trend adjustments.

AA.3.14 – Post-Eligibility Treatment of Income (PETI)

Capitation rates are developed net of patient liability. Base MCOs' financial summary data are net of patient liability, so no adjustment to the data is necessary for this issue.

AA.3.15 – Incomplete Data Adjustment

The FY 2022 financial summary data was provided with limited months of runout. Plans provided IBNR amounts as part of the submission to include in the base data development. These amounts were reviewed for reasonableness and included as part of the base data. See Section II for additional details.

AA.3.16 – Primary Care Rate Enhancement

Not applicable.

AA.3.17 – Health Homes

The cost of health care homes is included in the SNBC rates.

AA.4.0 – Establish Rate Category Groupings

The rate category groupings are described in Section II.A of the rate report. The details for the development of the rates for each rate category are included in Exhibit 1.

AA.4.1 – Eligibility Categories

There is one eligibility category for SNBC; those individuals with disabilities who are ages 18 to 64.

AA.4.2 – Age

Those ages 18 to 64 are eligible for enrollment in the SNBC program.

AA.4.3 – Gender

Gender is not used for rate category groupings.

AA.4.4 – Locality / Region

Geographic regions are defined in Appendix A.

AA.4.5 – Risk Adjustments

The risk adjustment model is described in Appendix G.

AA.5.0 – Data Smoothing

We did not perform any data smoothing.

AA.5.1 – Cost-Neutral Data Smoothing Adjustment

We did not perform any data smoothing.

AA.5.2 – Data Distortion Assessment

Our review of the base MCO financial summary and encounter data did not detect any material distortions or outliers.

AA.5.3 – Data Smoothing Techniques

We determined that a data smoothing mechanism resulting from data distortions was not required.

AA.5.4 – Risk Adjustments

The capitation rates use an actuarially sound risk adjustment model based on MCO submitted encounter data to adjust the rates for each participating MCO. Please see Appendix G of this report.

AA.6.0 – Stop Loss, Reinsurance, or Risk Sharing Arrangements

For 2024, there will be an additional payment for individuals with claims over $2 million for consecutive years. Please refer to the contract for specific details.

APPENDIX I

RATE SETTING CHECKLIST

AA.6.1 – Commercial Reinsurance

DHS does not require entities to purchase commercial reinsurance.

AA.6.2 – Stop-Loss Program

A stop-loss provision is included that covers individuals who have outlier costs above $2 million in the contract year, as well as in the previous contract year.

AA.6.3 – Risk Corridor Program

Not applicable.

AA.7.0 – Incentive Arrangements

There are no incentive arrangements in the programs.

Capitation rates are certified as actuarially sound net of the portion of funds withheld from capitation that is not reasonably expected to be returned to the MCOs (0.25%).

AA.7.1 – Electronic Health Records (EHR) Incentive Payments

DHS has not implemented incentive payments related to EHRs for the contract period.

APPENDIX J

Responses to CMS Rate Setting Guide

APPENDIX J

RESPONSES TO 2023-2024 MANAGED CARE RATE SETTING GUIDE

SECTION I. MEDICAID MANAGED CARE RATES

1. **General Information**

   A. **Rate Development Standards**

      i. The CY 2024 capitation rates do not include a rate range.

      ii. The rate certification included in Appendix H is for the January 2023 to December 2024 (CY 2024) contract period.

      iii. The rate certification includes all of the items required in the rate development guide.

         a. The rate certification is included in Appendix H.

         b. The final capitation rates are shown in Exhibit 2.

         c. The descriptions of SNBC can be found in Section I of the report.

         The SNBC program began in 2008 and provides voluntary coverage to adults with disabilities ages 18 to 64. This program provides coverage for basic acute care services, such as emergency room, hospital, preventative care services, and behavioral health services, and offers a care coordinator or navigator to help enrollees get health care and support services. Additionally, the program provides coverage for home health services, including skilled nursing visits, home health aide and home care therapies, and 100 days of nursing facility coverage through the SNBC Nursing Facility Add-on. Personal care assistance, home care nursing, and home and community based waiver services are provided to SNBC enrollees on a fee-for-service (FFS) basis.

