State of Wisconsin
Capitation Rate Development
January 1, 2017 through December 31, 2017
BadgerCare Plus Standard and Childless Adult Programs

Prepared for:
Wisconsin Department of Health Services

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I. SUMMARY OF RESULTS AND CAVEATS

This report documents the development of capitation rates effective January 1, 2017 through December 31, 2017 for Wisconsin's BadgerCare Plus (BCP) Standard and Childless Adult (CLA) programs.

The Wisconsin Department of Health Services (DHS) retained Milliman, Inc. (Milliman) to develop and certify its 2017 BCP capitation rates. Milliman's role is to calculate and certify actuarially sound capitation rates to comply with CMS regulations and the CMS rate setting checklist.

A. CAPITATION RATE CHANGES

Table 1 shows a comparison of the 2017 and 2016 per member per month (PMPM) medical, dental, and chiropractic capitation rates and maternity kick payments by geographic rate region and eligibility category. Exhibits 17 through 19 contain more detailed comparisons summarizing the rate changes for all coverage types (medical only, medical / dental, medical / chiropractic, and medical / dental / chiropractic) separately for each HMO based on August 2016 enrollment. Exhibit 21 shows the final 2017 capitation rates, including provider access payments.

Table 1A
Summary of Capitation Rate Changes by Region (Excluding Provider Access Payments)
February – December 2016 to Calendar Year 2017
BadgerCare Plus Standard

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Medical Capitation Rates							
2017 Capitation Rate	$128.42	$108.53	$114.17	$111.50	$112.89	$120.82	$116.41
2016 Capitation Rate	$130.75	$106.24	$113.95	$109.92	$107.46	$116.64	$114.16
Rate Change	-1.8%	2.2%	0.2%	1.4%	5.1%	3.6%	2.0%
Maternity Kick Payments							
2017 Kick Payment	$6,666.88	$4,732.50	$5,464.65	$5,072.17	$5,214.67	$5,694.41	$5,470.85
2016 Kick Payment	$6,184.43	$4,480.67	$5,131.05	$5,012.63	$4,496.81	$5,248.11	$5,097.03
Kick Payment Change	7.8%	5.6%	6.5%	1.2%	16.0%	8.5%	7.3%
Dental Capitation Rates							
2017 Capitation Rate[2]	n/a	n/a	n/a	n/a	$10.13	$9.12	$9.42
2016 Capitation Rate	n/a	n/a	n/a	n/a	$7.59	$6.41	$6.76
Rate Change	n/a	n/a	n/a	n/a	33.5%	42.2%	39.3%
Chiropractic Capitation Rates							
2017 Capitation Rate	$3.27	$2.45	$3.48	$2.06	$1.36	$0.37	$1.87
2016 Capitation Rate	$2.13	$1.17	$1.87	$1.12	$0.81	$0.28	$1.07
Rate Change	53.3%	109.5%	86.0%	83.8%	68.3%	32.4%	75.6%

[1] Statewide changes in medical and dental capitation rates are based on August 2016 enrollment; statewide changes in maternity kick payments are based on deliveries by region from November 2014 through October 2015.

[2] Dental capitation rates for Regions 1 through 4 are not applicable since no HMOs cover dental in these regions.

Table 1B Summary of Capitation Rate Changes by Region (Excluding Provider Access Payments) February – December 2016 to Calendar Year 2017 Childless Adults							
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Medical Capitation Rates							
2017 Capitation Rate	$311.71	$286.58	$274.46	$275.88	$307.23	$282.54	$287.90
2016 Capitation Rate	$314.46	$268.45	$247.76	$261.03	$308.69	$285.55	$281.52
Rate Change	-0.9%	6.8%	10.8%	5.7%	-0.5%	-1.1%	2.3%
Dental Capitation Rates							
2017 Capitation Rate	n/a	n/a	n/a	n/a	$10.29	$9.56	$9.76
2016 Capitation Rate	n/a	n/a	n/a	n/a	$7.41	$6.71	$6.90
Rate Change	n/a	n/a	n/a	n/a	38.9%	42.5%	41.4%
Chiropractic Capitation Rates							
2017 Capitation Rate	$4.08	$4.03	$4.31	$3.09	$2.14	$0.71	$2.57
2016 Capitation Rate	$3.08	$2.98	$3.36	$2.34	$1.42	$0.57	$1.93
Rate Change	32.5%	35.4%	28.3%	32.2%	50.0%	25.0%	33.2%

[1] *Statewide changes in medical and dental capitation rates are based on August 2016 enrollment.*
[2] *Dental capitation rates for Regions 1 to 4 are not applicable since no HMOs cover dental services in these regions.*

Table 2 provides a high level summary of each rate component and the impact on the overall medical capitation rate change from February - December 2016 to CY 2017. For example, updating the reimbursement change projection factors increased the BCP Standard rates by an average of 1.5%.

Table 2 High Level Summary of Medical Capitation Rate Changes between 2016 and 2017		
Rate Component	BadgerCare Plus Standard	Childless Adults
Updated base period encounter data	+1.3%	-5.0%
Change in CLA durational adjustment	n/a	+4.8%
Reimbursement change between base period and rating period	+1.5%	-1.7%
Trend and other projection factor changes	+0.1%	+0.7%
Impact of rate cell mix on prior rates	-0.9%	+3.9%
Total rate change	**+2.0%**	**+2.3%**

B. CAPITATION RATE CELL STRUCTURE

Separate capitation rates are calculated by eligibility category, region, and rate cell for each type of coverage (medical, maternity, dental, and chiropractic).

Eligibility Categories

We developed capitation rates for the following eligibility categories:

- **BCP Standard:**
  - Parents and caretakers with incomes at or below 100 percent of the Federal Poverty Limit (FPL)
  - Pregnant women with incomes at or below 300 percent of the FPL
  - Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL
  - Transitional medical assistance individuals, also known as members on extensions, with incomes over 100 percent of the FPL

  Prior to April 1, 2014, the BCP Benchmark plan provided coverage to children eligible for Medicaid under the State Plan and children ineligible for Medicaid because their household income was greater than 250 percent of the FPL. Effective April 1, 2014, the Benchmark plan was eliminated and the subset of BCP Benchmark plan members meeting the new eligibility requirements were rolled into the BCP Standard plan.

- **BCP Childless Adults:** Prior to April 1, 2014, the BCP CLA program provided Medicaid services to childless adults with income at or below 200 percent of the FPL, but enrollment was capped. Effective April 1, 2014, the CLA program was expanded to include all childless adults with incomes less than or equal to 100 percent of the FPL, including members previously enrolled in other Medicaid programs, as well as individuals not previously eligible for Medicaid benefits. Benefit coverage in the CLA plan was aligned with the BCP Standard plan benefits effective April 1, 2014. The newly covered CLA population began enrollment into managed care on July 1, 2014.

Rate Regions

The capitation rates are developed for each of six geographic rate regions:

- Region 1 – North
- Region 2 – North East
- Region 3 – West Central
- Region 4 – Madison
- Region 5 – South East
- Region 6 – Milwaukee

Appendix A contains a mapping of Wisconsin counties to the six rate regions.

Rate Cells

The capitation rates are paid separately by age category as well as rate region. Table 3 summarizes the age categories used within each eligibility category.

Table 3 Age Rate Cells by Eligibility Category	
BCP Standard	**BCP Childless Adults**
Age 0	n/a
Ages 1 - 14	
Ages 15 - 20	Ages 19 - 44
Ages 21 - 44	
Ages 45+	Ages 45+

Covered Services

HMOs are responsible for providing comprehensive health care to BCP members, including inpatient facility, outpatient facility, professional, and other services. Prescription drugs are carved out of the capitation rates. Maternity services are paid through a maternity kick payment paid per delivery within the BCP Standard plan. Dental and chiropractic capitation rates are developed separately. Dental coverage is optional in Regions 1 through 4 and mandatory in Regions 5 and 6. Chiropractic coverage is optional in all regions.

C. HIGH LEVEL RATE METHODOLOGY

The BCP program has been in operation since 2008, when the BadgerCare and Children's Health Insurance Program (CHIP) programs were merged. DHS currently contracts with 18 Health Maintenance Organizations (HMOs) to provide services to BCP members.

The capitation rates are first developed by eligibility category and rate region, and then by age category within each eligibility category using age factors that reflect statewide cost relationships by age category within an eligibility category.

The risk adjustment process adjusts the capitation rates for estimated differences in acuity by HMO.

Material Changes to Rate Methodology

We made the following material changes to the 2017 rate methodology:

- Base data sources – The February - December 2016 rates were based on HMO encounter data and financial data from calendar years 2013 and 2014. The 2017 rates are based on more recent HMO encounter and financial data from calendar years 2014 and 2015.

- Dental rate methodology

  – In the 2017 rate development, we used dental financial data provided by the HMOs to develop base period experience for dental services in Regions 5 and 6. In the prior rate development, we used dental encounter data for the base period experience. We determined the dental encounter data was materially under-reported due to the prevalence of subcapitation and therefore we believe the HMO financial data is a more accurate summary of historical dental claims.

  – We calculated optional dental capitation rates in Regions 1 through 4 using FFS dental claims for HMO members. HMO encounter data for dental services is not available in these regions

since no HMOs currently provide dental coverage. We did not calculate dental rates in these regions in the prior rate development.

– We removed the HMO-specific dental utilization adjustment included in the prior rates since we observed dental cost variation between HMO has decreased.

- Chiropractic rate methodology – We developed 2017 optional chiropractic capitation rates using FFS chiropractic claims for HMO members (excluding members that received chiropractic services from the two HMOs providing chiropractic services during the base period). The prior rates were developed based on FFS claims for FFS members. We made this change to better reflect the population which may be covered by this benefit through the HMOs.

- Maternity kick payment logic – We updated delivery counts and maternity claims assignment to be consistent with the DHS maternity kick payment methodology effective January 1, 2017.

- Risk adjustment model – The February - December 2016 BCP Standard rates were risk adjusted using the concurrent standard CDPS+Rx model developed by the University of California - San Diego, applied prospectively. CLA rates were not risk adjusted due to low credible experience. For the 2017 rate development, we developed custom prospective risk score model weights using the CDPS+Rx model structure for Wisconsin Medicaid Standard plan experience for HMO members. For the 2017 BCP Standard rates, we blended the new and prior models, assigning 50% weight to each model, to phase in the impact of the model change. The 2017 CLA rates are risk adjusted using the custom model weights.
- Risk score normalization – The February - December 2016 BCP Standard risk scores were normalized to a 1.00 average for each region (across all rate cells). The 2017 risk scores are normalized to a 1.00 average for each combination of region and rate cell. Newborn rate cells are not risk adjusted.
- Rate cells – We reduced the number of rate cell categories since the CDPS+Rx model includes demographic weights to reflect age / gender differences.

