15800 Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3680

milliman.com

Shelly S. Brandel, FSA, MAAA
Principal and Consulting Actuary

shelly.brandel@milliman.com

January 30, 2019

Mr. Chad Lillethun
Division of Medicaid Services
Wisconsin Department of Health Services
One West Wilson Street
PO Box 309
Madison, WI 53701-0309

Re: January 1, 2019 through December 31, 2019 Rate Report and Actuarial Certification – BadgerCare Plus Program

Dear Chad:

Thank you for the opportunity to assist the Wisconsin Department of Health Services (DHS) with this important project. The attached report summarizes the development and actuarial certification of the January 1, 2019 through December 31, 2019 (CY 2019) capitation rates for the BadgerCare Plus program.

❖ ❖ ❖ ❖ ❖

Please call Jill Brostowitz at 262 641 3561 or me at 262 796 3482 if you have questions.

Sincerely,

Shelly Brandel

Shelly S. Brandel, FSA, MAAA
Principal and Consulting Actuary

SSB/mb

Attachments

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2019 through December 31, 2019
BadgerCare Plus Standard and Childless Adult Programs

Prepared for:
Wisconsin Department of Health Services

Prepared by:
Milliman, Inc.

Shelly S. Brandel, FSA, MAAA
Principal and Consulting Actuary

Jill H. Brostowitz, FSA, MAAA
Consulting Actuary

Katarina N. Lorenz, FSA, MAAA
Actuary

15800 Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3680

milliman.com

January 30, 2019

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January 30, 2019

I. SUMMARY OF RESULTS AND CAVEATS

This report documents the development of capitation rates effective January 1, 2019 through December 31, 2019 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 2019 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.

The capitation rates provided under this certification are actuarially sound for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b)

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification)

- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the CY 2019 managed care program rating period

- The most recent Medicaid Managed Care Rate Development Guide published by CMS

Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" will be defined as in ASOP 49:

> *"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes (excluding income taxes)."*

A. CAPITATION RATE CHANGES

Table 1 shows a comparison of the 2019 and 2018 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 Health Maintenance Organization (HMO) based on July 2018 enrollment. Exhibit 21 shows the final 2019 capitation rates, including provider access payments.

Table 1A
Wisconsin Department of Health Services
Summary of Capitation Rate Changes by Region (Excluding Provider Access Payments)
Calendar Year 2018 to Calendar Year 2019
BadgerCare Plus Standard

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Medical Capitation Rates							
2019 Capitation Rate	$141.28	$108.94	$113.68	$116.21	$117.11	$124.41	$119.61
2018 Capitation Rate	$130.32	$108.26	$113.22	$113.01	$115.02	$122.20	$116.89
Rate Change	8.4%	0.6%	0.4%	2.8%	1.8%	1.8%	2.3%
Maternity Kick Payments							
2019 Kick Payment	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,245.10
2018 Kick Payment	$7,005.44	$5,206.45	$5,860.01	$5,610.53	$5,660.49	$6,336.76	$5,957.32
Kick Payment Change	18.8%	2.7%	3.7%	9.3%	5.0%	-0.4%	4.8%
Dental Capitation Rates							
2019 Capitation Rate[2]	n/a	n/a	n/a	n/a	$11.27	$11.87	$11.70
2018 Capitation Rate[2]	n/a	n/a	n/a	n/a	$12.41	$12.36	$12.37
Rate Change	n/a	n/a	n/a	n/a	-9.2%	-3.9%	-5.5%
Chiropractic Capitation Rates							
2019 Capitation Rate	$2.91	$2.19	$3.19	$1.90	$1.07	$0.33	$1.68
2018 Capitation Rate	$3.10	$2.26	$3.25	$1.97	$1.17	$0.35	$1.74
Rate Change	-6.1%	-3.1%	-1.8%	-3.6%	-8.5%	-5.1%	-3.4%

[1] *Statewide changes in medical and dental capitation rates are based on July 2018 enrollment; statewide changes in maternity kick payments are based on deliveries by region from November 2016 through October 2017.*
[2] *Dental capitation rates for Regions 1 through 4 are not applicable since no HMOs cover dental services in these regions.*

Table 1B
Wisconsin Department of Health Services
Summary of Capitation Rate Changes by Region (Excluding Provider Access Payments)
Calendar Year 2018 to Calendar Year 2019
BadgerCare Plus Childless Adults

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Medical Capitation Rates							
2019 Capitation Rate	$347.96	$302.45	$308.63	$293.47	$307.80	$304.59	$307.54
2018 Capitation Rate	$343.77	$321.35	$313.16	$295.09	$331.24	$310.25	$315.48
Rate Change	1.2%	-5.9%	-1.4%	-0.5%	-7.1%	-1.8%	-2.5%
Dental Capitation Rates							
2019 Capitation Rate[2]	n/a	n/a	n/a	n/a	$9.79	$10.24	$10.12
2018 Capitation Rate[2]	n/a	n/a	n/a	n/a	$10.18	$10.12	$10.14
Rate Change	n/a	n/a	n/a	n/a	-3.8%	1.2%	-0.2%
Chiropractic Capitation Rates							
2019 Capitation Rate	$3.29	$3.25	$3.68	$2.69	$1.65	$0.66	$2.16
2018 Capitation Rate	$3.73	$3.55	$3.84	$2.87	$1.82	$0.70	$2.33
Rate Change	-11.8%	-8.5%	-4.2%	-6.3%	-9.3%	-5.7%	-7.3%

[1] *Statewide changes in medical and dental capitation rates are based on July 2018 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 2018 to 2019. For example, the CLA rate decrease is driven by changes in the reimbursement change projection factors.

Table 2
Wisconsin Department of Health Services
High Level Summary of Medical Capitation Rate Changes between 2018 and 2019

Rate Component	BCP Standard	BCP Childless Adults
Updated base period encounter data	2.5%	5.8%
Change in CLA durational adjustment	n/a	-3.2%
Benefit adjustment change	-0.7%	-1.1%
Eligibility adjustment change	-0.5%	-0.5%
Reimbursement change between base period and rating period	0.3%	-2.8%
Trend factor changes	-0.1%	-0.5%
Other changes	0.8%	0.0%
Total rate change	**2.3%**	**-2.5%**

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

Managed care enrollment for eligible BCP Standard and BCP Childless Adults members is mandatory with a few exceptions (e.g., tribal members). 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
- **BCP Childless Adults:** The CLA program covers childless adults with incomes less than or equal to 100 percent of the FPL. Prior to April 1, 2014, the 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 enrollment cap was removed, individuals with incomes above 100 percent of the FPL were disenrolled, and the CLA benefits were aligned with the BCP Standard plan. 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 for the 2019 capitation rates.

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
Wisconsin Department of Health Services
Age Rate Cells by Eligibility Category

BCP Standard	BCP Childless Adults
Age 0	n/a
Ages 1 to 14	
Ages 15 to 20	Ages 19 to 44
Ages 21 to 44	
Ages 45+	Ages 45+

Covered Services

HMOs are responsible for providing comprehensive health care to BCP members, including hospital inpatient, hospital outpatient, 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. We describe exclusions applied to the HMO encounter data in Section II.B. We also remove methadone related claims and Institution for Mental Disease (IMD) claims for stays greater than 15 days in a given month as described in Section III.B.

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 held contracts with 18 Health Maintenance Organizations (HMOs) to provide services to BCP members during the experience period. The following changes occurred between the experience and rating period:

- Effective January 1, 2018, CompCare and Health Tradition Health Plan exited the BCP program. The experience for both HMOs is included in the base data, and the impact of member enrollment changes by HMO after these HMO terminations are reflected in the July 2018 member counts used to develop the CDPS risk score adjustments.

- Effective October 1, 2018, Gundersen Health Plan (Gundersen), Unity Health Insurance (Unity), and Physicians Plus Insurance Corporation (PPlus) integrated under the Quartz brand name. Based on discussion with DHS, we developed combined 2018 capitation rates for Gundersen and Unity under the Quartz name, and maintained separate capitation rates for PPlus. For the 2019 rate development, we combined all three HMOs under the Quartz brand name.

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, with some exceptions such as newborns and HMOs with low credibility.

Material Changes to Rate Methodology

We made the following material changes to the 2019 rate methodology:

- Rating regions – We moved three counties to different regions effective January 1, 2019 to better align cost and provider network arrangements between counties. The 2016 and 2017 experience reflects the new rate region definitions, with Chippewa and Marathon Counties moved from Region 1 to Region 3 and Menominee County moved from Region 2 to Region 1.

