17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com

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

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 Partnership 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 Partnership program.

❖ ❖ ❖ ❖ ❖

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

Sincerely,

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

MCC/zk

Attachments

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

MILLIMAN REPORT

State of Wisconsin

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

November 21, 2022

Michael Cook, FSA, MAAA
Principal and Consulting Actuary

Mathieu Doucet, FSA, MAAA
Senior Consulting Actuary

Briana Botros, FSA, MAAA
Consulting Actuary

17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

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EXHIBITS (Provided in Excel Format Only)

Capitation Rate Development – Acute and Primary Services

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A2: CY 2021 MCO Encounter Data – Medicaid Only
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B1: CY 2021 MCO Encounter Data with Age / Gender Groupings
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C: Projected CY 2023 Enrollment by MCO / GSR and Age / Gender Category

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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 Partnership program. The Wisconsin Department of Health Services (DHS) retained Milliman to calculate, document, and certify its capitation rate development. The capitation rates developed in this report reflect only the Medicaid liability and exclude Medicare liability for Dual Eligible members. We developed the capitation rates using the methodology described in this report.

Our role is to certify that the CY 2023 Family Care Partnership 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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- ASOP No. 56 – Modeling
- Other applicable standards of practice

CY 2023 CAPITATION RATES

The statewide average gross capitation rate for CY 2023 is $4,721.35 for the Family Care Partnership population. Table 1 shows the statewide gross capitation rate change from the CY 2022 rate certification dated December 15, 2021 to the CY 2023 capitation rates.

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

CY 2022 Rates	$4,529.12
CY 2023 Rates	$4,721.35
% Change	4.2%

The 4.2% increase in gross capitation rates from CY 2022 to CY 2023 can be broken down as follows:

- -5.6% decrease due to the actual CY 2021 base cohort LTC service 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.

- 0.5% increase due to the difference in projected enrollment by target group from CY 2022 to CY 2023. Specifically, projected enrollment for the higher-cost DD target group increased by approximately 4%, while projected enrollment for the lower-cost FE target group decreased by approximately 6%.

- 2.6% increase due to increased Family Care Partnership acuity relative to the Family Care program as of CY 2021.

- -1.0% decrease due to the update of geographic factors from CY 2022 to CY 2023, with the most significant decrease in GSR 8.

- 1.7% increase due to differences in the CY 2019 to CY 2022 LTC trends estimated in CY 2022 rate setting compared to those used in CY 2023 rate setting.

- 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.
- 0.2% 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.
- 1.3% increase due to application of nursing home reimbursement and personal care to project CY 2022 to CY 2023.
- 2.8% increase due to the application of LTC service cost trends to project CY 2022 costs to CY 2023.
- 1.1% increase due to the application of LTC acuity trend to project CY 2022 acuity to CY 2023.
- -0.4% decrease due to the update of A&P base period data from CY 2019 to CY 2021.
- 0.5% increase due to the increase in the projection of Medicaid-only enrollment from CY 2022 to CY 2023; the proportion of Medicaid-only enrollees is projected to increase from 26.4% in 2022 to 27.9% in 2023.
- 0.7% increase due to the application of CY 2022 to CY 2023 A&P trends.
- Negligible change due to the differences in the administrative loads as a percent of the capitation rates from CY 2022 to CY 2023.

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.

The change in gross capitation rates for the DD, PD, and FE target groups is -1.8%, +4.1%, and +9.1%, respectively. The rate change by target group differs from the composite change due to differing base period data changes and target group-specific service cost and acuity trend values, and the varying impact of provider rate increases.

Projected CY 2023 expenditures split between federal and state liability are included in Exhibit J.

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 five 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 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.

- Family Care Partnership LTC base data is developed using the Family Care NH LOC population and is then adjusted for differences between the two programs using an experience adjustment factor. We have not seen CY 2021 Family Care Partnership claims rebound from the pandemic as quickly as 2021 Family Care claims, and thus continue to use the experience adjustment based on CY 2019 claims, as discussed later in this report.

- Due to the more recent entrance into GSR 12 for Family Care relative to Family Care Partnership, the cost profile in GSR 12 remains higher in the Family Care program than in the Family Care Partnership program when compared to other GSRs. We thus use the Family Care Partnership GSR 12 experience to develop the Family Care Partnership GSR 12 factor while all other GSRs use geographic factors derived from Family Care data. Due to CY 2021 FCP data concerns (similar to the Family Care Partnership experience adjustment, noted above) we developed the Family Care Partnership GSR 12 geographic factor using data from CY 2018 and CY 2019 consistent with CY 2022 rate setting assumptions.

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 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 Sections III and IV of this report.

Administrative Load

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, MCWHP will begin operations in GSR 9 and 13. We make the following assumptions in developing the various acute care and LTC costs for these regions:

- Exhibits D1 to D3 develop the acute and primary service cost based on the statewide average of the existing service areas.

- Exhibits F1, F2, and F3 develop each target group risk score based on the statewide average for the existing service areas.

