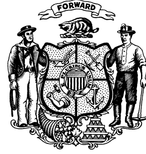
Jim Doyle
Governor

Karen E. Timberlake
Secretary



State of Wisconsin
Department of Health Services

DIVISION OF LONG TERM CARE

1 WEST WILSON STREET
PO BOX 7851
MADISON WI 53707-7851

Telephone: 608-266-2000
FAX: 608-266-2579
TTY: 888-241-9432
dhs.wisconsin.gov

February 13, 2009

Mr. Martin E. Staehlin, F.S.A.
PricewaterhouseCoopers LLP
One North Wacker
Chicago, IL 60606

Ms. Jinn-Feng Lin, F.S.A.
PricewaterhouseCoopers LLP
One North Wacker
Chicago, IL 60606

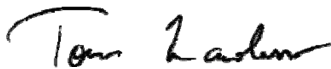
Dear Mr. Staehlin and Ms. Lin:

I, Tom Lawless, Fiscal Management and Business Services Section Chief for the Wisconsin Department of Health Service's Division of Long-Term Care, hereby affirm that the following data prepared and submitted to PricewaterhouseCoopers LLP for the purpose of developing 2009 Family Care, Family Care Partnership, and PACE capitation rates were prepared under my direction, and to the best of my knowledge and belief, are accurate and complete. These data include:

1. MA Card fee-for-service claim data files for 2005 through 2007, for the nursing home and home and community-based waiver populations;
2. MA eligibility data files for 2005 through 2007, for the nursing home and home and community-based waiver populations;
3. HSRS fee-for-service claim data files for 2005 through 2007;
4. A data file containing a crosswalk of HSRS service categories by SPC code;
5. Functional screen information for Family Care and Family Care Partnership members, as well as for home and community-based waiver and wait list clients;
6. Eligibility information for Family Care and Family Care Partnership members;
7. Mapping of IDs that are employed in various data systems;
8. MCO encounter file containing units of service and program costs for Family Care members;
9. Potential contracting agencies and anticipated start dates in regions of the state to which the program is expected to expand;
10. Projected Family Care enrollment months for CY2008 and CY 2009 in light of the program's anticipated expansion;
11. Level of start-up per capita costs contained in the capitation rates;
12. Cost sharing amounts PMPM for the Family Care MA-eligible population;
13. BLS wage data;
14. Metropolitan statistical areas (MSA) for Wisconsin counties;
15. Residential service costs;
16. Institutional service costs;

17. Diagnostic information submitted by the MCOs to the Department and the Hierarchical Coexisting Condition (HCC) Model scores for individuals enrolled in the PACE/FCP sites, calculated by the Department, using the CMS HCC software;
18. Dental per capita costs submitted by the PACE/FCP sites for 2005 through 2007; and
19. Drug metrics provided by the health plans, to be used in the determination of the pharmacy rebate.

Sincerely,



Tom Lawless
Section Chief
DLTC/FMBS

Wisconsin Department of Health Services
Crosswalk from CMS Rate Setting Checklist to 2009 Family Care Report

Item		Location	Comments
AA.1.0	Overview of Ratesetting Methodology	Entire Report	
AA.1.1	Actuarial Certification	Pages 23-25	
AA.1.2	Projection of Expenditures	NA	DHFS will provide
AA.1.3	Procurement, Prior Approval and Ratesetting	NA	State Set Rates
AA.1.5	Risk contracts	NA	
AA.1.6	Limit on Payment to other providers	NA	
AA.1.7	Rate Modifications	NA	
AA.2.0	Base Year Utilization and Cost Data	Pages 9-16	
AA.2.1	Medicaid Eligibles under the Contract	NA	Data submitted by participating health plans
AA.2.2	Dual Eligibles	NA	
AA.2.3	Spenddown	NA	
AA.2.4	State Plan Services only	NA	Data submitted by participating health plans
AA.2.5	Services that may be covered out of contract savings	NA	
AA.3.0	Adjustments to Base Year Data	Pages 9-16	
AA.3.1	Benefit Differences	NA	No Changes in Benefits
AA.3.2	Administrative Cost Allowance Calculations	Page 20	Exhibit III-1
AA.3.3	Special Populations' Adjustments	NA	
AA.3.4	Eligibility Adjustments	NA	
AA.3.5	DSH Payments	NA	
AA.3.6	Third Party Liability	NA	
AA.3.7	Copayments, Coinsurance and Deductibles in Capitated Rates	Page 21	Exhibit III-1
AA.3.8	Graduate Medical Education	NA	
AA.3.9	FQHC and RHC Reimbursement	NA	
AA.3.10	Medical Cost / Trend Inflation	Pages 17	
AA.3.11	Utilization Adjustments	Page 9-10, & 15-16	
AA.3.12	Utilization and Cost Assumptions	NA	
AA.3.13	Post-Eligibility Treatment of Income	NA	
AA.3.14	Incomplete Data Adjustment	Pages 7	
AA.4.0	Establish Rate Category Groupings	Pages 4-5	Exhibit III-1 and III-2
AA.4.1	Age	NA	
AA.4.2	Gender	NA	
AA.4.3	Locality / Region	Pages 1-3	Exhibit III-1 and III-2
AA.4.4	Eligibility Categories	Pages 4-5	
AA.5.0	Data Smoothing	NA	
AA 5.1	Special Population and Assesment of the Data for Distortions	NA	
AA.5.2	Cost-neutral data smoothing adjustment	NA	
AA.5.3	Risk Adjustment	Pages 10-14, & 16	
AA.6.0	Stop Loss, Reinsurance or Risk Sharing arrangements	NA	
AA.6.1	Commercial Reinsurance	NA	
AA.6.2	Simple stop loss program	NA	
AA.6.3	Risk corridor program	NA	
AA.7.0	Incentive Arrangements	NA	

Wisconsin Department of Health Services

Calendar Year 2009 Family Care Capitation Rates

Prepared by:

PricewaterhouseCoopers

December 2008

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers LLP
One North Wacker
Chicago, IL 60606
Telephone (312) 298-3792
Facsimile (813) 329-8798

February 16, 2009

Mr. Thomas Lawless
Fiscal Management and Business Services Section Chief
Office of Family Care Expansion
Division of Long-Term Care
One West Wilson Street
Madison, WI 53701

Re: 2009 Managed Care Capitation Rate Development for Family Care

Dear Tom:

The enclosed report provides a detailed description of the methodology used to develop the 2009 managed care capitation rates for the Family Care program effective January 1, 2009 through December 31, 2009 in Wisconsin. The methods used for calculating these costs are consistent with Centers for Medicare and Medicaid Services requirements that the capitation rates be actuarially sound and appropriate for the population covered by the program.

The development of these rates was overseen by Sandra Hunt, Principal, and Martin Staehlin, Lead Actuary.

Please call Sandra Hunt at 415-498-5365 or Marty Staehlin at 312-298-3689 if you have any questions regarding these rates.