- Experience data sources – The 2018 rates were based on HMO encounter data and financial data from calendar years 2015 and 2016. The 2019 rates are based on more recent HMO encounter and financial data from calendar years 2016 and 2017.

- Risk adjustment weights – We developed separate custom prospective risk adjustment weights for the BCP Standard and BCP CLA populations using the Chronic Illness and Disability Payment

System plus Prescription Drug model (CDPS+Rx) with Wisconsin-specific BCP Standard and BCP CLA experience, respectively. The 2018 capitation rates for both BCP Standard and BCP CLA used the custom prospective risk adjustment weights developed for the 2017 BCP Standard capitation rates using the BCP Standard experience. We developed separate BCP CLA custom weights for 2019 capitation rates because the BCP CLA population now has sufficient credible base period experience to calculate separate weights. For 2019 capitation rates, we also updated to version 6.3 of the CDPS+Rx model from version 6.0.

- HMO-specific dental capitation rates – We added an adjustment to the 2019 dental rate development in Regions 5 and 6 to reflect historical differences in dental claims PMPM by HMO. This adjustment was not included in the 2018 rate development.

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 2019 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 2018-2019 CMS Medicaid Managed Care Rate Development Guide

Exhibits 1 through 26 summarize the 2019 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 E contains the actuarial certification.

E. IMPORTANT LIMITATIONS AND CAVEATS

We relied on several sources of HMO and FFS claims and eligibility data to develop the capitation rates in this report, including HMO encounter data, HMO financial data, FFS data, hospital inpatient and outpatient 2019 re-pricing 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 hospital inpatient and outpatient 2019 re-pricing 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.

This report is intended for the internal use of DHS to develop 2019 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 contract between DHS and Milliman effective January 1, 2015.

II. BASE DATA DEVELOPMENT

This section of the 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 2019 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 9A: Dental – BCP Standard
- Exhibit 9B: Dental – BCP CLA
- Exhibit 14A: Chiropractic – BCP Standard
- Exhibit 14B: Chiropractic – BCP CLA

A. BASE DATA SOURCES

The data sources used in the 2019 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 re-prices 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 CY 2016, CY 2017, and YTD April 2018 financial incurred 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
   - A reconciliation to HMO financial statements

   We used the financial data to calculate missing data adjustments to apply to the encounter data payments, develop adjustments to reflect claims paid outside of FFS claims systems, analyze historical trends, and develop the administrative cost allowances included in the capitation rates.

We also used financial data to develop the dental capitation rates in Regions 5 and 6. We believe the HMO financial data is a more accurate summary of historical dental claims due to under-reporting of dental encounter data due to the prevalence of sub-capitation.

3. **Fee-For-Service (FFS) Data** – Includes claims paid by DHS on a FFS basis. We used FFS data 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 2019 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 along with HMO-specific data questions. After receiving answers to our questions and a few data resubmissions from the HMOs, we released base data summaries on August 6, 2018 for HMO review and comment. Additionally, we presented the information to the HMOs with DHS on September 20, 2018 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
Wisconsin Department of Health Services
Base Data Time Periods

Data Source	Data Time Period Used	Paid Through Date
HMO Encounter Data	CY 2016 and CY 2017	May 2018[1]
HMO Financial Data	CY 2016 and CY 2017	April 2018
HMO Emerging 2018 Financial Data	YTD April 2018	June 2018
FFS Data	CY 2016 and CY 2017	May 2018

[1] *Encounter data files received from DHS on June 18, 2018; 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, DXC Technology, performs a re-pricing analysis on the encounter data records and assigns re-priced Medicaid allowed and paid amounts for accepted encounter records. The encounter records also include HMO paid amounts in addition to the re-priced Medicaid paid amounts. We included HMO paid amounts from the encounter data for accepted records only to develop missing data adjustments and provider contracting adjustments, thereby excluding any potential duplicate rejected claims.

The encounter data provided to Milliman includes services incurred during 2015 through 2017. As noted above, we used 2016 and 2017 encounter data to develop the base period costs. We summarized the 2016 and 2017 encounter data using the methodology described in the following sections.

We identified the submitting HMO based on the HMO ID field and the eligibility category based on the Medical Status code 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. **Claims incurred outside of 2016 and 2017:** We excluded claims for services provided outside of the period January 1, 2016 through December 31, 2017.

2. **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.

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 HMOs 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. **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.

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

7. **Chiropractic claims:** We excluded chiropractic claims from the HMO encounter data used for rate development and used chiropractic claims covered under the FFS program, since only two HMOs covered chiropractic services during the base period.

8. **Invalid ages or regions:** We excluded immaterial claim amounts with invalid ages or regions.

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 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 in the base period experience is consistent with how HMOs are instructed by DHS to report deliveries for maternity kick payment reimbursement.

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 in 2016 for MS-DRG encounters equal to 765, 766, 767, 768, 774, or 775. Since DHS switched to APR-DRG codes effective January 1, 2017, the 2017 experience used 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
- Procedure code of 01958 - 01961, 01967 - 01968, 59000 - 59899, or 76801 - 76828

We included maternity claims for completed pregnancies in the base period experience by limiting delivery dates to the time period from November 2016 through October 2017. We excluded experience for other BCP Standard pregnancies meeting the maternity kick payment criteria, but outside of this time period. Because the maternity kick payment is developed and paid per delivery, the projected number of deliveries is not needed to develop the maternity kick payment amount so we excluded “non-completed” pregnancies to develop a complete cost per delivery.

Dental

Encounters with procedure codes from D0120 – D9999 were identified as dental services and carved out from the base data. We excluded claims for fluoride treatment provided outside of a dental office from dental claims and included those claims in the base coverage. We identified these claims using category of service code 58 and sub-category of service code 10, 15, or 20. In the base period, HMOs were required to cover dental services in Regions 5 and 6. Dental coverage is optional in other regions; however, no HMOs currently cover dental services in Regions 1 through 4.

Chiropractic

Encounters with category of service code 60 (chiropractic) were identified as chiropractic services.

Medical “Payments Made Outside Encounter Data”

We summarized “Payments Made Outside Encounter Data” from the HMO financial data 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. These payments are reported separately in the HMO financial data and were not included in the missing data adjustments discussed in Section D below.

In Lieu of Services

The BCP program allows HMOs to provide IMD benefits in lieu of inpatient psychiatric admissions. Reimbursement adjustments for IMDs are documented in Section III.A, and benefit 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, hospital outpatient, professional, FQHC / RHC, and other services). We identified IMD, hospice, zero copay preventive services, and family planning services based on criteria provided by DHS. We then used Milliman's *Health Cost Guidelines* Grouper to assign the remaining detailed service categories.

C. FFS DATA PROCESSING METHODOLOGY

We used FFS data for HMO members 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 2016 and 2017 data before projecting costs to the 2019 rating period. These adjustments are shown in the following exhibits:

- Exhibit 1A: Medical – BCP Standard
- Exhibit 1B: Medical – BCP CLA
- Exhibit 7: Maternity – BCP Standard
- Exhibit 9A: Dental – BCP Standard
- Exhibit 9B: Dental – BCP CLA
- Exhibit 14A: Chiropractic – BCP Standard
- Exhibit 14B: Chiropractic – BCP CLA

Missing Data Adjustment (Encounter Data)

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 claim payments reported in the HMO financial data (excluding IBNR with similar claims run-out to the encounter data as shown in Table 4). We combined FFS and sub-capitated claim payments together to develop the missing data adjustments since the encounter data does not consistently identify FFS versus sub-capitated claims separately. 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. The missing data adjustments have been decreasing consistently over the past several years, indicating increasing completeness of the encounter data submissions.

Table 5 Wisconsin Department of Health Services 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						
2016	1.022	1.037	1.020	1.038	1.041	1.041
2017	1.014	1.019	1.018	1.053	1.025	1.025
BadgerCare Plus Childless Adults						
2016	1.020	1.035	1.020	1.041	1.038	1.034
2017	1.014	1.019	1.018	1.051	1.022	1.021

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 dental financial data to summarize the base period experience for regions 5 and 6 and FFS data as the base period experience for regions 1 to 4. Chiropractic missing data adjustments are also not applicable because we used FFS data.

Completion Factor (Encounter and FFS Data)

Table 6 summarizes the completion factors applied to the base 2017 claims to adjust for incurred but not reported (IBNR) claims as of the claim submission date. 2016 claims are assumed to be complete since there are approximately 17 months of claims runout.