D. REPORT STRUCTURE

The remainder of this report includes the following information:

- Section II summarizes the development of the base period experience and data adjustments.

- Section III documents reimbursement changes, program changes, trend, and other adjustments applied to the adjusted base period data to develop projected 2017 base capitation rates by eligibility category, region, and age category.

- Section IV documents the development of final HMO-specific capitation rates, including risk score adjustments, pay-for-performance (P4P) withholds, and provider access payments.

- Section V documents the projected costs for services eligible for enhanced federal funding (applies to medical capitation rates and maternity kick payments).

- Section VI provides responses to the CMS rate setting checklist.

- Section VII provides responses to the 2017 CMS Medicaid Managed Care Rate Development Guide.

Exhibits 1 through 25 summarize the 2017 rate development. Appendix A provides a mapping of counties to rate regions. Appendices B and C contain details on the custom CDPS risk score model. Appendix D contains the actuarial certification.

E. IMPORTANT LIMITATIONS AND CAVEATS

We relied on several sources of HMO and fee-for-service (FFS) claims and eligibility data to develop the capitation rates in this report, including HMO encounter data, HMO financial reporting, FFS data, inpatient and outpatient facility 2017 repricing data, and other supporting information from DHS. **We did not audit any of the base data sources**, but we did assess the data for reasonableness.

We relied on DHS for the collection and processing of the HMO encounter data, the accuracy of the FFS data, and the inpatient and outpatient facility 2017 repricing data. We relied on the HMOs to provide accurate financial data to DHS. If the data used is inadequate or incomplete, the results will be likewise inadequate or incomplete.

Differences between the capitation rates and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate 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 better or worse than expected.

Our report is intended for the internal use of DHS to develop 2017 BCP capitation rates. 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. It 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.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

This letter is subject to the terms and conditions of the January 1, 2015 contract between DHS and Milliman.

II. BASE DATA DEVELOPMENT

This section of our report describes the base data development and the blending of the various data sources described in this report. In general, the base data used to calculate the 2017 capitation rates reflects the most current credible available data from DHS and the HMOs.

The following exhibits summarize the base data and adjustments by region for all age categories combined:

- Exhibit 1A: Medical – BCP Standard
- Exhibit 1B: Medical– BCP CLA
- Exhibit 7: Maternity – BCP Standard
- Exhibit 10A: Dental – BCP Standard
- Exhibit 10B: Dental – BCP CLA
- Exhibit 14A: Chiropractic – BCP Standard
- Exhibit 14B: Chiropractic – BCP CLA

A. BASE DATA SOURCES

The data sources used in the 2017 rate development are listed and described below:

1. **HMO Encounter Data** – Includes claims paid by HMOs on a FFS basis, as well as sub-capitated encounters. DHS reprices each HMO encounter based on the Medicaid fee schedule. The encounter data also includes HMO paid amounts. The re-priced Medicaid paid amounts are used to develop the base period claims experience.

2. **HMO Financial Data** – Participating HMOs were required to submit calendar year (CY) 2014 and CY 2015 financial data to DHS. The financial data included the following information by eligibility category, region, and calendar year:

   - Member months and maternity deliveries eligible for kick payments
   - Total revenue including capitation payments, maternity kick payments, and other sources
   - Claim payments to providers, including FFS claim payments, payments made to sub-capitated providers, provider risk sharing and incentive payments, and other payments made outside the FFS claims system
   - Administrative costs
   - Additional information on payments made to related parties
   - A certification from the HMO attesting the data is accurate, complete, and truthful

   The financial data was used to calculate missing data adjustments to apply to the encounter data payments, develop adjustments to reflect claims paid outside of FFS claims systems, and determine the appropriate administrative cost allowances to include in the capitation rate development.

3. **HMO Supplemental Dental Financial Data** – Participating HMOs submitted detailed dental financial data for CY 2014, CY 2015, and YTD June 2016 to DHS. We used this data to develop dental capitation rates in Regions 5 and 6 and determine the dental claims trend applied from 2015 to 2016.

4. **Fee-For-Service (FFS) Data** – Includes claims paid by DHS on a FFS basis. The FFS data was used to analyze historical trends, estimate the impact of certain program adjustments, and was used as the basis for developing capitation rates for dental services in Regions 1 to 4 and chiropractic services in all regions.

DHS and Milliman went through an extensive data validation process to review all HMO data included in the 2017 rate setting methodology. DHS collected monthly encounter reporting from each HMO to monitor the quality of encounter data submissions. After this process was complete, DHS forwarded the data to Milliman.

Milliman also reviewed the encounter data and financial data. We provided data summaries to all participating HMOs and held one-on-one conference calls with many HMO representatives to present the HMO-specific summaries, discuss data questions, and solicit feedback. After receiving answers to our questions and a few data resubmissions from the HMOs, we released base data summaries on September 20, 2016 for HMO review and comment. Additionally, we presented the information to the HMOs at the DHS meeting on September 22, 2016 to explain the base data and solicit feedback from the HMOs.

Table 4 summarizes the base data time periods for the various data sources.

Table 4
Base Data Time Periods

Data Source	Data Time Period Used	Paid Through Date
HMO Encounter Data	CY 2014 and CY 2015	June 2016[1]
HMO Financial Data	CY 2014 and CY 2015	May 2016
HMO Supplemental Dental Data	CY 2014, CY 2015, and YTD June 2016	August 2016
FFS Data	CY 2014 and CY 2015	July 2016

[1] *Encounter data files received from DHS on June 20, 2016; paid through date may differ by HMO.*

B. HMO ENCOUNTER DATA PROCESSING METHODOLOGY

HMO Encounter Data Submission

Participating HMOs are required to submit encounters for Medicaid covered services to DHS on a periodic basis. DHS, along with their contracted data processing vendor Hewlett Packard Enterprise (HPE), performs a re-pricing analysis on the encounter data records and assigns re-priced Medicaid allowed and paid amounts for accepted encounter records and in a few other situations based on ANSI codes. The encounter records also include HMO paid amounts in addition to the re-priced Medicaid paid amounts. However, there are a large number of duplicate rejected claims in the encounter databases as HMOs submit encounter records multiple times in an attempt to get claims through the DHS system edit process. DHS' re-pricing methodology only accepts unique claims, but the total HMO paid claims (which includes rejected duplicate claims) in the encounter data files are not reliable for summarizing claims experience.

The encounter data provided to Milliman includes services incurred during calendar years 2013 through 2015. As noted above, we used 2014 and 2015 encounter data to develop the base period costs. We summarized the 2014 and 2015 encounter data using the methodology described in the following sections.

We identified the submitting HMO based on the HMO ID field in the encounter data files using the mapping provided by DHS.

Excluded Claims

Some of the claims included in the encounter data files submitted by the HMOs are excluded from the base period encounter data. We excluded claims for the following reasons:

1. **Financial Indicator "N" claims:** We excluded claims with a Financial Indicator of "N" which were flagged by DHS as not having any payment made by the HMO.

2. **Claims incurred outside of CY 2014 and CY 2015**: We excluded claims for services provided outside of the period January 1, 2014 through December 31, 2015.

3. **Claims without a corresponding eligibility record for the month of service**: We matched the service date in the encounter data to the monthly capitation files provided by DHS. If there was no capitation payment made to any HMO for the member in the month of service, the claim was excluded.

4. **Ventilator dependent claims**: The HMOs are not at risk for claims for ventilator dependent members. DHS retroactively reimburses the HMOs for claims incurred and recoups capitation payments to the HMO for these members. Therefore, these claims are excluded from the base data used to develop the capitation rates, along with the corresponding member months from the same time period. We used the list of ventilator dependent member IDs provided by DHS for each year to exclude all claims and member months for these members for the time period they were ventilator dependent.

5. **Excluded populations**: Based on information we received from DHS, we assigned each member for each month to one of the BCP eligibility categories using the monthly capitation files. We also excluded populations no longer eligible as of April 1, 2014. Data for individuals not assigned to a BCP eligibility category are excluded.

6. **Physician administered drugs**: We excluded claims for physician administered drugs based on criteria provided by DHS, since these professional claims are reimbursed on a FFS basis by DHS. However, we later discovered the excluded claims were missing the place of service codes used in the PAD identification criteria and should not have been excluded. As a result, we included these claims back into the base claims data through the missing data adjustment described later in the report.

7. **Dental claims in Regions 1 - 4:** We excluded claims based on the dental criteria in Regions 1 - 4 since there were no HMOS providing dental coverage in these regions during the base period.

8. **Non-covered chiropractic claims:** We excluded chiropractic claims for HMOs that did not cover chiropractic services in 2014 or 2015 (two HMOs elected to cover chiropractic services over this period).

9. **CLA claims prior to April 1, 2014**: Effective April 1, 2014, the CLA plan eligibility requirements and benefits changed as a result of the Affordable Care Act (ACA). Due to the significant differences in covered population and benefits, we excluded CLA claims and eligibility prior to April 1, 2014.

Excluded HMO: Based on our review of the HMO encounter data in comparison to average results across all HMOs, HMO financial data, and other information, we determined the encounter data for one HMO was not reliable. Therefore, the claims and member months for this plan were excluded from the HMO encounter base data to produce a more credible result. This adjustment resulted in excluding approximately 3.7% and 11.1% of total member months (and a PMPM increase of 1.3% and 5.6%) in the base period experience in Region 4 for the Standard and CLA populations, respectively.

Included Claims

The total amounts after excluding the claims and member months listed above represent the encounter data used to develop the medical and maternity base period experience.

We confirmed with DHS the re-priced Medicaid paid and HMO paid amounts in the encounter data and financial data excluded any additional enhanced payments made to providers due to the ACA. The enhanced payments to PCPs ended on December 31, 2014 and, therefore, the 2017 capitation rates exclude the historical cost of these enhanced payments.

We developed separate capitation rates for medical coverage, maternity kick payments, dental services, and chiropractic services. Any included claims not identified as maternity, dental, or chiropractic services were classified as medical coverage.

Maternity (BCP Standard Only)

The methodology used to count deliveries is consistent with how HMOs are instructed by DHS to report deliveries for maternity kick payment reimbursement effective January 1, 2017.

The DRG code will trigger the maternity kick payment, when an HMO has a paid amount greater than $0 on the claim (i.e., other insurance is not covering the entire cost of the delivery). We identified deliveries for MS-DRG encounters equal to 765, 766, 767, 768, 774, or 775. Since DHS is switching to APR-DRG codes effective January 1, 2017, the rating period will use APR-DRG equal to 540, 541, 542, or 560.