         Seven health plans serve the SNBC population statewide. Two of the plans are County Based Purchasing (CBP) plans, while an additional plan, Hennepin Health, is owned and operated by Hennepin County, but does not receive the "CBP" designation. These three plans are referred to as County Owned and Operated Plans, or "COO" plans.

         The following directed payment arrangements apply to the SNBC program for CY 2024. Additional documentation of these arrangements is included below in Section I.4.D of this rate setting guide.

         - Inclusion of Care Coordination Services in a BHH minimum fee schedule
         - CCBHC minimum fee schedule
         - IHP shared savings arrangement
         - Substance Use Disorder 1115 Demonstration Waiver minimum fee schedule
         - Directed Payment for a Safety Net Hospital in Hennepin County
         - Dental Services minimum fee schedule
         - Culturally / disability responsive SUD minimum fee schedule
         - Managed long-term services and supports minimum fee schedule
         - Critical Access Mental Health Minimum Fee Schedule
         - Rate Increase for Outpatient Behavioral Health Services
         - Separate Reimbursement for Long-Acting Reversible Contraceptives (LARCs)
         - Fuel Adjustor for NEMT and Ambulance Services
         - Rate increase for Adult Day Treatment

      iv. Rate differences by rate cell are not based on federal financial participation rates.

      v. Rate cells do not cross-subsidize other rate cells.

      vi. The assumptions used to develop the capitation rates are consistent with the effective dates of all changes to the SNBC program from the fiscal year (FY) 2022 base period to CY 2024.

      vii. The target MLR within the CY 2023 rates is 90.2% on a statewide basis for the SNBC program using FY 2022 base period membership. As such, the capitation rates are developed, such that MCOs can reasonably achieve an MLR of greater than 85%.

viii. The CY 2024 capitation rates do not include a rate range.

ix. The CY 2024 capitation rates do not include a rate range.

x. The rate setting report includes documentation showing that the CY 2024 rates were developed using generally accepted actuarial practices and principles.

   a. All adjustment to the capitation rates reflect reasonable, appropriate, and attainable costs.

   b. No adjustments to the rates are performed outside of the initial rate setting process beyond those outlined in Sections III-VI of the report.

   c. The final contracted rates in each cell match the capitation rates in the certification.

xi. The rate certification covers the CY 2024 time period.

xii. Section I.D includes documentation of the COVID-19 and related unwinding considerations in the CY 2024 rate development.

xiii. The SNBC rate certification in Appendix H is consistent with CMS procedures. SNBC rates will be risk adjusted semi-annually according to the methodology documented in Appendix G.

B. **Appropriate Documentation**

i. The actuary is certifying CY 2024 capitation rates.

ii. We believe this report properly documents all the elements included in the rate certification and provides CMS enough detail to determine that regulation standards are met. Please see this report for the following details:

   a. Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources.

   b. Assumptions made, including any basis or justification for the assumption.

   c. Methods for analyzing data and developing assumptions and adjustments.

iii. The actuarial certification includes specific rates for each rate cell. Please see this report for support for the specific assumptions that underlie each certified rate. The assumptions used in rate development do not differ by managed care organization.

iv. The CY 2024 capitation rates do not include a rate range.

v. We detail within our responses in this guide the section of our report where each item described in the 2023-2024 Medicaid Managed Care Rate Development Guide can be found.

vi. All differences in the assumptions, methodologies, and factors used to develop capitation rates for covered populations comply with 42 C.F.R. § 438.4(b)(1), are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and do not vary with the rate of FFP associated with the covered populations.

vii. All services covered for the SNBC population are subject to the same Federal Medical Assistance Percentage (FMAP).

viii. Relative to the previous rating period:

   a. See Table 1 for a rate comparison of CY 2024 capitation rates to CY 2023 capitation rates. See Section I for additional information regarding this rate change.

b. The CY 2024 capitation rates do not include any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.

c. There were no de minimis adjustments made to the actuarially sound CY 2023 capitation rates.

ix. There are no anticipated amendments to this rate certification at this time. We expect to review capitation rates with DHS during the contract period should beneficiary redetermination timing, and associated average population acuity, be materially different than what is projected in this report.

x. Section I.D includes documentation of the COVID-19 and related unwinding considerations in the CY 2024 rate development. After reviewing FY 2022 experience, we believe the environment has stabilized enough to eliminate a risk mechanism. This is consistent with our use of FY 2022 for base data.