Table 6 Wisconsin Department of Health Services 2017 Completion Factors						
	HMO Encounter Claims			**Fee-For-Service Claims**		
	Hospital Inpatient	**Dental**	**Other Services**	**Hospital Inpatient**	**Dental**	**Other Services**
BCP Standard	1.016	1.002	1.008	n/a	1.002	1.024
BCP Childless Adults	1.013	1.002	1.007	n/a	1.002	1.021

We calculated the encounter claims completion factors based on reported IBNR amounts in the HMO financial data with adjustments for outliers, and reviewed the resulting factors for reasonableness. We developed the FFS completion factors based on 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 across the two years of base period experience data. Regions 5 and 6 include counties around the Milwaukee area, where some providers require higher reimbursement to participate in the Medicaid program. Table 7 summarizes the provider contracting adjustments applied to the re-priced Medicaid paid amounts in the encounter data.

Table 7 Wisconsin Department of Health Services Provider Contracting Adjustments						
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Hospital Inpatient	1.01	1.01	1.01	1.01	1.02	1.02
Hospital Outpatient	1.00	1.00	1.00	1.00	1.06	1.06
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

III. PROJECTED 2019 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 2019 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 2019 claim costs:

- Exhibit 2A: Medical – BCP Standard
- Exhibit 2B: Medical – BCP CLA
- Exhibit 7: Maternity – BCP Standard
- Exhibit 9A: Dental – BCP Standard
- Exhibit 9B: Dental – BCP CLA
- Exhibit 14A: Chiropractic – BCP Standard
- Exhibit 14B: Chiropractic – BCP CLA

A. REIMBURSEMENT CHANGES

Generally, the HMOs are not required to pay the Medicaid fee schedule with a few exceptions. The five areas that HMOs are contractually required to pay a minimum of 100% of the FFS Medicaid rate are Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Indian Health Care Provider or Service (Indian Tribe, Tribal Organization, or Urban Indian Organization, or I / T / U), dental, and out-of-network emergency services. However, most HMOs reimburse providers at the Medicaid fee schedule or at a percentage of the Medicaid fee schedule. In these instances, they would be required to apply changes to the Medicaid fee schedule as appropriate. Therefore, we applied reimbursement adjustments to the experience consistent with projected Medicaid fee schedule changes. We are not aware of any other material anticipated fee changes other than the items mentioned in this section.

Hospital Inpatient Re-Pricing Adjustment

Hospital inpatient claims, excluding skilled nursing facility (SNF), were re-priced by DHS to the inpatient Medicaid reimbursement rates effective January 1, 2019. We used detailed re-pricing data, provided by DHS, to calculate the impact of reimbursement changes on the historical 2016 and 2017 hospital inpatient claims. 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 hospital inpatient re-pricing adjustments for 2019 fee changes (prior to the 'other reimbursement adjustments' described below) applied to the base encounter hospital inpatient claims.

Table 8 Wisconsin Department of Health Services Hospital Inpatient Re-Pricing Adjustments (Excluding Skilled Nursing Facility)						
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
BadgerCare Plus Standard						
Medical – 2016	1.140	1.069	1.161	1.066	1.172	1.134
Medical – 2017	1.050	1.022	1.098	1.078	1.065	1.072
Maternity	1.066	1.107	1.140	1.144	1.141	1.144
BadgerCare Plus Childless Adults						
Medical – 2016	1.026	1.050	1.066	1.086	1.049	1.052
Medical – 2017	1.018	1.030	1.017	1.017	0.996	1.001

Hospital Outpatient Re-Pricing Adjustment

Similar to hospital inpatient claims, DHS provided re-priced hospital outpatient claims, excluding hospice, based on the Medicaid fees effective January 1, 2019. Table 9 summarizes the hospital outpatient re-pricing adjustments for 2019 fee changes (prior to the 'other reimbursement adjustments' described below) applied to the base encounter hospital outpatient claims.

Table 9 Wisconsin Department of Health Services Hospital Outpatient Re-Pricing Adjustments (excluding Hospice)						
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
BadgerCare Plus Standard						
Medical – 2016	0.926	1.053	0.939	0.980	1.075	1.062
Medical – 2017	0.990	1.035	0.975	1.037	1.032	1.019
Maternity	0.955	1.277	0.973	0.976	1.010	1.009
BadgerCare Plus Childless Adults						
Medical – 2016	0.903	1.018	0.915	0.938	1.043	0.992
Medical – 2017	0.954	1.028	0.967	0.999	1.013	1.004

Other Reimbursement Adjustments

Ambulatory Surgery Center (ASC)

The ASC provider access payments were discontinued as of October 1, 2017, and DHS increased ASC Medicaid fees by 51.3% between the experience period and the contract period. We applied reimbursement factors based on the proportion of these ASC claims to total claims in the "Professional Outpatient Surgery" service category.

Behavioral Health

DHS expects Medicaid fees for specific behavioral health services to increase 30.5% effective January 1, 2018. We applied reimbursement factors based on the proportion of these behavioral health claims to total claims in the "Professional Psychiatric / Substance Abuse," "Professional Other," and "FQHC Other" service categories.

Durable Medical Equipment (DME)

DHS expects Medicaid fees for DME services to decrease 11.1% effective January 1, 2019. The Medicaid fee schedule for DME services will decrease over several years to phase in requirements to reimburse DME providers no more than the Medicare fee schedule, with the first change effective January 1, 2019. We applied reimbursement factors to the "Other Durable Medical Equipment" service category to reflect the estimated decrease in Medicaid reimbursement.

Hospice

The Medicaid fee schedule for hospice services changed on January 1, 2016, October 1, 2016, and October 1, 2017. DHS estimated the impact of these fee schedule changes to be a 4.2% increase for 2016 claims and a 3.2% increase for 2017 claims. We applied reimbursement factors to the Hospice service category to reflect the estimated increase in Medicaid reimbursement.

IMD

CMS requires IMD experience included in the capitation rate development to be based on the unit costs for State plan services. To be consistent with this requirement, we applied a 0.85 unit cost adjustment to HMO encounter base period IMD claims based on a comparison of the historical average cost per day for inpatient psychiatric stays and IMD stays.

Personal Care

Medicaid fees for personal care services (procedure codes T1019 and 99509) are projected to increase by 4.0% from 2016 to 2019 and 3.0% 2017 to 2019 based on information provided by DHS. There was a 2% increase effective July 1, 2017 and another 2% increase effective July 1, 2018. Personal care services are included in the "Other / Other" service category. We applied reimbursement factors based on the proportion of these personal care claims to total claims in the "Other / Other" service category.

B. PROGRAM CHANGES

Benefit Changes

IMD Utilization Adjustment

IMD services are routinely provided by HMOs in lieu of inpatient psychiatric admissions. Consistent with CMS rate setting requirements, 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. These adjustments are shown in the benefit adjustment column of Exhibit 2 in the 'Hospital Inpatient IMD' service category.

We also reviewed the impact of removing the member months and non-IMD claims for members with over 15 days in an IMD for a given month from the 2019 capitation rates. Similar to the 2018 rate development, we determined the impact of this adjustment was not material, so we did not incorporate any specific adjustments into the rate development.

Methadone Treatment Claim Removal

DHS will reimburse the cost of methadone treatment on a FFS basis outside the capitation rates in 2019, similar to 2018, due to uncertainty around the base period experience as a result of claim payment issues between narcotic treatment service (NTS) providers and the HMOs. Therefore, we removed these services from the base period experience. These adjustments are shown in the benefit adjustment column of Exhibit 2 in the "Professional Psychiatric / Substance Abuse" service category. DHS intends to include methadone treatment claims in the 2020 capitation rates, subject to data quality.

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 the second through fourth quarters of enrollment will be 8% lower than the first quarter of enrollment and the fifth and later quarters of enrollment will be 15% higher than the first quarter of enrollment. We performed the analysis using data re-priced to the 2018 Medicaid fee schedule to remove the impact of reimbursement changes. We also normalized the data used for the analysis for the impact of trend.

Table 10 summarizes the development of the durational adjustments applied to the base period CLA claim costs for 2016 and 2017. We assigned each individual included in the base period experience to one of the quarters of CLA enrollment shown below. We also estimated the distribution of CLA member months by enrollment quarter for 2019 and calculated the difference in the average durational factor for the base periods compared to the contract period. We assumed the projected 2019 distribution of member months would be the same as 2017 because the membership has become more stable. For example, the distribution of members for the first quarter of 2018 was similar to the first quarter of 2017.