The following additional claims incurred within nine months prior to the delivery or two months after the delivery were included in the maternity kick payment development (and excluded from the medical rate development):

- Revenue code of 0110 - 0539, 0560 - 0569, 0610 - 0649, or 0660 - 0999
- Revenue code of 01958 - 01961, 01967 - 01968, 59000 - 59899, or 76801 -76828

We included maternity claims for completed pregnancies only in the base period experience by limiting delivery dates to the time period from November 2014 through October 2015.

Dental

Encounters with procedure codes from D0120-D7210 or D7220-D9999 were identified as dental services.

Chiropractic

Encounters with Category of Service code 60 (chiropractic) were identified as chiropractic services. This is a change from prior years which identified chiropractic services as procedure codes 98940 – 98942. Two HMOs elected to cover chiropractic services during the base period.

Medical "Payments Made Outside Encounter Data"

We summarized "Payments Made Outside Encounter Data" from the HMO financial reporting by eligibility category and region to reflect provider risk sharing, incentives, and other miscellaneous provider payments made outside of the encounter data. These amounts are added to the base period experience and shown at the bottom of Exhibit 1.

In Lieu of Services

The BadgerCare Plus program allows HMOs to provide Institution for Mental Disease (IMD) benefits in lieu of inpatient psychiatric admissions. Reimbursement adjustments for IMDs are documented in Section III.A while utilization adjustments are documented in Section III.B.

Service Category Assignment

We relied on the claim type (and category of service for FQHC / RHC) in the encounter files provided by DHS to assign broad categories of service (hospital inpatient facility, hospital outpatient facility, professional, FQHC / RHC and other services). We then used Milliman's *Health Cost Guidelines* Grouper to assign the detailed service categories.

C. FFS DATA PROCESSING METHODOLOGY

FFS data for HMO members was used to develop capitation rates for dental services in Regions 1 to 4 and chiropractic services in all regions since credible encounter data is not available. We summarized dental and chiropractic FFS claims (using the service category criteria above) for members enrolled in HMOs during the base period.

D. ADJUSTMENTS TO THE BASE DATA

This section discusses the adjustments we made to the base 2014 and 2015 data before projecting costs to the 2017 rating period. These adjustments are shown in the following exhibits:

- Exhibit 1A: BCP Standard – Medical
- Exhibit 1B: BCP CLA – Medical
- Exhibit 7: BCP Standard – Maternity
- Exhibit 10A: BCP Standard – Dental
- Exhibit 10B: BCP CLA – Dental
- Exhibit 14A: BCP Standard – Chiropractic
- Exhibit 14B: BCP CLA – Chiropractic

Missing Data Adjustment (Encounter Data)

DHS has required contracted HMOs to submit encounter data files to be used for Medicaid managed care rate setting for many years. However, DHS system edits originally implemented in 2012 have resulted in

lower rates of accepted claims. In the 2016 rate development, we identified several issues with the 2014 and 2015 encounter data files:

- Encounter data submissions may not be complete (i.e., some encounters may not have been submitted to DHS).
- Encounters may have been submitted but did not pass the DHS system edits, resulting in encounters with a "denied" status that could not be re-priced even though the records may have represented valid encounters.
- Encounter data typically does not include payments made to providers outside the claim adjudication system, such as quality incentives or distribution of withhold payments, provider risk sharing settlements, or other miscellaneous claim payments. Excluding these amounts could understate or overstate the total payments from HMOs to providers.

We developed missing data adjustments for each HMO and calendar year based on a comparison of the total HMO paid amounts in the encounter data and the total FFS and sub-capitated claims payments reported in the HMO financial data. HMOs were instructed to include sub-capitated claims in their encounter data submissions with zero HMO paid amounts during the base period; however, it was difficult to identify these claims within the data due to encounter data reporting differences. Therefore, the missing data adjustments reflect the impact of missing encounters (including sub-capitated claims), as well as encounters that were submitted but not accepted by the DHS system edits.

Table 5 summarizes the medical missing data adjustments by eligibility category, region and calendar year. As noted above, we calculated missing data adjustments at the HMO level. Therefore, the differences shown in Table 5 are due to differences in the mix of HMO payments within each subcategory.

Table 5
Missing Data Adjustments Applied to HMO Encounter Data (Medical Services)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
BadgerCare Plus Standard						
2014	1.035	1.041	1.025	1.051	1.063	1.065
2015	1.041	1.044	1.034	1.060	1.057	1.056
BadgerCare Plus Childless Adults						
2014	1.035	1.042	1.026	1.047	1.047	1.048
2015	1.041	1.046	1.036	1.061	1.052	1.048

Dental missing data adjustments are not applicable since we used HMO supplemental financial data as the base period experience.

Maternity claims are assumed to be complete in the encounter data since we identify completed pregnancies directly in the encounter data. Dental missing data adjustments are not applicable since we used the HMO supplemental dental financial data to summarize the base period experience.

Completion Factor (Encounter and FFS Data)

Table 6 summarizes the 2015 completion factors applied to the base claims to allow for incurred but not reported (IBNR) claims as of the claim submission date. 2014 claims are assumed to be complete since there are approximately 18 months of claims runout.

Table 6
2015 Completion Factors

	HMO Encounter Claims		Fee-For-Service Claims	
	Inpatient Facility	Other Services	Inpatient Facility	Other Services
BCP Standard	1.012	1.008	n/a	1.012
BCP Childless Adults	1.011	1.010	n/a	1.008

We calculated the encounter claims completion factors based on reported IBNR amounts in the HMO financial data. We reviewed these completion factors for reasonableness compared to the HMO encounter claim lag patterns in the detailed encounter data. We developed FFS completion factors based on the FFS claim lag patterns.

Provider Contracting Adjustment (Encounter Data)

The base encounter data reflects the re-priced Medicaid paid amounts assigned by DHS to each encounter. We compared the total HMO paid amounts to the re-priced Medicaid paid amounts by broad service category and region to develop provider contracting adjustments that reflect average HMO contracting levels relative to Medicaid fees. Table 7 summarizes the provider contracting adjustments applied to the re-priced Medicaid paid amounts in the encounter data.

Table 7
Provider Contracting Adjustments

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Hospital Inpatient	1.02	1.02	1.02	1.02	1.06	1.06
Hospital Outpatient	1.00	1.00	1.00	1.00	1.10	1.10
Professional	1.01	1.01	1.01	1.01	1.02	1.02
FQHC / RHC	1.00	1.00	1.00	1.00	1.00	1.00
Other	1.00	1.00	1.00	1.00	1.00	1.00

CLA Seasonality Adjustment (Encounter Data)

Since we excluded January 1, 2014 through March 31, 2014 CLA base experience, we applied a seasonality adjustment of 1.003 to the CLA April 1, 2014 through December 31, 2014 base period experience to adjust it to a full calendar year.

III. PROJECTED 2017 BASE CAPITATION RATES

This section of the report documents reimbursement changes, program changes, trend, and other adjustments applied to the base data to develop projected 2017 base capitation rates by eligibility category, region and age category before risk adjustment, P4P withholds, and provider access payments are applied.

The following exhibits summarize the development of projected 2017 claim costs:

- Exhibit 2A: BCP Standard – Medical
- Exhibit 2B: BCP CLA – Medical
- Exhibit 8: BCP Standard – Maternity
- Exhibit 10A: BCP Standard – Dental
- Exhibit 10B: BCP CLA – Dental
- Exhibit 14A: BCP Standard – Chiropractic
- Exhibit 14B: BCP CLA – Chiropractic

A. REIMBURSEMENT CHANGES

Inpatient Facility Re-Pricing Adjustment

Inpatient facility claims, excluding skilled nursing facility, were re-priced by DHS to the inpatient rates effective January 1, 2017. We used this detailed re-pricing data, provided by DHS, to calculate the impact of reimbursement changes on the historical 2014 and 2015 inpatient facility claims (excluding nursing facility). Since the re-pricing impact varies by hospital, the rating adjustments are applied by eligibility category, year, and region to reflect the expected changes based on the historical volume of claims by hospital. Table 8 summarizes the inpatient facility re-pricing adjustments applied to the base encounter inpatient facility claims.

Table 8
Inpatient Facility Re-Pricing Adjustments (Excluding Skilled Nursing Facility)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
BadgerCare Plus Standard						
Medical – 2014	1.005	1.115	1.026	1.053	1.010	1.092
Medical – 2015	0.967	1.040	1.016	0.992	1.063	1.034
Maternity	1.054	1.123	1.069	1.056	1.157	1.121
Childless Adults						
Medical – 2014	0.950	1.045	1.009	1.102	0.972	1.022
Medical – 2015	0.978	0.993	0.999	0.995	1.000	0.999

Outpatient Facility Re-Pricing Adjustment

Similar to inpatient facility claims, DHS provided re-priced outpatient facility claims, excluding hospice, based on fees effective January 1, 2017. Table 9 summarizes the outpatient facility re-pricing adjustments applied to the base encounter outpatient facility claims excluding hospice.

Table 9 Outpatient Facility Re-Pricing Adjustments (Excluding Hospice)						
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
BadgerCare Plus Standard						
Medical – 2014	0.936	0.930	0.979	1.024	1.078	0.878
Medical – 2015	0.969	0.993	0.974	0.998	1.026	1.002
Maternity	0.865	0.870	0.907	0.860	0.967	0.917
Childless Adults						
Medical – 2014	1.221	1.194	1.224	1.256	1.430	1.126
Medical – 2015	1.005	1.034	1.025	1.044	1.064	1.005

Hospice Reimbursement Adjustment

Medicaid fees for hospice claims were increased by 11.1% on average effective January 1, 2016 based on calculations provided by DHS. We applied a reimbursement factor of 1.111 to hospice claims for all eligibility categories and regions to reflect this increase in Medicaid reimbursement.

IMD Reimbursement Adjustment

We applied a 1.10 unit cost adjustment to HMO encounter base period claims based on a comparison of the historical average cost per day for inpatient psychiatric stays and IMD stays.

B. PROGRAM CHANGES

Benefit Changes

IMD Utilization Adjustment

IMD services are routinely provided by HMOs in lieu of inpatient psychiatric admissions. We adjusted the HMO encounter base period utilization to exclude IMD stays of more than 15 days within a given month. For example, if a member was in an IMD for 20 days in one month, we excluded all 20 days for that month.

Eligibility Changes

Change in Enrollment Exemption Policy for Members Receiving Methadone Treatment

Prior to January 1, 2016, members receiving methadone treatment received an exemption to enroll into FFS instead of an HMO for the BCP Standard and CLA programs. Effective January 1, 2016, DHS no longer allows HMO enrollment exemptions due to methadone treatment. We analyzed the average risk score for the FFS members receiving methadone treatment compared to the average risk score for HMO enrolled members. Based on this analysis, we applied an adjustment of 1.004 to the projected 2017 BCP Standard and CLA claims to estimate the movement of previously exempted FFS members into HMOs.

