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November 24, 2020

Mr. Benjamin Nerad
Bureau of Rate Setting
Division of Medicaid Services
Wisconsin Department of Health Services
One West Wilson Street
PO Box 309
Madison, WI 53701-0309

[Sent via email: benjamin.nerad@dhs.wisconsin.gov]

Re: January 1, 2021 through December 31, 2021 Rate Report – BadgerCare Plus Program

Dear Ben:

Thank you for the opportunity to assist the Wisconsin Department of Health Services (DHS) with this important project. The attached report summarizes the development of the January 1, 2021 through December 31, 2021 (CY 2021) capitation rates for the BadgerCare Plus program.

❖ ❖ ❖ ❖ ❖

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

Sincerely,

Shelly Brandel

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

SSB/mb

Attachments (Provided in Excel)

MILLIMAN CLIENT REPORT

State of Wisconsin

Department of Health Services

Calendar Year 2021 Capitation Rate Development

BadgerCare Plus Standard and Childless Adult Programs

November 24, 2020

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EXHIBITS (PROVIDED IN EXCEL)

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2021 through December 31, 2021
BadgerCare Plus Standard And Childless Adult Programs

November 24, 2020

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APPENDICES

I. EXECUTIVE SUMMARY

This report documents the development of capitation rates effective January 1, 2021 through December 31, 2021 for Wisconsin's BadgerCare Plus (BCP) Standard and Childless Adult (CLA) programs.

The Wisconsin Department of Health Services (DHS) retained Milliman, Inc. (Milliman) to calculate, document, and certify its 2021 BCP capitation rates. Milliman's role is to calculate and certify actuarially sound capitation rates to comply with Centers for Medicare and Medicaid Services (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); ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP 56 (Modeling)

- 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 2021 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 2021 and 2020 per member per month (PMPM) medical, dental, and chiropractic capitation rates and maternity kick payments 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 2020 to Calendar Year 2021
BadgerCare Plus Standard

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Medical Capitation Rates							
2021 Capitation Rate	$144.90	$114.51	$123.65	$121.11	$124.84	$128.70	$125.37
2020 Capitation Rate	$146.18	$115.32	$120.45	$121.44	$124.54	$129.88	$125.54
Rate Change	-0.9%	-0.7%	2.7%	-0.3%	0.2%	-0.9%	-0.1%
Maternity Kick Payments							
2021 Kick Payment	$8,460.16	$5,434.91	$6,486.26	$6,489.98	$6,172.19	$6,556.22	$6,475.94
2020 Kick Payment	$8,386.11	$5,537.31	$6,477.62	$6,392.32	$6,128.95	$6,801.63	$6,548.15
Kick Payment Change	0.9%	-1.8%	0.1%	1.5%	0.7%	-3.6%	-1.1%
Dental Capitation Rates							
2021 Capitation Rate[2]	n/a	n/a	n/a	n/a	$12.95	$11.39	$11.84
2020 Capitation Rate[2]	n/a	n/a	n/a	n/a	$13.46	$12.15	$12.53
Rate Change	n/a	n/a	n/a	n/a	-3.9%	-6.3%	-5.5%
Chiropractic Capitation Rates							
2021 Capitation Rate	$2.99	$2.35	$3.13	$1.95	$1.13	$0.35	$1.73
2020 Capitation Rate	$2.94	$2.27	$3.17	$1.93	$1.13	$0.34	$1.71
Rate Change	1.7%	3.5%	-1.3%	1.0%	0.0%	2.9%	1.2%

[1]Statewide changes in medical and dental capitation rates are based on July 2020 enrollment; statewide changes in maternity kick payments are based on deliveries by region from November 2018 through October 2019.
[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 2020 to Calendar Year 2021
BadgerCare Plus Childless Adults

