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November 26, 2025

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

Re: CY 2026 PACE 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 the CY 2026 amount that would otherwise have been paid (AWOP) for the Program of All Inclusive Care for the Elderly (PACE) and the CY 2026 capitation rate for the PACE 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/bl

Attachment

MILLIMAN REPORT

State of Wisconsin

Department of Health Services
Calendar Year 2026 Capitation Rate Development
PACE Program

November 26, 2025

Michael Cook, FSA, MAAA
Briana Botros, FSA, MAAA
James Johnson, FSA, MAAA

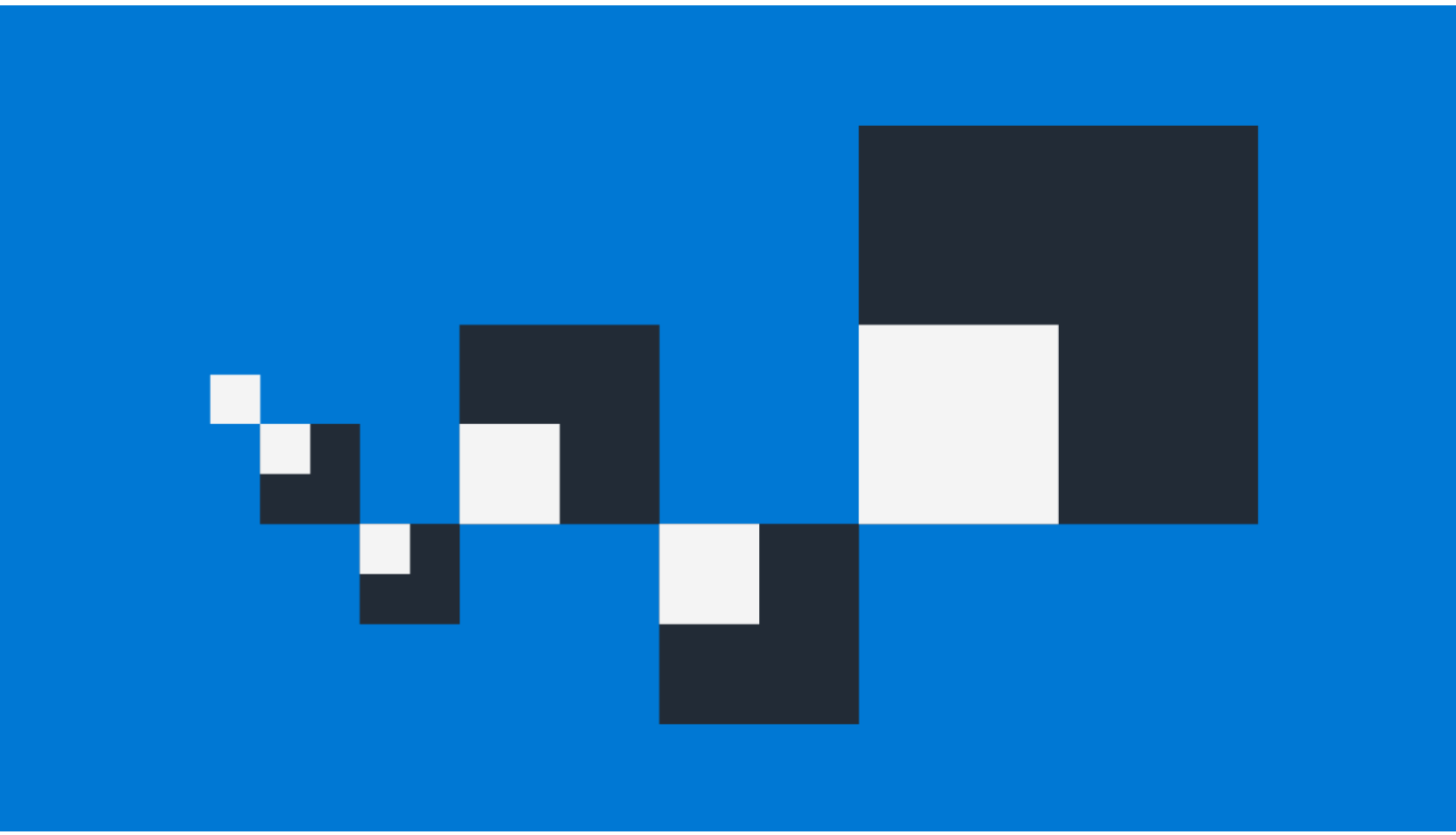

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Table of Contents

I. Executive Summary

The Wisconsin Department of Health Services (DHS) retained Milliman to calculate and document its capitation rate development for the Program of All-Inclusive Care for the Elderly (PACE) program. This report documents the development of the January 2026 to December 2026 (CY 2026) amount that would otherwise have been paid (AWOP) and CY 2026 capitation rates for the PACE program. We developed these amounts using the methodology described in this report.

Our role is to develop the CY 2026 PACE capitation rates and demonstrate that they are below the AWOP. While these rates are not required to be certified as actuarially sound, Milliman still closely followed the at-risk rate development actuarial opinion guidance outlined by CMS and the Academy of Actuaries 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
- ASOP No. 41 – Actuarial Communications
- ASOP No. 42 – Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims
- ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 49 – Medicaid Managed Care Capitation Rate Development and Certification
- ASOP No. 56 – Modeling
- Other applicable standards of practice

CY 2026 PACE RATE

The projected average CY 2026 capitation rate for the PACE program is $5,564.19 per member per month (PMPM). Table 1 shows the capitation rate change from CY 2025 rate certification dated November 26, 2024 to CY 2026.

TABLE 1
WISCONSIN DEPARTMENT OF HEALTH SERVICES
PACE
COMPARISON OF CY 2025 AND CY 2026 CAPITATION RATES

	PROJECTED MEMBER MONTHS	CAPITATION RATE
CY 2025 Rates	5,870	$5,183.41
CY 2026 Rates	5,920	$5,564.19
% Change		7.3%

Actual capitation rates by rate cell are included in Table 6 of this report.

The main drivers of this rate change are similar to those explained in Appendix B for the Family Care Partnership program. **Differences between the rate change for Family Care Partnership and PACE include:**

- 3.6% decrease due to the impact of projected CY 2026 acuity for the PACE population
- 0.8% decrease due to the relative impact of the geographic adjustment

NOTES ON REPORT STRUCTURE

This report provides a high-level overview of the "Amount that Would Otherwise have been Paid" (AWOP) development methodology. The Family Care Partnership enrollment comprises the population comparable to the PACE enrollment that is used to develop the service cost and non-service cost portions of the AWOP. PACE-eligible individuals also receive care through the Family Care program, the Include, Respect, I Self-Direct (IRIS) program, and fee-for service. Family Care Partnership is the only program which covers both acute care and long-term care services under a managed care arrangement and is reliable and credible enough on its own to serve as the basis for AWOP development. Please see the CY 2026 Family Care Partnership Rate report, which is included as Appendix B to this report, for full details of the service cost and non-benefit cost projection methodologies.

We adjust the Family Care Partnership acute care and long-term care service cost projections to reflect the demographics and risk scores of the population covered under PACE in Exhibits C through I of this report. Please note, for clarity, exhibits in this report match the naming convention of exhibits in the Family Care Partnership report. This results in some exhibits appearing to be excluded from this report.

This report then applies additional services cost adjustments to reflect differences in covered benefits and MCO financial responsibility between PACE and Partnership. Finally, the report applies non-service costs, equal to the Partnership values, to develop the final AWOP rates. Final capitation rates are confirmed to be below the AWOP rates.

DATA RELIANCE AND IMPORTANT CAVEATS

Milliman prepared this report for the specific purpose of developing CY 2026 PACE AWOP and 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 2026 PACE AWOP development and PACE capitation rate. 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 2022, CY 2023, CY 2024 and May 2025, and other information provided by DHS to develop the PACE capitation rate 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. See Appendix B for a full list of the data relied upon to develop the CY 2026 PACE AWOP development and PACE capitation.

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 PACE 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.

II. Background

PACE 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. PACE is a national model of care delivery for beneficiaries aged 55 and older. 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.

Eligibility for PACE 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 PACE is voluntary. The risk adjustment model mechanism helps to adjust rates for any differences in average member acuity over time.

PACE operates in Milwaukee County, Waukesha County, Racine County, and Kenosha County. MCOs contract with service providers to deliver all State Plan and waiver LTC services, as well as all acute care and primary care services.

The AWOP rate for the PACE program reflects costs that would have been incurred by PACE enrollees under the Family Care Partnership program (after adjustment for benefit differences) if PACE were not in existence. The Family Care Partnership population meets the criteria of a comparable, PACE-eligible population and is of sufficient size (as measured by enrollment) and quality (as measured by the accessibility and reasonability of data) to be used in isolation in developing the AWOP. The covered population and benefit set are very similar between the Family Care Partnership program and the PACE program. Therefore, in this report we adjust the Family Care Partnership costs to reflect the specific characteristics of the PACE program and enrolled population. We give consideration to the unique attributes of the PACE program and covered population for the following rate setting assumptions:

- Projected enrollment
- Population acuity, as measured by the PACE population’s functional status
- Projected target group distribution
- Projected Medicare eligibility distribution
- Projected age group distribution
- Service area
- Administrative allowance
- Coverage of pharmacy claims, which are not covered under the Family Care Partnership program
- Pharmacy rebate collection
- Coverage of acute and primary services for ventilator dependent members, which are carved out of the Family Care Partnership program
- Costs for certain substance abuse disorder (SUD) services, which are carved out of the Family Care Partnership program

III. Acute and Primary Service Cost AWOP Methodology Overview

This section of the report describes the acute and primary service cost portion of the initial CY 2026 PACE AWOP development.

The methodology used to project the Family Care Partnership MCO encounter data used in the calculation of the AWOP can be outlined in the following steps. Steps 1 to 3 develop the underlying cost projections for various cohorts of the Partnership population and are unchanged from the Partnership rate development, included as Appendix B to this report. Step 4 blends these cohort projections to match the PACE-specific population demographics.

1. Extract and summarize CY 2024 MCO encounter base experience data for the Dual Eligible and Medicaid Only populations by target group for the Family Care Partnership program only. We reviewed the data and validated both provider service and case management expenditures against financial statements for accuracy and completeness of the data provided through the new MMIS system. As a result, we have identified discrepancies between the encounter data reporting in the new system and the financial reporting which is larger than prior years and varies by MCO and category of service. Therefore, for CY 2024 FCP A&P base data we rely on the CY 2024 audited financials, adjusted to exclude Medicare liability based on separate reporting by each MCO. **PACE experience is not included in the base experience data.**

   We use the relative distribution of service costs by category of service, MCO / GSR combination, target group, and Dual status using the CY 2023 encounter data with 14 months of runout, which is summarized in Exhibits A1 through A3 in Appendix B. The data adjustments used to scale the CY 2023 data to the CY 2024 audited financials are applied in Exhibit B.

2. Further summarize CY 2024 Family Care Partnership MCO encounter base experience data by age and gender groupings.

   Exhibit B1 in Appendix B shows the detailed summary of the relative distribution of service costs for the base experience period data by age and gender groupings for each target group and Medicare eligibility status.

3. Apply adjustments to project CY 2026 services costs.

   Exhibit B1 in Appendix B shows each adjustment factor by category of service; Exhibit B2 in Appendix B shows the adjusted and trended values for each target group and age / gender breakout and for each target group and Medicare eligibility status. These trends were developed from a comparable PACE-eligible population. This also includes the financial data adjustments.

4. Blend the projected CY 2026 service costs into a PACE-specific projected cost based on the projected demographic distribution of CY 2026 PACE enrollees.

   Exhibit C of this report shows the projected CY 2026 enrollment distribution, while Exhibits D1 to D3 of this report shows the blended PACE acute and primary service cost for the Dual Eligible, Medicaid Only, and total populations split by target group, respectively. Capitation rates will be paid separately for each target group and for Dual Eligible and Medicaid Only members, so Composite rates in Exhibits D1 and D2, as well as total population rates in Exhibit D3, are for illustrative purposes only.

See Section III steps 1 through 4 in Appendix B to this report for details for each of these steps.

IV. Long-Term Care Service Cost AWOP Methodology Overview

This section of the report describes the LTC service cost portion of the initial CY 2026 PACE AWOP development.

The methodology used to calculate the LTC portion of the AWOP can be outlined in the following steps. Step 1 develops the underlying base period costs and acuity for various cohorts of the Partnership population and are unchanged from the Partnership rate development included as Appendix B to this report. Steps 2 through 4 blend these cohort costs to match the PACE-specific population geography and acuity and project the resulting costs to the contract period for each target group:

1. The LTC base data used for the AWOP development is comprised of LTC data for the Family Care Partnership program. **PACE experience is not included in the base experience data.**

   Adjustments were applied to account for the Q1-Q3 2024 MFS impacts to be consistent with the increase observed in Q4 2024. The adjustments were set as the weighted average of Super Regions 3 and 4 in order to account for the unique service area covered by the PACE program.

2. Apply adjustments to account for the member acuity level of the PACE population using May 2025 PACE screens and the functional status acuity model developed from Family Care and Family Care Partnership experience. Note, this acuity adjustment includes consideration for a wide variety of member needs that could drive utilization of nursing facilities and other services and is much more precise than simply adjusting for differences in nursing facility utilization between Partnership and PACE.

   The functional status models are shown in Exhibits G1 to G3 of Appendix B for the Developmentally Disabled, Physically Disabled, and Frail Elderly population, respectively. **PACE experience is not included in the development of these models.**

   Exhibits H1B, H2B, and H3B of this report show the proportion of the May 2025 PACE enrolled population with each variable for the three functional status models used in calculating the PACE specific risk score.

   Consistent with CY 2026 Family Care Partnership rate development, the PACE AWOP rate development limits the preliminary CY 2026 risk scores to a 3.5% increase or decrease from 2025 rates for each MCO and target group combination. This includes a one-time increase or decrease of 1.5% in previous years to account for the potential varying fiscal impact of the minimum fee schedule (MFS) by MCO. This phases in changes to individual MCO revenues associated with changes in member assessment protocols and other potential changes over time. The bottom lines of Exhibits H1B, H2B, and H3B apply a factor to risk scores calculated from May 2025 member screens on the MCO and target group basis to limit this risk score change between years and re-normalize the risk scores. The normalization factors used to develop these exhibits are the same as those used in Appendix B.

3. Apply adjustments to the risk adjusted costs to project CY 2026 services costs for each target group. Exhibit I of this report shows adjusted and trended values for each target group and in total. The trends were developed from a comparable PACE-eligible population and are equal to those used in Appendix B. The geographic adjustment and nursing home rate increases for PACE were set as the weighted average of Super Regions 3 and 4 in order to account for the unique service area covered by the PACE program. We weighted each Super Region based on the distribution of projected PACE enrollment by county as illustrated below. The geographic factors were normalized in Partnership rate development to reflect a 1.000 program-wide average.

   The PACE blend of super-regional factors is different than the Partnership blend as shown in Table 2. This single PACE geographic factor is then converted to target group-specific factors using the same adjustments as applied for Partnership rate development.

TABLE 2
WISCONSIN DEPARTMENT OF HEALTH SERVICES
DISTRIBUTION OF PROJECTED PACE ENROLLMENT

SUPER REGION	DISTRIBUTION OF PROJECTED CY 2026 PACE ENROLLMENT	PRELIMINARY GEOGRAPHIC FACTOR	
Super Region 3: GSR 6, 11	33.3%	1.025	
Super Region 4: GSR 8	66.7%	0.925	
PACE Total	**100.0%**	**0.958**	
	DD	**PD**	**FE**
PACE Normalized Geographic Factor	0.966	0.962	0.940

4. Blend the projected CY 2026 service costs by target group into a PACE-specific projected cost. The Composite costs are shown in the bottom section of Exhibit I and are for illustrative purposes only.

See Section IV steps 1 through 4 in Appendix B to this report for details for each of these steps.

V. Pace-Specific AWOP Adjustments

This section of the report describes adjustments made to the initial AWOP rates to address benefit coverage differences between the Family Care Partnership program and the PACE program. The exhibits in this report reflect the development of an initial AWOP prior to the following additional adjustments, which are implemented in Table 5 of this report:

- The PACE program retains financial liability for acute and primary costs for individuals with ventilator dependency, while the Family Care Partnership program does not. The acute and primary costs in Exhibit D of this report are calculated after removing members associated with ventilator dependency. Therefore, we increased the acute and primary service cost component of the acute and primary costs in Exhibit D by a factor of 1.0030 for the Dual Eligible population and 1.0085 for the Medicaid Only population to reflect the increased PACE liability. We developed this percentage as the ratio of the ventilator dependent acute and primary service costs underlying the Family Care Partnership base period data to the base period acute and primary costs shown in Exhibit A of Appendix B.
- Costs for most pharmacy services are carved out of Family Care Partnership; these carved-out claims were then paid on an FFS basis. The acute and primary costs in Exhibit D of this report, thus, omit most pharmacy services that will remain the liability of the PACE plan.

  To estimate pharmacy expenditures for the PACE program, we relied on CY 2024 FFS pharmacy expenditures for Family Care Partnership enrollees, limited to the 55 and older population, net of rebate amounts typically collected for Medicaid-only members. DHS provided us rebate percentages of 0% for Dual Eligibles and 60% for Medicaid Only Eligibles, which we believe to be reasonable.

  We reviewed historical pharmacy experience, gross of rebates, for CY 2022, CY 2023 and CY 2024 in order to develop our pharmacy trend as seen in Table 3A. We trended the CY 2024 base pharmacy claims to CY 2026 using a 6.00% annual trend. This annual trend assumption is also comparable to pharmacy trends realized in other Medicaid managed care programs in recent years. We observed a negative pharmacy trend from CY 2023 to CY 2024 that we do not expect to continue through future years.

TABLE 3A
WISCONSIN DEPARTMENT OF HEALTH SERVICES
AWOP PHARMACY TRENDS

	CY 2022 FFS FCP	CY 2023 FFS FCP	CY 2024 FFS FCP	ANNUAL CY 2023 / CY 2022	ANNUAL CY 2024 / CY 2023
Dual Eligible	$4.54	$6.38	$8.17	40.5%	28.0%
Medicaid Only	$1,096.64	$1,158.32	$1,115.88	5.6%	-3.7%
Total Population	$82.03	$88.11	$86.76	7.4%	-1.5%

This projection process resulted in an addition of pharmacy expenditures of $44.11 PMPM related to services covered under PACE, but not under Family Care Partnership.

TABLE 3B
WISCONSIN DEPARTMENT OF HEALTH SERVICES
AWOP PHARMACY ADJUSTMENT

	CY 2026 PROJECTED EXPOSURE MONTHS – PACE	CY 2024 PHARMACY PMPM	REBATE PERCENTAGE	CY 2024 PHARMACY NET OF REBATES	TREND ADJUSTMENT	CY 2026 PHARMACY PROJECTION PMPM
Dual Eligible	5,500	$8.17	0%	$8.17	1.1236	$9.18
Medicaid Only	420	$1,115.88	60%	$446.35	1.1236	$501.52
Blended Experience	**5,920**	**$86.76**	**54.75%**	**$39.26**	**1.1236**	**$44.11**

- Costs for certain substance abuse disorder (SUD) services are carved out of Family Care Partnership and are paid outside of the Medicaid managed care capitation rate on an FFS basis, but should be included in AWOP development. The acute and primary costs in Exhibit D of this report omit these services. We relied on CY 2024 experience provided by DHS to quantify this amount, which had no utilization in CY 2024.

  We trended these CY 2024 claims to CY 2026 using a 6.00% annual trend from 2024 to 2026, as shown by Table 4 below. This annual trend assumption aligns with the annual trend applied to other A&P services underlying AWOP development. This resulted in an estimate of substance abuse expenditures of $0.00 PMPM related to eligible services covered under FFS that are added to the AWOP.