Change in Enrollment Exemption Policy for Individuals with HIV / AIDS

Prior to January 1, 2016, members diagnosed with HIV / AIDS received an exemption to enroll into FFS instead of an HMO for the BCP Standard and CLA programs. Effective January 1, 2016, DHS no longer allows HMO enrollment exemptions due to HIV / AIDS status. Similar to the methadone adjustment, we analyzed the average risk score for FFS members with HIV / AIDS compared to the average risk score for the HMO enrolled population. Based on this analysis, we made an adjustment of 1.001 to the projected 2017 BCP CLA claims to estimate the movement of previously exempted FFS members into HMOs. We did not apply an adjustment to the BCP Standard claims since the calculated impact was less than 0.1%.

C. BCP CLA DURATIONAL ADJUSTMENT

Prior to April 1, 2014, the BCP CLA program provided Medicaid services to childless adults with income at or below 200 percent of the FPL, but enrollment was capped. Effective April 1, 2014, the CLA program was expanded to include all childless adults with incomes less than 100 percent of the FPL, including members previously enrolled in other Medicaid programs as well as individuals not previously eligible for Medicaid benefits. Benefit coverage in the CLA plan was aligned with the BCP Standard plan benefits effective April 1, 2014. The newly covered CLA population began enrollment into managed care on July 1, 2014.

We reviewed quarterly costs for the CLA population by quarter of entry into the program to estimate durational utilization factors. Based on this analysis, we assumed pent-up demand was higher during the quarter of initial enrollment and decreased by 5% in the following quarter of enrollment.

Table 10 summarizes the development of the 0.98 and 1.00 durational adjustments applied to the base period CLA claim costs for April through December 2014 and CY 2015, respectively. We assigned each individual included in the base period experience to one of the two enrollment categories shown below. We also estimated the distribution of CLA member months by enrollment category for 2017 and calculated the difference in the average pent-up demand factor for the base periods compared to the contract period.

Table 10
BCP CLA Durational Utilization Adjustment

		Distribution of Member Months		
Quarter of CLA Enrollment	**Estimated Durational Factor**	**April through December 2014**	**CY 2015**	**Projected CY 2017**
1	1.00	48%	12%	7%
2+	0.95	52%	88%	93%
Average Pent-Up Demand Factor		0.974	0.956	0.954
April through December 2014 to CY 2017 Durational Adjustment: 0.954 / 0.974 = 0.98 (rounded)				
CY 2015 to CY 2017 Durational Adjustment: 0.954 / 0.956 = 1.00 (rounded)				

D. TREND

The annual trend assumptions are shown below by broad category of service. The trend assumptions were developed based on historical trends, Medicaid industry trends, and actuarial judgment.

- Inpatient facility = 1%
- Outpatient facility = 4%
- Professional and Other = 2%
- Dental = 30% for HMO encounter claims from 2015 to 2016; otherwise 5%

We did not apply utilization trends to maternity kick payment claims since the kick payments are made per delivery.

As part of our trend analysis, we reviewed historical trends from 2013 to 2015 in the HMO encounter and FFS data by eligibility category, region, and broad category of service.

- Inpatient facility utilization trends have generally been negative in the HMO encounter data. We assumed an inpatient facility utilization trend of 1% per year since we do not expect these negative trends to continue.

- We reviewed historical HMO encounter outpatient facility claim PMPM trends from 2014 to 2015 using claims re-priced to 2017 Medicaid fees to remove the impact of reimbursement changes. The historical trend was about 1% statewide. The utilization trend assumption of 4% per year reflects an overall shift towards hospital outpatient services in the healthcare system.

- The average historical BCP encounter trend for professional services (including chiropractic services) was about -1% annually from 2013 to 2015 statewide. There were not any significant changes in professional Medicaid fees between the base period and 2017 and, therefore, no re-pricing adjustments were required for this analysis. We assumed an annual trend of 2% for professional and other services since we do not expect these negative trends to continue.

- Historical financial data dental trends for BCP Standard members in Regions 5 and 6 were about 9% from 2014 to 2015. Historical FFS trends for BCP Standard members in Regions 1 through 4 were about 4% from 2014 to 2015. We used a 30% HMO encounter dental trend from 2015 to 2016 based on the supplemental dental data submitted by the HMOs indicating high trends in the emerging 2016 dental experience in Regions 5 and 6 due to increased access to dental services. We assumed an annual dental trend of 5% for the other time periods (2014 to 2015 and 2016 to 2017) and in the dental FFS claims. This is closer to the historical dental trend since we do not expect the large dental trend experienced from 2015 to 2016 dental trends to continue into 2017.

The trend assumptions are meant to reflect utilization and cost impacts not already specifically accounted for in the other adjustments documented in this report.

We also reviewed the claim trends summarized in Table 11 from the CMS Office of the Actuary (OACT) in the *2015 Actuarial Report on the Financial Outlook for Medicaid*. This report projects future Medicaid per enrollee cost trends will be higher than historical trends and states the higher trends are, in part, to anticipated higher provider reimbursement. We projected the BadgerCare Plus provider reimbursement trends separately from the remainder of the claim trend. As a result, our remaining claim trend projection is expected to be lower than OACT's total claim trend projected in Table 11.

Table 11
Summary of Projected National Medicaid Benefit Expenditures per Enrollee
Table 19 of the 2015 Actuarial Report on the Financial Outlook for Medicaid
Published by the CMS Office of the Actuary

	Children		Adults*	
Federal Fiscal Year	Projected Medicaid Cost per Enrollee	Annual Trend	Projected Medicaid Cost per Enrollee	Annual Trend
2014	$3,141	n/a	$4,914	n/a
2015	$3,298	5.0%	$5,159	5.0%
2016	$3,471	5.2%	$5,431	5.3%
2017	$3,654	5.3%	$5,720	5.3%
Average Projected Annual Trend		5.2%		5.2%

**Adults exclude aged and disabled.*

E. BLENDING OF 2017 PROJECTED CLAIMS BY YEAR

For all eligibility categories and regions, we weighted the 2017 claim projections from 2014 (April 2014 - December 2014 for BCP CLA) and 2015 experience based on the member month volume in each period.

F. ADMINISTRATIVE COST AND MARGIN ALLOWANCE

The following exhibits add the administrative cost and margin allowance to the projected 2017 claim costs by eligibility category and region:

- Exhibit 3: Medical
- Exhibit 9: Maternity
- Exhibit 11: Dental
- Exhibit 15: Chiropractic

Administrative Cost / Margin Allowance for Medical, Dental, and Chiropractic Rates

The administrative allowances in the 2017 capitation rates were developed based on the 2014 and 2015 financial data provided by the HMOs (these assumptions are unchanged from the prior rate development). Table 12 summarizes the administrative cost and margin assumptions applied to the medical, dental, and chiropractic rates, which use the same percentages.

Table 12 Administrative Cost and Margin Assumptions Medical, Dental, and Chiropractic Capitation Rates		
	BCP Standard	**BCP Childless Adults**
2017 Administrative Cost Components:		
Direct Expenses	7.5%	6.0%
Indirect Expenses	5.0%	4.0%
Care Coordination	3.0%	2.3%
Sales and Marketing	0.5%	0.2%
Total Administrative Cost Allowance	16.0%	12.5%
Margin Allowance	2.0%	2.0%
2017 Administrative Cost / Margin Allowance	18.0%	14.5%

The 2017 BadgerCare capitation rates do not include any provision for taxes, fees, or assessments. HMOs are expected to pay any applicable federal or state taxes out of the margin included in the capitation rates.

The margin allowance is 2% of capitation for all rate cells. The recommended administrative loads are higher on a percentage basis than are typically used in other states because Wisconsin carves out prescription drugs from the capitation rates, resulting in a lower medical cost. On average, the projected 2017 statewide administrative allowance for medical services is $19.17 PMPM for BCP Standard and $36.79 PMPM for CLA as shown in Exhibit 3 based on the base period demographic mix by rate cell and region. The resulting PMPM administrative loads are consistent with Wisconsin HMO reported experience.

Administrative Cost / Margin Allowance for Maternity Kick Payments

We applied an administrative cost allowance of 5% and margin allowance of 2% for the maternity kick payments. The rate year statewide administrative cost allowance for maternity kick payments is about $274 per delivery or about $25 PMPM assuming there are eleven months of eligibility per delivery (including two months post-delivery).

G. ALLOCATION OF BASE CAPITATION RATES BY RATE CELL

The 2017 base capitation rates are allocated by rate cell using the cost relativities among age bands based on statewide data. The regional rates by eligibility category are based on region specific total costs, but the relationships between age bands were standardized to statewide relativities.

The following exhibits show the calculation for each eligibility category and type of coverage:

- Exhibit 4A: BCP Standard – Medical
- Exhibit 4B: CLA – Medical
- Exhibit 12A: BCP Standard – Dental
- Exhibit 12B: CLA – Dental
- Exhibit 16A: BCP Standard – Chiropractic
- Exhibit 16B: CLA – Chiropractic

The following steps were used to calculate capitation rates by rate cell and region:

1. **Develop statewide rate cell factors by eligibility category and rate cell**: For each eligibility category, type of coverage, and rate cell, we calculated the statewide projected costs by rate cell and calculated the relativity PMPM to the overall costs PMPM.

2. **Normalize statewide rate cell factors to 1.0 by region and eligibility category**: For each region and eligibility category, the statewide rate cell factors must be normalized so the rates by rate cell will produce the overall capitation rate by region and eligibility category based on the member months in the base data used in the 2017 rate calculation. The statewide rate cell factors for each age category are divided by the average statewide rate cell factor (weighted by member months) to calculate the regional rate cell factors.

3. **Apply rate cell factors to capitation rates by region and eligibility category**: The normalized regional rate cell factors in step 2 are multiplied by the base capitation rates by region, type of coverage, and eligibility category to determine the normalized rates by rate cell and region.

H. BCP STANDARD DENTAL PILOT UTILIZATION ADJUSTMENT

DHS is implementing a pilot program, effective in October 2016, to increase dental reimbursement for pediatric dental and emergency adult dental services by roughly 25% in four pilot counties (Brown, Marathon, Polk, and Racine counties). The higher reimbursement will be paid outside of the dental capitation rates. However, we applied utilization adjustments to reflect the estimated impact of higher dental reimbursement on dental utilization in the pilot counties.

We assumed the dental fee increases in the pilot counties would increase pediatric dental utilization by 25% and have no impact on adult dental services since the higher reimbursement applies to emergency services only. In developing this assumption, we reviewed a March 2008 study performed by the California HealthCare Foundation entitled “Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?” We then calculated the average pediatric impact across each region using the Aug 2016 membership across all ages in the pilot counties versus total region membership. We calculated dental utilization adjustments of 6% in Region 1, 7% in Region 2, and 9% in Region and applied these adjustments to the child BCP Standard rate cells.

