Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2020 through December 31, 2020
SSI Medicaid Managed Care Programs

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I. SUMMARY OF RESULTS AND CAVEATS

This report documents the development of capitation rates effective January 1, 2020 through December 31, 2020 for Wisconsin's Supplemental Security Income (SSI) Medicaid managed care programs.

The Wisconsin Department of Health Services (DHS) retained Milliman, Inc. (Milliman) to develop and certify its 2020 SSI 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 12 (Risk Classification); 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 2020 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 2020 and 2019 per member per month (PMPM) medical, dental, and chiropractic capitation rates by geographic rate region and eligibility category.

Table 1A
Wisconsin Department of Health Services
Summary of Capitation Rate Changes by Region (Excluding Provider Access Payments)
Calendar Year 2019 to Calendar Year 2020
SSI Medicaid Only

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Medical Capitation Rates							
2020 Capitation Rate	$523.93	$503.85	$489.89	$486.01	$538.27	$819.08	$627.51
2019 Capitation Rate	$493.23	$514.82	$508.02	$488.11	$501.40	$775.88	$607.72
Rate Change	6.2%	-2.1%	-3.6%	-0.4%	7.4%	5.6%	3.3%
Dental Capitation Rates							
2020 Capitation Rate[2]	n/a	n/a	n/a	n/a	$10.60	$9.76	$9.96
2019 Capitation Rate[2]	n/a	n/a	n/a	n/a	$9.94	$10.52	$10.38
Rate Change	n/a	n/a	n/a	n/a	6.6%	-7.2%	-4.1%
Chiropractic Capitation Rates							
2020 Capitation Rate	$3.14	$2.38	$2.76	$1.90	$0.83	$0.48	$1.48
2019 Capitation Rate	$3.42	$2.32	$3.47	$1.88	$1.06	$0.59	$1.64
Rate Change	-8.2%	2.6%	-20.5%	1.1%	-21.7%	-18.6%	-9.8%

[1] Statewide changes in capitation rates are based on July 2019 enrollment.
[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 2019 to Calendar Year 2020
SSI Dual Eligible

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Medical Capitation Rates							
2020 Capitation Rate	$70.87	$62.26	$62.04	$67.25	$60.82	$162.60	$109.25
2019 Capitation Rate	$75.01	$59.68	$55.31	$70.79	$50.99	$138.57	$96.42
Rate Change	-5.5%	4.3%	12.2%	-5.0%	19.3%	17.3%	13.3%
Dental Capitation Rates							
2020 Capitation Rate[2]	n/a	n/a	n/a	n/a	$9.66	$9.13	$9.26
2019 Capitation Rate[2]	n/a	n/a	n/a	n/a	$8.83	$9.18	$9.10
Rate Change	n/a	n/a	n/a	n/a	9.4%	-0.5%	1.8%
Chiropractic Capitation Rates							
2020 Capitation Rate	$0.74	$0.50	$0.90	$0.43	$0.09	$0.08	$0.28
2019 Capitation Rate	$0.28	$0.57	$0.94	$0.38	$0.13	$0.08	$0.27
Rate Change	164.3%	-12.3%	-4.3%	13.2%	-30.8%	0.0%	3.7%

[1] Statewide changes in capitation rates are based on July 2019 enrollment.
[2] Dental capitation rates for Regions 1 through 4 are not applicable, since no HMOs cover dental services in these regions.

Exhibits 15 through 17 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 2019 enrollment. Exhibit 19 shows the final 2020 capitation rates for each HMO, including provider access payments.

Table 2 provides a high level summary of each rate component and the impact on the overall medical capitation rate change from 2019 to 2020.

Table 2 Wisconsin Department of Health Services High Level Summary of Medical Capitation Rate Changes between 2019 and 2020		
Rate Component	**SSI Medicaid Only**	**SSI Dual Eligible**
Updated base period data	8.0%	7.7%
Reimbursement change between base period and rating period	0.3%	6.3%
Trend and other projection factor changes	-3.9%	-0.6%
Decrease in administrative load	-0.6%	-0.6%
Impact of rate cell mix on prior rates	-0.2%	0.1%
Total rate change	**3.3%**	**13.3%**

The SSI Medicaid Only average medical rate increase of 3.3% is driven by changes to the base period data due to mandatory HMO expansion, and partly offset by a decrease in trend assumptions between rate years. In addition, the increase in Region 6 is also driven by fee increases for personal care services, which represent a higher percentage of total claims in Region 6 compared to other regions. The SSI Medicaid Only dental rate changes are driven by updates to the base period data.

The average SSI Dual Eligible medical rate increase of 13.3% and the variation by region is driven by updates to the base period data. In addition, similar to SSI Medicaid Only, the increase in Region 6 is also driven by fee increases for personal care services, which represent a higher percentage of total claims in Region 6 compared to other regions. The variation in dental rates by region is driven by changes in the base period data.

B. CAPITATION RATE CELL STRUCTURE

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

Eligibility Categories

We developed capitation rates for the following eligibility categories:

- **SSI Medicaid Only:** Includes SSI and Medicaid Purchase Plan (MAPP) Medicaid Only members ages 19 and over who are not eligible for Medicare benefits. SSI members receive SSI or SSI-related Medicaid benefits due to a disability. MAPP members are low-income disabled individuals that purchase Medicaid coverage through the Wisconsin Medicaid Purchase Plan. Members may not be residing in an institution or nursing home and may not be receiving home and community based waiver benefits.
- **SSI Dual Eligible:** Includes SSI and MAPP members ages 19 and over who are eligible for Medicare benefits.

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 2020 capitation rates.

Rate Cells

The capitation rates are paid separately by age category and rate region. Table 3 summarizes the age categories used within the SSI Medicaid Only and SSI Dual Eligible eligibility categories.

Table 3 Wisconsin Department of Health Services Age Rate Cells SSI Medicaid Only and SSI Dual Eligible
Ages 19 to 39
Ages 40 to 64
Ages 65+

Covered Services

HMOs are responsible for providing comprehensive health care to SSI members, including hospital inpatient, hospital outpatient, professional, and other services. Prescription drugs are carved out of the capitation rates. Dental and chiropractic capitation rates are developed separately. HMOs must provide dental coverage in Region 6 (Milwaukee) and part of Region 5 (Kenosha, Racine, and Waukesha counties). Dental coverage is optional in all other counties, and chiropractic coverage is optional in all regions. We describe exclusions applied to the HMO encounter and fee-for-service (FFS) data in Sections II.B. and II.C., respectively. 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.

Encounter-based payments paid on a FFS basis outside of the capitation rates, including the Dental Pilot, SSI intensive care management, Long-Acting Reversible Contraception (LARC), HIV / AIDS Medical Home, and Narcotic Treatment Services, are reimbursed to the HMOs at the Medicaid fee schedule in compliance with the upper payment regulations outlined at 42 CFR §447.362. Any services incurred under the waiver approved for substance abuse not normally covered under the HMO capitation will be reimbursed to HMOs outside of the capitation.

C. GENERAL PROGRAM INFORMATION AND HIGH-LEVEL RATE METHODOLOGY

The SSI managed care program started in Milwaukee and expanded into additional counties in 2007. DHS held contracts with 10 Health Maintenance Organizations (HMOs) to provide services to SSI members during the experience period. The following changes occurred between the experience and rating period:

- Effective January 1, 2018, CompCare and Trilogy Health Insurance exited the SSI program. The experience for both HMOs is included in the 2017 base data, and the impact of member enrollment changes by HMO after these HMO terminations are reflected in the July 2019 member counts used to develop the CDPS risk score adjustments.

- Prior to 2018, managed care enrollment was voluntary for all SSI members. During 2018, DHS implemented a mandatory HMO expansion for SSI Medicaid Only members for counties with two or more participating HMOs (all except Menominee County). The expansion was implemented on

a phased-in basis by county and auto-enrollment for eligible members was complete by June 2018. Enrollment for Dual Eligibles remains voluntary.