Table 10
Wisconsin Department of Health Services
BCP CLA Durational Utilization Adjustment

Quarter of CLA Enrollment	Estimated Durational Factor	Distribution of Member Months		
		Actual 2016	Actual 2017	Projected 2019
1	1.000	8%	7%	7%
2-4	0.920	29%	24%	24%
5+	1.150	63%	69%	69%
Average Duration Factor		1.073	1.085	1.085
Durational Adjustment		1.011	1.000	n/a
2016 to 2019 Durational Adjustment: 1.085 / 1.073 = 1.011				
2017 to 2019 Durational Adjustment: 1.085 / 1.085 = 1.000				

D. TREND

The annual trend assumptions (excluding Medicaid reimbursement changes and CLA durational impacts) are shown in Table 11. We developed the trend assumptions based on historical trends, Medicaid industry trends, and actuarial judgment.

Table 11
Wisconsin Department of Health Services
Annual Trend Factors

	BCP Standard	BCP Childless Adults
Hospital Inpatient	3.0%	3.0%
Hospital Outpatient	2.0%	2.0%
Professional and Other	1.5%	1.5%
Dental	9.0%	9.0%

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 2015 to 2017 in the HMO encounter data, HMO financial data (including emerging 2018 experience), and FFS data by eligibility category, region, and broad category of service. We also reviewed historical hospital inpatient and outpatient trends from 2015 to 2017 re-priced to the 2018 Medicaid fee schedule to remove the impact of annual reimbursement changes. Table 12 summarizes the historical HMO encounter utilization and case mix trends.

Table 12
Wisconsin Department of Health Services
Annual 2015 to 2017 Utilization and Case Mix Trends

	BCP Standard			BCP Childless Adults		
	Utilization	Case Mix[1]	Combined	Utilization	Case Mix[1]	Combined
Hospital Inpatient	-1.0%	3.7%	2.7%	4.7%	2.7%	7.5%
Hospital Outpatient	-0.9%	3.2%	2.2%	0.6%	1.6%	2.3%
Professional	3.1%	-2.1%	0.9%	12.2%	-7.2%	4.1%

[1] Case Mix trend is the change in the PMPMs re-priced at the 2018 facility fee schedule after excluding the impact of utilization

- Hospital Inpatient: We assumed an annual hospital inpatient utilization and case mix combined trend of 3.0%. This assumption is largely based on the BCP Standard historical hospital inpatient combined utilization and case mix trends shown in Table 12, driven by case mix trend and partly offset by a 1% utilization decrease based on admissions. Note the BCP CLA trends from 2015 to 2017 are generally higher than the projected trends since this time period also included an enrollment durational impact that we do not expect to continue going forward.

- Hospital Outpatient: We assumed an annual hospital outpatient utilization and case mix combined trend of 2.0%. The assumption is based mainly on the historical hospital outpatient combined utilization and case mix trends for both populations shown in Table 12.

- Professional and Other: We assumed an annual physician utilization and case mix combined trend of 1.5%. This assumption is based mainly on the BCP Standard historical physician combined utilization and case mix trends shown in Table 12. We also applied the professional trend to other services.

- Dental: We assumed an annual dental trend of 9% for both populations. This assumption is mainly based on the historical 2016 to 2017 and emerging 2018 dental trends for BCP Standard in both the HMO financial and FFS data. The historical BCP CLA trends are roughly flat in the encounter data but higher in the FFS data, so we used the same trend for both populations.

The trend assumptions are intended 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 13 from the CMS Office of the Actuary (OACT) in the 2017 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, due to anticipated higher provider reimbursement. We projected the BCP provider reimbursement trends and CLA duration impact 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 13.

Table 13
Wisconsin Department of Health Services
Summary of Projected National Medicaid Benefit Expenditures per Enrollee
Table 22 of the 2017 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**
2015	$3,555	n/a	$5,159	n/a
2016	$3,592	1.0%	$5,288	2.5%
2017	$3,822	6.4%	$5,645	6.8%
2018	$3,952	3.4%	$5,855	3.7%
Average Projected Annual Trend		3.6%		4.3%

**Adults exclude aged and disabled.*

E. BLENDING OF 2019 PROJECTED CLAIMS BY YEAR

For all eligibility categories and regions, we weighted the 2019 claim projections from 2016 and 2017 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 2019 claim costs by eligibility category and region:

- Exhibit 3: Medical
- Exhibit 8: Maternity
- Exhibit 10: Dental
- Exhibit 15: Chiropractic

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

We developed the administrative allowances in the 2019 capitation rates based on the 2016 and 2017 financial data provided by the HMOs, projected to 2019 assuming an annual administrative cost trend of 1.5% per year. Table 14 summarizes the administrative cost and margin assumptions applied to the medical, dental, and chiropractic rates, which use the same percentages. We used the same administrative cost and margin allowances as the 2018 capitation rates for each program.

Table 14
Wisconsin Department of Health Services
2019 Administrative Cost and Margin Assumptions
Medical, Dental, and Chiropractic Capitation Rates

Administrative Cost Components	BCP Standard	BCP Childless Adults
Direct Expenses	5.9%	4.7%
Indirect Expenses	7.1%	5.8%
Care Coordination	1.8%	1.5%
Licensing and Regulatory Fees	0.1%	0.1%
Sales and Marketing	1.1%	0.4%
Total Administrative Cost Allowance	**16.0%**	**12.5%**
Margin Allowance	2.0%	2.0%
Administrative Cost / Margin Allowance	**18.0%**	**14.5%**

The 2019 BCP capitation rates exclude any provision for federal or state income taxes or state premium taxes, since HMOs are expected to pay any of these applicable taxes out of the margin included in the capitation rates.

The 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 lower medical costs. On average, the projected 2019 statewide administrative allowance for medical services is $20.01 PMPM for BCP Standard and $39.88 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.

The margin allowance is 2% of capitation for all rate cells.

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 2019 statewide administrative cost allowance for maternity kick payments is about $312 per delivery or about $28 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 2019 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: Medical – BCP Standard
- Exhibit 4B: Medical – BCP CLA
- Exhibit 11A: Dental – BCP Standard
- Exhibit 11B: Dental – BCP CLA
- Exhibit 16A: Chiropractic – BCP Standard
- Exhibit 16B: Chiropractic – BCP CLA

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

1. **Develop statewide rate cell factors:** 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 are normalized so the rates by rate cell produce the overall capitation rate by region and eligibility category based on the member months in the base data used in the 2019 rate calculation.

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 implemented a pilot program, effective 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 dental fees are paid as Medicaid FFS reimbursement outside of the dental capitation rates. However, we applied utilization adjustments to the 2016 base period experience to reflect the estimated impact of higher dental reimbursement on dental utilization in the pilot counties.

Similar to the 2018 rates, we assumed the dental fee increases in the pilot counties increased pediatric dental utilization by 25% and had no impact on adult dental services since the higher adult reimbursement applies to emergency services only. We analyzed historical dental claims data in the pilot counties compared to the other counties in each region to review the 25% utilization increase assumption for reasonableness. The results of our analysis varied by region, but overall supported the assumed 25% utilization increase.

We calculated the average pediatric impact across each region using the December 2016 membership across all ages in the pilot counties versus total region membership and dampened the result by multiplying by the ratio of the 2016 member months to the combined 2016 and 2017 member months to only apply the adjustment to the 2016 experience. We assumed the fee increase effective October 2016 first impacted utilization in 2017. We applied the following adjustments to the child BCP Standard rate cells in Exhibit 11A:

- Region 1 = 1.01
- Region 2 = 1.03
- Region 3 = 1.02
- Region 5 = 1.04

I. DENTAL UTILIZATION ADJUSTMENT

The 2019 dental capitation rates include HMO-specific adjustments to compensate HMOs with higher utilization, while still providing funding to HMOs with lower dental utilization to provide an incentive to provide increased dental services. The adjustments are budget neutral across the HMOs based on July 2018 membership and reflect 25% of the difference between each HMO's dental claims PMPM relative to the average cost for HMOs included in the adjustment calculation. The adjustments are shown in Exhibit 12 and applied in Exhibit 13.

J. POTENTIAL RETROACTIVE RATE AMENDMENTS

Health Insurer Provider Fee

Plan reimbursement for costs related to the Affordable Care Act (ACA) HIF have historically been developed outside of the rate development. The base period claims experience excludes HIF payments. There is currently a moratorium on the HIF for 2019. If the HIF would be required for 2019, subject to any legal determinations, we will file a retroactive amendment to the capitation rates.

HMO Encounter Based Payments Paid on a FFS Basis Outside of Capitation Rates

DHS is currently in discussions with CMS regarding whether DHS will be required to file retroactive rate amendments to include HMO encounter-based payments paid on a FFS basis outside of the capitation rates, such as the Dental Pilot, Long-Acting Reversible Contraception (LARC), HIV/AIDS Medical Home, and Narcotic Treatment Services. These services are all contractually required to be provided by HMOs, but are not included in the capitation rates since the HMOs will be reimbursed for the cost of these services on a FFS basis outside of the 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: Medical– BCP Standard
- Exhibit 6B: Medical – BCP CLA
- Exhibit 13A: Dental – BCP Standard
- Exhibit 13B: Dental – BCP CLA
- Exhibit 21A: Final HMO-Specific Capitation Rates by Type of Coverage – BCP Standard
- Exhibit 21B: Final HMO-Specific Capitation Rates by Type of Coverage – BCP CLA

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 risk adjust payments for the 2019 BCP Standard and CLA capitation rates.