I. HEALTH INSURER PROVIDER FEE

Plan reimbursement for costs related to the ACA Health Insurer Provider Fee (HIF) have historically been developed outside of the rate development. The base period claims experience excludes HIF. CMS will not be imposing HIF fees for 2017 capitation rates and, therefore, there is no HIF impact on the 2017 capitation rates.

IV. FINAL HMO-SPECIFIC CAPITATION RATES

This section of the report summarizes the development of final medical (HMO-specific) and dental capitation rates, including applicable risk score adjustments, P4P withholds, and provider access payments.

These adjustments are summarized in the following exhibits:

- Exhibit 6A: BCP Standard – Medical
- Exhibit 6B: CLA – Medical
- Exhibit 13A: BCP Standard – Dental
- Exhibit 13B: CLA – Dental
- Exhibit 21A: BCP Standard – Final HMO-Specific Capitation Rates by Type of Coverage
- Exhibit 21B: CLA – Final HMO-Specific Capitation Rates by Type of Coverage

A. RISK SCORE ADJUSTMENTS

Risk adjustment is an important tool for the development and sustainability of Medicaid managed care programs and helps align incentives between capitated plans and state Medicaid managed care programs. Risk adjustment, if done properly, allows capitated plans to succeed based on how efficiently they can deliver care and negotiate provider reimbursement, rather than on how well they can enroll the healthiest individuals.

Risk adjusted payment systems are intended to alleviate some of the inequities brought on by selection. If a capitated plan enrolls a healthier population, the risk adjustment system will lower its payments and reduce overpayments to capitated plans that experience positive selection. Likewise, if a capitated plan experiences adverse selection and consequently enrolls a sicker population, the risk adjustment system will increase its payments to reflect their enrollees' sicker health status.

Risk adjustment models measure the relative morbidity of individuals. The tools use demographic and health care claims data to develop these morbidity measures. These measures can be used to better predict future health care costs in order to adjust payment.

This section describes the development of the risk adjustment system that will be used to provide HMOs with risk adjusted payments for the 2017 BCP Standard capitation rates.

Exhibit 5 summarizes the risk score adjustments applied to the base 2017 capitation rates to calculate HMO specific risk adjusted 2017 BCP medical capitation rates (before P4P withholds and provider access payments).

CDPS Risk Score Model Overview

The BCP risk adjustment process uses the Chronic Illness and Disability Payment System plus Prescription Drug model (CDPS+Rx) developed by the University of California San Diego (UCSD).

The CDPS+Rx model includes the full set of diagnosis categories from the CDPS model, as well as 15 MRX categories from the Medicaid Rx model that are embedded within the CDPS hierarchy. The researchers at UCSD who developed the CDPS+Rx model decided to limit the MRX categories to the 15 that added predictive power to the diagnostic model (i.e., both relatively common and significant predictors of cost) and that were relatively less susceptible to variations in practice patterns.

- The Chronic Illness and Disability Payment System (CDPS) is a diagnostic classification system that Medicaid programs can use to make health-based capitated payments for TANF and disabled Medicaid beneficiaries. CDPS uses ICD-9 and ICD-10 diagnostic codes to assess risk and assigns each member to one or more of 67 possible medical condition categories from 19 major diagnostic categories. Each member is also assigned to one of 16 age / gender categories. All of the 19 major diagnostic categories are "hierarchic" categories in that only the single most severe diagnostic within the major category is counted. This counting rule simplifies the model and strengthens its resistance to additional coding. Single counting within major categories is intended to avoid encouraging a proliferation of different diagnoses reported for a single disease process just to increase payment. However, as with most models, CDPS considers not only a person's single most serious diagnosis within a major category but also diagnoses from other major categories.

- Medicaid Rx is a pharmacy based risk adjustment model that may be used to adjust capitated payments to capitated plans that enroll Medicaid beneficiaries. The Medicaid Rx model assigns each member to one or more of 45 medical condition categories based on the prescription drugs used by each member and to one of 11 age / gender categories.

CDPS, Medicaid Rx, and CDPS+Rx are widely used in the Medicaid industry because they are designed specifically for the Medicaid population. We used the structure of version 6.0 which is free to use for states and capitated plans, and can be downloaded at http://cdps.ucsd.edu/.

Risk adjustment can be implemented in one of two ways:

- Concurrent risk adjustment: Diagnoses and pharmacy data from one time period are used to predict the acuity of the population in that same time period. Risk scores under concurrent risk adjustment methods are influenced by acute and one-time conditions in addition to reflecting chronic conditions.

- Prospective risk adjustment: Diagnoses and pharmacy data from a prior time period are used to predict the acuity of the population in a future time period. There is typically a lag of 6 to 12 months between the historical period and the prediction period. The longer the lag is, the less accurate the prediction of future costs becomes.

Historically, DHS has used concurrent risk score weights for BCP Standard risk adjustment applied prospectively. We will refer to this as the "standard concurrent model".

For the 2017 rate development, we developed custom CDPS+Rx risk weights based on historical Wisconsin Medicaid BCP Standard plan experience. The custom risk weights reflect Wisconsin's specific covered benefits, eligibility rules, provider reimbursement, and practice patterns. We used one set of cost weights for BCP children and adults. We will refer to this as the "custom prospective model".

R-squared measures the variability in a data set accounted for by the statistical model. R-squared values for regression models vary from 0% to 100%, with 100% indicating a model that explains all the variation in a particular data set. The regression model calibrated to BCP population has an R-squared measure of 15%, which is comparable to typical prospective model predictive powers for comparable Medicaid populations.

Attachment B contains the risk weights for the BCP population and shows the statistical significance (p-value) and prevalence of each disease category.

Attachment C shows the mapping of the risk categories from the standard to the custom CDPS+Rx models. We combined standard categories where the individual categories did not provide additional statistical predictive ability (for example, we combined the eye very low and low categories).

For 2017 BCP Standard rates, we blended the new and prior models, assigning 50% weight to each model, to phase in the impact of the model change on HMO capitation rates. Since CLA rates were not risk adjusted in prior years, we used 100% of the custom model weights.

Risk Adjustment Methodology and Data

The risk scores shown in Exhibit 5 are based on 2015 fee-for-service (FFS) claims and HMO encounter claims for HMO members from the encounter data extracts submitted to DHS by the HMOs.

We used version 6.0 of the CDPS+Rx model to assign individuals to a demographic category and disease categories based on their diagnostic information and pharmacy utilization during 2015. Each scored individual receives a demographic relative cost weight and can have multiple disease categories assigned depending on that individual's health status. The recipient age and gender is calculated as of July 1, 2015 and is used for demographic classification. In the prior model, the standard CDPS+Rx cost weights reflecting a prescription drug carve-out were used, reflecting that all prescription drugs are paid through FFS, and not included in the capitation rate paid to the HMOs. In addition, the pregnancy complete diagnostic classification was removed from the model as all delivery costs are paid through a non-risk adjusted delivery kick payment. In both models, all diagnostic codes from laboratory, radiology, and DME claims were excluded to avoid including false positive diagnostic indicators for tests run on individuals.

For each member, the weights for all of the disease categories assigned are combined with their demographic information to calculate a total individual risk score under both the standard concurrent and custom prospective models. Scored members are assigned to the BCP Standard and CLA populations and to each HMO using capitation data provided by DHS for August 2016. The unadjusted individual risk score for BCP Standard members is calculated as the weighted average risk score under the standard concurrent model and custom prospective model, assigning 50% weight to each risk score. The unadjusted individual risk score for CLA members is based on the custom prospective model.

For each HMO, the unadjusted plan factors are derived by performing a weighted average of the cost weights using the count of member months for scored members associated with each demographic and diagnostic category. An example of the weighted average is given below:

> *([Scored Member Months in Demographic Bucket #1] x [Demographic Bucket #1 Risk Weight] + [Scored Member Months with Condition #1] x [Condition #1 Risk Weight] + [Scored Member Months with Condition #2] x [Condition #2 Risk Weight]) / [Total HMO Scored Member Months] = [Unadjusted Plan Factor]*

A Budget Neutral Plan Factor is calculated for each HMO by rate cell, region, and eligibility category by dividing each individual HMO's Unadjusted Plan Factor by the total enrolled population's Unadjusted Plan Factor within each rate cell, region, and eligibility category. An example of the budget neutral calculation is shown below:

> *[HMO Unadjusted Plan Factor] / [Weighted Average Unadjusted Plan Factor] = [HMO Budget Neutral Plan Factor]*

The final HMO rates are calculated by applying each HMO's applicable Budget Neutral Plan Factor by rate cell, region, and eligibility category to the effective medical capitation rates. New HMOs will receive capitation rates based on 1.000 risk scores. We also assigned 1.000 risk scores to two current BCP Standard HMOs which grew significantly during 2014 and had a materially lower percentage of scored members compared to other HMOs.

BCP Standard capitation rates for newborns (age zero) are not risk adjusted since they do not have experience in the prior year to develop their prospective risk score.

Risk Adjustment Implementation Considerations

We made several adjustments to the "raw" risk score results to calculate the risk scores shown in Exhibit 5:

- *Membership threshold for scoring a member* – Risk adjustment methods typically use 12 months of historical data to assess risk. For members with less than 12 months of eligibility in that historical period, a determination is needed as to how to handle their risk assessment. We used a minimum of 6 months of eligibility for risk scoring.

- *Treatment of non-scored members* – Individuals with too short of an eligibility span to assess their risk are often assigned risk based on their age and gender and / or based on some portion of the risk assessed in the capitated plan's population with full eligibility. We assumed that non-scored members of an HMO have a risk score equal to that HMO's rate cell average risk score within a given combination of region and eligibility category.

- *Normalization by rate cell within each region and eligibility category* – Risk adjustment is intended to measure the relative risk of populations enrolled by HMOs to develop capitation rate adjustments by HMO that are budget neutral. HMO risk factors are normalized to be budget neutral for each rate cell within each region and eligibility category based on projected (i.e., August 2016) member months.

- *Credibility adjustments* – Risk scores developed for small populations may not be credible due to the inherent variability of risk scores. For HMOs with less than 50 scored members in a given rate cell within a given combination of region and eligibility category, the normalized HMO risk score was set to 1.00 since the risk score result is not considered to be a credible measure of estimated future morbidity.

- *HMOs with large enrollment growth* – Two HMOs (Trilogy and Independent Care) lack sufficient data to develop credible risk scores for BCP Standard due to large enrollment growth during 2015. Therefore, their BCP Standard normalized risk scores are set to 1.00 for each rate cell.

Midyear Risk Score Adjustments

As noted above, we developed 2017 risk score adjustments for each HMO based on their August 2016 enrollment. Historically, risk scores have been established prospectively for each calendar year with no midyear adjustments. For 2017, DHS will consider a midyear update to the CLA risk scores if we observe material changes in enrollment between 2016 and 2017. If implemented, the midyear risk score updates will be effective July 1, 2017 and will be budget neutral.