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Medical Capitation Rates							
2021 Capitation Rate	$372.49	$321.16	$325.21	$308.16	$323.78	$294.25	$315.43
2020 Capitation Rate	$355.66	$307.11	$314.69	$296.47	$313.73	$303.01	$310.14
Rate Change	4.7%	4.6%	3.3%	3.9%	3.2%	-2.9%	1.7%
Dental Capitation Rates							
2021 Capitation Rate[2]	n/a	n/a	n/a	n/a	$9.39	$8.42	$8.68
2020 Capitation Rate[2]	n/a	n/a	n/a	n/a	$10.24	$9.52	$9.71
Rate Change	n/a	n/a	n/a	n/a	-8.3%	-11.6%	-10.6%
Chiropractic Capitation Rates							
2021 Capitation Rate	$2.84	$3.01	$3.26	$2.50	$1.60	$0.69	$1.98
2020 Capitation Rate	$3.03	$3.08	$3.43	$2.55	$1.66	$0.67	$2.04
Rate Change	-6.3%	-2.3%	-5.0%	-2.0%	-3.6%	3.0%	-2.9%

[1]Statewide changes in medical and dental capitation rates are based on July 2020 enrollment.
[2]Dental capitation rates for Regions 1 to 4 are not applicable since no HMOs cover dental services in these regions.

Exhibits 17 through 19 contain more detailed comparisons summarizing the rate changes for all coverage types (medical only, medical / dental, medical / chiropractic, and medical / dental / chiropractic) separately for each Health Maintenance Organization (HMO) based on July 2020 enrollment. Exhibit 21 shows the final 2021 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 2020 to 2021.

Table 2
Wisconsin Department of Health Services
High Level Summary of Medical Capitation Rate Changes between 2020 and 2021

Rate Component	BCP Standard	BCP Childless Adults
Updated base period encounter data	1.3%	0.4%
Reimbursement change between base period and rating period	-1.0%	0.9%
Trend and other projection factor changes	-0.5%	-0.4%
Impact of rate cell mix on prior rates	0.1%	0.7%
Total rate change	**-0.1%**	**1.7%**

The capitation rate changes by region for medical / maternity kick payment services differ from the composite changes due to differences in the impact of updating the base period data (including the mix of services), facility reimbursement adjustments by region, and rate cell mix. For dental services, the rate decreases are driven by lower trend projection factors as well as lower updated base data. For chiropractic services, rate decreases for Childless Adults are driven by updated base experience and lower trend projection factors.

B. CAPITATION RATE CELL STRUCTURE

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

Eligibility Categories

Managed care enrollment for eligible BCP Standard and BCP CLA members is mandatory with a few exceptions (e.g., tribal members). We developed capitation rates for the following eligibility categories:

- **BCP Standard:**
  - Parents and caretakers with incomes at or below 100 percent of the Federal Poverty Limit (FPL)
  - Pregnant women with incomes at or below 300 percent of the FPL
  - Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL
  - Transitional medical assistance individuals, also known as members on extensions, with incomes over 100 percent of the FPL
- **BCP Childless Adults:** The CLA program covers childless adults with incomes less than or equal to 100 percent of the FPL. Prior to April 1, 2014, the CLA program provided Medicaid services to childless adults with income at or below 200 percent of the FPL, but enrollment was capped. Effective April 1, 2014, the enrollment cap was removed, individuals with incomes above 100 percent of the FPL were disenrolled, and the CLA benefits were aligned with the BCP Standard plan. The currently covered CLA population began enrollment into managed care on July 1, 2014.

Rate Regions

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

- Region 1 – North
- Region 2 – North East
- Region 3 – West Central

- Region 4 – Madison
- Region 5 – South East
- Region 6 – Milwaukee

Appendix A contains a mapping of Wisconsin counties to the six rate regions for the 2021 capitation rates.

Rate Cells

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

Table 3
Wisconsin Department of Health Services
Age Rate Cells by Eligibility Category

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

Covered Services

HMOs are responsible for providing comprehensive health care to BCP members, including hospital inpatient, hospital outpatient, professional, and other services. Prescription drugs are carved out of the capitation rates. Maternity services are paid through a maternity kick payment paid per delivery within the BCP Standard plan. Dental and chiropractic capitation rates are developed separately. Dental coverage is optional in Regions 1 through 4 and mandatory in Regions 5 and 6. Chiropractic coverage is optional in all regions. We describe exclusions applied to the HMO encounter data in Section II.B. We remove Institution for Mental Disease (IMD) claims for stays greater than 15 days in a given month and the member months and non-IMD related claims for these members during these months, as described in Section III.B.