2. Data

A. Rate Development Standards

i. The SNBC rate development process follows CMS rate development standards related to base data.

a. Service data sources are included in Section II.A. DHS has provided encounter and FFS data for CY 2017 to through Q2 2023 to the state's actuaries for this rate development. Managed care plans and DHS have provided detailed financial reporting data for CY 2017 through Q2 2023 to the State's actuaries for this and prior year rate development.

b. Section II includes documentation of the FY 2022 base data period used to develop the CY 2024 SNBC capitation rates.

c. Base data is specific to the population and services expected to be covered by the SNBC program during the CY 2024 rate period.

d. The CY 2024 rate calculation uses FY 2022 base data, which is within the CMS three year requirement.

B. Appropriate Documentation

i. Section II includes documentation of the base data used for SNBC rate development. DHS provided detailed financial reporting data for CY 2017 through Q2 2023 and FFS and encounter data for CY 2017 to Q2 2023 to the state's actuaries for this year's rate development.

ii. Section II thoroughly describes the base data used to calculate the CY 2024 SNBC rates.

a. The CY 2024 capitation rates for the SNBC programs are developed using FY 2022 encounter data, financial data, FFS data, and other information. The financial data is the primary source of base data for sub-capitated services.

b. DHS and Milliman went through an extensive data validation process to review all capitated plan data included in the CY 2024 rate setting methodology. DHS internally reviews encounter data submissions and notifies plans of corrections necessary to allow for records to be accepted. Milliman reviewed the encounter and financial data. We provided data summaries to all participating capitated plans and requested feedback on these summaries, asked pertinent questions, and revised and adjusted the base data accordingly based on plan responses.

The capitated plan financial data, encounter data, and FFS data, are all of high quality and appropriate for use in rate development.

c. All base data is specific to the populations that will be covered under the CY 2024 SNBC capitation rates.

d. The rate documentation methodology does not use a data book separate from what is shown in the report.

iii. Sections III-VI thoroughly documents all adjustments made to the base data.

3. **Projected Benefit Costs and Trends**

A. **Rate Development Standards**

i. Final capitation rates are based only upon services described in 42 CFR 438.3(c)(1)(ii) and 438.3(e).

ii. This report includes a detailed discussion on the methodology used to develop benefit utilization and unit cost trends.

a. Basic Care – Section IV
b. NF add-on – Section VI

iii. Section II discusses costs for in lieu of services or settings (ILOS). The ILOS services were required to be cost-effective relative to the covered service.

iv. The projected ILOS Cost Percentage is less than 0.1% as described in Section II.B.

v. Refer to Section III.A of this report for more information regarding IMD services.

B. **Appropriate Documentation**

i. Final projected benefit costs are shown in Exhibit 1.

ii. Sections II and III (Basic Care) and Section VI (NF Add-on) of this report document the development of projected benefit costs from the base period data to CY 2024. The health plans reported $2.9 million for SNBC in overpayments to providers in FY 2022. The base period costs used in rate development are net of these overpayments.

iii. Section IV of this report includes a detailed discussion on the methodology used to develop benefit utilization and unit cost trends.

iv. No adjustments for the Mental Health Parity and Addiction Equity Act were made as part of rate development.

v. The ILOS that will be provided during 2024 are outlined below. The projected ILOS Cost Percentage is less than 0.1%. We projected this percentage based on reviewing the estimated CY 2024 ILOS amounts of $36 thousand compared to the total estimated capitation amount of $1.16 billion.

a. Unattended Sleep Study: This ILOS will offer unattended sleep studies in the home, in lieu of the lab setting. A sleep study is a non-invasive test that tracks what happens to a person's body while they sleep.