Retrospective Risk Score Adjustment

In addition to the risk scores being budget neutral on a prospective basis (based on August 2016 enrollment), DHS will perform a risk score settlement calculation to ensure risk scores are budget neutral on a retrospective basis based on actual 2017 enrollment by HMO.

B. PAY-FOR-PERFORMANCE WITHHOLDS

A P4P withhold of 2.5% of the capitation payment (prior to risk adjustment and provider access payments) applies to the BCP Standard and CLA capitation rates with the exception of the maternity kick payment and chiropractic capitation rates.

Based on historical withhold payment data from DHS, BCP HMOs have earned back at least 75% of the P4P withhold from 2011 to 2014 in aggregate. At this time, we are not aware of any significant changes in the withhold quality measures that would impact 2017 withhold payouts. Additionally, the 2% margin allowance would be sufficient to cover a significant decrease in withhold earn back. Therefore, we are comfortable that the capitation rates included in this report are actuarially sound net of the P4P withholds.

C. PROVIDER ACCESS PAYMENTS

DHS provides funding to promote access for Medicaid individuals to acute care, rehabilitation, and critical access hospitals and ambulatory surgery centers (ASCs). This funding is included in the capitation rates for the BCP Standard population. DHS performs an annual reconciliation to ensure the total funding allocated in the budget is fully expended. The CLA population is not currently eligible for access payments.

The provider access payments are intended to reimburse providers based on Medicaid utilization. Therefore, the payment amounts per service do not vary based on acuity or provider billed charges. The total access payment funding amounts for the BCP and SSI programs combined are appropriated in the Wisconsin state budget on a State Fiscal Year (SFY) basis. For SFY 2017 (July 2016 through June 2017), the funding amounts for HMOs are as follows:

- Inpatient acute and rehabilitation: $243,946,417
- Outpatient acute and rehabilitation: $199,592,523
- Inpatient critical access: $4,569,949
- Outpatient critical access: $3,739,049
- Ambulatory Surgical Center: $5,520,522

The total access payment funding amounts are allocated to each program (BCP and SSI) and then by HMO based on total projected 2017 admissions (inpatient access payments) or visits (outpatient and ASC access payments) and converted to a fixed PMPM amount per HMO added to the 2017 capitation rates.

The methodology used to calculate the 2017 provider access rate adjustments is summarized in the following steps:

1. **Summarize Historical Utilization**: We summarized the total base period (2014 and 2015) utilization PMPM by HMO, region, and rate cell for providers eligible to receive access payments. The utilization counts are admissions for inpatient access payments and visits for outpatient and ASC access payments. DHS provided a list of National Provider Identification (NPI) codes for facilities eligible for each type of access payment. We summarized historical discharges for inpatient acute / rehabilitation and critical access hospital payments and visits for outpatient acute / rehabilitation hospital, critical access hospital, and ASC payments.

2. **Project 2017 Utilization**: We projected the base period utilization PMPM by HMO, region, and rate cell to 2017 using the adjustment factors that would materially impact utilization:

   - Missing data adjustments
   - Completion factors
   - Utilization trends

   For rate cells with at least 250 member months in the base period, the projected 2017 utilization PMPM is calculated as the base period utilization multiplied by the adjustments listed above. For other rate cells with less than 250 member months, the projected 2017 utilization PMPM is developed based on the regional average base period utilization PMPM across all HMOs.

   The projected 2017 utilization PMPM is converted to total utilization counts based on the projected 2017 member months by rate cell (i.e., the August 2016 enrollment by rate cell multiplied by 12).

3. **Calculate Access Payment Rate Adjustments:** We allocated the total access payments by HMO based on the projected 2017 utilization and calculated the access payment rate adjustments PMPM by dividing the total allocated access payments by the total projected 2017 member months.

   The access payment add-ons are calculated for each HMO with credible membership. For new HMOs, the average regional PMPM adjustment will be paid. Exhibit 20 summarizes the 2017 access payments.

Exhibit 21 shows the final 2017 capitation rates by HMO and type of coverage, including CDPS, P4P, and access payments.

V. CAPITATION RATES FOR ENHANCED FMAP SERVICES

DHS receives enhanced Federal Medical Assistance Percentage (FMAP) for certain preventive services provided without member copayments and for family planning services. This section of the report documents the development of the 2017 capitation rates for services eligible for enhanced FMAP. There are no services eligible for enhanced FMAP in the dental or chiropractic capitation rates.

The medical capitation rates or services eligible for enhanced FMAP are summarized in the following exhibits:

- Exhibit 22: Overall FMAP capitation rates
- Exhibit 23: FMAP capitation rates by rate cell (preventive services)
- Exhibit 24: FMAP capitation rates by rate cell (family planning services)
- Exhibit 25: FMAP maternity kick payments

A. SERVICES ELIGIBLE FOR ENHANCED FMAP

The preventive and family planning services eligible for enhanced FMAP are each identified separately using criteria provided by DHS.

B. METHODOLOGY USED TO DEVELOP FMAP PORTION OF CAPITATION PAYMENTS / MATERNITY KICK PAYMENTS

The methodology used to develop the portion of the medical capitation rates and maternity kick payments represented by enhanced FMAP services is summarized in the following steps:

- **Project 2017 claim costs**:

  - Preventive Services: The projected 2017 professional medical cost PMPM (from Exhibit 2) is multiplied by the projected portion of those services eligible for enhanced FMAP. We did not identify any zero copay preventive services in the maternity kick payment base experience.

  - Family Planning Services: The projected 2017 family planning services PMPM is developed in Exhibit 2 (medical capitation rates) and Exhibit 8 (maternity kick payments).

  Please refer to Section II for a discussion of the base period data and adjustments and Section III for the assumptions used to project the base period experience to 2017.

- **Add administrative cost and margin allowance**: The administrative cost and margin allowance is added to the projected claim costs in Exhibit 22 (medical capitation rates) and Exhibit 25 (maternity kick payments). The administrative cost and margin allowance added to the services eligible for enhanced FMAP is the same as the allowance added to the total medical capitation rate and maternity kick payments and is summarized in Section III.F.

- **Allocate regional capitation rates by rate cell**: The medical capitation rates are allocated by rate cell based on statewide rate cell factors normalized to the base period mix of member months by rate cell in each region. These calculations are shown in Exhibit 23 (preventive services) and Exhibit 24 (family planning). This methodology is described in detail in Section III.G. This step does not apply for the maternity kick payments since these payments do not vary by rate cell.

- **Apply P4P withholds:** The P4P withhold of 2.5% is applied to the capitation rates by rate cell in Exhibit 23 (preventive services) and Exhibit 24 (family planning). This step does not apply for the maternity kick payments since these payments are not subject to the P4P withhold.

VI. CMS RATE SETTING CHECKLIST ISSUES

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

AA.1.0 – OVERVIEW OF RATE SETTING METHODOLOGY

Please refer to Sections II through IV of the report for a description of the rate setting methodology.

AA.1.1 – ACTUARIAL CERTIFICATION

Appendix D includes the actuarial certification.

AA.1.2 – PROJECTION OF EXPENDITURES

Exhibits 17 through 19 show the expected rate change from the February – December 2016 capitation rates to the 2017 capitation rates by eligibility category, HMO, and rate cell excluding access payments.

AA.1.3 – RISK CONTRACTS

DHS' contract with the HMO receiving the capitation rates in this report meet the criteria of a risk contract.

AA.1.4 – RATE MODIFICATIONS

The 2017 capitation rates are the initial rates for the contract period.

NOTE – THERE IS NO ITEM AA.1.5 IN THE CHECKLIST

AA.1.6 – LIMIT ON PAYMENT TO OTHER PROVIDERS

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

AA.1.7 – RISK AND PROFIT

Targeted margin is considered as part of the final rate development as described in Section III.F of the report.

AA.1.8 – FAMILY PLANNING ENHANCED MATCH

DHS currently claims enhanced match for family planning services and the administrative and margin portion associated with the delivery of those services. Please refer to Section V of this report for the development of capitation rates for services eligible for enhanced match.

AA.1.9 – INDIAN HEALTH SERVICE FACILITY ENHANCED MATCH

DHS does not claim enhanced match for services provided through Indian Health Service Facilities for the population covered under this program.

AA.1.10 – NEWLY ELIGIBLE ENHANCED MATCH

Wisconsin has not expanded its Medicaid eligibility rules to include adult populations that can be covered under the Medicaid expansion provisions of the Affordable Care Act.

AA.1.11 – RETROACTIVE ADJUSTMENTS

The 2017 rates documented in this report are the initial capitation rates for the rate period and do not contain any retroactive adjustments. Any future retroactive capitation adjustments will be limited to a maximum period of two years.

AA.2.0 – BASED ONLY UPON SERVICES COVERED UNDER THE STATE PLAN

The Medicaid base data includes only State Plan services covered by the BadgerCare Plus Medicaid managed care program and IMD experience (with adjustments) which are covered in lieu of inpatient psychiatric admissions.

AA.2.1 – PROVIDED UNDER THE CONTRACT TO MEDICAID-ELIGIBLE INDIVIDUALS

Data for populations not eligible to enroll in a BadgerCare Plus HMO has been excluded from the base data. The payment rates provided under the contract are for Medicaid-eligible individuals only.

AA.2.2 – DATA SOURCES

Please refer to Section II.A of this report for a discussion of the base year utilization and cost data.

AA.3.0 – ADJUSTMENTS TO BASE YEAR DATA

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

AA.3.1 – BENEFIT DIFFERENCES

The base data used to calculate the capitation rates only includes services covered under the managed care contract.

AA.3.2 – ADMINISTRATIVE COST ALLOWANCE CALCULATIONS

The administrative cost allowances are discussed in Section III.F of this report and summarized in Table 12.

AA.3.3 – SPECIAL POPULATION ADJUSTMENTS

The base data used to calculate the capitation rates is consistent with the managed care population. No special population adjustments were necessary.

AA.3.4 – ELIGIBILITY ADJUSTMENTS

The base data used to calculate the capitation rates is consistent with the managed care population. No eligibility adjustments were necessary.

AA.3.5 – THIRD PARTY LIABILITY (TPL)

The HMOs are responsible for the collection of any TPL recoveries. As such, the HMO encounter data already includes the impact of TPL recoveries.

AA.3.6 – INDIAN HEALTH CARE PROVIDER PAYMENTS

The HMOs are responsible for the entirety of the IHC payments, which are fully reflected in the encounter data.

AA.3.7 – DSH PAYMENTS

DSH payments are not included in the capitation rates.