Encounter-based payments paid on a fee-for-service (FFS) basis outside of the capitation rates, including the Dental Pilot, 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 BCP program has been in operation since 2008, when the BadgerCare and Children's Health Insurance Program (CHIP) programs were merged. DHS held contracts with 15 Health Maintenance Organizations (HMOs) to provide services to BCP members during the experience period. The following changes occurred between the experience and rating period:

- Effective October 1, 2018, Gundersen Health Plan (Gundersen), Unity Health Insurance (Unity), and Physicians Plus Insurance Corporation (PPlus) integrated under the Quartz brand name. Consistent with the 2020 rate development, we combined all three HMOs under the Quartz brand name.

- Effective January 1, 2020, My Choice Family Care, Inc. and Care Wisconsin merged into My Choice Wisconsin. Later in 2021, this new name will also apply to Trilogy Health Insurance, Inc. (Trilogy), which was also part of the merger. Trilogy and Care Wisconsin participated in the BCP and Supplemental Security Income (SSI) programs, respectively, during the experience period. We reflect the combined entity as CWHP-THI in this rate report.

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

The risk adjustment process adjusts the capitation rates for estimated differences in acuity by HMO, with some exceptions, such as newborns and HMOs with low credibility in a rate cell.

Material Changes to Rate Methodology

The 2021 capitation rate methodology is generally consistent with the 2020 rate methodology. We made the following material changes to the 2021 rate methodology:

- Risk corridor – At this time, there is substantial uncertainty regarding the impact of the COVID-19 pandemic on future costs, including whether the pandemic will increase or decrease costs in 2021. Costs associated with preventing and treating COVID-19, as well as testing for viral infection and / or presence of COVID-19 antibodies, may exert upward pressure on overall medical costs in 2021. There may also be increases in claims due to the releasing of pent-up demand from services deferred in 2020, if any such deferral is significant, further contributing to that upward pressure. However, there may also be decreases to future claims due to stay-at-home orders, efforts to expand hospital capacity to serve COVID-19 patients, and general care avoidance if the pandemic is still ongoing. We have chosen not to make an explicit adjustment to the 2021 capitation rates for the impact of the pandemic.

  For 2021, the BCP and SSI programs will have a two-way risk corridor program to control the risk associated with the significant uncertainty related to the ongoing COVID-19 pandemic. This program, described in Section IV.E. of this report, allows DHS and each HMO to share in the financial risk of the program. The extent to which each party shares in the risk is determined by each HMO's realized loss ratio (LR) for the BCP and SSI programs combined after the conclusion of the rate year.

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 2021 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, delivery system and provider payment initiatives, and risk corridor
- Section V documents the projected costs for services eligible for enhanced federal funding (applies to medical capitation rates and maternity kick payments)
- Section VI provides responses to the CMS rate setting checklist
- Section VII provides responses to the 2020 – 2021 CMS Medicaid Managed Care Rate Development Guide

Exhibits 1 through 26 summarize the 2021 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. DATA RELIANCE AND IMPORTANT CAVEATS

This report is intended for the internal use of DHS for the purpose of developing 2021 capitation rates for the BadgerCare Plus program. It may not be appropriate, and should not be used, for other purposes. This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of DHS. We recognize that materials we deliver to DHS may be public records subject to disclosure to third parties; however, we do not intend to benefit, and assume 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.

In order to provide the information requested by DHS, we developed certain models to estimate the values included in this report. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs). The models, including all input, calculations, and output may not be appropriate for any other purpose.

