



State of Wisconsin

Department of Health and Family Services

DIVISION OF DISABILITY AND ELDER SERVICES

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Jim Doyle
Governor

Helene Nelson
Secretary

November 20, 2006

Ms. Jinn-Feng Lin, FSA MAAA
PricewaterhouseCoopers LLP
One North Wacker
Chicago, IL 60606

Re: Actuarial Certification of CY 2007 Wisconsin Partnership Program (WPP) Capitation Rates for the expansion counties

Dear Jinn Lin,

I, Elizabeth Stephenson, PPA for Wisconsin Department of Health and Family Services, hereby affirm that the data prepared and submitted to PricewaterhouseCoopers LLP, for the purpose of reviewing the CY 2007 Program of All-Intensive Care for the Elderly (PACE) and Wisconsin Partnership Program (WPP) Capitation Rates were prepared under my direction, and to the best of my knowledge and belief are accurate and complete. This data includes:

1. Calendar years 2003 through 2005 Statewide Medicaid fee-for-service claims and eligibility data for recipients eligible for enrollment in the PACE/WPP program.
2. Calendar years 2003 through 2005 Statewide Human Services Reported claims and eligible months data for Home and Community Based Waiver (HCBW) recipients who are also eligible for enrollment in the PACE/WPP program.
3. The definitions of individuals and services to be included/excluded from the development of the capitation rates. All reported paid amounts are net of costs to be excluded, net of copay and deductibles and cost share (except for DSH payments).
4. Department of Health and Family Services administration amounts adjusted by CMS based on the Federal 64 reports for claims paid through the Medicaid system, 4.57% for CY2007.

5. The MMIS MARS Expenditure report HMGR505Q with the Lag Adjustment Factors as of June 2006 matching the base data extract. State Category of Service Cost Detail with the Lag factors.
6. The functional screen data for all PACE/WPP sites and waiver population for CY2005 and CY2006 used in the development of the regression model for the long-term care component of the capitation rate.
7. The Office of the Commissioner of Insurance (OCI) National Association of Insurance Commissioners (NAIC) financial reports for all PACE/WPP sites for CY 2006.
8. HCBW and HCBW Waitlist Enrollment data with age, Medicare coverage status, gender, Level of Care through October 2006.
9. Calendar years 2003 through 2005 dental per capita costs submitted by the WPP sites.

I further affirm that the number of eligibles, claims incurred dates, paid claim dates, paid claim amounts, summaries and related data submitted to PricewaterhouseCoopers LLP. are, to the best of my knowledge and belief, accurately stated.

Elizabeth Stephenson
Elizabeth Stephenson,

DHFS/DDES/BLTS

Program and Planning Analyst Advanced

November 20, 2006

Wisconsin Department of Health and Family Services
Crosswalk from CMS Rate Setting Checklist to 2007 Kenosha WPP Report

Item	Location	Comments
AA.1.0 Overview of Ratesetting Methodology	Entire Report	
AA.1.1 Actuarial Certification	Pages 13-15	
AA.1.2 Projection of Expenditures	NA	DHFS will provide
AA.1.3 Procurement, Prior Approval and Ratesetting	NA	
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 5, 7-8	Exhibits I and II
AA.2.1 Medicaid Eligibles under the Contract	NA	
AA.2.2 Dual Eligibles	NA	
AA.2.3 Spenddown	NA	
AA.2.4 State Plan Services only	NA	
AA.2.5 Services that may be covered out of contract savings	NA	
AA.3.0 Adjustments to Base Year Data	Pages 7-8	
AA.3.1 Benefit Differences	NA	No Changes in Benefits
AA.3.2 Administrative Cost Allowance Calculations	Page 9	Exhibits V and VI
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	NA	
AA.3.8 Graduate Medical Education	NA	
AA.3.9 FQHC and RHC Reimbursement	NA	
AA.3.10 Medical Cost / Trend Inflation	Page 8	Exhibits I and II
AA.3.11 Utilization Adjustments	Pages 8-9	
AA.3.12 Utilization and Cost Assumptions	Pages 8-9	
AA.3.13 Post-Eligibility Treatment of Income	NA	
AA.3.14 Incomplete Data Adjustment	Page 7	
AA.4.0 Establish Rate Category Groupings	Page 4	
AA.4.1 Age	Page 4	Exhibits III and IV
AA.4.2 Gender	NA	
AA.4.3 Locality / Region	Page 4	Exhibits V and VI
AA.4.4 Eligibility Categories	Page 4	Exhibits V and VI
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	Page 9	
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 and Family Services**

**Calendar Year 2007
Wisconsin Partnership Programs (WPP) Managed Care Equivalent Values
Kenosha County**

Prepared by:

PricewaterhouseCoopers

November 2006

November 30, 2006

Ms. Elizabeth Stephenson
DHFS-DDES
Center for Delivery Systems Development
1 W. Wilson Street (Room 518)
P.O. Box 7851
Madison WI 53707-7851

Re: 2007 Managed Care Equivalent and Capitation Rate Development for the Kenosha County WPP Program

Dear Liz:

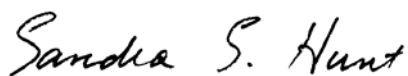
The enclosed report provides a detailed description of the methodology used to develop the 2007 managed care equivalent estimates and MCO capitation rates for the Kenosha County WPP managed care programs effective January 1, 2007 through December 31, 2007 in Wisconsin. The methods used for calculating 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.

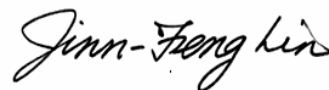
Please call Sandra Hunt at 415-498-5365 or Jinn Lin at 312-298-3792 if you have any questions regarding these rates.

