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November 21, 2022

Elizabeth Doyle, Section Manager
Long Term Care Rate Setting Section
Bureau of Rate Setting
Division Medicaid Services
1 West Wilson Street
Madison, WI 53701-0309
Sent via email: elizabeth.doyle@dhs.wisconsin.gov

Re: CY 2023 Family Care Capitation Rate Report

Dear Elizabeth:

Thank you for the opportunity to assist the Wisconsin Department of Health Services (DHS) with this important project. Our report summarizes the development of CY 2023 capitation rates for Wisconsin's Family Care program.

❖ ❖ ❖ ❖ ❖

Please contact us with any questions.

Sincerely,

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

MCC/laa

cc: David Albino, DHS
Daniel Bush, DHS
James Cronmiller, DHS
Grant Cummings, DHS
Dylan Helmenstine, DHS
Ben Johnson, DHS
Sangeetha Kakulla, DHS
Alysa Steenport, DHS
Christina Wen, DHS

MILLIMAN REPORT

State of Wisconsin

Department of Health Services
Calendar Year 2023 Capitation Rate Development
Family Care Program

November 21, 2022

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I. EXECUTIVE SUMMARY

This report documents the development of the January 2023 to December 2023 (CY 2023) capitation rates for Wisconsin's Family Care program. The Wisconsin Department of Health Services (DHS) retained Milliman to calculate, document, and certify its capitation rate development. We developed the capitation rates using the methodology described in this report.

Our role is to certify that the CY 2023 capitation rates produced by the rating methodology are actuarially sound to comply with Centers for Medicare and Medicaid Services (CMS) regulations. We developed actuarially sound capitation rates using published guidance from the American Academy of Actuaries (AAA), CMS, and federal regulations to ensure compliance with generally accepted actuarial practices and regulatory requirements. Specific Actuarial Standards of Practice (ASOPs) we considered include:

- ASOP No. 1 – Introductory Actuarial Standard of Practice
- ASOP No. 5 – Incurred Health and Disability Claims
- ASOP No. 12 – Risk Classification
- ASOP No. 23 – Data Quality
- ASOP No. 25 – Credibility Procedures
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- Other applicable standards of practice

CY 2023 CAPITATION RATES

The statewide average CY 2023 capitation rate is $3,953.68 for the Nursing Home Level of Care (NH LOC) population and $592.18 for the Non-Nursing Home Level of Care (Non-NH LOC) population. Table 1 shows the statewide rate change from the CY 2022 capitation rate certification dated December 15, 2021 to the CY 2023 capitation rates for each population.

Table 1
Wisconsin Department of Health Services
Comparison of CY 2022 and CY 2023 Capitation

	NH LOC	Non-NH LOC
CY 2022 Rates	$3,964.66	$579.89
CY 2023 Rates	$3,953.68	$592.18
% Change	-0.3%	2.1%

The -0.3% change in capitation rate for CY 2022 to CY 2023 for NH population can be broken down as follows:

- -6.9% decrease due to the actual CY 2021 base cohort costs compared to the CY 2021 costs predicted as part of CY 2022 rate development. The projection of CY 2021 costs in CY 2022 rate development included trend estimates that were significantly higher than the actual medical cost trend from CY 2019 to CY 2021.
- 1.7% increase due to differences in the CY 2021 to CY 2022 trends estimated in CY 2022 rate setting compared to those used in CY 2023 rate setting.
- 3.0% increase due to application of service trend to project CY 2022 costs to CY 2023.
- 1.2% increase due to application of acuity trend to project CY 2022 acuity to CY 2023.
- -0.4% decrease due to differences in the target group distribution between the CY 2021 base data and CY 2023 projected enrollment.
- -0.4% decrease due to projected acuity and geographic differences for GSR 12 relative to CY 2022 rates.

- Negligible change due to the restatement of legislated changes in CY 2021 and CY 2022 nursing home reimbursement, personal care, the 2021 HCBS provider rate increase, and additional reimbursement increases for waiver service providers.
- 0.3% increase due to application of the CY 2022 ARPA rate increase for certain HCBS services. This is driven by the difference between the proportion of the HCBS services applicable for the increase on CY 2019 claims used in CY 2022 rate setting and the proportion of those same services in the CY 2021 base data.
- 1.4% increase due to application of nursing home reimbursement and personal care to project CY 2022 to CY 2023.
- 0.2% increase due to the differences in the administrative load as a percent of the capitation rate.

The change in capitation rates for the DD, PD, and FE target groups is -3.9%, -0.8%, and 6.6%, respectively. The rate change by target group differs from the composite change due to differing base period data changes, target group-specific service cost and acuity trend values, and the varying impact of provider rate increases.

The 2.1% change in capitation rate certification for CY 2022 to CY 2023 for Non-NH population can be broken down as follows:

- 3.7% decrease due to the actual CY 2021 base cohort costs and the CY 2021 costs predicted as part of CY 2022 rate development. The main driver of this decrease is the trends used to project the CY 2019 base data in CY 2022 rate setting to CY 2021 were higher than expected.
- 0.2% decrease due to the updated geographic factor methodology applied to GSR 12, as well as changes in the projected IADL / ADL membership mix for members in GSR 12.
- Negligible change due to changes in base to projection period IADL / ADL membership mix for members outside of GSR 12.
- 0.9% increase due to differences in the CY 2021 to CY 2022 trends estimated in CY 2022 rate setting compared to those used in CY 2023 rate setting.
- 3.6% increase due to application of service trend to project CY 2022 costs to CY 2023.
- 1.4% increase due to application of acuity trend to project CY 2022 acuity to CY 2023.
- Negligible change due to the restatement of legislated changes in CY 2021 and CY 2022 nursing home reimbursement, personal care, the 2021 HCBS provider rate increase, and additional reimbursement increases for waiver service providers.
- 0.1% decrease due to application of the CY 2022 ARPA rate increase for certain HCBS services. This is driven by the difference between the distribution of the HCBS services on CY 2019 claims used in CY 2022 rate setting and the distribution of those same services in the CY 2021 base data.
- 0.3% increase due to application of nursing home reimbursement and personal care to project CY 2022 to CY 2023.
- 0.1% increase due the differences in the administrative loads as a percent of the capitation rates.

Projected CY 2023 expenditures split between federal and state liability are included as Exhibit O1 to O3.

Please note, the sum of the rate change drivers may not equal the total rate change, because the change drivers are calculated as multiplicative factors. The product of “one plus” each change driver equals “one plus” the total rate change.

COVID-19 CONSIDERATIONS IN CY 2023 RATE DEVELOPMENT

The COVID-19 pandemic and determination of a public health emergency (PHE) have impacted health care costs significantly since March 2020. The impact of the COVID-19 pandemic and PHE on CY 2023 capitation rates is difficult to predict due to the evolving nature of the pandemic. To develop our best estimates of future costs, we considered a wide array of potential impacts based on information from publicly available sources, internal Milliman research, and MCO feedback. The program continues to include a risk corridor around target medical loss ratios to provide financial protection to the state and MCOs.

We applied three methodological changes to reflect the impact of the COVID-19 pandemic on projected CY 2023 expenditures:

- Without the presence of the pandemic, Milliman would have used CY 2019 to CY 2021 experience to estimate trends to apply to CY 2021 experience to project it to a CY 2023 level. Due to the COVID-19 pandemic, CY 2020 costs were significantly depressed relative to CY 2019 levels, and thus we reverted to the three years of experience preceding the pandemic (CY 2017 through CY 2019) to estimate service cost trends consistent with CY 2022 capitation rate development (with an adjustment to reflect emerging market trends).

- Milliman has historically used two consecutive years of data to develop cost weights used to measure member acuity levels. Due to the COVID-19 pandemic, we opted to use CY 2021 data only rather than a combination of CY 2020 and CY 2021 data as the basis for updated cost weights.

- For the DD Nursing Home Level of Care (NH LOC) population, claims in the Adult Day Activities, Habitation / Health, and Vocational service categories were all dramatically reduced (more than 25% reduction from CY 2019 levels) during CY 2020. Claims remained lower during the initial months of CY 2021, after which they appeared to stabilize at a higher level relative to those initial months. For this population, we applied scaling factors to adjust experience in these service categories incurred during early CY 2021 to reflect levels observed later in CY 2021 which are expected to continue through CY 2023.

The capitation rates do not currently include explicit provisions for expected vaccination administration fees or other costs related to COVID-19 in CY 2023 above CY 2021 levels. Should such costs prove to be material and in excess of any continuing utilization decreases in CY 2023, we will consider revising capitation rates.

We made no other explicit adjustment for the PHE since the 2021 experience utilization is generally consistent with pre-pandemic levels. For the categories of service not fully recovered to pre-pandemic levels, we either adjusted in the base data to reflect increases during 2021, or we still do not expect significant increases in 2023 relative to 2021.

METHODOLOGY CHANGES FROM CY 2022 RATES

This section describes significant methodology changes from the CY 2022 capitation rate methodology.

Base Data

We relied on CY 2021 base data (paid through February 2022) to develop CY 2023 rates while CY 2022 rate setting used CY 2019 base data for a second consecutive year to avoid using COVID-19-depressed CY 2020 data. Thus, while CY 2022 rates had a three-year gap between base and projection periods, CY 2023 rates have only a two-year gap. The use of this data is described in greater detail in section III of this report.

GSR Consolidation

Effective January 1, 2023, GSRs formerly identified as GSRs 1 and 7 will combine into GSR 1, and GSR 7 will cease to exist. Experience shown on Exhibits A and B show these GSRs split (consistent with the definition of these GSRs in 2021), while Exhibits C onward reflect the combination of these two GSRs.

Administrative Load

With the consolidation of MCOs in recent years, the number of data points from which to build a detailed, ground-up administrative cost model has decreased to four. Additionally, MCO administrative costs have been impacted by newer responsibilities related to Electronic Visit Verification, interoperability, and state directed payments, not clearly captured in the historical administrative model. Therefore, this year we have developed administrative loads using historical MCO administrative costs PMPM and trending forward to the contract period along with giving consideration to small health plan operating needs.

Service Area Changes

Effective January 1, 2023, MCW will begin operations in the former GSR 7, which is included in the consolidated GSR 1.

DATA RELIANCE AND IMPORTANT CAVEATS

Milliman prepared this report for the specific purpose of developing the CY 2023 Family Care capitation rates. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of DHS. We understand this report may be shared with participating MCOs, CMS, and other interested parties. Milliman does not intend to benefit, or create a legal duty to, any third-party recipient of its work. This report should only be reviewed in its entirety.

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

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate CY 2023 capitation rates for Family Care. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We used MCO financial reporting, as well as encounter, eligibility, and functional screen data for CY 2017, CY 2018, CY 2019, CY 2020, CY 2021 and June 2022, and other information provided by DHS to develop the Family Care capitation rates shown in this report. We have relied upon this data and information provided by DHS for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose. Please see Appendix B for a full list of the data relied upon to develop the CY 2023 Family Care capitation rates.

Differences between the capitation rates and actual MCO experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. These rates may not be appropriate for all MCOs. Any MCO considering participating in Family Care should consider their unique circumstances before deciding to contract under these rates.

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

The terms of Milliman's contract with the Wisconsin Department of Health Services effective on January 1, 2020, apply to this report and its use.