Exhibit 5 summarizes the risk score adjustments applied to the base 2019 capitation rates to calculate HMO-specific risk-adjusted 2019 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 (CDPS+Rx) model structure developed by The University of California – San Diego (UCSD). UCSD developed three models, as described below.

- 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-10 diagnostic codes to assess risk and assigns each member to one or more of 58 possible medical condition categories from 19 major diagnostic categories. Each member is also assigned to one of 11 age / gender categories. All of the 19 major diagnostic categories are "hierarchic" categories in that only the single most severe diagnostic category within the major category is counted. 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.

- MRX is a pharmacy based risk adjustment model that may be used to adjust capitated payments to capitated plans that enroll Medicaid beneficiaries. The MRX 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+Rx includes the full set of diagnosis categories from the CDPS model, as well as 15 categories from the MRX model that are embedded within the CDPS hierarchy. The researchers at UCSD limited 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 were relatively less susceptible to variations in practice patterns.

CDPS, MRX, 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 6.3 for the 2019 capitation rates. The 2018 capitation rates used version 6.0.

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 uses diagnoses and pharmacy data from a prior time period to predict the acuity of the population in a future time period.

For 2018 capitation rate development, BCP Standard capitation rates were risk adjusted based on custom CDPS+Rx prospective risk weights developed in 2016, which used 2013-2014 diagnoses to predict 2014 to 2015 costs from the Wisconsin BCP Standard population. 2018 CLA members were risk adjusted using the same BCP Standard model. For 2019 capitation rates, we developed separate prospective risk weight models for the BCP Standard and CLA populations, which used 2015-2016 diagnoses to predict 2016 to 2017 costs. These custom risk weight models, which we will refer to as the "custom prospective models," reflect Wisconsin's specific covered benefits, eligibility rules, provider reimbursement, and practice patterns.

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 custom prospective regression models calibrated to the BCP Standard and BCP CLA populations have R-squared measures of 13.4% and 14.5%, respectively, which is comparable to typical prospective model predictive powers for comparable Medicaid populations.

Attachments B1 and B2 contain the model intercept and risk weights for the BCP Standard and BCL CLA populations, respectively and show the statistical significance (p-value) and prevalence of each category.

Attachments C1 and C2 show the mapping of the risk categories from the standard to the custom CDPS+Rx models for the BCP Standard and BCP CLA populations, respectively. For purposes of developing risk weights, we combined severity levels for several of the CDPS+Rx standard risk categories to ensure a logical relationship between the risk weights and the severity level or in situations where individual categories did not provide additional statistical predictive ability.

Risk Adjustment Methodology and Data

The risk scores shown in Exhibit 5 are based on 2017 FFS claims and HMO encounter claims for HMO members from the encounter data extracts submitted to DHS by the HMOs.

We used version 6.3 of the CDPS+Rx model to assign individuals to a demographic category and disease categories based on their diagnostic information and pharmacy utilization during 2017. 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, 2018 and is used for demographic classification. Diagnostic codes from laboratory, radiology, and DME and medical supplies claims were excluded to avoid including false positive diagnostic indicators for tests run on individuals and equipment and supplies used.

For each member, the weights for all of the disease categories assigned are combined with their demographic information and the model intercept to calculate a total individual risk score under the custom prospective model. Scored members are assigned to the BCP Standard and CLA populations and to each HMO using capitation data provided by DHS for July 2018.

For each HMO, the unnormalized risk scores are derived by performing a weighted average of the cost weights using the count of risk scored member months associated with each demographic and diagnostic category. An example of the weighted average is provided below:

> (Model Intercept + [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] = [Unnormalized Risk Score]

In order to ensure budget neutrality, the risk scores are normalized within each combination of rate cell, region, and eligibility category by dividing each individual HMO's unnormalized risk score by the total enrolled population's unnormalized risk score.

The final HMO rates are calculated by multiplying the base capitation rates (before CDPS) by the HMO-specific normalized risk scores. New HMOs will receive capitation rates based on 1.000 risk scores.

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., July 2018) 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 fewer 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 1.000 since the risk score result is not considered to be a credible measure of estimated future morbidity.

- HMOs with large enrollment growth or a lower percentage of scored members – Two HMOs (Trilogy and Independent Care) lack sufficient data to develop credible risk scores for BCP Standard due to large enrollment growth during 2017. Therefore, their BCP Standard normalized risk scores are set to 1.000 for each rate cell. One HMO (Trilogy) has a lower percentage of BCP CLA scored members than other HMOs. Therefore, we assigned partial (50%) credibility to their calculated BCP CLA normalized risk scores.

Retrospective Risk Score Adjustment

In addition to the risk scores being budget neutral on a prospective basis (based on July 2018 enrollment), DHS will perform a risk score settlement calculation to ensure risk scores are budget neutral on a retrospective basis based on actual 2019 enrollment by HMO.

Potential Risk Score Adjustments Based on Actual Membership

As noted above, we developed 2019 risk score adjustments for each HMO based on their July 2018 enrollment. Historically, risk scores have been established prospectively for each calendar year with no midyear adjustments. DHS will consider an update to average risk scores (i.e., using the same risk scores by member developed from 2017 experience) if we observe material changes in enrollment between 2018 and 2019.

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 74% of the P4P withhold from 2011 to 2016 in aggregate. At this time, we are not aware of any significant changes in the withhold quality measures that would impact 2019 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. QUALITY INCENTIVE PAYMENTS

DHS has a potentially preventable re-admissions (PPR) incentive payment program. The maximum incentive payment to any HMO may not be more than 5% of their capitation rate.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

Provider Access Payments

DHS provides funding to promote access for Medicaid individuals to acute care, rehabilitation, and critical access hospitals. This funding is included in the capitation rates for the BCP Standard population. The CLA population is not eligible for provider access payments.

The provider access payments are intended to reimburse providers based on Medicaid utilization. Therefore, the prospective payment amounts per service do not vary based on acuity or provider billed charges. The total provider access payment funding amounts for the BCP and Supplemental Security Income (SSI) programs combined are appropriated in the Wisconsin state budget on a State Fiscal Year (SFY) basis.

Table 15 shows the SFY 2019 (July 2018 through June 2019) funding amounts for HMOs in total and the projections for BCP Standard versus SSI Medicaid.

Table 15
Wisconsin Department of Health Services
Projected 2019 Provider Access Payment Funding

	BCP Standard	SSI Medicaid Only	Total
Inpatient acute and rehabilitation	$ 209,942,315	$ 37,700,259	$ 247,642,575
Outpatient acute and rehabilitation	$ 166,403,047	$ 36,213,605	$ 202,616,652
Inpatient critical access	$ 3,754,230	$ 178,445	$ 3,932,675
Outpatient critical access	$ 2,913,161	$ 304,482	$ 3,217,643

The fiscal year access payments are budgeted for and fully expended in the given fiscal year. DHS performs an annual reconciliation process to ensure the budgeted amount is fully expended. While the fiscal year does not align completely with the calendar year, there is no bias in our rate setting for these payments, as the rate charged is an unbiased estimate of the budgeted and spent amount.

We allocated the funding amounts to BCP Standard versus SSI Medicaid Only and then by HMO based on the total projected mix of 2019 admissions (inpatient access payments) or visits (outpatient access payments) based on the 2016 and 2017 experience, adjusted to reflect the impact of missing data adjustments. We then calculated a fixed PMPM amount for each HMO by program to add to the 2019 capitation rates.

The methodology used to calculate the 2019 provider access rate adjustments is summarized in the following steps:

1. **Summarize Historical Utilization**: We summarized the total HMO encounter base period (2016 and 2017) utilization PMPM by HMO, eligibility category, region, and rate cell for providers eligible to receive provider access payments. The utilization counts are admissions for inpatient access payments and visits for outpatient access payments. DHS provided a list of National Provider Identification (NPI) codes for facilities eligible for each type of provider access payment.

2. **Project 2019 Utilization Mix**: We projected the mix of utilization PMPM by HMO, eligibility category, region, and rate cell to 2019.