- Exhibit G shows adjusted and trended values for each target group and in total. For the new service areas, we assume the following for each adjustment:

  - Columns E1 through E3 are based on the target group specific average.
  - Column E4 through E5 is based on the Family Care adjustments for GSR 9 and 13.
  - Column E6 through E9 are based on the target group specific average.

- Exhibit H1 to H3 assumes the same administrative and margin load as statewide.

DATA RELIANCE AND IMPORTANT CAVEATS

Milliman prepared this report for the specific purpose of developing CY 2023 Family Care Partnership 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 Partnership. 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, diagnostic, 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 Partnership 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 Partnership 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 Partnership 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 Partnership is a full-risk, fully-integrated Medicaid-Medicare managed care delivery system for the full range of LTC and acute and primary care services, which strives to foster people's independence and quality of life. Participating MCOs have contracts with both the State of Wisconsin and with CMS, and receive monthly capitation payments from each entity for dually eligible beneficiaries.

Since 1999, Family Care Partnership has served people ages 18 and older with physical disabilities, people with intellectual / developmental disabilities, and frail elders, with the specific goals of:

- Improving quality of health care and service delivery, while containing costs
- Reducing fragmentation and inefficiency in the existing health care delivery system
- Increasing the ability of people to live in the community and participate in decisions regarding their own health care

Eligibility for Family Care Partnership 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. All members in this program meet the Nursing Home Level of Care criteria. Enrollment in Family Care Partnership is voluntary. The risk adjustment model mechanism helps to adjust rates for any differences in average member acuity over time.

In 2023 the state will be comprised of 13 distinct GSRs for rate setting and other purposes, which are grouped into seven distinct Geographic Service Regions (GSRs), consistent with the Family Care program definitions, for rate setting and other purposes.

III. ACUTE AND PRIMARY SERVICE COST METHODOLOGY OVERVIEW

This section of the report describes the acute and primary service cost portion of the CY 2023 Family Care Partnership capitation rate methodology.

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 Dual Eligible and Medicaid Only populations by target group.
2. Further summarize CY 2021 MCO encounter base experience data by age and gender groupings.
3. Apply IBNR assumptions and other adjustments to project CY 2023 services costs.
4. Blend the projected CY 2023 service costs into a MCO / GSR specific projected cost.

Each of the above steps is described in detail below.

STEP 1: EXTRACT AND SUMMARIZE REPRICED ENCOUNTER BASE EXPERIENCE DATA

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

Exhibits A1 and A2 show the summarized repriced CY 2021 MCO acute and primary base experience data by target group for the Dual Eligible and Medicaid only populations, respectively. Exhibit A3 shows repriced CY 2021 MCO encounter base experience data in composite.

Please see Appendix A for a map showing the counties included in each GSR.

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 encounter data includes both services for which Medicaid is the primary payer, as well as costs associated with Medicare cost sharing.

We reviewed and summarized the data and compared to plan financial reporting and previous rate reports for accuracy and completeness. We ultimately included a missing data adjustment as a result of this review as outlined later in this section.

Under the contract between DHS and the MCOs, the MCOs are not ultimately liable for acute and primary service costs, reimbursed up to the FFS fee schedule, for members meeting certain criteria associated with ventilator dependency. Therefore, we excluded all base period acute and primary costs for members identified using the same criteria.

Costs for most pharmacy services will be carved out of the Family Care Partnership program for CY 2023. The encounter data used to develop the acute and primary portion of the capitation rates excludes most pharmacy costs, including physician administered drugs, since these claims were reimbursed on a FFS basis in CY 2021 and will continue to be reimbursed on a FFS basis in CY 2023.

The base data used in capitation rate setting is net of historical recoveries of provider overpayments.

It is our understanding 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.

The CY 2023 rate methodology relies on CY 2021 MCO encounter data for all MCO / GSR combinations.

Target Group Assignment

The capitation rates rely on a member's classification into one of three target groups: Developmentally Disabled, Physically Disabled, and Frail Elderly. Each Family Care Partnership 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 new 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 base data shown in Exhibit A1 through A3 reflects this target group assignment.

STEP 2: SUMMARIZE CY 2021 MCO ENCOUNTER DATA BY AGE AND GENDER GROUPINGS

In this step we further summarize the base period experience data for both the Dual Eligible and Medicaid Only populations by age and gender category. The age / gender classification is used as a form of risk adjustment for both populations as described in Step 4 below. Because of the small number of Frail Elderly Medicaid Only beneficiaries, we do not project their service costs separately by age and gender.

Exhibit B1 shows the detailed summary of the base experience period data by age and gender groupings for each target group and Medicare eligibility status.

STEP 3: APPLY IBNR ASSUMPTIONS AND OTHER ADJUSTMENTS TO PROJECT CY 2023 SERVICE COSTS

In this step we apply an adjustment to the base period costs to account for outstanding service cost liability and to reflect differences between the base period encounter data and the projected CY 2023 Family Care Partnership program service costs. Each adjustment factor is explained in detail below.

Exhibit B1 shows each adjustment factor by category of service; Exhibit B2 shows the adjusted and trended values for each target group and age / gender breakout for each target group and Medicare eligibility status.