The SSI 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 for the SSI Medicaid Only eligibility category, with some exceptions such as Ages 65+ and HMOs with low credibility in a rate cell. The SSI Dual Eligible capitation rates are not risk adjusted.

Material Changes to Rate Methodology

The 2020 capitation rate methodology is generally consistent with the 2019 rate methodology. We made the following material change to the 2020 rate methodology:

- Experience data sources – The 2019 rates were based on HMO encounter and financial data from calendar years 2016 and 2017, as well as FFS data for SSI Medicaid Only members who enrolled with an HMO as of July 2018. The 2020 rates for Dual Eligibles are based on more recent HMO encounter and financial data from calendar years 2017 and 2018. The 2020 rates for SSI Medicaid Only are based on 2018 HMO encounter and financial data, as well as 2018 FFS data for SSI Medicaid Only members who were enrolled with an HMO at any point during 2018. We limited the base data to 2018 to reflect the complete year of experience during HMO expansion.

- Member copays – We applied adjustments for changes to member copays between the experience years and rate year for SSI Medicaid Only and SSI Dual Eligibles as described in Section III.B.

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 2020 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)

- Section VI provide responses to the CMS rate setting checklist

- Section VII provides responses to the 2019 - 2020 CMS Medicaid Managed Care Rate Development Guide

Exhibits 1 through 23 summarize the 2020 rate development. Appendix A provides a mapping of counties to rate regions. Appendices B and C contain details on the custom CDPS risk score model.

Appendix D summarizes the enhanced FMAP identification criteria. Appendix E contains the actuarial certification.

E. IMPORTANT LIMITATIONS AND CAVEATS

This report is intended for the internal use of DHS to assist in developing 2020 capitation rates for the SSI Medicaid program. It may not be appropriate, and should not be used, for other purposes. Milliman recognizes that materials it delivers to DHS may be public records subject to disclosure to third parties; however, Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. It should only be distributed and reviewed in its entirety.

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

We 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 2020 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 2020 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.

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 report is subject to the terms and conditions of 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 2020 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 (separate exhibits are provided by eligibility category):

- Exhibit 1A: Medical (for HMO encounter and FFS claims separately) – SSI Medicaid Only
- Exhibit 1B: Medical (for HMO encounter claims only) – SSI Dual Eligible
- Exhibit 7A: Dental – SSI Medicaid Only
- Exhibit 7B: Dental – SSI Dual Eligible
- Exhibit 12A: Chiropractic – SSI Medicaid Only
- Exhibit 12B: Chiropractic – SSI Dual Eligible

A. BASE DATA SOURCES

The data sources used in the 2020 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. The re-priced paid amounts are net of all applicable, cost sharing amounts for the Medicaid program, even if an HMO waives the cost sharing amounts.

2. **HMO Financial Data** – Participating HMOs were required to submit CY 2017, CY 2018, and YTD April 2019 financial data to DHS. The financial data included the following information by eligibility category, region and calendar year:

   - Member months
   - Total revenue including capitation 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 including overpayments to providers not already reflected in the FFS claim payments
   - 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 through 4 and chiropractic services in all regions. We also used FFS data for SSI expansion members to develop the SSI Medicaid Only capitation rates for medical, dental, and chiropractic services.

DHS and Milliman went through an extensive data validation process to review all HMO data included in the 2020 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 comparing the results of their encounter and financial data, along with HMO-specific data questions. After receiving answers to our questions and a few data re-submissions from the HMOs, we released base data summaries for HMO review and comment. Additionally, we presented the information to the HMOs to explain the base data and solicit feedback from the HMOs.

Based on our analysis, we found the HMO encounter data to be of appropriate quality for developing the 2020 capitation rates. As discussed in Section D below, we applied missing data adjustments to the base encounter data to address encounter data under-reporting.

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 2017 and CY 2018	May 2019[1]
HMO Financial Data	CY 2017 and CY 2018	April 2019
HMO Emerging 2019 Financial Data	YTD April 2019	June 2019
FFS Data	CY 2017 and CY 2018	May 2019

[1] Encounter data files received from DHS on May 30, 2019; 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 calendar years 2016 through 2018. As noted above, we used 2017 and 2018 encounter data for SSI Dual Eligibles and 2018 encounter data for SSI Medicaid Only to develop the base period costs. We summarized the 2017 and 2018 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 and Medicare status 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 CY 2017 and CY 2018:** We excluded claims for services provided outside of the period January 1, 2017 through December 31, 2018.

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 premiums provided 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 one HMO 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 base period experience. We developed separate capitation rates for medical

coverage, dental services, and chiropractic services. Any included claims not identified as dental or chiropractic services were classified as medical coverage.

Dental

Encounters with procedure codes from D0120 – D9999 were identified as dental services and carved out from the base data. In the base period, HMOs were required to cover dental services in Region 6 (Milwaukee) and part of Region 5 (Kenosha, Racine, and Waukesha counties). Dental coverage is optional in other counties; 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 SSI Medicaid Only program covers an in lieu of service called "sub-acute psychiatric community-based psychiatric and recovery center services." These services are defined in Section IV.B.12 of the HMO contract. The benefit is limited to short term residential (non-hospital residential treatment program) for behavioral health. Sub-acute community based clinical treatment may be used in lieu of inpatient psychiatric hospitalization. The benefit is re-priced at $450 per diem in the encounter data. This benefit is cost effective, since the $450 per diem is much lower than the SSI Medicaid Only inpatient psychiatric cost per day.

The SSI program also allows HMOs to provide IMD benefits in lieu of inpatient psychiatric and substance abuse 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, personal care, Indian health services, 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 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 through 4 and chiropractic services in all regions, since credible encounter data is not available. We summarized dental and chiropractic FFS claims (using the service criteria above) for members enrolled in HMOs during the base period.

We also used FFS data to develop the SSI Medicaid Only rates in combination with the HMO encounter data for existing HMO members. The data exclusions in the encounter data section also apply to the FFS data. In addition to the encounter data adjustments, we applied the following adjustments to the FFS data:

1. Excluded populations
    - Patients residing in ICF / MR or IMDs
    - Members receiving home and community based waiver services
    - Members enrolled in HMOs
    - Members in an HMO exemption status (other than HIV positive / AIDS, methadone treatment, SSI opt out, and SSI waiver program opt out exemptions)
    - Members with a non-SSI Medical Status code
2. Excluded services (not covered by the capitation rate)
    - Targeted case management
    - School-based services
    - Prenatal care coordination
    - Community Support Program
    - Crisis intervention services
    - Prescription drugs

For the SSI Medicaid Only capitation rates, we used the 2018 FFS data for members enrolled in an HMO at any point during calendar year 2018.

D. ADJUSTMENTS TO THE BASE DATA

This section discusses the adjustments we made to the base 2017 and 2018 data before projecting costs to the 2020 rating period.

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. We calculated the adjustments gross of ventilator recoupments and applied a separate adjustment to reflect ventilator recoupments not yet identified in the 2018 encounter data.

Table 5 summarizes the medical missing data adjustments by eligibility category, region, and calendar year. For 2018, we calculated missing data adjustments for SSI Medicaid Only personal care services separately from other services due to a material amount of known claims missing for personal care services. As noted above, missing data adjustments were developed at the HMO level. Therefore, the variance in missing data

adjustments by eligibility category and region is 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
SSI Medicaid Only						
2017	1.018	1.015	1.021	1.034	1.013	1.012
2018 Personal Care	1.111	1.075	1.237	1.063	1.202	1.161
2018 Other Services	1.019	1.025	1.021	1.041	1.024	1.024
SSI Dual Eligibles						
2017	1.018	1.015	1.022	1.032	1.013	1.011
2018	1.020	1.024	1.017	1.036	1.024	1.026

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 through 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 base 2018 claims to adjust for incurred but not reported (IBNR) claims as of the claim submission date before the additional adjustments described in this section. CY 2017 claims are assumed to be complete, since there are approximately 17 months of claims runout.