The models rely on data and information as input to the models. 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 reporting, FFS data, hospital inpatient and outpatient 2021 re-pricing data, and other supporting information from DHS. We have not audited this data and other information. If the data used is inadequate or incomplete, the results will be likewise inadequate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable, or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

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 due to many different factors, including the impact of the COVID-19 pandemic.

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, 2020.

II. BASE DATA DEVELOPMENT

This section of the report describes the base data development and various data sources described in this report. In general, the base data used to calculate the 2021 capitation rates reflects the most current credible available data from DHS and the HMOs.

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

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

A. BASE DATA SOURCES

The data sources used in the 2021 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 Medicaid 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 2018, CY 2019, and YTD March 2020 financial incurred data to DHS. The financial data included the following information by eligibility category, region, and calendar year:

   - Member months and maternity deliveries eligible for kick payments
   - Total revenue including capitation payments, maternity kick payments, and other sources
   - Claim payments to providers, including FFS claim payments, payments made to sub-capitated providers, provider risk sharing and incentive payments, and other payments made outside the FFS claims system 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 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.

DHS and Milliman went through an extensive data validation process to review all HMO data included in the 2021 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 2021 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 2018 and CY 2019	May 2020[1]
HMO Financial Data	CY 2018 and CY 2019	April 2020
HMO Emerging 2020 Financial Data	YTD March 2020	June 2020
FFS Data	CY 2018 and CY 2019	May 2020

[1]*Encounter data files received from DHS on June 4, 2020; 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, Gainwell, 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 2017 through May 2020. As noted above, we used 2018 and 2019 encounter data to develop the base period costs. We summarized the 2018 and 2019 encounter data using the methodology described in the following sections.

We identified the submitting HMO based on the HMO ID field and the eligibility category based on the Medical Status code in the encounter data files using the mapping provided by DHS.

Excluded Claims

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

1. **Claims incurred outside of 2018 and 2019** – We excluded claims for services provided outside of the period January 1, 2018 through December 31, 2019.

2. **Financial Indicator "N" claims** – We excluded claims with a Financial Indicator of "N," which were flagged by DHS as not eligible for rate development.

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

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

5. **Physician administered drugs** – We excluded claims for physician administered drugs based on criteria provided by DHS, since these professional claims are reimbursed on a FFS basis by DHS.

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

7. **Chiropractic claims** – We excluded chiropractic claims from the HMO encounter data used for rate development and used chiropractic claims covered under the FFS program, since only 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 re-priced Medicaid paid amounts after the adjustments described above represent the encounter data used to develop the medical and maternity base period experience. We developed separate capitation rates for medical coverage, maternity kick payments, dental services, and chiropractic services. Any included claims not identified as maternity, dental, or chiropractic services were classified as medical coverage.

Maternity (BCP Standard Only)

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

We identified deliveries as encounters with APR-DRGs equal to 540, 541, 542, or 560 during the base period based on APR-DRG version 36. In 2021, we understand deliveries will be identified with the APR-DRG version 37 codes of 539, 540, 541, 542, or 560. APR-DRG 540 under version 36 (Cesarean Delivery) was split into the two separate codes in version 37 of APR-DRG 539 (Cesarean Section with Sterilization) and APR-DRG 540 (Cesarean Section without Sterilization). The DRG code for a delivery will trigger the maternity kick payment when an HMO has a paid amount greater than $0 on the claim (i.e., other insurance is not covering the entire cost of the delivery).

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

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

We included maternity claims for completed pregnancies in the base period experience by limiting delivery dates to the time period from November 2018 through October 2019. We excluded experience for other BCP Standard pregnancies meeting the maternity kick payment criteria, but outside of this time period. Because the maternity kick payment is developed and paid per delivery, the projected number of deliveries is not needed to develop the maternity kick payment amount, so we excluded “non-completed” pregnancies to develop a complete cost per delivery.

Dental

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

Chiropractic

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

Medical "Payments Made Outside Encounter Data"

We summarized "Payments Made Outside Encounter Data" from the HMO financial data by eligibility category and region to reflect provider risk sharing, incentives, and other miscellaneous provider payments made outside of the encounter data. These amounts are added to the base period experience and shown at the bottom of Exhibit 1. These payments are reported separately in the HMO financial data and were not included in the missing data adjustments discussed in Section D below.