Very truly yours,

PricewaterhouseCoopers LLP



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



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

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SUMMARY OF EXHIBITS

Exhibit I	Waiver Population Historical Experience; Trended to Baseline CY 2007 Cost
Exhibit II	Nursing Home Population Historical Experience; Trended to Baseline CY 2007 Cost
Exhibit III	Waiver Population Age / Gender Factors by Service Category
Exhibit IV	Nursing Home Population Age / Gender Factors by Service Category
Exhibit V	2007 Kenosha Managed Care Equivalent Development
Exhibit VI	2007 Kenosha Capitation Rates

I. EXECUTIVE SUMMARY

The Wisconsin Partnership Program (Partnership) 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 and social worker or independent living coordinator. Medicare and Medicaid services are delivered in a single setting and payment rates to participating contractors are set as a single capitation rate. The WPP program is available to younger disabled adults, and operates as a demonstration project. Currently, the WPP program is in operation in Milwaukee, Racine, Dane, Chippewa, Dunn, and Eau Claire counties. The state of Wisconsin is expanding the WPP program to new counties starting in CY 2007.

This report describes the methodology used to develop Managed Care Equivalent amounts for the Medicaid component of the payment rate for the WPP program in Kenosha County.

Individuals eligible to enroll in WPP include those receiving Medicaid coverage under categorically or medically needy categories. Individuals in WPP may be Medicaid eligible under the special income limit available for long-term care services (i.e., an individual's income level may be between 100% and 300% of the Supplemental Security Income (SSI) benefit rate). This includes enrollees who are either Medicaid-only or who have dual Medicare/Medicaid eligibility and have also been certified. Participation is voluntary, and the rate setting methodology should consider the relative risk difference in the enrolled population compared to the population represented in the base data used for rate development.

The primary and acute care component of the capitation rate is based on the experience of the fee-for-service population in Kenosha County, adjusted for the particular characteristics of the WPP population. A new rate development methodology for the LTC rate was introduced last year to better reflect the variation in level of need for services between the FFS base data and the enrollees in the WPP. The methodology relies on a regression model that estimates differences in expected costs by functional screen scores. The results of the model establish a baseline per capita cost used for calculating the long-term care component of the capitation rate.

The base data is trended and adjusted to reflect the mix of services expected to be required by the WPP population; an Incurred But Not Reported (IBNR) claims adjustment is applied to complete the data, and allowance is made for plan administrative expense.

Relationship of Rate Setting Methods to CMS Requirements

PricewaterhouseCoopers LLP (PwC) has calculated 2007 Managed Care Equivalence (MCE) rates for the Kenosha WPP 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. To ensure compliance with CMS requirements, we have followed the Medicaid managed care checklist in developing the MCEs in this report.

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, and health status;
- 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 Wisconsin 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 WPP, 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 2007 MCE values will vary based on the following criteria:

Health Plan: For the first year of operation in CY 2007, there will be one health plan that is participating in the Kenosha WPP program, Community Care Health Plan (CCHP). CCHP is currently participating in the WPP program in Milwaukee and Racine counties and is expanding its coverage to Kenosha. CCHP covers elderly population defined as over 54 years of age that meet NH criteria and are defined as frail elderly. All participants must be Medicaid or Dually eligible and meet nursing home (NH) level of care criteria

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.
- ♦ 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)

Age Cohorts, Capitation rates will be paid separately by the following age groups:

- CCHP Health Plan:
 - Age 55 – 59
 - Age 60 – 64
 - Age 65 – 69
 - Age 70 – 74
 - Age 75 – 79
 - Age 80 – 84
 - Age 85 – 89
 - Age 90 – 94
 - Age 95+

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

- ♦ CCHP: Kenosha

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 rate development described here relies on FFS and encounter data for a comparable population, so satisfies the rate development requirements.

As a starting point for the primary and acute care analysis we received summarized data that separately reported 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 populations. This segregation is done to accommodate the materially different cost experience of the individuals in these two service settings. For the long-term care component, we received Family Care encounter claim and eligibility data for calendar year 2005.

IV. RATE SETTING METHODOLOGY

A. Overview

The CY 2007 Kenosha MCE estimate is developed through the following steps:

1. The preliminary primary and acute FFS cost per eligible month for WPP eligibles in Kenosha County was developed using CY 2003-2005 claims and eligibility data.
2. The preliminary long-term care cost per eligible month was developed using CY 2005 Family Care encounter data.
3. The projected increase from CY 2005 to CY 2007 was developed based on budgeted provider reimbursement increases and historical utilization/mix annual trend analysis.
4. An adjustment was made to reflect drug rebates collected by the State on FFS pharmacy claims for the Medicaid-only SSI population.
5. An adjustment was made to reflect estimated utilization savings under a managed care environment relative to fee-for-service on the primary and acute component of the rates.
6. An administrative allowance was added to reflect estimated program administrative costs as a percentage of revenue.
7. Since CY 2007 will be the first year the WPP expansion program is in operation, the risk profile of the enrollees is not known at this time. Therefore, no prospective adjustments are made to reflect the difference in illness burden between the FFS population used as a basis for the Primary and Acute portion of the MCE estimates and the MCO enrolled population. DHFS is implementing a retrospective adjustment process to adjust rates using the acuity and functional status based on actual program enrollment.
8. An adjustment was made to reflect higher levels of access to dental service for WPP enrollees.
9. An adjustment for Medicare eligibility Age and Level of Care site enrollment factors was made to determine the payment amount by rate cell for each of the programs.

B. Detailed Methodology Description

The methodology used to calculate the CY 2007 WPP Kenosha MCE estimates is described in this section.