II. BACKGROUND

Family Care is a full-risk, comprehensive Medicaid managed care delivery system for the full range of long-term care (LTC) services, which strives to foster people's independence and quality of life. Since 2000, Family Care has served people ages 18 and older with physical disabilities, people with intellectual / developmental disabilities, and frail elders, with the specific goals of:

- Giving people better choices about where they live and what kinds of services and supports they get to meet their needs
- Improving access to services
- Improving quality through a focus on health and social outcomes
- Creating a cost-effective system for the future

Eligibility for Family Care is determined through the Wisconsin Long Term Care Functional Screen and detailed decision trees involving individual information about type of disability, activities of daily living, instrumental activities of daily living, and certain other medical diagnoses and health related services. While enrollment in Family Care is not mandatory, in recent years the significant majority of nursing home eligible beneficiaries in regions in which Family Care operates have been enrolled in Family Care, with others being enrolled in a self-directed care option or fee-for-service (FFS). The percentage of eligibles who enroll in the program has grown slowly over time. The risk adjustment model mechanism helps to adjust rates for any differences in average member acuity, as the enrollment percentage increases.

Since July 2018 Family Care has operated statewide in Wisconsin. In 2023 the state will be comprised of 13 distinct GSRs for rate setting and other purposes. Please see Appendix A for a map showing the counties included in each GSR. MCOs contract with service providers to deliver all State Plan and waiver LTC services. Acute care services are provided under FFS Medicaid. In select counties, individuals eligible for Family Care can enroll in the Family Care Partnership program, in which both acute and long-term care services are managed by MCOs. The Family Care Partnership program capitation rates are developed in a separate report.

III. NURSING HOME LEVEL OF CARE METHODOLOGY OVERVIEW

This section of the report describes the CY 2023 Family Care capitation rate methodology for the NH LOC population.

The methodology used to project the MCO encounter data used in the calculation of the capitation rates can be outlined in the following steps:

1. Extract and summarize CY 2021 MCO encounter base experience data for the NH LOC population by target group.
2. Apply IBNR assumptions.
3. For the DD population, adjust early 2021 experience to levels seen later in 2021 for service categories significantly depressed due to the COVID-19 pandemic.
4. Calculate MCO / GSR specific risk adjusted base rates using June 2022 screens and the functional status acuity model relativities.
5. Apply adjustments to the risk adjusted base rates to project CY 2023 services costs for each MCO / GSR combination and target group.
6. Add allowances for non-benefit costs and margin.
7. Blend the projected CY 2023 service costs, including allowances for non-benefit costs, by target group into an MCO / GSR specific projected cost.

Each of the above steps is described in detail below.

STEP 1: EXTRACT AND SUMMARIZE ENCOUNTER BASE EXPERIENCE DATA

In this step the MCO encounter experience for CY 2021 is summarized by MCO / GSR and service category for the NH LOC populations enrolled in the Family Care program.

DHS and Milliman performed a substantial review of the CY 2021 experience. For most service categories, CY 2021 experience rebounded to pre-pandemic levels. However, certain service categories for the DD population did not stabilize until the later months of CY 2021. We thus elected to use CY 2021 data for the purposes of CY 2023 rate setting with adjustments for select DD service categories (detailed in Step 3 below).

Exhibit A shows the summarized CY 2021 MCO encounter base experience data by MCO / GSR combination and target group.

Base Data

We received detailed MCO encounter claims data from DHS for claims with dates of service between January 2020 and December 2021 with dates of payment through February 2022. This data reflects payments net of any third-party liability. These costs are also gross of member cost share / patient liability, as DHS adjusts capitation payments to MCOs for each member to reflect that particular member's cost share (also known as Post Eligibility Treatment of Income).

We believe the encounter data is of appropriate quality and completeness to use as the primary basis for developing actuarially sound rates for the Wisconsin Family Care program. We reviewed the data and validated both provider service and case management expenditures against financial statements for accuracy and completeness of the data provided. We did not identify any material concerns with the quality or availability of the data with respect to total claims in aggregate and detailed summaries by category of service.

The base period data includes only those individuals actually enrolled in the Wisconsin Family Care program, so no adjustment for retroactive eligibility periods is needed. The base experience data also excludes member expenses outside of the Family Care benefit package for service locations not allowed in Family Care. No member supplemental room and board expenses are included in the base data. The base data used in capitation rate setting is net of historical recoveries of provider overpayments.

For the CY 2021 data, approximately 0.03% of total provider service and case management dollars are excluded due to a lack of corresponding enrollment records.

The CY 2023 rate methodology relies on CY 2021 MCO encounter data for MCO / GSR combinations that are deemed credible based on MCO / GSR size and program maturity. This includes experience for all MCOs in all GSRs excluding GSR 12.

The base data cohort encompasses 97.2% of the total CY 2021 exposure. Excluding the service costs for the excluded MCO / GSR combinations reduces the rate development base data PMPM by 0.2%. The cohort excluded from the base data is identified in Exhibits E and F (labeled as the expansion cohort). It represents experience from MCOs in GSR 12 that have shown experience relative to the regression model that is not expected to continue.

MCOs provided attestations that the base experience data complies with requirements of 438.602(i) in that no claims paid by an MCO to a provider outside of the United States are included in the base period data.

Target Group Assignment

The NH LOC capitation rates rely on a member's classification into one of three target groups: Developmentally Disabled, Physically Disabled, and Frail Elderly. Each Family Care enrollee is assigned a target group based on information collected using LTCFS, administered to program participants at least annually. The assigned target group is only valid for the period covered by the screen. Therefore, individuals could potentially change target groups at each screening.

For members in the PD or FE target groups as defined by LTCFS, we calculated the age for each member as of the first day of each enrollment month; thus a member could be defined as PD in their most recent functional screen but would be assigned to the FE target group once achieving age 65. Based on this age calculation, we transitioned a small number of members from FE members to the PD target group (if their calculated age was 64 or below) or from the PD target group to the FE target group (if their calculated age was 65 or above).

The experience summaries shown in Exhibit A reflects this target group assignment.

Case Management Expenditures

Case management expenditures are included in the base cohort data as a service cost, consistent with contract terms. The case management expenses are trued up to financial statements due to the difficulty in properly and completely reporting full service cost information in the encounter data format.

Table 2 below shows the CY 2021 encounter data to financial statement reconciliation adjustment for case management expenditures.

Table 2
Wisconsin Department of Health Services
Encounter Data to Financial Statement Reconciliation Adjustment
For Case Management Services

MCO	CY 2019
CCI	-2.2%
Inclusa	17.1%
LCI	-4.2%
MCW	6.7%

Case management expenditures are reconciled for the NH LOC and Non-NH LOC populations in aggregate.

Non-Covered Services Adjustments

Approximately 0.75% of expenditures for services not covered under the Family Care benefit set were removed from the base data. This includes any payments made for member supplemental room and board expenses not included in the Institutional or Residential categories of service. No services were provided in lieu of a covered service for the Nursing Home LOC population.

Institution for Mental Disease (IMD) services are not a covered benefit under Family Care. Such services are covered via the FFS delivery system. If individuals enter an IMD, they are disenrolled from the Family Care program. Therefore, no adjustment to the base data is required.

Sub-Capitated Services

The base data does not include any sub-capitated services as the MCOs operating in Family Care currently do not contract for sub-capitated services.

STEP 2: APPLY IBNR ASSUMPTIONS

We used Milliman's Claim Reserve Estimation Workbook (CREW) to calculate the IBNR adjustment factors shown in Table 3 below. We developed Completion factors (CFs) by MCO in aggregate across all service types due to the small magnitude of the adjustments, using experience data for the combined NH LOC and Non-NH LOC populations. CREW calculates incurred but not reported (IBNR) reserve estimates by blending two different estimation methods: the lag completion method and the projection method.

The lag method reflects the historical average lag between the time a claim is incurred and the time it is paid. To measure this average lag, claims are separated by month of incurral and month of payment. Using this data, historical lag relationships are used to estimate ultimate incurred claims (i.e., total claims for a given incurral month after all claims are paid) for a specific incurral month based on cumulative paid claims for each month.

The projection method develops estimates for incurred claims in recent incurral months by trending an average base period incurred cost per unit to the midpoint of the incurred month at an assumed annual trend rate and applying an additional factor to account for the seasonality of claim costs and the differing number of working days between months. The base period is chosen by selecting a group (usually 12) of recent consecutive months for which the lag completion method provides reasonable results.

The lag completion and projection methods are combined to produce the final incurred claim estimate. Final incurred claim estimates are calculated as a weighted average of these two methods. Because of the amount of claim runout available in the encounters, no weight is placed on the projection method results.

Exhibit P provides additional detail on the calculation of the IBNR adjustments applied to each MCO's CY 2021 experience data. This exhibit includes CY 2021 provider services paid through February 2022, estimated incurred claims and outstanding liability, and the implied IBNR adjustment factor for each incurred month. Table 3 below shows the cumulative IBNR adjustment applied to the CY 2021 experience data. While our IBNR calculation accounts for outstanding provider service costs, in practice the adjustment factor is applied to both provider service costs and case management; as such, the adjustment factors shown in Table 3 are slightly dampened from those underlying Exhibit P to account for the proportion of base period experience attributable to case management to avoid double counting.

Note, that due to the merger of MCFCI and Care Wisconsin in 2020, the completion factors for MCW (developed from temporarily slower 2020 completion patterns) do not reflect the expected completion of CY 2021 data. We instead use the completion factors developed for all three other MCOs in aggregate to complete MCW CY 2021 claims.

Table 3 Wisconsin Department of Health Services Family Care Program LTC IBNR Adjustment Factors	
MCO	**IBNR Factor**
CCI	1.0050
Inclusa	1.0051
LCI	1.0059
MCW	1.0053

STEP 3: COVID-19 IMPACTED SERVICES ADJUSTMENT

For the DD Nursing Home Level of Care (NH LOC) population, claims in the Adult Day Activities, Habitation / Health, and Vocational service categories were all dramatically reduced (more than 25% reduction from CY 2019 levels) during CY 2020 as a result of the COVID-19 pandemic. Claims remained lower during the initial months of CY 2021, after which they appeared to stabilize at a higher level relative to those initial months. We thus performed the following steps to increase these claims incurred during early CY 2021 to levels observed later in CY 2021, as shown by Exhibit Q:

A. We determined the first month in CY 2021 during which services stabilized:

   1. June for Adult Day Activities and Habitation / Health services.
   2. March for Vocational services.

B. We compared the costs in the months prior to these stabilized months (the “low claim period”) to months including and following these months (the “high claim period”).

C. We calculated the increase in the low claim period to the high claim period after consideration for seasonality.

D. We calculated the aggregate factor across all CY 2021 claims, including the factor calculated by Step C applied to claims incurred during the low claim period during CY 2021 blended with a 1.00 factor applied to claims incurred during the high claim period during CY 2021.

Exhibit B shows the application of the results from Step D above to the proportion of CY 2021 claims in these three service categories blended with a 1.00 factor for all other service categories.

STEP 4: CALCULATE MCO / GSR SPECIFIC RISK ADJUSTED BASE RATE USING JUNE 2022 ENROLLMENT AND THE FUNCTIONAL STATUS ACUITY MODEL RELATIVITIES

For CY 2023 rate setting, Milliman developed the NH LOC regression models using individuals’ functional status to predict costs from MCO-reported experience for CY 2021. This model is an acuity adjustment model which is used to adjust the data to better reflect the acuity of the population covered under each MCO / GSR relative to the base data cohort. Because GSR 12 in not part of the base data, the program-wide impact of applying the regression model will not be budget neutral. In this way, the average population acuity projected from the base data will better match the 2023 population.

Previous functional status models used two years of data to improve the credibility and stability of the models, but due to the COVID-19 pandemic we exclude CY 2020 experience from this model development. We developed risk weights for each of the three target groups independently using the corresponding population's functional screen, claim, and eligibility data. Wisconsin's LTCFS system provided the member level detail underlying each model.

The attached Exhibits C1 through C3 show the NH LOC functional status acuity models for the DD, PD, and FE populations, respectively. The estimated impact on the cost for each variable is shown, along with its significance (i.e., *p*-value), relative contribution in explaining the variation (i.e., Incremental Partial R^2), and the proportion of the population with the characteristic.

