

February 18, 2008

Mr. Thomas Lawless
Section Chief
Financial & Business Management Services
Department of Health and Family Services
One West Wilson Street
Madison, WI 53701

Re: Contract Period 2008 Family Care Partnership Program Capitation Rates for Expansion Counties

Dear Tom:

The enclosed report provides a detailed description of the methodology used to develop the contract period 2008 managed care equivalent estimates and HMO capitation rates for the Family Care Partnership managed care program 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 Jinn-Feng Lin, Lead Actuary.

Please call Sandra Hunt at 415-498-5365 or Jinn Lin at 312-298-3792 if you have any questions regarding these rates.

Very truly yours,

PricewaterhouseCoopers LLP



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



Jinn-Feng Lin, F.S.A., M.A.A.A.
Director

**Wisconsin Department of
Health and Family Services**

**Contract Period 2008
Family Care Partnership Program (FCP) Capitation Rates for Expansion
Regions**

Prepared by:

PricewaterhouseCoopers

February 2008

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SUMMARY OF EXHIBITS

Exhibit I	Waiver and Nursing Home Population Historical FFS Experience
Exhibit II	Waiver and Nursing Home Population Historical Adjusted Baseline Per Capita Costs
Exhibit III	Community Care Managed Care Equivalent Development
Exhibit IV	Care Wisconsin Managed Care Equivalent Development
Exhibit V	Partnership Health Plan Managed Care Equivalent Development

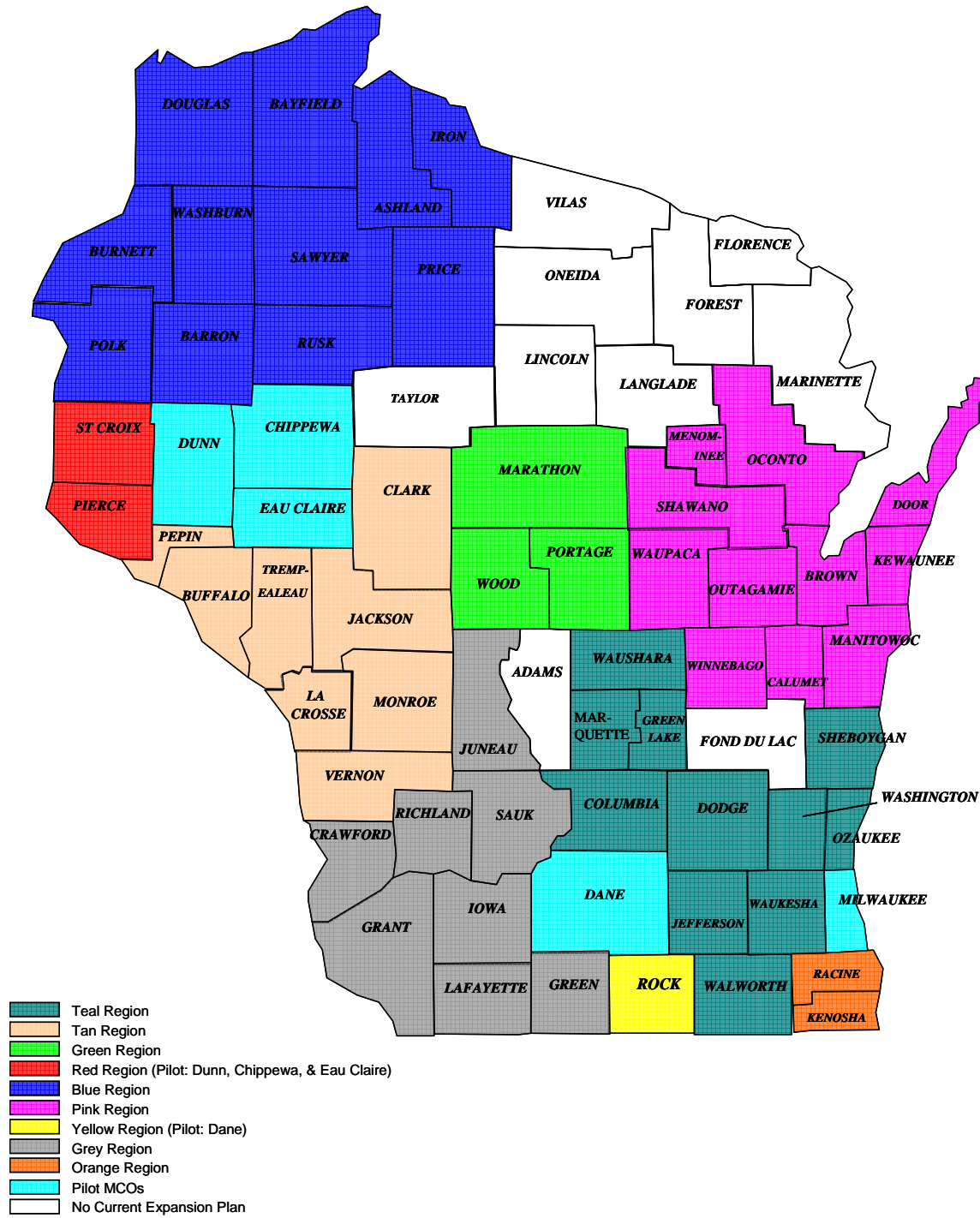
I. EXECUTIVE SUMMARY

The Family Care Partnership Program (Partnership or FCP) is an integrated program of acute and long-term care (LTC) services designed to improve access and quality while achieving cost savings. Acute and long-term support services are coordinated across care settings using an interdisciplinary team comprised of a physician, nurse practitioner, registered nurse and social worker or independent living coordinator. Medicare and Medicaid services are coordinated from a single setting and payment rates to participating contractors are set as a single capitation rate. The following table shows the Managed Care Organizations (MCOs) that are currently participating in the FCP program.