Very truly yours,

PricewaterhouseCoopers LLP

By: Sandra S. Hunt, M.P.A.
Principal

Martin Staehlin, F.S.A., M.A.A.A.
Managing Director

Table of Contents

Executive Summary **1**

I. Data Sources **7**

II. Nursing Home Level of Care Functional Screen Methodology **9**

III Non-Nursing Home Level of Care Functional Screen Methodology **15**

IV. Trend Development **17**

V. Rate Development for Current versus New MCOs **18**

VI. Per Capita Cost Development **20**

VII. Final Capitation Rates **22**

VIII. Actuarial Certification **23**

SUMMARY OF EXHIBITS

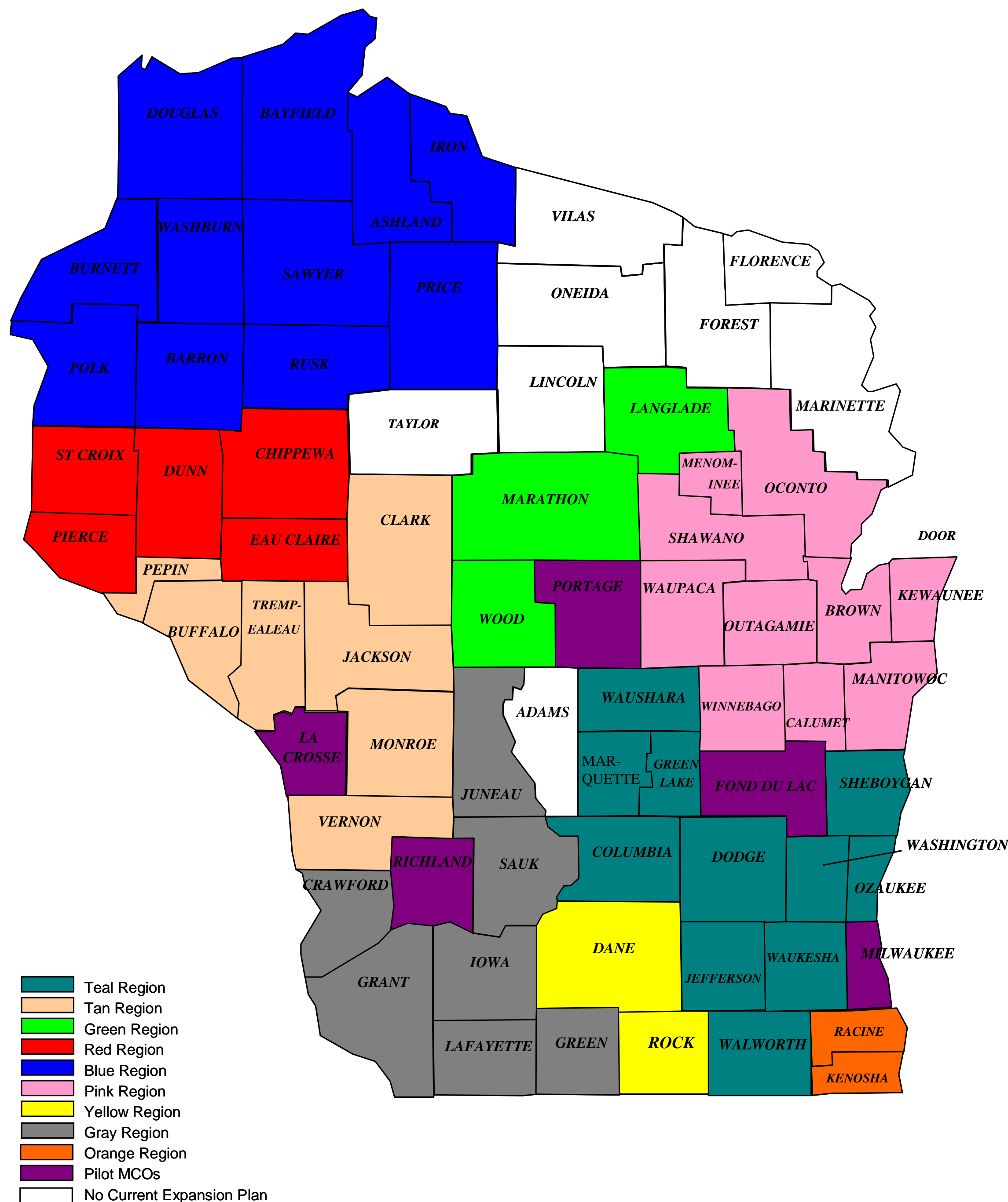
Exhibit I-1	Summary of 2007 Actual Experience by County; Nursing Home Level of Care
Exhibit I-2	Summary of 2007 Actual Experience by County; Non-Nursing Home Level of Care
Exhibit-II-1	Functional Screen Regression Model of 2007 PMPM; NH Level of Care - Fond du Lac, La Crosse, Milwaukee, Portage, Richland, and Community Care
Exhibit-II-2	Functional Screen Regression Model of 2007 PMPM; NH Level of Care - Expansion Regions
Exhibit II-3	Summary of Proportion of MCO Population with Rating Characteristics - Fond du Lac, La Crosse, Milwaukee, Portage, Richland, and Community Care
Exhibit II-4	Summary of Proportion of MCO Population with Rating Characteristics - Expansion Regions
Exhibit III-1	Development of the Pilot 2009 Preliminary Rates; Nursing Home and Non-Nursing Home Level of Care
Exhibit III-2	Development of the MCO 2009 Final Rates; Nursing Home and Non-Nursing Home Level of Care

I. EXECUTIVE SUMMARY

This report describes the methodology used to develop monthly capitation payments for Family Care for Calendar Year 2009. This program is sponsored by the State of Wisconsin Department of Health Services and covers long-term care (LTC) services previously provided through the Medicaid State Plan, the Medicaid Home and Community Based Waivers (Waiver), and the Community Options Program (COP). Primary and acute medical services are not covered by Family Care. The following table shows the five pilot MCOs that are currently participating in the Family Care program.

Family Care Pilot MCOs		
MCO	**Implementation Date**	**Covered Counties**
Creative Care Options of Fond du Lac County (CCO of FDL)	Pilot MCO	Fond du Lac
Western Wisconsin Cares (WWC)	Pilot MCO	La Crosse
Milwaukee County Department on Aging (MCDA)	Pilot MCO	Milwaukee
Community Care of Central Wisconsin (CCCW)	Pilot MCO	Portage
Southwest Family Care Alliance (SFCA)	Pilot MCO	Richland

The State has been continuing the effort to expand the Family Care program outside of the current service areas. The expansion plan that DHS has provided categorizes the State into nine regions; each region being comprised of multiple counties. MCOs will not expand to all counties in their region at the same time. The map below provides the regional configuration for the Family Care program.



The anticipated implementation dates for various MCOs as well as the counties to which they are expanding coverage to are detailed below. Implementation dates included in this report reference the date the first County in a region is expanded to by an MCO.

Family Care Expansion Details		
MCO	**Implementation Date**	**Expansion Counties**
Community Care	**Jan. 1, 2007**	**Kenosha, Racine, Ozaukee, Sheboygan, Washington, & Waukesha**
Care Wisconsin	**Mar. 1, 2008**	**Columbia, Dodge, Green Lake, Jefferson, Marquette Washington, Waukesha, & Waushara**
CHP	**May 1, 2008**	**Chippewa, Dunn, Eau Claire, Pierce, & St. Croix**
SFCA	**Sept. 1, 2008**	**Sauk, Green, Crawford, Juneau, & Lafayette**
CCCW	**Nov. 1, 2008**	**Marathon & Wood**
WWC	**Nov. 1, 2008**	**Vernon, Jackson, Monroe, Trempealeau, Buffalo, Pepin, & Clark**
Northern Bridges	**Mar. 1, 2009**	**Barron, Douglas, Burnett, Polk, Washburn, Ashland, Bayfield, Rusk, Iron, Price, & Sawyer**

Noted in the above table, some MCOs are currently participating in the Family Care program and will be expanding coverage to additional counties. As a result, the capitation rates for these providers will be calculated using a blend of the following two rates:

1. Current capitation rate for the pilot MCO effective for calendar year 2009 and
2. Capitation rate developed for those individuals eligible to enroll in expansion counties not currently participating in the Family Care program.

Community Care expanded coverage to Racine and Kenosha counties in January and February 2007. Over the course of calendar year 2007, Community Care did not enroll a sufficiently large base population to be included in the rate development. Additionally, for other expansion regions, there is no readily available managed care claim experience that could be used for rate development. As a result, the capitation rates for expansion regions are developed based on encounter data reported from the five pilot MCOs for calendar year 2007.

The rates are based on the five pilot MCOs' encounter data, with adjustments for variation in functional status as measured by each recipient's Long-Term Care Functional Screen (LTCFS) based on eligibles from specific expansion regions. The encounter data is adjusted to remove costs of non-state plan services and the waiver services contained in the baseline claims experience that were not cost effective in comparison with their in-lieu-of substitute service. Baseline experience data is adjusted for trend, recognizing changes in utilization, cost, technology, and the different timing of an MCO's implementation date. An allowance is also made for administrative costs and prospective risk margin, and the claims data is adjusted to account for incomplete claims.

Nursing Home Level of Care Functional Status Model

The NH level of care rates are based on a regression model of functional status developed from MCO-reported experience for calendar year 2007. Regression is a statistical technique that produces an estimate of the effect of each factor individually on the cost for an individual. The final model uses the following "functional" measures to develop the capitation rates:

- County
- SNF level of care for the elderly
- Type of developmental disability for the disabled, if any
- Number of IADLs
- ADLs and their levels of help
- Interaction terms among various ADLs
- Behavioral indicators
- Medication management

The county values from the regression model recognize county-to-county cost differences that are not explained by the other factors in the model. Variation in county experience results from differences in provider fee levels, resource availability, potentially incomplete data, MCO management and other factors. Although the regression model yields county parameters, there remains a material difference in the per member per month costs among counties that is not fully explained by that model. Consequently, we blended the results of the regression model with measures of differences in costs by geography for a market basket of LTC services.

The expanding MCO's NH level of care rate is based on a regression model developed from the claims experience of the five pilot MCOs. Since the expansion MCOs are operated in counties that are distinct from the five pilot counties, the County variable in the regression is omitted. Similarly, an adjustment is made to account for the differences in cost between the expansion counties and the five pilot counties.

Trend was developed separately for the Developmentally Disabled, Physically Disabled, and Elderly populations based on an analysis of managed care claims experience. An annual trend of 2.5% for the Developmentally Disabled population, 4.5% for the Physically Disabled and 4.0% for the Elderly population, was developed using managed care claim and eligibility data, which

measures the annual mix, cost, and utilization trend. The current mix of participants is used to determine the two-year trend rates for each County.

An additional adjustment will be made by DHS to account for member-specific cost sharing. Finally, the rates include an allowance for health plan administrative expenses and reasonable risk charges.

Non-Nursing Home Level of Care Functional Status Model

The non-NH level of care rates are based on MCO-reported experience for calendar year 2007. The non-NH level of care rates are developed using a functional status based model that stratifies claims experience based on an individual's level of need, using their sum of ADLs and IADLs. The ADLs and IADLs are each separated into "low" and "high" levels of need. A "low" level of need corresponds to an individual that has an ADL/IADL count of two or less. A "high" level of need corresponds to an individual that has an ADL/IADL count of three or more. The rates are developed based on four distinct cohorts:

- Low IADL and low ADL level of need,
- Low IADL and high ADL level of need,
- High IADL and low ADL level of need, and
- High IADL and high ADL level of need

For example, assume an individual requires bathing assistance (ADL), dressing assistance (ADL), and medication management (IADL). This individual has an ADL count of two and an IADL count of one. Therefore the claim and eligibility experience of this individual are bucketed into the "low" ADL and "low" IADL level of need cohort.

For a Family Care provider that is expanding coverage to additional counties, the non-NH expansion capitation rate is equivalent to the current MCO non-NH capitation rate. For those providers who are not currently participating in the Family Care program, a program-wide non-NH level of care capitation rate applies to all providers.

Similar to the NH level of care rate development, the non-NH rates are adjusted for trend and an administrative allowance.

Disclaimer

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

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and believe the data appear to be reasonable for this rate development. If there are material errors or omissions in the data, it is possible that they would be uncovered by a detailed,

systematic review and comparison search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual results depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis.