Table 4 below provides a high-level comparison between the CY 2021, which was used in CY 2022 rate setting, and CY 2023 models for each target group:

Table 4
Wisconsin Department of Health Services
Comparison of CY 2022 and CY 2023 Functional Status Models
Nursing Home Level of Care

	Developmentally Disabled	Physically Disabled	Frail Elderly
CY 2023 R^2	43.8%	42.9%	34.9%
CY 2022 R^2	47.0%	46.5%	35.5%
R^2 Percentage Change	-3.3%	-3.6%	-0.6%

The "Proportion with Variable" statistics shown in Exhibit C represent the proportion of the base cohort target group population identified with each variable used in the regression model. This is identified directly from a review of an individual's functional screen. It is calculated as "Number of individuals with condition" divided by "Number of individuals in the target group base cohort."

The "Statewide Estimate" in Exhibit C represents the estimated incremental dollar cost associated with each variable for the entire target group base data cohort. The values are the result of the multivariable linear regression exercise.

The product of the statewide estimate and the proportion with variable equals the "incremental increase" value. The sum of the incremental increase values equals the total PMPM target group base data cohort cost. For example, the sum of the incremental increase values on Exhibit C1 is $3,799.90, which is equal to the completed DD base data cost shown on Exhibit B.

Exhibits D1A, D2A, and D3A develop the restated base period costs for each MCO / GSR combination, as modeled by the functional status acuity model. The acuity model is normalized to be budget neutral across all base data GSRs. Therefore, the CY 2021 costs for each target population base data cohort are unaffected in total.

Exhibits D1B, D2B, and D3B develop the final composite risk score as modeled by the functional status acuity model using the June 2022 Family Care NH LOC population enrollment. For credibility purposes, each MCO / GSR / target group combination with fewer than 100 members enrolled in June 2022 will use a blend of the MCO-specific regression results and the regression results for the entire GSR / target group combination. We calculate the credibility-adjusted regression result using the following formulas:

$$\text{Adjusted Regression Result} = \text{Credibility\%} \times \text{MCO / GSR / TG Risk Score} + (1\text{-Credibility\%}) \times \text{GSR / TG Risk Score}$$

$$\text{Credibility\%} = MIN\left[\sqrt{\frac{\text{June Enrollment}}{100}}, 100\%\right]$$

MCOs with 100 members or more enrolled in a particular GSR and target group in June 2022 are considered fully credible.

STEP 5: APPLY ADJUSTMENTS TO THE RISK ADJUSTED BASE RATE TO PROJECT CY 2023 SERVICE COSTS

In this step, we apply adjustment factors to reflect differences between the base period encounter data and the projected CY 2023 Family Care program contract period service costs. Each adjustment factor is explained in detail below and shown in Exhibit E.

Exhibit E also shows adjusted and trended values for each target group and in total.

Service Cost Trend from CY 2021 to CY 2023

We used service cost trend rates to project the CY 2021 baseline cost data to the CY 2023 contract period, to reflect changes in provider payment levels and changes in average service utilization and mix. This requires application of 24 months of trend from the midpoint of the baseline cost period to the contract period.

To assist in developing these trend rate projections, we analyzed monthly Family Care MCO encounter data from CY 2017 through CY 2019 in several ways using data consistent with the MCO / GSR combinations included in the base data cohort. We limited this study to only include 2017 through 2019 because this timeframe excludes impacts due to the COVID-19 pandemic; CY 2020 costs showed a material decrease relative to CY 2019 base data experience, and we do not expect that these service cost changes are reflective of service cost trends after the pandemic and they are not considered in the development of projecting CY 2021 experience to CY 2023.

We thus used CY 2017 through CY 2019 experience as the basis for our service cost trend development, but applied adjustments to account for emerging and expected higher provider rate increases seen through mid-year 2022 as communicated by DHS and participating MCOs.

Exhibit R1 summarizes the results of our 2017 through 2019 trend analysis. Based on this analysis, consistent with CY 2022 rate setting, we initially selected trends of 0.0%, 1.8%, and 2.1% for the DD, PD, and FE target groups, respectively. Beginning with these trends (shown in Column A), we applied experience adjustments for emerging and expected future provider unit cost increase pressures and discussed with DHS and participating MCOs (shown in Columns B and C). Our final trends, including emerging experience adjustments, are thus shown in Columns D and E. While 2020 through 2021 data was not usable for determining service cost trends, we noted measured member acuity remained stable during the public health emergency. Therefore, the acuity trends shown on Exhibit R1 are thus not used directly in setting the acuity trends from CY 2021 to CY 2023.

Table 5 illustrates the service cost trend values implemented for the CY 2023 rate development, split between utilization and unit cost trends for each target group. Unit cost projections are consistent with emerging and expected provider trends seen through mid-year 2022. Utilization trends are then calculated to arrive at the targeted PMPM trend after the unit cost emerging experience adjustment described in the previous paragraph.

Table 5
Wisconsin Department of Health Services
Annual Trend Rates by Target Group

	Utilization Trend		Unit Cost Trend		PMPM Trend	
Target Group	CY 2021 to CY 2022	CY 2022 to CY 2023	CY 2021 to CY 2022	CY 2022 to CY 2023	CY 2021 to CY 2022	CY 2022 to CY 2023
Developmentally Disabled	0.00%	0.00%	2.00%	2.00%	2.00%	2.00%
Physically Disabled	1.80%	1.80%	0.00%	2.00%	1.80%	3.84%
Frail Elderly	2.10%	2.10%	0.00%	2.00%	2.10%	4.14%

Acuity Trend from CY 2021 to CY 2023

In addition to the above service cost trends, which determine historical cost increases on a risk-neutral basis, we also apply acuity trends to CY 2021 experience to reflect population acuity changes from CY 2021 to CY 2023.

To develop these acuity trends, we analyzed annual risk scores from CY 2019 through CY 2021 for each target group independently. We used these risk scores to calculate the annual trend from CY 2019 through CY 2021, as shown in Exhibit R2. The selected annual trends, shown in Table 6 below, will be used to acuity trend CY 2021 to CY 2023.

Table 6
Wisconsin Department of Health Services
Annual Acuity Trend Rates by Target Group

Target Group	Annual Acuity Trend
Developmentally Disabled	1.30%
Physically Disabled	1.90%
Frail Elderly	0.70%

Geographic Adjustment

The functional status acuity model does not include a consideration for the difference in service costs associated with providing care in different regions of the state. Therefore, we developed geographic factors based on an analysis of CY 2018, 2019, and 2021 plan performance relative to the costs projected using the regression model and rate setting assumptions. CY 2020 costs were materially impacted by the public health emergency and are excluded from this analysis. The methodology to calculate the geographic factors is as follows:

1. We summarize actual experience by MCO / GSR combination using MCO encounter data for each of CY 2018, 2019, and 2021. The following adjustments are made to MCO encounter data, consistent with their treatment in rate development:

    a. Services covered outside of the capitation rate are excluded.

    b. Case management expenses, which are historically underreported in the MCO encounter data, are adjusted to match the values reported in the MCO's financial data.

    c. An adjustment is made to the reported amounts to reflect our estimate of incurred but not reported (IBNR) claims.

    d. Experience for GSRs 1 and 7 is separated consistent with CY 2021 regional definitions. Since both GSRs are later aggregated within Super Region 1 (as described below), results would remain unchanged whether we combine or segregate these GSRs for this analysis.

2. We aligned the regression models used for each year of the actual to expected analysis such that we did not require any trend assumptions for our calculations. For example, the CY 2018 analysis used the regression model developed for CY 2021 rates and calibrated to CY 2018 data. We make no adjustment to the projected costs for geographical wage differences by GSR since the intention of these analyses is to identify geographical differences by GSR.

3. We normalized the actual to expected results such that within each given year of data used for the geographic factor analysis, all base data GSRs aggregate to a 1.0 actual to expected ratio.

4. We review the actual and projected costs for each MCO / GSR combination across all three years to identify any anomalous results that may have a material impact on the final geographic adjustment factors. The preliminary geographic adjustment factor is calculated as the average of three years of the ratios of actual and expected costs weighted 1/6, 2/6, and 3/6 from the oldest to the newest year. The projected costs serve as a form of "risk adjustment" to account for differences in target group, member acuity and other issues between GSRs that are already accounted for in MCO payment and should not be part of the geographic factor calculations. Exhibit S shows this calculation for each GSR.

5. For GSR 12 only, we give 100% weight to the CY 2021 actual to expected results in Exhibit S. The 2018 and 2019 actual to expected results are not reliable since GSR 12 had recently entered the Family Care program and had cost profiles much higher than other GSRs. By 2021, initiatives to reduce member service expenses, evaluate care management activities, and review provider contracting brought GSR 12 costs more in line with other GSRs. We anticipate this year of data will reflect future costs and thus opted to use only CY 2021 actual to expected results for GSR 12.

6. As part of capitation rate development, we scale the preliminary geographic factors to maintain budget neutrality relative to the MCO / GSR combinations used in base data development. We normalize geographic factors such that each target group is independently budget neutral; thus, the geographic normalization factor applied to each target group within a GSR will differ. Table 7 below shows the normalization factor applied to normalize the preliminary geographic adjustment factors by target group.

Table 7
Wisconsin Department of Health Services
Geographic Factor Normalization by Target Group

Target Group	Normalization Factor
Developmentally Disabled	1.0027
Physically Disabled	0.9978
Frail Elderly	0.9986

To increase the credibility of this calculation and to limit the maximal market share achieved by a single MCO, the geographic factors for certain GSRs are calculated as the combination of results across several GSRs. These combinations, referred to as "Super Regions," are defined in Exhibit S.

Nursing Home Rate Adjustment

The Wisconsin biennial budgets direct DHS to provide a 14.1% rate increase for SFY 2022 and an additional 23.1% increase for SFY 2023. Based on historical rate increases and guidance from DHS, we assume an additional 3.0% increase for SFY 2024. We applied an adjustment specific to each target group and GSR based on the proportion of service costs for nursing home services in CY 2021. Table 8 shows the calculation of this adjustment, which is included in Exhibit E.

Table 8
Wisconsin Department of Health Services
Nursing Home Rate Adjustment

	Percentage of Nursing Home Cost in CY 2021			Adjustment Factor		
GSR	DD	PD	FE	DD	PD	FE
GSR 1	3.8%	12.6%	21.8%	1.0117	1.0393	1.0685
GSR 2	5.6%	9.3%	34.4%	1.0175	1.0289	1.1090
GSR 3	6.3%	12.4%	33.1%	1.0195	1.0387	1.1047
GSR 4	2.6%	9.0%	10.1%	1.0081	1.0280	1.0313
GSR 5	3.4%	16.9%	22.0%	1.0106	1.0527	1.0690
GSR 6	3.9%	14.7%	21.2%	1.0119	1.0461	1.0666
GSR 8	9.0%	11.1%	25.2%	1.0281	1.0346	1.0792
GSR 9	5.0%	19.2%	22.6%	1.0156	1.0600	1.0711
GSR 10	2.6%	12.9%	14.3%	1.0080	1.0404	1.0446
GSR 11	4.4%	20.3%	20.3%	1.0137	1.0636	1.0636
GSR 12	3.8%	13.8%	15.1%	1.0118	1.0429	1.0472
GSR 13	2.6%	11.4%	17.8%	1.0080	1.0355	1.0557
GSR 14	1.4%	13.2%	15.3%	1.0044	1.0411	1.0477

Personal Care Rate Adjustment

DHS increased fee-for-service personal care rates from $19.16 per hour in CY 2021 to $20.80 per hour in CY 2022 and $23.44 per hour in CY 2023. Personal care costs represented between 0.12% and 0.44% of base period costs across the three target groups. Applying these rate increases to these portions of the cost results in adjustments of 0.03%, 0.09%, and 0.02% for the DD, PD, and FE target groups, respectively. This adjustment is made in Exhibit E.