Family Care Partnership Current MCOs		
MCO	Implementation Date	Covered Counties
Community Care Health Plan (CCHP)	Pilot MCO	Milwaukee and Racine
Care Wisconsin Health Plan (CWHP)	Pilot MCO	Dane
Health Plan for Community Living (HPCL)	Pilot MCO	Dane
Partnership Health Plan (PHP)	Pilot MCO	Chippewa, Dunn, and Eau Claire

The State has been continuing the effort to expand the FCP program outside of the current service areas. The expansion plan for the Family Care and Family Care Partnership programs that DHFS has provided categorizes the State into roughly ten regions, with each region comprised of multiple counties. MCOs will initially expand to selected counties within regions, with further expansion planned as capacity is developed. Expansion during 2008 is planned for two of the ten regions (the Teal and Red Regions). The map below provides the regional configuration for the FCP program.

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Rates are calculated for the Skilled Nursing Facility (SNF) / Intermediate Care Facility (ICF) and the Intensive Skilled Nursing (ISN) level of care populations. The level of care capitation rates are separately developed for the three expansion MCOs: Care Wisconsin, Community Care, and Partnership Health Plan (PHP). For payment purposes, these rates are blended into one aggregate payment rate.

The implementation dates for various MCOs as well as the counties to which they are expanding coverage to are detailed below.

Family Care Partnership Expansion Details		
MCO	First Implementation Date	Expansion Counties
Community Care	Apr. 1, 2008	Ozaukee, Washington, & Waukesha
Care Wisconsin	Mar. 1, 2008	Columbia, Dodge, & Jefferson
PHP	July 1, 2008	Pierce & St. Croix (Pilot MCO = Chippewa, Dunn, & Eau Claire)

Noted in the above table, PHP is currently participating in the Partnership program in Chippewa, Dunn and Eau Claire counties. As a result, for the contract period effective from July 1, 2008 through December 31, 2008, the capitation rates for the provider will be calculated using a blend of the following two rates:

1. Current capitation rate for the pilot MCO effective for calendar year 2008, as detailed in the Family Care Partnership Capitation Report provided to CMS dated December 21, 2007.
2. Capitation rate developed for those individuals eligible to enroll in expansion counties not currently participating in the Partnership program.

This report describes the methodology used to develop Managed Care Equivalent amounts for the Medicaid component of the payment rate for the FCP program expansion regions.

Individuals eligible to enroll in a FCP program include those receiving Medicaid coverage in the Supplemental Security Income (SSI) categories (if income level is below 300% of SSI benefit rate.), including enrollees who are in Medicaid-only and Dual Medicare/Medicaid eligibility categories and who have been certified as being Nursing Home-eligible based on a functional screen administered by state certified screeners. Participation is voluntary and the rate setting

methodology considers the relative risk difference in the enrolled population compared to the population represented in the base data used for rate development.

A rate development methodology for the LTC portion of the MCE rate was developed to better reflect the variation in level of need for services for the enrollees in the FCP program. This portion of the rate is calculated using calendar year 2006 Family Care cost and eligibility data. The methodology relies on a regression model that estimates differences in expected costs by functional screen scores.

The acute and primary portion of the MCE rates are based on the experience of the fee-for-service population in each of the geographies with a FCP program, adjusted for the particular characteristics of the FCP population. To reflect higher levels of access to dental service for FCP enrollees, the dental services rates are developed using actual experience reported by the providers currently participating in the FCP program. The base data is trended and adjusted to reflect the mix of services expected to be required by the FCP population; an Incurred But Not Reported (IBNR) claims adjustment is applied to complete the data, an allowance is made for plan administrative expense and an adjustment is made to account for managed care efficiencies.

Rate Setting Methods to CMS Requirements

PricewaterhouseCoopers LLP (PwC) has calculated 2008 Managed Care Equivalence (MCE) rates for the FCP program. Effective August 13, 2003, regulations issued by the Centers for Medicare and Medicaid Services govern the development of capitation payments for Medicaid managed care programs. The rate setting regulations for managed care programs require that rates be “actuarially sound”.

While there are no definitive criteria for determining actuarial soundness for Medicaid managed care programs, CMS has issued a checklist that provides guidance, and we have followed that checklist in developing the proposed rates shown here. The final rates will be established through signed contracts with Managed Care Organizations (MCO), which will ensure that the plans concur that the rates paid will allow for contracting with sufficient numbers of providers to ensure appropriate access to health care and that they expect to remain financially sound throughout the contract period.

The general guidelines for developing actuarially sound payment rates encompass the following concepts:

- Data appropriate for the population to be covered by the managed care program should be used for the analysis;
- Payment rates should be sufficiently differentiated to reflect known variation in per capita costs related to age, gender, Medicaid eligibility category, health status and geographic area;

- Where rate cells have relatively small numbers of individuals, cost neutral data smoothing techniques should be used;
- Medicaid fee-for-service payment rates per unit of service are an appropriate benchmark for developing capitation rates;
- Differences in expected utilization rates between fee-for-service and managed care programs should be accounted for;
- Appropriate levels of HMO administrative costs should be included in the rates;
- Programmatic changes in the Medicaid program between the data and contract period should be reflected in the rates; and
- A range of appropriate rates could emerge from the rate-setting process.

These MCE rates are developed to be consistent with the concepts described above.