This report is intended to assist the State in developing Family Care capitation rates. It may not be appropriate for other uses. PricewaterhouseCoopers does not intend to benefit and assumes no duty or liability to other parties who receive this work. This report should only be reviewed in its entirety. It assumes the reader is familiar with Family Care, the Wisconsin Medicaid long-term care and Waiver programs, and managed care rating principles.

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

I. DATA SOURCES

A first step in developing capitation rates is identifying the data that will be used for the calculations. The CMS regulations call for use of data that is appropriate for the population to be covered by the program. Those regulations also indicate it is CMS' intent that the data be no more than five years old. A number of sources of data may be considered appropriate including:

- Fee-for-service data for the Medicaid population in the geographic area to be covered by managed care plans;
- Health plan encounter data for their Medicaid population;
- Health plan encounter data for other populations, with appropriate adjustments to reflect utilization patterns of Medicaid enrollees;
- For some components of the analysis, health plan financial data;
- For some components of the analysis, data from other Medicaid programs.

The capitation rates are developed separately for those individuals that meet a nursing home level of care criteria and those that do not. Managed care eligibility and claims experience data from the five pilot Wisconsin MCOs for calendar year 2007 is used to establish baseline costs for both populations. In addition to claims and eligibility data, functional screen data were provided by the State. To correct for missing functional screen data, missing values were assumed to have a value of "0". In other words, we assumed that the individual did not have the characteristic addressed by the question unless it was affirmatively reported.

Each recipient's cost for 2007 was matched to their corresponding eligible days. Therefore a cost PMPM was determined for each eligibility group as the total payments divided by total eligibility days times 30.41667 (the average number of days in a month).

Claims Experience

The claims data covers dates of service for calendar year 2007 with run out through July 2008. These data must be adjusted to reflect claims that were Incurred But Not Reported (IBNR) in order to "complete" the starting claims database. IBNR adjustments are made by MCO across both eligibility categories: Fond du Lac data was increased by 0.24%, La Crosse by 0.20%, Milwaukee by 0.09%, Portage by 0.02%, and Richland by 0.09%. An IBNR adjustment of 0.11% was applied to all other expansion counties. IBNR claims have been estimated using standard actuarial methods.

Functional Status Information

All recipients were given health status and functional screens annually prior to 2007 or at the point of Family Care enrollment during 2007. Such information is readily available on the State's administrative system and is expected to continue to be available while the Family Care program is in effect.

The health status and functional screens collect the following information on recipients:

- Type of living situation, level of care (e.g., skilled nursing)
- The presence of a developmental disability
- The level of assistance for each instrumental activity of daily living (i.e., IADLs)
- The level of assistance for each activity of daily living (i.e., ADLs)
- The presence of one of 64 diagnosis groups, summarized into 10 diagnostic classes
- The use of medications and the level of assistance required to correctly administer them
- The frequency of certain health related services (e.g., pain management, TPN, dialysis, etc.)
- The levels of communication, memory, and cognition
- The presence and extent of certain behaviors (wandering, self-injurious, offensive, etc.)

Legal and administrative information is also collected but not used for risk adjuster development. All screeners are trained by the State to ensure that the screens are administered consistently.

To appropriately reflect the relative risk of enrollees in the Family Care program, a risk assessment model was developed that measures differences in utilization of services based on functional status. A Family Care-specific model was developed because available risk assessment and risk adjustment models were deemed to be a poor fit for measuring differences in expected Long Term Care costs among enrollees. Available models are largely designed to estimate the need for acute care services, and do not take into account such factors as frailty and the need for assistance with activities of daily living. A description of each risk assessment model is contained in the NH and non-NH rate development sections of the report.

II. NH LEVEL OF CARE FUNCTIONAL SCREEN METHODOLOGY

This section of the report details the development and statistical validity of a risk adjustment methodology used to calculate the Nursing Home level of care baseline per capita costs.

Base Data

The base data consists of calendar year 2007 encounter eligibility and claim data for the five pilot MCOs. Performing a detailed analysis of costs used in the rate setting process last year versus those costs in the base data this year, two anomalies were observed. Additionally, DHS indicated that there was going to be a prospective change in nursing home payment methods beginning in January 2009.

1. Care Management Costs: When comparing the care management encounter data costs with the care management costs contained in the MCOs financial statements, material variances were noted. A downward adjustment to the data was made by MCO to appropriately reflect the care management costs contained in the financial statements.

2. Provider Rate Increase: Based on conversations between DHS and the MCOs, it was determined that two plans had passed through provider rate increases starting in calendar year 2007. The impact of the provider rate increases resulted in approximately a 5% increase in costs for the two plans. The State has made a policy decision to include approximately one-half of the provider rate increases in the rate development. DHS will work collaboratively with the MCOs to assess appropriate levels of future provider rate increases to be applied on a program-wide basis.

3. Nursing Home Payment Method: Beginning in January 2009, a change will be made to the method by which nursing homes will be paid. Specifically, an acuity-based nursing home system will be used to determine the payments for nursing home costs. An adjustment to the data has been made to reflect the level of costs that would have been paid by the MCO had the acuity-based method been in place in calendar year 2007.

After making these adjustments to the base data, the resulting aggregate 2007 claims for the five pilot MCOs are $255,955,063, and the exposure months totaled 116,805, resulting in a PMPM of $2,191.30 for the NH level of care population. Exhibit I-1 shows the experience by county, target group, and category of service for the NH population, after the three adjustments described above were made. Based on discussions with DHS staff, we understand that reported costs are prior to any participant cost sharing and net of any third party liability.

Non State Plan Services Adjustment

A non-state plan service included in the calendar year 2007 data is non-covered residential care services. Non-covered residential care services are provided in-lieu-of nursing home stays for nursing home eligible enrollees. A cost effectiveness analysis was completed for the non-residential care services. A service is cost effective if the cost of providing that service is less than or equal to the cost of its in-lieu-of substitute. We have utilized the data to determine the cost of

residential care and the comparable institutional care which would be utilized by a proportion of those currently using residential care. The results of our analysis show that non-covered residential care is a cost effective substitute for nursing home stays, therefore no adjustment to the data was made.

Approach to NH Rate Development

Estimated costs PMPM are determined for recipients based on each recipient's IADL count, specific levels of ADL assistance needed, the presence of certain behavioral problems, detail on medication assistance provided, the level of care provided, the type of developmental disability (if any), certain combinations of ADLs, and geographic region. Monthly screen information of the cost period (calendar year 2007) is used, resulting in a concurrent risk adjustment model.[1]

Ordinary Least Squares regression was used to model the effects of the above factors in predicting costs PMPM. The overall cost estimate for a recipient is determined by summing the coefficients for the factors applicable to the recipient, and adding the regression intercept. This method essentially results in an individual rate for each recipient rather than categorizing them into mutually exclusive groups, as would be done with other approaches to rate development.

Exhibit II-1 shows the results of the regression analysis. The R-squared of the risk adjustment model is approximately 40%. This value is similar to, but somewhat higher than the R-squared value for many concurrent physical health models. The high predictive power results in part from use of a concurrent model, and in part from the fact that use of LTC services is more persistent on average than use of acute health care services.

When used with the 2007 functional status indices, the regression model estimates a baseline cost by MCO for the current NH population in 2007. To better assess the prospective cost in a region, we used the latest credible functional screens for the Family Care population enrolled in each county in 2007. This risk adjustment technique is discussed in further detail later in the report.

Regression Modeling Details

The calendar year 2007 NH data for the five pilot MCOs (Fond du Lac, La Crosse, Milwaukee, Portage, and Richland) is used as the basis to develop a regression model. Using this data, two ordinary least squares linear regression models are created to relate monthly costs to recipient functional characteristics; one model is developed for the five pilot MCOs and another for the MCOs expanding coverage to other counties.

Consistent with the development of the prior year's model, the first regression model is developed by including county variables in the regression. Since the base data consists of the five pilot

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[1] Note: Risk adjustment models are typically termed "concurrent" or "prospective". A concurrent model measures expected costs in the current period based on claims and screening data for the current period. A prospective model measures expected costs in a subsequent period based on claims and screening data for a current period. The choice of whether to use a concurrent or prospective model depends on a number of factors, including the stability of the population. For the Family Care population, we believe a concurrent model is appropriate, although a prospective model is not expected to yield materially different results for this program, given the limited turn-over of the population.

MCOs, this model will be used to calculate the average PMPM cost for the five corresponding counties.

Expansion counties have little to no credible managed care experience in the calendar year 2007 data period. As a result, a second regression model is needed to develop costs for the expansion counties. This second model uses the aggregate experience of the five pilot MCOs. After removing the county variables, the health status parameter values have been recalibrated based on the aggregate MCO experience. Therefore, the only difference between the two models is the inclusion of the county variables. All other health status and functional screen information is consistent between the two regression models.

For each model, the unit of analysis is the recipient month. That is, the monthly 2007 cost and the recipient's corresponding functional screen constitute one observation. The statistical analyses weigh experience in proportion to each recipient's days of eligibility.

Modeling proceeds in a stepwise manner, starting with variables that explain the most variation and incrementally adding variables that have a marginally decreasing effect on improving the model's R-squared value and increasing the model's overall predictive capacity. Note also that all predictor variables are coded as binary, (i.e., having a value of "0" or "1".) Thus, a recipient either has a particular characteristic or they do not. With this approach we avoid forcing a relationship upon the variables, such as doubling the expected costs for an individual with twice as many ADLs as another individual.

When considering variables to include in the model, we used the following criteria:

- Variables are included in the model if they show a 5% level of significance.
- Variables are excluded if, when included, multicollinearity is present. That is, when an additional variable is included it shows a strong linear relationship among one or more of the other variables.
- Variables are excluded to simplify the model if including them only marginally increases model fit.