TABLE 4
WISCONSIN DEPARTMENT OF HEALTH SERVICES
AWOP SUD ADJUSTMENT

	CY 2026 PROJECTED MEMBER MONTHS – PACE	CY 2024 SUD FFS EXPERIENCE PMPM	CY 2024 TO CY 2026 TREND ADJUSTMENT	CY 2026 SUD PROJECTION PMPM
Dual Eligible	5,500	$0.00	1.1236	$0.00
Medicaid Only	420	$0.00	1.1236	$0.00
Total Population	**5,920**	**$0.00**	**1.1236**	**$0.00**

- The 2024-2026 Wisconsin biennial budget includes additional funding to Family Care Partnership MCOs to distribute to direct care workforce (DCW) providers through a directed payment arrangement. The estimated total for CY 2026 is $9.2 million, equivalent to $210.93 PMPM (the aggregate total of Exhibit Q of Appendix B), which we add to AWOP development.
- For CY 2026 Family Care Partnership rate development, we assume 100% of the capitation withhold is expected to be earned back by the MCOs. Therefore, we apply the same adjustment in the PACE AWOP development.
- We assume average incentive payments of 0.26% of capitation rates, consistent with the average earned incentive in CY 2024 by the Family Care Partnership MCOs weighted on membership.

VI. Non-Service Cost AWOP Allowance

This section of the report describes the development of the non-service cost allowance for the initial CY 2026 PACE AWOP development. Non-service expense loads and resulting capitation rates are equal to the values used for Family Care Partnership capitation and are implemented in Table 5 of this report.

ADMINISTRATIVE COST ALLOWANCE

In order to develop administrative costs, DHS and Milliman reviewed Family Care Partnership program experience from plan reported financial summaries for CY 2024. We set overall CY 2026 administrative costs based on the CY 2024 administrative cost PMPM level with two years of 3.9% annual trend applied, which is comparable to recent Employment Cost Index calculations published by the Bureau of Labor Statistics. **PACE experience was not included in the development of the administrative costs.**

See Section V in Appendix B to this report for additional details regarding the administrative cost model.

Targeted Risk Margin / Contribution to Reserves

We include an explicit targeted margin of 2.0% of the AWOP, less costs that would not have otherwise been paid through Partnership for PACE eligible members, to account for risk margin and cost of capital. This target margin is the same as Family Care Partnership. We believe that this margin is appropriate given the predictability of expenses under the program and margins included for similar programs nationally.

VII. Final Pace AWOP Allowance

Table 5 below shows the final PACE AWOP calculation for each target group and Medicare eligibility status. The CY 2026 blended AWOP for the PACE program is $5,789.58.

TABLE 5
WISCONSIN DEPARTMENT OF HEALTH SERVICES
FINAL AWOP CALCULATION

DUAL ELIGIBLE				
	PMPM			
AWOP Component	**DD**	**PD**	**FE**	**Exhibit Reference**
Acute Care Costs – Starting	$148.14	$201.37	$146.64	Exhibit D1
× FFS Vent Adjustment	1.0030	1.0030	1.0030	
+ FFS Pharmacy Adjustment	$9.18	$9.18	$9.18	
+ FFS SUD Adjustment	$0.00	$0.00	$0.00	
Acute Care Costs – Final	$157.77	$211.16	$156.27	
Long Term Care Costs	$6,033.92	$5,588.83	$4,509.16	Exhibit I, Column (F)
Admin Allowance	$295.16	$295.16	$295.16	Appendix B, Exhibit J1, Column (D)
Target Margin	$132.19	$124.19	$101.04	2% of Final AWOP less Withhold, Incentive, DCW, and FFS adj.
Final Costs Before Withholds, Incentives, and DCW	$6,619.04	$6,219.34	$5,061.63	
× Non-Return of Withhold	1.0000	1.0000	1.0000	
× Average Incentive Payment	1.0026	1.0026	1.0026	
+ DCW Adjustment	$210.93	$210.93	$210.93	
Final AWOP	$6,847.17	$6,446.43	$5,285.72	
Medicaid Only				
	PMPM			
AWOP Component	**DD**	**PD**	**FE**	**Exhibit Reference**
Acute Care Costs – Starting	$2,051.45	$2,064.08	$1,938.34	Exhibit D2
× FFS Vent Adjustment	1.0085	1.0085	1.0085	
+ FFS Pharmacy Adjustment	$501.52	$501.52	$501.52	
+ FFS SUD Adjustment	$0.00	$0.00	$0.00	
Acute Care Costs – Final	$2,570.45	$2,583.18	$2,456.37	
Long Term Care Costs	$6,033.92	$5,588.83	$4,509.16	Exhibit I, Column (F)
Admin Allowance	$295.16	$295.16	$295.16	Appendix B, Exhibit J2, Column (D)
Target Margin	$171.03	$162.21	$137.61	2% of Final AWOP less Withhold, Incentive, DCW, and FFS adj.
Final Costs Before Withholds, Incentives, and DCW	$9,070.56	$8,629.38	$7,398.30	
× Non-Return of Withhold	1.0000	1.0000	1.0000	
× Average Incentive Payment	1.0026	1.0026	1.0026	
+ DCW Adjustment	$210.93	$210.93	$210.93	
Final AWOP	$9,305.06	$8,862.74	$7,628.46	

VIII. Pace Capitation Rate Development

Table 6 below shows the CY 2026 capitation rate for each combination of target group and Medicare eligibility status. These values are less than the AWOP amounts shown in Table 5 above to be in compliance with the rate requirements of 42 CFR 460.182. We adjust each AWOP for the following issues to develop the final capitation rates:

- We remove the portion of the AWOP rate associated with the DCW directed payment, since PACE providers are not subject to directed payments.
- We add back any adjustment made to the AWOP for Partnership non-return of withhold, since there is no withhold program for PACE.
- We remove any adjustment made to the AWOP for Partnership incentives, since there is no incentive program for PACE.
- We make no adjustment for the portion of the AWOP rate associated with ventilator dependency costs, pharmacy, or FFS SUD services, since PACE providers are financially responsible for these services.

TABLE 6
WISCONSIN DEPARTMENT OF HEALTH SERVICES
CAPITATION RATE DEVELOPMENT

DUAL ELIGIBLE PMPM			
	DD	**PD**	**FE**
Final AWOP - Dual Eligible	$6,847.17	$6,446.43	$5,285.72
- DCW Adjustment	($210.93)	($210.93)	($210.93)
+ Impact of AWOP Withhold	$0.00	$0.00	$0.00
- Impact of AWOP Incentive	($17.20)	($16.16)	($13.15)
Capitation Rate - Dual Eligible	$6,619.04	$6,219.34	$5,061.63
MEDICAID ONLY PMPM			
	DD	**PD**	**FE**
Final AWOP - Medicaid Only	$9,305.06	$8,862.74	$7,628.46
- DCW Adjustment	($210.93)	($210.93)	($210.93)
+ Impact of AWOP Withhold	$0.00	$0.00	$0.00
- Impact of AWOP Incentive	($23.57)	($22.42)	($19.22)
Capitation Rate - Medicaid Only	$9,070.56	$8,629.38	$7,398.30

Additional rate reductions from each AWOP are not necessary since the basis of the AWOP rates already reflects experience from a mature managed care program. Documentation of compliance with the January 2025 PACE Medicaid Rate Setting Guide is included as Appendix A. The PACE rates are prospective in nature and do not include any retrospective adjustments or incentives.

EXHIBITS

(Provided in Excel Format Only)

APPENDIX A

Responses to January 2025 PACE Medicaid Capitation Rate Setting Guide

APPENDIX A

Responses to January 2025 PACE Medicaid Capitation Rate Setting Guide

This section of our report addresses the critical elements of rate-setting requested in the January 2025 PACE Capitation Rate Setting Guide for use by the CMS regional office. In this section, our responses below are in blue font.

1. Development of the amount that would have otherwise been paid (AWOP) and the required documentation:

   a. Identify the AWOP separately by rate cell.

      The AWOP is presented separately by rate cell (Target Group and Medicare status) in Table 5.

      i. The AWOP is calculated on a per member per month basis and includes all Medicaid covered services for the eligible population.

      The AWOP is a per member per month amount which includes all PACE covered services for the eligible population. Sections III through VI provide the methodology used to develop the AWOP amounts.

      ii. Demonstrate basis for rate categories applied.

         1. Separate rate categories may be used to more accurately project amounts that would have otherwise been paid.

         2. Rate cells can vary by age, gender, geographic region, eligibility category, Medicare status.

         3. Rate cells should not cross-subsidize payments in another cell.

      The acute and primary portion of the AWOP is developed separately for Medicare and Medicaid-only eligibles. The long-term care portion of the AWOP is developed separately by target group (physically disabled, developmentally disabled, and frail elderly). Rate cells are developed independently and do not cross-subsidize one another.

   b. Identify the future effective date for the projected AWOP.

      i. The AWOP should be established prospectively.

      ii. The AWOP should be calculated for a period no longer than 12 months. Mid-year changes to the AWOP are not allowed without CMS' prior approval.

         1. CMS recognizes there may be unanticipated changes in costs and conditions during the year, but it is the expectation that those changes would be addressed by the state during the next rate period. In limited circumstances, CMS may consider a mid-year update to the AWOP in writing to CMS for approval prior to submitting a revised rate package to CMS for review.

      iii. For rates that are effective longer than 12 months, separate AWOPs must be calculated, so that each AWOP is no longer than 12 months.

         1. States must submit separate AWOPs for each year of the proposed rating period at the time of the submission.

      The calculated AWOP amounts were developed prospectively for the 12-month period January 2026 through December 2026. Capitation rates are effective for the same 12-month period. No mid-year change is anticipated.

   c. Describe how the state determined the AWOP under the state plan.

      i. Base period data used.

         1. Demonstrate that cost and utilization data used is reflective of the population consistent with frailty and age of PACE participants.

            The FCP population used as the basis for the AWOP has been adjusted to reflect a population consistent with the frailty and age of individuals eligible for PACE, including an adjustment for geography and acuity.

2. Acceptable data may include FFS experience, managed care plan encounter data, managed care plan financial data and reports.

   The AWOP uses FCP managed care program experience. The Family Care Partnership enrollment comprises the population comparable to the PACE enrollment that is used to develop the service cost and non-service cost portions of the AWOP. PACE-eligible individuals also receive care through the Family Care program, the Include, Respect, I Self-Direct (IRIS) program, and fee-for service. Family Care Partnership is the only program which covers both acute care and long-term care services under a managed care arrangement and is reliable and credible enough on its own to serve as the basis for AWOP development.

3. Document how the base data was reviewed and validated, along with any concerns related to the quality of the data and steps being taken to enhance data quality.

   The base data was reviewed and validated as part of FCP rate setting. Details are contained in the capitation rate report in Appendix B.

4. Clearly identify the time period of the base data used - most recent available year of data should be used, but should not be more than three years old.

   Base period costs for January 2024 through December 2024.

ii. Provide a narrative description of the data, assumptions and methodologies used to develop any adjustments, factors and costs applied to the amount that would have otherwise been paid, including, but not limited to:

1. Completion factors applied (such as any adjustments to account for claims that have been received, but have not yet been paid).

   See Section III and IV of Appendix B for adjustments related to completion factors made as part of the AWOP.

2. Adjustments applied, including payments / recoupments not processed through the MMIS, retrospective eligibility costs, FQHC / RHC cost settlements, disproportionate share hospital payments, graduate medical education, pharmacy rebates, third party liability payments, patient liability, and copayments.

   No additional adjustments related to these items are required beyond any consideration given in rate setting, with the exception of pharmacy rebates. See Section V of this report for additional considerations related to pharmacy rebates.

3. Adjustments for changes in benefits, fee schedules, or eligibility requirements.

   All adjustments from the base data to CY 2026 are discussed in III and IV of Appendix B.

4. Trend factors applied, the projection period, and the basis for any trend factors used.

   Trend adjustments from the base data to CY 2026 are discussed in III and IV of Appendix B.

5. Non-benefit costs included - should only represent state costs for administering the program. Should not include PACE administrative costs.

   Section VI documents the build-up of the non-benefit expense load for the AWOP. This considers only managed care administrative costs, excluding the PACE organizations.

6. Risk / Acuity adjustment to properly reflect the expected costs and frailty of the comparable PACE population.

   Sections III and IV discuss adjustments related to acuity.

7. The proportion of the comparable population expected to reside in an institution or community if not enrolled in PACE.

   18.0% of the comparable population's costs are nursing facility costs. The acuity adjustment accounts for differences between the comparable population and the PACE-enrolled population.

d. Additional documentation for states using Medicaid managed care data, including Medicaid managed long term services and supports program (MLTSS) data in development of the AWOP. Refer to Appendix A for additional guidance.

   i. Percentage of the PACE eligible population enrolled in Medicaid managed care.

      We expect that all PACE eligibles not enrolled in PACE are enrolled in Medicaid managed care.

   ii. Documentation of any differences between the Medicaid managed care program and PACE and how these differences were considered in the rate setting for PACE. Differences should include any differences in eligibility, such as age or acuity / level of care, and services included / excluded in the managed care program.

      Differences in eligibility between the FCP program and the PACE program are discussed in Section V, as well as documentation of how these differences were accounted for.

   iii. Actuarial certification of Medicaid managed care rates for the same rating period. If applicable, describe any differences between the AWOP and Medicaid managed care program rate development assumptions and methodologies including base data, base data adjustments, trend, non-benefit costs (including taxes, fees and other assessments), incentive / withhold payments, and acuity / risk adjustment.

      Actuarial certifications for the FCP program is included in Appendix B.

2. Development of the PACE rates and required documentation.

   a. Confirm and demonstrate that the PACE rate methodology is consistent with the AWOP and not in conflict with the rate description in the state plan. Describe the method for setting rate, for example a percentage discount off of AWOP, actuarial approach, other.

      Capitation rates were developed as a discount off of the AWOP. This is consistent with the rate description in the state plan.

   b. Identify proposed PACE rates by rate cell

      PACE rates by rate cell are shown in Table 6.

      i. Rate is for a prospective payment paid on a per member per month capitated basis

         Confirmed.

      ii. Rate cells should be the same as those used for AWOP as identified in section 1. a. ii.

         Confirmed.

   c. Identify proposed effective dates of PACE rates, including start and end dates

      The PACE rates are effective from January 1, 2026 through December 31, 2026.

      i. Rates should be established prospectively.

         Confirmed.

      ii. Effective dates of rates should be no less than one year but no more than 2 years.

         Confirmed.

iii. Time period for the rates should be consistent with that for the AWOP.

Confirmed.

iv. Rates should not be adjusted prospectively or retroactively during the year. Mid-year changes to the PACE rate are not allowed without CMS's prior approval.

Rates will not be adjusted during the year. We do not expect to require a mid-year change.

1. CMS recognizes there may be unanticipated changes in costs and conditions during the year, but it is the expectation that those changes would be addressed by the state during the next rate period. In limited circumstances, CMS will consider a mid-year update to the PACE rates in circumstances such as mandated across the board state legislative rate changes. States are required to submit documented justification for a mid-year change to the PACE rates in writing to CMS for approval prior to submitting a revised rate package to CMS for review.

   We do not expect to require a mid-year change.

d. PACE organizations must be at full financial risk. Risk sharing and other risk mitigation mechanisms are not permitted for PACE.

No risk sharing or risk mitigation mechanisms are included in the PACE contract.

e. Include additional documentation needed for CMS to make a determination of compliance with requirements.

i. Comparison of the PACE rates to the AWOP by rate cell

See Table 6.

ii. Documentation of any incentive arrangements

1. Describe how the arrangement is implemented.
2. Quantify the incentive payments' expected impact on PACE rates.
3. Provide the expected amount of the incentive payment and demonstrate that the sum of the PACE rate and the incentive payment is below the AWOP for each rate cell.
4. States are not required to submit additional documentation of the final incentive payments made to PACE plans, but the state must make sure:
   a. The actual payments made are equal to or below the expected amount of the incentive payment included in the approved rate package.
   b. The total PACE capitation rate plus actual incentive payments made are below the AWOP for each rate cell in the approved rate package.

   No incentive arrangements are included in the PACE contract.

iii. Projected member months for each rate cell

Attachments 1 through 3 show the projected member months for each rate cell.

3. While federal regulations at 42 CFR 460.182 do not require an actuary to certify the amounts that would have otherwise been paid or the payment rates paid to PACE organizations, CMS encourages states to submit an actuarial certification with their rate package. If an actuary provides a certification, the rate review package should contain adequate actuarial documentation to support the data, assumptions and methodologies used. The actuary should provide sufficient documentation as described by the Actuarial Standards of Practice.

A certification of the AWOP amounts is included as Appendix A.

APPENDIX B

CY 2026 Family Care Partnership Report

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November 26, 2025

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

Re: CY 2026 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 2026 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

Briana S. Botros, FSA, MAAA
Senior Consulting Actuary

James S. Johnson, FSA, MAAA
Senior Consulting Actuary

MCC/BSB/JSJ/cl

Attachments

MILLIMAN REPORT

State of Wisconsin

Department of Health Services
Calendar Year 2026 Capitation Rate Development
Family Care Partnership Program

November 26, 2025

Michael Cook, FSA, MAAA
Briana Botros, FSA, MAAA
James Johnson, FSA, MAAA

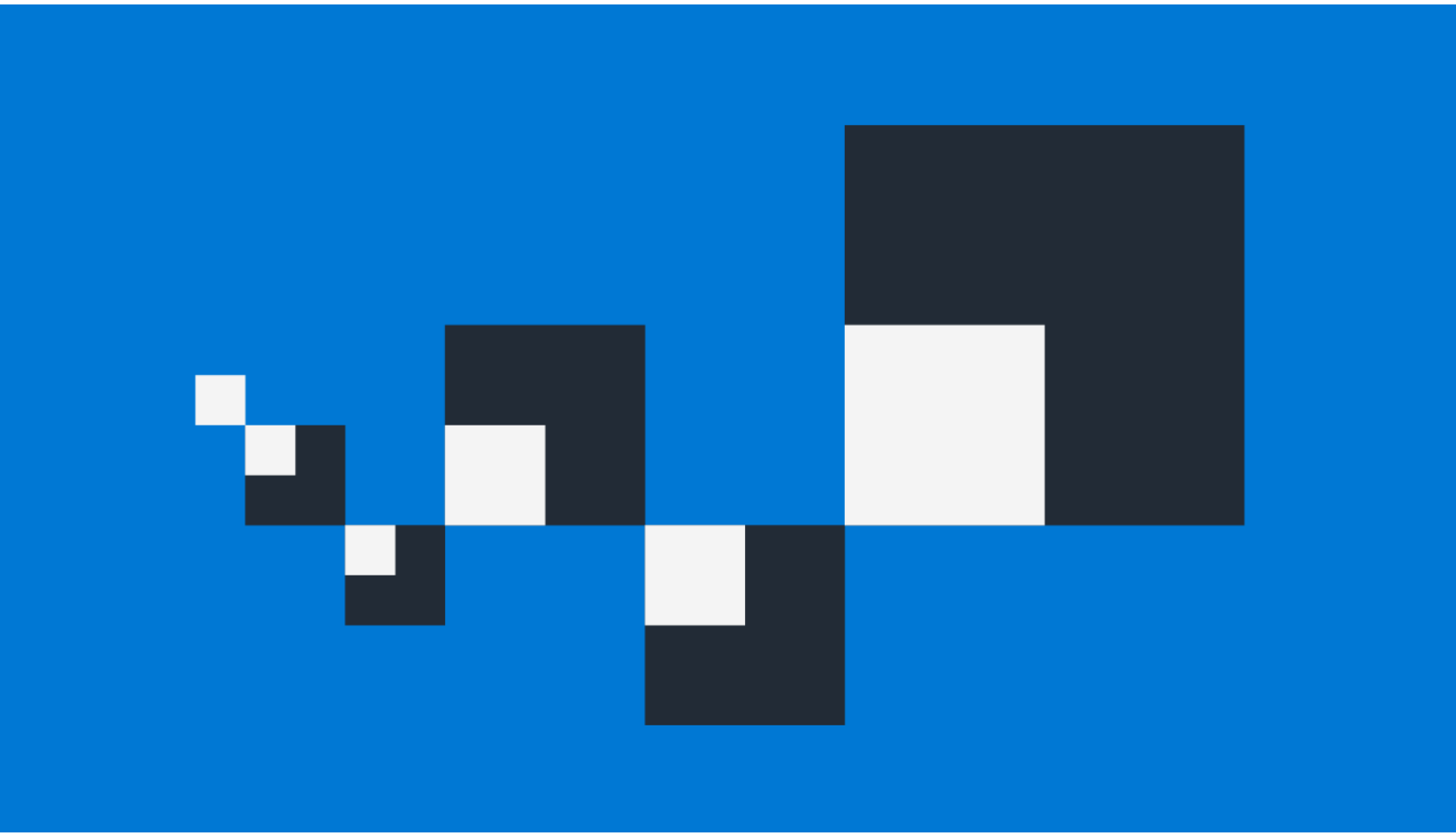

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Table of Contents

EXHIBITS (Provided in Excel Format Only)

Capitation Rate Development – Acute and Primary Services

A1: CY 2024 MCO Encounter Data – Dual Eligibles

A2: CY 2024 MCO Encounter Data – Medicaid Only

A3: CY 2024 MCO Encounter Data – Total Population

Table of Contents *(continued)*

Table of Contents *(continued)*

APPENDICES

I. Executive Summary

This report documents the development of the January 2026 to December 2026 (CY 2026) 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 2026 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
- ASOP No. 41 – Actuarial Communications
- ASOP No. 42 – Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims
- ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 49 – Medicaid Managed Care Capitation Rate Development and Certification
- ASOP No. 56 – Modeling
- Other applicable standards of practice

CY 2026 CAPITATION RATES

The statewide average gross capitation rate for CY 2026 is $6,315.35 for the Family Care Partnership population. Table 1 shows the statewide gross capitation rate change from the CY 2025 capitation rate recertification dated October 1, 2025 to the CY 2026 capitation rates for each population.