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 to develop Family Care Partnership Program 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 the FCP, the Wisconsin Medicaid acute, 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.

II. RATE CELLS

The 2008 MCE values will vary based on the following criteria:

Health Plan: All participants must be Medicaid or Dually eligible and meet nursing home (NH) level of care criteria.

- ◆ Community Care
- ◆ Care Wisconsin
- ◆ Partnership Health Plan (PHP)

Aid Category:

- Medical Assistance (MA)
- Dually Eligible: individuals who are eligible for both Medicare and Medicaid

Eligibility Group: Members eligible for participation in these programs include:

- ◆ Nursing Home Population: those individuals enrolled in the program whose care is provided in a nursing home setting.
- ◆ Home and Community Based Services (HCBS) Waiver Population: those nursing home eligible individuals enrolled in the program whose care is provided in a community-based setting.

Level of Care, eligible members are placed in one of two classifications based on their need / level of care:

- SNF/ICF: those individuals who require treatment in a skilled nursing facility (SNF) or intermediate care facility (ICF)
- ISN: those individuals who require treatment via intensive skilled nursing (ISN)

Region: The health plans provide coverage in the following expansion counties:

- ◆ Community Care: Ozaukee, Washington, and Waukesha
- ◆ Care Wisconsin: Columbia, Dodge, and Jefferson
- ◆ PHP: Pierce and St. Croix

III. DATA SOURCES

A first step in developing MCE rates is identifying the data that will be used for the calculations. The CMS regulations relating to the development of actuarially sound rates 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 long-term care portion of the rate is calculated using calendar year 2006 Family Care cost and eligibility data. The dental services rates are developed using actual experience reported by the providers currently participating in the FCP program. The rate development for the remaining services described here relies on the most recent FFS data for a comparable population.

As a starting point in our analysis we received detailed claims and eligibility data. We then worked with the State to summarize the claims experience by year for each of the rate cells. The data were further segregated to reflect the experience of the Nursing Home and Home and Community Based Waiver (HCBW) populations. The Nursing Home and HCBW experience is used as the basis to develop the baseline per capita costs for the ISN and SNF/ICF level of care, respectively. This segregation is done to accommodate the materially different cost experience of the individuals in these two service settings.

IV. RATE SETTING METHODOLOGY

A. Overview

The 2008 MCE estimates are developed through the following steps:

1. The preliminary primary and acute FFS cost per eligible month for FCP eligibles in each geographic region was developed using CY 2004-2006 claims and eligibility data (refer to Exhibits I and II).
2. The projected increase from CY 2006 to CY 2008 was developed based on budgeted provider reimbursement increases and historical utilization/mix annual trend analysis.
3. An adjustment was made to reflect effective drug rebates collected by the health plans.
4. An adjustment was made to reflect estimated utilization savings under a managed care environment relative to fee-for-service.
5. An administrative allowance was added to reflect estimated program administrative costs as a percentage of revenue.
6. A model has been developed to appropriately risk adjust the Long Term Care component of the rate to reflect the relative needs of the expansion FCP population
7. An aggregate MCE is calculated based on the proportion of ISN and SNF/ICF level of care individuals that are anticipated to enroll in the expansion counties.

B. Detailed Methodology Description

The methodology used to calculate the Contract Period 2008 FCP program MCE estimates is described in this section.

1. Preliminary FFS Cost per Eligible Month

For the primary and acute component of the capitation rates, the CY 2006 cost per eligible month is based on the FFS costs for the relevant populations in each of the geographies with a FCP program. The base period used in our calculation is CY 2004-2006. Paid claim amounts and eligible month totals for each of the base years are taken from the data provided by the State and include payments through July 31, 2007. Three years of cost data are used as the base period to help smooth annual cost fluctuations.

Due to the implementation of Medicare Modernization Act at the beginning of 2006, the prescription drug benefits are being covered by Medicare Part D for the Medicare eligible population. Therefore, calendar year 2006 pharmacy costs are used as the basis to develop per

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capita costs for the Dual eligible population and CY 2004-2006 pharmacy costs are used as the basis to develop per capita costs for the Medicaid-only population.

To reflect the variation in level of need for services between the FFS population and the enrollees in the FCP program, the long-term care component of the capitation rate is calculated using calendar year 2006 Family Care cost and eligibility data.

- ♦ **Hospital Inpatient Adjustments** – The hospital inpatient paid amounts are adjusted to reflect payments made to hospitals that are not reflected in the base period paid claim amounts in the rate setting data (e.g., cash recoupments) and also to remove Disproportionate Share (DSH) payments from the base period paid claim amounts. The following table shows the adjustments made to each health plan’s inpatient claims experience:

	IP Adjustment
Community Care	0.997
Care Wisconsin	0.999
PHP	0.998

- ♦ **Critical Access Hospital Adjustment** - An adjustment factor is applied to reflect the higher FFS DRG payments that will be made to critical access hospitals. The adjustment varies by health plan to reflect the usage of critical access hospitals by region. Both inpatient and outpatient adjustment factors by health plan were calculated and provided by DHFS. The following tables show the adjustments made to each health plan’s inpatient and outpatient claims experience:

Inpatient Adjustment	2004	2005	2006
Community Care	1.000	1.000	1.000
Care Wisconsin	1.003	1.003	1.000
PHP	1.008	1.008	1.017

Outpatient Adjustment	2004	2005	2006
Community Care	1.000	1.000	1.001
Care Wisconsin	1.003	1.003	1.005
PHP	1.000	1.000	1.000

- ♦ **Completion Factors** – Total FFS paid claims are adjusted by a completion factor, which reflects incurred but not yet paid claims. Based on an analysis of statewide FFS data, the completion factor for 2006 non-pharmacy claims used in the analysis is 1.0008. All pharmacy claims and 2004 / 2005 non-pharmacy claims are assumed to be complete. Cost PEPM is calculated as completed claims divided by months.