1. Preliminary FFS Cost per Eligible Month

Exhibits 1 and 2 show the development of CY 2005 equivalent FFS cost per eligible month for each cohort by eligibility category for the covered population and covered services. Costs per eligible month are calculated for all covered services.

Due to the implementation of Medicare Modernization Act at the beginning of 2006, the prescription drug benefits will be covered by Medicare Part D for the Medicare eligible population; drugs not covered by Medicare Part D continue to be covered under the WPP program.

- ◆ **Base Period Costs** – The CY 2005 cost per eligible month is based on the FFS costs for the relevant populations in each of the geographies with the WPP program. The base period used in our calculation is CY 2003-2005. Paid claim amounts and eligible month totals for each of the base years are taken from the data provided by the State (adjusted as discussed in the previous section) and include payments through July 31, 2006. Three years of cost data are used as the base period to help smooth annual cost fluctuations (Refer to exhibits 1 and 2).

For the long-term care component of the capitation rate, an adjustment is made to reflect the variation in level of need for services between the FFS base data and the enrollees in the WPP. This portion of the rate is calculated using calendar year 2005 Family Care¹ cost and eligibility data, and excludes all FFS costs.

- ◆ **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:

Hospital Inpatient Adjustments			
	2003	2004	2005
Kenosha; Ages 55 & Over	0.9973	0.9978	0.9979

- ◆ **Completion Factors** – Total 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 2005 non-pharmacy claims used in the analysis is 1.0008. All pharmacy claims and 2003 / 2004 non-pharmacy claims are assumed to be complete. Cost PEPM is calculated as completed claims divided by months.

¹ The Family Care program is sponsored by the State of Wisconsin Department of Health and Family 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).

- **Dental Adjustment** - Access to dental services has been shown to be materially higher for most enrollees in WPP. Health plans provided actual per member per month costs for dental services provided during calendar years 2004 and 2005. For Kenosha, a blended dental rate was calculated using the data submitted from the current WPP health plans who serve the same age demographic. Adjustments were made to the fee-for-service dental claims experience to reflect the difference in levels of cost and utilization between FFS and managed care experience.

For example, a 6.00 factor means that the FFS PMPM costs are multiplied by 6 to develop costs consistent with health plan experience. The following tables illustrate the dental adjustments made by health plan and by eligible population, subset by calendar year.

Nursing Home Population Dental Adjustment			
	2003	2004	2005
Kenosha; Ages 55 & Over	3.36	3.36	6.31

HCBS Waiver Population Dental Adjustment			
	2003	2004	2005
Kenosha; Ages 55 & Over	5.06	5.06	9.81

- ♦ **Trending to Calendar Year 2005** – The cost PEPM for CY 2003 and 2004 is trended to CY 2005 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 2005 cost PEPM in Exhibits 1 and 2 are the weighted average of each year’s cost PEPM trended to CY 2005.

2. Projected Increase from Base Period to Rate 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: 8.0% (Applies to the Medicaid-only population)
- ♦ Long Term Care 3.0%

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.

3. Drug Rebate Budgeted Adjustment

Prescription drug rebates of 27.3% are applied to the drug portion of the analysis. This rebate amount was provided by DHFS staff and is reflected in Exhibit V. The exhibits show the projected CY 2007 prescription drug rebates PEPM. The calculation is based on the CY 2005 rebate PEPM for Medicaid-only eligibles.

The resulting CY 2007 rebate PEPM are subtracted from the overall CY 2007 costs PEPM in Exhibits V and VI 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, with variation by site. The managed care savings has been assumed to be 5.0% for the primary and acute component of the capitation rate. The long-term care component of the capitation rate is calculated using managed care experience, thus a managed care savings has not been assumed. The estimate was provided by DHFS staff, and is within a range of reasonable values for managed care utilization savings.

5. Administrative Allowance

An administrative allowance of 6.25% was applied to the LTC service component of the capitation rate, which is consistent with the administrative allowance used for Family Care and is based on the historical administrative costs as a percentage of revenue for the participating plans. An administrative allowance of 4.57% was applied to the remaining services used in estimating the 2007 MCE. The 4.57% administrative allowance is based on the state's average FFS administrative expense provided by CMS. Both rates are within a range of reasonable values for the administrative allowance.

6. Severity Adjustments

Since CY 2007 will be the first year the WPP expansion program is in operation, the risk profile of the enrollees is not known at this time. Therefore, no prospective adjustments are made to reflect the difference in illness burden between the FFS population used as a basis for the Primary and Acute portion of the MCE estimates and the MCO enrolled population. DHFS is implementing a retrospective adjustment process to adjust rates using the acuity and functional status based on actual program enrollment.

7. Age/Level of Care Factors and Plan-Specific Managed Care Equivalents

Age and Level of Care factors are used to determine the payment amount by rate cell for the primary and acute component of the capitation rate. Statewide data are used to calculate age and LOC factors. The derivation of the factors is shown in Exhibits III and IV. The methodology is described below:

- ◆ For the data period, the total statewide cost per eligible month by age/LOC category was calculated for each of the rate cells. We then calculated the ratio of the cost PEPM for each age/LOC category to the combined statewide cost PEPM for each year and averaged the results for the three years.

We used the average cost ratios developed above, adjusted to the site's mix of eligible months in each category for calendar years 2004 and 2005, to determine the cost PEPM relativities for each eligibility category. The rates are shown in Exhibits V and VI.

- ◆ The final primary and acute capitation rates, shown in Exhibit VII, were derived based on actual MCO enrollment as of July 1, 2006 to reflect the population mix as of the most recent date.