Home and Community-Based Services State Directed Provider Increase - June 2021 Reimbursement Increase

Effective June 1, 2021, DHS required MCOs participating in Family Care to increase provider reimbursement rates by approximately 4.24% for certain home and community-based services.

Providers of the following services are eligible for these payments, excluding self-directed services and services for providers with no current provider contract:

- Providers of adult day care services
- Daily living skills training
- Habilitation services
- Residential care, including:
  - Adult family homes of 1 to 2 beds
  - Adult family homes of 3 to 4 beds
  - Community-based residential facilities
  - Residential care apartment complexes
- Individual and group supported employment
- Prevocational employment
- Vocational futures planning
- Respite care provided outside of a nursing home
- Supportive home care

The adjustment, shown in Column D7 of Exhibit E, applies this rate increase to the portion of CY 2021 experience incurred prior to June 1, 2021 matching the above criteria. This calculation was done specific to each combination of target group and GSR.

CY 2022 ARPA Reimbursement Increase

Effective January 1, 2022, DHS required MCOs participating in Family Care to increase provider reimbursement rates by 5% for certain home and community-based services. This is in addition to the provider rate increase described previously. This provider rate increase is intended to be funded using the enhanced FMAP the State received through the American Rescue Plan Act.

A comprehensive list of benefit categories to which this rate increase applies can be found in the attached Exhibit T.

The adjustment, shown in Column D8 of Exhibit E, applies this rate increase to only the applicable portion of base data experience. This calculation was done specific to each combination of target group and GSR.

State Budget Provider Rate Increases SFY 2021-2023

Per the 2021 to 2023 state fiscal budget, DHS elected to increase funding for certain services, including Home Health, Physical Therapy, Speech Therapy, and Outpatient Mental Health. Effective January 1, 2022, DHS is requiring the following:

- An increase to Medical Assistance rates paid for nursing care in home health agencies that are licensed under WI Statute 50.49 to support licensed practical nurses, registered nurses, and nurse practitioners in those agencies
- An increase in the reimbursement rates for physical therapy
- An increase to reimbursement rates paid for speech and language pathology services at 75% of the amount paid by Medicare
- An increase to reimbursement rates paid for outpatient services for mental health and substance abuse

Overall, service costs for the Family Care NH LOC population are expected to increase the NH LOC projected service costs 0.15%, 0.23%, and 0.08% for the DD, PD, and FE target groups, respectively. This adjustment is shown in Column D9 of Exhibit E where this rate increase is applied to only the applicable portion of base data experience. This calculation was done specific to each combination of target group and GSR.

STEP 6: ADD ALLOWANCE FOR NON-BENEFIT EXPENSES

In this step we develop the non-benefit cost allowance for the Nursing Home-eligible population. Non-benefit expense loads are shown in Exhibit F.

Administrative Costs

In order to develop administrative costs, DHS and Milliman reviewed program experience from plan reported financial summaries for CY 2021. We set overall CY 2023 administrative costs based on the CY 2021 administrative cost PMPM level with two years of 4.0% annual trend applied, which is comparable to recent Employment Cost Index calculations published by the Bureau of Labor Statistics. This considers the high levels of inflation and wage growth seen in early 2022 at 5.0% trend for CY 2021 to CY 2022 and the expectation of the return to closer to the historical average in 2023 at 3.0% trend from CY 2022 to CY 2023.

We then make an adjustment to account for the size of the MCO to ensure sufficient funding of the required administrative infrastructure costs to operate in the program which do not vary by the member months of the MCO. MCOs with enrollment less than 100,000 member months are increased an additional 20%, based on a review of the historical administrative cost relativities, emerging experience and known staffing increases needed to meet the contractual requirements of the Family Care contract. Since larger MCOs spread fixed costs across more member months, this adjustment ensures sufficient funding for smaller MCOs when the total administrative funding is calculated by the weighted average PMPM.

This results in an overall CY 2023 administrative load of $122.49 PMPM for Family Care.

OCI Adjustment

DHS is providing a modest amount of funding ($0.18 PMPM) to be used as a provision for the Office of the Commissioner of Insurance's (OCI's) financial oversight function. This amount was derived by dividing the total contracted amount ($117,000) by the total NH LOC projected enrollment in CY 2023. By contract, MCOs will be required to use 100% of these funds to pay for these OCI services, as a cost of doing business.

Targeted Risk Margin / Contribution to Reserves

We include an explicit 2.0% targeted margin to account for risk margin and cost of capital. We believe that this margin is appropriate given the predictability of expenses under the program, and margins included for similar programs nationally. Approximately 70% of the P4P withhold is expected to be returned to MCOs as described in Section V of this report.

STEP 7: BLEND NET CAPITATION RATE BY TARGET GROUP

In this step we blend the CY 2023 MCO / GSR capitation rates for each target group based on the projected CY 2023 target group membership. The blended capitation rates are reflected in the last section of Exhibits F and G. These blended rates are illustrative only, since the program information technology started paying separate capitation rates for each target group in CY 2021.

IV. NON-NURSING HOME LEVEL OF CARE METHODOLOGY OVERVIEW

This section of the report describes the CY 2023 Family Care capitation rate methodology for the Non-Nursing Home Level of Care (Non-NH LOC) population.

The methodology used to project the MCO encounter data used in the calculation of the capitation rates can be outlined in the following steps:

1. Extract and summarize CY 2021 MCO encounter base experience data for the Non-NH LOC population by target group.
2. Apply IBNR assumptions and in-lieu-of services adjustments to establish base period cost.
3. Convert target group-based summaries to functional status categories.
4. Blend the base functional status model amounts into an MCO specific projected cost.
5. Apply adjustments to the base experience data to project CY 2023 services costs for each MCO / GSR.
6. Add allowance for non-benefit costs.

Each of the above steps is described in detail below.

STEP 1: EXTRACT AND SUMMARIZE ENCOUNTER BASE EXPERIENCE DATA

In this step the MCO encounter experience for CY 2021 is summarized by MCO / GSR and service category for the Non-NH LOC populations enrolled in the Family Care program.

DHS and Milliman performed a substantial review of the CY 2021 experience. For most service categories, CY 2021 experience rebounded to pre-pandemic levels. We used the same process to summarize and validate the MCO encounter data for the Non-NH LOC population as the one described in Section III of this report for the NH LOC population. The CY 2023 Non-NH LOC rate methodology also relies on CY 2021 MCO encounter data for the same MCO / GSR combinations that are deemed credible for the NH LOC population. The base data cohort encompasses 98% of the total Non-NH LOC CY 2021 exposure. Excluding the service costs for the excluded MCO / GSR combinations increases the rate development base data PMPM by approximately 0.3%.

Identical processes are used to assign target group and reconcile case management expenses as used for the NH LOC population.

STEP 2: APPLY IBNR ASSUMPTION / IN LIEU OF ADJUSTMENT

In this step we apply an adjustment to the base period costs to account for outstanding service cost liability for each MCO and GSR combination using the same IBNR factors shown in Table 3, which were calculated using a combination of NH and Non-NH LOC experience due to the non-credible size of the Non-NH LOC experience.

Exhibit I shows adjusted values for each target group.

Non-Covered Services Adjustment

MCOs are allowed to provide LTC waiver services under Family Care that are not explicitly covered for Non-NH LOC beneficiaries, most often in lieu of a covered service. As part of the capitation rate development process, the encounter data is adjusted to remove the portion of the cost of in-lieu-of services that exceeds the cost of the corresponding state plan service. The two most significant covered services that are substituted for are personal care and state plan transportation services.

In addition, costs for certain non-covered services were excluded because they do not have a comparable covered service under Family Care. According to regulation, non-covered services that do not have a comparable covered service cannot be included in the capitation rate development. These services include supported employment, certain institutional services, and other services.

Table 9 below shows a summary of the amounts for non-covered services we exclude for the Non-NH LOC base data cohort.

Table 9
Wisconsin Department of Health Services
Excluded Amounts for Non-Covered Services

MCO	Amount
CCI	97,311
Inclusa	38,682
LCI	5,013
MCW	6,794
Total	**$147,799**

In total, we excluded $147,799 from the Non-NH base data underlying CY 2023 capitation rate development for costs related to non-covered services that are not cost effective in comparison with their corresponding covered service.

Exhibit I shows the summarized CY 2021 MCO encounter base experience data by target group net of the non-covered services exclusion.

STEP 3: CONVERT TARGET GROUP BASED SUMMARIES TO FUNCTIONAL STATUS CATEGORIES

The Non-NH LOC functional status model is based on MCO-reported experience for calendar year 2021. Like the above NH LOC model, this model has typically been developed based on two years of data but using a single year of data for the CY 2023 model avoids using depressed CY 2020 experience. The Non-NH level of care functional status model stratifies claims experience based on an individual's level of need, using their count of ADLs and IADLs. The ADLs and IADLs are each separated into "low" and "high" levels of need. A "low" level of need corresponds to an individual that has an ADL or IADL count of two or less. A "high" level of need corresponds to an individual that has an ADL or IADL count of three or more. The rates are developed based on four distinct cohorts:

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

Consistent with the summaries by target group, the cost for each functional status category is adjusted for in-lieu-of services that are excluded from the base period and adjusted for IBNR.

Exhibit J shows the PMPM values for each functional status category.

STEP 4: BLEND THE BASE FUNCTIONAL STATUS MODEL AMOUNTS INTO AN MCO-SPECIFIC PROJECTED COST

In this step we develop a MCO / GSR specific PMPMs by blending the functional status PMPMs calculated in Step 3 above with projected enrollment by functional status category. This enrollment projection uses actual CY 2021 experience within each MCO / GSR to distribute projected CY 2023 enrollment across functional status categories. Due to credibility concerns, MCO / GSR combinations with fewer than 100 exposure months in CY 2021 instead allocate CY 2023 enrollment across functional status categories using all Family Care enrollees in that GSR, regardless of MCO.

Table 10 shows the non-credible MCO / GSR combinations.

Table 10
Wisconsin Department of Health Services
Low Credibility MCO / GSR Combinations – Non-NH LOC

MCO	Low Credibility Combinations
CCI	GSR 12
Inclusa	GSR 6, GSR 9, GSR 10, GSR 13
LCI	GSR 10
MCW	GSR 11

Exhibit K shows the blending process for each MCO / GSR combination.

STEP 5: APPLY ADJUSTMENTS TO THE BASE EXPERIENCE DATA TO PROJECT CY 2023 SERVICE COSTS FOR EACH MCO / GSR

In this step we apply adjustments to the base period costs to project costs from the CY 2021 base period to the CY 2023 contract period. These adjustments are shown in Exhibit L.

CY 2021 to CY 2023 Trend Adjustment

Service cost and acuity changes are applied for 24 months to project the CY 2021 base data to the CY 2023 contract period. Service cost and acuity trends used for the Non-NH LOC population are consistent with those shown in Table 5 and Table 6, respectively, for the NH LOC population. The same trend values as the NH LOC population are used because of the non-credible size of the Non-NH LOC experience. Given the significant similarity of covered populations, benefits, provider reimbursement, and geography between the NH and Non-NH LOC populations, we believe the NH trend rates are the most appropriate to use for the Non-NH population.

Geographic Adjustment

Since the base cost data represents an average program cost, an adjustment for each MCO / GSR is needed to reflect the difference in service costs associated with providing care in different regions of the Family Care service area.

We used the same geographic adjustment factors as for the NH LOC population and documented in Exhibit S of this report because of the non-credible size of the Non-NH LOC experience. Given the significant similarity of covered populations, benefits, provider reimbursement, and geography between the NH and Non-NH LOC populations, we believe the NH wage factors are the most appropriate to use for the Non-NH population. The geographic factors are normalized to 1.0 for the base cohort.