TABLE 1
WISCONSIN DEPARTMENT OF HEALTH SERVICES
FAMILY CARE PARTNERSHIP
COMPARISON OF CY 2025 AND CY 2026 CAPITATION RATES

	PROJECTED MEMBER MONTHS	CAPITATION RATE
CY 2025 Rates	45,274	$5,714.73
CY 2026 Rates	43,419	$6,315.35
% Change		10.5%

The 10.5% increase in gross capitation rates from CY 2025 rates to CY 2026 rates can be broken down as follows:

- 3.4% increase due to the actual CY 2024 base cohort LTC service costs compared to the CY 2024 costs predicted as part of CY 2025 rate development. The projection of CY 2024 costs in CY 2025 rate development included trend and programmatic rate increase estimates. This excludes differences in the projected and actual impact of the minimum fee schedule for 2024 Q4.
- 1.2% increase due to differences in the CY 2024 to CY 2025 LTC trends estimated in CY 2025 rate setting compared to those used in CY 2026 rate setting.

- 3.8% increase due to the application of LTC service cost trends to project CY 2025 costs to CY 2026.
- 0.7% increase due to the application of LTC acuity trend to project CY 2025 acuity to CY 2026.
- 0.4% increase due to the difference in projected enrollment by target group from CY 2025 to CY 2026. Specifically, projected enrollment for the higher-cost DD target group increased by approximately 0.9%, and projected enrollment for the lower-cost PD and FE target groups decreased by approximately 6.5%.
- 0.5% decrease due to the restatement of legislated changes in CY 2024 and CY 2025 nursing home reimbursement and personal care.
- 0.6% increase due to application of nursing home reimbursement to project CY 2025 to CY 2026.
- 0.7% increase due to the application of personal care, home health, and private duty nursing reimbursement to project CY 2025 to CY 2026.
- 0.5% decrease due to differences in the impact of the application of HCBS minimum fee schedule in CY 2025 and CY 2026.
- 0.9% decrease due to the update of acute and primary (A&P) base period data from CY 2023 to CY 2024.
- Negligible change due to differences in the CY 2024 to CY 2025 A&P trends estimated in CY 2025 rate setting compared to those used in CY 2026 rate setting.
- 0.6% increase due to the application of CY 2025 to CY 2026 A&P trends.
- 0.2% increase due to the increase in the projection of Medicaid-only enrollment from CY 2025 to CY 2026; the proportion of Medicaid-only enrollees is projected to increase from 29.3% in 2025 to 30.5% in 2026.
- 0.4% increase due to the differences in the administrative loads as a percent of the capitation rates from CY 2025 to CY 2026.

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 +11.0%, +8.5%, and +10.5%, 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 2026 expenditures split between federal and state liability are included in Exhibit L.

COVID-19 CONSIDERATIONS IN CY 2026 RATE DEVELOPMENT

The COVID-19 pandemic and determination of a public health emergency (PHE) have impacted health care costs significantly since March 2020, though we believe the 2024 base data underlying CY 2026 capitation rates has substantially moved past these impacts to an environment that is appropriate to use for projections moving forward. The impact of the COVID-19 pandemic and PHE on CY 2026 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.

The capitation rates do not currently include explicit provisions for expected vaccination administration fees or other costs related to COVID-19 in CY 2026 above CY 2024 levels. Should costs prove to be material and in excess of any continuing utilization decreases in CY 2026, we will consider revising capitation rates.

We made no other explicit adjustment for the PHE since the base period experience exhibits stable utilization patterns consistent with pre-pandemic levels.

METHODOLOGY CHANGES FROM CY 2025 RATES

This section describes significant methodology changes from the CY 2025 capitation rate methodology.

GSR Consolidation

Effective January 1, 2025, GSRs formerly identified as GSRs 5, 12, and 14 will combine into GSR 5; GSRs 12 and 14 will cease to exist. Effective January 1, 2026, GSRs formerly identified as GSRs 2 and 3 will combine into GSR 2; GSR 3 will cease to exist. Additionally, the GSR formerly identified as GSR 8 will be identified as GSR 7.

Experience shown on Exhibit A, E, F, and P shows these GSRs split (consistent with the definition of these GSRs in 2024), while remaining exhibits reflect the combination of these GSRs.

Service Area Changes

As a result of the recent reprocurement, the MCOs servicing GSR 7 will change during CY 2026. CCHP will terminate operations and will transition existing members to other MCOs. Additionally, MCWHP will begin operations in the consolidated GSR 7 when the required contracting contingencies described in article XIX.C. of the DHS MCO Contract have been met.

Consistent with previous rate setting exercises, we do not project enrollment levels for MCOs new to a GSR, but we develop a rate for them equal to the average rate in that region.

Missing Data Adjustment

Beginning with CY 2024, DHS has transitioned to a new MMIS system to collect encounter data submitted by Family Care Partnership plans. Milliman and DHS have reviewed the data submitted by MCOs and collected by DHS through this new system and have identified discrepancies between the encounter data reporting in the new system and the financial reporting which is larger than prior years and varies by MCO and category of service.

Therefore, for CY 2024 FCP LTC base data there is a missing data adjustment on an MCO and category of service basis. For CY 2024 FCP A&P base data we rely on the CY 2024 audited financials, adjusted to exclude Medicare liability based on separate reporting by each MCO. We use the relative distribution of service costs by category of service, MCO / GSR combination, target group, and Dual status using the CY 2023 encounter data with 14 months of runout.

As Milliman and DHS work collaboratively with the Family Care Partnership plans, we anticipate that future rate development cycles will rely less on this missing data adjustment.

DATA RELIANCE AND IMPORTANT CAVEATS

Milliman prepared this report for the specific purpose of developing CY 2026 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 2026 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 2022 through CY 2024 and May 2025, 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 2026 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.

Michael Cook is an actuary for Milliman, member of the American Academy of Actuaries, and meets the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of his knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

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. While most pharmacy services are carved out of the capitation rate, a small portion of pharmacy products are still included. 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. All of the dual enrollees in Family Care Partnership are in plans operating as Fully integrated Dual Eligible Special Needs Plans (FIDE-SNP).

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 2026, the state will be comprised of 10 distinct GSRs for rate setting and other purposes, consistent with the Family Care program definitions, for rate setting and other purposes. Of these 10 distinct GSRs, Family Care Partnership operates in eight; however, the Family Care Partnership program does not operate in all counties within each GSR. Please see Appendix A for a map showing the counties included in each GSR.

III. Acute and Primary Service Cost Methodology Overview

This section of the report describes the acute and primary service cost portion of the CY 2026 Family Care Partnership capitation rate methodology.

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

1. Extract and summarize CY 2024 MCO encounter base experience data for the Dual Eligible and Medicaid Only populations by target group.
2. Further summarize CY 2024 MCO encounter base experience data by age and gender groupings.
3. Apply IBNR and other base data adjustments to project CY 2026 services costs.
4. Blend the projected CY 2026 service costs into a MCO / GSR specific projected cost.

Each of the above steps is described in detail below.

STEP 1: EXTRACT AND SUMMARIZE ENCOUNTER BASE EXPERIENCE DATA

In this step we evaluate the MCO encounter experience for CY 2024 by MCO / GSR and service category for the populations enrolled in the Family Care Partnership program.

Base Data

We received detailed MCO encounter claims data from DHS for claims with dates of service between January 2023 and December 2024 with dates of payment through February 2025. This encounter data includes both services for which Medicaid is the primary payer, as well as costs associated with Medicare cost sharing and expenditures related to coordination of benefits between Medicaid and Medicare.

We reviewed the data and compared both provider service and case management expenditures against financial statements for accuracy and completeness of the data provided through the new MMIS system. As a result, we have identified discrepancies between the encounter data reporting in the new system and the financial reporting which is larger than prior years and varies by MCO and category of service. Therefore, for CY 2024 FCP A&P base data we rely on the CY 2024 audited financials, adjusted to exclude Medicare liability based on separate reporting by each MCO. We use the relative distribution of service costs by category of service, MCO / GSR combination, target group, and Dual status using the CY 2023 encounter data with 14 months of runout, which is summarized in Exhibits A1 through A3. The data adjustments used to scale the CY 2023 data to the CY 2024 audited financials are applied in Exhibit B and discussed in Step 2.

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 2026. The encounter data used to develop the acute and primary portion of the capitation rates excludes all pharmacy claims which are carved out of the program.

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

There are no in lieu of services provided to FCP enrollees in the base data or expected for the contract period.

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 2026 rate methodology relies on CY 2024 audited financial data for all MCO / GSR combinations, adjusted to exclude Medicare liability based on separate reporting by each MCO. We use the relative distribution of service costs by category of service, MCO / GSR combination, target group, and Dual status using the CY 2023 encounter data with 14 months of runout.

Target Group Assignment

The capitation rates rely on a member's classification into one of three target groups: Developmentally Disabled (DD), Physically Disabled (PD), and Frail Elderly (FE). Each Family Care Partnership enrollee is assigned a target group based on information collected using Long-Term Care Functional Screens (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 2024 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 B 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 2026 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 2026 Family Care Partnership program service costs. Each adjustment factor is explained in detail below.

Exhibit B shows each adjustment factor by category of service, as well as the adjusted and trended values for each target group and age / gender breakout for each target group and Medicare eligibility status.

IBNR Adjustment

The CY 2026 rate methodology relies on CY 2024 audited financial data for all MCO / GSR combinations, adjusted to exclude Medicare liability based on separate reporting by each MCO. The CY 2024 audited financials includes IBNR, so no explicit adjustment is made.

Sub-Capitation Adjustment

The only sub-capitated arrangement is for dental services for one MCO. The CY 2024 audited financials include this arrangement.

Data Adjustment to CY 2024 Financials

DHS requires completion of an encounter to financial reconciliation template in the MCO quarterly financial reporting submissions. The reporting includes service costs reported in the financial reporting versus the encountered service costs variances against the incurred but not reported (IBNR) reporting and an explanation of variances greater than 0.5%. The fiscal oversight team uses encounter data extracts to validate MCO reported encounters and identify potential reporting issues and reviews the explanation of variances to determine additional areas of investigation and follow. Additionally, Milliman reviewed the data and compared both provider service and case management expenditures against financial statements for accuracy and completeness of the data provided through the new MMIS system. As a result, we have identified discrepancies between the encounter data reporting in the new system and the financial reporting which is larger than prior years and varies by MCO and category of service. Therefore, for CY 2024 FCP A&P base data we rely on the CY 2024 audited financials, adjusted to exclude Medicare liability based on separate reporting by each MCO. We use the relative distribution of service costs for non-ventilator utilizing members by category of service, MCO / GSR combination, target group, and Dual status using the CY 2023 encounter data with 14 months of runout. The data adjustments to scale CY 2023 experience based on CY 2024 audited financial data are applied in Exhibit B.

Service Cost, Utilization, and Acuity Trend from CY 2024 to CY 2026

We used trend rates to project the CY 2024 baseline cost data to the CY 2026 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. We used experience from CY 2021 to CY 2024 to determine A&P service cost trends. Due to issues around A&P encounter data reporting discussed above, we only summarize information from MCO financials after adjusting for excluded services. Pharmacy trends are excluded from this analysis as a result of most pharmacy expense being carved out of the FCP program and moved into FFS. Additionally, we reviewed emerging year-to-date 2025 experience and program trends from other Wisconsin public programs covering similar benefit sets. 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 M for a summary of historical A&P service cost trends from CY 2021 to CY 2024. Due to the issues around A&P encounter reporting discussed above, we only summarize information from MCO financials, after adjusting for excluded services.

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 no IMD stay of over 15 days during CY 2024 for individuals in this age range.

We observed 23 IMD stays of 15 days and under for Medicaid Only individuals in this age range during 2024, totaling approximately $134,000. 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 1.05 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.

STEP 4: BLEND PROJECTED SERVICE COSTS BY TARGET GROUP

In this step we blend the projected CY 2026 service costs for each target group, Medicare eligibility status, and age / gender grouping based on the projected CY 2026 target group membership. Exhibit C shows the projected CY 2026 enrollment distribution while Exhibits D1 to D3 show the blended acute and primary service cost by MCO / GSR / Target Group 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 2026 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. Extract and summarize CY 2024 MCO encounter base experience data for the FCP LTC benefit package by target group.
2. Apply IBNR assumptions and other base data adjustments to project CY 2026 services costs.
3. Calculate MCO / GSR specific risk adjusted base rates using May 2025 screens and the functional status acuity model relativities.
4. Apply adjustments to the risk adjusted base rates to project CY 2026 services costs for each MCO / GSR combination and target group.
5. Blend the projected CY 2026 service costs, including allowances for non-benefit costs, by target group into an MCO / GSR specific projected cost.

Each of the above steps is described in detail below.

STEP 1: EXTRACT AND SUMMARIZE ENCOUNTER BASE EXPERIENCE DATA

In this step the MCO encounter experience for CY 2024 is summarized by MCO / GSR and service category for the FCP LTC population.

Exhibit E shows the summarized CY 2024 MCO encounter base experience data by MCO / GSR combination and target group.

Base Data

We received detailed MCO encounter claims data from DHS for claims with dates of service between January 2023 and December 2024 with dates of payment through February 2025. This data reflects payments net of any third-party liability. These costs are also gross of member cost share / patient liability, as DHS adjusts capitation payments to MCOs for each member to reflect that particular member's cost share (also known as Post Eligibility Treatment of Income).

We reviewed the data and compared both provider service and case management expenditures against financial statements for accuracy and completeness of the data provided through the new MMIS system. As a result, we have identified discrepancies between the encounter data reporting in the new system and the financial reporting which is larger than prior years and varies by MCO and category of service. Therefore, for CY 2024 base data we apply a missing data adjustment applied on an MCO and category of service basis. The missing data adjustments are applied in Exhibit F and discussed in Step 2.

The base period data includes only those individuals actually enrolled in the Wisconsin Family Care Partnership program, so no adjustment for retroactive eligibility periods is needed. The base experience data also excludes 0.19% of total expenses for which there is not a corresponding member eligibility record. 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 CY 2026 rate methodology relies on CY 2024 MCO encounter data for all MCOs in all GSRs with missing data adjustments applied on an MCO and category of service basis.

There are no in lieu of services provided to FCP enrollees in the base data or expected for the contract period.

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

Target Group Assignment

The FCP 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 age calculation, we transitioned a small number of members from FE members to the PD target group (if their calculated age was 64 or below) or from the PD target group to the FE target group (if their calculated age was 65 or above).

The experience summaries shown in Exhibit E reflect this target group assignment.

Case Management Expenditures

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

Table 2 below shows the CY 2024 encounter data to financial statement reconciliation adjustment for case management expenditures. These adjustments are made as part of the missing data adjustment in Exhibit F.

TABLE 2
WISCONSIN DEPARTMENT OF HEALTH SERVICES
FAMILY CARE PARTNERSHIP
ENCOUNTER DATA TO FINANCIAL STATEMENT RECONCILIATION ADJUSTMENT FOR CASE MANAGEMENT SERVICES

MCO	CY 2024
MCWHP	6.85%
CCHP	-5.82%
iCare	-17.93%

*Adjustments are negative when case management reported in financials are less than the case management amounts included in encounters.

HCBS Minimum Payment Rate (MFS)

DHS has instituted a minimum payment rate for residential and supportive home care services effective October 1, 2024. The purpose of the minimum payment rates is to establish a "floor" that supports a minimum payment amount for residential and supportive home care services that is consistent with efficiency, economy, quality of care, and access to care.

We reviewed Q4 2024 experience after the implementation of the MFS by MCO to evaluate MFS adherence by plan and the remaining fiscal impact of repricing Q4 2024 experience to the MFS. We found that the majority of Residential and Supportive Home Care (SHC) experience was reimbursed consistent with the MFS. We adjust the Q1-Q3 2024 MFS impacts to be consistent with the increase observed in Q4 2024. These adjustments are made in Exhibit I on a geographic and target group basis and discussed in Step 2.

Non-Covered Services Adjustments

We removed approximately 0.97% of expenditures for services not covered under the Family Care Partnership benefit set from the base data. This includes any payments made for member supplemental room and board expenses not included in the Institutional or Residential categories of service. No services were provided in lieu of a covered service for the FCP LTC population.

Sub-Capitated Services

The base data includes sub-capitated services for one MCO that contracts for sub-capitated services for Transportation with a vendor unrelated to the MCO. However, the encounters for this service were substantially incomplete, and we included costs in the base data from the financial reporting instead.

STEP 2: APPLY IBNR ASSUMPTIONS AND OTHER BASE DATA ADJUSTMENTS

IBNR

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

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

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

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

Exhibit N provides additional detail on the calculation of the IBNR adjustments applied to each MCO's CY 2024 experience data. This exhibit includes CY 2024 provider services paid through February 2025, estimated incurred claims and outstanding liability, and the implied IBNR adjustment factor for each incurred month. Table 3 below shows the cumulative IBNR adjustment applied to the CY 2024 experience data. While our IBNR calculation accounts for outstanding provider service costs, in practice the adjustment factor is applied to both provider service costs and case management; as such, the adjustment factors shown in Table 3 are slightly dampened from those underlying Exhibit N to account for the proportion of base period experience attributable to case management to avoid double counting.

Because of the delayed provider payment patterns in recent time periods for institutional services that we do not expect to extend into the future, we relied on the completion factors from non-institutional services to complete the CY 2024 institutional claims. For all other service categories, we relied on CY 2023 and CY 2024 experience data.

TABLE 3
WISCONSIN DEPARTMENT OF HEALTH SERVICES
FAMILY CARE PARTNERSHIP PROGRAM
LTC IBNR ADJUSTMENT FACTORS

MCO	IBNR Factor
MCWHP	1.0065
CCHP	1.0044
iCare	1.0183

Sub-Capitation Adjustment

The only sub-capitated arrangement is for transportation services for one MCO. We increase the encounter data to reflect the full amount of the sub-capitation arrangement from the financial data in Exhibit F.

Case Management Associated with Medicare Services Adjustment

We developed a data adjustment for CY 2024 to remove the portion of case management associated with managing Medicare-covered services. We estimate the portion of costs to remove based on the portion of the total revenue associated with Medicare revenue reported in the financial data. We decrease the encounter data to reflect only the amount of case management applicable to managing Medicaid services in Exhibit F.

Missing Data Adjustment

DHS requires completion of an encounter to financial reconciliation template in the MCO quarterly financial reporting submissions. The reporting includes service costs reported in the financial reporting versus the encountered service costs variances against the incurred but not reported (IBNR) reporting and an explanation of variances greater than 0.5%. The fiscal oversight team uses encounter data extracts to validate MCO reported encounters and identify potential reporting issues and reviews the explanation of variances to determine additional areas of investigation and follow. Additionally, Milliman reviewed the data and compared both provider service and case management expenditures against financial statements for accuracy and completeness of the data provided through the new MMIS system. As a result, we have identified discrepancies between the encounter data reporting in the new system and the financial reporting which is larger than prior years and varies by MCO and category of service. Therefore, for CY 2024 base data we apply a missing data adjustment applied on an MCO and category of service basis. This also includes the case management expenditures adjustments by MCO outlined above. The missing data adjustments are applied in Exhibit F. These adjustments are often below 1.0, indicating that the encounter data is higher than the financial data. This is driven by a variety of factors, including duplication of claims in the encounter data, reporting of aggregated Medicare and Medicaid liability in the encounter data, and the differences in case management expenditures discussed above.