8. Long-Term Care Rate Development

A new model has been developed to appropriately risk adjust the Long Term Care component of the rate to reflect the relative needs of the WPP population compared to the FFS base data available for rate development. Using calendar year 2005 Family Care encounter data, an ordinary least squares linear regression model is created to relate monthly costs to recipient functional characteristics. The base costs used cover all state plan services included in the WPP benefit package. The unit of analysis is the recipient month. That is, the monthly 2005 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. Refer to Appendix A for a detailed description of the regression modeling.

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), and certain combinations of ADLs. Linear 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. A rate is developed separately for SNF/ICF and ISN to reflect known variation in per capita costs related to level of care.

The baseline long-term care cost is adjusted for the following:

- Trend to contract period: Baseline calendar year 2005 costs are projected to the calendar year 2007 contract period using an annual trend rate of 3.0%
- Adjust for cost-sharing: The cost share estimate is based on the most recent Family Care data available and will be adjusted to actual individually calculated cost share amounts at the end of the contract year.

V. REGRESSION MODEL METHODOLOGY

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.

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 two variables to predict cost. The variables are separated into the following seven classes: target group, number of IADLs, specific ADLs and their levels of help, interactions, behavioral indicators, overnight care and supervision, and count of health related services. 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 R²) and the proportion of the population with the characteristic.

Appendix B shows the final statistical model. The model explains approximately 40% of the variation in the data.

APPENDIX B

**Wisconsin Partnership Program
CY 2007 Capitation Rate Development**

**Functional Screen Regression Model of 2005 PMPM; Expansion Counties
Kenosha Rate Development**

Variable	Estimate	Proportion with Variable	
		ISN	SNF
Intercept (Grid Component)	659.63		
DD/NH Level of Care (Grid Component)			
Vent Dependent	3,199.42	0.3333	-
DD1A	1,259.97	-	0.0041
DD1B	1,787.08	-	0.0041
DD2	906.56	-	0.0413
SNF	273.32	-	0.2149
Number of IADLs (Grid Component)			
IADL_3	23.85	-	0.1570
IADL_4	171.93	0.6667	0.4174
IADL_5	227.71	0.3333	0.2397
IADL_6	1,096.94	-	0.0207
Specific ADLs / Equipment Used (Add-On)			
Bathing_2	273.27	1.0000	0.6529
Dressing_2	84.74	0.6667	0.3802
Eating_2	96.46	0.6667	0.1157
Toileting_1	179.84	-	0.1860
Toileting_2	382.24	1.0000	0.1983
Transfer_2	239.32	0.3333	0.1777
Interaction Terms (Add-On)			
Dressing_Toileting	114.72	1.0000	0.6157
Bathing_Equip_Dressing	128.18	1.0000	0.6901
Transfer_Equip_Mobility	390.27	0.3333	0.1777
Bathing_Equip_Eating	68.66	1.0000	0.3182
Behavioral Variables (Add-On)			
Communication_2	54.00	-	0.0868
Communication_3	174.63	-	0.0331
Cognition_3	76.16	0.3333	0.1612
Resistive	168.32	-	0.0702
Injury	360.61	-	0.0124
Offensive_1-2	332.70	-	0.1281
Offensive_3	739.02	-	0.0083
Medication Use (Add-On)			
Meds_2A	370.06	-	0.1818
Meds_2B	559.46	1.0000	0.4339

VI. ACTUARIAL CERTIFICATION

This section includes our actuarial certification for the 2007 capitation rates.

**Actuarial Certification of
Proposed 2007 WPP 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 2007 capitation rates developed for the Medicaid managed care programs known as the Wisconsin Partnership Program. I have been retained by the Wisconsin Department of Health and Family Services (DHFS) to perform an actuarial certification of the Wisconsin Partnership Program Kenosha county capitation rates for calendar year 2007 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 by DHFS in setting the capitation rates for calendar year 2007.

To the best of my information, knowledge and belief, for the period from January 1, 2007 to December 31, 2007, 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 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

November 30, 2006

Date

Exhibits

Waiver Population Historical Experience; Trended to Baseline CY 2007 Cost
WPP - Kenosha; Ages 55 & Over