With a baseline model established, the effects of interaction are considered. Interaction terms are important since the effect of, for example, a bathing ADL requiring assistance with a dressing ADL requiring assistance, may be greater or less than the sum of these effects modeled individually.

The final regression model consists of twenty eight variables to predict cost. The variables are separated into the following seven classes: region, level of care, IADLs, specific ADLs, interactions, behavioral, and medication use. The estimated impact on the cost for each variable is shown along with its significance (i.e., p-value), relative contribution in explaining the variation (i.e., Incremental Partial R^2) and the proportion of the population with the characteristic.

Exhibit II-1 shows the final statistical model for the five pilot MCOs and Exhibit II-2 shows the final statistical model for the expansion counties. The models each explain approximately 40% of the variation in the data. Each model has a mean of $2,191 PMPM.

The average effect of each variable shows how the aggregate cost PMPM are allocated among individual characteristics in the population. For example, referring to Exhibit II-1, the model attributes $81.87 PMPM of the aggregate PMPM ($2,191) to IADL-5. Thus to derive the average PMPM cost for a given population, one would cross-multiply all regression parameter estimates by the proportion of the population with the respective characteristic.

Factors to Reflect County Economic Differences

For the five pilot MCOs, the county values developed by the regression represent differences in costs by county that are not explained by other variables in the model. The county estimates represent differences due to historical costs by county, and can result from a variety of factors, including MCO management, provider fee levels, resource availability, potentially incomplete data and others. The intent of using the county experience factors is to recognize differences in costs that cannot be explained directly by the regression model, and to provide stability to funding for the Family Care program.

We separately developed factors based on the relative wage levels and fees paid in the five MCO counties. We used wage data collected by the State / Federal government, and reported by the U.S. Bureau of Labor Statistics, for occupations involved in providing care: registered nurses, social workers, home health aides, personal care / home care aides and personal care / service. Average fees paid by Medicaid for nursing home and residential care days were also reviewed. The relative wage and fee levels were aggregated using the relative costs for these services for all MCOs combined. This process estimates the potential costs faced by the MCOs and the expansion counties.

We averaged these relative values with the county factors from the regression model. The table below shows the combined effects of this adjustment.

Family Care County Effect Adjustment		
	Regression Values PMPM	**Adjusted Values PMPM**
Fond du Lac	**($314.73)**	**($238.92)**
La Crosse	**(96.63)**	**(172.88)**
Milwaukee	**0.00**	**15.87**
Portage	**116.70**	**(36.16)**
Richland	**158.24**	**(76.41)**
Composite	**0.00**	**0.00**

Additionally, we have developed factors based on the wage levels and fees paid in the expansion counties. Since the base data consists of encounter eligibility and claim data for the pilot MCOs, the potential costs faced by the expansion regions were calculated relative to the current five pilot

MCOs. To account for the difference in wage and fee levels, the baseline per capita costs for the expanding MCOs are adjusted by these wage factors. For example, a factor of 0.994 means that the potential costs faced by an MCO were on average 0.6% lower than the five pilot MCOs. In the rate development last year, the wage factors were applied to a percentage of an MCO's cost approximately equal to the intercept value contained in the regression as a percentage of total costs.

Over the course of this year, DHS worked collaboratively with the MCOs to determine if the methodology currently in place could be refined. Based on their analyses, they determined that the wage factor should apply to 70% of an MCOs cost on average. The methodology change would be applied to both the pilot MCOs, in addition to the expansion counties. DHS will phase in the impact of realigning the wage adjustment. Specifically the final wage adjustment will be based on equally weighting the prior year methodology with the new methodology proposed this year.

The following table provides the final wage factors, based on a blend of the two methodologies, that are applied to an MCOs per capita costs.

MCO	Wage Factor
Creative Care Options	0.984
WWC	0.977
Milwaukee	1.002
CCCW	0.977
SFCA	0.957
Community Care (Kenosha/Racine)	0.988
Community Care (Teal Region)	1.000
Care Wisconsin	0.989
CHP	1.000
Northern Bridges	0.983

Application of the Model

The regression model was developed using 2007 cost and functional screen data. To determine expected costs for the contract period, we obtained updated functional screen information as of August 2008. This August 2008 data was applied to the regression coefficients to derive costs by MCO. Exhibits II-3 and II-4 shows the distribution of the population by MCO and functional measure used to calculate the final base rates.

Using August 2008 functional screen data provides a snapshot of the estimated average cost for each of the pilot MCOs at a point in time. The estimated costs only measure a change in the proportion of individuals with a given characteristic from the two periods: calendar year 2007 and August 2008. As a result, using the updated functional screen data does not have a direct impact on the aggregate baseline costs. This approach quantifies a relative change in acuity between the plans, and thus shifts expected costs among counties.

For expansion regions, we obtained the latest credible functional screen information for the Waiver and Waitlist populations to determine expected costs for the contract period. This data was applied to the regression coefficients to derive costs by MCO. Exhibit II-4 shows the distribution of the population by MCO, population type, and functional measure used to calculate the final base rates. Using the functional screen data provides a snapshot of the estimated average cost for each of the counties at a point in time.

The most recent functional screen information is used to better assess the relative prospective cost in a region.

III. NON-NURSING HOME LEVEL OF CARE

This section of the report details the development and statistical validity of a risk adjustment methodology used to calculate the Non-Nursing Home level of care baseline per capita costs.

Base Data

Aggregate 2007 claims are $3,785,216, and the exposure months totaled 6,143, resulting in a PMPM of $616.18 for the non-NH level of care population. However, an adjustment to the base data costs needs to be made to remove the costs of certain non-covered waiver services. The section below provides a complete description of the costs that were removed. Exhibit I-2 shows the experience by county, target group, and category of service for the Non-NH population after adjusting the baseline experience; the adjusted aggregate PMPM is $600.25. Based on discussions with DHS staff, we understand that the non-nursing home level of care population is not subject to cost sharing.

Waiver Services Cost Adjustment

The non-NH population's calendar year 2007 claims data is further adjusted to remove costs of non-covered waiver services that were not cost effective in comparison with their in-lieu-of substitute service.

A cost effectiveness analysis was completed for each waiver service. A service is cost effective if the cost of providing that service is less than or equal to the cost of its in-lieu-of substitute. The two significant services that waiver services are "in-lieu-of" are personal care and transportation services. PwC consulted with DHS on the appropriate measure of personal care for a majority of the waiver services including daily living skills training, day services, adult day care, supportive home care, and residential services. For example, daily living skills training is purchased by a MCO so that consumers can learn skills to provide their own personal care that would otherwise have to be purchased by a MCO. For those services that were cost effective no adjustment to the data was made. However, some waiver services were determined to not be cost effective; consequently we have removed the additional costs incurred as a result of providing a service that is partially cost effective.

Some waiver services were not explicitly included in the cost effectiveness analysis because they do not have a comparable service under Wisconsin's state plan services. For example, the waiver service supported employment may avoid occupational and physical therapy costs in the future by keeping individuals' minds and bodies active through employment. It may also reduce the need for personal care if individuals are at home all day rather than employed, however according to CMS it does not have a comparable state plan service. Consequently we have removed the entire cost for those services that do not have a comparable state plan service.

The exclusion of costs for waiver services that are not cost effective or that do not have a comparable state plan service is done on an MCO basis: Fond du Lac claims decreased by $2,159, La Crosse by $14,862, Milwaukee by $49,022, Portage by $14,740, and Richland by $17,057.

The remainder of this section summarizes the methodology used to develop the proposed payment rates. The results include the regression analysis conducted on the MCO calendar year 2007 encounter data and the functional measures reported from the screens conducted by the Resource Centers and MCOs.

Approach to Non-NH Rate Development

The non-NH level of care rates are developed using a functional status based model that stratifies claims experience based on an individual's level of need, using their sum of ADLs and IADLs. The ADLs and IADLs are each separated into "low" and "high" levels of need. A "low" level of need corresponds to an individual that has an ADL/IADL count of two or less. A "high" level of need corresponds to an individual that has an ADL/IADL count of three or more. The rates are developed based on four distinct cohorts:

- Low IADL and low ADL level of need,
- Low IADL and high ADL level of need,
- High IADL and low ADL level of need, and
- High IADL and high ADL level of need

For example, assume an individual requires bathing assistance (ADL), dressing assistance (ADL), and medication management (IADL). This individual has an ADL count of two and an IADL count of one. Therefore the claim and eligibility experience of this individual are bucketed into the "low" ADL and "low" IADL level of need cohort.

Estimated costs PMPM are calculated by combining the claim and eligibility data for all individuals that correspond to a given cohort. The table below provides the cost PMPM for the four cohorts. To calculate rates for an MCO, the MCO's enrollees are bucketed into the four levels of need cohorts. The distribution of enrollees is then used to calculate a weighted average of the PMPM costs across the four cohorts. A similar methodology is used for all pilot MCOs. For a current Family Care provider that is expanding coverage to additional counties, the non-NH expansion capitation rate is equivalent to the current pilot MCO capitation rate. However, for those providers who are not currently participating in the Family Care program, a program-wide non-NH level of care capitation rate is calculated using the five pilot MCOs experience, and is applied to all expansion providers.

	Functional Based PMPM
Low IADL, Low ADL	$ 550.03
Low IADL, High ADL	$ 694.76
High IADL, Low ADL	$ 690.01
High IADL, High ADL	$ 948.56

To better assess the prospective cost in a county, we used the functional screens active in August 2008 for the Family Care population enrolled in each county in 2007.