   For rate cells with at least 250 member months in the base period, the adjusted utilization PMPM is calculated as the base period utilization multiplied by the missing data adjustment. For other rate cells with less than 250 member months, we developed the adjusted utilization PMPM based on the regional average base period utilization PMPM with missing data adjustment across all HMOs. We excluded the 2017 utilization data for one HMO due to encounter data submission issues.

   We converted the adjusted utilization PMPM to total utilization counts based on the projected 2019 member months by rate cell (based on July 2018 membership).

3. **Calculate Provider Access Payment Rate Adjustments:** We allocated the total provider access payments by HMO based on the adjusted utilization and calculated the provider access payments PMPM by dividing the total allocated provider access payments by the total projected 2019 member months.

   The provider access payment add-ons are calculated for each HMO with credible membership. New HMOs, if applicable, will be paid the average regional PMPM adjustment. Exhibit 20A summarizes the 2019 provider access payments PMPM. Exhibits 20B through 20E show the adjusted utilization, July 2018 membership, and projected 2019 provider access payment dollars by HMO and region for each type of provider access payment.

Exhibit 21 shows the final 2019 capitation rates by HMO and type of coverage, including any applicable CDPS, P4P, and provider access payments.

Other Delivery System and Provider Payment Initiatives

HMOs are contractually required to pay a minimum of 100% of the FFS Medicaid rate for the following providers / services:

- FQHC and RHC providers
- Indian Health Care providers or services (Indian Tribe, Tribal Organization, or Urban Indian Organization or I/T/U)
- Dental services
- Out of network emergency services

DHS is currently in discussions with CMS regarding whether 438.6(c) preprints for these services need to be submitted and approved by CMS. We did not include any capitation rate adjustments for these services since the base data used for rate development reflects the Medicaid fee schedules for all claims.

V. CAPITATION RATES FOR ENHANCED FMAP SERVICES

DHS receives enhanced Federal Medical Assistance Percentage (FMAP) for certain preventive services provided without member copayments, family planning services, and services provided to Native Americans or Alaskan Native members at facilities officially recognized as Indian Health Services (IHS) facilities. This section of the report documents the development of the 2019 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 for services eligible for enhanced FMAP are summarized in the following exhibits:

- Exhibit 22: Overall FMAP capitation rates
- Exhibit 23A: FMAP capitation rates for BCP Standard rate cells (preventive services)
- Exhibit 23B: FMAP capitation rates for BCP CLA rate cells (preventive services)
- Exhibit 24A: FMAP capitation rates for BCP Standard rate cells (family planning services)
- Exhibit 24B: FMAP capitation rates for BCP CLA rate cells (family planning services)
- Exhibit 25A: FMAP capitation rates for BCP Standard rate cells (IHS)
- Exhibit 25B: FMAP capitation rates for BCP CLA rate cells (IHS)
- Exhibit 26: FMAP maternity kick payments

A. SERVICES ELIGIBLE FOR ENHANCED FMAP

Appendix D includes a summary of the criteria used to identify services eligible for enhanced FMAP in the base data. We assigned the categories in the hierarchical order of family planning, preventive, and IHS so no services are double counted.

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 2019 claim costs**:

  - Preventive Services: The projected 2019 medical cost PMPM for zero copay preventive services is developed in Exhibit 2 (medical capitation rates). We did not identify any zero copay preventive services in the maternity kick payment base experience.

  - Family Planning Services: The projected 2019 medical cost PMPM for family planning services is developed in Exhibit 2 (medical capitation rates) and Exhibit 7 (maternity kick payments).

  - IHS: The projected 2019 medical cost PMPM for IHS services is developed in Exhibit 2 (medical capitation rates) and Exhibit 7 (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 2019.

- **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 26 (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), Exhibit 24 (family planning), and Exhibit 25 (IHS). 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), Exhibit 24 (family planning), and Exhibit 25 (IHS). This step does not apply to 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 I through V of the report for a description of the rate setting methodology.

AA.1.1 – ACTUARIAL CERTIFICATION

Appendix E includes the actuarial certification.

AA.1.2 – PROJECTION OF EXPENDITURES

Exhibits 17 through 19 show the expected rate change from the 2018 to 2019 capitation rates by eligibility category, HMO, and rate cell excluding provider access payments.

AA.1.3 – RISK CONTRACTS

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

AA.1.4 – RATE MODIFICATIONS

The 2019 capitation rates in this report 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 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 claims enhanced match for services provided to Native Americans or Alaskan Native members at facilities officially recognized as IHS facilities and the administrative and margin associated with the delivery of these services for the population covered under this program. Please refer to Section V of this report for the development of capitation rates for services eligible for enhanced match.

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

Please see response to Section AA.1.4. 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 BCP 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 BCP 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 and the IMD in lieu of service.

AA.3.2 – ADMINISTRATIVE COST ALLOWANCE CALCULATIONS

The administrative cost allowances are discussed in Section III.F of this report and summarized in Table 14.

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 at a minimum of 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 Sections 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 BCP. The base utilization and cost data for the capitation rates includes HMO encounter data, HMO financial data, and FFS data. The blending of each claim projection by base period year is discussed in Section III.E.

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 BCP 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 2016 and 2017 base period data excludes enhancements to payment rates made to primary care providers, which expired on December 31, 2014. Therefore, no adjustments were necessary.

AA.3.17 – HEALTH HOMES

The Wisconsin Department of Health Services 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 were no longer required to disenroll from Medicaid managed care HMOs. As discussed in Section III.J, DHS is in discussions with CMS regarding whether a retroactive rate amendment will be required to include the cost of services provided outside the capitation rates 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 BCP 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 uses two years of base data to smooth random fluctuation that occurs on a year-to-year basis.
- Capitation rates are first set by eligibility category and region in Exhibit 3 (medical), Exhibit 10 (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 11 (dental), and Exhibit 16 (chiropractic).

AA.5.1 – COST-NEUTRAL DATA SMOOTHING ADJUSTMENT

Exhibit 4 (medical), Exhibit 11 (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 BCP 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

DHS has an incentive arrangement for 2019 as described in Section IV.C. The HMO contract does not permit the incentive payment for any HMO to be more than 5% of their capitation rate.

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

DHS has not implemented incentive payments related to EHRs for the 2019 contract period.

VII. RESPONSES TO 2018 - 2019 CMS MANAGED CARE RATE DEVELOPMENT GUIDE

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

- Rate period – The capitation rates are in effect for the twelve month period from January 1, 2019 through December 31, 2019.
- Actuarial rate certification – See Appendix E.
- Final capitation rates – Please refer to Exhibit 6 (medical capitation rates), Exhibit 8 (maternity kick payments), Exhibit 13 (dental capitation rates), and Exhibit 16 (chiropractic capitation rates) for the final capitation rates. Exhibit 21 summarizes the final capitation rates for each coverage option (Medical only, Medical and Dental, Medical and Chiropractic, or All Services).
- Rate ranges – Not applicable.
- Program descriptions – See Section I.B.
- Federal Medical Assistance Percentage – The assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards and do not vary based on the rate of Federal financial participation associated with the covered populations.
- Cross-subsidies – Payments from one rate cell are not cross-subsidized by payments from any other rate cell.
- Rate change from prior period – See Section I.A. and Exhibits 17 to 19.
- Material changes to capitation rate methodology – See Section I.C.

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 2015 and 2016 to calendar years 2016 and 2017.
- 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 continue to 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

- Please refer to Section III of this report for the methodology and assumptions we used to project contract period benefit costs. These assumptions 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, and we considered the impact of removing the member months and non-IMD claims for members with over 15 IMD days in an IMD for a given month from the 2019 capitation rates and determined the impact was not material. We removed Narcotic Treatment Services from the base period experience because DHS will reimburse HMOs for these claim on a FFS basis outside of capitation in 2019 (similar to 2018).

- Projected benefit cost trends:

  - Annual trend assumptions excluding Medicaid FFS reimbursement changes – See Section III.D.

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

- In-lieu-of services – See Section II.B. CMS requested the following information for programs that allow IMDs to be used as an in-lieu of service:

  - Of members ages 21 to 64 who received treatment in an IMD through managed care organizations in the base period, 41 and 44 had a stay greater than 15 days in a given month in 2016 and 2017, respectively, and 2,407 and 2,853 had a stay less than 15 days in a given month in 2016 and 2017, respectively.

  - The tables below outline the requested information for enrollees who received care in an IMD during the base period. We provide data under two scenarios: members with stays that equated to less than 15 days in a given month (although the stay may exceed 15 days overall if it overlaps multiple months) and members with stays greater than 15 days in a given month.