AA.3.8 – FQHC AND RHC REIMBURSEMENT

HMOs are required to reimburse Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) centers based on Medicaid rates.

AA.3.9 – GRADUATE MEDICAL EDUCATION (GME)

GME payments are excluded from the base data.

AA.3.10 – COPAYMENTS, COINSURANCE, AND DEDUCTIBLES IN CAPITATED RATES

The base data reflects appropriate cost sharing provisions. No adjustments were necessary.

AA.3.11 – MEDICAL COST TREND INFLATION

Please refer to Section III.D of this report.

AA.3.12 – UTILIZATION ADJUSTMENTS

Please refer to Section III.B, III.C, III.D, and III.H of this report.

AA.3.13 – UTILIZATION AND COST ASSUMPTIONS

The base data for all capitation rates is appropriate for the populations to be covered. Managed care enrollment is mandatory for BadgerCare Plus. The base utilization and cost data for the capitation rates is mainly HMO encounter data supplemented with financial data. The dental rates in regions 1 to 4 are based on FFS data since HMOs do not currently cover dental services in those regions. Chiropractic rates in all regions are based on FFS data since very few HMOs were contracted to cover chiropractic services during the base period and, therefore, credible HMO encounter data is not available.

AA.3.14 – POST-ELIGIBILITY TREATMENT OF INCOME (PETI)

The BadgerCare Plus program excludes members and services subject to this type of patient liability.

AA.3.15 – INCOMPLETE DATA ADJUSTMENT

The capitation rates include an adjustment to reflect IBNR claims. We also adjusted the HMO encounter data for apparent underreporting. See Section II.D for additional details.

AA.3.16 – PRIMARY CARE RATE ENHANCEMENT

The base period data is net of any enhancements to payment rates made to primary care providers. Therefore, no adjustments were necessary.

AA.3.17 – HEALTH HOMES

The State of Wisconsin has a health home pilot for members with AIDS / HIV who receive services provided through the AIDS Resource Center of Wisconsin (ARCW). Effective January 1, 2016, members enrolled in this health home pilot program are no longer required to disenroll from Medicaid managed care HMOs. As discussed in Section III.B, this change is not anticipated to have a material impact on the 2017 capitation rates. DHS will perform a settlement outside of the capitation rates to reflect the cost of services provided through the ARCW to HMO covered members.

AA.4.0 – ESTABLISH RATE CATEGORY GROUPINGS

Please refer to Section I.B of this report.

AA.4.1 – ELIGIBILITY CATEGORIES

Please refer to Section I.B of this report.

AA.4.2 – AGE

Please refer to Section I.B of this report.

AA.4.3 – GENDER

The capitation rates do not vary by gender.

AA.4.4 – LOCALITY / REGION

Please refer to Section I.B of this report.

AA.4.5 – RISK ADJUSTMENT

The BadgerCare Plus Standard and CLA medical capitation rates are risk adjusted using an actuarially sound CDPS + Rx methodology. Please refer to Section IV.A for a description of the risk adjustment methodology.

AA.5.0 – DATA SMOOTHING

In general, the medical capitation rate methodology uses smoothing techniques in two ways:

- The methodology generally uses two years of base data to smooth random fluctuation that occurs on a year-to-year basis. The CLA rates are based on 21 months of base period data due to enrollment and benefit changes occurring in April 2014.

- Capitation rates are first set by eligibility category and region in Exhibit 3 (medical), Exhibit 11 (dental), and Exhibit 15 (chiropractic). Statewide cost relationships are then used to develop statewide rate cell factors within each eligibility category, which are applied on a cost-neutral basis to convert the region capitation rates into capitation rates by rate cell and region in Exhibit 4 (medical), Exhibit 12 (dental), and Exhibit 16 (chiropractic).

AA.5.1 – COST-NEUTRAL DATA SMOOTHING ADJUSTMENT

Exhibit 4 (medical), Exhibit 12 (dental), and Exhibit 16 (chiropractic) demonstrate the rate cell factors are cost neutral in each individual region. Please see Section III.G for additional details.

AA.5.2 – DATA DISTORTION ADJUSTMENT

We did not identify any material distortions caused by special populations.

AA.5.3 – DATA SMOOTHING TECHNIQUES

We determined that data smoothing techniques other than those described in AA5.0 and AA.5.1 were not required.

AA.5.4 – RISK ADJUSTMENT

The BadgerCare Plus Standard and CLA medical capitation rates are risk adjusted using an actuarially sound CDPS + Rx methodology. Please refer to Section IV.A for a description of the risk adjustment methodology.

AA.6.0 – STOP LOSS, REINSURANCE, OR RISK SHARING ARRANGEMENTS

DHS' contract with the HMOs does not include any provisions for stop loss, reinsurance, or risk sharing arrangements.

AA.6.1 – COMMERCIAL REINSURANCE

DHS does not require entities to purchase commercial reinsurance.

AA.6.2 – SIMPLE STOP LOSS PROGRAM

None.

AA.6.3 – RISK CORRIDOR PROGRAM

None.

AA.7.0 – INCENTIVE ARRANGEMENTS

Please refer to Section IV.B of this report for a description of the P4P withhold arrangements.

AA.7.1 – ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE PAYMENTS

DHS has not implemented incentive payments related to EHRs for the 2017 contract period.

VII. RESPONSES TO 2017 CMS MANAGED CARE RATE SETTING GUIDE

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

- Rate certification – See Appendix D.
- Final capitation rates – Please refer to Exhibit 6 (medical capitation rates), Exhibit 9 (maternity kick payments), Exhibit 13 (dental capitation rates), and Exhibit 16 (chiropractic capitation rates) for the final capitation rates excluding access payments. Exhibit 21 summarizes the final capitation rates, including access payments.
- Program descriptions – See Section I.B.

2. Data

- Service data sources – See Sections II.A through II.C.
- Validation and quality adjustments – See Section II.D.
- Changes in data sources – Base period HMO encounter and financial data was updated from calendar years 2013 - 2014 to calendar years 2014 - 2015.
- Potential future data improvements – As described in Section II.D, we applied missing data adjustments to the encounter data. DHS anticipates missing data adjustments will decrease going forward as encounter data improves over time.
- Other data adjustments – See Section II.D.
- Blending of data sources – See Section III.E.

3. Projected Benefit Costs and Trends

- The assumptions used to develop the projected benefit costs for covered populations do not vary based on the rate of Federal financial participation associated with the covered populations.
- Changes in covered services and benefits:
  - Various legislative and program changes effective between the base period and contract period – See Section III.B. The costs associated with IMD stays of more than 15 days within a given month were removed from the base data; however, these members and their non-IMD claims were not removed since DHS does not intend to disenroll them from managed care. DHS will be developing a methodology to provide 100% State funding for these member costs in 2017. They believe disenrolling a member from their current support network based on a day limit is not in the best interest of the member.
- Projected benefit cost trends:
  - Annual trend assumptions excluding Medicaid FFS reimbursement changes – See Section III.D.

  - Medicaid FFS reimbursement changes between the base period and contract period – See Section III.A.

- Other adjustments:
  - CLA durational adjustment – See Section III.C.
  - Dental pilot utilization adjustment – See Section III.H.
- Final projected benefit costs – See Exhibit 3 (medical capitation rates), Exhibit 9 (maternity kick payments), Exhibit 11 (dental capitation rates), and Exhibit 15 (chiropractic capitation rates).
- Retrospective eligibility periods:
  - HMOs are not responsible for claims incurred during retroactive eligibility periods. If there are claims for retrospective disenrollment periods, these claims are excluded from the base period encounter data since there is no corresponding eligibility record in the eligibility data. There is no explicit data adjustment to the capitation rates to reflect the impact of claim payments made for retroactively disenrolled members. However, the missing data adjustments add these costs into the base data.
- Conditions of any litigation to which the state is subjected – Not applicable; no impact on rates.

4. Pass-Through Payments

- Pass-through payments – Not applicable.

5. Projected Non-Benefit Costs

- Administrative costs and provision for margin – See Section III.F.
- Health Insurer Fee treatment – See Section III.I.

6. Rate Range Development

- Assumption variation for rate range endpoints – Not applicable.

7. Risk and Contractual Provisions

- Risk adjustment – See Section IV.A and Exhibits 5 and 6.
- Withholds – See Section IV.B, Exhibit 6 (medical capitation rates), and Exhibit 13 (dental capitation rates).
- Incentives, MLR requirements, reinsurance requirements – None.

8. Other Rate Development Considerations

- Federal Medical Assistance Percentage (FMAP) – DHS receives enhanced FMAP for family planning services and certain preventive services provided without member copayments. See Section V and Exhibits 22 through 25.

- Final certified rates – See Exhibit 6 (medical capitation rates), Exhibit 9 (maternity kick payments), Exhibit 13 (dental capitation rates), and Exhibit 16 (chiropractic capitation rates). Exhibit 21 summarizes the final capitation rates, including access payments, by type of coverage.

- Area and rate cell relativity factors – See Section III.G, Exhibit 4 (medical capitation rates), Exhibit 12 (dental capitation rates), and Exhibit 16 (chiropractic capitation rates).

- Enhanced hospital and GME payments – See Section IV.C for provider access payments.

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES

This section does not apply, as BadgerCare Plus is not a primarily long-term care service program.

SECTION III. NEW ADULT POPULATION CAPITATION RATES

Introduction

Prior to April 1, 2014, the BCP CLA program provided Medicaid services to childless adults with income at or below 200 percent of the FPL, but enrollment was capped. Effective April 1, 2014, the CLA program was expanded to include all childless adults with incomes less than or equal to 100 percent of the FPL, including members previously enrolled in other Medicaid programs, as well as individuals not previously eligible for Medicaid benefits. Benefit coverage in the CLA plan was aligned with the BCP Standard plan benefits effective April 1, 2014. The newly covered CLA population began enrollment into managed care on July 1, 2014.

1. Data

Milliman used detailed HMO encounter data for the period April through December 2014 and calendar year 2015 for rate development for all individuals, along with 2014 and 2015 supplemental financial data, as described in Section II.

2. Projected Benefit Costs

See section III for a summary of rate adjustments applied to project benefit costs to the contract period and specifically Sections II.D and III.C for the adjustments to remove the impact of pent-up demand wear-off and seasonality. In projecting 2014 and 2015 medical benefit costs to 2017, we examined high level HMO encounter payments through June.

3. Projected Non-Benefit Costs

See Section III.F for the development of projected administrative costs and contribution to surplus. The assumption is based on 2014 and 2015 health plan financial reporting.

4. Final Certified Rates or Rate Ranges

Material changes to the rate development methodology are described in Section I.C.

Overall, the CLA medical rates increased by 2.3% statewide. See Exhibits 17B to 19B for a comparison of February – December 2016 and 2017 rates by HMO. Drivers of the rate change are discussed in Section I.A. and summarized in Table 2.