In Lieu of Services

The BCP program 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. This benefit is cost effective, since its reimbursement of $450 per diem is much lower than the BCP inpatient psychiatric cost per day.

The BCP 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 remaining detailed service categories.

C. FFS DATA PROCESSING METHODOLOGY

We used FFS data for HMO members to develop capitation rates for dental services in Regions 1 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 category criteria above) for members enrolled in HMOs during the base period.

D. ADJUSTMENTS TO THE BASE DATA

This section discusses the adjustments we made to the base 2018 and 2019 data before projecting costs to the 2021 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 2019 encounter data.

Table 5 summarizes the medical missing data adjustments by eligibility category, region, and calendar year. As noted above, we calculated missing data adjustments at the HMO level. Therefore, the 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 generally been decreasing over the past several years, indicating increasing completeness of the encounter data submissions.

Table 5
Wisconsin Department of Health Services
Missing Data Adjustments Applied to HMO Encounter Data (Medical Services)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
BadgerCare Plus Standard						
2018	1.011	1.021	1.011	1.017	1.009	1.007
2019	1.013	1.023	1.014	1.031	1.020	1.020
Childless Adults						
2018	1.011	1.019	1.011	1.017	1.014	1.013
2019	1.014	1.024	1.015	1.029	1.023	1.022

Maternity claims are assumed to be complete in the encounter data since we identify completed pregnancies directly in the encounter data. Dental missing data adjustments are not applicable, since we used the HMO dental financial data to summarize the base period experience for regions 5 and 6 and FFS data as the base period experience for regions 1 through 4. Chiropractic missing data adjustments are also not applicable because we used FFS data.

Completion Factor (Encounter and FFS Data)

We applied completion factors to the encounter data in the May 2020 extracts to account for incurred but not reported (IBNR) claims as of the claim submission date. 2018 claims are assumed to be complete, since there are approximately 17 months of claims runout.

Similar to the 2020 rate development, we applied the following adjustment to the 2019 completion factors:

- 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 2019 encounter data based on historical patterns of ventilator recoupments by incurred and rate development years. We applied these additive adjustments to 2019 hospital inpatient claims in the encounter base data.

Table 6 summarizes the completion factors applied to the base 2019 claims before and after we apply the ventilator recoupment adjustments.

Table 6
Wisconsin Department of Health Services
2019 Completion Factors

	Hospital Inpatient				
	Before Ventilator Recoupment Adjustment	Ventilator Recoupment Adjustment	After Ventilator Recoupment Adjustment	Other Medical	Dental and Chiropractic
BCP Standard	1.022	-0.034	0.988	1.006	1.002
BCP Childless Adults	1.023	-0.016	1.007	1.004	1.002

We calculated the completion factors using primarily the HMO financial data with adjustments for outliers, and reviewed the completion factors implied by the encounter and FFS data for reasonableness.

We assumed 2018 encounter and FFS data are complete, but we applied the following adjustment to reflect claims incurred in 2018 not reflected in the base data:

- 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. Therefore, 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 2019 re-priced Medicaid paid to billed amounts in the May 2020 HMO encounter and FFS data extracts.

Table 7
Wisconsin Department of Health Services
2018 New Marshfield Clinic Hospital Adjustments (Medical Services)

	Region 1	Region 3
Hospital Inpatient	0.007	0.013
Hospital Outpatient	0.001	0.003

Provider Contracting Adjustment (Encounter Data)

The base encounter data reflects the re-priced Medicaid paid amounts assigned by DHS to each encounter. We compared the total HMO paid amounts to the re-priced Medicaid paid amounts by broad service category and region to develop provider contracting adjustments that reflect average HMO contracting levels relative to Medicaid fees across the two years of base period experience data. Regions 5 and 6 include counties around the Milwaukee area, where some providers require higher reimbursement to participate in the Medicaid program. Table 8 summarizes the provider contracting adjustments applied to the re-priced Medicaid paid amounts in the encounter data.