Nursing Home Rate Adjustment

The Wisconsin biennial budgets direct DHS to provide a 14.1% rate increase for SFY 2022 and an additional 23.1% increase for SFY 2023. Based on historical rate increases and guidance from DHS, we assume an additional 3.0% increase for SFY 2024. We applied an adjustment specific to each target group and GSR based on the proportion of service costs for nursing home services in CY 2021. This adjustment is made in Exhibit L.

Personal Care Rate Adjustment

DHS increased fee-for-service personal care rates from $19.16 per hour in 2021 to $20.80 per hour in 2022 and $23.44 per hour in 2023. Personal care costs represented 0.05% of base period costs for the Non-NH LOC population. Applying these rate increases to the portion of the cost results in an adjustment of 0.01%. This adjustment is made in Exhibit L.

Home and Community-Based Services State Directed Provider Increase - June 2021 Reimbursement Increase

Effective June 1, 2021, DHS required MCOs participating in Family Care to increase provider reimbursement rates by approximately 4.24% for certain home and community-based services.

Providers of the following services are eligible for these payments, excluding self-directed services and services for providers with no current provider contract:

- Providers of adult day care services
- Daily living skills training
- Habilitation services
- Residential care, including:
  - Adult family homes of 1 to 2 beds
  - Adult family homes of 3 to 4 beds
  - Community-based residential facilities
  - Residential care apartment complexes
- Individual and group supported employment
- Prevocational employment
- Vocational futures planning
- Respite care provided outside of a nursing home
- Supportive home care

The adjustment, shown in Column B7 of Exhibit L, applies this rate increase to the portion of CY 2021 experience incurred prior to June 1, 2021 matching the above criteria. This calculation was done specific to each GSR.

CY 2022 ARPA Reimbursement Increase

Effective January 1, 2022, DHS required MCOs participating in Family Care to increase provider reimbursement rates by 5% for certain home and community-based services. This is in addition to the provider rate increase described previously. This provider rate increase is intended to be funded using the enhanced FMAP the State received through the American Rescue Plan Act.

A comprehensive list of benefit categories to which this rate increase applies can be found in the attached Exhibit T.

The adjustment, shown in Column B8 of Exhibit L, applies this rate increase to only the applicable portion of base data experience. This calculation was done specific to each GSR.

State Budget Provider Rate Increases SFY 2021-2023

Per the 2021 to 2023 state fiscal budget, DHS elected to increase funding for certain services, including Home Health, Physical Therapy, Speech Therapy, and Outpatient Mental Health. Effective January 1, 2022, DHS is requiring the following:

- An increase to Medical Assistance rates paid for nursing care in home health agencies that are licensed under WI Statute 50.49 to support licensed practical nurses, registered nurses, and nurse practitioners in those agencies
- An increase in the reimbursement rates for physical therapy
- An increase reimbursement rates paid for speech and language pathology services at 75% of the amount paid by Medicare
- An increase to reimbursement rates paid for outpatient services for mental health and substance abuse

Overall, service costs for the Family Care Non-NH LOC population are expected to increase by approximately 0.10%. This adjustment is shown in Column B9 of Exhibit L applies this rate increase to only the applicable portion of base data experience. This calculation was done specific to each combination of target group and GSR.

STEP 6: ADD ALLOWANCE FOR NON-BENEFIT COSTS

In this step we develop the non-benefit cost allowance for the Non-NH eligible population. Non-benefit expense loads and resulting MCE and capitation rates are shown in Exhibit M.

It is our understanding that the Non-NH LOC and NH LOC populations are administered similarly by the MCOs. The non-benefit cost model developed by DHS models MCO expenses compared to actual. In addition, the revenue associated with the Non-NH program is small enough that we do not believe it would be possible to develop a credible, standalone administrative cost model.

Therefore, the allowance for Non-NH LOC administrative cost allowance PMPM for each MCO is set equal to approximately 16% of the MCO's NH LOC administrative cost allowance, based on the ratio of the monthly CY 2021 NH LOC service costs gross of HCRP and Non-NH LOC service costs. See Section III of this report for details of the development of the allowance for administrative costs for the NH LOC population.

We include an explicit 2.0% targeted margin to account for risk margin and cost of capital. We believe that this margin is appropriate given the predictability of expenses under the program, and margins included for similar programs nationally. In 2023, approximately 70% of the P4P withhold is expected to be returned to MCOs.

Exhibit N shows the monthly capitation rates.

V. OTHER RATE CONSIDERATIONS

All actual and potential adjustments outlined in this section have been developed in accordance with generally accepted actuarial principles and practices.

RISK CORRIDOR

For CY 2023 Family Care will continue to have a risk corridor mechanism to mitigate the uncertainty outside of MCO control related to the ongoing COVID-19 pandemic, as well as the unique operational circumstances that MCOs in this program face. The risk corridor will address variances in costs for all services other than care management. The pricing assumptions in this report create an average target risk corridor loss ratio of 84.5%, excluding care management, based on the following components:

- Average administrative allowance of 3.1%
- Average care management load of 10.4%
  - DD target group – 8.2%
  - PD target group – 15.0%
  - FE target group – 11.7%
  - Non-NH LOC – 63.6%
- Margin of 2.0%

MCO / GSR-specific administrative allowance and care management loads will be developed to match actual target group mix, LOC mix and pricing assumptions made in rate development. Note, the actual rate development MLR including covered care management services is well above the 85% minimum required under federal regulation.

DHS and each MCO will share the marginal financial risk of actual results above or below the target risk corridor loss ratio as shown in the table below:

Table 11
Wisconsin Department of Health Services
Risk Corridor Program – Family Care

Variance from Target	Average Loss Ratio Claims Corridor	MCO Share of Gain / Loss in Corridor	DHS Share of Gain / Loss in Corridor
< -6.0%	< 78.5%	0%	100%
-6.0% to -2.0%	78.5% to 82.5%	50%	50%
-2.0% to +2.0%	82.5% to 86.5%	100%	0%
+2.0% to +6.0%	86.5% to 90.5%	50%	50%
> +6.0%	> 90.5%	0%	100%

The risk corridor settlement will occur after the CY 2023 rate year has ended, and enough time has passed to collect and validate CY 2023 encounter data and financial data. We anticipate performing an initial settlement no earlier than four months after the rate year has ended and a final settlement no earlier than nine months after the rate year has ended.

Only medical benefit services costs, as defined in the contract and this report, other than care coordination, will be included in the numerator of the loss ratio calculation for the risk corridor program. Care coordination, quality improvement, and other non-medical benefit service costs will not be included in the numerator of the loss ratio calculation, consistent with the development of the target risk corridor target loss ratio. All capitation revenue, assuming 100% return of withhold, will be included in the denominator of the loss ratio calculation other than any incentive payments earned.

Consistent with contract expectations, DHS expects reimbursement made for medical benefit services should be at market-based levels and should incent efficient and high-quality care. As such, DHS reserves the right to review encounters and other information associated with such payments and adjust the risk corridor calculation as necessary to reflect those expectations.

WITHHOLDS AND INCENTIVES

The total value of incentives outlined in this section will not exceed 5% of total capitation received by any MCO.

Pay for Performance Withhold and Incentive

Beginning in CY 2018, DHS implemented pay for performance (P4P) in the Family Care program. For CY 2023, DHS will withhold 0.5% of each MCO's gross capitation rate. MCOs will be allowed to earn back the withhold based on their performance on the following metrics:

1. Meeting the final submission of all required components of the collaborative strategic plan will result in the full amount of the 0.25% of capitation withhold returned. A 0.08% incentive for protocol development will be awarded if MCO submits documentation of completed tools and systems changes outlined in the strategic plan requirements. If the MCO meets the standard for the protocol development incentive, it is eligible to earn up to an additional 0.12% incentive for completing MCO staff training based on approved training plan outlined in the withhold. The MCO will receive 50% of the 0.12% for training 75% of its interdisciplinary (IDT) staff and 100% for training 90% of its IDT staff.

2. MCOs that maintain between 80% and 89% of their current competitive integrated employment rate will earn back 0.125% withheld from the capitation. MCOs that maintain between 90% and 100% of their current competitive integrated employment rate will earn back 0.25% withheld from the capitation. MCOs will earn an incentive of 0.05% of the capitation if they increase the number of members in competitive integrated employment by between 2.0% and 3.9% and an incentive of 0.1% if they increase the number of members by at least 4.0%.

Based on past performance and expectations under measure revisions, DHS and Milliman estimate that 0.35% of the 0.5% withhold (70% of the total P4P withhold) will be returned to MCOs under the pay for performance terms, assuming no material changes to the program are made. These capitation rates are certified as being actuarially sound assuming that 0.35% of the 0.5% withhold is returned.

Assisted Living Quality Incentive Payment

MCOs may receive incentive payments of no more than 0.1% of the total capitation received by the MCO for each member residing in assisted living facilities that meet one of two performance benchmarks. The amount of the incentive payment depends on which of the two performance benchmarks the facility meets:

1. Licensed for three years with no enforcement actions or substantiated complaints for three years.

2. Licensed for three years with no enforcement actions or substantiated complaints for three years, has a rate of less than three falls with injury per 1,000 occupied bed days, and is a member of the Wisconsin Coalition for Collaborative Excellence in Assisted Living.

Transition Incentive Payment

DHS may provide a one-time incentive payment to the MCO for each MCO member who is relocated from an institution into a community setting consistent with federal Money Follows the Person (MFP) guidelines, contingent on the availability of federal MFP funding.

ALTERNATIVE PAYMENT ARRANGEMENTS

The following describes alternative payment arrangements in the Family Care program. Additional documentation of these arrangements in provided in our response to the CMS Medicaid Managed Care Rate Development Guide in Appendix D.

We certify that the Family Care capitation rates, including these alternative payment arrangements, are actuarially sound.

Maximum Provider Fee Schedule

Per the contract between DHS and the participating MCOs, State Plan services provided under the Family Care benefit package are subject to a maximum fee schedule established by the state. The use of this maximum fee schedule promotes efficient, and cost effective care by controlling the growth in Medicaid expenditures. Most providers of State Plan services are subject to the maximum fee schedule, though MCOs have the ability to exceed the limit when necessary for executing a reimbursement contract. This arrangement does not include a separately distributed directed payment. DHS will submit a §438.6(c) pre-print proposal for an alternative payment arrange to implement the maximum fee schedule for CMS approval. The maximum fee schedule was built into rates in a manner consistent with the §438.6(c) payment arrangement.

The base data developed in Sections III and IV of this report was developed based on historical Family Care experience, which reflects the long-standing maximum fee schedule arrangement and approved exceptions. We expect no material change to the total value of exceptions made over the maximum fee schedule, which was $0 for 2021 base data. This base data was used to develop rates for all regions, including expansion regions. No further adjustment to provider reimbursement levels are made as part of rate development.

Direct Care Workforce

Wisconsin Statute §49.45(47m) directs DHS to make payments for CY 2023 services to Family Care MCOs to distribute to direct care workforce (DCW) providers. The 2021-2023 Wisconsin biennial budget includes additional funding for these providers and the estimated total for CY 2023 is $125 million of which $117.8 million is estimated to be allocated to Family Care. These payments will be made retrospectively after the conclusion of the rate year and are intended to be consistent with an §438.6(c) payment arrangement which has not yet been submitted. Providers of the following services are eligible for these payments:

- Providers of adult day care services
- Daily living skills training
- Habilitation services
- Residential care
- Respite care provided outside of a nursing home
- Supported employment
- Prevocational employment
- Vocational futures planning
- Supportive home care

Exhibit U includes a preliminary estimate of the allocation of total DCW funding for each MCO / GSR combination. Funding has been allocated between Family Care NH LOC, Family Care Non-NH LOC, and FCP programs and between MCO / GSR combinations within each program using actual CY 2021 MCO expenditures. We developed PMPM values from those funding allocations using projected CY 2023 MCO / GSR enrollment.