Table 16
Wisconsin Department of Health Services
Number of Months Enrollees Received Care in an IMD

Year	Stay Grouping	Minimum	Maximum	Mean	Median
2016	Less Than or Equal to 15 Days in a Given Month	1.0	7.0	1.4	1.0
2016	Greater Than 15 Days in a Given Month	1.0	2.0	1.0	1.0
2017	Less Than or Equal to 15 Days in a Given Month	1.0	10.0	1.5	1.0
2017	Greater Than 15 Days in a Given Month	1.0	3.0	1.2	1.0

Table 17 Wisconsin Department of Health Services Length of Stay for Enrollees who Received Care in an IMD					
Year	**Stay Grouping**	**Minimum**	**Maximum**	**Mean**	**Median**
2016	Less Than or Equal to 15 Days in a Given Month	1.0	15.0	4.0	4.0
2016	Greater Than 15 Days in a Given Month	16.0	47.0	23.4	21.5
2017	Less Than or Equal to 15 Days in a Given Month	1.0	15.0	4.3	4.0
2017	Greater Than 15 Days in a Given Month	16.0	92.0	25.6	21.0

- The percentage of overall projected costs that reflect IMD services is 0.7% in the BCP Standard and 3.2% in the BCP CLA capitation rates and 0.6% in the maternity kick payment. The impact of providing treatment through IMDs is a 0.1% and 0.7% decrease to the overall projected costs in the BCP Standard and CLA capitation rates, respectively, and a 0.1% decrease in the maternity kick payment.

- IMD services – Reimbursement adjustments for IMDs are documented in Section III.A, and benefit adjustments are documented in Section III.B.

- Mental Health Parity and Addiction Equity Act – No additional services were necessary to add to the program to achieve compliance with the act.

- 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.

- Changes in covered services and benefits – There were no benefit changes between the base period and contract period other than the covered service changes described in Section III.B.

- 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 8 (maternity kick payments), Exhibit 10 (dental capitation rates), and Exhibit 15 (chiropractic capitation rates).

- Conditions of any litigation to which the state is subjected – Not applicable; no impact on rates.

4. Special Contract Provisions Related to Payment

- Incentive Arrangements – See Section IV.C
- Withhold Arrangements – See Section IV.B
- Risk Sharing – Not applicable
- Delivery System and Provider Payment Initiatives – See Section IV.D
- Pass-through payments – Not applicable.

5. Projected Non-Benefit Costs

- Assumptions used to project non-benefit costs do not vary based on the rate of federal financial participation associated with the covered populations.
- Administrative costs and provision for margin – See Section III.F.
- Health Insurer Fee treatment – See Section III.J.

6. Risk Adjustment and Acuity Adjustments

- Risk adjustment – See Section IV.A and Exhibits 5 and 6.
- Acuity adjustments – See Section III.C for the BCP CLA durational adjustment.

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

This section does not apply, as BCP 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 2016 and 2017 for rate development for all individuals, along with 2016 and 2017 supplemental financial data, as described in Section II.

Starting with the 2016 rating period, the CLA rates have been based on encounter data. The rate setting data and methodology have largely been consistent over time. As described in Section III.C, we perform a durational analysis each year to project cost differences impacted by the length of member duration in the

CLA population between the base period and rating period. With each year, we include more data in this durational analysis, resulting in annual updates to the durational adjustments by quarter of enrollment.

2. Projected Benefit Costs

See section III for a summary of rate adjustments applied to project benefit costs to the contract period and specifically Section III.C describing the durational adjustments applied.

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 2016 and 2017 health plan financial reporting.

4. Final Certified Rates or Rate Ranges

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

5. Risk Mitigation Strategies

The 2019 rates are risk adjusted. Please refer to section IV.A of the rate report.

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

2019 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 2019 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.

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2019 through December 31, 2019
BadgerCare Plus Standard and Childless Adult Programs

January 30, 2019

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 2019 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.

Wisconsin Department of Health Services
Capitation Rate Development
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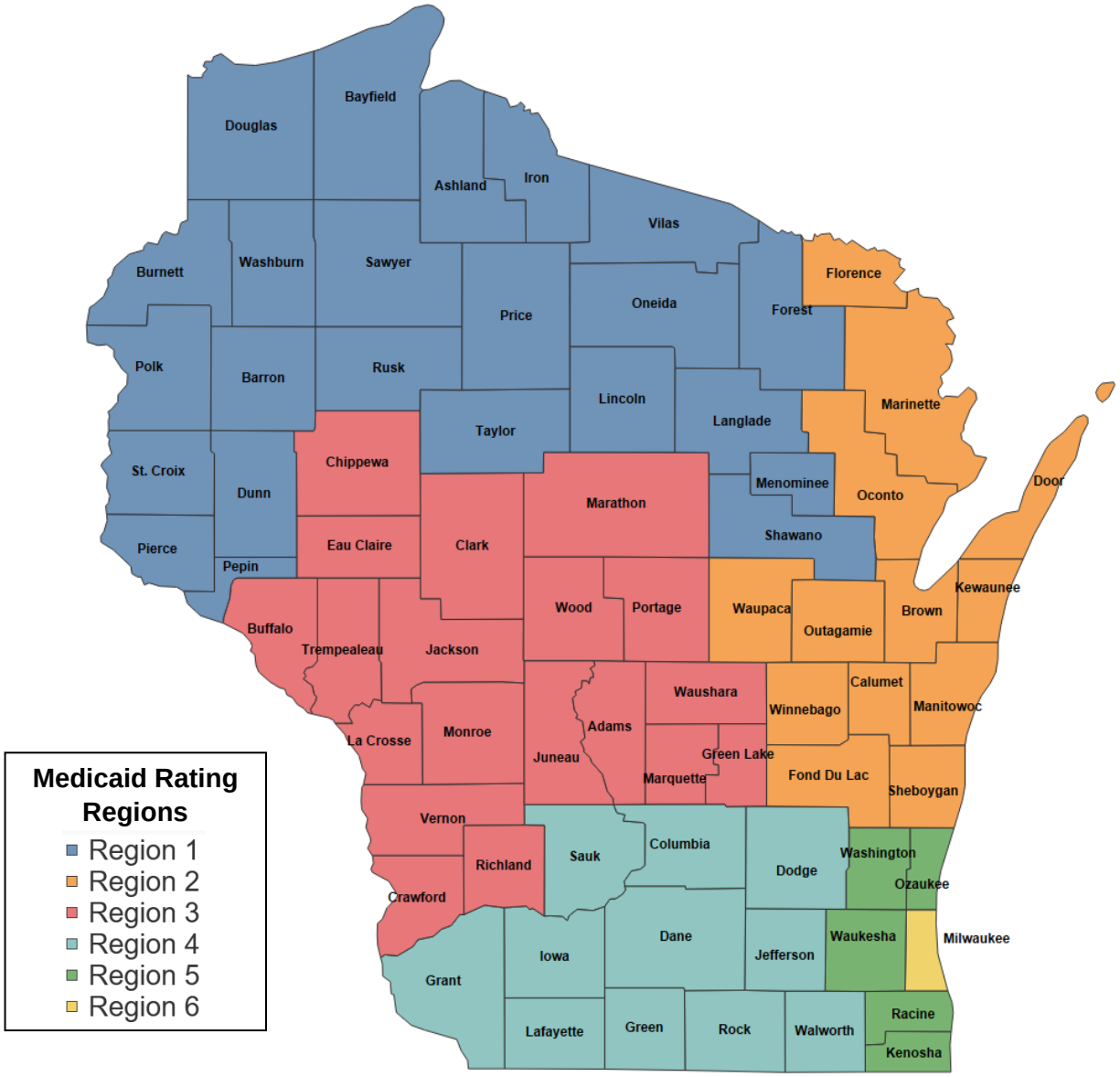
BadgerCare Plus Standard and Childless Adult Programs

January 30, 2019



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 2019 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.

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2019 through December 31, 2019
BadgerCare Plus Standard and Childless Adult Programs

January 30, 2019

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 2019 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.

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2019 through December 31, 2019
BadgerCare Plus Standard and Childless Adult Programs

January 30, 2019

Appendix D

Enhanced FMAP Identification Criteria

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 2019 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.

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2019 through December 31, 2019
BadgerCare Plus Standard and Childless Adult Programs

January 30, 2019

APPENDIX D
ENHANCED FMAP IDENTIFICATION CRITERIA

We identified the family planning and IHS services eligible for enhanced FMAP using FMAP indicators in the encounter data. We identified the preventive services eligible for enhanced FMAP using criteria provided by DHS.

FAMILY PLANNING SERVICES

Family planning claims are identified as service codes 48 (Family Planning) and 50 (FQHC) and the specific sub-category of service codes listed below.