b. Hospital Based Peer Support SUD: This ILOS will provide hospital-based peer support services consisting of counseling and connection with community resources and support. Continuity of care is a challenging aspect of care for individuals with substance use disorder (SUD), and identification and engagement in the hospital setting offers an opportunity to engage and intervene to reduce risk of overdose and subsequent inpatient and emergency department utilization.

c. Maternal Health: This ILOS will offer new moms support from the first trimester to 12-month post-partum. This program offers application technology, outreach from a telehealth doula (teledoula), member education, specific durable medical equipment based on risk for complications for in home monitoring. This program is introduced to the member at the first county public health visit to bring this prenatal support as soon as possible. In addition to pregnancy support, the 12-month post pregnancy offers the same technology, education, and teledoula support for the full one year following birth to provide support and guidance for the mother and well-baby education.

vi. Retrospective eligibility periods are excluded from the Basic Care program and all rate calculations.

vii. Exhibit 1 quantifies the impact of program changes implemented for CY 2024.

viii. Exhibit 1 quantifies the impact of program changes implemented for CY 2024.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

The SNBC program does not include an incentive arrangement.

B. Withhold Arrangements

Nominal withholds of 8.0% for SNBC, 5% of which is based on performance, are required by Minnesota law to be removed from plan payments. However, the ultimate amount at risk to health plans is only 0.25% of capitation, because the plan contracts will include “loss limit” and payment timing provisions. The remainder of the nominal withhold is required to be returned to health plans and ultimately only impacts the cash flow of DHS and the plans. The plans are adequately capitalized, and we have no concerns that this payment delay affects the fiscal stability of the organizations. Based on our review of the withhold return metrics and the ultimate amount at risk to health plans, we believe a minimal amount of the 0.25% will be paid back to plans. Therefore, final plan payments, assuming none of the 0.25% at-risk withhold is returned, will also be subject to the actuarial certification.

C. Risk Sharing Mechanisms

The SNBC program does not include risk sharing mechanisms.

D. State Directed Payments

Please see Tables 1 and 2 below for the requested information regarding the state directed payments.

Table 1
State Directed Payments

Control name of the state directed payment	Type of payment	Brief description	Is the payment included as a rate adjustment or separate payment term?
Minimum fee schedule for Behavioral Health Homes (BHH)	Minimum fee schedule (using Medicaid State plan approved rates)	The MCO shall pay a certified BHH provider at least the ongoing standard care BHH rate established in the STATE’s fee schedule for each month after the completion of the six month BHH care engagement rate.	Rate Adjustment (base data reflects the long-standing minimum fee schedule arrangement).
Minimum fee schedule for Certified Community Behavioral Health Clinics (CCBHC)	Minimum fee schedule (using Medicaid State plan approved rates)	In addition to billed claims from CCBHCs, the MCO shall be responsible for a supplemental CCBHC payment as directed by the STATE. Additionally, the MCO shall be responsible for payment of CCBHC claims at each CCBHC’s prospective payment system (PPS) rate or greater as directed by the STATE.	Rate Adjustment (base data reflects the long-standing minimum fee schedule arrangement).