Exhibit I

	MA						Dual					
	Male			Female			Male			Female		
	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005
Cross-Over Claims												
Per Capita Cost	-	-	-	-	-	0.51	107.72	111.87	111.83	132.39	134.46	118.47
Trend to 2005	<u>1.085</u>	<u>1.102</u>	<u>1.000</u>	<u>1.085</u>	<u>1.102</u>	<u>1.000</u>	<u>1.085</u>	<u>1.102</u>	<u>1.000</u>	<u>1.085</u>	<u>1.102</u>	<u>1.000</u>
2005 Per Capita Cost	-	-	-	-	-	0.51	116.87	123.31	111.83	143.63	148.21	118.47
Weighted Ave. 2005 PCC		-			0.16			117.37			137.02	
Trend to 2007		1.082			1.082			1.082			1.082	
2007 Per Capita Cost		-			0.18			126.95			148.21	
Dental												
Per Capita Cost	5.50	217.49	-	20.17	7.15	20.76	35.56	25.81	55.76	19.01	22.39	29.81
Trend to 2005	<u>1.053</u>	<u>1.000</u>	<u>1.000</u>	<u>1.053</u>	<u>1.000</u>	<u>1.000</u>	<u>1.053</u>	<u>1.000</u>	<u>1.000</u>	<u>1.053</u>	<u>1.000</u>	<u>1.000</u>
2005 Per Capita Cost	5.79	217.49	-	21.24	7.15	20.76	37.44	25.81	55.76	20.02	22.39	29.81
Weighted Ave. 2005 PCC		81.17			16.32			39.63			24.05	
Trend to 2007		1.082			1.082			1.082			1.082	
2007 Per Capita Cost		87.80			17.65			42.87			26.01	
Pharmacy												
Per Capita Cost	486.35	396.96	267.92	527.47	598.72	533.50	8.30	9.92	12.43	10.47	11.82	14.16
Trend to 2005	<u>1.255</u>	<u>1.000</u>	<u>1.000</u>	<u>1.255</u>	<u>1.000</u>	<u>1.000</u>	<u>1.255</u>	<u>1.000</u>	<u>1.000</u>	<u>1.255</u>	<u>1.000</u>	<u>1.000</u>
2005 Per Capita Cost	610.38	396.96	267.92	661.98	598.72	533.50	10.41	9.92	12.43	13.13	11.82	14.16
Weighted Ave. 2005 PCC		431.18			599.43			10.92			13.01	
Trend to 2007		1.166			1.166			1.166			1.166	
2007 Per Capita Cost		502.93			699.18			12.74			15.17	
Not Medicare Benefit												
Per Capita Cost	626.89	1,613.13	681.04	341.36	201.01	415.37	6.48	4.94	23.45	7.39	9.85	21.82
Trend to 2005	<u>1.447</u>	<u>1.116</u>	<u>1.000</u>	<u>1.447</u>	<u>1.116</u>	<u>1.000</u>	<u>1.447</u>	<u>1.116</u>	<u>1.000</u>	<u>1.447</u>	<u>1.116</u>	<u>1.000</u>
2005 Per Capita Cost	907.20	1,800.48	681.04	494.00	224.35	415.37	9.38	5.51	23.45	10.70	10.99	21.82
Weighted Ave. 2005 PCC		1,165.52			377.55			12.79			14.43	
Trend to 2007		1.082			1.082			1.082			1.082	
2007 Per Capita Cost		1,260.63			408.35			13.83			15.61	
Medicare-Like Benefit												
Per Capita Cost	734.05	285.93	241.56	151.89	88.55	171.41	1.14	1.92	1.95	1.52	1.43	1.70
Trend to 2005	<u>1.022</u>	<u>1.000</u>	<u>1.000</u>	<u>1.022</u>	<u>1.000</u>	<u>1.000</u>	<u>1.022</u>	<u>1.000</u>	<u>1.000</u>	<u>1.022</u>	<u>1.000</u>	<u>1.000</u>
2005 Per Capita Cost	750.44	285.93	241.56	155.28	88.55	171.41	1.17	1.92	1.95	1.55	1.43	1.70
Weighted Ave. 2005 PCC		430.49			137.85			1.69			1.56	
Trend to 2007		1.082			1.082			1.082			1.082	
2007 Per Capita Cost		465.62			149.10			1.82			1.68	

Nursing Home Population Historical Experience; Trended to Baseline CY2007 Cost
WPP - Kenosha; Ages 55 & Over

Exhibit II

	MA						Dual					
	Male			Female			Male			Female		
	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005
Cross-Over Claims												
Per Capita Cost	-	-	-	-	16.09	-	127.38	152.72	151.90	102.14	83.01	102.85
Trend to 2005	<u>1.085</u>	<u>1.102</u>	<u>1.000</u>	<u>1.085</u>	<u>1.102</u>	<u>1.000</u>	<u>1.085</u>	<u>1.102</u>	<u>1.000</u>	<u>1.085</u>	<u>1.102</u>	<u>1.000</u>
2005 Per Capita Cost	-	-	-	-	17.74	-	138.20	168.34	151.90	110.82	91.51	102.85
Weighted Ave. 2005 PCC		-			8.29			153.12			101.64	
Trend to 2007		1.082			1.082			1.082			1.082	
2007 Per Capita Cost		-			8.96			165.62			109.94	
Dental												
Per Capita Cost	91.37	28.50	16.11	3.63	5.88	38.61	15.73	21.89	39.22	21.24	26.79	31.02
Trend to 2005	<u>1.053</u>	<u>1.000</u>	<u>1.000</u>	<u>1.053</u>	<u>1.000</u>	<u>1.000</u>	<u>1.053</u>	<u>1.000</u>	<u>1.000</u>	<u>1.053</u>	<u>1.000</u>	<u>1.000</u>
2005 Per Capita Cost	96.19	28.50	16.11	3.83	5.88	38.61	16.56	21.89	39.22	22.37	26.79	31.02
Weighted Ave. 2005 PCC		48.93			12.89			26.22			26.71	
Trend to 2007		1.082			1.082			1.082			1.082	
2007 Per Capita Cost		52.92			13.94			28.36			28.89	
Pharmacy												
Per Capita Cost	316.31	367.08	377.22	562.79	435.32	526.61	8.29	14.47	16.81	9.25	14.10	16.48
Trend to 2005	<u>1.255</u>	<u>1.000</u>	<u>1.000</u>	<u>1.255</u>	<u>1.000</u>	<u>1.000</u>	<u>1.255</u>	<u>1.000</u>	<u>1.000</u>	<u>1.255</u>	<u>1.000</u>	<u>1.000</u>
2005 Per Capita Cost	396.97	367.08	377.22	706.31	435.32	526.61	10.41	14.47	16.81	11.61	14.10	16.48
Weighted Ave. 2005 PCC		380.39			537.85			14.00			14.05	
Trend to 2007		1.166			1.166			1.166			1.166	
2007 Per Capita Cost		443.69			627.35			16.33			16.39	
Not Medicare Benefit												
Per Capita Cost	523.15	231.39	178.60	692.38	436.15	641.34	30.66	39.91	80.87	39.89	82.46	128.85
Trend to 2005	<u>1.447</u>	<u>1.116</u>	<u>1.000</u>	<u>1.447</u>	<u>1.116</u>	<u>1.000</u>	<u>1.447</u>	<u>1.116</u>	<u>1.000</u>	<u>1.447</u>	<u>1.116</u>	<u>1.000</u>
2005 Per Capita Cost	757.07	258.27	178.60	1,001.96	486.80	641.34	44.37	44.55	80.87	57.72	92.04	128.85
Weighted Ave. 2005 PCC		411.98			677.29			57.10			92.73	
Trend to 2007		1.082			1.082			1.082			1.082	
2007 Per Capita Cost		445.60			732.56			61.75			100.29	
Medicare-Like Benefit												
Per Capita Cost	242.25	129.01	79.22	245.37	209.28	141.77	5.32	1.36	4.25	0.93	1.21	1.01
Trend to 2005	<u>1.022</u>	<u>1.000</u>	<u>1.000</u>	<u>1.022</u>	<u>1.000</u>	<u>1.000</u>	<u>1.022</u>	<u>1.000</u>	<u>1.000</u>	<u>1.022</u>	<u>1.000</u>	<u>1.000</u>
2005 Per Capita Cost	247.66	129.01	79.22	250.85	209.28	141.77	5.44	1.36	4.25	0.95	1.21	1.01
Weighted Ave. 2005 PCC		157.10			206.02			3.65			1.06	
Trend to 2007		1.082			1.082			1.082			1.082	
2007 Per Capita Cost		169.92			222.83			3.95			1.14	