IBNR Adjustment

Due to the small enrollment base and amount of claim runout available to us, we developed a single completion factor of 1.0478. This IBNR factor was developed using all acute and primary data categories except for pharmacy, which we assume is complete given two months of runout. We apply this factor consistent with this development to all service categories excluding pharmacy.

We used Milliman's *Claim Reserve Estimation Workbook (CREW)* to calculate the completion factor used for the CY 2021 data. *CREW* calculates incurred but not reported (IBNR) reserve estimates using the lag completion method.

The lag method reflects the historical average lag between the time a claim is incurred and the time it is paid. In order 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.

Service Cost, Utilization, and Acuity Trend from CY 2021 to CY 2023

Trend rates were used to project the CY 2021 baseline cost data beyond the base cost period to the CY 2023 contract period, to reflect changes in provider payment levels, average service utilization and mix, and changes in member acuity. Separate trends were not developed for utilization, unit cost, and acuity. Milliman and DHS reviewed the following information to determine the annual trend rates:

- Historical encounter data experience
- Budgeted provider rate increases
- Known policy changes that may impact utilization patterns
- Industry experience for other comparable Medicaid programs

We reviewed experience trends for the Family Care Partnership program in recent years as the primary support for trend development. Due to the impact of COVID-19 on claim costs in CY 2020 and CY 2021, those years are included for informational purposes only. We used experience from CY 2017 through CY 2019 to determine A&P service cost trends. Given the large variances in experience trends, we did not feel comfortable using those trends at the category of service level. Instead, we used an overall trend rate of 6.0% applied to all services, consistent with historical experience for the Family Care Partnership programs.

Please see Exhibit K for a summary of historical A&P service cost trends from CY 2017 through CY 2019.

Treatment of IMD Costs

Effective July 5, 2016, federal regulation requires rate development to include special treatment for costs associated with stays in an Institution for Mental Diseases (IMD) for individuals between ages 21 and 64. We identified one IMD stay of over 15 days during CY 2021 for individuals in this age range. All experience for this member during this month was excluded from the base data as part of Step 1.

Eight IMD stays of 15 days and under were observed for Medicaid Only individuals in this age range during 2021, totaling approximately $28,000. CMS requires IMD utilization for these stays to be based on the unit costs for State plan services. To be consistent with this requirement, we applied a unit cost adjustment factor of 0.69 to encounter base period IMD claims based on a comparison of the historical average cost per day for inpatient psychiatric stays and IMD stays for the comparable Medicaid Only population served under the SSI Medicaid managed care program.

State Budget Provider Rate Increases SFY 2021-2023

Per the 2021 to 2023 state fiscal budget, DHS elected to increase funding for Dental services. Effective January 1, 2022, DHS is implementing a FFS rate increase to reimbursement rates for dental providers that meet quality of care standards, as established by the Department, and one of the following qualifications:

- For a non-profit or public provider, fifty percent or more of the individuals served by the provider lack dental insurance or are enrolled in Medical Assistance
- For a for-profit provider, five percent or more of the individuals served by the provider are enrolled in Medical Assistance

Overall, dental service costs for the Family Care Partnership population are expected to increase by 44.9% for dental services.

Missing Data Adjustment

We developed a missing data adjustment in aggregate across all MCOs for CY 2021 based on a comparison of the total paid amounts in the encounter data and the total MCO liability in the financial data, excluding pharmacy and including IBNR estimates. This missing data adjustment was based on only experience for acute and primary claims. We combined FFS and sub-capitated claim payments together to develop the missing data adjustments, since the encounter data does not consistently and completely identify FFS versus sub-capitated claims separately. Therefore, the missing data adjustment reflects the impact of missing encounters (including sub-capitated claims), as well as encounters that were submitted, but not accepted by the DHS system edits. The only sub-capitated arrangement is for dental services for one MCO, so the value of subcapitated claims is very small as a percentage of total costs. DHS has carefully reviewed the discrepancies between encounter and financial data and believes the costs missing from the encounter data represent valid costs for rate development. We have no concerns with the results of the DHS review.

We apply the full value of the missing data impact through an adjustment factor of 1.0430 to non-pharmacy service categories in Exhibit B1.

STEP 4: BLEND PROJECTED SERVICE COSTS BY TARGET GROUP

In this step we blend the projected CY 2023 service costs for each target group, Medicare eligibility status, and age / gender grouping based on the projected CY 2023 target group membership. Exhibit C shows the projected CY 2023 enrollment distribution while Exhibits D1 to D3 show the blended acute and primary service cost by MCO / GSR for the Dual Eligible, Medicaid Only, and total populations, respectively.

The age / gender and target group breakout is used as a form of risk adjustment for both the Dual Eligible and Medicaid Only population, since the costs can materially differ among these demographic groups.

IV. LONG-TERM CARE SERVICE COST METHODOLOGY OVERVIEW

This section of the report describes the CY 2023 Family Care Partnership capitation rate methodology for the Long-Term Care portion of the rate.

The methodology used to calculate the LTC portion of the capitation rates can be outlined in the following steps:

1. Apply an adjustment to the Family Care base costs to account for recent experience in the Family Care Partnership program relative to the Family Care program, after accounting for population differences.