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RESPONSES TO 2023-2024 MANAGED CARE RATE SETTING GUIDE

Table 1
State Directed Payments

Control name of the state directed payment	Type of payment	Brief description	Is the payment included as a rate adjustment or separate payment term?
Integrated Health Partnerships (IHP)	Value-based purchasing model	The MCO and the STATE will participate in a quarterly population-based payment and shared savings and losses payment methodology through the IHP Demonstration with the STATE's contracted IHP Entities in the MCO's provider network.	Rate Adjustment
Minimum fee schedule for Substance Use Disorder (SUD) 1115 Demonstration Waiver services	Minimum fee schedule (using Medicaid State plan approved rates)	MCOs must reimburse Providers an amount that is at least equal to the FFS base rate payment for the SUD services described in Minnesota Statutes, §256B.0759, subd. 4, (b) and (c).	Rate Adjustment
Directed Payment for a Safety Net Hospital in Hennepin County	Specific fee schedule	In accordance with MN State Statute 256B.1973, effective January 1, 2022 or upon federal approval, Minnesota implemented a payment arrangement that is a state-directed fee schedule in which a uniform payment adjustment factor is to be applied to each claim submitted by eligible providers to a participating health plan. Eligible providers under this section are non-state government teaching hospitals with high medical assistance utilization and a level 1 trauma center and the hospital's affiliated billing professionals, ambulance services, and clinics. Hennepin County Medical Center qualifies as an eligible provider. The uniform payment adjustment equals the estimated difference between the average commercial rate of the top five contracted payers for services rendered by the eligible provider and the amounts paid for those services by MCOs.	Rate Adjustment
Minimum fee schedule for Dental Services	Minimum fee schedule (using Medicaid State plan approved rates)	MCOs are required to reimburse dental providers at least equal to FFS rates. Critical Access Dental (CAD) providers receive an additional 20% rate increase.	Rate Adjustment
Minimum fee schedule for Culturally / disability responsive SUD services	Minimum fee schedule (using Medicaid State plan approved rates)	The definition of "culturally specific programs" was expanded to include "culturally responsive programs" and "disability responsive program." A 5% rate increase for SUD treatment services provided by culturally specific programs, culturally	Rate Adjustment

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RESPONSES TO 2023-2024 MANAGED CARE RATE SETTING GUIDE

Table 1
State Directed Payments

Control name of the state directed payment	Type of payment	Brief description	Is the payment included as a rate adjustment or separate payment term?
		responsive programs, or disability responsive programs is required.	
Minimum fee schedule for MLTSS	Minimum fee schedule	MCOs are required to reimburse providers of Home Care Services at least equal to FFS rates. MCOs are required to establish contracts with providers that are not less than the State-established rate.	Rate Adjustment (base data reflects the long-standing minimum fee schedule arrangement).
Minimum fee schedule for Critical Access Mental Health	Minimum fee schedule (using Medicaid State plan approved rates)	Effective January 1, 2023, MCOs will be required to reimburse providers of critical access mental health services at rates at least equal to FFS rates.	Rate Adjustment
Rate Increase for Outpatient Behavioral Health Services	Uniform Percentage Increase	Effective January 1, 2024, payment rates for treatment are increased by 3%. In January of each year starting in 2025, rates are also increased by the expected change in the CPI for medical Care Services.	Rate Adjustment
Separate Reimbursement for Long-Acting Reversible Contraceptives (LARCs)	Uniform Dollar	Effective January 1, 2024, the Minnesota legislature requires reimbursement of LARCs outside of the DRG when placed immediately postpartum.	Rate Adjustment
Fuel Adjustor for NEMT and Ambulance Services	Uniform Percentage Increase	Effective January 1, 2024, the commissioner will be required to adjust the rate paid per mile for NEMT and ambulance services when the price of gasoline exceeds $3.00 per gallon, which will be evaluated on the first day of each quarter.	Rate Adjustment
Rate increase for Adult Day Treatment	Uniform Percentage Increase	Effective January 1, 2024, the Minnesota legislature enacts a 50% rate increase for adult day treatment (ADT) services	Rate Adjustment

DHS will submit 438.6(c) preprints to CMS for 2024 for the Directed Payment for a Safety Net Hospital in Hennepin County and for Integrated Health Partnerships (IHP). The 2024 preprint for the Directed Payment for a Safety Net Hospital in Hennepin County is consistent with the approved 2022 preprint and the 2023 preprint now in CMS review. The 2024 preprint for IHP is consistent with the approved 2021 preprint (this is a three-year approval).