Table 6
Wisconsin Department of Health Services
2018 Completion Factors (Before Additional Adjustments)

	HMO Encounter Data			FFS Data		
	Hospital Inpatient	**Dental**	**Other Services**	**Hospital Inpatient**	**Dental**	**Other Services**
SSI Medicaid Only	1.033	1.002	1.013	1.011	1.002	1.002
SSI Dual Eligibles	1.033	1.002	1.010	n/a	1.002	1.002

Note: 2017 encounter data is assumed to be complete.

We calculated the encounter completion factors using primarily the HMO financial data with adjustments for outliers, and reviewed the completion factors implied by the encounter data for reasonableness. We developed the FFS completion factors based on FFS claim lag patterns.

We also applied the following adjustments to the completion factors:

- New Marshfield Clinic Hospital Adjustments – A new facility opened in the Eau Claire area in July 2018 that impacted Regions 1 and 3. Any claims incurred at this facility during the second half of 2018 were excluded from the encounter data, since the facility was not licensed as a Medicaid provider until January 1, 2019. We increased the inpatient and outpatient completion factors by the

additive adjustments shown in Table 7 to account for these estimated 2018 claims based on 2018 billed amounts provided by DHS and the ratio of early 2019 re-priced Medicaid paid to billed amounts in the May 2019 HMO encounter and FFS data extracts.

Table 7
Wisconsin Department of Health Services
New Marshfield Clinic Hospital Adjustments

	HMO Encounter Data		FFS Data	
	Region 1	Region 3	Region 1	Region 3
Hospital Inpatient	0.005	0.016	0.003	0.010
Hospital Outpatient	0.001	0.004	0.001	0.004

- Ventilator Recoupment Adjustments – Based on an analysis of historical data, we observed ventilator recoupment amounts are consistently higher in the encounter data with an additional year of claims runout compared to the extract used for the prior year's capitation rate development. We estimated ventilator recoupments not yet approved by DHS in the 2018 encounter data based on historical patterns of ventilator recoupments by incurred and rate development years. We applied the additive adjustments shown in Table 8 to 2018 hospital inpatient claims in the encounter base data.

Table 8
Wisconsin Department of Health Services
2018 Ventilator Recoupment Adjustments

	Ventilator Recoupment Hospital Inpatient Adjustments
SSI Medicaid Only	-0.044
SSI Dual Eligibles	-0.044

Table 9 shows the final medical completion factors applied to the 2018 data after combining the adjustments in Tables 6 through 8.

Table 9
Wisconsin Department of Health Services
Final 2018 Completion Factors

	Region 1	Region 3	Regions 2, 4, 5, 6
SSI Medicaid Only – Encounter Data			
Hospital IP	0.994	1.005	0.989
Hospital OP	1.014	1.017	1.013
Other	1.013	1.013	1.013
SSI Dual Eligible – Encounter Data			
Hospital IP	0.994	1.005	0.989
Hospital OP	1.011	1.014	1.010
Other	1.010	1.010	1.010
SSI Medicaid Only - FFS Data			
Hospital IP	1.014	1.021	1.011
Hospital OP	1.003	1.006	1.002
Other	1.002	1.002	1.002

Provider Contracting Adjustment (Encounter and FFS 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 10 summarizes the provider contracting adjustments applied to the SSI Medicaid Only re-priced Medicaid paid amounts in the encounter data. We did not apply provider contracting adjustments to the SSI Dual Eligible population.

Table 10
Wisconsin Department of Health Services
Provider Contracting Adjustments

	Regions 1 through 4	Regions 5 and 6
Hospital Inpatient	1.01	1.02
Hospital Outpatient	1.00	1.06
Professional	1.02	1.04
FQHC / RHC	1.00	1.00
Other	1.00	1.00

Managed Care Savings Factors (FFS Data)

We applied adjustments to the medical FFS data to reflect estimated savings due to members being enrolled into managed care. The medical managed care savings adjustments shown in Table 11 were developed by comparing the concurrent risk-adjusted claims PMPM for HMO enrolled members to FFS claims PMPM for expansion members by broad category of service:

Table 11
Wisconsin Department of Health Services
Managed Care Savings

Eligibility Category	Managed Care Savings
Hospital Inpatient	0.85
Hospital Outpatient	0.97
Professional	0.94
Personal Care	0.87
All Other	0.90

We did not assume managed care savings for dental or chiropractic claims.

III. PROJECTED 2020 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 2020 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 2020 claim costs:

- Exhibit 2A: Medical (for HMO encounter and FFS claims separately) – SSI Medicaid Only
- Exhibit 2B: Medical (for HMO encounter claims only) – SSI Dual Eligible
- Exhibit 7A: Dental – SSI Medicaid Only
- Exhibit 7B: Dental – SSI Dual Eligible
- Exhibit 12A: Chiropractic – SSI MA Only
- Exhibit 12B: Chiropractic – SSI Dual Eligible

A. REIMBURSEMENT CHANGES

Generally, the HMOs are not required to reimburse providers in relation to the Medicaid fee schedule with a few exceptions. There are five areas where HMOs are contractually required to pay a minimum of 100% of the FFS Medicaid rate: 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 SSI Medicaid Only experience consistent with projected Medicaid fee schedule changes.

We describe the in lieu of service for "Sub-Acute Psychiatric Community-Based Psychiatric and Recovery Center Services" in Section II. B. We did not make any reimbursement adjustment for this benefit, since the encounter data is re-priced at $450 per diem.

Because the reimbursement changes for the SSI Dual Eligible population are primarily impacted by changes in Medicare cost sharing and fee schedules rather than Medicaid fee schedules, we applied annual reimbursement trends to the SSI Dual Eligible population of 2% for hospital inpatient and 1% for all other service categories except personal care and "Payments Made Outside Encounter Data." We assumed 2% for hospital outpatient because the Part A deductible increased annually by 1.8% from 2017 to 2019. We assumed 1% for other services, since the Part B deductible increased 1.1% from 2018 to 2019 and projected annual fee schedule increases for Part B services are expected to be about 1%. We did not apply any of the other reimbursement adjustments in this section to the SSI Dual Eligible population, except for personal care since these services are reimbursed at the Medicaid fee schedule.

We are not aware of any other material anticipated fee changes other than the items mentioned in this section.

Hospital Inpatient Re-Pricing Adjustment (Encounter and FFS Data)

DHS provides a detailed encounter dataset with hospital inpatient claims, excluding skilled nursing facility (SNF), re-priced to the inpatient Medicaid reimbursement rates effective January 1, 2020. We used this data to calculate the impact of reimbursement changes on the historical 2017 and 2018 hospital inpatient claims by eligibility category, year, and region. Table 12 summarizes the hospital inpatient re-pricing

adjustments for 2020 fee changes (prior to the 'other reimbursement adjustments' described below) applied to both the base HMO encounter and FFS hospital inpatient claims for the SSI Medicaid Only population.

Table 12
Wisconsin Department of Health Services
SSI Medicaid Only
Hospital Inpatient Re-Pricing Adjustments (excluding Skilled Nursing Facility)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
HMO Encounter Data						
2018	1.014	0.979	1.004	0.970	0.988	1.001
FFS Data						
2018	1.028	0.970	0.985	0.989	0.981	0.991

Hospital Outpatient Re-Pricing Adjustment (Encounter and FFS Data)

Similar to hospital inpatient claims, DHS provided re-priced hospital outpatient claims, excluding hospice, based on the Medicaid fees effective January 1, 2020. Table 13 summarizes the HMO encounter hospital outpatient re-pricing adjustments for 2020 fee changes (prior to the 'other reimbursement adjustments' described below) applied to both the base HMO encounter and FFS hospital outpatient claims for the SSI Medicaid Only population.