HCBS Provider Rate Increase – Effective June 2021

Effective June 1, 2021, DHS is requiring MCOs participating in Family Care to increase provider reimbursement rates for certain home and community-based services. This increase is 4.24% for eligible providers. An explicit adjustment was made as part of this certification to projected service costs, as outlined in Sections III (Step 5) and IV (Step 5). We certify that these capitation rates are actuarially sound and is intended to be consistent with a forthcoming §438.6(c) payment arrangement. This increase is in addition to the funding provided to providers through the DCW arrangement described previously.

ARPA Provider Rate Increase – Effective January 2022

Effective January 1, 2022, DHS is requiring MCOs participating in Family Care to increase provider reimbursement rates by 5.0% for certain home and community-based services. An explicit adjustment was made as part of this certification to projected service costs, as outlined in Sections III (Step 5) and IV (Step 5). We certify that these capitation rates are actuarially sound and is intended to be consistent with a forthcoming §438.6(c) payment arrangement. This increase is in addition to the funding provided to providers through the DCW arrangement described previously.

EXHIBITS A through U

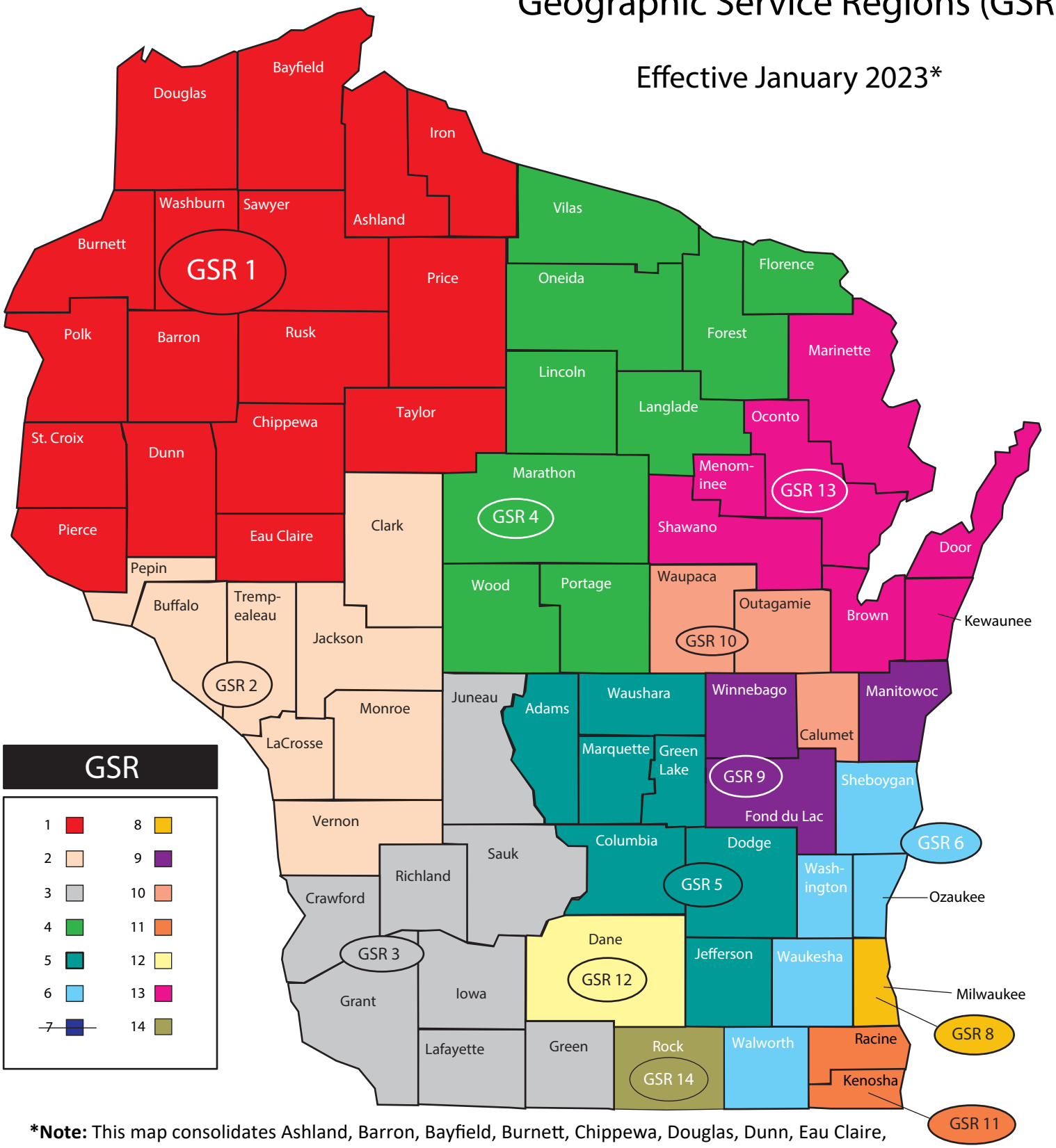
(Provided in Excel Format Only)

APPENDIX A

Geographical Service Region Map

Family Care and IRIS Geographic Service Regions (GSR)

Effective January 2023*



***Note:** This map consolidates Ashland, Barron, Bayfield, Burnett, Chippewa, Douglas, Dunn, Eau Claire, Iron, Pierce, Polk, Price, Rusk, St. Croix, Sawyer, Taylor, and Washburn counties (formerly GSRs 1 and 7) into new GSR 1.

APPENDIX B

Actuarial Certification of CY 2023 Wisconsin Family Care Capitation Rates

State of Wisconsin Department of Health Services
Calendar Year 2023 Capitation Rate Development Family Care Program

November 21, 2022

This report assumes that the reader is familiar with the State of Wisconsin's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2023 capitation rates for the Family Care program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

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

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November 21, 2022

Wisconsin Department of Health Services
Capitated Contracts Ratesetting
Actuarial Certification
CY 2023 Family Care Program Capitation Rates

I, Michael Cook, am associated with the firm of Milliman, Inc., am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion.

I was retained by the Wisconsin Department of Health Services (DHS) to perform an actuarial certification of the Family Care program capitation rates for calendar year (CY) 2023 for filing with the Centers for Medicare and Medicaid Services (CMS).

I reviewed the calculated capitation rates and am familiar with the following regulation and guidance:

- The requirements of 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7
- CMS "Appendix A, PAHP, PIHP, and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting dated November 10, 2014"
- 2022 to 2023 Medicaid Managed Care Rate Development Guide
- Actuarial Standard of Practice 49

The payment rates, methodology, data, and assumptions used to calculate the January 1, 2023 through December 31, 2023 rates are documented in this report to DHS, of which this certification is a part.

In making my opinion, I relied upon the accuracy of the underlying claims and eligibility data records and other information. The report referenced above includes a description of the data and information upon which I relied. I did not audit the data and calculations, but did review them for reasonableness and consistency and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary.

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

1. Have been developed in accordance with generally accepted actuarial principles and practices and Actuarial Standards of Practice.
2. Are appropriate for the populations to be covered and the services furnished.
3. Meet the relevant actuarial requirements of 42 CFR §438.4(b).

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

It should be emphasized, that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted managed care organization's situation and experience. These capitation rates may not be appropriate for all health plans. Any health plan considering participating in the Family Care program should consider their unique circumstances before deciding to contract under these rates.

This Opinion assumes the reader is familiar with the Wisconsin Medicaid program, Family Care programs, and actuarial rating techniques. The Opinion is intended for the State of Wisconsin and the 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.

Michael Cook
Member, American Academy of Actuaries
November 21, 2022

RELIANCE LETTER

Tony Evers
Governor

Karen E. Timberlake
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF MEDICAID SERVICES

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November 1, 2022

Michael Cook, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
17335 Golf Parkway, Suite 100
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RE: Data Reliance for Actuarial Certification of CY 2023 Family Care, Family Care Partnership, and PACE Capitation Rates

Dear Michael:

I, Grant Cummings, Director for the Bureau of Rate Setting, hereby affirm that the listings and summaries prepared and submitted to Milliman, Inc. for the development of the CY 2023 Family Care, and Family Care Partnership, and PACE capitation rates were prepared under my direction, and to the best of my knowledge and belief are accurate and complete. These listings and summaries include:

1. Health Plan encounter data files containing claims information on capitated plan assignment, detailed service category, target group, geographic indicators, and demographic indicators for calendar years (CYs) 2017 through 2021 for the Family Care, Family Care Partnership, and PACE programs.

2. Fee-for-service, Waitlist, and Waiver data files containing claims information on detailed service category, geographic indicators, and demographic indicators for CYs 2017 through 2021 for the Family Care program.

3. Long Term Care Functional Screen (LTCFS) data extracts through June 2022 for the Family Care, Family Care Partnership, and PACE programs, and data files containing a list of non-victim incidents by member.

4. Data files containing enrollment information on capitated plan assignment, program and target group, geographic indicators, and demographic indicators (including ventilator-dependent members, tribal members, and other distinguishing characteristics) for CY 2017 through 2021, and January 2022 through June 2022 for the Family Care, Family Care Partnership, and PACE programs.

5. Data file containing IMD claims for Family Care Partnership members.

6. Personal Care Assistance (PCA) fee schedules from CY 2021 through CY 2023, including definitions of covered PCA services.

7. Data file containing a list of screens impacted by changes to the target group automation algorithm.

8. Data files containing claims and enrollment information for the acute and primary portion of the Family Care Partnership and PACE programs.

9. Data files containing estimated monthly enrollment projections for CY 2023 in total and by health plan, geographic indicator, Medicare status, and target group for the Family Care, Family Care Partnership, and PACE programs.

10. Data dictionary files for the encounter, enrollment, and LTCFS files for the Family Care, Family Care Partnership, and PACE programs, including definitions of low and high activities of daily living, and instrumental activities of daily living, definitions of base and expansion cohorts, data files containing a mapping of functional screen fields to cost weight variables, and data files containing a mapping of services to broad categories of service.

11. Mapping file summarizing the consolidation and expansion of MCO/GSRs for CY 2023 relative to CY 2022.

12. CY 2017 through 2021 financials and CY 2019 through CY 2020 IBNR actual to expected analysis for health plans participating in the Family Care, Family Care Partnership, and PACE programs.

13. An administrative cost model for CY 2023 non-service costs to be applied to the Family Care, Family Care Partnership, and PACE programs as well as an estimate for expenses related to the Office of the Commissioner of Insurance's (OCI's) financial oversight function.

14. A data file containing lists of allowed and dis-allowed services under managed care and estimates of pharmacy rebates for the Family Care, Family Care Partnership, and PACE programs.

15. A summary of non-covered claims to be reclassified as covered.

16. Emerging experience adjustments to trend.

17. Information and direction regarding the MCO business plans for the Family Care, Family Care Partnership, and PACE programs.

18. Information and direction regarding the goals of the PACE rate development.

19. Information and direction regarding the Pay for Performance and incentive payment mechanisms for the Family Care and Family Care Partnership programs, including expectations around withhold return.

20. Results of analyses performed by DHS regarding the fiscal impact of legislative and policy changes for the Family Care, Family Care Partnership, and PACE programs.

21. Estimated impacts of legislated increases in FFS reimbursement rates for certain services as part of the 2021-2023 biannual state budget.

22. Information and direction regarding Directed Payments for the Family Care and Family Care Partnership programs, including Maximum Provider Fee Schedule, Direct Care Workforce, HCBS Provider Rate Increase, and American Plan Rescue Act (ARPA) Provider Rate Increase.