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RESPONSES TO 2023-2024 MANAGED CARE RATE SETTING GUIDE

Table 2 includes the details for these state directed payment incorporated as rate adjustments:

Table 2
State Directed Payments Rate Adjustment

Control name of the state directed payment	Rate cells affected	Impact	Description of the adjustment	Confirmation the rates are consistent with the preprint	For maximum fee schedules, provide the information requested
Minimum fee schedule for Behavioral Health Homes (BHH)	All rate cells	N/A – included in base data	The minimum fee schedule is a long-standing arrangement which was in effect during the base data period. Please refer to Section V of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Minimum fee schedule for Certified Community Behavioral Health Clinics (CCBHC)	All rate cells	N/A – included in base data	The minimum fee schedule is a long-standing arrangement which was in effect during the base data period. Please refer to Section V of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Integrated Health Partnerships (IHPs)	All rate cells	Please refer to Exhibit 1 of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section IIII of the CY 2024 rate certification for additional information.	Rates are consistent with preprint	N/A
Minimum fee schedule for Substance Use Disorder (SUD) 1115 Demonstration Waiver services	All rate cells	Please refer to Exhibit 1 (Impact for Other Program Adjustment) of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section III of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Directed Payment for a Safety Net Hospital in Hennepin County	All rate cells	Please refer to Exhibit 2 of the CY 2024 rate certification for the impact by rate cell.	Implemented as a PMPM add-on in Exhibit 2. Please refer to Section V of the CY 2024 rate certification for additional information.	Rates are consistent with preprint	N/A
Minimum fee schedule for Dental Services	All rate cells	Please refer to Exhibit 1 of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section III of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Minimum fee schedule for Culturally / disability responsive	All rate cells	Please refer to Exhibit 1 (Impact for Other Program Adjustment) of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section III of the CY 2024 rate certification	Preapproval not required	N/A

Table 2
State Directed Payments Rate Adjustment

Control name of the state directed payment	Rate cells affected	Impact	Description of the adjustment	Confirmation the rates are consistent with the preprint	For maximum fee schedules, provide the information requested
SUD services			for additional information.		
Minimum fee schedule for MLTSS	All rate cells	N/A – included in base data	The minimum fee schedule is a long-standing arrangement which was in effect during the base data period.	Preapproval not required	N/A
Minimum fee schedule for Critical Access Mental Health	All rate cells	Please refer to Exhibit 1 (Impact for Other Program Adjustment) of the CY 2023 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section III of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Rate increase for Outpatient Behavioral Health Services	All rate cells	Please refer to Exhibit 1 of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section III of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Separate Reimbursement for Long-Acting Reversible Contraceptives (LARCs)	All rate cells	Please refer to Exhibit 1 (Impact for Other Program Adjustment) of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section III of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Fuel Adjustor for Ambulance and NEMT Services	All rate cells	Please refer to Exhibit 1 (Impact for Other Program Adjustment) of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section III of the CY 2024 rate certification for additional information.	Preapproval not required	N/A
Rate increase for Adult Day Treatment	All rate cells	Please refer to Exhibit 1 (Impact for Other Program Adjustment) of the CY 2024 rate certification for the impact by rate cell.	Implemented as a program adjustment in Exhibit 1. Please refer to Section III of the CY 2024 rate certification for additional information.	Preapproval not required	N/A

E. Pass-Through Payments

Not applicable.

5. **Projected Non-Benefit Costs**

A. **Rate Development Standards**

i. Please refer to Section V.B for a description of the data and methodology used to develop the projected non-benefit costs included in the capitation rates.

ii. The non-benefit costs included in the CY 2024 capitation rates are developed as a projected PMPM load. The targeted margin is applied as a percentage of the total rate for each eligibility category. The administrative costs are developed as a blend of 30% fixed / 70% variable administrative costs when applied to the eligibility category. The final PMPM administrative load is reviewed for reasonableness compared to national benchmarks. Please see Section V.B for additional detail on how the administrative component is calculated.

B. **Appropriate Documentation**

i. Please refer to Section V for a description of the data and methodology used to develop the projected non-benefit costs included in the capitation rates.

ii. The administrative and targeted margin components of the non-benefit costs are separately identified in the report.

iii. Historical non-benefit cost information includes case management and administrative expenses for integrated products allocated to Medicare. These historical costs serve as the basis for projected administrative load.

a. CY 2018 administrative expenses PMPM were $163.68.
b. CY 2019 administrative expenses PMPM were $142.65.
c. CY 2020 administrative expenses PMPM were $143.89

6. **Risk Adjustment**

A. **Rate Development Standards**

The SNBC population capitation rates will use an actuarially sound prospective risk adjustment model to adjust rates for each participating capitated plan. The SNBC risk adjustment methodology is documented in Appendix G.