IV. TREND DEVELOPMENT

Trend rates are used to project the 2007 baseline cost data beyond the base cost period to the 2009 contract period, to reflect changes in payment levels and utilization. To determine the annual trend rates the following information is assessed:

- Historical encounter data experience;
- Budgeted provider increases;
- Known policy changes that may impact utilization patterns; and
- Industry experience for other comparable Medicaid long-term care programs.

Trend was developed separately for the Developmentally Disabled, Physically Disabled, and Elderly. An annual trend was developed analyzing Family Care encounter claim and eligibility data from calendar years 2006 and 2007. The trend over this period includes annual mix, fee increases, and utilization trend. The following table summarizes the trend by each eligibility category.

Eligibility Category	Annual Trend
Developmentally Disabled	**2.5%**
Physically Disabled	**4.5%**
Elderly	**4.0%**

V. RATE DEVELOPMENT FOR CURRENT VERSUS NEW FAMILY CARE MCOs

The capitation rate development process will differ depending on each MCO's current status. Specifically there are different methods for:

- A provider that is either not currently participating in the Family Care program, or that has little or no credible base data experience, and

- A current Family Care managed care provider that is expanding coverage to additional counties.

For a provider that is not currently participating in the Family Care program, a single rate will be developed for the 2009 contract period. The effective period for the capitation rate will begin on the first county's anticipated start date and span through December 31, 2009. For example, Northern Bridges is anticipating expanding to Barron and Douglas counties in March, and nine additional counties after March in calendar year 2009. One composite capitation rate will be calculated for Northern Bridges effective March 1, 2009 through December 31, 2009. Per capita costs will be calculated for each county based on the individuals eligible to enroll in the county. Additionally, based on a county's date of implementation, the base period per capita costs are trended to the midpoint of the county's contract period based. Since the size of the eligible population may differ by county, the average capitation rate for the contract period will be based on the estimated distribution of eligible lives by region.

The second consideration is the development of a capitation rate where providers are currently participating in the Family Care program. For these providers, two capitation rates will be calculated; one rate for the MCO currently operating that is effective from January 1, 2009 through the first 2009 expansion county's implementation date, and another rate effective from the first 2009 expansion county's implementation date through December 31, 2009. Therefore a new capitation rate will be calculated for each provider using a blend of the pilot MCO capitation rate and the expansion county rate at the date of each MCOs expansion. For MCOs that have expanded prior to calendar year 2009, the composite capitation rate will be effective beginning January 1, 2009.

The weighted average provider capitation rate will be calculated using actual managed care enrollment and the estimated enrollment in the expansion counties. Some providers have worked with DHS to develop enrollment assumptions by county. Where applicable we have used these assumptions to blend the rates. For those providers who have not submitted enrollment plans, we have assumed that after a county's date of implementation, the Waiver and Waitlist populations will be enrolled evenly over a six month and twenty four month coverage period, respectively. We have assumed no selection bias will occur within a county.

To adjust for any risk selection that may occur once enrollment begins, the State will retroactively adjust rates for variation in measured functional status for two contract periods after the date of implementation. The risk variation will be measured based on the regression model (with the

functional screen data from those people that have enrolled in a plan) that we include as shown in Exhibit II-2.

VI. PER CAPITA COST DEVELOPMENT

In summary, the 2009 per capita costs were developed as described below.

1. Determine functional status based costs for the NH and non-NH populations using the 2007 MCO reported experience and functional screens as outlined in Section II and III. These cost estimates are adjusted to reflect an estimate for IBNR using payments through July 2008.

2. Reduce care management costs to account for the difference between the plan financial experience and the level of costs contained in the encounter data.

3. Adjust costs to reflect the amount of provider rate increases that will be passed through to the rate setting process.

4. Adjust costs to reflect a change to an acuity-based nursing home payment system.

5. Exclude costs for waiver services that were not fully cost effective or did not have a comparable state plan service that were included in the 2007 encounter data for the non-NH population.

6 Project adjusted 2007 costs two years using the annualized Developmentally Disabled, Physically Disabled, and Elderly trend rates discussed in Section IV.

7 Divide the projected rates by an administration / risk allowance to develop a capitation rate. The administrative allowance was developed based on a review of MCO reported administrative costs in 2007 and year-to-date 2008. The DHS is engaging in a year long project to better understand the reasonable administrative costs for a managed long-term care MCO. The risk allowance is provided to accommodate the adverse effects of volatility in delivery care patterns. Since smaller MCOs are subject to greater risk fluctuations, risk margins were determined based on the size of the population enrolled in each MCO. The following table summarizes the administrative / risk allowance for each MCO.

MCO	Admin/Risk Rate
Creative Care Options	5.75%
WWC	5.75%
Milwaukee	5.35%
CCCW	5.75%
SFCA	9.00%
Care Wisconsin	5.75%
Community Care	5.75%
CHP	5.75%
Northern Bridges	5.75%

8 For those providers that are currently participating in the Family Care program, a blended capitation rate is calculated for a contract period starting at the expansion MCO's first implementation date through December 31, 2009, as discussed in Section V.

We adjusted the NH sets of rates for cost-sharing to produce preliminary net rates from the gross cost projection. The estimate is based on the most recent Family Care data available and will be adjusted to actual individually calculated cost share amounts at the time of payment. We understand the department's new payment system has the functionality to pay the gross capitation rate and deduct member specific cost share amounts as directed by CMS.

Exhibit III-1 and Exhibit III-2 shows the development of the NH and non-NH 2009 contract period capitation rates, respectively.

VII. FINAL CAPITATION RATES

The Wisconsin Department of Health Services determined the final 2009 capitation rates for each MCO participating in a region that participates in the Family Care program. DHS developed the 2009 capitation rates with reference to the following: 2009 managed care equivalent (MCE) rates, 2008 capitation rates, and aggregate financial results as reported by the MCOs. With the exception of the Care Wisconsin and CHP MCOs, all other MCOs' capitation rates are effective for calendar year 2009. Interim capitation rate certifications for Care Wisconsin and CHP were provided to DHS on January 7, 2009 to be submitted to CMS for approval. As such, the capitation rate for Care Wisconsin provided in this report is effective for the contract period February 1, 2009 through December 31, 2009, and effective March 1, 2009 through December 31, 2009 for the CHP MCO. Exhibits III-1 and III-2 illustrate the 2009 capitation rates.

Due to the statewide expansion initiative, DHS has worked collaboratively with the MCOs to assist with addressing projected financial shortfalls that MCOs may incur over the calendar year 2009 contract period. Since each MCO begins expansion from a different financial position and with a different implementation plan, considerations were made on an MCO specific basis. DHS has chosen the following mechanisms to mitigate a portion of the financial risk assumed by MCOs.

> ***Start-Up Costs:*** A level of funding will be provided to accommodate the initial cost outlay when an MCO expands coverage. This arrangement is typically a short-term payment that can be made to newly participating MCOs or MCOs that do not have a sufficiently large base population. Funding for start-up costs is based on the efforts needed to upgrade systems, contract with additional providers, and integrate new members, particularly in geographic areas that a plan has not previously covered.
>
> ***Risk Sharing:*** Capitation rates are based upon the probability of a population having a certain average cost, considering risk variation in the population. Even if the MCOs capitation rates are sufficient to cover the probable average costs for the population to be served, the entity is always at risk for the volatility of the mix of new membership and the need for care not predicted by the regression model. A new entity, with a small enrollment, could be adversely impacted by one or two catastrophic cases. Risk sharing limits the risk of the MCO while its enrollment grows and stabilizes. The risk sharing arrangement is valid to the extent that the entity can appropriately document gains or losses corresponding to the covered population and services, in accordance with CMS requirements.

The 2009 per capita costs developed in this report are within a reasonable range of rates for the Family Care population, as defined by reasonable ranges on several important assumptions including annual trend rates and appropriate administrative loadings, among others.

VIII. ACTUARIAL CERTIFICATION

Following is our actuarial certification for the 2009 capitation rates.

Actuarial Certification of
Proposed 2009 Family Care Capitated Rates
State of Wisconsin Department of Health and Family Services

I, Martin E. Staehlin, am associated with the firm of PricewaterhouseCoopers. I am a member of the American Academy of Actuaries and meet its Qualification Standards to certify as to the actuarial soundness of the 2009 capitation rates developed for the Medicaid managed care programs known as Family Care. I have been retained by the Wisconsin Department of Health Services (DHS) to perform an actuarial certification of the Family Care capitation rates for calendar year 2009 for filing with the Centers for Medicare and Medicaid Services (CMS). I have reviewed the capitation rates developed by DHS and am familiar with the Code of Federal Regulations, 42 CFR 438.6(c) and the CMS "Appendix A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting."

I have examined the actuarial assumptions and actuarial methods used by DHS in setting the capitation rates for calendar year 2009.

To the best of my information, knowledge and belief the capitation rates offered by DHS are in compliance with 42 CFR 438.6(c), with respect to the development of Medicaid managed care capitation rates. The attached actuarial report describes the rate development methodology used by DHS. I believe that the 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. The capitation rates are based solely on the projected costs for State Plan services.

In making my opinion, I have relied upon the accuracy of the underlying enrollment, encounter, and other data and summaries prepared by DHS and the participating contracted MCOs. A copy of the reliance letter received from DHS is attached and constitutes part of this opinion. I reviewed the data for reasonableness; however, I performed no independent verification and take no responsibility as to the accuracy of these data.

The proposed actuarially sound rates shown are a projection of future events. It may be expected that actual experience will vary from the values shown here. Actuarial methods, considerations, and analyses used in developing the proposed capitation rates conform to the appropriate Standards of Practice promulgated from time to time by the Actuarial Standards Board.