Table 13
Wisconsin Department of Health Services
SSI Medicaid Only
Hospital Outpatient Re-Pricing Adjustments (excluding Hospice)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
HMO Encounter Data						
2018	1.044	1.077	1.056	1.077	1.097	1.041
FFS Data						
2018	0.969	1.030	0.986	1.069	1.046	1.025

Other Reimbursement Adjustments

Ambulatory Surgery Center (ASC)

The Medicaid fee schedule for ASC services changed effective January 1, 2018 and July 1, 2018. DHS repriced all ASC claims incurred between January 2017 through December 2018 at the new Medicaid rate effective July 1, 2018, and provided the percentage change between each experience period and contract period. The overall ASC reimbursement change is a 54.3% increase for 2017 and a 6.9% decrease for 2018. We applied reimbursement factors based on the proportion of ASC claims to total claims in the "Professional Outpatient Surgery" service category for the SSI Medicaid Only population.

Durable Medical Equipment (DME)

The Medicaid fee schedule for specific DME services decreased 11.1% effective January 1, 2019 and an additional 25% decrease is planned for four oxygen-related CPT codes (E0424, E0431, E0434, E0439) effective January 1, 2020. We applied reimbursement factors to the "Other Durable Medical Equipment"

service category to reflect the estimated decrease in Medicaid reimbursement for the SSI Medicaid Only population.

Hospice

The Medicaid fee schedule for hospice services changed on October 1, 2017 and October 1, 2018. DHS repriced all hospice claims incurred from January 1, 2017 through September 30, 2018 to the current rate effective October 1, 2018. DHS estimated the impact of these fee schedule changes to be an 11.8% increase for 2017 claims and a 4.4% increase for 2018 claims. We applied reimbursement factors to the hospice service category to reflect the estimated increase in Medicaid reimbursement for the SSI Medicaid Only population.

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 0.91 unit cost adjustment to HMO encounter base period IMD claims for the SSI Medicaid Only population based on the ratio of the historical average cost per day for inpatient psychiatric stays to IMD stays using 2018 encounter data re-priced to 2020.

Personal Care

The Medicaid fee schedule for personal care services (procedure codes T1019 and 99509) increased by 2% effective July 1, 2017, another 2% effective July 1, 2018, and an additional 14.41% increase will become effective January 1, 2020. We applied an increase of 17.9% for 2017 (i.e., 1.01 * 1.02 * 1.1441) and 15.6% for 2018 (i.e., 1.01 * 1.1441). We applied reimbursement factors to the "Other - Personal Care" service category for the SSI Medicaid Only and Dual Eligible populations to reflect the increase applicable to each year.

Professional Evaluation and Management

The Medicaid fee schedule for specific professional evaluation and management services will increase effective January 1, 2020 by either 33% or 6% depending on the provider type, specialty type, and procedure code. We applied reimbursement factors to the applicable detailed service categories within the broad service categories of professional and FQHC / RHC.

Private Duty Nursing

The Medicaid fee schedule for specific private duty nursing services increased between 10% and 30% on September 1, 2018. We did not apply any adjustments because the impact was immaterial due to the low volume of these services in the base period experience.

B. PROGRAM CHANGES

Benefit Changes

IMD Utilization Adjustment (Encounter Data)

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 is 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 did not need to make any IMD adjustments to the FFS base data because IMD services were not covered under FFS.

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 2020 capitation rates. Similar to the 2019 rate development, we determined the impact of this adjustment was not material, so we did not incorporate any specific adjustments into the rate development. We deemed these adjustments to be immaterial, since they round to 1.00 in most regions, as shown in Table 14.

Table 14
Wisconsin Department of Health Services
IMD Removal Impact Considered

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
SSI Medicaid Only	1.000	0.999	1.000	0.998	0.999	0.999
SSI Dual Eligible	1.000	1.000	1.000	0.997	1.000	1.000

Methadone Treatment Claim Removal

DHS will reimburse the cost of methadone treatment on a FFS basis outside the capitation rates in 2020, similar to 2018 and 2019, due to uncertainty around the base period experience as a result of claim payment issues between narcotic treatment service (NTS) providers and the HMOs. We removed the 2017 methadone treatment claims from the base period encounter data as shown in the benefit adjustment column of Exhibit 2 in the "Professional Psychiatric / Substance Abuse" service category. The 2018 methadone treatment claims were already excluded from the base period encounter data and therefore no further adjustment was necessary. We removed the 2018 methadone treatment claims from the FFS data, since these services are covered in the FFS program.

Addition of Coverage for Transgender Services

DHS added coverage for transgender services in response to a permanent injunction signed on October 31, 2019. We did not apply an explicit adjustment to the capitation rates for this additional coverage because we determined the impact of this change is expected to be immaterial.

Copay Changes

The base data used for rate setting is net of member cost sharing, even if an HMO waives the cost sharing amounts. We removed all member cost sharing from January 1, 2020 through June 30, 2020, since members will not have cost sharing during this period as DHS implements the reporting of actual member cost sharing in the encounter data. These adjustments are shown in the copay adjustment column of Exhibit 2.

C. TREND

The annual trend assumptions (excluding Medicaid reimbursement changes) are shown in Table 15. We developed the trend assumptions based on historical trends, Medicaid industry trends, and actuarial judgment.

Table 15 Wisconsin Department of Health Services Annual Trend Factors		
	SSI Medicaid Only	**SSI Dual Eligible**
Hospital Inpatient	2.0%	1.0%
Hospital Outpatient	2.0%	2.0%
Professional and Other	1.0%	1.0%
Dental	5.0%	5.0%

As part of our trend analysis, we reviewed historical trends from 2016 to 2018 in the HMO encounter data, HMO financial data (including emerging 2019 experience), and FFS data by eligibility category, region, and broad category of service. We also reviewed historical hospital inpatient and outpatient trends from 2016 to 2018 re-priced to the 2019 Medicaid fee schedule to remove the impact of annual reimbursement changes. Table 16 summarizes the historical HMO encounter utilization and case mix trends.

Table 16 Wisconsin Department of Health Services Annual 2016 to 2018 Medical Utilization and Case Mix Trends						
	SSI Medicaid Only			**SSI Dual Eligible**		
	Utilization	Case Mix[1]	Combined	Utilization	Case Mix[1]	Combined
2016 to 2017						
Hospital Inpatient	-0.3%	-2.2%	-2.6%	6.6%	n/a	n/a
Hospital Outpatient	-0.1%	2.5%	2.4%	7.2%	n/a	n/a
Professional	-1.0%	-1.0%	-2.0%	-5.2%	-1.5%	-6.7%
2017 to 2018[2]						
Hospital Inpatient	0.3%	4.9%	5.2%	0.1%	n/a	n/a
Hospital Outpatient	3.6%	6.8%	10.6%	21.6%	n/a	n/a
Professional	0.6%	-0.1%	0.5%	2.6%	0.5%	3.1%
Average 2016 to 2018						
Hospital Inpatient	0.0%	1.3%	1.3%	3.3%	n/a	n/a
Hospital Outpatient	1.7%	4.7%	6.5%	14.4%	n/a	n/a
Professional	-0.2%	-0.5%	-0.7%	-1.3%	-0.5%	-1.8%

[1] Case mix trend is the change in the PMPMs re-priced at 2019 fees after excluding the impact of utilization.
[2] 2017 to 2018 SSI Medicaid Only trends are impacted by HMO expansion. Our estimate of the combined utilization and case mix trends for the pre-expansion population is 0.0% for hospital inpatient, -1.0% for hospital outpatient, and -0.9% for professional. We were not able to normalize the historical facility claims for fee schedule changes for the Dual Eligible population.