HCBS Minimum Payment Rate (MFS)

We reviewed Q4 2024 experience after the implementation of the MFS by MCO to evaluate MFS adherence by plan and the remaining fiscal impact of repricing Q4 2024 experience to the MFS. We reviewed utilization levels for Residential and SHC services by quarter to ascertain whether there were significant changes in the utilization rates of these services. Through this review, we did not observe material utilization shifting upon implementation of the MFS. We also evaluated the quarterly fiscal impact of repricing Residential and SHC experience for Q1-Q3 2024 compared to the quarterly fiscal impacts assumed as part of CY 2025 rate setting. We generally observed these fiscal impacts to be in line with prior analyses. We reviewed Q4 2024 experience after the implementation of the MFS by MCO to evaluate MFS adherence by plan and the remaining fiscal impact of repricing Q4 2024 experience to the MFS. DHS has not received feedback from providers that MCOs have reimbursed at levels lower than the MFS during Q4 2024. Therefore, we believe the process to estimate the impact of the MFS on Q4 2024 is appropriate to estimate the impact on Q1-Q3 2024 base data. These adjustments are in Exhibit I on a geographic and target group basis.

STEP 3: CALCULATE MCO / GSR SPECIFIC RISK ADJUSTED BASE RATE USING MAY 2025 ENROLLMENT AND THE FUNCTIONAL STATUS ACUITY MODEL RELATIVITIES

For CY 2026 rate setting, Milliman developed the FCP regression models using individuals' functional status to predict costs from MCO-reported experience for CY 2022 and CY 2023. We do not include CY 2024 experience due to challenges around data collection at a member level for CY 2024 resulting from the transition to the state's new MMIS system. While we can adjust for these missing claims in aggregate, we cannot recreate claim level information.

This model is a budget-neutral risk adjustment, which is used to adjust the data to better reflect the acuity of the population covered under each MCO / GSR relative to the base data cohort. We used two years of combined Family Care and FCP data in order to improve the credibility and stability of the models. We developed risk weights for each of the three target groups independently using the corresponding population's functional screen, claim, and eligibility data. Wisconsin's LTCFS system provided the member level detail underlying each model.

The CY 2026 cost weights are calibrated using experience adjusted to reflect the MFS. By doing so, we reflect the material impact on relative costs for functional screen categories that are highly correlated with supportive home care and residential services utilization.

The attached Exhibits G1 through G3 show the Family Care Partnership functional status acuity models for the DD, PD, and FE populations, respectively. The estimated impact on the cost for each variable is shown, along with its significance (i.e., *p*-value), relative contribution in explaining the variation (i.e., Incremental Partial R^2), and the proportion of the population with the characteristic.

Table 4 below provides a high-level comparison between the CY 2025 and CY 2026 models for each target group:

TABLE 4
WISCONSIN DEPARTMENT OF HEALTH SERVICES
FAMILY CARE PARTNERSHIP
COMPARISON OF CY 2025 AND CY 2026 FUNCTIONAL STATUS MODELS
FAMILY CARE PARTNERSHIP

	DEVELOPMENTALLY DISABLED	PHYSICALLY DISABLED	FRAIL ELDERLY
CY 2026 R^2	42.4%	42.5%	34.8%
CY 2025 R^2	43.5%	42.5%	32.5%
R^2 Percentage Change	-1.2%	0.0%	2.3%

The "Proportion with Variable" statistics shown in Exhibit G 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 G 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 G1 is $5,259.82 which is equal to the completed DD base data cost shown on Exhibit F.

Exhibits H1A, H2A, and H3A develop the restated base period costs for each MCO / GSR combination, as modeled by the functional status acuity model. The acuity model is normalized to be budget neutral across all base data GSRs. Therefore, the CY 2024 costs for each target population base data cohort are unaffected in total.

Exhibits H1B, H2B, and H3B develop the final composite risk score as modeled by the functional status acuity model using the May 2025 FCP population enrollment. For credibility purposes, each MCO / GSR / target group combination with fewer than 100 members enrolled in May 2025 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:

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

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

MCOs with 100 members or more enrolled in a particular GSR and target group in May 2025 are considered fully credible.

In order to phase in changes to individual MCO revenues associated with changes in member assessment protocols and other potential changes, the bottom lines of Exhibits D1B, D2B, and D3B limit the preliminary 2025 risk scores to a 3.5% increase or decrease from 2025 rates for each MCO and target group combination. This includes a one-time increase or decrease of 1.5% from previous years to account for the potential varying fiscal impact of the MFS by MCO. We apply a factor to risk scores calculated from May 2025 member screens on the MCO and target group basis to limit this risk score change between years and then re-normalize the risk scores on the projected CY 2026 enrollment.

Special Considerations for Changes in Service Areas

As a result of the recent reprocurement, the MCOs servicing GSR 7 will change during CY 2026. CCHP will terminate operations and will transition existing members to other MCOs. Additionally, MCWHP will begin operations in the consolidated GSR 7 when the required contracting contingencies described in article XIX.C. of the DHS MCO Contract have been met.

The capitation rate for MCWHP in GSR 7 for all of CY 2026 assumes a risk score equal to the region-average risk score. Based on guidance from DHS, we expect that a portion of CCHP's membership will be assumed by iCare. Therefore, iCare's capitation rate assumes a risk score that is a blend CCHP and iCare's historical risk scores. In effect, this is equivalent to the region-average risk score. Consistent with previous rate setting exercises, we do not project enrollment levels for MCOs new to a GSR, but we develop a rate for them equal to the average rate in that region.

STEP 4: APPLY ADJUSTMENTS TO THE RISK ADJUSTED BASE RATE TO PROJECT CY 2026 SERVICE COSTS

In this step, we apply adjustment factors to reflect differences between the base period encounter data and the projected CY 2026 Family Care Partnership program service costs. Each adjustment is explained in detail below.

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

Service Cost Trend from CY 2024 to CY 2026

We used service cost trend rates to project the CY 2024 baseline cost data to the CY 2026 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 and Family Care Partnership MCO encounter data from CY 2022 through 2024 encounter data in several different ways using data consistent with the Family Care and Family Care Partnership MCO / GSR combinations included in the base data cohort. CY 2024 encounter data is adjusted to account for IBNR and the missing data adjustment, consistent with Step 2.

To ensure we are not double counting any program change adjustments in trends, we have repriced all claims to a December 2024 level to account for the following programmatic changes already reflected in rates:

- CY 2022 to CY 2024 FFS nursing home rate changes
- Personal Care FFS rate changes
- 2024 MFS adjustments

All trends described below are inclusive of this claim repricing.

Results of the Family Care Partnership trend analysis are shown in Exhibit O1 and the Family Care population results are shown in Exhibit O2. Based on these analyses, we selected trends of 4.25%, 5.75%, and 3.25% for the DD, PD, and FE target groups. This is a blended average of the FCP trends and Family Care trends above. Given the significant similarity of covered populations, benefits, provider reimbursement, and geography between the Family Care and Family Care Partnership populations, we believe blending the FCP trend rates is an acceptable approach to ensure stability while still recognizing the recent FCP experience.

Table 5 illustrates the service cost trend values implemented for the CY 2026 rate development. Our trend assumption is inclusive of both utilization and unit cost. Table 5 represents an approximate split between utilization and unit cost trends for each target group. Based on discussions between Milliman, DHS, and MCOs, we determined that a unit cost trend of 2.0% is a reasonable estimate for historical and expected changes in provider reimbursement rates in absence of other DHS-mandated reimbursement changes.

TABLE 5
WISCONSIN DEPARTMENT OF HEALTH SERVICES
FAMILY CARE PARTNERSHIP
ANNUAL TREND RATES BY TARGET GROUP – CY 2024 TO CY 2026

TARGET GROUP	UTILIZATION TREND	UNIT COST TREND	PMPM TREND
Developmentally Disabled	2.21%	2.0%	4.25%
Physically Disabled	3.68%	2.0%	5.75%
Frail Elderly	1.23%	2.0%	3.25%

Acuity Trend from CY 2024 to CY 2026

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 2024 experience to reflect expected population acuity changes from CY 2024 to CY 2026.

To develop these acuity trends, we analyzed annual risk scores from CY 2022 through 2024 for each target group independently. We used these risk scores to calculate the annual trend from CY 2022 through 2024 for the Family Care Partnership and Family Care populations, as shown in Exhibit O1 and O2, respectively. Based on these analyses, we selected acuity trends to be a blended average of the FCP trends and Family Care trends. Given the significant similarity of covered populations, benefits, provider reimbursement, and geography between the Family Care and Family Care Partnership populations, we believe blending the FCP trend rates is an acceptable approach to ensure stability while still recognizing the recent FCP experience. The selected annual trends, shown in Table 6 below, will be used to acuity trend CY 2024 to CY 2026.

TABLE 6
WISCONSIN DEPARTMENT OF HEALTH SERVICES
FAMILY CARE PARTNERSHIP
ANNUAL ACUITY TREND RATES BY TARGET GROUP

TARGET GROUP	ANNUAL ACUITY TREND
Developmentally Disabled	1.50%
Physically Disabled	0.25%
Frail Elderly	0.50%

Because the service cost trends in the previous section are net of changes in member acuity, there is no double-counting between the service cost and acuity trends.

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 2022, 2023, and 2024 plan performance relative to the costs projected using the regression model and rate setting assumptions. 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 2022, CY 2023, and CY 2024. 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.
    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. CY 2024 experience reflects missing data adjustments described above.
    d. Adjustment to remove the portion of case management associated with managing Medicare-covered services.
    e. An adjustment has been made to the reported amounts to reflect our estimate of incurred but not reported (IBNR) claims.
    f. Experience for GSRs 1 and 7 are combined consistent with CY 2024 regional definitions. Both GSRs are aggregated within Super Region 1 (as described below), so results would remain unchanged whether we combine or segregate these GSRs for this analysis.
    g. Experience for GSRs 5, 12, and 14 are separated consistent with CY 2024 regional definitions. These GSRs will be combined into a single GSR (GSR 5) for CY 2026 rates.
    h. Experience for GSRs 2 and 3 are separate consistent with CY 2024 regional definitions. These GSRs will be combined into a single GSR (GSR 2) for CY 2026 rates.
    i. Experience for GSR 8 will be mapped into GSR 7 for CY 2026 rates.

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 2022 analysis used the regression model developed for CY 2024 rates and calibrated to CY 2022 data. We make no adjustment to the projected costs for geographical wage differences by GSR since the intention of these analyses is to identify geographical differences by GSR.
3. We normalized the actual to expected results such that within each given year of data used for the geographic factor analysis, all base data GSRs aggregate to a 1.0 actual to expected ratio.
4. We review the actual and projected costs for each MCO / GSR combination across all three years to identify any anomalous results that may have a material impact on the final geographic adjustment factors. The preliminary geographic adjustment factor is calculated as the average of three years of the ratios of actual and expected costs weighted 1/6, 2/6, and 3/6 from the oldest to the newest year. The projected costs serve as a form of "risk adjustment" to account for differences in target group, member acuity and other issues between GSRs that are already accounted for in MCO payment and should not be part of the geographic factor calculations. Exhibit P shows this calculation for each GSR.
5. For FCP GSRs 9 and 13 only, we apply the ratio of the CY 2023 experience to CY 2022 from GSR 10, because operations in GSRs 9 and 13 did not begin until January 1, 2023. In this way, the changing GSR composition of the super region across years does not artificially impact the 2026 geographic factor for Super Region 1.
6. As part of capitation rate development, we scale the preliminary geographic factors to maintain budget neutrality relative to the Family Care Partnership MCO / GSR combinations used in base data development. This budget neutrality adjustment will be performed separately for each target group. Table 7 below shows the normalization factor applied to the preliminary geographic adjustment factors by target group.

TABLE 7
WISCONSIN DEPARTMENT OF HEALTH SERVICES
FAMILY CARE PARTNERSHIP
GEOGRAPHIC FACTOR NORMALIZATION BY TARGET GROUP

TARGET GROUP	NORMALIZATION FACTOR
Developmentally Disabled	0.9923
Physically Disabled	0.9966
Frail Elderly	1.0195

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 P.

Nursing Home Rate Adjustment

The Wisconsin biennial budgets direct DHS to provide a 10.2% rate increase for SFY 2025, and the NH payment standard requires an additional 6.4% increase for SFY 2026. Based on guidance from DHS, we assume an additional 3.0% increase for SFY 2027. Table 8A summarizes these rate increases and the percentage applied to adjust CY 2024 base data to a CY 2026 basis.

TABLE 8A
WISCONSIN DEPARTMENT OF HEALTH SERVICES
NURSING HOME RATE ADJUSTMENT

YEAR	RATE INCREASE	PERCENT OF INCREASE APPLIED
SFY 2024	10.2%	50%
SFY 2025	6.4%	100%
SFY 2026	3.0%	50%

Beginning during CY 2024, DHS began including additional funding for nursing homes. This additional funding was incorporated into the nursing home per diems, incremental to the rate increases outlined above. DHS included an additional $6.2 million in funding for nursing homes in CY 2024. For CY 2026, DHS is including an additional $3.9 million in funding. In order to incorporate the additional funding for CY 2026, we first removed the additional funding from CY 2024, which was included in our base period experience, and then added additional funding for CY 2026. The funding is allocated across the managed care programs proportional to the programs' nursing home expenditures.

We applied an adjustment specific to each target group and GSR, inclusive of both rate increases in Table 8A and the additional add-on funding, based on the proportion of service costs for nursing home services in CY 2024. Table 8B shows the calculation of this adjustment, which is included in Exhibit I.

TABLE 8B
WISCONSIN DEPARTMENT OF HEALTH SERVICES
FAMILY CARE PARTNERSHIP
NURSING HOME RATE ADJUSTMENT

	PERCENTAGE OF NURSING HOME COST IN CY 2024			ADJUSTMENT FACTOR		
GSR	DD	PD	FE	DD	PD	FE
GSR 2	19.9%	1.4%	53.0%	1.0149	1.0018	1.0641
GSR 5	16.6%	13.2%	23.9%	1.0203	1.0162	1.0293
GSR 6	9.3%	22.8%	47.1%	1.0115	1.0282	1.0579
GSR 7	11.6%	14.8%	24.5%	1.0142	1.0180	1.0299
GSR 9	0.0%	33.9%	15.9%	1.0000	1.0434	1.0200
GSR 10	9.4%	38.4%	28.0%	1.0116	1.0478	1.0343
GSR 11	5.9%	17.5%	29.0%	1.0072	1.0217	1.0356
GSR 13	24.9%	41.3%	4.1%	1.0318	1.0523	1.0051

Personal Care Rate Adjustment

DHS increased fee-for-service personal care rates $24.51 per hour in CY 2024 to $25.04 per hour in CY 2026. Personal care costs represented between 0.88% and 2.19% of base period costs across the three target groups. Applying these rate increases to these portions of the cost results in adjustments of 0.02%, 0.05%, and 0.02% for the DD, PD, and FE target groups, respectively. This adjustment is made in Exhibit I.

Home Health Rate Adjustment

DHS increased fee-for-service home health rates $96.96 per visit in CY 2024 to $117.86 per visit in CY 2026. Home health visit costs represented between 0.70% and 1.44% of base period costs across the three target groups. Applying these rate increases to these portions of the cost results in adjustments of 0.24%, 0.31%, and 0.15% for the DD, PD, and FE target groups, respectively. This adjustment is made in Exhibit I.

Private Duty Nursing Rate Adjustment

DHS increased fee-for-service private duty nursing rates for various procedure codes from CY 2024 to CY 2026. RNs performing ventilator dependent care increased from $48.18 in CY 2024 to $75.00 in CY 2026. LPNs/LVNs performing ventilator dependent care increased from $32.11 in CY 2024 to $61.05 in CY 2026. RNs performing non-ventilator dependent care increased from $40.76 in CY 2024 to $67.55 in CY 2026. LPNs/LVNs performing non-ventilator dependent care increased from $27.17 in CY 2024 to $55.00 in CY 2026. Private duty nursing costs represented between 0.00% and 1.84% of base period costs across the three target groups. Applying these rate increases to these portions of the cost results in adjustments of 1.02%, 0.00%, and 0.20% for the DD, PD, and FE target groups, respectively. This adjustment is made in Exhibit I.

STEP 5: BLEND NET CAPITATION RATE BY TARGET GROUP

In this step we blend the projected CY 2026 MCO / GSR service costs for each target group based on the composite projected CY 2026 target group membership. The blended costs are reflected in the bottom section of Exhibit I. However, these blended service costs are for illustrative purposes only, since the capitation payment system pays separate capitation rates for each target group.

V. Non-Service Cost Allowance

This section of the report describes the development of the non-service cost allowance for the CY 2026 Family Care Partnership capitation rate. Non-service expense loads and resulting capitation rates are shown in Exhibits J1 through J3. Exhibits K1 through K3 restate the components of the MCO / GSR capitation rates net of withhold. However, the blended rates in Exhibits J and K are for illustrative purposes only, since the program information technology pays separate capitation rates for each target group.

ADMINISTRATIVE COST ALLOWANCE

In order to develop administrative costs, DHS and Milliman reviewed program experience from plan reported financial summaries for CY 2024. We set overall CY 2026 administrative costs based on the CY 2024 administrative cost PMPM level with two years of 3.9% annual trend applied, which is comparable to recent Employment Cost Index calculations published by the Bureau of Labor Statistics.

This results in an overall CY 2026 administrative load of $295.16 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, the existence of a permanent risk corridor mechanism, and margins included for similar programs nationally. All of the P4P withhold is expected to be returned to MCOs as described in Section VI of this report.

VI. Other Rate Considerations

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

RISK CORRIDOR

For CY 2026, Family Care Partnership will continue to have a risk corridor mechanism to mitigate the uncertainty associated with the unique ownership and operational circumstances that some 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 85.0%, excluding care management, based on the following components:

- Average administrative allowance of 4.7%
- Average care management load of 8.4%:
  - DD target group – 6.8%
  - PD target group – 8.9%
  - FE target group – 9.9%
- 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 9
WISCONSIN DEPARTMENT OF HEALTH SERVICES
FAMILY CARE PARTNERSHIP
RISK CORRIDOR PROGRAM

VARIANCE FROM TARGET	AVERAGE LOSS RATIO CLAIMS CORRIDOR	MCO SHARE OF GAIN / LOSS IN CORRIDOR	DHS SHARE OF GAIN / LOSS IN CORRIDOR
< -6.0%	< 79.0%	0%	100%
-6.0% to -2.0%	79.0% to 83.0%	50%	50%
-2.0% to +2.0%	83.0% to 87.0%	100%	0%
+2.0% to +6.0%	87.0% to 91.0%	50%	50%
> +6.0%	> 91.0%	0%	100%

The risk corridor settlement will occur after the CY 2026 rate year has ended and enough time has passed to collect and validate CY 2026 encounter data and financial data with sufficient run-out. 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 2026, 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. MCOs are eligible to earn back up to 0.10% withheld from the capitation based on the percentage of members who have completed and documented Community Connections (CC) Interest Inventories. If the MCO meets each of three documentation timelines and works with members to develop at least one CC Outcome and complete at least one approved activity, it is eligible to earn back up to 0.15% withheld from the capitation. The amount the MCO is eligible to receive is based on the percentage of members the MCO worked with to complete and document a CC Outcome.

   If the MCO earns back the full amount withheld, it is eligible to receive up to 0.20% incentive for implementing the CC Strategic Plan as it relates to building community and residential provider capacity. The MCO will receive 0.10% for completing interest inventories for members in varying residential settings as well as developing a CC Outcome and completing a follow-up activity for 80% of members in a given cohort. To receive the additional 0.10% incentive, MCOs must submit documentation related to Building Inclusive Communities Assessments in a timely manner.

2. MCOs are eligible to earn back 0.15% withheld from the capitation for increasing the rate of their SDS member population that are Certified Direct Care Professionals (CDCP) employers by 5 percentage points. MCOs that increase the rate of their CDCP employers with a Handshake account by 10 percentage points are eligible to earn back 0.10% withheld from the capitation.