2. Apply adjustments to account for the member acuity level of each MCO / GSR combination and target group using June 2022 screens and the functional status acuity model.

3. Apply adjustments to the risk adjusted costs to project CY 2023 services costs for each MCO / GSR combination and target group.

4. Blend the projected CY 2023 service costs by target group into a MCO specific projected cost.

Each of the above steps is described in detail below.

STEP 1: APPLY FAMILY CARE PARTNERSHIP EXPERIENCE ADJUSTMENT

In this step, we start with the CY 2021 Family Care Nursing Home Level of Care (NH LOC) experience data PMPM and apply an adjustment to reflect differences in program experience after accounting for differences in demographic mix, geography, and member acuity (which are accounted for elsewhere in rate development).

Base Data

The Family Care and Family Care Partnership 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). 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. The data has been restated to reflect the target group assignment changes discussed in Section III of this report.

Table 2 below shows the CY 2021 Family Care NH LOC experience data PMPM by target group.

Table 2
Wisconsin Department of Health Services
Family Care Base Experience Costs PMPM

Target Group	Cost PMPM
Developmentally Disabled	$3,799.90
Physically Disabled	$2,523.47
Frail Elderly	$2,767.35

Family Care Partnership Adjustment

We performed a comparison of CY 2019 Family Care Partnership experience to CY 2019 Family Care experience. We relied on CY 2019 to develop this factor as CY 2021 Family Care Partnership claims have not recovered from the pandemic as thoroughly as have Family Care claims and, therefore, reflect lower utilization levels than we would expect for CY 2023. We reweighted CY 2019 Family Care experience by target group and GSR to match the CY 2019 Family Care Partnership distribution. Family Care began operations in GSR 12 in February 2018 and 2019 costs for that region do not yet reflect a mature managed care program. As such, Family Care Experience for GSR 12 was excluded from this analysis.

We applied an acuity adjustment to the experience for each program (discussed in Step 2 below) to develop the projected cost Regression Results in Table 3 below. Based on the adjusted service costs and the Regression Results, we applied an adjustment factor of 1.0955 to the Family Care base experience as shown below:

Table 3
Wisconsin Department of Health Services
Family Care Partnership Experience Adjustment

(A)	Family Care Service Costs [1]	$2,959.98
(B)	Family Care Regression Result	$2,970.24
(C)	Family Care Partnership Service Costs	$3,081.78
(D)	Family Care Partnership Regression Result	$2,822.91
[(C) / (D)] / [(A) / (B)]	**FCP Experience Adjustment**	**1.0955**

[1]Experience reweighted to match the target group and geographic distribution underlying FCP, excluding GSR 12.

Implicitly included in this adjustment are additional benefits offered under the Family Care Partnership program, which is mainly comprised of nurse practitioner services. These additional benefits represented approximately 2.7% of service costs. In addition, this adjustment accounts for other differences, such as member selection, provider contracting, and care management not already accounted for by the acuity adjustment.

STEP 2: APPLY RISK ADJUSTMENT RELATIVITIES FOR EACH MCO / GSR AND TARGET GROUP

Milliman developed functional status models for each target group of NH LOC individuals enrolled in Family Care and Family Care Partnership. These functional status models are used to measure the CY 2021 LTC service cost for a population based on their LTCFS. The development of these models is described in the final CY 2023 Family Care rate report. These functional status models are shown in Exhibits E1 to E3 for the Developmentally Disabled, Physically Disabled, and Frail Elderly population, respectively.

The functional status regression models are calibrated to the CY 2021 Family Care experience for each target group for the base cohort population. For example, the CY 2021 Family Care experience for the developmentally disabled population adjusted for pooled claims and IBNR liability of $3,799.90 found in Exhibit B of the Family Care capitation rate report can be matched to the sum of the “Incremental Increase” column in Exhibit C1 of the same report. A similar comparison can be made for each target group.

We do not believe the Family Care Partnership program to be of sufficient size to support its own acuity model, since the individual risk factors used in the regression model are often specific to a very small subset of individuals. Given the significant similarity of covered populations, benefits, provider reimbursement, and geography between the Family Care and Family Care Partnership populations, we believe an acuity model based on the combined Family Care and Family Care Partnership population is the most appropriate to use for the Family Care Partnership population.

The “Proportion with Variable” statistics shown in Exhibit E 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 E 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 E1 is $3,799.90, which is equal to the DD completed base data cost on Exhibit G column (A).

We used information contained in the LTCFS for the Family Care Partnership population enrolled in June 2022 to develop MCO / GSR specific modeled LTC service costs and risk scores. Exhibits F1, F2, and F3 show the proportion of the June 2022 Family Care Partnership enrolled population with each variable for the three functional status models used in calculating the MCO / GSR specific risk score. 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.

The preliminary risk score is calculated as the ratio of the June 2022 risk score for a given MCO / GSR combination and the June 2022 risk score statewide, separately by target group. In order to account for differences in the average acuity level between Family Care and Family Care Partnership, we apply a Family Care Partnership acuity adjustment in Exhibits F1 through F3, calculated as the ratio of the CY 2021 regression result for Family Care Partnership and the CY 2021 regression result for Family Care.