- **Hospital Inpatient:** We assumed an annual hospital inpatient trend of 2% for SSI Medicaid Only. This assumption assumes about a 1% increase in utilization and 1% increase in case mix and is largely based on the historical hospital inpatient trends. We assumed an annual hospital inpatient utilization trend of 1% for SSI Dual Eligibles. The historical utilization trend varied from 0.1% to 6.6% from 2016 to 2018. We assumed no case mix trend, since the Medicare Part A deductible paid by Medicaid is not impacted by case mix.

- **Hospital Outpatient:** We assumed an annual hospital outpatient trend of 2% for SSI Medicaid Only, consistent with the historical 2016 to 2018 utilization trend. The higher case mix trend from 2017 to 2018 for SSI Medicaid Only was impacted by the HMO expansion during 2018. We did not

base the trends for SSI Dual Eligibles on the historical experience because changes in the mix of the types of services over time can have a material impact on utilization counts, particularly for hospital outpatient services.

- **Professional and Other:** We assumed an annual physician utilization and case mix combined trend of 1% for both populations. We do not expect the negative historical trends to continue. We also applied the professional trend to the services in the "FQHC / RHC" and "Other" broad service categories.

- **Dental:** We assumed an annual dental trend of 5% for both populations. We considered 2016 to 2018 dental trends in the HMO financial data in regions 5 and 6, as shown in Table 17. We also considered early 2019 HMO financial data to support our trend assumptions. The 2017 to 2018 trend for SSI Medicaid Only in the HMO encounter data was impacted by the HMO expansion, since members previously enrolled in FFS had lower dental costs PMPM. Consistent with the 2019 rate development, we relied entirely on the HMO financial data (rather than blending with FFS data) because we assume members have better access to dental care under HMO coverage. The SSI Dual Eligible historical trends have varied significantly between years, so we assumed the same dental trend as SSI Medicaid Only.

Table 17
Wisconsin Department of Health Services
Annual 2016 to 2018 PMPM HMO Financial Data Dental Trends

	SSI MA Only	SSI Dual Eligible
2016 to 2017	6.5%	-11.1%
2017 to 2018	-5.6%	0.6%
Average 2016 to 2018	0.4%	-5.2%

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 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 SSI provider reimbursement trend impact separately from the remainder of the claim trend. As a result, our remaining claim trend projection is expected to be generally lower than OACT's total claim trend projected in Table 18.

Table 18 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				
	Aged		Disabled	
Federal Fiscal Year	Projected Medicaid Cost per Enrollee	Annual Trend	Projected Medicaid Cost per Enrollee	Annual Trend
2016	$14,700	n/a	$19,754	n/a
2017	$14,769	0.5%	$20,048	1.5%
2018	$15,595	5.6%	$21,209	5.8%
2019	$15,991	2.5%	$21,853	3.0%
2020	$16,623	4.0%	$22,878	4.7%
Average Projected Annual Trend		**3.1%**		**3.7%**

D. BLENDING OF 2020 PROJECTED CLAIMS BY YEAR

For the Dual Eligible population, we weighted the 2020 claim projections from 2017 and 2018 experience by region based on the member month volume in each period. We only used the 2018 experience for the SSI Medicaid Only population, so we did not need to blend projections based on different experience years.

E. BLENDING EXHIBITS AND ADMINISTRATIVE COST AND RISK MARGIN ALLOWANCE

The following exhibits combine the results of the detailed claim cost projections by eligibility category, region, and delivery system (FFS and HMO encounter data). After blending, we added an administrative cost and risk margin allowance to the blended 2020 claim costs:

- Exhibit 3: Medical
- Exhibit 8: Dental
- Exhibit 13: Chiropractic

FFS / Encounter Data Blending Percentages

This section discusses the blending of FFS and encounter data (applicable when FFS data is used for rate development).

Medical Capitation Rates

The SSI Medicaid Only capitation rates are based on the combined 2018 encounter data for all members and 2018 FFS data for expansion members. This combined experience represents a full year of experience for all SSI Medicaid Only members enrolled in an HMO after expansion occurred, including the FFS claims for expansion members before managed care enrollment. The HMO expansion during 2018 resulted in about a 50% increase in SSI Medicaid Only managed care member months between 2017 and 2018. We blended the claim projections for each data source based on the 2018 member months in each data source.

Dental and Chiropractic Capitation Rates

The dental rates in Regions 1 through 4 are based on 100% FFS data, since no HMOs provide coverage for dental services in these regions. The dental rates in Regions 5 and 6 are based on 100% HMO financial data, since HMOs must provide dental coverage in Region 6 and most of Region 5. For SSI Medicaid Only in Regions 5 and 6, we assumed the expansion members will have better access to dental services once enrolled in an HMO compared to the FFS program. As a result, we set the 2020 FFS blending weight to zero and relied entirely on the projected dental claims from the HMO financial data.

The chiropractic rates are based on 100% FFS data, since only one HMO provided chiropractic coverage during the base period and, therefore, credible encounter data is not available.

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

We developed the administrative allowances in the 2020 capitation rates based on the 2017 and 2018 financial data provided by the HMOs. HMOs generally allocated their administrative expenses by eligibility category using simple methods, such as member months, claims, or revenue. As a result, we grouped HMOs by their participating eligibility categories to better estimate administrative expenses by eligibility category and projected expenses from 2018 to 2020 using a 3.1% annual trend. Table 19 summarizes the administrative cost and risk margin assumptions applied to the medical, dental, and chiropractic rates, which use the same percentages within each population. We decreased the administrative cost allowances in total by 0.5% from the 2019 capitation rates for each program and used the same risk margin allowances as the 2019 capitation rates.

Table 19
Wisconsin Department of Health Services
2020 Administrative Cost and Risk Margin Assumptions
Medical, Dental, and Chiropractic Capitation Rates

Administrative Cost Components	SSI Medicaid Only	SSI Dual Eligible
Direct Expenses	4.1%	4.8%
Indirect Expenses	3.9%	4.6%
Care Coordination	1.4%	1.6%
Licensing and Regulatory Fees	0.0%	0.0%
Sales and Marketing	0.1%	0.5%
Total Administrative Cost Allowance	**9.5%**	**11.5%**
Margin Risk Allowance	2.0%	2.0%
Administrative Cost / Risk Margin Allowance	**11.5%**	**13.5%**

The 2020 SSI 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 risk margin included in the capitation rates. Through our financial reporting template, we asked for other historical MLR qualified taxes and fee amounts (excluding the health insurer fee reimbursed outside of the capitation for applicable experience years) and did not observe any material reported amounts.

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 2020 statewide administrative allowance for medical services is $60.92 PMPM for SSI Medicaid Only and $12.81 for SSI Dual Eligibles, as shown in Exhibit 3 based on the base period demographic mix by rate cell and region.

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

F. ALLOCATION OF BASE CAPITATION RATES BY RATE CELL

The 2020 SSI MA Only and SSI Dual Eligible 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 – SSI Medicaid Only
- Exhibit 4B: Medical – SSI Dual Eligible
- Exhibit 9A: Dental – SSI Medicaid Only
- Exhibit 9B: Dental – SSI Dual Eligible
- Exhibit 14A: Chiropractic – SSI Medicaid Only
- Exhibit 14B: Chiropractic – SSI Dual Eligible

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 2020 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.

G. DENTAL UTILIZATION ADJUSTMENT

The 2020 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 variation in dental PMPM by HMO is driven by differences in the utilization of dental services and promoting access to dental care, and also by differences in dental provider networks and negotiated reimbursement. The adjustments are budget neutral across the HMOs based on July 2019 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 10 and applied in Exhibit 11.