The long-term care component of the MCE rate is calculated using Family Care encounter data. The claims data covers dates of service for calendar year 2006 with run out through July 2007. A completion factor of 1.0006 was applied to the long-term care claims data.

- **Dental Adjustment** - Access to dental services has been shown to be materially higher for most enrollees in FCP. Health plans currently participating in the FCP program provided actual per member per month costs for dental services provided during calendar years 2004, 2005 and 2006. Since the expansion counties do not have actual claims experience, we have set the baseline dental per capita costs for the expansion regions equal to the aggregate managed care health plan reported experience.

All adjustments made to the baseline per capita costs discussed above are reflected in Exhibit II.

2. Projected Increase from Base Period to Rate Period

The primary and acute cost PEPM for CY 2004 and 2005 is trended to CY 2006 separately by service category. The trend factor is based on the statewide historical changes in cost PEPM separately for Medicaid-only and Dual eligible. The preliminary CY 2006 cost PEPM are the weighted average of each year's cost PEPM trended to CY 2006.

To project the baseline cost data beyond the base cost period to the midpoint of the 2008 contract period, we developed separate trend factors by eligibility category, by level of care, and for Drug and other medical service categories. Annual trend rates are calculated and applied for three types of services as follows. Based on examination of the data, the same trend rates are applied to the Medicaid-only and Dual populations.

- ◆ Acute care non-RX: 4.0%
- ◆ Prescription Drug: 6.0% (Applies to the Medicaid-only population)
- ◆ Long Term Care:
 - Elderly: 3.6%
 - Disabled: 1.9%

We developed the trend factors based on an analysis of provider reimbursement increases we received from the State, estimated utilization and mix annual trends, and estimated annual prescription drug trends. The trend factors for the long-term care services were developed using the managed care cost and eligibility data of the Family Care program.

3. Drug Rebate Budgeted Adjustment

A Medicaid-Only prescription drug rebate of 31.6% and Dual eligible drug rebate of 27.1% is applied to the drug portion of the analysis. The drug rebate is calculated and applied separately by eligibility category to reflect the difference in underlying drug mix between the two populations. The rebate amount is reflected in Exhibits III, IV, and V, and show the projected CY 2008 prescription drug rebates PEPM.

The resulting CY 2008 rebate PEPM are subtracted from the overall CY 2008 costs PEPM in Exhibits III through V to reflect estimated FFS prescription drug rebates collected by the State.

4. Managed Care Adjustment

The State is expecting more cost effective provision of services resulting in managed care efficiencies compared to projected FFS experience. The managed care savings assumption is applied only to the portion of the per capita costs that are based on FFS data. Therefore, no managed care adjustment is applied to the health plan reported dental per capita costs and the regression/encounter data-based LTC per capita costs. The managed care savings has been assumed to be 5.0% for all health plans. The estimates were provided by DHFS staff, and are within a range of reasonable values for managed care utilization savings.

5. Administrative Allowance

The administrative allowance applied to the LTC service component of the MCE was developed based on a review of reported administrative costs in 2006 and year-to-date 2007 for MCOs currently participating in the Family Care program. The LTC service component administrative allowance for all expanding MCOs is 5.75% of the managed care equivalent rate. An administrative allowance of 4.71% was applied to the remaining services used in estimating the 2008 MCE. Both rates are within a range of reasonable values for the administrative allowance.

6. Long-Term Care Rate Development

A model has been developed to appropriately risk adjust the Long Term Care component of the rate to reflect the relative needs of the FCP population. Using calendar year 2006 Family Care encounter data, an Ordinary Least Squares linear regression model is created to relate monthly costs to recipient functional characteristics. The unit of analysis is the recipient month. That is, the monthly 2006 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. The resulting per capita costs are shown in Exhibits I and II. Please refer to Appendix A for a detailed description of the regression modeling.

7. Calculation of the Aggregate MCE Rates

Contract period per capita costs for each MCO are developed separately for the ISN and SNF/ICF level of care populations. Only a small number of ISN individuals are anticipated to enroll into the expansion MCOs. As a result of the limited number of enrollees, the MCE is calculated as a weighted average of the two populations' contract period per capita costs. Since actual enrollment in an expansion MCO is not known, we have used the estimated enrollment in the expansion counties to calculate the MCE rates.

V. RATE DEVELOPMENT FOR CURRENT PARTICIPATING MCOs VERSUS NEW MCOs

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

- A provider that is not currently participating in the FCP program in a given region, and
- A current FCP managed care provider that is expanding coverage to additional counties within a region.

For a provider that is not currently participating in the FCP program in a given region, a single rate will be developed for the 2008 contract period. The effective period for the capitation rate will begin on the first county's anticipated start date and span through December 31, 2008. For example, Community Care anticipates expanding to Ozaukee in April, Washington in April, and Waukesha in July. One composite capitation rate will be calculated for Community Care effective April 1, 2008 through December 31, 2008. 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. 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 effective contract periods for providers that are not currently participating in the Family Care Partnership program within a given region are provided in the following table:

Provider	Contract Period
Community Care	Apr. 1, 2008 - Dec. 31, 2008
Care Wisconsin	Mar. 1, 2008 - Dec. 31, 2008

The second consideration is the development of a capitation rate for a region where a provider is currently participating in the FCP program. PHP currently participates in the FCP program in Chippewa, Dunn, and Eau Claire counties. For this provider, two capitation rates will be calculated: one rate for the MCO currently operating that is effective from January 1, 2008 through the first expansion county's implementation date, and another rate effective from the first implementation date through December 31, 2008. Note that the capitation rate development for the MCOs currently operating in pilot counties is contained in the FCP Capitation Report submitted to CMS dated December 20, 2007.