Waiver Population Age / Gender Factors by Service Category
 Populations Age 55 & Over

Exhibit III

	MA				Dual			
	SNF / ICF		ISN		SNF / ICF		ISN	
	Male	Female	Male	Female	Male	Female	Male	Female
<i>Cross-Over Services</i>								
Ages 55 - 59	0.000	0.000	0.000	0.000	1.202	1.456	0.000	0.000
Ages 60 - 64	0.000	1.936	0.000	0.000	1.124	1.630	0.000	0.000
Ages 65 - 69	0.000	3.626	0.000	0.000	1.228	1.295	0.000	0.000
Ages 70 - 74	0.000	0.000	0.000	0.000	1.017	1.167	0.000	0.000
Ages 75 - 79	5.506	0.662	0.000	0.000	0.978	1.048	0.000	0.000
Ages 80 - 84	0.000	1.044	0.000	0.000	0.876	0.915	0.000	0.000
Ages 85 - 89	0.000	5.122	0.000	0.000	0.714	0.784	0.000	0.000
Ages 90 - 94	50.018	0.000	0.000	0.000	0.818	0.640	0.000	0.000
Ages 95 & Over	0.000	3.829	0.000	0.000	0.886	0.673	0.000	0.000
<i>LTC Benefit</i>								
Ages 55 - 59	1.106	1.105	0.000	0.000	1.294	1.110	0.000	0.000
Ages 60 - 64	0.895	0.852	0.000	0.000	1.129	1.069	0.000	0.000
Ages 65 - 69	1.262	0.972	0.000	0.000	1.005	0.946	0.000	0.000
Ages 70 - 74	0.998	1.056	0.000	0.000	0.957	0.938	0.000	0.000
Ages 75 - 79	1.049	1.180	0.000	0.000	0.892	0.934	0.000	0.000
Ages 80 - 84	0.817	1.006	0.000	0.000	0.958	0.995	0.000	0.000
Ages 85 - 89	0.725	1.324	0.000	0.000	0.939	1.019	0.000	0.000
Ages 90 - 94	0.558	1.006	0.000	0.000	0.911	1.052	0.000	0.000
Ages 95 & Over	0.386	0.961	0.000	0.000	1.223	1.177	0.000	0.000
<i>Dental</i>								
Ages 55 - 59	1.094	1.111	0.000	0.000	1.471	1.723	0.000	0.000
Ages 60 - 64	1.181	1.014	0.000	0.000	1.452	1.931	0.000	0.000
Ages 65 - 69	0.233	0.838	0.000	0.000	1.219	1.346	0.000	0.000
Ages 70 - 74	0.000	0.741	0.000	0.000	1.042	1.383	0.000	0.000
Ages 75 - 79	0.071	0.971	0.000	0.000	0.920	0.992	0.000	0.000
Ages 80 - 84	1.188	0.021	0.000	0.000	0.804	0.796	0.000	0.000
Ages 85 - 89	0.054	0.019	0.000	0.000	0.734	0.702	0.000	0.000
Ages 90 - 94	0.202	0.000	0.000	0.000	0.337	0.644	0.000	0.000
Ages 95 & Over	0.000	0.000	0.000	0.000	0.210	0.372	0.000	0.000

Waiver Population Age / Gender Factors by Service Category
 Populations Age 55 & Over (cont'd)