The capitation rates may not be appropriate for any specific MCO. Each MCO will need to review the rates in relation to the benefits provided. The MCOs should compare the rates with their own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The MCO may require rates above, equal to, or below the proposed actuarially sound capitation rates.

This Opinion assumes the reader is familiar with the Family Care program, eligibility rules, and actuarial rating techniques. The Opinion is intended for the State of Wisconsin and Centers for Medicare and Medicaid Services and should not be relied on by other parties. The reader should be

advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.

Martin E. Staehlin
Member, American Academy of Actuaries

February 16, 2009
Date

Exhibits

Wisconsin Department of Health Services
CY 2009 Family Care Capitation Rate Development

Summary of 2007 Actual Experience by County
Nursing Home Level of Care

	Fond du Lac			La Crosse			Milwaukee			Portage		
	DD	PD	Elderly	DD	PD	Elderly	DD	PD	Elderly	DD	PD	Elderly
Exposure Months	4,768	3,888	2,628	7,003	7,062	4,621	5,632	42,500	24,455	3,374	2,460	4,551
State Plan Services												
Adaptive Equipment	28.83	65.13	24.32	57.73	131.95	58.43	54.05	83.27	63.35	74.31	88.25	58.60
Adult Day Activities	260.99	13.72	15.61	186.14	18.26	9.10	399.67	36.24	53.15	320.64	24.86	14.55
Case Management	321.66	368.46	256.85	301.58	333.15	282.51	387.33	325.06	296.65	283.37	376.84	269.66
Community At Large	-	-	-	-	-	-	-	-	-	-	-	-
Family Support Funding	-	-	-	-	-	-	-	-	-	-	-	-
Habilitation / Health	7.68	33.17	8.49	39.04	41.50	17.61	15.04	20.58	10.97	19.77	31.78	7.66
Home Care	229.60	378.37	66.49	274.44	204.95	128.60	296.44	563.63	495.54	571.83	579.59	288.71
Home Health Care	19.88	68.63	8.64	134.47	262.14	96.18	67.17	110.51	86.61	42.83	23.20	4.64
Housing	-	-	-	0.72	2.92	0.15	0.92	2.25	1.62	0.87	0.04	0.01
Institutional	41.88	341.14	296.63	98.10	291.14	742.77	331.53	442.51	413.37	72.19	217.33	498.27
Member Tracking	-	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	-
Residential Care	1,249.92	505.89	1,107.00	1,252.15	285.67	555.45	1,703.95	386.56	606.28	1,585.86	252.81	657.55
Respite Care	40.82	8.15	4.40	105.04	16.94	25.77	3.85	2.89	3.11	89.69	19.92	5.51
Transportation	92.65	33.37	16.07	145.27	37.61	9.25	152.84	46.19	40.91	63.97	67.55	23.63
Vocational	244.71	3.78	1.56	322.56	13.23	0.35	119.39	1.68	0.17	339.32	15.40	3.35
Total State Plan Services	2,538.64	1,819.80	1,806.05	2,917.24	1,639.46	1,926.17	3,532.18	2,021.37	2,071.72	3,464.66	1,697.58	1,832.13
Room and Board												
Room and Board - Collections	(239.13)	(171.48)	(228.27)	(225.35)	(59.40)	(143.46)	(344.32)	(102.37)	(171.51)	(232.85)	(69.76)	(285.89)
Room and Board - Costs	276.22	224.22	323.18	265.35	75.35	158.82	367.73	97.24	153.63	283.67	117.00	465.71
Total Room and Board	37.08	52.74	94.91	39.99	15.95	15.36	23.42	(5.13)	(17.88)	50.82	47.24	179.83
Grand Total	2,575.72	1,872.54	1,900.96	2,957.23	1,655.41	1,941.53	3,555.59	2,016.24	2,053.85	3,515.48	1,744.82	2,011.96
Composite PMPM		2,176.26			2,214.04			2,148.35			2,437.14	

Wisconsin Department of Health Services
CY 2009 Family Care Capitation Rate Development

Summary of 2007 Actual Experience by County
Nursing Home Level of Care

	Richland			Original 5 Pilots			Community Care			Grand Total		
	DD	PD	Elderly	DD	PD	Elderly	DD	PD	Elderly	DD	PD	Elderly
Exposure Months	1,405	990	1,467	22,182	56,901	37,722	5,024	2,666	2,290	27,206	59,567	40,012
State Plan Services												
Adaptive Equipment	21.57	135.11	39.20	50.82	89.19	58.51	60.82	158.26	63.78	52.67	92.28	58.81
Adult Day Activities	160.75	0.16	-	275.30	31.35	38.41	37.06	19.99	46.67	231.31	30.84	38.88
Case Management	355.20	404.53	358.78	328.30	332.65	291.30	271.81	297.06	222.32	317.87	331.06	287.35
Community At Large	-	-	-	-	-	-	-	-	-	-	-	-
Family Support Funding	-	-	-	-	-	-	-	-	-	-	-	-
Habilitation / Health	22.56	97.68	21.22	22.23	25.86	11.61	7.06	28.45	20.01	19.43	25.98	12.09
Home Care	495.93	429.53	444.54	329.66	504.81	393.76	355.96	496.32	157.25	334.51	504.43	380.22
Home Health Care	7.88	19.32	5.99	70.79	121.11	69.32	299.42	645.44	307.95	113.01	144.57	82.98
Housing	0.05	0.38	0.18	0.60	2.06	1.08	-	-	-	0.49	1.96	1.02
Institutional	157.64	451.42	882.06	145.12	407.21	474.06	82.35	133.61	112.23	133.53	394.97	453.36
Member Tracking	-	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	-
Residential Care	695.27	412.35	529.37	1,381.87	376.86	638.13	1,671.70	580.03	927.05	1,435.39	385.95	654.67
Respite Care	56.71	10.39	5.40	60.15	5.86	6.35	12.59	10.78	1.94	51.36	6.08	6.10
Transportation	32.41	23.92	14.53	116.37	44.78	32.19	161.08	32.49	35.92	124.62	44.23	32.41
Vocational	328.83	54.01	-	257.19	4.76	0.67	374.49	13.46	3.45	278.85	5.15	0.82
Total State Plan Services	2,334.80	2,038.80	2,301.27	3,038.38	1,946.50	2,015.41	3,334.33	2,415.89	1,898.57	3,093.02	1,967.51	2,008.72
Room and Board												
Room and Board - Collections	(124.70)	(87.45)	(121.80)	(253.28)	(100.09)	(183.89)	(112.16)	(46.24)	(119.85)	(227.23)	(97.68)	(180.23)
Room and Board - Costs	137.78	101.94	165.36	288.39	104.14	204.19	141.73	101.48	226.31	261.31	104.02	205.45
Total Room and Board	13.08	14.49	43.57	35.10	4.04	20.30	29.56	55.24	106.46	34.08	6.34	25.23
Grand Total	2,347.89	2,053.29	2,344.84	3,073.48	1,950.54	2,035.70	3,363.90	2,471.13	2,005.03	3,127.10	1,973.84	2,033.95
Composite PMPM		2,271.23			2,191.30			2,813.60			2,240.28	

Wisconsin Department of Health Services
CY 2009 Family Care Capitation Rate Development

Summary of 2007 Actual Experience by County
Non-Nursing Home Level of Care

	Fond du Lac			La Crosse			Milwaukee			Portage		
	DD	PD	Elderly	DD	PD	Elderly	DD	PD	Elderly	DD	PD	Elderly
Exposure Months	61	380	154	175	1,964	267	10	1,315	736	29	506	102
State Plan Services												
Adaptive Equipment	3.56	46.71	13.06	7.00	46.44	38.62	-	40.87	29.59	-	26.22	14.97
Adult Day Activities	5.06	-	37.19	0.18	5.06	10.45	34.34	12.84	7.94	-	3.74	16.46
Case Management	200.42	303.11	290.25	219.94	243.99	216.19	533.52	333.75	270.80	258.52	325.10	127.78
Community At Large	-	-	-	-	-	-	-	-	-	-	-	-
Family Support Funding	-	-	-	-	-	-	-	-	-	-	-	-
Habilitation / Health	0.17	16.81	17.72	58.83	32.29	1.30	-	22.62	5.41	29.99	21.46	0.78
Home Care	30.24	160.59	76.86	57.49	107.35	120.40	53.71	277.22	291.41	26.48	136.17	144.72
Home Health Care	-	12.77	35.12	-	10.00	9.22	-	12.64	31.16	-	-	-
Housing	-	-	-	-	2.97	-	-	2.06	1.45	-	0.61	-
Institutional	-	-	-	-	-	-	-	-	-	-	-	-
Member Tracking	-	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	-
Residential Care	-	-	611.72	-	11.76	23.47	-	17.06	20.81	-	0.08	-
Respite Care	-	0.09	-	-	2.69	4.50	-	-	0.45	-	-	-
Transportation	49.67	21.00	78.22	14.53	17.15	5.45	8.20	34.78	26.06	34.58	27.32	7.60
Vocational	46.26	-	-	6.00	3.61	(0.00)	-	0.03	-	8.51	4.10	(0.00)
Total State Plan Services	335.39	561.09	1,160.13	363.97	483.30	429.59	629.77	753.87	685.07	358.09	544.81	312.31
Room and Board												
Room and Board - Collections	-	-	-	-	(2.01)	(23.67)	-	(2.24)	(6.50)	-	-	-
Room and Board - Costs	-	-	-	-	7.59	42.09	-	4.80	5.17	-	0.08	-
Total Room and Board	-	-	-	-	5.58	18.42	-	2.55	(1.32)	-	0.08	-
Grand Total	335.39	561.09	1,160.13	363.97	488.89	448.01	629.77	756.42	683.75	358.09	544.89	312.31
Composite PMPM		692.69			475.27			729.86			499.39	