   If the MCO earns back the full amount withheld, it is eligible to receive an incentive of 0.05% if the MCO increases the rate of their CDCP employers with a Handshake account by 25 percentage points.

Based on past performance and expectations under measure revisions, DHS and Milliman estimate that all of the 0.5% 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 all of the 0.5% withhold is returned.

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 is provided in our response to the CMS Medicaid Managed Care Rate Development Guide in Appendix C.

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. We built the maximum fee schedule into rates in a manner consistent with the §438.6(c) payment arrangement.

We developed the base data discussed in Sections III and IV of this report using historical Family Care 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 2024 base data. We used this base data to develop rates for all regions. No further adjustment to provider reimbursement levels is made as part of rate development.

Direct Care Workforce

Wisconsin Statute §49.45(47m) directs DHS to make payments for CY 2026 services to Family Care Partnership MCOs to distribute to direct care workforce (DCW) providers. The 2024 to 2026 Wisconsin biennial budget includes additional funding for these providers and the estimated total for CY 2026 is $147.0 million of which $9.2 million is estimated to be allocated to Family Care Partnership. **This estimate is preliminary and expected to be updated in a future certification.** 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 Q includes a preliminary estimate of the allocation of total DCW funding for each MCO / GSR combination. We allocated the total funding between the Family Care NH LOC, Family Care Non-NH LOC and FCP programs and between MCO / GSR combinations within each program using actual CY 2024 MCO expenditures. We then developed PMPM values using projected CY 2026 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. No explicit adjustment was necessary as part of this certification since our base data reflects this increase. We certify that these capitation rates are actuarially sound and are 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. No explicit adjustment was necessary as part of this certification since our base data reflects this increase. We certify that these capitation rates are actuarially sound and are 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.

HCBS Minimum Payment Rate

DHS has instituted a minimum payment rate for residential and supportive home care services effective October 1, 2024. The purpose of the minimum payment rates is to establish a "floor" that supports a minimum payment amount for residential and supportive home care services that is consistent with efficiency, economy, quality of care, and access to care. We certify that these capitation rates are actuarially sound and are intended to be consistent with a forthcoming §438.6(c) payment arrangement, which has not yet been submitted.

We make an adjustment to account for the difference in reimbursement rates in our base data relative to these minimum payment rates in Exhibit I. See Section IV and Appendix D for details surrounding this adjustment.

EXHIBITS A through D

Capitation Rate Development – Acute and Primary Services

(Provided in Excel Format Only)

EXHIBITS E through I

Capitation Rate Development – Long Term Care Services

(Provided in Excel Format Only)

EXHIBITS J through K

Capitation Rate Development – Capitation Rates

(Provided in Excel Format Only)

EXHIBIT L

Expenditure Projection

(Provided in Excel Format Only)

EXHIBITS M through Q

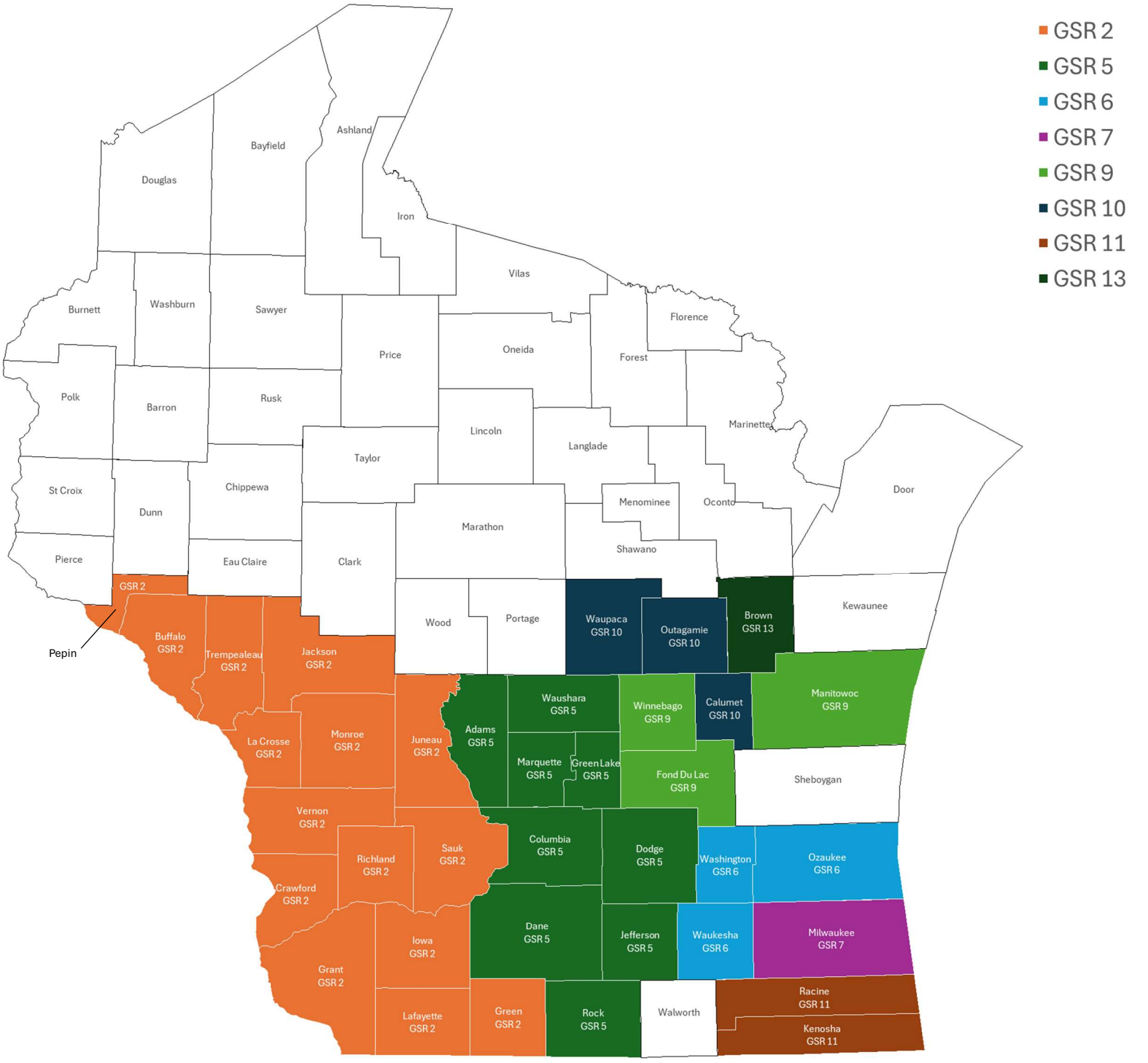
Assumption Development Support

(Provided in Excel Format Only)

APPENDIX A

Geographical Service Region Map

Family Care Partnership Geographic Service Regions (GSR) - Effective January 2026



Family Care Partnership coverage within GSRs varies by MCO.

APPENDIX B

Actuarial Certification of CY 2026 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 2026 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.

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November 26, 2025

Wisconsin Department of Health Services
Capitated Contracts Ratesetting
Actuarial Certification
CY 2026 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) 2026 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"
- 2025 to 2026 Medicaid Managed Care Rate Development Guide
- Actuarial Standard of Practice 49 and other applicable standards of practice

The payment rates, methodology, data, and assumptions used to calculate the January 1, 2026 through December 31, 2026 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 26, 2025

Milliman

RELIANCE LETTER

November 14, 2025

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 2026 Family Care, Family Care Partnership, and PACE Capitation Rates

Dear Michael:

I, Krista Willing, Assistant Administrator for Systems, Fiscal and Operations, hereby affirm that the listings and summaries prepared and submitted to Milliman, Inc. for the development of the CY 2026 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, including DHS review on encounter data quality for calendar years (CYs) 2022 through 2024 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 2022 through 2024 for the Family Care and Family Care Partnership programs.

3. Long Term Care Functional Screen (LTCFS) data extracts through May 2025 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 2022 through 2024, and January 2025 through May 2025 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), Home Health (HH), and Private Duty Nursing (PDN) fee schedules from CY 2024 through CY 2026, including definitions of covered services.

7. Nursing Home rate increases from SFY 2025 to SFY 2027.

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 2026 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 2026 relative to CY

2025.

12. Mapping file summarizing the MCO ID to MCO / GSR crosswalk.

13. CY 2022 through year-to-date 2025 financials and CY 2021 through CY 2024 IBNR actual to expected analysis for health plans participating in the Family Care, Family Care Partnership, and PACE programs. CY 2024 financials for Family Care Partnership include splits of service costs between Medicare and Medicaid.

14. Information and analysis regarding provider unit cost trends.

15. An estimate for expenses related to the Office of the Commissioner of Insurance's (OCI's) financial oversight function.

16. 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.

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

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

19. Information regarding the covered services for PACE rate development.

20. Information and direction regarding the HCBS Minimum Payment Rate.

21. 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.

22. 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.

23. Information and direction regarding Directed Payments for the Family Care and Family Care Partnership programs, including Maximum Provider Fee Schedule, and Direct Care Workforce.

24. Any other items provided to Milliman to support the 2026 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.

Krista Willing, Assistant Administrator of Systems, Fiscal and Operations

Name, Title

11/14/2025

Date

APPENDIX C

CMS Medicaid Managed Care Rate Development Guide

APPENDIX C

Response to 2025 to 2026 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) 2026 contract period. The previous certification was for the CY 2025 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 K.

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 2026. 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)
- Supportive Home Care and Residential Care Fee Schedule Increases (effective October 2024)

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 2026 rates is 93.3%. As such, the capitation rates are developed such that MCOs is expected to 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 2026 rate development.

xiii. This rate certification conforms to the procedure for rate certifications and for rate and contract amendments. The CY 2026 rates documented in this report are the initial capitation rates for the CY 2026 Wisconsin Medicaid LTC managed care contracts.

APPENDIX C

Response to 2025 to 2026 Managed Care Rate Development Guide

B. Appropriate Documentation

i. The actuary is certifying CY 2026 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. The actuarial certification includes a target MLR for CY 2026 that is greater than 85%, so we believe the capitation rates are developed, such that MCOs is expected to a federal MLR of greater than 85%. We reviewed MCOs past financial results as part of this process.

iv. 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.

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

vi. We detail within our responses in this guide the section of our report where each item described in the 2025 to 2026 Medicaid Managed Care Rate Development Guide can be found.

vii. 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.

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

ix. 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.

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

Section I includes documentation of the COVID-19 considerations and related unwinding considerations in the CY 2026 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 2022 through CY 2024 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 2024 base data period used to develop the CY 2026 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. The CY 2026 rate calculation uses CY 2024 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 and long term care data is summarized in Exhibit E. DHS provided detailed financial reporting data for CY 2024 and encounter data for CY 2022 through CY 2024 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 2026 capitation rates for the Family Care Partnership program are developed using CY 2024 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 2026 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 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 2026 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 K are based only upon services described in 42 CFR 438.3(c)(1)(ii) and 438.3(e).

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

iii. Please refer to Sections III and IV of this report for the details related to the treatment of in-lieu of services (ILOS). There are no ILOS services in the base data or expected for the contract period.

iv. There are no ILOS services in the base data or expected for the contract period.

v. 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 2026. Section I of the report highlights key methodological changes since the previous rate development. The base period costs used in rate development are net of these overpayments.

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 ILOS in the base data or expected for the contract period.

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 2026.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

The pay for performance and the member incentives 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. Withhold Arrangements

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 2026 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.

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_Oth_Renewal_20260101-20261231	Minimum and 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_Renewal_20260101-20261231	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_Renewal_20260101-20261231	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.	Rate adjustment (Base data reflects the existing uniform increase for the network provider arrangement).

APPENDIX C

Response to 2025 to 2026 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)
		This increase is 4.24% for eligible providers.	
ARPA Increase: WI_Fee_HCBS3_Renewal_20260101-20261231	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 (Base data reflects the existing uniform increase for the network provider arrangement).
RC and SHC Increase: WI_Fee_HCBS9_Renewal_20260101-20261231	Minimum fee schedule	Effective October 1, 2024, DHS is requiring MCOs to meet minimum fee schedule requirements for certain residential care and supportive home care services.	Rate adjustment

DHS will submit 438.6€ preprints to CMS for 2026 for each of the payments included in the table above. The 2026 preprints will be consistent with the prior preprints approved by CMS. There are no other directed payments in these programs that are not addressed in this certification.

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

APPENDIX C

Response to 2025 to 2026 Managed Care Rate Development Guide

CONTROL NAME OF THE STATE DIRECTED PAYMENT	RATE CELLS AFFECTED (SEE (A) BELOW)	IMPACT (SEE (B) BELOW)	DESCRIPTION OF THE ADJUSTMENT (S€(C) BELOW)	CONFIRMATION THE RATES ARE CONSISTENT WITH THE PREPRINT (SEE (D) BELOW	FOR MAXIMUM FEE SCHEDULES, PROVIDE THE INFORMATION REQUESTED (E) BELOW
Over MA FFS: WI_Fee_Oth_Renewal_20260101-20261231	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. Please refer to Section VI of the rate certification for additional information.	The fee schedule is consistent with the preprint.	MCOs have the ability to exceed the limit when necessary for executing a reimbursement contract. We expect no material change to the value of exceptions made over the maximum fee schedule relative to the base data, so no adjustments were made.
HCBS Increase: WI_Fee_HCBS4_Renewal_20260101-20261231	All rate cells	Reflected in Base Data summarized in Exhibits A and E	The arrangement was in effect during the base data period. 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_Renewal_20260101-20261231	All rate cells	Reflected in Base Data summarized in Exhibits A and E	The arrangement was in effect during the base data period. Please refer to Section VI of the rate certification for additional information.	This rate increase is consistent with the preprint.	Not applicable.
RC and SHC Increase: WI_Fee_HCBS9_Renewal_20260101-20261231	All rate cells	Reflected in the HCBS Minimum Fee Schedule Adjustment in Exhibit I	Implemented as a base data adjustment, specific to each combination of target group and GSR. Please refer to Section IV of the rate certification for additional information.	The adjustment is consistent with the preprint	Not Applicable

APPENDIX C

Response to 2025 to 2026 Managed Care Rate Development Guide

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	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_Renewal_20260101-20261231	The aggregate amount of the payment applicable to the rate certification is $147.0 million, of which $9.2 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 2026 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 2026 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 2026 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 30% of reported FCP administrative expenses are attributable to Medicare based on the relativity of Medicare and Medicaid service costs for the FCP program.

APPENDIX C

Response to 2025 to 2026 Managed Care Rate Development Guide

WISCONSIN DEPARTMENT OF HEALTH SERVICES COMPARISON OF CY 2024 AND CY 2026 ADMINISTRATIVE PMPMS			
HMO	CY2026 MEDICAID ADMIN PMPM	YEAR ENDING DECEMBER 31, 2024 FINANCIALS PMPM	DIFFERENCE
iCare	$295.16	$279.07	$16.09
MCWHP	$295.16	$276.04	$19.12
CCHP- FCP	$295.16	$255.99	$39.17

6. Risk 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.

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).

7. Acuity Adjustment

A. Rate Development Standards

i. 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 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. 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.

APPENDIX D

Report03 - ARPA Home and Community Based Services Minimum Payment Rate Development – Residential and Supportive Home Care Services

MILLIMAN CLIENT REPORT

ARPA Home and Community Based Services Minimum Payment Rate Development – Residential and Supportive Home Care Services

State of Wisconsin Department of Health Services

January 30, 2024

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Table of Contents

I. Executive Summary

Milliman, Inc. (Milliman) has been retained by the Wisconsin Department of Health Services (DHS) to develop Medicaid home and community-based services (HCBS) minimum payment rates for the following HCBS provided in the Family Care, Family Care Partnership and PACE managed care programs, with an anticipated effective date of July 1, 2024. The minimum payment rates developed herein would not apply to the IRIS (Include, Respect, I Self-Direct) program.

- Adult family homes (AFHs)
- Residential care apartment complexes (RCACs)
- Community-based residential facilities (CBRFs)
- Agency supportive home care (SHC) services
- Non-agency SHC services, per DHS these are considered to occur under self-direction

The purpose of the minimum payment rates is to establish a "floor" that supports a minimum payment amount for residential and supportive home care services that is consistent with efficiency, economy, quality of care, and access to care. These minimum payment rates are also intended to provide a transparent, objective benchmark that DHS and stakeholders can use to monitor rates over time.

DHS has indicated the following regarding implementation of the minimum payment rates and managed care organization (MCO) contracted amounts, which reflects conversations with MCOs during minimum payment rate development:

- MCOs will give SHC and residential service providers a rate increase for any member for whom they currently receive reimbursement below the minimum fee for the provider type and tier.
- MCOs and providers can still negotiate higher rates than the minimums based on provider or member needs, and MCOs are not required to change their payment methodologies as long as providers are not paid less than the minimum by tier and setting (described later in this report).
- DHS will not require or expect that MCOs reduce rates to other providers to offset the cost of implementing the minimum payment rates.
- In the case of payment for SHC using per diems or payment units other than 15 minute increments, DHS will require that MCOs pay SHC rates that are no less than what they would have paid using the 15-minute SHC minimum fee.
- DHS' implementation will require minimum payment rates for AFH 1-2 bed owner occupied residences to be no less than the equivalent of the SHC minimum payment rate multiplied by the hours of 1:1 care.
- DHS expects that MCOs will continue to negotiate payment rates for members requiring 1:1 care and will monitor that MCOs are paying at least the minimum payment rate associated with Tier 3.

The minimum payment rates and corresponding fiscal impacts presented in this report are intended to support DHS and Joint Finance Committee budget discussions and reflect a direct support professional (DSP) hourly wage of $15.75, per DHS' request. Payment rate assumptions also reflect consideration of program and service requirements, provider feedback gathered via regular workgroups and other stakeholder meetings, input from MCOs regarding current service delivery and billing practices, national and state workforce and provider cost data, and discussions with DHS program experts.

RESULTS

Figure 1 below shows the proposed July 1, 2024 minimum payment rates for each tier and setting of care. SHC services have separate minimum payment rates for services provided through an agency and those that are contracted directly with the service provider. Residential minimum payment rates vary by member acuity tier and setting of care. Tiers 1 to 3 are determined through key member behavioral and functional needs identified in the member's functional screen. Not all settings of care are expected to serve members at all levels of acuity, so some settings do not have minimum rates for all three tiers.

FIGURE 1: PROPOSED MINIMUM PAYMENT RATES

Setting	15 Min Rate	Single Tier	Tier 1 Per Diem	Tier 2 Per Diem	Tier 3 Per Diem
SHC – Agency	$6.38				
SHC – Non-Agency*	$4.08				
AFH 1 – 2			$373.80	$406.36	$423.65
AFH 3 – 4			$203.50	$220.79	$238.08
CBRF 5 – 8			$141.35	$158.65	$168.31
CBRF 9+			$100.75	$115.07	$133.38
RCAC		$67.41			

** Per DHS, these are considered to occur under self-direction*

Implementation of these minimum payments is projected to increase Family Care, Family Care Partnership and PACE program costs by an estimated $258 million in combined state and federal funds between July 1, 2024 and June 30, 2025 (State Fiscal Year 2025 or SFY 2025) as illustrated in Table 2 below. We developed the estimated fiscal impact using Calendar Year (CY) 2022 MCO encounter data and member functional screens and then trended to CY 2024. The two residential adjustments in Figure 2 adjust at a high level for limitations in the encounter data that are not able to be attributed to the more granular fiscal impact analyses in the appendices of this report.

FIGURE 2: TOTAL FISCAL IMPACT DEVELOPMENT

	Estimated Fiscal Impact ($millions)
Supportive Home Care	$37.3
Residential Care	232.1
Residential Day Programs Adjustment	-22.6
Residential Unit Limit Adjustment	11.3
Total Fiscal Impact	$258.1

The projected wage, employee-related benefits and fiscal impacts in this report include trending to CY 2024 levels. We do not anticipate that wages and estimated fiscal impacts would vary significantly between CY 2024 and SFY 2025. Should DHS implement and maintain the minimum payment rate structure beyond SFY 2025, we recommend updating the minimum payment rates to incorporate updated wage and service utilization experience.