The column labeled "MCO / GSR Specific Risk Adjusted Rate" in Exhibit G illustrates the acuity-adjusted service cost for each MCO / GSR combination using the base period regression model (reflecting the CY 2021 utilization and unit cost structure for Family Care and applying the Family Care Partnership experience and acuity adjustments) and the June 2022 Family Care Partnership population functional screens.

The functional screen risk adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.

STEP 3: APPLY ADJUSTMENTS TO RISK ADJUSTED COST TO PROJECT CY 2023 SERVICES COSTS

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

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

Service Cost Trend from CY 2021 to CY 2023

Service cost trend rates were used 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 different ways using data consistent with the Family Care MCO / GSR combinations included in base data development. 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.

The trend analysis excludes Family Care Partnership encounter data because of the small size and incompleteness of the encounter data. Given the significant similarity of covered populations, benefits, provider reimbursement, and geography between the Family Care and Family Care Partnership populations, we believe the Family Care trend rates are the most appropriate to use for the Family Care Partnership population.

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 L1 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 L1 are thus not used directly in setting the acuity trends from CY 2021 to CY 2023.

Table 4 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 4
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 L2. The selected annual trends, shown in Table 5 below, will be used to acuity trend CY 2021 to CY 2023.

Table 5
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 results of this analysis are shown in Exhibit M. We used the Family Care geographic adjustments for Family Care Partnership because of the small size and variability in recent claim experience for Family Care Partnership, with the notable exception of GSR 12, described later in this section.

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 the treatment in rate development:

    a. Services covered outside of the capitation rate are excluded, such as supplemental net member room and board expenses.

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 has been made to the reported amounts to reflect our estimate of incurred but not reported (IBNR) claims.

d. Both the actual and projected amounts are net of pooled claims associated with the HCRP risk mitigation mechanism, which was in effect prior to CY 2023.

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.

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 (or 1/3 and 2/3 for GSR 12, which only has two years of data). 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 M shows this calculation for each GSR.

5. As part of capitation rate development, we scale the preliminary geographic factors to maintain budget neutrality relative to the Family Care MCO / GSR combinations used in base data development. This budget neutrality adjustment will be performed separately for each target group. Table 6 below shows the normalization factor applied to the preliminary geographic adjustment factors by target group.

Table 6
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

Note, while the geographic adjustments are designed to be budget-neutral for the base data cohort within the Family Care program, they are expected to vary from 1.0 for Family Care Partnership. This is appropriate because the geographic mix in Family Care Partnership differs from that in Family Care.

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 are referred to as "Super Regions" in Exhibit M.

As noted above, the geographic factor for GSR 12 has been developed separately using Family Care Partnership rather than Family Care experience; Family Care GSR 12 experience is less mature and reflects a materially different mix of enrollees relative to Family Care Partnership, and the Family Care Partnership program has enough exposure in GSR 12 that we feel comfortable using Family Care Partnership data to directly calculate a geographic adjustment. The GSR 12 geographic factor uses identical methodologies as described above, but we rely on CY 2018 and CY 2019 data since the CY 2021 claims haven't rebounded from the pandemic as quickly as Family Care. The resulting GSR 12 calculation has largely already been accounted for using the Family Care Partnership experience adjustment, and thus we back out the Family Care Partnership experience adjustment when calculating the final Family Care Partnership GSR 12 geographic factor. Note, that like the GSR 12 geographic factor, the Family Care Partnership experience adjustment also excludes CY 2021 data. This calculation is also shown in Exhibit M.

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 7 shows the calculation of this adjustment, which is included in Exhibit G.

Table 7
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 3	6.3%	12.4%	33.1%	1.0195	1.0387	1.1047
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

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 G.

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

Effective June 1, 2021, DHS is requiring MCOs participating in Family Care Partnership to increase provider reimbursement rates by 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 E7 of Exhibit G, applies this rate increase to only the applicable 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 is requiring MCOs participating in Family Care Partnership to increase provider reimbursement rates by 5.0% 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 Appendix N.

The adjustment, shown in Column E8 of Exhibit G, 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 Partnership NH LOC population are expected to increase the Family Care Partnership projected service costs of 0.18%, 0.31%, and 0.17% for the DD, PD, and FE target groups, respectively. This adjustment is shown in Column E9 of Exhibit G 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 4: BLEND PROJECTED SERVICE COSTS BY TARGET GROUP

In this step we blend the projected CY 2023 MCO / GSR service costs for each target group based on the composite projected CY 2023 target group membership. The blended costs are reflected in the bottom section of Exhibit G. However, these blended service costs are for illustrative purposes only, since the program information technology started paying separate capitation rates for each target group in 2021.

V. NON-SERVICE COST ALLOWANCE

This section of the report describes the development of the non-service cost allowance for the CY 2023 Family Care Partnership capitation rate. Non-service expense loads and resulting capitation rates are shown in Exhibits H1 through H3. Exhibits I1 through I3 restate the components of the MCO / GSR capitation rates net of withhold. However, the blended rates in Exhibits H and I are for illustrative purposes only, since the program information technology started paying separate capitation rates for each target group in 2021.