H. POTENTIAL RETROACTIVE RATE AMENDMENT

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. If the HIF would be required for 2020, subject to any legal determinations, we will file a retroactive amendment to 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 – SSI Medicaid Only
- Exhibit 6B: Medical – SSI Dual Eligible
- Exhibit 11A: Dental – SSI Medicaid Only
- Exhibit 11B: Dental – SSI Dual Eligible
- Exhibit 19A: Final HMO-Specific Capitation Rates by Type of Coverage – SSI Medicaid Only
- Exhibit 19B: Final HMO-Specific Capitation Rates by Type of Coverage – SSI Dual Eligible

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 estimate 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 2020 SSI Medicaid Only capitation rates.

Exhibit 5A summarizes the risk score adjustments applied to the base 2020 capitation rates to calculate HMO-specific risk-adjusted 2020 SSI Medicaid Only medical capitation rates (before P4P withholds and provider access payments).

CDPS Risk Score Model Overview

The SSI Medicaid Only 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 and 2020 capitation rates.

Risk adjustment can be implemented in one of two ways:

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

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

For 2019 capitation rates, we developed prospective risk weight models for the SSI Medicaid Only population (including MAPP Medicaid Only), which used 2015 to 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. We used these same custom risk weight models for the 2020 capitation rates.

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 model calibrated to the SSI Medicaid Only population has an R-squared measure of 25%, which is comparable to typical prospective model predictive powers for comparable Medicaid populations.

Attachment B contains the model intercept and risk weights for the SSI Medicaid Only population and shows the statistical significance (p-value) and prevalence of each category.

Attachment C shows the mapping of the risk categories from the standard to the custom CDPS+Rx models. 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 5A are based on 2018 FFS claims and HMO encounter claims for HMO members from the encounter data extracts submitted to DHS by the HMOs.

Each scored individual receives a demographic relative cost weight and can have multiple disease categories assigned depending on that individual's health status. 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 2018. The recipient age and gender is calculated as of July 1, 2019 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 SSI Medicaid Only population and each HMO using capitation enrollment data provided by DHS for July 2019.

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] x [Demographic Bucket 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 and region within the SSI Medicaid Only population 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.

SSI Medicaid Only Ages 65+ rate cells are not risk adjusted due to credibility issues associated with low membership. SSI Dual Eligible capitation rates are also not risk adjusted.

Risk Adjustment Implementation Considerations

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

- 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 six 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 2019) 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 each 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.

Retrospective Risk Score Adjustment

In addition to the risk scores being budget neutral on a prospective basis (based on July 2019 enrollment), DHS will perform a risk score settlement calculation on the SSI Medicaid Only capitation rates to ensure risk scores are budget neutral on a retrospective basis based on actual 2020 enrollment by HMO.

Potential Risk Score Adjustments Based on Actual Membership

As noted above, we developed 2020 risk score adjustments for each HMO based on their July 2019 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 2018 experience) if we observe material changes in enrollment between 2019 and 2020.

B. PAY-FOR-PERFORMANCE WITHHOLDS

A pay-for-performance (P4P) withhold of 2.5% of the medical capitation payment (prior to risk adjustment and provider access payments) applies to the SSI Medicaid Only medical capitation rates. There are no P4P withholds for SSI Dual Eligible for any coverage types and no SSI Medicaid Only P4P withholds on dental or chiropractic rates.

Based on historical withhold payment data from DHS, SSI HMOs have earned back at least 71% of the P4P withhold from 2011 to 2017 in aggregate. At this time, we are aware of some potential changes to the withhold quality measures for 2020 such as focusing on fewer measures and using 1% of the 2.5% for performance improvement plans to reduce health disparities. DHS believes the HMOs can improve their performance by focusing on fewer measures, and we are not aware of any significant changes expected for the 2020 withhold payouts. Additionally, the 2% risk 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. 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 SSI Medicaid Only population. The SSI Dual Eligible population is not eligible for provider access payments.

The provider access payments will be made under a 438.6(c) preprint. The access payment preprint for the prior period is currently being reviewed by CMS, and DHS will submit the 2020 preprint to CMS for review once the prior preprint is approved. The access payments included in the 2020 capitation rates are consistent with the prior preprint submitted to CMS, and we do not anticipate any material changes between the prior and 2020 preprint. After the 2020 rating period is complete, DHS will submit documentation to CMS summarizing the total amount of access payments by rate cell, consistent with the rate certification.

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 BadgerCare Plus (BCP) and SSI programs combined are appropriated in the Wisconsin state budget on a State Fiscal Year (SFY) basis. The provider access payments are distributed based on utilization in the prior month (e.g., January 2020 payments are based on December 2019 admissions and visits).

Table 20 shows the SFY 2020 (July 2019 through June 2020) funding amounts for HMOs in total and the projections for BCP Standard versus SSI Medicaid Only.

Table 20
Wisconsin Department of Health Services
Projected 2020 Provider Access Payment Funding

	BCP Standard	SSI Medicaid Only	Total
Inpatient acute and rehabilitation	$226,460,063	$39,663,301	$266,123,364
Outpatient acute and rehabilitation	$180,790,955	$36,946,343	$217,737,298
Inpatient critical access	$3,712,670	$300,602	$4,013,272
Outpatient critical access	$2,920,908	$362,678	$3,283,586

We do not anticipate the provider access payments to the HMOs will change from the amounts included in the 2020 capitation rates. To the extent the actual access payments do change, we will file a rate amendment to reflect these changes.

We allocated the funding amounts to BCP Standard versus SSI Medicaid Only and then by HMO based on the total projected mix of 2020 admissions (inpatient access payments) or visits (outpatient access payments) based on the base period 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 2020 capitation rates.

The methodology used to calculate the 2020 provider access rate adjustments is summarized in the following steps:

1. **Summarize Historical Utilization**: We summarized the total HMO encounter base period 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. We used the lists of National Provider Identification (NPI) codes for facilities eligible for each type of provider access payment provided by DHS. All hospitals in the state qualify for access payments with the exception of psychiatric hospitals.

2. **Project 2020 Utilization Mix**: We projected the mix of utilization PMPM by HMO, eligibility category, region, and rate cell to 2020.

   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 converted the adjusted utilization PMPM to total utilization counts based on the projected 2020 member months by rate cell (based on July 2019 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 2020 member months.

   The provider access payment add-ons are calculated for each HMO with credible membership. New HMOs, if applicable, will receive the average regional PMPM adjustment. Exhibit 18A summarizes the 2020 provider access payments PMPM. Exhibits 18B through 18E show the adjusted utilization, July 2019 membership, and projected 2020 provider access payment dollars by HMO and region for each type of provider access payment.

Exhibit 19 shows the final 2020 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

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. DHS will submit 438.6(c) preprints to CMS for 2020 provider access payments, dental services, and sub-acute psychiatric community-based psychiatric and recovery center services.

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 2020 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 20: Overall FMAP capitation rates
- Exhibit 21: FMAP capitation rates for SSI Medicaid Only rate cells (preventive services)
- Exhibit 22A: FMAP capitation rates for SSI Medicaid Only rate cells (family planning services)
- Exhibit 22B: FMAP capitation rates for SSI Dual Eligible rate cells (family planning services)
- Exhibit 23A: FMAP capitation rates for SSI Medicaid Only rate cells (IHS)
- Exhibit 23B: FMAP capitation rates for SSI Dual Eligible rate cells (IHS)

A. SERVICES ELIGIBLE FOR ENHANCED FMAP

Appendix D includes a summary of the criteria DHS used to identify services eligible for enhanced FMAP in the base data. We assigned the categories in the hierarchical order of IHS, family planning, and preventive so no services are double counted. The preventive services enhanced FMAP does not apply to the SSI Dual Eligible population.