It is our understanding that DHS will incorporate the estimated fiscal impact calculations into managed care capitation to fund the cost of the minimum payment rate increases, and MCOs will not need to reduce rates to other providers to offset the cost of implementing the minimum payment rates.

The remainder of this report provides an in-depth description of the approach, methodology, and assumptions used to develop the minimum payment rates and related fiscal impact estimates.

II. Notable Work Contributing to the Minimum Payment Rates

The development of the minimum payment rates reflects intensive work with DHS and other stakeholders to better understand the costs associated with delivery of the included services. This process has included the following notable efforts:

Quarterly Stakeholder Meetings (April 2022 – April 2023): DHS held quarterly meetings with representatives from key stakeholders, e.g., associations, providers, managed care entities. Meetings provided a forum for key aspects of the project, such as:

- Project status updates
- Feedback on the minimum payment rate assumptions and preliminary payment rates (e.g., wage levels and approach to tiering rates)
- Provider cost survey approach
- Minimum payment rate implementation considerations

Monthly Provider Workgroup Meetings (May 2022 – April 2023): DHS held separate monthly Workgroup meetings with residential care providers and SHC providers. These two workgroups provided:

- Subject matter expertise regarding service delivery and related costs for services
- Feedback from the perspective of their organization and other organizations across the state providing similar services
- Feedback on survey approach, survey tool and instructions, key minimum payment rate assumptions and rates

Focus Groups for 1-2 Bed Owner-Occupied AFHs (October 2022): DHS held five focus groups reflecting owner-occupied AFH 1-2 bed providers contracting with the Family Care / Family Care Partnership MCOs, facilitated by Milliman. The focus groups discussed staffing structure and service delivery costs and challenges specific to the service setting.

Technical Staffing Subgroups by Provider Setting (October 2022 and April 2023): DHS invited residential care providers to participate in subgroup meetings facilitated by DHS contractor Kaphengst Consulting LLC. Kaphengst Consulting, LLC provides consulting services to small and medium-sized companies that provide home and community-based, long-term care, and assisted living services in the community to children and adults with disabilities and older adults. These subgroup meetings were used to collect information on staffing assumptions specific to DHS' proposed residential care tier definitions.

Family Care and Family Care Partnership MCO meetings (2022-2023): DHS held meetings to obtain additional information to inform the fiscal impact estimates of the minimum payment rates. Topics included payments when a member is enrolled in day treatment activities, encounter adjustments, member-specific negotiated rates, and compliance practices.

American Rescue Plan Act (ARPA) Adult HCBS Minimum Fee Schedule Provider Cost Survey (October – November 2023): DHS requested that Family Care and Family Care Partnership providers delivering AFH, RCAC, CBRF, SHC and personal care services respond to a provider survey specifically targeted to support minimum payment rate development. Live-in caregivers, owner-occupied AFHs with 1 to 2 beds, and any providers that use their social security number as their provider ID for billing purposes were not asked to complete the survey. This survey collected information on provider operating costs, such as employee wages, employee benefits and taxes, transportation costs, and administrative costs. Milliman developed and administered the survey, including providing technical assistance, multiple training sessions, and responses to frequently asked questions.

Two hundred nineteen providers responded reflecting a wide range of services, as illustrated in Figure 3. Due to quality concerns for some data elements submitted, it was possible to review the survey data to inform assumptions, but survey results were not used as direct inputs into the minimum payment rate assumptions.

FIGURE 3: PROVIDER RESPONSE BY SETTING

SETTING	NUMBER OF SURVEYS WITH SETTING*
AFH 1-2	25
AFH 3-4	82
RCAC	40
CBRFs<=8	39
CBRFs>8	84
SHC	56
PC	28

**Individual provider surveys may reflect more than one setting.*

Feedback from MCOs (2022-2023): DHS had numerous discussions with Family Care / Family Care Partnership MCOs throughout the development phase to further understand current payment methodologies, and contracting and billing practices, including self-direction and non-agency and agency-based SHC. These conversations informed DHS' input on the minimum payment rate and fiscal impact assumptions presented in this report.

III. Key Stakeholder Feedback

DHS collected stakeholder feedback on key aspects of current service delivery related expenses, challenges, and operations framework. Figure 4 below highlights key stakeholder feedback received to date through the stakeholder engagement efforts described in *Section I. Notable Work Contributing to the Minimum Payment Rates.*

FIGURE 4: KEY THEMES FROM CROSS WORKGROUP: RESIDENTIAL AND SHC / PC SERVICES PROVIDERS

TOPIC	KEY THEMES
Workforce and Staffing Dynamics	▪ Providers have been experiencing ongoing staffing challenges, which have been exacerbated by the pandemic. ▪ Wages for direct care staff (frontline workers and their supervisors, nursing staff) have not been able to keep up with inflation. ▪ Competing industries offer higher wages and benefits for positions that are not as intensive or demanding as those for HCBS (e.g., retail, fast food, and light industrial). ▪ Individuals with complex needs and high behavioral health needs require more staffing on average. ▪ Overall concern regarding the lack of a BLS Standard Occupational Classification (SOC) code for DSPs in particular, as DSP responsibilities include more than personal care tasks. ▪ Individuals range in their intensity of needs, in particular related to high behavioral health needs.
Housing-related costs for residential care	▪ Room and board payments do not always cover the necessary housing-related costs. *Note: Room and board costs were not included in minimum payment rate determination based on Medicaid regulations.* ▪ Home modifications that are necessary for care and supervision should be included under the care and supervision part of the payment rate.
Transportation associated costs	▪ Current payment rates do not fully cover the costs of fuel, obtaining new provider vehicles and maintaining existing vehicles. ▪ MCOs often require that the payment rate for residential care includes all of a member's transportation needs without further definition; this is not reasonable due to the extensive transportation needs of some members. ▪ Having separate staff for residential care transportation tasks is not always possible.
Variation in residential care staffing during the day	▪ The COVID pandemic has changed the extent to which individuals participate in services outside of the home, changing residential care staffing needs during the day. Some providers report that staffing does not vary that much throughout the day as some individuals will remain in the home during the day, and because staff must still be available to support individuals that are outside of the home (e.g., picking up early, as needed).
Other topics	▪ Some providers reported increased costs related to meeting regulatory requirements, e.g., related to increasing nursing time, and space needed to train staff.

IV. Methodology

A. MINIMUM PAYMENT RATE DEVELOPMENT APPROACH

We used an independent rate model (IRM) approach to calculate the average costs that a reasonably efficient provider would be expected to incur while delivering the services discussed in this report. As denoted by its description — *independent* rate model — this approach determines the costs related to the individual components shown in Figure 5 and sums the component amounts to derive a rate for each service. The IRM approach serves to capture and document the average expected costs a reasonably efficient provider would incur while delivering a service. Rather than relying on actual costs incurred from a prior time period to determine what the rates should be, the IRM approach builds rates from the "ground up" and considers what the costs may be to provide the service based on a set of assumptions. This approach provides transparency to rates that are consistent with efficiency, economy, quality of care, and access to care. This transparency includes clear and concise documentation of the rate development process, where each component can be independently reviewed and assessed. The identification of assumptions by individual rate model component allows for easy updates to accommodate the ever-changing healthcare landscape and regulatory environment.

The IRM approach can be distinguished from other provider payment methodologies in that it estimates the costs for each service given the resources (salaries and other expenses) reasonably expected to be required, on average, while delivering the service. This approach relies on multiple independent data sources to develop rate model assumptions. By contrast, many cost-based methods rely primarily on the actual reported historical costs incurred while delivering services, which can be affected by operating or service delivery decisions made by providers. These operating or service delivery decisions may be inconsistent with program service delivery standards or be caused by program funding limitations that do not necessarily consider the average resource requirements associated with providing these services.

To the extent actual costs incurred by service providers are affected by external factors, such as legislatively-mandated funding levels that are not consistent with factors that drive the market, the IRM approach also provides a means to communicate what costs may reasonably be incurred, and the issues faced by providers, so decision makers can more equitably allocate resources based on this information.

FIGURE 5: INDEPENDENT RATE MODEL COMPONENTS

COMPONENT	ELEMENTS	SUB-ELEMENTS	CLARIFYING NOTES
Clinical Staff and Supervisor Salaries and Wages	Service-related time	Direct time	Corresponding time unit, or staffing requirement assumptions where not defined Adjusted for staffing ratios for some services (i.e., more than one person served concurrently, e.g., in group counseling sessions or for residential services).
		Indirect time	Service-necessary planning, note taking and preparation time
		Transportation time	Travel time related to providing service
		PTO / training / conference time	Paid vacation, holiday, sick, training and conference time. Also considers additional training time attributable to employee turnover
		Supervisor time	Accounted for using a span of control variable
	Wage rates	Can vary for overtime and weekend shift differentials	Wage rates vary depending on types of direct service employees, which have been assigned to provider groups
Employee Related Expenses	Payroll-related taxes and fees	Federal Insurance Contributions Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Insurance (SUI), Workers Compensation	Applicable to all employees, and varies by wage level assumption
	Employee benefits	Health, dental, vision, life and disability insurance, and retirement benefits	Amounts may vary by provider group
Transportation	Vehicle operating expenses	Includes all ownership and maintenance-related expenses	Varies by service with costs estimated based on the federal reimbursement rate.
Administration, Program Support, Overhead	All other business-related costs	Includes program operating expenses, including management, accounting, legal, information technology, etc.	Excludes room and board expenses.

Section III.B provides a detailed description of each of the components in Figure 2. The first two – clinical staff and supervisor salary and wages, and employee related expenses (EREs) – comprise the largest portion of the expected costs built into the rate models. We have excluded room and board expenses from the minimum payment rate calculations as these expenses are not allowed for Medicaid payment per federal Medicaid regulation.

We used two different types of rate models to develop the residential and SHC minimum payment rates, described in Figure 6. These rate models include similar types of assumptions, cost components, and elements with adjustments based on service-specific requirements.

FIGURE 6: RATE MODEL APPROACHES

MODEL	RELATED SERVICE	OVERALL DESCRIPTION
Per Unit Rate Model	SHC 15 min rate	▪ Used when the service time assumptions related to providing the service can be reasonably determined on a per unit basis. ▪ Relies on the assumption that direct care staff incur time when a unit of service is provided, with supervision as necessary. ▪ The resulting rate per unit reflects the adjusted total minutes multiplied by the hourly labor-related cost components, and then adding all other applicable rate components. The administration / program support/overhead component is included in the rate per unit by taking the total cost of all prior components divided by one minus the administration / program support / overhead percentage amount
24/7 Shift-Based Rate Model	Residential care services	▪ Used for services where more than one individual is served by a direct care staff group, typically in a residential setting, where direct care staff are expected to be on-site for scheduled periods or shifts, set up to provide service coverage over an extended period of time, or on a 24/7 basis. ▪ Considers the number of direct care staff required for each shift for each day, including separate staffing patterns for weekday periods and weekends. ▪ Incorporates an assumption for a reasonable percentage of hours paid at time and a half pay rate since the direct care staff delivering these services commonly earn time and a half pay by working overtime or holiday hours. ▪ Calculates separate weekly wage expenses and ERE expenses (including time and a half pay) for the direct care staff groups delivering the service. These values are then converted to an average daily expense amount per individual served. ▪ Adjusted weekly service time sub-elements include direct care staff and supervisor time per week and a PTO adjustment factor. ▪ Add-on cost components per unit – Transportation expenses – Caseload efficiency – Program support costs, administration, and overhead

While the IRM is intended to be as inclusive as possible for the purpose of explicitly accounting for the key cost components of delivering a specific service, there are situations which may require special considerations of the cost structure or cost elements unique to a specific service operation environment or need. The minimum payment rates are intended to establish a "floor" and are not meant to exclude the ability of MCOs and providers to consider these types of situations as part of payment rate negotiations.

In *Section III.B. Direct Care Staff Categories* and *Section III.C. Rate Model Components* we provide more detail regarding each of IRM components along with their elements and sub-elements. *Subsection III.C.5* provides payment rate assumptions specific to the SHC non-agency-based minimum payment rate.

B. DIRECT CARE STAFF CATEGORIES

We determined model assumptions that drive the staff salaries and wages, PTO assumptions, and ERE components (described in *Section III.B. Rate Model Components*) at the direct care staff category level. These categories, developed based on DHS and stakeholder feedback, reflect the staff types needed to deliver the SHC and residential care services under analysis.

FIGURE 7: DIRECT CARE STAFF CATEGORIES

Direct Support Professional (DSP) *Note:* This direct care staff category reflects frontline workers for residential and SHC services and includes staff responsible for transportation of members.
DSP Supervisor
Registered Nurse / Behavioral Health Professional
Registered Nurse

Section III.B.1 Direct Care Staff and Supervisor Salary and Wages provides a description of how we identified the BLS SOC code(s) for each of these categories for purposes of wage development.

C. RATE MODEL COMPONENTS

This subsection provides a description of the key rate components listed in Figure 5, which are:

- Direct care staff and supervisor salary and wages
- Employee related expenses
- Transportation
- Administration, program support, overhead

This subsection also includes considerations specific to the non-agency SHC minimum payment rate.

1. Direct Care Staff and Supervisor Salary and Wages

The direct care staff salary and wage components are typically the largest components of the payment rates, comprising the labor-related cost, or the product of the time and expected wage rates for the direct care staff who deliver each of the services. This component includes costs associated with the direct care staff expected to deliver the services and their immediate supervisors.

Staff Time

We identified direct care staff time using staffing assumptions provided by DHS, and included adjustments for PTO, holidays, and in some cases overtime.

- **Residential Care** – DHS developed initial staffing assumptions by residential care setting and held technical staffing subgroup meetings in October 2022 and in April 2023 to further refine assumptions. DHS shared staffing assumptions with workgroup members to obtain additional feedback prior to finalizing the assumptions for Milliman's inclusion in payment rate development. Appendix A provides the staffing assumptions by residential care service setting included in the minimum payment rates.
- **SHC** – Minimum payment rates reflect face-to-face time spent with members, billed in 15 minute increments. DHS program staff indicated that no indirect time should be included in the payment rates based on DHS expectations regarding service-related documentation by DSPs occurring concurrently with service provision, and DHS' discussions with MCOs regarding current service delivery expectations and contracting practices. We based DSP supervisor time on a 1:20 supervisor span of control (1 supervisor to 20 DSPs) based on DHS program experts' input.

Staff time also included assumptions related to training time, PTO, overtime / holidays, turnover and a residential care caseload efficiency factor, as described below in Figure 8. *Subsection III.C.5* provides information regarding the SHC non-agency-based minimum payment rate.

FIGURE 8: SUMMARY OF SUB-ELEMENTS RELATED TO PROVIDER GROUPS TIME

TIME SUB-ELEMENT	DEFINITION	ASSUMPTIONS
Training hours	▪ Accounts for annual training and / or conference time expected to be incurred by direct care staff and supervisors.	▪ Training hours informed by stakeholder feedback ▪ New hire training hours set by service setting: – Residential Care: 80 hours – SHC: 45 hours ▪ Ongoing training hours (annual) of 20 total
PTO – annual hours	▪ Accounts for additional time that must be covered over the course of a year by other direct care staff, thereby representing additional direct care staff time per unit: – Annual time related paid vacation, holiday, and sick time.	▪ 10 holidays (9 state holidays and a floating holiday). Overtime is applied to these days at time and a half. ▪ 2.5 weeks of additional PTO (8 hours per day) ▪ Adjusted based on the Wisconsin-specific median percentage of employees that are full-time.[1]
Overtime / Holiday	▪ Accounts for overtime hours and holidays	▪ 1.5 applied to 10 holidays
Turnover	▪ The turnover rate is the assumed percentage of employed staff that leave an organization during the same time period. ▪ The turnover rate is used to identify the number of training hours needed for new hires that is reflected in the payment rate.	▪ 35%, informed by other state payment rate assumptions and assumes increased stability in DSP workforce. For context, recently reported turnover rates for HCBS agencies include: – 51%: Median turnover rate reported by Wisconsin HCBS providers via DHS' HCBS 2022 Cost and Wage Survey (146 responses, all direct care staff, with agencies reporting turnover rates >100% excluded) – 34%: Median turnover rate for Wisconsin reported in the 2021 NCI / IDD Staff Stability Survey (203 responses, DSPs only, with agencies reporting turnover rates >=500% excluded)
Residential care – Caseload efficiency factor	▪ Accounts for staff productivity	▪ 95%, informed by other state payment rate assumptions for similar services

The minimum payment rates are not intended to reflect all circumstances. As such, we have developed minimum payment rates using the maximum number of residents for AFH and CBRF settings, and staffing needed per 10 residents for CBRFs 9+ and RCACs.

Wage Rate Assumptions for Direct Care Staff and Supervisors

We developed the direct care staff hourly wage for each direct care staff category using Wisconsin-specific May 2021 wage data from the BLS and input from DHS specific to the DSP wage. We used BLS wage data because it is publicly available, state-specific, updated on an annual basis, collected in a consistent and statistically credible manner, and allows for wage assumptions to vary by wage percentile and by direct care staff category. We aligned Standard Occupational Classification (SOC) codes from the BLS data to the direct care staff categories based on position responsibilities, a review of SOC code descriptions, and feedback from DHS and provider workgroup discussions.

DSP – Identification of BLS SOC Codes As BLS data does not include an SOC code that reflects the wide range of responsibilities for HCBS frontline direct care workers, we relied on a blend of relevant BLS SOC codes to define the DSP staff category. This blending approach is a common approach used by other states, with the Home Health and Personal Care Aide BLS SOC code often receiving the largest weight for HCBS frontline workers and blended with one or more occupational code(s) that recognize the variable nature of delivering HCBS. BLS SOC codes that have been considered by other states during blending for purposes of HCBS frontline worker wage identification include:

[1] National Core Indicators Intellectual and Developmental Disabilities. 2021 State of the Workforce NCI / DD Report. 2022. Table 23. Accessed online: https://idd.nationalcoreindicators.org/wp-content/uploads/2023/02/2021StateoftheWorkforceReport-20230209.pdf

- Social and Human Service Assistant (21-1093)
- Recreation Workers (39-9032)
- Rehabilitation Counselors (21-1015)
- Psychiatric Aides (31-1133)
- Psychiatric Technicians (29-2053)
- Medical Assistants (31-9092)
- Residential Advisors (39-9041)
- Passenger Vehicle Drivers (53-3058)
- Physical Therapist Aides (31-2022)
- Community and Social Service Specialist, All Other (21-1099)
- Healthcare Support Worker, All Other (31-9099)

After a thorough review of the BLS definitions for each of these occupational definitions, consideration of provider feedback, and extensive discussion with DHS staff, we chose to use the following BLS SOC codes and blending weights for the DSP staff category:

- Home Health and Personal Care Aides (31-1120): 95%
- Rehabilitation Counselors (21-1015): 5%

Registered Nurse / Behavioral Health Professional – Identification of BLS SOC Codes We defined the Registered Nurse / Behavioral Health Professional using the following BLS SOC codes and blending weights:

- Healthcare Social Workers (21-1022): 25%
- Mental Health and Substance Abuse Social Workers (21-1023): 25%
- Registered Nurses (29-1141): 50%

Trending We trended wages to CY 2024 levels and do not anticipate that wages would vary significantly between CY 2024 and SFY 2025. Should DHS implement and maintain the minimum payment rate structure beyond CY 2025, we recommend updating the payment rates to incorporate updated wage and service utilization experience. We applied an annual trend factor of 4.00% to the base wage rates based on analyses of the Wisconsin annual wage trend from BLS wage data for related BLS SOC codes, and Federal Reserve Economic Data hourly wage trend for all employees. The use of 4.00% wage trend factor resulted in an overall assumed aggregate increase of 13.2% in direct care worker wages from May 2021 to July 2024.

Wage Identification Figure 9 provides a summary of the direct care staff category wages and related BLS percentile selections for purposes of minimum payment rate development. The wage identification process included discussion with DHS, consideration of provider feedback and a review of Wisconsin-specific wage data from BLS, the provider survey, and the National Core Indicators Intellectual and Developmental Disabilities State of the Workforce Survey.