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Effective July 1, 2008, PHP will expand coverage to Pierce County. Therefore a new capitation rate will be calculated for the provider using a blend of the pilot MCO capitation rate and the expansion county rate at the date of the MCO's expansion. The weighted average provider capitation rate will be calculated using actual managed care enrollment and the estimated enrollment in the expansion counties. Based on conversations with DHFS, 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 health status for two contract periods after the date of implementation. The risk selection adjustment will be based on the following:

- For the long-term care component of the MCE, 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 is shown in Appendix B.
- For acute care services, the Hierarchical Coexisting Condition (HCC) model will be applied. Adjustments will be made to reflect the difference in illness burden between the most recent health plan enrolled population and the FFS population used as a basis for establishing the MCE estimates. Since health plan diagnosis data is not available, the FFS HCC scores of those individuals enrolled by an expansion MCO will be used to reflect the illness burden of the managed care population.

VI. APPENDIX A

Regression 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.

The base data used to develop the regression model consists of Family Care calendar year 2006 claim, eligibility, and functional screen data.

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 six variables to predict cost. The variables are separated into the following six classes: target group, number of IADLs, specific ADLs and their levels of help, interactions, behavioral indicators, and medication management use. The estimated impact on the cost for each variable is shown along with its significance (i.e., p-value), and relative contribution in explaining the variation (i.e., Incremental Partial R²). Appendix B shows the final statistical model. The model explains approximately 40% of the variation in the data.

To determine those individuals that are eligible to enroll in each MCO, we obtained functional screen information as of August 2007 for the Waiver and Waitlist populations. Based on conversations with DHFS, 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.

Appendix C shows the estimated proportion of the population having a given characteristic. The proportion is calculated as the number of individuals expected to enroll in a MCO with the specified variable, divided by the total number of individuals in a MCO. Thus to derive the average PMPM cost for a given population, one would cross-multiply all regression parameter

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estimates by the proportion of the population with the respective characteristic, and add the regression intercept.

APPENDIX B

Wisconsin Department of Health and Family Services Contract Period 2008 FCP Capitation Rates for Expansion Regions *Family Care Based Functional Screen Regression Model of 2006 PMPM*

Variable	Estimate	p-Value	Incremental Partial R2
Intercept (Grid Component)	746.06	0.0001	
DD/NH Level of Care (Grid Component)			
Vent Dependent	2,713.38	0.0001	0.00299
DD1A	1,495.38	0.0001	0.01939
DD1B	2,347.24	0.0001	0.09032
DD2	876.04	0.0001	0.02846
SNF	320.24	0.0001	0.08150
Number of IADLs (Grid Component)			
IADL_3	76.30	0.0001	0.01271
IADL_4	249.99	0.0001	0.00009
IADL_5	283.29	0.0001	0.03882
IADL_6	1,072.60	0.0001	0.03976
Specific ADLs / Equipment Used (Add-On)			
Bathing_2	330.45	0.0001	0.03209
Dressing_2	102.60	0.0001	0.01199
Eating_2	119.48	0.0001	0.00313
Toileting_1	226.38	0.0001	0.00056
Toileting_2	331.26	0.0001	0.00791
Transfer_2	327.33	0.0001	0.00179
Interaction Terms (Add-On)			
Bathing_Equip_Dressing	165.48	0.0001	0.00159
Transfer_Equip_Mobility	314.52	0.0001	0.00154
Bathing_Equip_Eating	77.20	0.0001	0.00021
Behavioral Variables (Add-On)			
Communication_3	162.00	0.0001	0.00043
Cognition_3	75.74	0.0001	0.00075
Resistive	166.55	0.0001	0.00199
Injury	411.86	0.0001	0.00209
Offensive_1-2	314.27	0.0001	0.00152
Offensive_3	1,089.26	0.0001	0.00267
Medication Use (Add-On)			
Meds_2A	302.78	0.0001	0.00018
Meds_2B	554.44	0.0001	0.00463

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APPENDIX C

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Summary of Proportion of MCO Population with Rating Characteristics