B. METHODOLOGY USED TO DEVELOP FMAP PORTION OF CAPITATION PAYMENTS

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

- **Project 2020 claim costs**:
  - Preventive Services: The projected 2020 medical cost PMPM for zero copay preventive services is developed in Exhibit 2
  - Family Planning Services: The projected 2020 medical cost PMPM for family planning services is developed in Exhibit 2
  - IHS: The projected 2020 medical cost PMPM for IHS services is developed in Exhibit 2

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 2020.

- **Add administrative cost and margin allowance**: The administrative cost and margin allowance is added to the projected claim costs in Exhibit 20. 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 is summarized in Section III.E.

- **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 21 (preventive services), Exhibit 22 (family planning), and Exhibit 23 (IHS). This methodology is described in detail in Section III.F.

- **Apply P4P withholds:** The SSI Medicaid Only P4P withhold of 2.5% is applied to the capitation rates by rate cell in Exhibit 21 (preventive services), Exhibit 22 (family planning), and Exhibit 23 (IHS). This step does not apply to the SSI Dual Eligible capitation rates since these payments are not subject to the P4P withhold.

VI. CMS RATE SETTING CHECKLIST

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 15 through 17 show the expected rate change from the 2019 to 2020 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 2020 capitation rates in this report are the initial rates for the contract period.

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

AA.1.6 – LIMIT ON PAYMENT TO OTHER PROVIDERS

It is our understanding no payment is made to a provider other than the 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.E 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 SSI Medicaid managed care program, including Medicare crossover benefits, and IMD (with adjustments) and "Sub-Acute Psychiatric Community-Based Psychiatric and Recovery Center Services" 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 SSI 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 in lieu of services mentioned in item AA.2.0. Please see Section III.B. for details regarding benefit changes.

AA.3.2 – ADMINISTRATIVE COST ALLOWANCE CALCULATIONS

The administrative cost allowances are discussed in Section III.E of this report and summarized in Table 19.

AA.3.3 – SPECIAL POPULATION ADJUSTMENTS

The base data used to calculate the capitation rates is consistent with the managed care population. This includes FFS base period experience for SSI Medicaid Only members who enrolled in an HMO during the 2018 expansion. 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. Any TPL recovered outside of the encounter data (e.g., subrogation) is included in the "Payments Made Outside Encounter Data" row of Exhibits 1 and 2.

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

Please refer to Section III.B of this report for details regarding copay adjustments applied in the capitation rate development.

AA.3.11 – MEDICAL COST TREND INFLATION

Please refer to Sections III.A and III.C of this report.

AA.3.12 – UTILIZATION ADJUSTMENTS

Please refer to Sections III.B, III.C, and III.G 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. During 2018, DHS required SSI Medicaid Only members to enroll in managed care unless they met specific exemption criteria.

The base utilization and cost data for the capitation rates includes HMO encounter data, HMO financial data, and FFS data. The FFS data has managed care savings factors applied. The blending of the data sources is discussed in Sections III.D and 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 only one HMO was 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 SSI 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 2017 and 2018 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.

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 SSI Medicaid Only medical capitation rates are risk adjusted using an actuarially sound CDPS + Rx methodology. The SSI Dual Eligible rates will not be risk adjusted. 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 for the Dual Eligible population 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 8 (dental), and Exhibit 13 (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 9 (dental), and Exhibit 14 (chiropractic).

AA.5.1 – COST-NEUTRAL DATA SMOOTHING ADJUSTMENT

Exhibit 4 (medical), Exhibit 9 (dental), and Exhibit 14 (chiropractic) demonstrate the rate cell factors are cost neutral in each individual region. Please see Section III.F 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 SSI Medicaid Only medical capitation rates are risk adjusted using an actuarially sound CDPS + Rx methodology. The SSI Dual Eligible rates will not be risk adjusted. 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

None.

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

DHS has not implemented HMO incentive payments related to EHRs for the 2020 contract period.

VII. RESPONSES TO 2019 - 2020 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, 2020 through December 31, 2020.
- Actuarial rate certification – See Appendix E.
- Final capitation rates – Please refer to Exhibit 6 (medical capitation rates), Exhibit 11 (dental capitation rates), and Exhibit 14 (chiropractic capitation rates) for the final capitation rates. Exhibit 19 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.
- MLR – The projected SSI MLR for 2020 is greater than 85%. There is no minimum MLR or remittance provision in place for the SSI program.
- 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 15 to 17.
- 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 2016 and 2017 to calendar years 2017 and 2018.
- 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 Sections III.D and III.E.

- Data reliance – Please refer to the actuarial certification included as Appendix A for the data reliance letter provided by DHS.

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:

  a. 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 2020 capitation rates and determined the impact was not material. We removed Narcotic Treatment Services from the 2017 base period experience because DHS will reimburse HMOs for these claim on a FFS basis outside of capitation in 2020 (similar to 2018 and 2019). Adjustments were also applied to reflect member cost sharing changes during 2020.

- Projected benefit cost trends:

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

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

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

- In-lieu-of services – See Section II.B.

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

- 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.

- Overpayments to providers – we collected information on HMO recoveries for overpayments to providers and considered these payments when summarizing the base data used to develop 2020 capitation rates. The base period data is net of these recoveries, which totaled $14.6 million collected in 2018 across the BCP and SSI programs.

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

- Other adjustments – See Section II.D for a description of the managed care savings factors applied to the FFS data.

- Final projected benefit costs – See Exhibit 3 (medical capitation rates), Exhibit 8 (dental capitation rates), and Exhibit 13 (chiropractic capitation rates).

- Conditions of any litigation to which the state is subjected – DHS settled a lawsuit related to transgender services, which added new coverage to the BCP program. We did not make an explicit adjustment for this coverage change because we determined the impact to be immaterial as described in Section III.B. Please also see Section III.H. regarding the Health Insurer Provider Fee.

4. Special Contract Provisions Related to Payment

- Incentive Arrangements – Not applicable.

- Withhold Arrangements – See Section IV.B.

- Risk Sharing – Not applicable.

- Delivery System and Provider Payment Initiatives – See Section IV.C.

  - DHS submitted the following pre-prints for 2019 state directed payments and plans to submit the same pre-prints for 2020 once the 2019 pre-prints are approved by CMS:

    - Provider access payments: Uniform dollar or percentage increase. See funding amounts in Section IV.C.

    - Dental fee schedule: Minimum fee schedule based on the state's FFS Medicaid fee schedule.

    - Sub-acute psychiatric community-based psychiatric and recovery center services: Maximum fee schedule of $450 per day.

  a. These arrangements are incorporated into the base capitation rates.

  b. Provider access payments are the only directed payment included as a separate adjustment in the capitation rates.

     - All SSI Medicaid Only rates cells are impacted by these payments. These payments do not apply to the SSI Dual Eligible population.

     - Refer to Section IV.C for a description of the data, assumptions, and methodologies.

     - The payment is consistent with the 2019 pre-print information, except for updated funding amounts. DHS will submit the 2020 pre-print after the 2019 pre-print is approved by CMS.

- 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.E.
- Health Insurer Fee treatment – See Section III.H.

6. Risk Adjustment and Acuity Adjustments

- Risk adjustment – See Section IV.A and Exhibits 5 and 6.
- Acuity adjustments – Not applicable.

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

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

SECTION III. NEW ADULT POPULATION CAPITATION RATES

This section is not applicable. There was no SSI Medicaid expansion due to the Affordable Care Act.