5. Risk Mitigation Strategies

The 2017 rates are risk adjusted. Please refer to section IV.A of the rate report. Previously, the CLA rates were not risk adjusted.

No risk corridors, minimum loss ratios, reinsurance, high cost risk pools, or other mechanisms will be incorporated into the CLA capitation rates.

2017 Rate Exhibits

(Provided in Excel Format)

This material assumes the reader is familiar with the State of Wisconsin's Medicaid program, Wisconsin Medicaid benefits, and rate setting principles. The material was prepared solely to provide assistance to DHS to set 2017 capitation rates for the BadgerCare Plus Standard and Childless Adults programs. 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.

State of Wisconsin
Capitation Rate Development
January 1, 2017 through December 31, 2017
BadgerCare Plus Standard and Childless Adult Programs

December 22, 2016

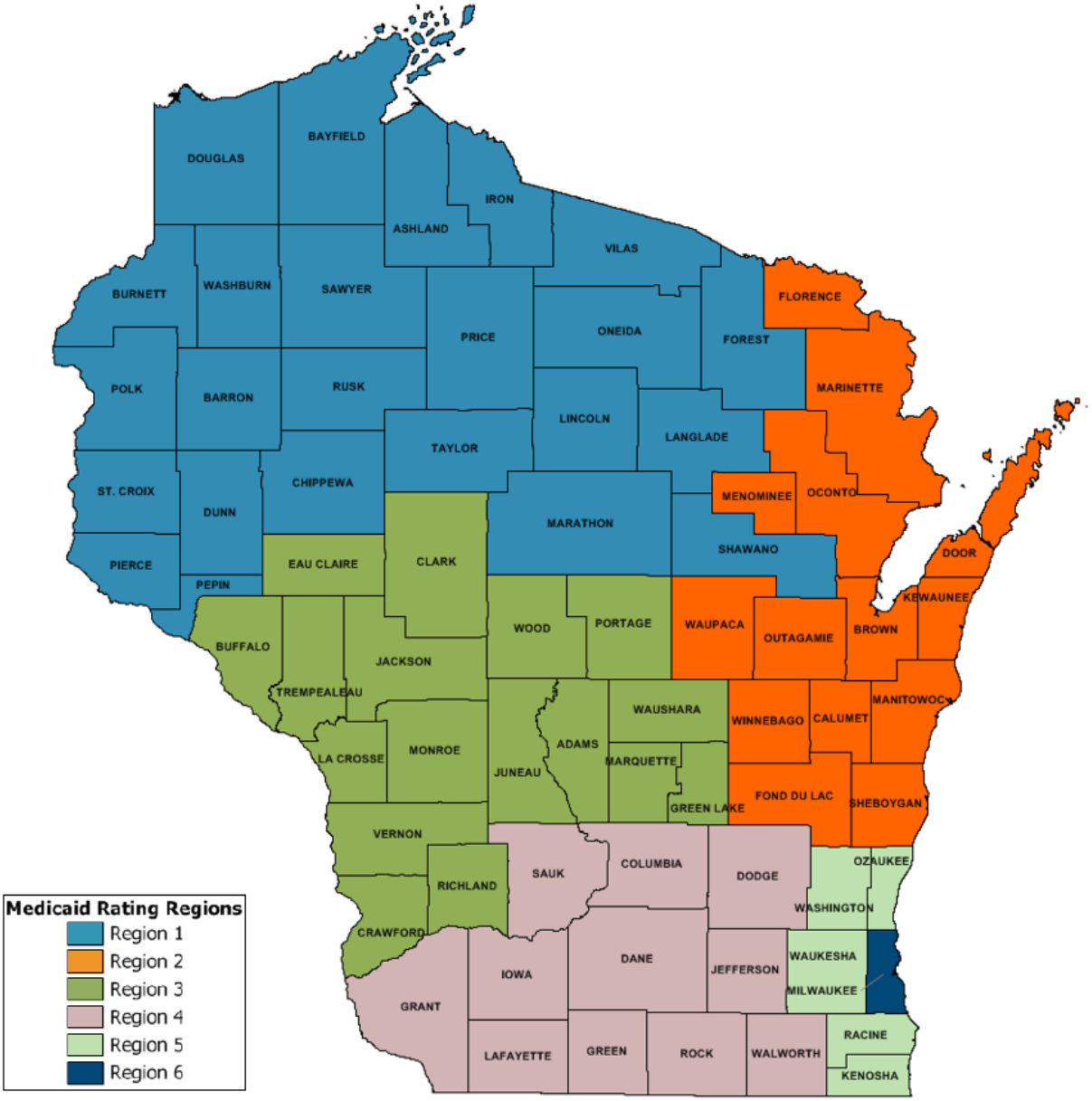
Appendix A

Mapping of Wisconsin Counties to Medicaid Rate Regions

This material assumes the reader is familiar with the State of Wisconsin's Medicaid program, Wisconsin Medicaid benefits, and rate setting principles. The material was prepared solely to provide assistance to DHS to set 2017 capitation rates for the BadgerCare Plus Standard and Childless Adults programs. 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.

State of Wisconsin
Capitation Rate Development
January 1, 2017 through December 31, 2017
BadgerCare Plus Standard and Childless Adult Programs

December 22, 2016



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Wisconsin Department of Health Services
Capitation Rate Development January 1, 2017 – December 31 2017
BadgerCare Plus Standard and Childless Adults Programs

November 9, 2016

Appendix B

Custom Risk Model Weights

(Provided in Excel Format)

This material assumes the reader is familiar with the State of Wisconsin's Medicaid program, Wisconsin Medicaid benefits, and rate setting principles. The material was prepared solely to provide assistance to DHS to set 2017 capitation rates for the BadgerCare Plus Standard and Childless Adults programs. 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.

State of Wisconsin
Capitation Rate Development
January 1, 2017 through December 31, 2017
BadgerCare Plus Standard and Childless Adult Programs

December 22, 2016

Appendix C

Custom Risk Model Category Mapping

(Provided in Excel Format)

This material assumes the reader is familiar with the State of Wisconsin's Medicaid program, Wisconsin Medicaid benefits, and rate setting principles. The material was prepared solely to provide assistance to DHS to set 2017 capitation rates for the BadgerCare Plus Standard and Childless Adults programs. 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.

State of Wisconsin
Capitation Rate Development
January 1, 2017 through December 31, 2017
BadgerCare Plus Standard and Childless Adult Programs

December 22, 2016

Appendix D

Actuarial Certification

This material assumes the reader is familiar with the State of Wisconsin's Medicaid program, Wisconsin Medicaid benefits, and rate setting principles. The material was prepared solely to provide assistance to DHS to set 2017 capitation rates for the BadgerCare Plus Standard and Childless Adults programs. 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.

State of Wisconsin
Capitation Rate Development
January 1, 2017 through December 31, 2017
BadgerCare Plus Standard and Childless Adult Programs

December 22, 2016

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Principal and Consulting Actuary

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December 22, 2016

Wisconsin Department of Health Services
BadgerCare Plus Standard and Childless Adults Medicaid Managed Care Programs
January – December 2017 Capitation Rates
Actuarial Certification

I, Shelly S. Brandel, am associated with the firm of Milliman, Inc. and am a member of the American Academy of Actuaries and meet its Qualification Standards for Statements of Actuarial Opinion. I have been retained by the Wisconsin Department of Health Services (DHS) to perform an actuarial certification of the BadgerCare Standard and Childless Adults program capitation rates for January – December 2017 for filing with the Centers for Medicare and Medicaid Services (CMS). I reviewed the calculated capitation rates and am familiar with the Code of Federal Regulations, the relevant requirements of 42 CFR 438.4(b) and the CMS "Appendix A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting."

I examined the actuarial assumptions and actuarial methods used in setting the capitation rates for January – December 2017. To the best of my information, knowledge and belief, for the period from January – December 2017, the capitation rates offered by DHS are in compliance with 42 CFR 438.4(b). The attached actuarial report describes the capitation rate setting methodology.

In my opinion, the capitation rates are actuarially sound, as defined in Actuarial Standard of Practice (ASOP) 49, were developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract.

In making my opinion, I relied upon the accuracy of the underlying records, data summaries, and calculations prepared by DHS, as well as encounter data and financial data summaries prepared by the participating HMOs. 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.

The capitation rates developed may not be appropriate for any specific HMO. Any HMO will need to review the rates in relation to the benefits provided. Each HMO should compare the rates with its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with DHS. The HMO may require rates above, equal to, or below the actuarially sound capitation rates.

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 HMO's situation and experience.

This Opinion assumes the reader is familiar with the Wisconsin Medicaid program, Medicaid eligibility rules, and actuarial rating techniques. The Opinion is intended for the State of Wisconsin and Centers for Medicare and Medicaid Services and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.

Shelly S. Brandel
Member, American Academy of Actuaries

December 22, 2016

Scott Walker
Governor

Linda Seemeyer
Secretary

State of Wisconsin

Department of Health Services

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December 20, 2016

Ms. Shelly S. Brandel, FSA
Principal and Consulting Actuary
Milliman, Inc.
15800 Bluemound Road, Suite 100
Brookfield, WI 53005

RE: January 1, 2017 through December 31, 2017 Wisconsin Medicaid BadgerCare Plus and Supplemental Security Income (SSI) Managed Care Rate Development Data Reliance Letter

Dear Shelly:

I, Krista Willing, Director of the Bureau of Fiscal Management for the Wisconsin Department of Health Services (DHS), hereby affirm that the data prepared and submitted to Milliman, Inc. (Milliman) for the purpose of certifying Wisconsin Medicaid BadgerCare Plus and Supplemental Security Income (SSI) rate development for 2017 were prepared under my direction, and to the best of my knowledge and belief are accurate and complete. This includes the following information supporting the rate development:

1. Data files supporting the January – December 2017 capitation rate development, including:
   a. Fee-for-service claim data
   b. HMO encounter data
   c. Eligibility data
   d. Hospital inpatient and outpatient facility 2017 re-pricing data

2. Other supporting data, including:
   a. Monthly identification of ventilator-dependent members
   b. HMO financial data
   c. 2017 provider access payment funding amounts
   d. Historical performance withhold payments
   e. Information regarding program changes effective prior to December 31, 2017
   f. Details regarding the scope of HMO covered services and eligible recipients
   g. Identification criteria for preventive and family planning services for enhanced FMAP
   h. Other computer files and clarifying correspondence

Milliman relied on DHS for the collection and re-pricing of the FFS and encounter data. Milliman relied on the HMOs to provide accurate financial data as certified by the HMOs. Milliman did not audit the data, but did assess the data for reasonableness.

Sincerely,

Krista Willing

Krista Willing, Director
Bureau of Fiscal Management
Division of Health Care Access & Accountability