FIGURE 9: SUMMARY OF DIRECT CARE STAFF CATEGORY WAGES USED IN MINIMUM PAYMENT RATE DEVELOPMENT

STAFF CATEGORY	WAGE	DESCRIPTION
DSP	$15.75	Wage value was provided by DHS and is equivalent to the 50th percentile of wages for the selected BLS SOC codes (described above)
DSP Supervisor	$20.25	Set relative to the DSP wage based on the relationship between the following: 50th percentile of BLS wages for the DSP staff category 50th percentile of the BLS wage for the Rehab Counselors BLS SOC code
RN / BH Professional	$35.44	50th percentile of BLS wages for selected BLS SOC codes (described above)
RN	$41.41	50th percentile of the BLS wage for the Registered Nurse BLS SOC code

2. Employee Related Expenses

The ERE component captures the expenditures expected to be incurred for direct care staff and is expressed as a percentage specific to each direct care staff category. The ERE component includes:

- Employer portion of payroll taxes
- Employer portion of employee medical and other insurance benefits
- Employer portion of retirement expenses

A significant portion of the ERE is driven by the cost of health insurance and retirement benefits the employer provides to its employees. Assumptions developed for the health insurance and retirement benefits components were based on the following considerations:

- Health insurance – $4,218 per year based on:
  - BLS hourly insurance cost[2]
  - Adjustment made to reflect differences in health insurance offer and take-up rates between Wisconsin HCBS-specific data (2021 NCI-IDD Staff Stability Survey) and nationwide data
  - Review of employee-related benefit costs in Wisconsin HCBS provider survey data
- Retirement benefit percentage – 1.68% based on:
  - Defined contribution retirement as a percent of wages and salaries and paid leave from BLS data
  - Adjustments made for differences in the percentage of employers offering sponsored retirement plans between Wisconsin HCBS-specific data (2021 NCI / IDD Staff Stability Survey) and nationwide data
  - Review of Wisconsin HCBS provider survey data collected for minimum payment rate development purposes

Figure 10 provides a summary of the ERE assumptions and their related sources. *Subsection III.C.5* provides information regarding the ERE assumptions for the SHC non-agency-based minimum payment rate.

[2] BLS' definition of insurance encompasses life, health, and short- and long-term disability costs

FIGURE 10: EMPLOYEE RELATED EXPENSE ASSUMPTIONS

COMPONENTS	ASSUMPTIONS FOR CY 2024	SOURCE
FICA Limit	$162,900	$162,900 projected for 2024 Source: 2021 OASDI Trustees Report. Section C: Program-Specific Assumptions and Methods. Accessed online (April 20, 2023): https://www.ssa.gov/OACT/TR/2021/V_C_prog.html#1047210
FICA Percentage	7.65%	FICA consists of Social Security and Medicare Withholding Rates (6.2% and 1.45%, respectively). Social security tax has a wage base limit (projected to be $162,900 in 2024). *Source:* Internal Revenue Service. Topic 751, Social Security and Medicare Withholding Rates. Accessed online (Apil 20, 2023): https://www.irs.gov/taxtopics/tc751
FUTA Tax	$420	6% of first $7,000 *Source:* Internal Revenue Service. Topic No. 759 Form 940 – Employer's Annual Federal Unemployment (FUTA) Tax Return – Filing and Deposit Requirements. Accessed online (April 20, 2023): https://www.irs.gov/taxtopics/tc759#:~:text=FUTA%20tax%20rate%3A%20The%20FUTA,federal%20or%20FUTA%20wage%20base
SUI Tax	$427	Set at 3.05 percent of up to $14,000, using all other industries with payroll less than $500,000. *Source:* Wisconsin Department of Workforce Development. Unemployment Insurance 2023 Tax Rates. Accessed online (April 20, 2023): https://dwd.wisconsin.gov/ui/employers/taxrates.htm
Workers Comp	1.44%	Workers compensation as a percent of wages and salaries and paid leave. *Source:* Bureau of Labor Statistics. December 2022. Employer Costs of Employee Compensation – December 2022. Table 1, Civilian Workers Category.
Health insurance	$4,218	BLS hourly insurance for health care and social assistance group multiplied by 2,080 hours and adjusted for differences in offer and take-up rates between Wisconsin HCBS-specific and nationwide data using the NCI-IDD survey information and a review of Wisconsin HCBS provider survey data collected for minimum payment rate development purposes. BLS' definition of insurance encompasses life, health, and short- and long-term disability costs. *Source:* U.S. Bureau of Labor Statistics. (December 2022). Economic News Release, Table 2. Employer Costs for Employee Compensation for civilian workers by occupational and industry group.
Retirement	1.68%	BLS-defined contribution retirement as a percent of wages and salaries and paid leave adjusted for differences in the percentage of employers offering sponsored retirement plans in Wisconsin HCBS-specific and nationwide data using the NCI-IDD survey information and a review of Wisconsin HCBS provider survey data collected for minimum payment rate development purposes. *Source:* Bureau of Labor Statistics. December 2022. Employer Costs of Employee Compensation – December 2022. Table 1, Civilian Workers Category.

The detailed calculations related to the ERE percentage are shown by provider group in Appendix B.

3. Vehicle Costs – Residential Care

The IRM's transportation expense component reflects vehicle expenses; staff time for transporting members is included in the staffing assumptions described in Appendix A. The per diem minimum payment rates calculated for residential care services include non-emergency transportation for members as those transportation services may not be billed separately for the services under analysis.

Transportation costs vary by setting, with expenses spread across all billable units of a claim in the same way that the transportation time is incorporated into the rate models. The transportation cost assumptions are as follows:

- AFH and CBRF <=8: 100 miles per resident per month (no variance by tier). We multiplied the number of miles by the 2023 federal mileage reimbursement allowance of $0.655 per mile. This approach assumes that the federal mileage reimbursement would be sufficient to cover the cost of either employee-owned or provider-owned vehicles.

- CBRF > 8: For Tier 1, we used the estimated per diem cost of a car assuming 10,000 miles per year (without lift). For Tiers 2-3, we used the estimated per diem cost of one van / residence / 8 individuals, assuming 20,000 miles total per year blended with and without lift.
- RCAC: Estimated cost of one van per 10 individuals, assuming 20,000 miles total per year (without lift).

When using direct vehicle cost to develop the transportation allowance, we considered the cost of a vehicle and its expected longevity, insurance and registration, gas prices and basic vehicle maintenance, including oil changes, brake replacement, tire replacement and rotation, battery replacement and air filter replacement.

4. Administration / Program Support / Overhead

The administrative cost factor is intended to account for the following types of costs:

- **Administrative-related expenses –** Generally, administrative-related expenses would include all expenses incurred by the provider entity necessary to support the provision of services but not directly related to providing services to individuals. These expenses exclude transportation, wages, and employee-related expenses for direct care, and may include, but not be limited to:
  - Salaries and wages, and related employee benefits for employees or contractors that are not clinical / direct service workers or first- and second- line supervisors of direct service workers
  - Liability and other insurance
  - Licenses and taxes
  - Legal and audit fees
  - Accounting and payroll services
  - Billing and collection services
  - Bank service charges and fees
  - Information technology
  - Telephone and other communication expenses
  - Office and other supplies including postage
  - Accreditation expenses, dues, memberships, and subscriptions
  - Meeting and administrative travel related expenses
  - Training and employee development expenses, including related travel
  - Human resources, including background checks and other recruiting expenses
  - Community education
  - Marketing / advertising
  - Interest expense and financing fees
  - Facility and equipment expense and related utilities (excluding room and board)
  - Vehicle and other transportation expenses not related to transporting individuals receiving services or transporting employees to provide services to individuals
  - Board of director-related expenses
- **Program support costs –** include supplies, materials, and equipment necessary to support service delivery

We used a 15.0% administrative cost rate for residential care and 10% for SHC services. We reviewed Wisconsin HCBS provider survey data but did not use it directly to establish this assumption as the range of administrative and program support costs as a percentage of total costs (excluding room and board) varied widely. Additionally, data reported by many providers resulted in percentages that appeared higher than expected for administrative costs as defined in the survey (e.g., over 30%).

5. Considerations for SHC Non-Agency Rate

According to DHS, the non-agency SHC minimum payment rate for self-direction is assumed to be lower than the agency-based minimum payment rate after excluding the below rate components and sub-elements at DHS' direction. It is our understanding that these exclusions are made to replicate the current payment structure in the marketplace as, per DHS, almost all non-agency services are self-directed.

- PTO allowance
- Employee turnover rate
- ERE
  - Payroll taxes (FICA, FUTA, SUI)
  - Workers compensation insurance contributions
  - Health insurance
  - Retirement contributions
- DSP supervisor time
- Administrative cost, program support and other overhead expenditures

For the purpose of calculating the fiscal impact of the non-agency minimum rate, we assumed that MCOs would need to increase members' Self-Directed Supports (SDS) budgets (outside of the minimum rate paid to providers) to reflect continued payment of payroll taxes (FICA, FUTA, SUI) and workers compensation insurance contributions.

D. RESIDENTIAL ACUITY TIER DEFINITIONS AND THEIR USE BY SETTING

DHS developed residential acuity tiers based on stakeholder feedback, staffing input from Kaphengst Consulting LLC, and Milliman analysis of the relationship between Long Term Care Functional Screen elements and CY 2021 provider reimbursement. Figure 11 provides a summary of the resulting Tier 1, 2 and 3 functional screen value definitions.

FIGURE 11: RESIDENTIAL CARE TIER 1-3 DEFINITIONS

TIER 1	TIER 2	TIER 3
▪ WANDERING = 0 ▪ SELF_INJURIOUS = 0 ▪ SELF_INJRIOUS = 1 – Weekly intervention or less ▪ OFFENSIVE / VIOLENT = 0 ▪ OFFENSIVE / VIOLENT = 1 – Weekly intervention or less	▪ WANDERING = 1 – Daytime wandering but sleeps nights ▪ SELF_INJURIOUS = 2 – Intervention 2 to 6 times per week or 1 to 2 times per day ▪ OFFENSIVE / VIOLENT = 2 – Intervention 2 to 6 times per week or 1to 2 times per day	▪ WANDERING = 2 – Wanders during night or both day and night ▪ SELF_INJURIOUS = 3 – Intensive one-on-one interventions more than twice a day ▪ OFFENSIVE / VIOLENT = 3 – Intensive one-on-one interventions more than twice a day
	Dressing help – 2 (Helper present)	Transfer with Mechanical Lift – 'Y' (Yes)
	Toileting help – 2 (Helper present)	Tracheostomy exists – Not 'NR' (Even if independent)
	Ostomy exists – Not 'NR' (Even if independent)	Tube Feeding – Not 'NR' (Even if independent)
	Transfer help – 2 (Helper present)	Positioning in Bed or Chair – Not 'NR' (3+ times per day)

Once the tier definitions were established, DHS determined that certain levels of acuity were unlikely to occur in certain settings of care. Most individuals in RCACs have lower needs, so their minimum rate is associated with a single tier. Milliman analyzed the levels and variation in current MCO reimbursement to confirm the validity of this approach. Figure 12 illustrates the tiers created for each residential provider type.

FIGURE 12: SUMMARY OF RESIDENTIAL TIERS STRUCTURE BY SETTING

SETTING	SINGLE TIER	TIER 1 PER DIEM	TIER 2 PER DIEM	TIER 3 PER DIEM
AFH 1-2 (corporate owned)		X	X	X
AFH 3-4		X	X	X
CBRF 5-8		X	X	X
CBRF 9+		X	X	X
RCAC	X			

Appendix C provides the detailed rate buildup for the minimum payment rates for services included in this report.

V. Fiscal Impact Analysis

The fiscal impact analysis seeks to connect the minimum payment rate development phase with the implementation phase by estimating the additional cost required to fully fund the implementation of the HCBS minimum payment rates between July 1, 2024 and June 30, 2025. Figure 13 below shows our estimate of the combined state and federal funding needed to properly fund the Family Care, Family Care Partnership and PACE capitation rates to account for this new payment floor.

FIGURE 13: TOTAL ESTIMATED FISCAL IMPACT DEVELOPMENT

	FISCAL IMPACT ($MILLIONS)
Supportive Home Care	$37.3
Residential Care	232.1
Residential Day Programs Adjustment	-22.6
Residential Unit Limit Adjustment	11.3
Total Fiscal Impact	**$258.1**

The following are important notes regarding the development of the fiscal impact:

- The residential day program adjustment is equivalent to -2% of certain MCO projected 2024 expenditures to account for reimbursement being reduced when individuals attend day treatment programs, consistent with current practices.
- The residential unit limit adjustment is equivalent to 1% of projected 2024 expenditures to account for our analysis limiting all monthly encounters to 31 units (i.e., days). The encounter data underlying the fiscal impact includes some experience reported as members receiving more than 31 units in a month, some portion of which may be consolidated into fewer units if the minimum rates are implemented. In our analysis, we limited all units to 31 in a month, which increased the calculated per diems and reduced the fiscal impact. To offset some of this reduction, which may remain outside the residential per diem in the future, we increased the fiscal impact by 1% of projected residential expenditures based on our analysis of the experience.
- We assumed that SHC services provided on a per diem basis increase by the same percentage as the corresponding service provided on a 15-minute basis.
- We calculated fiscal impacts for Tiers 1 and 2 for the AFH 1-2 setting using the overall SHC fiscal impact percentage as a proxy for the location and reimbursement methodology for owner-occupied family homes. We assumed that Tier 3 represents the majority of corporate-owned AFH 1-2 and calculated its fiscal impact in the same manner as for other residential settings.
- DHS expects that MCOs will continue to negotiate payment rates for members requiring 1:1 care and will monitor that MCOs are paying at least the minimum payment rate associated with Tier 3.
- The projected wage and fiscal impacts in this document include trending to CY 2024 levels. We do not anticipate that wages and fiscal impacts would vary significantly between CY 2024 and SFY 2025. Should DHS implement and maintain the minimum payment rate structure beyond CY 2025, we recommend updating the payment rates to incorporate updated wage and service utilization experience.

Figure 14 below provides additional information on the impact of minimum payment rates by setting.

FIGURE 14: ESTIMATED FISCAL IMPACT STATISTICS

RESIDENTIAL SETTING / PROVIDER TYPE	PERCENTAGE OF SERVICE UNITS IMPACTED	RATE INCREASE FOR IMPACTED SERVICES	RATE INCREASE ACROSS ALL SERVICES
AFH 1-2	69.4%	58.2%	20.2%
AFH 3-4	67.2%	49.5%	28.2%
CBRF<=8	61.0%	33.4%	16.4%
CBRF>8	68.3%	27.4%	16.4%
RCAC	41.0%	21.7%	6.8%
Total Residential Services	**64.1%**	**40.5%**	**20.5%**
Agency	76.6%	6.1%	4.3%
Non-Agency	75.1%	23.8%	16.3%
Total SHC Services	**75.6%**	**16.2%**	**11.3%**

A. METHODOLOGY

The fiscal impact analysis is based on CY 2022 functional screens, MCO encounter data and uses the tier definitions provided by DHS on March 22, 2023, and discussed in Section III of this report. We trended the base experience period to CY 2024 using an aggregate trend rate of 3.0%, consistent with Family Care and Family Care Partnership capitation rate development.

The residential care portion of the fiscal impact is based on the average monthly rate paid to providers for each member while the SHC are done at the claim level. Per DHS instructions and MCO-provided contracting information, we assumed SHC services were non-agency based when the unit cost found on a claim in the MCO encounter data was below thresholds specific to each MCO. DHS has indicated that majority of these services are self-directed.

We then compared the average encounter data provider payment to the corresponding minimum payment rate. If the average encounter-based payment was lower than the minimum payment rate, we included the difference in the total fiscal impact.

For purpose of calculating the fiscal impact for SHC non-agency minimum payment rates, we considered that some of the financial components excluded from the rate development process are typically still paid through SDS budgets, which MCOs would need to increase in order to meet the minimum payment requirements. These components are payroll taxes (FICA, FUTA, SUI) and workers compensation insurance contributions. This increase used for fiscal impact calculations was equivalent to a minimum payment rate of $4.56 per 15 minute unit, which is $0.48 higher than the actual non-agency minimum rate.

VI. Limitations and Data Reliance

The information contained in this report, including the appendices, has been prepared for the Wisconsin Department of Health Services (DHS). To the extent that the information contained in this report is provided to third parties, the report should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

The contents of this report are not intended to represent a legal or professional opinion or interpretation on any matters. Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this information prepared for DHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The analyses contained in this correspondence 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.

We developed these proposed minimum payment rates using an independent rate model, which calculates rates based on the sum of independently determined rate inputs and components. Inputs are based on expected resources required to provide the service. It is certain that actual individual provider cost experience will not conform exactly to the assumptions used to develop these proposed minimum payments rates. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

We used Calendar Years 2021 and 2022 managed care encounter data and member functional screens, publicly available data sources, Wisconsin HCBS provider survey data, feedback from providers and other stakeholders, and staffing assumptions provided by DHS to develop the proposed minimum payment rates included in this correspondence and have accepted this data without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in these exhibits may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose.

Please note, projected wage and fiscal impacts in this document include trending to CY 2024 levels. We do not anticipate that wages and fiscal impacts would vary significantly between CY 2024 and SFY 2025. Should DHS implement and maintain the minimum payment rate structure beyond CY 2025, we recommend updating the payment rates to incorporate updated wage and service utilization experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The responsible actuaries for this analysis, Michael Cook and Mathieu Doucet, are members of the American Academy of Actuaries and meets the qualification standards for developing this report.

APPENDIX A

Appendix A
State of Wisconsin
Department of Health Services
ARPA HCBS Minimum Payment Rate Development
Assumptions Used in Payment Rate Development - Staffing Hours by Setting and Provider Type

Setting	AFH 1-2 - Corporate (2 residents assumed)			AFH 3-4 (4 residents assumed)			CBRF <=8 (8 residents assumed)			CBRF >8 (10 residents assumed)			RCAC
	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	
DSP Base - DSP Works	148.0	148.0	148.0	148.0	148.0	148.0	148.0	148.0	148.0	120.0	120.0	129.3	108.0
DSP Base - Supervisor Works	20.0	20.0	20.0	20.0	20.0	20.0	20.0	20.0	20.0	20.0	20.0	20.0	20.0
DSP Intermittent	-	14.0	21.0	14.0	28.0	42.0	70.0	98.0	112.0	56.0	84.0	112.0	14.0
Activities Staff	-	-	-	-	-	-	-	-	-	20.0	20.0	20.0	-
Specialty Vehicle Driver	-	-	-	-	-	-	16.0	16.0	16.0	3.0	3.0	3.0	-
RN/BH Professional Oversight	-	0.5	1.0	-	1.0	2.0	-	2.0	4.0	-	2.5	5.0	0.1
DSP Supervisory Hours	14.8	16.2	16.9	16.2	17.6	19.0	21.8	24.6	26.0	19.6	22.4	26.1	12.2
Total	**182.8**	**198.7**	**206.9**	**198.2**	**214.6**	**231.0**	**275.8**	**308.6**	**326.0**	**238.6**	**271.9**	**315.5**	**154.3**

APPENDIX B

Appendix B1
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Employee Related Expenses - 50th Percentile

	A	B	C	D	E	F	G	H	I	J	K
Direct Care Staff Category	Trended Wage	Annual Employee Salary	FICA	FUTA	SUI	Workers Comp	Health Insurance	Retirement	ERE per Employee	ERE Percentage	Annual Salary and ERE
Notes	Trended from 07/01/2021 to 07/01/2024 at a rate of 4.00%	A * 2080	A * 2080 * 7.65% up to $162,900 taxable limit	6% of First $7,000 Earned	B * 3.05% up to $14,000 estimated taxable limit	B * 1.44%		B * 1.68%	SUM (C through H)	I / B	B * (1 + J)
Direct Care Staff Category 1	$ 15.75	$ 32,760	$ 2,506	420	427	472	4,218	550	**$ 8,593**	**26.2%**	**$ 41,353**
Direct Care Staff Category 2	$ 20.25	$ 42,124	$ 3,223	420	427	607	4,218	708	**$ 9,602**	**22.8%**	**$ 51,726**
Direct Care Staff Category 3	$ 35.44	$ 73,709	$ 5,639	420	427	1,061	4,218	1,238	**$ 13,003**	**17.6%**	**$ 86,712**
Direct Care Staff Category 4	$ 41.41	$ 86,127	$ 6,589	420	427	1,240	4,218	1,447	**$ 14,341**	**16.7%**	**$ 100,468**

Appendix B2
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Employee Related Expenses - 75th Percentile