ADMINISTRATIVE COST ALLOWANCE

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% trend for CY 2021 to CY 2022 and the expectation of the return to the historical average in 2023 at 3% trend from CY 2022 to CY 2023.

This results in an overall CY 2023 administrative load of $220.68 PMPM for Family Care Partnership.

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 60% of the 0.5% P4P withhold is expected to be returned to MCOs as described in Section VI of this report.

VI. OTHER RATE CONSIDERATIONS

All calculations and 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 Partnership 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 82.2%, excluding care management, based on the following components:

- Average administrative allowance of 4.7%
- Average care management load of 11.1%, including the portion of the FCP experience adjustment attributed to additional care management costs covered under the Family Care Partnership program:
  - DD target group – 8.2%
  - PD target group – 12.9%
  - FE target group – 12.6%
- 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 8
Wisconsin Department of Health Services
Risk Corridor Program – Family Care Partnership

Variance from Target	Average Loss Ratio Claims Corridor	MCO Share of Gain / Loss in Corridor	DHS Share of Gain / Loss in Corridor
< -6.0%	< 76.2%	0%	100%
-6.0% to -2.0%	76.2% to 80.2%	50%	50%
-2.0% to +2.0%	80.2% to 84.2%	100%	0%
+2.0% to +6.0%	84.2% to 88.2%	50%	50%
> +6.0%	> 88.2%	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 Family Care Partnership MCO.

Pay for Performance Withhold and Incentive

Beginning in CY 2018, DHS implemented pay for performance (P4P) in the Family Care Partnership program. For CY 2023, DHS intends to 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 that 0.30% of the 0.5% withhold (approximately 60% of the total P4P withhold) of the total 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 0.30% 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 Family Care Partnership 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 Partnership 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 Partnership 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 Partnership 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 and Partnership experience adjustment developed in Sections III and IV of this report were developed based on historical Family Care and Partnership 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 Partnership MCOs to distribute to direct care workforce (DCW) providers. DHS will estimate the value of these payments for CY 2023 for the final certification. The 2021-2023 Wisconsin biennial budget includes additional funding for these providers and the estimated total for CY 2023 is $125 million of which $7.2 million is estimated to be allocated to Family Care Partnership. 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 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 O includes a preliminary estimate of the allocation of total DCW funding for each MCO / GSR combination. We will allocate the total funding between Family Care NH LOC, Family Care Non-NH LOC and the FCP program and between MCO / GSR combinations within each program using actual CY 2021 MCO expenditures and developed PMPM values 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 Partnership 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 3) and IV (Step 3). 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 Partnership to increase provider reimbursement rates by 5% 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 4) 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 D

Capitation Rate Development – Acute and Primary Services

(Provided in Excel Format Only)

EXHIBITS E through G

Capitation Rate Development – Long Term Care Services

(Provided in Excel Format Only)