Exhibit III

	MA				Dual			
	SNF / ICF		ISN		SNF / ICF		ISN	
	Male	Female	Male	Female	Male	Female	Male	Female
<i>Drugs</i>								
Ages 55 - 59	1.094	1.150	0.000	0.000	1.641	1.731	0.000	0.000
Ages 60 - 64	1.184	1.028	0.000	0.000	1.076	1.699	0.000	0.000
Ages 65 - 69	0.644	0.668	0.000	0.000	1.824	1.444	0.000	0.000
Ages 70 - 74	0.356	0.536	0.000	0.000	0.980	1.239	0.000	0.000
Ages 75 - 79	0.239	0.453	0.000	0.000	0.755	1.004	0.000	0.000
Ages 80 - 84	0.140	0.216	0.000	0.000	0.583	0.793	0.000	0.000
Ages 85 - 89	0.098	0.218	0.000	0.000	0.553	0.707	0.000	0.000
Ages 90 - 94	0.249	0.059	0.000	0.000	0.536	0.680	0.000	0.000
Ages 95 & Over	0.238	0.039	0.000	0.000	0.486	0.655	0.000	0.000
<i>Non-Medicare Benefit</i>								
Ages 55 - 59	0.840	1.048	0.000	0.000	1.002	1.356	0.000	0.000
Ages 60 - 64	1.397	1.035	0.000	0.000	0.848	1.724	0.000	0.000
Ages 65 - 69	0.582	1.218	0.000	0.000	0.891	1.383	0.000	0.000
Ages 70 - 74	0.719	0.779	0.000	0.000	1.295	1.159	0.000	0.000
Ages 75 - 79	0.033	0.945	0.000	0.000	1.060	0.853	0.000	0.000
Ages 80 - 84	1.116	0.273	0.000	0.000	0.865	0.882	0.000	0.000
Ages 85 - 89	0.291	0.145	0.000	0.000	1.044	0.832	0.000	0.000
Ages 90 - 94	0.405	0.388	0.000	0.000	0.827	0.822	0.000	0.000
Ages 95 & Over	0.696	0.033	0.000	0.000	0.839	0.802	0.000	0.000
<i>Medicare-Like Benefit</i>								
Ages 55 - 59	1.129	1.128	0.000	0.000	1.672	2.117	0.000	0.000
Ages 60 - 64	1.103	0.991	0.000	0.000	1.614	3.354	0.000	0.000
Ages 65 - 69	0.383	1.061	0.000	0.000	0.396	1.967	0.000	0.000
Ages 70 - 74	0.732	0.556	0.000	0.000	2.819	1.278	0.000	0.000
Ages 75 - 79	0.080	0.765	0.000	0.000	0.716	0.727	0.000	0.000
Ages 80 - 84	0.471	0.217	0.000	0.000	0.229	0.678	0.000	0.000
Ages 85 - 89	0.429	0.348	0.000	0.000	0.302	0.615	0.000	0.000
Ages 90 - 94	0.146	0.306	0.000	0.000	0.119	0.315	0.000	0.000
Ages 95 & Over	0.186	0.011	0.000	0.000	0.096	0.246	0.000	0.000

Nursing Home Population Age / Gender Factors by Service Category
 Populations Age 55 & Over

Exhibit IV

	MA				Dual			
	SNF / ICF		ISN		SNF / ICF		ISN	
	Male	Female	Male	Female	Male	Female	Male	Female
<i>Cross-Over Services</i>								
Ages 55 - 59	0.000	0.000	0.000	0.000	1.494	2.299	2.650	4.201
Ages 60 - 64	0.113	0.000	0.000	0.001	1.566	1.814	5.151	4.574
Ages 65 - 69	0.000	0.963	0.000	0.000	1.388	1.925	4.369	4.585
Ages 70 - 74	1.995	0.186	0.000	0.913	1.184	1.450	2.840	3.840
Ages 75 - 79	4.838	1.060	0.000	0.000	0.920	1.245	2.174	2.685
Ages 80 - 84	8.408	4.326	0.000	9.133	0.825	0.946	1.832	2.131
Ages 85 - 89	7.474	8.857	0.000	0.000	0.729	0.837	1.786	1.618
Ages 90 - 94	0.000	1.039	0.000	0.000	0.642	0.750	1.142	1.548
Ages 95 & Over	0.000	2.504	0.000	237.022	0.486	0.623	0.433	1.171
<i>LTC Benefit</i>								
Ages 55 - 59	1.028	1.041	1.485	1.294	0.976	1.037	1.258	1.290
Ages 60 - 64	0.965	0.999	1.155	1.209	0.978	1.058	1.111	1.240
Ages 65 - 69	0.957	1.000	1.181	1.200	1.007	1.050	1.156	1.197
Ages 70 - 74	0.865	0.988	1.625	1.168	1.006	1.025	1.156	1.173
Ages 75 - 79	0.902	0.888	0.870	1.213	0.994	1.014	1.121	1.188
Ages 80 - 84	0.971	0.861	1.299	1.131	1.003	0.989	1.120	1.166
Ages 85 - 89	0.776	0.772	0.923	1.222	0.975	0.978	1.227	1.150
Ages 90 - 94	0.752	0.768	0.000	0.000	0.975	0.983	1.225	1.219
Ages 95 & Over	0.499	0.736	0.000	0.626	0.982	1.000	1.312	1.160
<i>Dental</i>								
Ages 55 - 59	1.320	1.055	0.530	0.614	1.339	1.564	1.176	1.064
Ages 60 - 64	1.012	1.202	0.789	0.535	1.322	1.544	1.306	2.716
Ages 65 - 69	1.771	0.212	0.000	4.988	1.268	1.537	0.932	1.047
Ages 70 - 74	0.210	1.735	0.421	0.075	1.205	1.319	0.742	1.687
Ages 75 - 79	0.542	0.183	0.971	0.000	1.071	1.205	1.006	1.087
Ages 80 - 84	0.670	0.869	0.000	0.073	0.931	1.085	0.634	1.246
Ages 85 - 89	0.645	1.105	0.000	0.091	0.907	0.949	0.775	1.339
Ages 90 - 94	0.164	0.273	0.000	0.000	0.835	0.852	0.816	0.831
Ages 95 & Over	0.131	0.827	0.000	0.000	0.712	0.642	1.783	0.588

Nursing Home Population Age / Gender Factors by Service Category
 Populations Age 55 & Over (cont'd)