Variable	Community Care		Care Wisconsin		PHP	
	SNF/ICF	ISN	SNF/ICF	ISN	SNF/ICF	ISN
Disability or Nursing Home						
Vent Dependent	0.1%	30.4%	0.0%	70.0%	0.2%	18.8%
DD1A	2.7%	56.5%	1.8%	80.0%	3.7%	56.3%
DD1B	5.6%	8.7%	7.7%	0.0%	16.3%	0.0%
DD2	39.7%	0.0%	45.6%	0.0%	37.6%	0.0%
SNF	4.4%	0.0%	7.7%	0.0%	7.7%	0.0%
Instrumental Activities of Daily Living						
IADL_3	12.1%	4.3%	12.0%	0.0%	10.4%	0.0%
IADL_4	31.2%	21.7%	27.8%	0.0%	20.5%	25.0%
IADL_5	32.6%	60.9%	32.2%	70.0%	35.1%	56.3%
IADL_6	13.5%	13.0%	16.7%	30.0%	19.7%	18.8%
Activities of Daily Living						
Bathing_2	51.0%	87.0%	51.4%	100.0%	45.4%	100.0%
Dressing_2	27.7%	91.3%	30.0%	100.0%	25.3%	81.3%
Eating_2	15.8%	82.6%	15.8%	100.0%	23.9%	75.0%
Toileting_1	15.9%	13.0%	21.2%	0.0%	20.2%	43.8%
Toileting_2	20.3%	82.6%	20.7%	100.0%	20.2%	56.3%
Transfer_2	15.8%	69.6%	17.8%	100.0%	18.4%	56.3%
Interaction Terms						
Bathing_Equip_Dressing	29.1%	56.5%	35.0%	80.0%	34.5%	43.8%
Transfer_Equip_Mobility	9.6%	47.8%	11.4%	100.0%	12.2%	37.5%
Bathing_Equip_Eating	17.5%	56.5%	20.7%	80.0%	25.0%	43.8%
Behavioral Variables						
Communication_3	6.9%	26.1%	10.7%	30.0%	7.6%	37.5%
Cognition_3	20.9%	60.9%	23.9%	65.0%	30.6%	56.3%
Resistive	10.3%	8.7%	7.3%	0.0%	14.2%	18.8%
Injury	9.1%	4.3%	6.2%	20.0%	12.2%	0.0%
Offensive_1-2	22.5%	8.7%	19.9%	0.0%	32.9%	0.0%
Offensive_3	0.5%	0.0%	1.2%	0.0%	2.1%	0.0%
Medication Use						
Meds_2A	24.9%	21.7%	24.5%	15.0%	19.7%	25.0%
Meds_2B	42.0%	78.3%	47.7%	85.0%	50.0%	75.0%

VII. ACTUARIAL CERTIFICATION

**Actuarial Certification of
Proposed 2008 PACE/FCP Capitation Rates
State of Wisconsin Department of Health and Family Services**

I, Jinn-Feng Lin, 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 2008 capitation rates developed for the Medicaid managed care programs known as the Family Care Partnership Program. I have been retained by the Wisconsin Department of Health and Family Services (DHFS) to perform an actuarial certification of the Family Care Partnership Program capitation rates for expansion regions for contract period 2008 for filing with the Centers for Medicare and Medicaid Services (CMS). I have reviewed the capitation rates developed by DHFS 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 Rate setting."

I have examined the actuarial assumptions and actuarial methods used in setting the capitation rates for calendar year 2008.

To the best of my information, knowledge and belief the capitation rates offered by DHFS 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 DHFS. 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 DHFS and the participating contracted HMOs. A copy of the reliance letter received from DHFS 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.

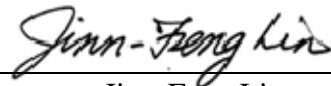
The proposed actuarially sound rates shown are a projection of future events. It may be expected that actual experience will vary from the values shown here. Actuarial methods, considerations, and analyses used in developing the proposed capitation rates conform to the appropriate Standards of Practice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

The capitation rates may not be appropriate for any specific HMO. Each HMO will need to review the rates in relation to the benefits provided. The HMOs should compare the rates with their own experience, expenses, capital and surplus, and profit requirements prior to agreeing to

Wisconsin Department of Health and Family Services
FCP Capitation Rates for Expansion Regions Contract Period 2008

contract with the State. The HMO may require rates above, equal to, or below the proposed actuarially sound capitation rates.

This Opinion assumes the reader is familiar with the Wisconsin Medicaid program, Medicaid 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.



Jinn-Feng Lin
Member, American Academy of Actuaries

February 18, 2008
Date

Exhibits

Waiver and Nursing Home Population Historical FFS Experience

Exhibit I

Community Care

	SNF / ICF						ISN					
	MA			Dual			MA			Dual		
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006
Inpatient	\$ 310.98	\$ 524.93	\$ 361.20	\$ 37.44	\$ 38.49	\$ 29.26	\$ 127.12	\$ 1,538.11	\$ 75.18	\$ 6.19	\$ 13.47	\$ 10.63
Outpatient	\$ 97.58	\$ 116.61	\$ 73.95	\$ 14.08	\$ 9.86	\$ 8.26	\$ 113.99	\$ 56.99	\$ 118.04	\$ 11.57	\$ 4.19	\$ 6.39
Rx	\$ 616.39	\$ 658.20	\$ 690.38	n/a	n/a	\$ 13.94	\$ 646.99	\$ 712.76	\$ 938.08	n/a	n/a	\$ 39.09
Dental	\$ 5.53	\$ 7.00	\$ 12.62	\$ 4.52	\$ 4.48	\$ 5.01	\$ 7.87	\$ 3.81	\$ 2.34	\$ 6.38	\$ 5.93	\$ 6.04
LTC Benefit	n/a	n/a	\$ 2,553.87	n/a	n/a	\$ 2,553.87	n/a	n/a	\$ 4,951.84	n/a	n/a	\$ 4,951.84
Other	\$ 279.30	\$ 250.89	\$ 216.63	\$ 28.21	\$ 37.73	\$ 37.61	\$ 476.08	\$ 462.18	\$ 674.67	\$ 31.88	\$ 53.60	\$ 54.80