	A	B	C	D	E	F	G	H	I	J	K
Direct Care Staff Category	Trended Wage	Annual Employee Salary	FICA	FUTA	SUI	Workers Comp	Health Insurance	Retirement	ERE per Employee	ERE Percentage	Annual Salary and ERE
Notes	Trended from 07/01/2021 to 07/01/2024 at a rate of 4.00%	A * 2080	A * 2080 * 7.65% up to $162,900 taxable limit	6% of First $7,000 Earned	B * 3.05% up to $14,000 estimated taxable limit	B * 1.44%		B * 1.68%	SUM (C through H)	I / B	B * (1 + J)
Direct Care Staff Category 1	$ 16.61	$ 34,555	$ 2,643	420	427	498	4,218	581	**$ 8,787**	**25.4%**	**$ 43,342**
Direct Care Staff Category 2	$ 25.85	$ 53,778	$ 4,114	420	427	774	4,218	903	**$ 10,857**	**20.2%**	**$ 64,635**
Direct Care Staff Category 3	$ 38.45	$ 79,974	$ 6,118	420	427	1,152	4,218	1,344	**$ 13,678**	**17.1%**	**$ 93,652**
Direct Care Staff Category 4	$ 43.32	$ 90,105	$ 6,893	420	427	1,298	4,218	1,514	**$ 14,769**	**16.4%**	**$ 104,874**

APPENDIX C

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - AFH CO 1-2 Bed T1

Service Information

Service Code: AFH CO 1-2 Bed T1
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	148.00	-	34.80	-	-	-		The assumed number of weekly staff hours
B	Number of individuals served							2.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	160.87	-	37.83	-	-	-		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,534	$ 0	$ 766	$ 0	$ 0	$ 0		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,568.42	$ 0.00	$ 776.56	$ 0.00	$ 0.00	$ 0.00	**$ 3,344.98**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 673.72	$ 0.00	$ 177.01	$ 0.00	$ 0.00	$ 0.00	**$ 850.73**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 30.14**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 4,225.86**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$745.74**	Q = (O * P) / (1 - P)
R	Total cost per week							**$4,971.60**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$373.80**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 251.50	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 63.96	
AE	Transportation & fleet vehicle expenses	$ 2.27	
AF	Administration, program support & overhead	$ 56.07	
AG	**Total Rate**	**$373.80**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - AFH CO 1-2 Bed T2

Service Information

Service Code: AFH CO 1-2 Bed T2
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	148.00	14.00	36.20	-	-	0.50		The assumed number of weekly staff hours
B	Number of individuals served							2.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	160.87	15.22	39.35	-	-	0.54		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,534	$ 240	$ 797	$ 0	$ 0	$ 19		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,568.42	$ 242.96	$ 807.80	$ 0.00	$ 0.00	$ 19.52	**$ 3,638.70**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 673.72	$ 63.73	$ 184.13	$ 0.00	$ 0.00	$ 3.44	**$ 925.03**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 30.14**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 4,593.87**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$810.68**	Q = (O * P) / (1 - P)
R	Total cost per week							**$5,404.56**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$406.36**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 273.59	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 69.55	
AE	Transportation & fleet vehicle expenses	$ 2.27	
AF	Administration, program support & overhead	$ 60.95	
AG	**Total Rate**	**$406.36**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - AFH CO 1-2 Bed T3

Service Information

Service Code: AFH CO 1-2 Bed T3
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	148.00	21.00	36.90	-	-	1.00		The assumed number of weekly staff hours
B	Number of individuals served							2.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	160.87	22.83	40.11	-	-	1.09		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,534	$ 360	$ 812	$ 0	$ 0	$ 39		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,568.42	$ 364.44	$ 823.42	$ 0.00	$ 0.00	$ 39.05	**$ 3,795.33**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 673.72	$ 95.60	$ 187.69	$ 0.00	$ 0.00	$ 6.89	**$ 963.90**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 30.14**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 4,789.37**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$845.18**	Q = (O * P) / (1 - P)
R	Total cost per week							**$5,634.55**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$423.65**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 285.36	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 72.47	
AE	Transportation & fleet vehicle expenses	$ 2.27	
AF	Administration, program support & overhead	$ 63.55	
AG	**Total Rate**	**$423.65**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - AFH CO 3-4 Bed T1

Service Information

Service Code: AFH CO 3-4 Bed T1
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	148.00	14.00	36.20	-	-	-		The assumed number of weekly staff hours
B	Number of individuals served							4.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	160.87	15.22	39.35	-	-	-		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,534	$ 240	$ 797	$ 0	$ 0	$ 0		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,568.42	$ 242.96	$ 807.80	$ 0.00	$ 0.00	$ 0.00	**$ 3,619.18**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 673.72	$ 63.73	$ 184.13	$ 0.00	$ 0.00	$ 0.00	**$ 921.58**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 60.29**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 4,601.05**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$811.95**	Q = (O * P) / (1 - P)
R	Total cost per week							**$5,413.00**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$203.50**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 136.06	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 34.65	
AE	Transportation & fleet vehicle expenses	$ 2.27	
AF	Administration, program support & overhead	$ 30.52	
AG	**Total Rate**	**$203.50**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - AFH CO 3-4 Bed T2

Service Information

Service Code: AFH CO 3-4 Bed T2
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	148.00	28.00	37.60	-	-	1.00		The assumed number of weekly staff hours
B	Number of individuals served							4.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	160.87	30.44	40.87	-	-	1.09		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,534	$ 479	$ 828	$ 0	$ 0	$ 39		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,568.42	$ 485.92	$ 839.04	$ 0.00	$ 0.00	$ 39.05	**$ 3,932.43**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 673.72	$ 127.46	$ 191.25	$ 0.00	$ 0.00	$ 6.89	**$ 999.32**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 60.29**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 4,992.04**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$880.95**	Q = (O * P) / (1 - P)
R	Total cost per week							**$5,872.99**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$220.79**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 147.84	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 37.57	
AE	Transportation & fleet vehicle expenses	$ 2.27	
AF	Administration, program support & overhead	$ 33.12	
AG	**Total Rate**	**$220.79**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - AFH CO 3-4 Bed T3

Service Information

Service Code: AFH CO 3-4 Bed T3
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	148.00	42.00	39.00	-	-	2.00		The assumed number of weekly staff hours
B	Number of individuals served							4.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	160.87	45.65	42.39	-	-	2.17		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,534	$ 719	$ 859	$ 0	$ 0	$ 77		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,568.42	$ 728.88	$ 870.28	$ 0.00	$ 0.00	$ 78.09	**$ 4,245.67**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 673.72	$ 191.19	$ 198.37	$ 0.00	$ 0.00	$ 13.78	**$ 1,077.06**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 60.29**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 5,383.02**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$949.95**	Q = (O * P) / (1 - P)
R	Total cost per week							**$6,332.97**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$238.08**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 159.61	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 40.49	
AE	Transportation & fleet vehicle expenses	$ 2.27	
AF	Administration, program support & overhead	$ 35.71	
AG	**Total Rate**	**$238.08**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - CBRF <= 8 T1

Service Information

Service Code: CBRF <= 8 T1
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	148.00	70.00	41.80	-	16.00	-		The assumed number of weekly staff hours
B	Number of individuals served							8.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	160.87	76.09	45.44	-	17.39	-		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,534	$ 1,198	$ 920	$ 0	$ 274	$ 0		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,568.42	$ 1,214.79	$ 932.76	$ 0.00	$ 277.67	$ 0.00	**$ 4,993.65**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 673.72	$ 318.65	$ 212.61	$ 0.00	$ 72.83	$ 0.00	**$ 1,277.82**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 120.58**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 6,392.05**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$1,128.01**	Q = (O * P) / (1 - P)
R	Total cost per week							**$7,520.06**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$141.35**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 93.87	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 24.02	
AE	Transportation & fleet vehicle expenses	$ 2.27	
AF	Administration, program support & overhead	$ 21.20	
AG	**Total Rate**	**$141.35**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - CBRF <= 8 T2

Service Information

Service Code: CBRF <= 8 T2
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	148.00	98.00	44.60	-	16.00	2.00		The assumed number of weekly staff hours
B	Number of individuals served							8.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	160.87	106.52	48.48	-	17.39	2.17		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,534	$ 1,678	$ 982	$ 0	$ 274	$ 77		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,568.42	$ 1,700.71	$ 995.25	$ 0.00	$ 277.67	$ 78.09	**$ 5,620.14**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 673.72	$ 446.11	$ 226.86	$ 0.00	$ 72.83	$ 13.78	**$ 1,433.30**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 120.58**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 7,174.02**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$1,266.00**	Q = (O * P) / (1 - P)
R	Total cost per week							**$8,440.02**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$158.65**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 105.64	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 26.94	
AE	Transportation & fleet vehicle expenses	$ 2.27	
AF	Administration, program support & overhead	$ 23.80	
AG	**Total Rate**	**$158.65**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - CBRF <= 8 T3

Service Information

Service Code: CBRF <= 8 T3
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	148.00	112.00	46.00	-	16.00	4.00		The assumed number of weekly staff hours
B	Number of individuals served							8.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	160.87	121.74	50.00	-	17.39	4.35		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,534	$ 1,917	$ 1,013	$ 0	$ 274	$ 154		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,568.42	$ 1,943.67	$ 1,026.49	$ 0.00	$ 277.67	$ 156.19	**$ 5,972.43**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 673.72	$ 509.84	$ 233.98	$ 0.00	$ 72.83	$ 27.55	**$ 1,517.93**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 120.58**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 7,610.94**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$1,343.11**	Q = (O * P) / (1 - P)
R	Total cost per week							**$8,954.05**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$168.31**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 112.26	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 28.53	
AE	Transportation & fleet vehicle expenses	$ 2.27	
AF	Administration, program support & overhead	$ 25.25	
AG	**Total Rate**	**$168.31**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - CBRF > 8 T1

Service Information

Service Code: CBRF > 8 T1
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	120.00	56.00	39.60	20.00	3.00	-		The assumed number of weekly staff hours
B	Number of individuals served							10.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	130.44	60.87	43.04	21.74	3.26	-		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,054	$ 959	$ 872	$ 342	$ 51	$ 0		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,082.50	$ 971.83	$ 883.67	$ 347.08	$ 52.06	$ 0.00	**$ 4,337.16**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 546.26	$ 254.92	$ 201.42	$ 91.04	$ 13.66	$ 0.00	**$ 1,107.31**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 250.37**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 5,694.84**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$1,004.97**	Q = (O * P) / (1 - P)
R	Total cost per week							**$6,699.81**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$100.75**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 65.22	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 16.65	
AE	Transportation & fleet vehicle expenses	$ 3.77	
AF	Administration, program support & overhead	$ 15.11	
AG	**Total Rate**	**$100.75**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - CBRF > 8 T2

Service Information

Service Code: CBRF > 8 T2
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	120.00	84.00	42.40	20.00	3.00	2.50		The assumed number of weekly staff hours
B	Number of individuals served							10.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	130.44	91.31	46.09	21.74	3.26	2.72		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,054	$ 1,438	$ 933	$ 342	$ 51	$ 96		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,082.50	$ 1,457.75	$ 946.15	$ 347.08	$ 52.06	$ 97.62	**$ 4,983.17**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 546.26	$ 382.38	$ 215.67	$ 91.04	$ 13.66	$ 17.22	**$ 1,266.23**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 255.16**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 6,504.57**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$1,147.86**	Q = (O * P) / (1 - P)
R	Total cost per week							**$7,652.43**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$115.07**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 74.93	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 19.04	
AE	Transportation & fleet vehicle expenses	$ 3.84	
AF	Administration, program support & overhead	$ 17.26	
AG	**Total Rate**	**$115.07**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - CBRF > 8 T3

Service Information

Service Code: CBRF > 8 T3
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	129.33	112.00	46.13	20.00	3.00	5.00		The assumed number of weekly staff hours
B	Number of individuals served							10.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	140.58	121.74	50.15	21.74	3.26	5.43		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 35.44		Based on separate wage build
F	Total wages expense per week	$ 2,214	$ 1,917	$ 1,016	$ 342	$ 51	$ 193		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 2,244.48	$ 1,943.67	$ 1,029.46	$ 347.08	$ 52.06	$ 195.23	**$ 5,811.99**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	17.6%		Based on separate ERE build
L	Total ERE expense per week	$ 588.75	$ 509.84	$ 234.66	$ 91.04	$ 13.66	$ 34.44	**$ 1,472.39**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 255.16**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 7,539.54**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$1,330.51**	Q = (O * P) / (1 - P)
R	Total cost per week							**$8,870.05**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$133.38**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 87.40	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 22.14	
AE	Transportation & fleet vehicle expenses	$ 3.84	
AF	Administration, program support & overhead	$ 20.01	
AG	**Total Rate**	**$133.38**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - RCAC

Service Information

Service Code: RCAC
Reporting Units: Per Diem

Ref.	Description	DSP	Intermittent DSP	DSP Supervisor	Activities Staff	Specialty Vehicle Driver	RN / BH Professional Oversight	Total	Notes
A	Total Staff Hours per Week	108.00	14.00	32.20	-	-	0.10		The assumed number of weekly staff hours
B	Number of individuals served							10.00	The assumed number of clients in the home
C	PTO / training / conference time adjustment factor	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%		Based on separate PTO build
D	Adjusted total hours of time per week	117.39	15.22	35.00	-	-	0.11		D = A * (1 + C)
E	Hourly wage	$ 15.75	$ 15.75	$ 20.25	$ 15.75	$ 15.75	$ 41.41		Based on separate wage build
F	Total wages expense per week	$ 1,849	$ 240	$ 709	$ 0	$ 0	$ 5		F = D * E
G	Holidays worked	10.00	10.00	10.00	10.00	10.00	10.00		10 holidays per year
H	Percent of non-holiday hours paid at time and a half	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Based on assumptions
I	Percent of total hours paid at time and a half	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%		I = (365.25 * H + G) / 365.25
J	Total direct care wage adjusted for overtime and holidays per week	$ 1,874.25	$ 242.96	$ 718.54	$ 0.00	$ 0.00	$ 4.56	**$ 2,840.31**	J = F * (1 - I) + F * I * 1.5
K	Employee related expense (ERE) percentage	26.2%	26.2%	22.8%	26.2%	26.2%	16.7%		Based on separate ERE build
L	Total ERE expense per week	$ 491.64	$ 63.73	$ 163.78	$ 0.00	$ 0.00	$ 0.76	**$ 719.91**	L = J * K
M	Mileage reimbursement or vehicle costs costs per week							**$ 250.37**	Based on van build-up estimates
N	Medication costs							**$ 0.00**	N = Medication Costs * B * T
O	Subtotal before administration / overhead / program support							**$ 3,810.60**	O = (J + L + M + N)
P	Administration / program support / overhead percentage							15.0%	
Q	Administration / overhead / program support cost per week							**$672.46**	Q = (O * P) / (1 - P)
R	Total cost per week							**$4,483.06**	R = O + Q
S	Caseload efficiency							**95.0%**	
T	Units per week							7.00	
U	**Per Diem Rate**							**$67.41**	**U = (((J + L + M + Q) / S) + N) / B) / T**

Ref.	Summary of Rate Model Components	Total	Notes
AA	Direct Service Employee Salaries & Wages	$ 42.71	
AB	Indirect Service Employee Salaries & Wages	$ 0.00	
AC	Transportation Service Employee Salaries & Wages	$ 0.00	
AD	Employee related expenses	$ 10.83	
AE	Transportation & fleet vehicle expenses	$ 3.77	
AF	Administration, program support & overhead	$ 10.11	
AG	**Total Rate**	**$67.41**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - SHC Agency

Service Information

Service Code: SHC Agency
Reporting Units: 15 Minutes

Ref.	Description	DSP	Supervisor	Total	Notes
A	Average minutes of direct time per unit	15.00			
B	Average minutes of indirect time per unit	-			
C	Average minutes of transportation time per unit	-			
D	**Total minutes per unit**	**15.00**			D = A + B + C
E	Staffing Ratio	1.00			
F	Supervisor span of control		20.00		20 employees assumed to be managed by 1 supervisor
G	Supervisor time per unit		0.75		G = D / E / F
H	PTO / training / conference time adjustment factor	8.7%	8.7%		Based on separate PTO build
I	**Adjusted Total minutes per unit**	**16.30**	**0.82**		I = D / E * (1 + H) || I = G * (1 + H)
J	Hourly wage	$15.75	$ 20.25		Based on separate wage build
K	**Total wages expense per unit**	**$ 4.28**	**$ 0.28**	**$ 4.56**	K = J * I / 60
L	Employee related expense (ERE) percentage	26.2%	22.8%		Based on separate ERE build
M	**Total ERE expense per unit**	**$ 1.12**	**$ 0.06**	**$ 1.19**	M = K * L
N	Estimated average MPH			25.00	Assumed MPH
O	Estimated miles driven per unit			-	O = C * N / 60
P	Federal reimbursement rate			$ 0.655	
Q	**Transportation fleet costs per unit**			**$ 0.00**	Q = O * P
R	On-Call Expenses			$ 0.00	No on-call expenses
S	Drug Cost			-	No drug expenses
T	Drug Administration			-	No drug administration expenses
U	Administration / program support / overhead			10.0%	Portion of total rate
V	**Administration Expenses**			**$ 0.64**	V = U * (K + M + Q + R + S + T) / (1 - U)
W	**15 Minutes Rate**			**$6.38**	**W = K + M + Q + R + S + T + V**

Ref.	Summary of Rate Model Components			Total	Notes
X	Direct Service Employee Salaries & Wages			$ 4.56	
Y	Indirect Service Employee Salaries & Wages			$ 0.00	
Z	Transportation Service Employee Salaries & Wages			$ 0.00	
AA	Employee Related Expenses			$ 1.19	
AB	Transportation & Fleet Vehicle Expenses			$ 0.00	
AC	Administration, Program Support & Overhead			$ 0.64	
AD	**Total Rate**			**$6.38**	

Appendix C
State of Wisconsin
Department of Health Services
HCBS Minimum Payment Rate Development
Exhibit 4 - SHC Non-Agency

Service Information

Service Code: SHC Non-Agency
Reporting Units: 15 Minutes

Ref.	Description	DSP	Supervisor	Total	Notes
A	Average minutes of direct time per unit	15.00			
B	Average minutes of indirect time per unit	-			
C	Average minutes of transportation time per unit	-			
D	**Total minutes per unit**	**15.00**			D = A + B + C
E	Staffing Ratio	1.00			
F	Supervisor span of control		-		0 employee assumed to be managed by 1 supervisor
G	Supervisor time per unit		-		G = D / E / F
H	PTO / training / conference time adjustment factor	3.6%	3.6%		Based on separate PTO build
I	**Adjusted Total minutes per unit**	**15.54**	**-**		I = D / E * (1 + H) || I = G * (1 + H)
J	Hourly wage	$15.75	$ 20.25		Based on separate wage build
K	**Total wages expense per unit**	**$ 4.08**	**$ 0.00**	**$ 4.08**	K = J * I / 60
L	Employee related expense (ERE) percentage	0.0%	0.0%		Based on separate ERE build
M	**Total ERE expense per unit**	**$ 0.00**	**$ 0.00**	**$ 0.00**	M = K * L
N	Estimated average MPH			25.00	Assumed MPH
O	Estimated miles driven per unit			-	O = C * N / 60
P	Federal reimbursement rate			$ 0.655	
Q	**Transportation fleet costs per unit**			**$ 0.00**	Q = O * P
R	On-Call Expenses			$ 0.00	No on-call expenses
S	Drug Cost			-	No drug expenses
T	Drug Administration			-	No drug administration expenses
U	Administration / program support / overhead			0.0%	Portion of total rate
V	**Administration Expenses**			**$ 0.00**	V = U * (K + M + Q + R + S + T) / (1 - U)
W	**15 Minutes Rate**			**$4.08**	**W = K + M + Q + R + S + T + V**

Ref.	Summary of Rate Model Components			Total	Notes
X	Direct Service Employee Salaries & Wages			$ 4.08	
Y	Indirect Service Employee Salaries & Wages			$ 0.00	
Z	Transportation Service Employee Salaries & Wages			$ 0.00	
AA	Employee Related Expenses			$ 0.00	
AB	Transportation & Fleet Vehicle Expenses			$ 0.00	
AC	Administration, Program Support & Overhead			$ 0.00	
AD	**Total Rate**			**$4.08**	

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