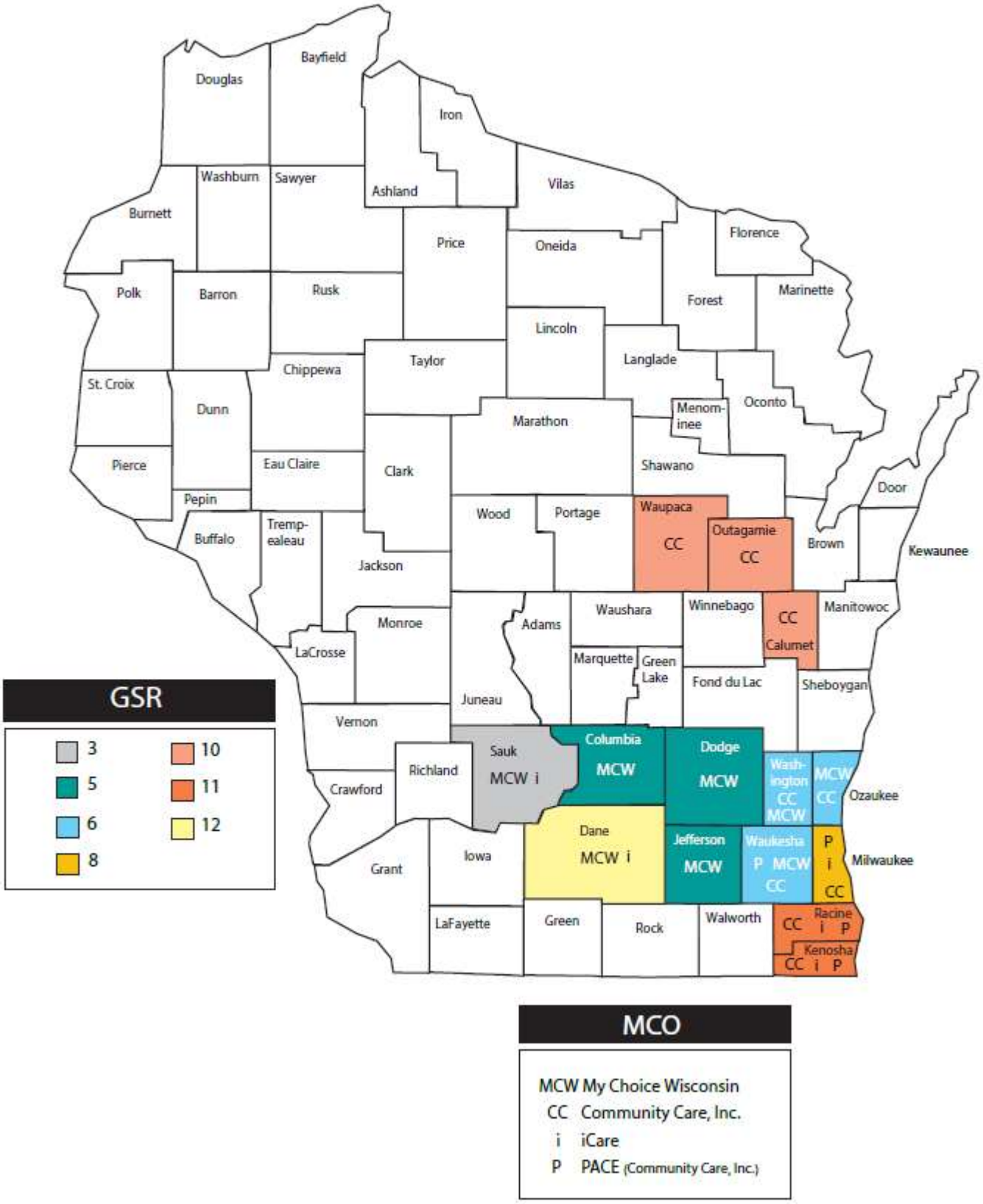
EXHIBITS H through O

Capitation Rate Development – Capitation Rates

(Provided in Excel Format Only)

APPENDIX A

Geographical Service Region Map


Douglas
Bayfield
Iron
Washburn
Sawyer
Ashland
Vilas
Florence
Burnett
Price
Oneida
Forest
Marinette
Polk
Barron
Rusk
Lincoln
Langlade
Taylor
Chippewa
St. Croix
Dunn
Marathon
Menom-inee
Oconto
Pierce
Eau Claire
Clark
Shawano
Door
Pepin
Wood
Portage
Waupaca
CC
Outagamie
CC
Brown
Kewaunee
Buffalo
Tremp-ealeau
Jackson
Waushara
Winnebago
CC
Calumet
Manitowoc
Monroe
Adams
LaCrosse
Marquette
Green Lake
Fond du Lac
Sheboygan
Juneau
Vernon
Columbia
MCW
Dodge
MCW
Sauk
MCW i
Wash-ington
CC
MCW
MCW
CC
Ozaukee
Richland
Crawford
Dane
MCW i
Jefferson
MCW
Waukesha
P MCW
CC
P
i
CC
Milwaukee
Grant
Iowa
LaFayette
Green
Rock
Walworth
CC
Racine
i P
Kenosha
CC i P
GSR
3
5
6
8
10
11
12
MCO
MCW My Choice Wisconsin
CC Community Care, Inc.
i iCare
P PACE (Community Care, Inc.)

APPENDIX B

Actuarial Certification of CY 2023 Wisconsin Family Care Partnership Capitation Rates

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 Partnership 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.

17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com

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

michael.cook@milliman.com

November 21, 2022

Wisconsin Department of Health Services
Capitated Contracts Ratesetting
Actuarial Certification
CY 2023 Family Care Partnership 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 Partnership 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. A copy of the reliance letter received from DHS is attached and constitutes part of this opinion. 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 Partnership 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 Partnership 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

Milliman

RELIANCE LETTER

Tony Evers
Governor

Karen E. Timberlake
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF MEDICAID SERVICES

1 WEST WILSON STREET
PO BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
Fax: 608-266-1096
TTY: 711

November 1, 2022

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

RE: Data Reliance for Actuarial Certification of 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 Partnership 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 to VI 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 care management 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 J includes a projection of total expenditures and Federal-only expenditures based on 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 Partnership program meet 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 Partnership 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 Partnership 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 CY 2023 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 for the Family Care and Family Care Partnership programs as the primary data sources. Only State Plan and waiver services that are covered under the Wisconsin Family Care Partnership contract have been included in the rate development.

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 and Family Care Partnership program and does not include experience for individuals not eligible to enroll in these programs.

AA.2.2 – Data Sources

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

Please refer to Section III to 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 Section III to 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 Section V 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 Partnership program population.

AA.3.4 – Eligibility Adjustments

The base MCO encounter data reflects experience for time periods where members were enrolled in a Family Care or Family Care Partnership MCO. Please see section IV of the report for more detail regarding eligibility adjustments.

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 responsible for the entirety of the IHC payments, which are fully reflected in encounters.

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)

GME payments are included as part of the hospital reimbursement formula. Therefore, the base data used in the capitation rate calculation includes GME payments. Separate FFS payments are not made to hospitals for members covered under managed care.