B. **Appropriate Documentation**

The SNBC population capitation rates will use an actuarially sound prospective risk adjustment model to adjust rates for each participating capitated plan. The methodology documenting the development of the SNBC risk adjustment methodology is in Appendix G. We will provide a separate report to the State documenting the magnitude of the impacts by region, rate cell and health plan at a later date when the data is available to complete the analysis consistent with the process outlined in this report.

7. **Acuity Adjustments**

A. **Rate Development Standards**

i. Section I.D details the acuity adjustment applied to account for the projected member month changes from the base period due to member eligibility redeterminations. We expect to review capitation rates with DHS during the contract period should beneficiary redetermination timing, and associated average population acuity, be materially different than what is projected in this report.

B. **Appropriate Documentation**

i. Section I.D and IV.B include a description of the acuity adjustment applied to account for the projected member month changes from the base period due to member eligibility redeterminations and how the adjustment is applied to CY 2024 capitation rates.

APPENDIX J

RESPONSES TO 2023-2024 MANAGED CARE RATE SETTING GUIDE

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

This section addresses the various requirements related to the capitation rate development for the NF Add-on. The description of the program follows:

NURSING FACILITY ADD-ON

The SNBC program provides coverage for the first 100 days of care in a nursing facility for enrollees who enter a nursing facility after enrollment. The NF Add-on payment is made for SNBC enrollees who live in the community as a pre-payment for the costs that will be incurred once an enrollee is admitted to a nursing facility. Once admitted, the MCO no longer receives the NF Add-on payment for that enrollee and only receives the Basic Care portion of the rate.

Section VI of the rate report contains a full description of the rate development for the NF Add-on rates, including a description of the base data, trends, charge per day assumptions, program adjustments, and final NF Add-on rate calculation.

1. **Managed Long-Term Services and Supports**

   A. For NF Add-on, the guidance above in Section I regarding the required standards for rate development and CMS's expectations for appropriate documentation required in the rate certification is also applicable.

   B. Rate Development Standards

      Please refer to Section VI (SNBC Nursing Facility Add-on Rate) for a description of the rate setting approaches.

   C. Appropriate Documentation

      i. Please refer to Section VI.C for a description of the rate cells and rating categories.

      ii. Please refer to Section V for a description of the data and methodology used to develop the projected non-benefit costs included in the capitation rates. The administrative and target margin components of the non-benefit costs are included by rate cell as part of the BasicCare rate development.

      iii. Please refer to Section VI (SNBC Nursing Facility Add-on Rate) for a description of the data sources used to develop the assumptions used for rate setting.

SECTION III. NEW ADULT POPULATION CAPITATION RATES

This section does not apply to the SNBC program.

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APPENDIX C

Responses to December 2015 PACE Medicaid Capitation Rate Setting Guide

This report assumes that the reader is familiar with the State of Minnesota Public Programs, their benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the PACE program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

APPENDIX C

Responses to December 2015
PACE Medicaid Capitation Rate Setting Guide

1. AWOP Development

    a. The AWOP rate cells adjust for geographic area, age, gender, and Medicare eligibility.

    b. The AWOP is developed prospectively for the calendar year and does not include any retrospective adjustments or incentives.

    c. The AWOP is developed from recent managed care data and is adjusted to reflect the population enrolled in PACE.

2. Rate Development

    a. The rate development is consistent with the established national processes and is lower than the rate that would have been paid had PACE individuals been enrolled in MSHO / MSC+ or SNBC.

    b. Capitation rates would be paid prospectively on a PMPM basis and reflect the same rate category grouping as the AWOP.

    c. Capitation rates would be paid prospectively for the 12-month contract period beginning January 1, 2024 and ending December 31, 2024.

    d. Capitation rates are lower than the corresponding AWOP. The PACE program has no incentive arrangements. The fiscal impact of potential enrollment is included in this report.

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