23. Any other items provided to Milliman to support the 2023 rate development not mentioned above for the Family Care, Family Care Partnership, and PACE programs.

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

Sincerely,

Grant Cummings
Director, Bureau of Rate Setting
Wisconsin Department of Health Services

APPENDIX C

CMS Rate Setting Checklist Issues

This report assumes that the reader is familiar with the State of Wisconsin's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2023 capitation rates for the Family Care program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Appendix C

Rate Setting Checklist

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

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

The calendar year (CY) 2023 managed care organization (MCO) capitation rates are developed using 2021 Wisconsin Medicaid long term care (LTC) MCO encounter data for the MCO eligible population, along with other information. DHS sets rates by MCO and Geographical Service Area (GSR).

Please refer to Sections II through V of this report for background on the program and more details around the rate development.

AA.1.1 – Actuarial Certification

The Actuarial Certification of the CY 2023 capitation rates is included as Appendix B of this report. The CY 2023 Wisconsin LTC Medicaid capitation rates have been developed in accordance with generally accepted actuarial principles and practices and are appropriate for the populations to be covered and the services to be furnished under the contract.

AA.1.2 – Projection of Expenditures

Exhibit O includes a projection of total expenditures and Federal-only expenditures based on actual Projected CY 2023 MCO enrollment and CY 2023 capitation rates. We used a 66.30% FMAP rate to calculate the Federal expenditures.

AA.1.3 – Risk Contracts

The Wisconsin Family Care program meets the criteria of a risk contract.

AA.1.4 – Modifications

The rates documented in this report are the initial capitation rates for the CY 2023 Wisconsin Medicaid LTC managed care contracts.

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

AA.1.6 – Limit on Payment to Other Providers

It is our understanding no payment is made to a provider other than the participating MCOs for services available under the contract.

AA.1.7 – Risk and Profit

The CY 2023 Family Care capitation rates include a targeted margin of 2.0% for risk, profit, and contribution to reserves. We believe that this margin is appropriate given low service cost trends and the predictability of expenses under the program.

AA.1.8 – Family Planning Enhanced Match

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

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

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

AA.1.10 – Newly Eligible Enhanced Match

The Wisconsin Family Care program does not cover the newly eligible Medicaid population. Therefore, none of the recipients are eligible for the enhanced Federal match under Section 1905(y).

Appendix C

Rate Setting Checklist

AA.1.11 – Retroactive Adjustments

The rates documented in this report are the initial capitation rates for the CY 2023 Wisconsin Medicaid LTC managed care contracts and do not contain any retroactive adjustments.

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

The CY 2023 rate methodology relies on CY 2021 MCO encounter data as the primary data source. Only State Plan and waiver services that are covered under the Wisconsin Family Care contract or are shown to be cost-effective "in-lieu-of services" have been included in the rate development.

Please refer to the Non-Covered Services portion of Sections III and IV of this report for more details.

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

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

AA.2.2 – Data Sources

The CY 2023 capitation rates are developed using Wisconsin Medicaid long term care (LTC) MCO encounter, eligibility, and functional screen data for CY 2021 for the MCO eligible population as the primary data source.

Please refer to Sections III and IV of this report for more details.

AA.3.0 – Adjustments to Base Year Data

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

AA.3.1 – Benefit Differences

The base data used to calculate the capitation rates has been adjusted to only include services covered under the Medicaid care management program contract.

AA.3.2 – Administrative Cost Allowance Calculations

The MCO capitation rates include explicit administrative allowances by MCO. Please see Step 6 in Section III and Step 6 in Section IV of the report for more details regarding the administrative cost calculation.

AA.3.3 – Special Populations' Adjustments

The CY 2023 capitation rates methodology does not include an adjustment for special populations as the base MCO encounter data used to calculate the capitation rates is consistent with the Wisconsin Family Care program population.

AA.3.4 – Eligibility Adjustments

The base MCO encounter data only reflects experience for time periods where members were enrolled in a Family Care MCO.

AA.3.5 – Third Party Liability (TPL)

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

AA.3.6 – Indian Health Care Provider Payments

The MCOs are not financially at risk for services provided to tribal members receiving care management from IHC providers. This includes fewer than 200 members located in GSRs 4,10, and 13.

Appendix C

Rate Setting Checklist

AA.3.7 – DSH Payments

DSH payments are not included in the capitation rates.

AA.3.8 – FQHC and RHC Reimbursement

The MCOs are responsible for the entirety of the FQHC and RHC payments, which are fully reflected in encounters.

AA.3.9 – Graduate Medical Education (GME)

Inpatient hospital services are not covered under Family Care. Therefore, GME payments are not included in the base data used in the capitation rate calculation.

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

The Wisconsin Family Care program does not include member cost sharing, so no adjustment to base period experience for this issue is required.

AA.3.11 – Medical Cost / Trend Inflation

Trend rates from CY 2021 to CY 2023 were developed by rate category and type of service for Family Care eligible services and individuals using historical MCO encounter data from January 2017 to December 2019 and actuarial judgment.

The trend rates and inflation factors represent the expected change in per capita cost between CY 2021 and CY 2023, net of acuity changes.

Please see Sections III and IV and Exhibit R for more details on the trend development.

AA.3.12 – Utilization Adjustments

Utilization trend is included in AA.3.11.

AA.3.13 – Utilization and Cost Assumptions

The CY 2023 capitation rates use an actuarially sound risk adjustment model to adjust the rates for each participating MCO in a particular GSR in order to reflect the acuity of enrolled members. Acuity adjustments were applied independently from the unit cost and utilization trend adjustments.

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

Capitation rates are developed gross of patient liability, and DHS adjusts capitation paid for each member to reflect that individual's specific patient liability. Encounter payment amounts are gross of patient liability, so no adjustment to the data is necessary for this issue.

AA.3.15 – Incomplete Data Adjustment

The capitation rates include an adjustment to reflect IBNR claims. Please refer to Section III of this report for more information on the development of the IBNR assumptions.

We apply an adjustment to true up care management expenditures to financial statements due to the difficulty in properly and completely collecting this information in the encounter data reporting format. Please refer to Sections III and IV of this report for more information on the development of these adjustment factors.

AA.3.16 – Primary Care Rate Enhancement

The CY 2023 capitation rates only include Long-Term Care services.

Appendix C

Rate Setting Checklist

AA.3.17 – Health Homes

Not Applicable.

AA.4.0 – Establish Rate Category Groupings

Please refer to Sections III and IV of this report.

AA.4.1 – Eligibility Categories

Target populations for individuals meeting the nursing home level of care requirement are defined in Step 1 of Sections III and IV .

AA.4.2 – Age

Age is not used for rate category groupings outside of the Target Population assignment.

AA.4.3 – Gender

Gender is not used for rate category groupings.

AA.4.4 – Locality / Region

Geographic regions are defined in Appendix A.

AA.4.5 – Risk Adjustments

Acuity adjustment models are described in Step 4 of Sections III and IV .

AA.5.0 – Data Smoothing

We did not perform any data smoothing.

AA.5.1 – Cost-Neutral Data Smoothing Adjustment

We did not perform any data smoothing.

AA.5.2 – Data Distortion Assessment

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

AA.5.3 – Data Smoothing Techniques

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

AA.5.4 – Risk Adjustments

The CY 2023 capitation rates use an actuarially sound risk adjustment model based on a functional screen (NH level of care) or ADL / IADL (Non NH level of care) to adjust the rates for each participating MCO. Please see Sections III and Section IV of this report. The functional screen risk adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.

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

Not applicable.

AA.6.1 – Commercial Reinsurance

DHS does not require entities to purchase commercial reinsurance.

AA.6.2 – Stop-Loss Program

Appendix C

Rate Setting Checklist

The CY 2023 capitation rates do not feature a stop-loss program.

AA.6.3 – Risk Corridor Program

The CY 2023 capitation rates will feature a risk corridor as described in Section V of this report.

AA.7.0 – Incentive Arrangements

Please see Section V.

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

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

APPENDIX D

CMS Medicaid Managed Care Rate Development Guide

Appendix D

Response to 2022 to 2023 Managed Care Rate Development Guide

I. MEDICAID MANAGED CARE RATES

1. General Information

A. Rate Development Standards

i. A single capitation rate, rather than a range of rates, is developed for each rate cell.

ii. The rate certification included herein is for the calendar year (CY) 2023 contract period. The previous certification was for CY 2022 contract period.

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

a. The rate certification is included in Appendix B.

b. The final and certified capitation rates for all rate cells and regions can be found in Exhibits G and N.

c. The descriptions of the Family Care program can be found in Section I and II of this report.

The following directed payment arrangements apply CY 2023. Additional documentation of these arrangements is included below in Section I.4.D of this rate setting guide.

- Maximum Provider Fee Schedule
- Direct Care Workforce
- Home and Community Based Services Provider Rate Increase (effective June 2021)
- American Rescue Plan Act Provider Rate Increase (effective January 2022)

iv. Differences in capitation rates for the covered population are based on valid rate development standards and are not based on the rate of Federal financial participation associated with the covered population. This was evaluated for the entire managed care program and includes all managed care contracts for all covered populations.

v. Each rate cell is developed independently to be actuarially sound and does not cross-subsidize payments for another rate cell.

vi. The effective dates of changes to the Medicaid program are consistent with the assumptions used to develop the capitation rates.

vii. The target rate development MLR for the CY 2023 rates is 94.9% for the NH LOC population and Non-NH LOC populations. As such, the capitation rates are developed such that MCOs can reasonably achieve a federal MLR of greater than 85%.

viii. A single capitation rate, rather than a range of rates, is developed for each rate cell.

ix. A single capitation rate, rather than a range of rates, is developed for each rate cell.

x. The rate certification submission does demonstrate that the capitation rates were developed using generally accepted actuarial practices and principles and are consistent with the regulatory requirements.

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

b. No adjustments to the rates are performed outside of the initial rate setting process beyond those outlined in Section V of the report.

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

xi. The capitation rates included in this submission are certified for all time periods in which they are effective. No rates for a previous time period are used for a future time period.

xii. The capitation rates were developed to account for the direct and indirect impacts of the COVID-19 public health emergency. Section I of this report contains detailed information about the COVID-19 considerations for the CY 2023 rate development.

xiii. This rate certification conforms to the procedure for rate certifications for rate and contract amendments. The CY 2023 rates documented in this report are the initial capitation rates for the CY 2023 Wisconsin Medicaid LTC managed care contracts.

B. Appropriate Documentation

i. The actuary is certifying CY 2023 capitation rates.

ii. We believe that the attached report properly documents all the elements included in the rate certification and provides CMS enough detail to determine that regulatory standards are met.

Please see Sections I, III and IV of this report for the following details:

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

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

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

iii. Service cost projection assumptions used in rate development do not differ by managed care organization. Capitation rates differ by MCO based on the MCO admin load and risk score.

iv. A single capitation rate, rather than a range of rates, is developed for each rate cell.

v. We detail within our responses in this guide the section of our report where each item described in the 2022 to 2023 Medicaid Managed Care Rate Development Guide can be found.

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

vii. All services and populations included in this rate certification are subject to the regular state Federal Medical Assistance Percentage (FMAP).

viii. Relative to the previous rating period, please see Section I of this report for the following details:

a. A comparison of the final certified rates in the prior certification.

b. A description of material changes to the capitation rate development process.

c. The capitation rates in the previous rating period were not adjusted by a *de minimis* amount.

ix. Section V of the report documents the only known future amendments to these rates for final direct care workforce payments.

x. Section 1 includes documentation of the COVID-19 considerations in the CY 2023 rate development.