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

The Wisconsin Family Care Partnership 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 Partnership 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 Section III-IV and Exhibits K and L 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 and a missing data adjustment to acute and primary claims. Please refer to Section III and IV of this report for more information on the IBNR assumptions and the missing data adjustment factor.

AA.3.16 – Primary Care Rate Enhancement

Acute and primary care base data is comprised of claims paid after January 1, 2018, and would not reflect the impact of the primary care rate enhancement.

AA.3.17 – Health Homes

Not Applicable.

APPENDIX C

Rate Setting Checklist

AA.4.0 – Establish Rate Category Groupings

Please refer to Sections III to 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 Section III and Section 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 1 of Section 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 LTC component of the CY 2023 capitation rates uses an actuarially sound risk adjustment model based on a functional screen to adjust the rates for each participating MCO. Please see Section III and IV of this report. The 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

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

APPENDIX C

Rate Setting Checklist

AA.6.3 – Risk Corridor Program

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

AA.7.0 – Incentive Arrangements

Please see Section VI of the rate report.

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 the 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 Exhibit I.

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

The following directed payment arrangements apply to 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 93.3%. 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 Sections III and VI 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 and 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, IV, and V of this report for the following details:

- Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources
- Assumptions made, including any basis or justification for the assumption
- 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, LTC risk score, and demographic mix.

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.

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. The rate development methodology uses current MCO encounter data. Sections III and IV include documentation of the CY 2021 base data period used to develop the CY 2023 Family Care capitation rates.

c. The base data used is derived from the Medicaid population served under the Family Care and Family Care Partnership programs.

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. Acute and primary care data is summarized in Exhibit A. 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 Sections III to IV of this report. Sections III to IV also include comments on the availability and quality of the data used for rate development.

a. The CY 2023 capitation rates for the Family Care Partnership 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 Partnership 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 Exhibit I 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. There are no services provided in lieu of State Plan covered services.

iv. See Step 3 of Section III of this report for details related to the treatment of IMD costs.

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 to IV of this report for the methodology and assumptions used to project contract period benefit costs from the base period 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 3 and 4 of Section III and Step 3 and 4 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. There are no services provided in lieu of State Plan covered 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 VI 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 VI of the report.

B. Risk Sharing Mechanism

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

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

D. State Directed Payments

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

APPENDIX D

Response to 2022 to 2023 Managed Care Rate Development Guide

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 Partnership 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 Partnership 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 Partnership to increase provider reimbursement rates for certain home and community-based services. This increase is 5.0% for eligible providers.	Rate adjustment

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_HCBS6_New_20220101-20221231	All rate cells	Reflected in Base Data summarized in Exhibit A	The maximum fee schedule is a long-standing arrangement which was in effect during the base data period.	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

			Please refer to Section VI of the rate certification for additional information.		the maximum fee schedule relative to the base data, so no adjustments were made.
HCBS Increase: WI_Fee_HCBS4_New_20220101-20221231	All rate cells	Exhibit G	Implemented as a base data adjustment, specific to each combination of target group and GSR. Please refer to Section VI of the rate certification for additional information.	This rate increase is consistent with the preprint.	Not Applicable
ARPA Increase: WI_Fee_HCBS3_New_20220101-20221231	All rate cells	Exhibit G	Implemented as a base data adjustment, specific to each combination of target group and GSR. Please refer to Section VI 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 $7.2 million is estimated to be allocated to Family Care Partnership	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 VI 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, IV, and V.

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 Section V for additional detail on how the administrative component is calculated.

B. Appropriate Documentation

i. Please refer to Section V 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 projected administrative load as described in Section V of this report. The table below summarizes current and historical administrative costs by MCO.

FCP MCOs receive capitation funding from Medicare that includes funds for administrative expenses. We assume that 39% of reported FCP administrative expenses are attributable to Medicare based on the relativity of Medicare and Medicaid service costs for the FCP program.

Wisconsin Department of Health Services
Comparison of CY 2021 and CY 2023 Administrative PMPMs

HMO	CY2023 Medicaid Admin PMPM	Year Ending December 31, 2021 Financials PMPM	Difference
iCare	$220.68	$144.17	$76.50
MCWHP	$220.68	$200.70	$19.98
CCHP- FCP	$220.68	$208.72	$11.96

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 risk adjustment models have been developed in accordance with generally accepted actuarial principles and practices and cost neutral to the state in total.

iii. Section IV of this report documents the use of acuity trends separate from benefit utilization and unit cost trends to consider the change in acuity for the Family Care Partnership population.

B. Appropriate Documentation

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

ii. Section VI 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 information included in Section I is applicable to both the acute and primary care and long-term care component of the capitation rates.

B. Rate Development Standards.

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

C. Appropriate Documentation.

i. Sections I to 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 Section V of this report for a detailed description of the data and methodology used to develop 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 Partnership 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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milliman.com

CONTACT

Michael C. Cook
michael.cook@milliman.com

Mathieu Doucet
mathieu.doucet@milliman.com

Briana Botros
briana.botros@milliman.com