Exhibit IV

	MA				Dual			
	SNF / ICF		ISN		SNF / ICF		ISN	
	Male	Female	Male	Female	Male	Female	Male	Female
<i>Drugs</i>								
Ages 55 - 59	1.086	1.133	1.350	1.390	1.581	1.222	2.208	2.357
Ages 60 - 64	0.959	1.072	1.432	1.071	1.469	1.262	1.682	1.963
Ages 65 - 69	1.131	1.082	2.141	1.340	1.224	1.363	1.796	2.134
Ages 70 - 74	0.754	1.049	0.639	0.990	0.994	1.048	1.856	2.153
Ages 75 - 79	0.836	0.819	0.552	1.512	0.831	1.067	1.522	1.916
Ages 80 - 84	0.610	0.731	0.315	0.782	0.872	0.989	1.412	1.579
Ages 85 - 89	0.539	0.590	0.234	0.766	0.921	0.958	1.562	1.545
Ages 90 - 94	0.549	0.313	0.000	0.000	0.895	0.902	2.434	1.447
Ages 95 & Over	0.353	0.267	0.000	0.073	0.855	0.851	1.410	1.130
<i>Non-Medicare Benefit</i>								
Ages 55 - 59	0.873	1.020	1.873	1.195	0.380	0.465	2.700	2.846
Ages 60 - 64	1.061	0.907	1.683	2.933	0.523	0.469	1.860	1.294
Ages 65 - 69	1.445	1.248	1.980	1.456	0.724	0.926	1.111	1.885
Ages 70 - 74	0.537	0.679	0.216	0.146	0.845	0.867	1.529	1.116
Ages 75 - 79	1.069	0.927	3.182	6.440	1.000	0.913	1.854	1.374
Ages 80 - 84	0.202	0.556	0.712	0.186	1.062	0.955	1.764	1.451
Ages 85 - 89	0.340	0.321	0.043	1.065	1.144	0.885	0.608	1.732
Ages 90 - 94	0.126	0.241	0.000	0.000	0.889	1.048	1.133	1.014
Ages 95 & Over	0.229	1.393	0.000	0.000	1.251	1.306	0.382	3.571
<i>Medicare-Like Benefit</i>								
Ages 55 - 59	1.610	0.749	1.889	1.448	4.390	2.076	22.095	18.241
Ages 60 - 64	0.680	1.016	0.927	4.302	1.324	4.168	0.940	5.333
Ages 65 - 69	1.044	0.754	2.305	0.989	1.474	3.174	1.017	5.560
Ages 70 - 74	0.290	0.548	0.308	0.374	0.615	0.951	1.895	1.592
Ages 75 - 79	0.538	0.869	0.348	5.032	0.935	1.089	0.667	1.742
Ages 80 - 84	0.176	0.484	0.232	0.121	0.759	1.183	1.316	0.975
Ages 85 - 89	0.492	0.112	0.025	0.748	0.891	0.703	1.740	4.435
Ages 90 - 94	0.175	0.242	0.000	0.000	0.285	0.640	1.576	0.674
Ages 95 & Over	0.503	1.262	0.000	0.000	0.173	0.406	0.000	0.696

2007 Kenosha Managed Care Equivalent Development

Exhibit V

	Kenosha	
	SNF / ICF	ISN
Acute and Primary Component		
HCC Adjusted Medicare Like Services PEPM	\$ 16.02	\$ 120.44
Pharmacy PEPM	\$ 67.67	\$ 254.16
Less Drug Rebate	\$ 18.47	\$ 69.39
Adjusted Pharmacy Costs PEPM	\$ 49.20	\$ 184.78
Adjusted Cross Over Claims PEPM	\$ 132.42	\$ 167.07
P4P Adjusted Dental PEPM	\$ 29.01	\$ 30.69
Medicaid State Plan PEPM	<u>\$ 51.07</u>	<u>\$ 408.06</u>
Subtotal Acute and Primary Component	\$ 277.73	\$ 911.02
Admin; Acute and Primary Care Component	<u>\$ 13.30</u>	<u>\$ 43.63</u>
Total Acute and Primary Component	\$ 291.03	\$ 954.65
Long Term Benefit Component		
Adjusted Long Term Care Benefit PEPM	\$ 1,988.13	\$ 3,957.61
Admin; Long Term Benefit Component	<u>\$ 132.54</u>	<u>\$ 263.84</u>
Total Long Term Benefit Component	\$ 2,120.67	\$ 4,221.45
Total Acute and Primary and LTC Benefit	\$ 2,411.69	\$ 5,176.10
Less: Managed Care Savings Adjustment	\$ 14.55	\$ 47.73
Plus: Risk Margin	<u>\$ 74.14</u>	<u>\$ 158.61</u>
2007 Managed Care Equivalent	\$ 2,471.28	\$ 5,286.98

2007 Kenosha Capitation Rates
Community Care Health Plan (CCHP)

Exhibit VI

	Kenosha	
	SNF/ICF	ISN
Subtotal Acute & Primary Services	\$ 277.73	\$ 911.02
Admin	\$ 13.30	\$ 43.63
Total Acute & Primary Services	\$ 291.03	\$ 954.65
Long-term Care Services	\$ 1,988.13	\$ 3,957.61
Admin	\$ 132.54	\$ 263.84
Total Long-Term Care Services	\$ 2,120.67	\$ 4,221.45
Total All Services	\$ 2,411.69	\$ 5,176.10
Less: Managed Care Savings	\$ 14.55	\$ 47.73
Plus: Risk Margin	\$ 74.14	\$ 158.61
2007 Managed Care Equivalent	\$ 2,471.28	\$ 5,286.98