Wisconsin Department of Health Services

CY 2009 Family Care Capitation Rate Development

Summary of 2007 Actual Experience by County
Non-Nursing Home Level of Care

	Richland			Original 5 Pilots		
	DD	PD	Elderly	DD	PD	Elderly
Exposure Months	20	311	113	295	4,476	1,372
State Plan Services						
Adaptive Equipment	-	39.50	25.05	4.89	42.06	28.04
Adult Day Activities	-	-	-	2.32	6.41	11.68
Case Management	271.65	374.42	219.56	233.78	293.61	247.52
Community At Large	-	-	-	-	-	-
Family Support Funding	-	-	-	-	-	-
Habilitation / Health	10.91	119.97	5.72	38.56	33.01	5.67
Home Care	1.80	139.26	132.36	44.88	167.25	210.05
Home Health Care	-	9.38	-	-	9.84	22.45
Housing	-	1.12	-	-	2.05	0.78
Institutional	-	-	-	-	-	-
Member Tracking	-	-	-	-	-	-
Other	-	-	-	-	-	-
Residential Care	-	-	258.11	-	10.18	105.63
Respite Care	-	0.72	-	-	1.24	1.12
Transportation	11.73	41.16	5.92	23.38	25.48	24.87
Vocational	29.05	9.28	(0.00)	15.99	2.70	(0.00)
Total State Plan Services	325.15	734.82	646.71	363.81	593.82	657.81
Room and Board						
Room and Board - Collections	-	-	(76.68)	-	(1.54)	(14.42)
Room and Board - Costs	-	-	88.15	-	4.75	18.25
Total Room and Board	-	-	11.47	-	3.21	3.82
Grand Total	325.15	734.82	658.18	363.81	597.03	661.63
Composite PMPM		696.72			600.25	

	Community Care			Grand Total		
	DD	PD	Elderly	DD	PD	Elderly
Exposure Months	2	120	27	297	4,596	1,399
State Plan Services						
Adaptive Equipment	-	129.19	25.70	4.87	44.32	28.00
Adult Day Activities	-	-	-	2.31	6.25	11.46
Case Management	195.77	271.12	217.35	233.57	293.03	246.94
Community At Large	-	-	-	-	-	-
Family Support Funding	-	-	-	-	-	-
Habilitation / Health	-	2.49	-	38.35	32.21	5.56
Home Care	-	156.74	290.06	44.63	166.97	211.60
Home Health Care	-	128.80	56.46	-	12.93	23.11
Housing	-	-	-	-	2.00	0.76
Institutional	-	-	-	-	-	-
Member Tracking	-	-	-	-	-	-
Other	-	-	-	-	-	-
Residential Care	-	-	-	-	9.92	103.58
Respite Care	-	-	-	-	1.20	1.10
Transportation	-	19.70	4.79	23.25	25.32	24.48
Vocational	-	-	-	15.90	2.63	(0.00)
Total State Plan Services	195.77	708.03	594.37	362.88	596.79	656.58
Room and Board						
Room and Board - Collections	-	-	-	-	(1.50)	(14.14)
Room and Board - Costs	-	-	-	-	4.63	17.89
Total Room and Board	-	-	-	-	3.12	3.75
Grand Total	195.77	708.03	594.37	362.88	599.91	660.33
Composite PMPM		681.60			602.17	

Wisconsin Department of Health Services
CY 2009 Family Care Capitation Rate Development

Functional Screen Regression Model of 2007 PMPM
Nursing Home Level of Care

Variable	Estimate	p-Value	Incremental Partial R2	Proportion with Variable	Incremental Increase
Intercept (Grid Component)	784.17	0.0001			784.17
County (Grid Component)					
Richland	139.21	0.0001	0.00014803	0.0331	4.60
La Crosse	(90.17)	0.0001	0.00002513	0.1600	(14.43)
Fond du Lac	(321.74)	0.0001	0.00000752	0.0966	(31.08)
Portage	105.21	0.0001	0.00244000	0.0889	9.36
DD/NH Level of Care (Grid Component)					
Vent Dependent	3,622.63	0.0001	0.00438000	0.0011	4.17
DD1A	1,639.64	0.0001	0.02164000	0.0138	22.66
DD1B	2,240.37	0.0001	0.09535000	0.0291	65.27
DD2	849.98	0.0001	0.02628000	0.1195	101.57
SNF	332.56	0.0001	0.08517000	0.2659	88.42
Number of IADLs (Grid Component)					
IADL_3	132.92	0.0001	0.01312000	0.1845	24.52
IADL_4	304.44	0.0001	0.00027981	0.3377	102.81
IADL_5	329.83	0.0001	0.03832000	0.2482	81.87
IADL_6	1,158.28	0.0001	0.04218000	0.0327	37.85
Specific ADLs / Equipment Used (Add-On)					
Bathing_2	254.33	0.0001	0.02587000	0.5034	128.04
Dressing_2	126.99	0.0001	0.01151000	0.2971	37.73
Eating_2	158.40	0.0001	0.00233000	0.0960	15.21
Toileting_1	211.91	0.0001	0.00043342	0.1828	38.73
Toileting_2	353.82	0.0001	0.00699000	0.2052	72.59
Transfer_2	397.26	0.0001	0.00170000	0.1885	74.88
Interaction Terms (Add-On)					
Bathing_Equip_Dressing	207.29	0.0001	0.00230000	0.4894	101.45
Transfer_Equip_Mobility	250.64	0.0001	0.00062365	0.0795	19.93
Bathing_Equip_Eating	68.91	0.0003	0.00012040	0.2167	14.93
Behavioral Variables (Add-On)					
Communication_3	50.17	0.0004	0.00005554	0.0417	2.09
Injury	383.56	0.0001	0.00207000	0.0254	9.75
Offensive_1-2	376.36	0.0001	0.00240000	0.1036	38.99
Offensive_3	1,599.59	0.0001	0.00632000	0.0094	15.05
Medication Use (Add-On)					
Meds_2A	314.99	0.0001	0.00041186	0.2160	68.05
Meds_2B	629.52	0.0001	0.00594000	0.4323	272.12

Wisconsin Department of Health Services
CY 2009 Family Care Capitation Rate Development

Family Care Based Functional Screen Regression Model of 2007 PMPM

Variable	Estimate	p-Value	Incremental Partial R2	Proportion with Variable	Incremental Increase
Intercept (Grid Component)	760.58	0.0001			760.58
DD/NH Level of Care (Grid Component)					
Vent Dependent	3,613.70	0.0001	0.00435	0.0011	4.15
DD1A	1,633.79	0.0001	0.02210	0.0138	22.58
DD1B	2,217.53	0.0001	0.09556	0.0291	64.60
DD2	802.44	0.0001	0.02195	0.1195	95.89
SNF	323.85	0.0001	0.08534	0.2659	86.10
Number of IADLs (Grid Component)					
IADL_3	127.25	0.0001	0.01331	0.1845	23.48
IADL_4	296.58	0.0001	0.00042	0.3377	100.16
IADL_5	315.69	0.0001	0.04029	0.2482	78.36
IADL_6	1,104.40	0.0001	0.04078	0.0327	36.09
Specific ADLs / Equipment Used (Add-On)					
Bathing_2	258.50	0.0001	0.02720	0.5034	130.13
Dressing_2	134.67	0.0001	0.01191	0.2971	40.01
Eating_2	169.16	0.0001	0.00243	0.0960	16.25
Toileting_1	214.75	0.0001	0.00048	0.1828	39.25
Toileting_2	353.01	0.0001	0.00688	0.2052	72.42
Transfer_2	390.58	0.0001	0.00163	0.1885	73.62
Interaction Terms (Add-On)					
Bathing_Equip_Dressing	214.14	0.0001	0.00247	0.4894	104.80
Transfer_Equip_Mobility	249.63	0.0001	0.00062	0.0795	19.85
Bathing_Equip_Eating	68.00	0.0003	0.00011	0.2167	14.73
Behavioral Variables (Add-On)					
Communication_3	48.31	0.0006	0.00005	0.0417	2.02
Injury	384.42	0.0001	0.00207	0.0254	9.78
Offensive_1-2	373.54	0.0001	0.00236	0.1036	38.70
Offensive_3	1,586.12	0.0001	0.00620	0.0094	14.92
Medication Use (Add-On)					
Meds_2A	321.45	0.0001	0.00039	0.2160	69.45
Meds_2B	632.43	0.0001	0.00602	0.4323	273.37

Wisconsin Department of Health Services
CY 2009 Family Care Capitation Rate Development

Summary of Proportion of Pilot MCO Population with Rating Characteristics
Nursing Home Level of Care