Care Wisconsin

	SNF / ICF						ISN					
	MA			Dual			MA			Dual		
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006
Inpatient	\$ 128.37	\$ 263.74	\$ 65.80	\$ 29.47	\$ 38.18	\$ 25.74	\$ 215.71	\$ -	\$ 326.57	\$ 14.11	\$ 8.40	\$ 14.16
Outpatient	\$ 72.69	\$ 87.63	\$ 116.47	\$ 8.78	\$ 10.97	\$ 10.83	\$ 2,314.29	\$ 720.10	\$ 459.14	\$ 1.77	\$ 7.85	\$ 45.25
Rx	\$ 273.06	\$ 423.77	\$ 384.83	n/a	n/a	\$ 10.47	\$ 665.57	\$ 557.74	\$ 497.12	n/a	n/a	\$ 21.39
Dental	\$ 1.29	\$ 3.16	\$ 1.77	\$ 4.38	\$ 4.66	\$ 3.94	\$ -	\$ -	\$ 0.72	\$ 3.14	\$ 6.79	\$ 4.10
LTC Benefit	n/a	n/a	\$ 2,696.32	n/a	n/a	\$ 2,696.32	n/a	n/a	\$ 6,756.59	n/a	n/a	\$ 6,756.59
Other	\$ 67.83	\$ 124.70	\$ 105.04	\$ 21.79	\$ 41.86	\$ 42.97	\$ 897.14	\$ 1,192.86	\$ 1,006.14	\$ 71.04	\$ 58.42	\$ 87.28

Partnership Health Plan

	SNF / ICF						ISN					
	MA			Dual			MA			Dual		
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006
Inpatient	\$ 298.60	\$ 152.54	\$ 313.99	\$ 36.57	\$ 27.33	\$ 35.49	\$ -	\$ 334.48	\$ 1,074.57	\$ 15.42	\$ 48.29	\$ 64.31
Outpatient	\$ 120.61	\$ 71.98	\$ 89.92	\$ 18.85	\$ 22.30	\$ 22.22	\$ 152.94	\$ 185.61	\$ 420.34	\$ 28.54	\$ 40.71	\$ 15.96
Rx	\$ 615.81	\$ 738.75	\$ 943.02	n/a	n/a	\$ 7.91	\$ 705.03	\$ 1,248.04	\$ 1,441.29	n/a	n/a	\$ 24.48
Dental	\$ 2.35	\$ 7.97	\$ 2.23	\$ 4.66	\$ 5.72	\$ 5.32	\$ -	\$ 18.19	\$ 13.45	\$ 0.12	\$ 3.82	\$ 3.95
LTC Benefit	n/a	n/a	\$ 3,013.37	n/a	n/a	\$ 3,013.37	n/a	n/a	\$ 4,364.92	n/a	n/a	\$ 4,364.92
Other	\$ 212.72	\$ 237.45	\$ 196.42	\$ 31.21	\$ 36.16	\$ 31.54	\$ 261.59	\$ 99.55	\$ 317.98	\$ 140.92	\$ 104.42	\$ 107.82

Waiver and Nursing Home Population Historical Adjusted Baseline Per Capita Costs

Exhibit II

Community Care

	SNF / ICF						ISN					
	MA			Dual			MA			Dual		
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006
Inpatient	\$ 304.36	\$ 513.76	\$ 353.85	\$ 36.64	\$ 37.67	\$ 28.66	\$ 126.72	\$ 1,533.18	\$ 75.01	\$ 6.17	\$ 13.43	\$ 10.60
Outpatient	\$ 97.61	\$ 116.66	\$ 74.07	\$ 14.08	\$ 9.87	\$ 8.27	\$ 114.03	\$ 57.02	\$ 118.23	\$ 11.57	\$ 4.19	\$ 6.40
Rx	\$ 616.39	\$ 658.20	\$ 690.38	n/a	n/a	\$ 13.94	\$ 646.99	\$ 712.76	\$ 938.08	n/a	n/a	\$ 39.09
Dental	\$ 23.84	\$ 30.76	\$ 38.87	\$ 23.84	\$ 30.76	\$ 38.87	\$ 23.84	\$ 30.76	\$ 38.87	\$ 23.84	\$ 30.76	\$ 38.87
LTC Benefit	n/a	n/a	\$ 2,555.32	n/a	n/a	\$ 2,555.32	n/a	n/a	\$ 4,954.65	n/a	n/a	\$ 4,954.65
Other	\$ 279.30	\$ 250.89	\$ 216.80	\$ 28.21	\$ 37.73	\$ 37.64	\$ 476.08	\$ 462.18	\$ 675.21	\$ 31.88	\$ 53.60	\$ 54.84

Care Wisconsin

	SNF / ICF						ISN					
	MA			Dual			MA			Dual		
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006
Inpatient	\$ 128.78	\$ 264.59	\$ 65.83	\$ 29.56	\$ 38.30	\$ 25.75	\$ 216.32	\$ -	\$ 326.59	\$ 14.15	\$ 8.42	\$ 14.16
Outpatient	\$ 72.89	\$ 87.88	\$ 117.11	\$ 8.81	\$ 11.00	\$ 10.89	\$ 2,320.78	\$ 722.12	\$ 461.67	\$ 1.77	\$ 7.87	\$ 45.50
Rx	\$ 273.06	\$ 423.77	\$ 384.83	n/a	n/a	\$ 10.47	\$ 665.57	\$ 557.74	\$ 497.12	n/a	n/a	\$ 21.39
Dental	\$ 23.84	\$ 30.76	\$ 38.87	\$ 23.84	\$ 30.76	\$ 38.87	\$ 23.84	\$ 30.76	\$ 38.87	\$ 23.84	\$ 30.76	\$ 38.87
LTC Benefit	n/a	n/a	\$ 2,697.85	n/a	n/a	\$ 2,697.85	n/a	n/a	\$ 6,760.44	n/a	n/a	\$ 6,760.44
Other	\$ 67.83	\$ 124.70	\$ 105.12	\$ 21.79	\$ 41.86	\$ 43.00	\$ 897.14	\$ 1,192.86	\$ 1,006.94	\$ 71.04	\$ 58.42	\$ 87.34