Appendix D

Response to 2022 to 2023 Managed Care Rate Development Guide

2. Data

A. Rate Development Standards

i. The rate development process follows CMS rate development standards related to base data.

a. DHS provided Milliman with validated encounter data and financial reports for at least the three most recent and complete years prior to the rating period. Managed care plans and DHS have provided detailed financial reporting data for CY 2019, CY 2020, and CY 2021 to the state's actuaries for this and prior year rate development.

b. Sections III and IV include documentation of the CY 2021 base data period used to develop the CY 2023 Family Care capitation rates.

c. Base data is specific to the population and services expected to be covered by the Family Care program during the CY 2023 rate period.

d. The CY 2023 rate calculation uses CY 2021 base data, which is within the CMS three-year requirement.

B. Appropriate Documentation

i. Milliman did request and receive a full claims and enrollment database from DHS. This information is summarized in Exhibits A and H. DHS provided detailed financial reporting data for CY 2021 and encounter data for CY 2018 through CY 2021 to the state's actuaries for this year's rate development.

ii. A detailed description of the data used in the rate development methodology can be found in Section III and Section IV of this report. Section III and Section IV also includes comments on the availability and quality of the data used for rate development.

a. The CY 2023 capitation rates for the Family Care program are developed using CY 2021 encounter data, financial data, and other information.

b. DHS and Milliman went through an extensive data validation process to review all capitated plan data included in the CY 2023 rate setting methodology. DHS internally reviews encounter data submissions and notifies plans of corrections necessary to allow for records to be accepted. Milliman reviewed the encounter and financial data.

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

c. All base data is specific to the populations that will be covered under the CY 2023 Family Care capitation rates.

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

iii. The rate certification and attached report thoroughly describe any material adjustments, and the basis for the adjustments, that are made to the data. Please see Section III and IV of this report for more details.

3. Projected Benefit Costs

A. Rate Development Standards

i. The final capitation rates shown in Exhibits G and N are based only upon services described in 42 CFR 438.3(c)(1)(ii) and 438.3(e).

ii. Each projected benefit cost trend assumption is reasonable and developed in accordance with generally accepted actuarial principles and practices using actual experience of the Medicaid population. Please refer to Sections III and IV of this report for the details.

iii. Please refer to Sections III and IV of this report for the details related to the treatment of in-lieu of services.

iv. The CY 2023 capitation rate methodology does not include any expenses for Institution for Mental Diseases (IMD).

B. Appropriate Documentation

i. The various exhibits included in this report document the final projected benefit costs by relevant level of detail and is consistent with how the State makes payments to the plans.

ii. Please refer to Sections III and IV of this report for the methodology and assumptions used to project contract period benefit costs from the base period data to CY 2023. Section I of the report highlights key methodological changes since the previous rate development.

iii. The rate certification includes a section on projected benefit cost trends in compliance with 42 CFR §438.7(b)(2). See Step 5 of Section III and Step 5 of Section IV for details related to the development of projected benefit cost trends.

iv. This certification does not include additional services deemed by the state to be necessary to comply with the parity standards of the Mental Health Parity and Addiction Equity Act.

v. Please refer to Sections III and IV of this report for the details related to the treatment of in-lieu of services.

vi. Since the rate development base data reflects actual program experience, no adjustment for retrospective eligibility periods is necessary.

vii. Section I documents the impact on projected costs for all material changes to covered benefits or services since the last rate certification. Impacts for all such changes are included in Sections III and IV.

viii. Sections III and IV of the rate certification includes an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment for each change related to covered benefits or services for CY 2023.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

The pay for performance, the member relocation incentive payment, and the assisted living quality incentive payment are described in Section V of the report. These incentives will not exceed 5% of the certified rates, and we made no adjustment for the incentive payments in rate development. The rate certification includes a description of the incentive arrangement. See Section V of the report.

B. Withhold Arrangements

The pay for performance withhold is described in Section V of the report. The rate certification includes a description of the withhold arrangement. See Section V of the report.

C. Risk Sharing Mechanism

The functional screen risk adjustment has been developed in accordance with generally accepted actuarial principles and practices and is cost neutral to the state in total.

The CY 2023 capitation rates will feature a risk corridor as described in Section V of this report.

The rate certification includes a description of the risk sharing mechanisms. See Section III of the report for the functional screen risk adjustment and Section V for the risk corridor mechanism.

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D. State Directed Payments

Information for each of the state directed payments is outlined in the tables below. Please see Section V of the rate report for additional documentation of these arrangements.

Control name of the state directed payment	Type of payment (see (i)(A) below)	Brief description (see (i)(B) below)	Is the payment included as a rate adjustment or separate payment term? (see (ii) and (iii) below)
Over MA FFS: WI_Fee_HCBS6_New_20220101-20221231	Maximum fee schedule	State Plan services provided under the Family Care benefit package are subject to a maximum fee schedule established by the state.	Rate adjustment (base data reflects the long-standing maximum fee schedule arrangement).
DCW: WI_Fee_HCBS5_New_20220101-20221231	Uniform increase for network providers that provide particular services under the contract	DHS will distribute an amount to the MCOs proportional to the total encounter-reported expenditures for eligible providers. This payment will then be passed through to eligible providers.	Separate payment term; Interim estimate included in this certification.
HCBS Increase: WI_Fee_HCBS4_New_20220101-20221231	Uniform increase for network providers that provide particular services under the contract	Effective June 1, 2021, DHS is requiring MCOs participating in Family Care to increase provider reimbursement rates for certain home and community-based services. This increase is 4.24% for eligible providers.	Rate adjustment (Part of the base data reflects the existing uniform increase for the network provider arrangement).
ARPA Increase: WI_Fee_HCBS3_New_20220101-20221231	Uniform increase for network providers that provide particular services under the contract	Effective January 1, 2022, DHS is requiring MCOs participating in Family Care to increase provider reimbursement rates for certain home and community-based services. This increase is 5.0% for eligible providers.	Rate adjustment

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Additional information for state directed payments included as rate adjustments is outlined in the table below

Control name of the state directed payment	Rate cells affected (see (A) below)	Impact (see (B) below)	Description of the adjustment (see (C) below)	Confirmation the rates are consistent with the preprint (see (D) below)	For maximum fee schedules, provide the information requested in (E) below
Over MA FFS: WI_Fee_HCBS 6_New_202201 01-20221231	All rate cells	Reflected in Base Data summarized in Exhibits A and H	The maximum fee schedule is a long-standing arrangement which was in effect during the base data period. Please refer to Section V of the rate certification for additional information.	The fee schedule is consistent with the preprint.	MCOs have the ability to exceed the limit when necessary for executing a reimbursement contract. We expect no material change to the value of exceptions made over the maximum fee schedule relative to the base data, so no adjustments were made.
HCBS Increase: WI_Fee_HCBS 4_New_202201 01-20221231	All rate cells	Exhibit E	Implemented as a base data adjustment, specific to each combination of target group and GSR. Please refer to Section IV of the rate certification for additional information.	This rate increase is consistent with the preprint.	Not Applicable
ARPA Increase: WI_Fee_HCBS 3_New_202201 01-20221231	All rate cells	Exhibit E	Implemented as a base data adjustment, specific to each combination of target group and GSR. Please refer to Section IV of the rate certification for additional information.	This rate increase is consistent with the preprint.	Not Applicable

The table below documents additional information for the state directed payments incorporated into the initial rate certification as a separate payment term.

Control name of the state directed payment 26	Aggregate amount included in the certification (see (A) below)	Statement that the actuary is certifying the separate payment term (see (B) below)	The magnitude on a PMPM basis (see (C) below)	Confirmation the rate development is consistent with the preprint (see (D) below)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable; see (E) below)
DCW: WI_Fee_HCBS5_New_20220101-20221231	The aggregate amount of the payment applicable to the rate certification is $125 million, of which $117.8 million is estimated to be allocated to Family Care.	Confirmed.	Implemented as a PMPM Add-On. The values specific to each rate cell are an estimate at this time. Capitation rates will be updated to reflect realized payments. Please refer to Section V of the rate certification for additional information.	This rate development is consistent with the preprint.	After the rating period is complete, the state will submit documentation to CMS that incorporates the total amount of the state directed payment specific to each rate cell into the rate certification's rate cell-specific capitation rate consistent with the distribution methodology.

E. Pass-Through Payments

The CY 2023 capitation rate methodology does not include any pass-through payments.

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. The development of the non-benefit component of the CY 2023 rates is compliant with 42 CFR §438.5(e) and includes reasonable, appropriate, and attainable expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital. Please see Sections III and IV.

ii. The non-benefit costs included in the CY 2023 capitation rates are developed as a per member per month for common categories of administrative expenses. Please see Sections III and IV for additional detail on how the administrative component is calculated.

B. Appropriate Documentation

i. Please refer to Step 6 in Section III and IV of this report for a detailed description of the data and methodology used to develop of the projected non-benefit costs included in the capitation rates. The report includes a description of changes made since the last rate development.

ii. The projected non-benefit costs include appropriate consideration for administrative costs, taxes, licensing and regulatory fees, other assessments and fees, contribution to reserves, risk margin, and cost of capital.

iii. Historical costs serve as the basis for the projected administrative load as described in Sections II and IV of this report. The table below summarizes current and historical administrative costs by MCO.

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Wisconsin Department of Health Services Comparison of Projected CY 2023 and Actual CY 2021 Administrative PMPMs			
		Year Ending December 31, 2021	
MCO	CY 2023 Admin PMPM	Actual Admin PMPM	Difference
CCI	$119.03	$72.78	$46.25
LCI	$142.84	$106.01	$36.83
MCW	$119.03	$106.33	$12.70
Inclusa	$119.03	$134.83	-$15.80

6. Risk Adjustment and Acuity Adjustment

A. Rate Development Standards

i. The functional screen and risk adjustment detailed in Sections III and IV of the report are used for explaining costs of services covered under the contract for defined populations across MCOs.

ii. The functional screen risk adjustment has been developed in accordance with generally accepted actuarial principles and practices and cost neutral to the state for the base period base data cohort.

iii. Section III of this report documents the use of more recent functional screens and acuity trends separate from benefit utilization and unit cost trends to consider the change in acuity for the Family Care population.

B. Appropriate Documentation

i. The functional screen and risk adjustment process are detailed in Sections III and IV of the report.

ii. Section V of the report documents the various retrospective risk adjustment mechanisms.

iii. The rate certification and supporting documentation do specifically include a description of any changes that are made to risk adjustment models since the last rating period and documentation that the risk adjustment model is budget neutral in accordance with 42 CFR §438.5(g).

iv. The rate certification includes a description of the acuity trend adjustment. This adjustment is developed according with generally accepted actuarial principles and practices.

II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

1. Managed Long-Term Services and Supports

A. The Wisconsin Family Care program only covers Long-Term Care services. Therefore, the information included in this rate certification and report is specific to MLTSS.

B. Rate Development Standards

i. The Wisconsin Family Care program capitation rates blend costs for individuals in all settings of care.

C. Appropriate Documentation

i. Sections I-IV of this report address the following items:

a. The structure of the capitation rates and rate cells or rating categories.

b. The structure of the rates and the rate cells, and the data, assumptions, and methodology used to develop the rates in light of the overall rate setting approach.

c. Any other payment structures, incentives, or disincentives used to pay the MCOs.

d. The expected effect that managing LTSS has on the utilization and unit costs of services.

e. Any effect that the management of this care is expected to have within each care setting and any effect in managing the level of care that the beneficiary receives.

ii. Please refer to Step 6 in Section III and Step 6 in Section IV of this report for a detailed description of the data and methodology used to develop of the projected non-benefit costs included in the capitation rates. The report includes a description of changes made since the last rate development.

iii. The Wisconsin Family Care capitation rates presented in this report are based entirely on historical MCO encounter data and financial experience.

iv. Please refer to Sections III and IV for a description of the data sources used to develop the assumptions used for rate setting.

III. NEW ADULT GROUP CAPITATION RATES

This certification does not include rates for the new adult group under 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

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