2020 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 2020 capitation rates for the SSI Medicaid managed care 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, 2020 through December 31, 2020
SSI Medicaid Managed Care Programs

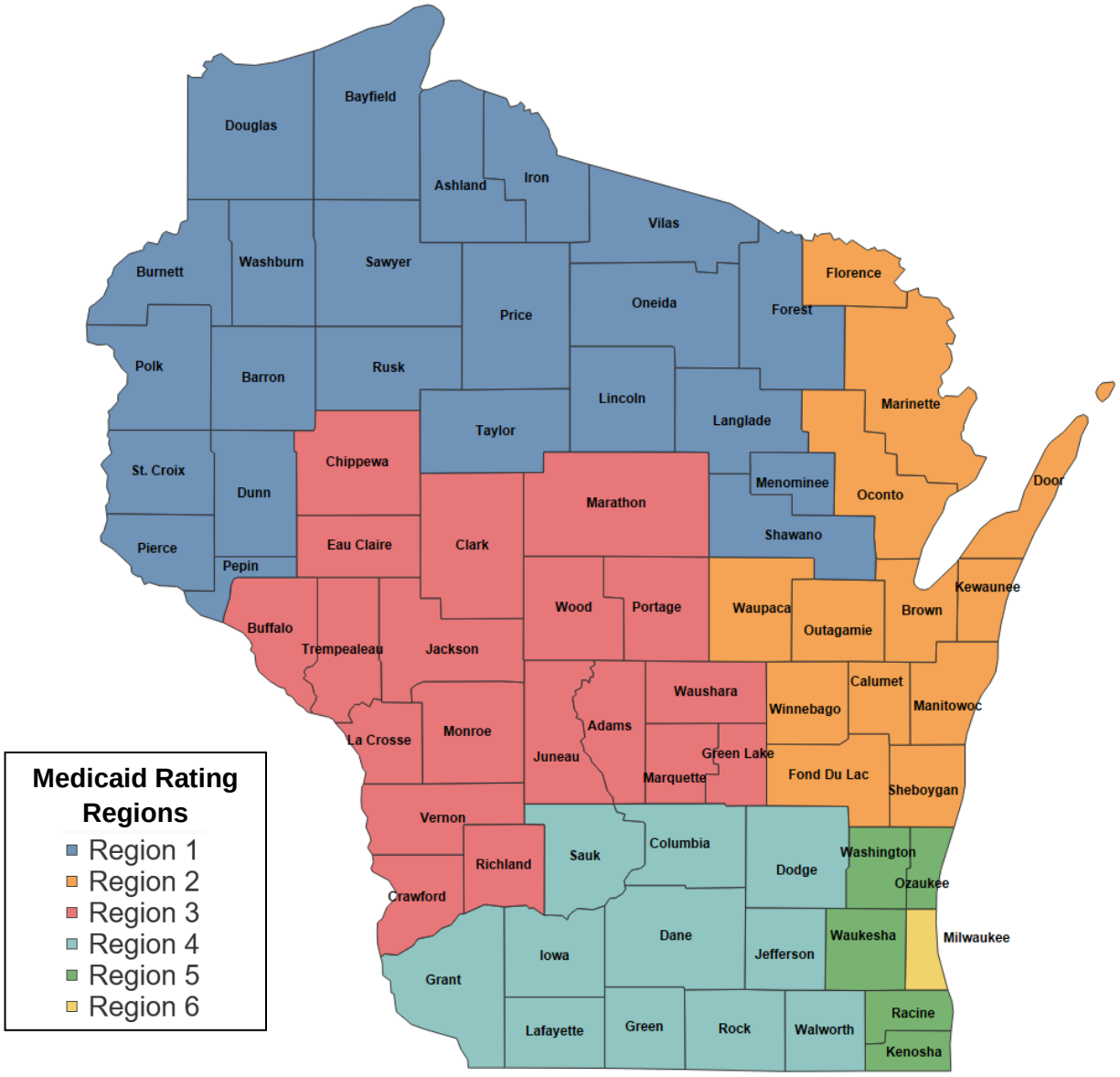
December 20, 2019

APPENDIX A

Mapping of Wisconsin Counties to Medicaid Rate Regions

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2020 through December 31, 2020
SSI Medicaid Managed Care Programs

December 20, 2019



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 2020 capitation rates for the SSI Medicaid managed care 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.

APPENDIX B

Custom Risk Model Weights

(Provided in Excel Format)

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2020 through December 31, 2020
SSI Medicaid Managed Care Programs

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APPENDIX C

Custom Risk Model Category Mapping

(Provided in Excel Format)

Wisconsin Department of Health Services
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APPENDIX D

Enhanced FMAP Identification Criteria

Wisconsin Department of Health Services
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APPENDIX D
ENHANCED FMAP IDENTIFICATION CRITERIA

We identified the family planning, Indian Health Services (IHS), and preventive services eligible for enhanced FMAP using FMAP indicators in the encounter data.

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
87490	5047	N/A
87491	5047	N/A
87492	5047	N/A

APPENDIX D
ENHANCED FMAP IDENTIFICATION CRITERIA

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
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
90733	5047	N/A

APPENDIX D
ENHANCED FMAP IDENTIFICATION CRITERIA

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
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

APPENDIX D
ENHANCED FMAP IDENTIFICATION CRITERIA

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
G0141	5047	N/A
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

APPENDIX D
ENHANCED FMAP IDENTIFICATION CRITERIA

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
45339	5048	33
45340	5048	33
45341	5048	33
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

APPENDIX D
ENHANCED FMAP IDENTIFICATION CRITERIA

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
80061	5048	33
80422	5048	33
82270	5048	33
82274	5048	33
82465	5048	33
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

APPENDIX D
ENHANCED FMAP IDENTIFICATION CRITERIA

Wisconsin Department of Health Services Procedure Codes Used to Identify Enhanced Match Zero Copay Preventive Claims		
Procedure Code	**Procedure Group Type**	**Procedure Code Modifier**
87390	5048	33
87534	5048	33
87535	5048	33
87536	5048	33
87590	5048	33
87591	5048	33
87592	5048	33
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 2020 capitation rates for the SSI Medicaid managed care 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, 2020 through December 31, 2020
SSI Medicaid Managed Care Programs

December 20, 2019

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Principal and Consulting Actuary

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December 20, 2019

Wisconsin Department of Health Services
SSI Medicaid Managed Care Programs
January – December 2020 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 SSI Medicaid managed care program capitation rates for January through December 2020 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 2019 - 2020 Medicaid Managed Care Rate Development Guide, and Actuarial Standard of Practice (ASOP) 49.

To the best of my information, knowledge, and belief, the 2020 SSI capitation rates offered by DHS are in compliance with the relevant requirements of § CFR 438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7.

The attached actuarial report describes the capitation rate setting methodology.

In my opinion, the capitation rates are actuarially sound, as defined in 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 Brandel

Shelly S. Brandel
Member, American Academy of Actuaries

December 20, 2019

Tony Evers
Governor

Andrea Palm
Secretary

DIVISION OF MEDICAID SERVICES

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State of Wisconsin
Department of Health Services

December 19, 2019

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

RE: January 1, 2020 through December 31, 2020 Wisconsin Medicaid BadgerCare Plus and Supplemental Security Income (SSI) Managed Care Rate Development Data Reliance Letter

Dear Shelly:

I, Benjamin Nerad, Director of the Bureau of Rate Setting 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 2020 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 2020 capitation rate development, including:
    a. Fee-for-service claim data
    b. HMO encounter data
    c. Eligibility data
    d. Hospital inpatient and outpatient facility 2020 re-pricing data
2. Other supporting data, including:
    a. Monthly identification of ventilator-dependent members
    b. HMO financial data
    c. 2020 provider access payment funding amounts
    d. Historical performance withhold payments
    e. Information regarding program changes effective prior to December 31, 2020 including fee schedule changes
    f. Details regarding the scope of HMO covered services and eligible recipients
    g. Identification of claims eligible for enhanced federal match
    h. Other computer files and clarifying correspondence

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

Signature

Benjamin Nerad
Print Name

Director, Bureau of Rate Setting
Title

12/19/19
Date