Partnership Health Plan

	SNF / ICF						ISN					
	MA			Dual			MA			Dual		
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006
Inpatient	\$ 296.04	\$ 151.23	\$ 314.47	\$ 36.25	\$ 27.10	\$ 35.55	\$ -	\$ 336.49	\$ 1,092.03	\$ 15.52	\$ 48.57	\$ 65.36
Outpatient	\$ 120.62	\$ 71.99	\$ 89.99	\$ 18.85	\$ 22.30	\$ 22.24	\$ 152.94	\$ 185.62	\$ 420.69	\$ 28.54	\$ 40.71	\$ 15.97
Rx	\$ 615.81	\$ 738.75	\$ 943.02	n/a	n/a	\$ 7.91	\$ 705.03	\$ 1,248.04	\$ 1,441.29	n/a	n/a	\$ 24.48
Dental	\$ 23.84	\$ 30.76	\$ 38.87	\$ 23.84	\$ 30.76	\$ 38.87	\$ 23.84	\$ 30.76	\$ 38.87	\$ 23.84	\$ 30.76	\$ 38.87
LTC Benefit	n/a	n/a	\$ 3,015.08	n/a	n/a	\$ 3,015.08	n/a	n/a	\$ 4,367.40	n/a	n/a	\$ 4,367.40
Other	\$ 212.72	\$ 237.45	\$ 196.57	\$ 31.21	\$ 36.16	\$ 31.56	\$ 261.59	\$ 99.55	\$ 318.23	\$ 140.92	\$ 104.42	\$ 107.91

Community Care Managed Care Equivalent Development
 Contract Period: April 1, 2008 through December 31, 2008

Exhibit III

	SNF / ICF	ISN
Primary and Acute Component		
Other Services PEPM	\$73.28	\$96.71
Pharmacy PEPM	122.98	109.16
Less Drug Rebate	38.27	32.65
Adjusted Pharmacy Costs PEPM	84.71	76.51
Inpatient Services PEPM	95.56	66.54
P4P Adjusted Dental PEPM	34.92	36.99
Outpatient PEPM	25.98	15.09
Subtotal Acute and Primary Component	314.45	291.83
Admin; Acute and Primary Care Component	15.54	14.42
Total Acute and Primary Component	330.00	306.26
Long Term Benefit Component		
Long Term Care Benefit PEPM	2,614.19	5,086.76
Admin; Long Term Benefit Component	159.49	310.33
Total Long Term Benefit Component	2,773.67	5,397.09
Total Acute and Primary and LTC Benefit	3,103.67	5,703.35
Less: Managed Care Savings Adjustment	14.67	13.37
Contract Period 2008 Total Per Capita Cost	\$3,089.00	\$5,689.98
Contract Period 2008 Managed Care Equivalent	\$3,118.47	

Care Wisconsin Managed Care Equivalent Development
 Contract Period: March 1, 2008 through December 31, 2008

Exhibit IV

	SNF / ICF	ISN
Primary and Acute Component		
Other Services PEPM	\$49.41	\$168.83
Pharmacy PEPM	69.88	72.35
Less Drug Rebate	21.63	21.86
Adjusted Pharmacy Costs PEPM	48.25	50.50
Inpatient Services PEPM	54.41	29.81
P4P Adjusted Dental PEPM	34.79	37.74
Outpatient PEPM	24.40	97.12
Subtotal Acute and Primary Component	211.26	384.01
Admin; Acute and Primary Care Component	10.44	18.98
Total Acute and Primary Component	221.70	402.99
Long Term Benefit Component		
Long Term Care Benefit PEPM	2,762.56	6,973.45
Admin; Long Term Benefit Component	168.54	425.44
Total Long Term Benefit Component	2,931.10	7,398.88
Total Acute and Primary and LTC Benefit	3,152.80	7,801.87
Less: Managed Care Savings Adjustment	9.26	18.17
Contract Period 2008 Total Per Capita Cost	\$3,143.54	\$7,783.70
Contract Period 2008 Managed Care Equivalent	\$3,167.00	

Partnership Health Plan Managed Care Equivalent Development
 Contract Period: July 1, 2008 through December 31, 2008

Exhibit V

	SNF / ICF	ISN
Primary and Acute Component		
Other Services PEPM	\$67.41	\$145.32
Pharmacy PEPM	136.91	219.21
Less Drug Rebate	42.95	68.21
Adjusted Pharmacy Costs PEPM	93.96	151.00
Inpatient Services PEPM	72.57	148.77
P4P Adjusted Dental PEPM	34.69	37.64
Outpatient PEPM	35.87	71.68
Subtotal Acute and Primary Component	304.50	554.41
Admin; Acute and Primary Care Component	15.05	27.40
Total Acute and Primary Component	319.55	581.81
Long Term Benefit Component		
Long Term Care Benefit PEPM	3,094.95	4,508.33
Admin; Long Term Benefit Component	188.82	275.04
Total Long Term Benefit Component	3,283.76	4,783.37
Total Acute and Primary and LTC Benefit	3,603.31	5,365.18
Less: Managed Care Savings Adjustment	14.16	27.12
Contract Period 2008 Total Per Capita Cost	\$3,589.15	\$5,338.06
Current MCO (Chippewa, Dunn, Eau Claire) MCE	\$3,109.81	\$4,069.81
Contract Period 2008 Managed Care Equivalent	\$3,341.72	