Wisconsin Department of Health Services
Codes Used to Identify Enhanced Match Family Planning Claims

Category of Service	Sub-Category of Service	Description
48	05	Sterilizations
48	10	Clinic
48	20	Outpatient Hospital
48	25	Physician / Nurse Practitioner
48	35	Lab and X-Ray Services
48	40	Other
50	06	Sterilizations
50	09	Family Planning Clinic
50	15	Family Planning Other

INDIAN HEALTH SERVICES

IHS claims are identified as services provided to Native Americans or Alaskan Native members at facilities officially recognized as IHS facilities.

ZERO COPAY PREVENTIVE SERVICES

Zero copay preventive services are identified using the following procedure codes provided by DHS. The codes in procedure code group 5048 require modifier 33 while the codes in procedure group 5047 do not require a modifier.

Wisconsin Department of Health Services
Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims

Procedure Code	Procedure Group Type	Procedure Code Modifier
77057	5047	N/A
86631	5047	N/A
86632	5047	N/A
87110	5047	N/A
87270	5047	N/A
87320	5047	N/A
87391	5047	N/A

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
87490	5047	N/A
87491	5047	N/A
87492	5047	N/A
87623	5047	N/A
87624	5047	N/A
87625	5047	N/A
87806	5047	N/A
87810	5047	N/A
88141	5047	N/A
88142	5047	N/A
88143	5047	N/A
88147	5047	N/A
88148	5047	N/A
88150	5047	N/A
88152	5047	N/A
88153	5047	N/A
88154	5047	N/A
88155	5047	N/A
88164	5047	N/A
88165	5047	N/A
88166	5047	N/A
88167	5047	N/A
88174	5047	N/A
88175	5047	N/A
90620	5047	N/A
90621	5047	N/A
90632	5047	N/A
90633	5047	N/A
90636	5047	N/A
90649	5047	N/A
90650	5047	N/A
90651	5047	N/A
90656	5047	N/A
90658	5047	N/A
90660	5047	N/A
90670	5047	N/A
90703	5047	N/A
90707	5047	N/A
90714	5047	N/A
90715	5047	N/A
90716	5047	N/A
90732	5047	N/A

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
90733	5047	N/A
90734	5047	N/A
90736	5047	N/A
90740	5047	N/A
90743	5047	N/A
90744	5047	N/A
90746	5047	N/A
90747	5047	N/A
99173	5047	N/A
99188	5047	N/A
99383	5047	N/A
99384	5047	N/A
99385	5047	N/A
99386	5047	N/A
99387	5047	N/A
99393	5047	N/A
99394	5047	N/A
99395	5047	N/A
99396	5047	N/A
99397	5047	N/A
99401	5047	N/A
99402	5047	N/A
99403	5047	N/A
99404	5047	N/A
99406	5047	N/A
99407	5047	N/A
99408	5047	N/A
99409	5047	N/A
99411	5047	N/A
99412	5047	N/A
A4281	5047	N/A
A4282	5047	N/A
A4283	5047	N/A
A4284	5047	N/A
A4285	5047	N/A
A4286	5047	N/A
E0602	5047	N/A
E0603	5047	N/A
E0604	5047	N/A
G0123	5047	N/A
G0124	5047	N/A
G0141	5047	N/A

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
G0143	5047	N/A
G0144	5047	N/A
G0145	5047	N/A
G0147	5047	N/A
G0148	5047	N/A
G0202	5047	N/A
G0297	5047	N/A
G0389	5047	N/A
H0002	5047	N/A
H0004	5047	N/A
H0049	5047	N/A
H0050	5047	N/A
H1003	5047	N/A
S3620	5047	N/A
S9443	5047	N/A
44388	5048	33
44389	5048	33
44390	5048	33
44391	5048	33
44392	5048	33
44393	5048	33
44394	5048	33
44397	5048	33
44401	5048	33
44402	5048	33
44403	5048	33
44404	5048	33
44405	5048	33
44406	5048	33
44407	5048	33
44408	5048	33
45330	5048	33
45331	5048	33
45332	5048	33
45333	5048	33
45334	5048	33
45335	5048	33
45337	5048	33
45338	5048	33
45339	5048	33
45340	5048	33
45341	5048	33

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
45342	5048	33
45345	5048	33
45346	5048	33
45347	5048	33
45349	5048	33
45350	5048	33
45355	5048	33
45378	5048	33
45379	5048	33
45380	5048	33
45381	5048	33
45382	5048	33
45383	5048	33
45384	5048	33
45385	5048	33
45386	5048	33
45387	5048	33
45388	5048	33
45389	5048	33
45390	5048	33
45392	5048	33
45393	5048	33
45398	5048	33
76705	5048	33
76770	5048	33
76775	5048	33
76977	5048	33
77051	5048	33
77052	5048	33
77055	5048	33
77056	5048	33
77078	5048	33
77079	5048	33
77080	5048	33
77081	5048	33
77082	5048	33
80055	5048	33
80061	5048	33
80422	5048	33
82270	5048	33
82274	5048	33
82465	5048	33

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
82728	5048	33
82947	5048	33
82948	5048	33
82950	5048	33
82951	5048	33
82952	5048	33
83020	5048	33
83021	5048	33
83700	5048	33
83701	5048	33
83704	5048	33
83718	5048	33
83721	5048	33
84030	5048	33
84443	5048	33
84478	5048	33
85025	5048	33
86592	5048	33
86593	5048	33
86689	5048	33
86701	5048	33
86702	5048	33
86703	5048	33
86704	5048	33
86705	5048	33
86706	5048	33
86900	5048	33
86901	5048	33
87070	5048	33
87081	5048	33
87086	5048	33
87088	5048	33
87340	5048	33
87341	5048	33
87389	5048	33
87390	5048	33
87534	5048	33
87535	5048	33
87536	5048	33
87590	5048	33
87591	5048	33
87592	5048	33

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
87850	5048	33
92002	5048	33
92004	5048	33
92012	5048	33
92014	5048	33
92587	5048	33
96040	5048	33
96150	5048	33
96151	5048	33
96152	5048	33
96153	5048	33
96154	5048	33
99174	5048	33
99201	5048	33
99202	5048	33
99203	5048	33
99204	5048	33
99205	5048	33
99211	5048	33
99212	5048	33
99213	5048	33
99214	5048	33
99215	5048	33
G0204	5048	33
G0206	5048	33

Appendix E

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 2019 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.

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2019 through December 31, 2019
BadgerCare Plus Standard and Childless Adult Programs

January 30, 2019

15800 Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3680

milliman.com

Shelly S. Brandel, FSA, MAAA
Principal and Consulting Actuary

shelly.brandel@milliman.com

January 30, 2019

Wisconsin Department of Health Services
BadgerCare Plus Standard and Childless Adults Medicaid Managed Care Programs
January – December 2019 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 Plus (BCP) Standard and Childless Adults program capitation rates for January – December 2019 for filing with the Centers for Medicare and Medicaid Services (CMS). I reviewed the calculated capitation rates and am familiar with the relevant requirements of 42 CFR 438, the CMS "Appendix A, PAHP, PIHP, and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting", the 2018-2019 Medicaid Managed Care Rate Development Guide, and Actuarial Standard of Practice (ASOP) 49.

To the best of my information, knowledge, and belief, the 2019 BCP capitation rates offered by DHS are in compliance with the relevant requirements of § CFR 438.3(c), 438.3(e), 438.4 (excluding paragraphs (b)(3),(b)(4) and (b)(9)), 438.5, 438.6, and 438.7 (excluding paragraph (c)(3)).

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

January 30, 2019

Scott Walker
Governor

Linda Seemeyer
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF MEDICAID SERVICES

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

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

December 20, 2018

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

RE: January 1, 2019 through December 31, 2019 Wisconsin Medicaid BadgerCare Plus and Supplemental Security Income (SSI) Managed Care Rate Development Data Reliance Letter

Dear Shelly:

I, Chad Lillethun, Director 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 2019 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 2019 capitation rate development, including:

    a. Fee-for-service claim data
    b. HMO encounter data
    c. Eligibility data
    d. Hospital inpatient and outpatient facility 2019 re-pricing data

2. Other supporting data, including:

    a. Monthly identification of ventilator-dependent members
    b. HMO financial data
    c. 2019 provider access payment funding amounts
    d. Historical performance withhold payments
    e. Information regarding program changes effective prior to December 31, 2019
    f. Details regarding the scope of HMO covered services and eligible recipients
    g. Identification criteria for services eligible for enhanced federal match
    h. Identification of SSI members eligible for HMO expansion
    i. 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.

Chad Lillethun
Director, Bureau of Fiscal Management, DHS

December 20, 2018