Variable	Fond Du Lac	La Crosse	Milwaukee	Portage	Richland	Community Care
Disability or Nursing Home						
Vent Dependent	0.1%	0.0%	0.1%	0.1%	0.0%	0.2%
DD1A	2.0%	3.0%	1.1%	1.8%	2.5%	0.8%
DD1B	5.2%	6.8%	0.6%	7.8%	5.0%	3.1%
DD2	29.1%	22.0%	5.4%	19.0%	21.4%	14.2%
SNF	21.3%	19.3%	31.5%	22.4%	18.5%	25.2%
Instrumental Activities of Daily Living						
IADL_3	15.9%	16.4%	18.3%	17.1%	16.7%	16.2%
IADL_4	29.0%	26.9%	38.1%	24.4%	27.5%	32.1%
IADL_5	31.9%	23.1%	24.9%	33.2%	27.5%	25.8%
IADL_6	10.5%	7.0%	0.7%	5.3%	4.2%	5.8%
Activities of Daily Living						
Bathing_2	46.6%	39.4%	57.0%	50.2%	38.2%	54.7%
Dressing_2	25.6%	23.6%	35.8%	29.3%	22.2%	36.2%
Eating_2	10.6%	9.0%	10.2%	12.7%	8.8%	15.8%
Toileting_1	18.5%	14.6%	18.4%	18.2%	17.1%	20.8%
Toileting_2	20.3%	16.8%	23.4%	21.3%	19.8%	23.5%
Transfer_2	16.7%	16.0%	21.7%	21.0%	13.9%	22.5%
Interaction Terms						
Bathing_Equip_Dressing	43.2%	34.1%	56.9%	45.5%	37.2%	46.9%
Transfer_Equip_Mobility	7.0%	9.3%	8.2%	8.6%	7.8%	11.2%
Bathing_Equip_Eating	23.8%	17.9%	22.5%	29.4%	18.2%	24.9%
Behavioral Variables						
Communication_3	5.1%	4.8%	3.5%	7.1%	4.2%	5.9%
Injury	3.1%	3.6%	1.8%	2.5%	2.8%	4.2%
Offensive_1-2	14.7%	12.2%	8.0%	10.8%	12.9%	14.6%
Offensive_3	0.7%	3.6%	0.3%	4.2%	1.1%	0.5%
Medication Use						
Meds_2A	22.2%	21.1%	23.0%	19.0%	28.4%	26.6%
Meds_2B	48.0%	36.7%	47.1%	43.3%	32.8%	42.4%

Wisconsin Department of Health Services

CY 2009 Family Care Capitation Rate Development

Summary of Proportion of Expansion MCO Population with Rating Characteristics
Nursing Home Level of Care

Variable	WWC	CCCW	SFCA	Community Care*	Care Wisconsin	CHP	Northern Bridges
Disability or Nursing Home							
Vent Dependent	0.0%	0.0%	0.1%	0.5%	0.3%	0.3%	0.1%
DD1A	2.1%	1.8%	2.1%	2.8%	2.6%	12.8%	2.7%
DD1B	7.4%	12.1%	5.7%	7.1%	7.7%	13.2%	4.3%
DD2	37.0%	36.9%	32.1%	41.1%	40.1%	43.5%	35.8%
SNF	8.8%	9.1%	12.0%	8.3%	7.9%	8.1%	9.6%
Instrumental Activities of Daily Living							
IADL_3	16.0%	13.0%	13.7%	13.9%	13.9%	11.8%	18.1%
IADL_4	22.4%	25.3%	24.6%	28.3%	26.7%	22.4%	26.6%
IADL_5	26.3%	30.5%	27.1%	31.2%	30.2%	36.0%	24.2%
IADL_6	12.7%	16.6%	16.2%	14.6%	15.4%	19.7%	12.8%
Activities of Daily Living							
Bathing_2	50.5%	47.4%	53.5%	52.6%	52.4%	45.0%	53.4%
Dressing_2	28.0%	27.4%	29.3%	31.7%	30.2%	30.1%	31.7%
Eating_2	16.0%	16.7%	13.4%	16.5%	18.1%	25.3%	17.5%
Toileting_1	20.5%	20.6%	21.3%	16.7%	18.6%	20.2%	17.3%
Toileting_2	20.2%	20.7%	20.0%	24.7%	22.4%	25.1%	20.8%
Transfer_2	14.6%	16.2%	17.2%	19.7%	18.1%	19.4%	16.2%
Interaction Terms							
Bathing_Equip_Dressing	40.9%	33.4%	43.7%	35.0%	35.9%	34.9%	42.4%
Transfer_Equip_Mobility	8.7%	7.1%	9.5%	6.6%	7.2%	10.3%	9.0%
Bathing_Equip_Eating	22.0%	20.6%	25.5%	21.3%	22.0%	26.8%	23.5%
Behavioral Variables							
Communication_3	6.6%	8.1%	7.3%	7.6%	8.5%	9.7%	8.6%
Injury	7.7%	7.6%	6.9%	8.1%	7.0%	12.1%	7.7%
Offensive_1-2	21.5%	26.8%	21.4%	22.7%	22.6%	30.7%	19.3%
Offensive_3	0.8%	2.5%	1.3%	1.1%	1.2%	1.9%	0.4%
Medication Use							
Meds_2A	21.3%	19.7%	21.7%	23.5%	23.8%	19.4%	20.0%
Meds_2B	38.0%	47.8%	45.4%	44.5%	45.4%	53.2%	41.0%

*The Community Care MCO rate is developed for the Teal Region which includes Ozaukee, Washington, Sheboygan, Waukesha, & Walworth counties.

Wisconsin Department of Health Services

CY 2009 Family Care Expansion Capitation Rate Development

Development of the 2009 Final Nursing Home Rates

Current MCO	Total Statistical Model 2007 PMPM Inc IBNR	Admin/Risk Rate	Two-Year Trend	2009 Gross Nursing Home Rates	2009 Ave. Cost Sharing PMPM	Preliminary 2009 MCE Rates
CCO (Fond du Lac)	$2,198.42	5.75%	6.9%	$2,493.95	$52.72	$2,441.23
WWC (La Crosse)	$2,143.47	5.75%	6.9%	$2,431.25	$64.67	$2,366.58
MCDA (Milwaukee)	$2,182.40	5.35%	8.3%	$2,497.94	$97.66	$2,400.28
CCCW (Portage)	$2,388.19	5.75%	6.9%	$2,708.35	$50.33	$2,658.02
SFCA (Richland)	$2,115.77	9.00%	7.2%	$2,493.27	$76.68	$2,416.59
Community Care (Kenosha/Racine)	$2,716.91	5.75%	6.5%	$3,071.20	$39.72	$3,031.48

Expanding MCO	Total Statistical Model 2007 PMPM Inc IBNR	Admin/Risk Rate	Two-Year Trend	2009 Gross Nursing Home Rates	2009 Ave. Cost Sharing PMPM	Preliminary 2009 MCE Rates
WWC	$2,475.15	5.75%	6.3%	$2,792.05	$64.67	$2,727.38
CCCW	$2,718.03	5.75%	6.1%	$3,060.15	$83.14	$2,977.01
SFCA	$2,476.38	9.00%	6.7%	$2,904.83	$83.14	$2,821.69
Community Care (Teal Region)[1]	$2,708.39	5.75%	6.3%	$3,054.53	$83.14	$2,971.39
Care Wisconsin[2]	$2,670.93	5.75%	6.2%	$3,010.30	$83.14	$2,927.16
CHP[3]	$3,186.85	5.75%	5.7%	$3,572.61	$83.14	$3,489.47
Northern Bridges	$2,453.73	5.75%	6.9%	$2,782.43	$83.14	$2,699.29

MCO	2009 Gross Nursing Home Rates	Start-Up Costs	2009 Gross MCE Rates	2009 Gross Capitation Rates	2009 Ave. Cost Sharing PMPM	2009 Capitation Rates Net of Cost Share
CCO (Fond du Lac)	$2,493.95		$2,493.95	$2,493.95	$52.72	$2,441.23
WWC	$2,579.25	$25.00	$2,604.25	$2,629.00	$64.67	$2,564.33
MCDA (Milwaukee)	$2,497.94		$2,497.94	$2,497.94	$97.66	$2,400.28
CCCW	$2,915.89		$2,915.89	$2,915.89	$69.69	$2,846.20
SFCA	$2,776.56		$2,776.56	$2,776.56	$81.13	$2,695.44
Community Care (Kenosha/Racine)	$3,071.20		$3,071.20	$3,071.20	$39.72	$3,031.48
Community Care (Teal Region)[1]	$3,054.53	$22.00	$3,076.53	$3,076.53	$83.14	$2,993.39
Care Wisconsin[2]	$3,010.30		$3,010.30	$3,010.30	$83.14	$2,927.16
CHP[3]	$3,572.61		$3,572.61	$3,572.61	$83.14	$3,489.47
Northern Bridges	$2,782.43		$2,782.43	$2,782.43	$83.14	$2,699.29

1. The Community Care MCO rate is developed for the Teal Region which includes Ozaukee, Washington, Sheboygan, Waukesha, & Walworth counties.
2. The effective contract period for the Care Wisconsin capitation rate is February 1, 2009 through December 31, 2009.
3. The effective contract period for the CHP capitation rate is March 1, 2009 through December 31, 2009.

Wisconsin Department of Health Services

CY 2009 Family Care Expansion Capitation Rate Development

Development of the 2009 Final Non-Nursing Home Rates

MCO	2009 Gross Nursing Home Rates	Admin/Risk Rate	Two-Year Trend	2009 Gross Capitation Rates	2009 Ave. Cost Sharing PMPM	2009 Capitation Rates Net of Cost Share
CCO (Fond du Lac)	$630.44	5.75%	6.91%	$715.12	$0.00	$715.12
WWC	$569.64	5.75%	6.89%	$646.02	$0.00	$646.02
MCDA (Milwaukee)	$628.11	5.35%	8.33%	$718.90	$0.00	$718.90
CCCW	$614.53	5.75%	6.88%	$696.87	$0.00	$696.87
SFCA	$587.35	9.00%	7.24%	$692.19	$0.00	$692.19
Community Care (Kenosha/Racine)	$635.49	5.75%	6.53%	$718.32	$0.00	$718.32
Community Care (Teal Region)[1]				$718.32	$0.00	$718.32
Care Wisconsin				$703.11	$0.00	$703.11
CHP				$703.11	$0.00	$703.11
Northern Bridges				$703.11	$0.00	$703.11

1. The Community Care MCO rate is developed for the Teal Region which includes Ozaukee, Washington, Sheboygan, Waukesha, & Walworth counties.