Table 8
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

III. PROJECTED 2021 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 2021 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 2021 claim costs:

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

A. REIMBURSEMENT CHANGES

Generally, 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 experience consistent with projected Medicaid fee schedule changes. We are not aware of any other material anticipated fee changes other than the items mentioned in this section.

Hospital Inpatient Re-Pricing Adjustment

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, 2021. We used this data to calculate the impact of reimbursement changes on the historical 2018 and 2019 hospital inpatient claims by eligibility category, year, and region. Table 9 summarizes the hospital inpatient re-pricing adjustments for 2021 fee changes (prior to the "other reimbursement adjustments" described below) applied to the base encounter hospital inpatient claims.

Table 9
Wisconsin Department of Health Services
Hospital Inpatient Re-Pricing Adjustments (Excluding Skilled Nursing Facility)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
BadgerCare Plus Standard						
Medical – 2018	1.154	1.125	1.204	1.111	1.164	1.154
Medical – 2019	1.133	1.118	1.112	1.039	1.126	1.147
Maternity[1]	0.990	0.995	1.003	0.980	0.998	0.999
BadgerCare Plus Childless Adults						
Medical – 2018	1.031	1.025	1.068	1.011	1.057	1.052
Medical – 2019	1.062	1.010	1.065	0.973	1.032	1.020

[1] *Maternity reflects the base period of deliveries during November 2018 through October 2019.*

Hospital Outpatient Re-Pricing Adjustment

Similar to hospital inpatient claims, DHS provided re-priced hospital outpatient claims, excluding hospice, based on the Medicaid fees effective January 1, 2021. Table 10 summarizes the hospital outpatient re-pricing adjustments for 2021 fee changes (prior to the "other reimbursement adjustments" described below) applied to the base encounter hospital outpatient claims.

Table 10
Wisconsin Department of Health Services
Hospital Outpatient Re-Pricing Adjustments (excluding Hospice)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
BadgerCare Plus Standard						
Medical – 2018	1.103	1.128	1.102	1.167	1.110	1.086
Medical – 2019	1.051	1.084	1.085	1.085	1.076	1.076
Maternity[1]	1.061	1.075	1.073	1.101	1.069	1.087
BadgerCare Plus Childless Adults						
Medical – 2018	1.081	1.107	1.096	1.130	1.103	1.086
Medical – 2019	1.051	1.097	1.069	1.082	1.079	1.074

** Maternity reflects the base period of deliveries during November 2018 through October 2019.*

Other Reimbursement Adjustments

Ambulatory Surgery Center (ASC)

The Medicaid fee schedule for ASC services changed effective July 1, 2018. DHS re-priced all ASC claims incurred during 2018 at the new Medicaid rate effective July 1, 2018 and calculated a 6.9% decrease between 2018 and 2021. We applied reimbursement factors based on the proportion of ASC claims to total claims in the "Professional Outpatient Surgery" service category.

Durable Medical Equipment (DME)

The Medicaid fee schedule for specific DME services decreased 11.1% effective January 1, 2019. Four oxygen-related CPT codes (E0424, E0431, E0434, E0439) decreased 25% effective January 1, 2020 and will decrease another 25% effective January 1, 2021. We applied reimbursement factors to the "Other Durable Medical Equipment" service category to reflect the estimated decrease in Medicaid reimbursement.

Hospice

The Medicaid fee schedule for hospice services changed on October 1, 2018 and October 1, 2019. DHS re-priced all hospice claims incurred from January 1, 2018 through September 30, 2019 to the current rate effective October 1, 2019. DHS estimated the impact of these fee schedule changes to be a 13.0% increase for 2018 claims and a 13.7% increase for 2019 claims. We applied reimbursement factors to the Hospice service category to reflect the estimated increase in Medicaid reimbursement.

IMD

CMS requires IMD experience included in the capitation rate development to be based on the unit costs for State plan services. To be consistent with this requirement, we applied a 0.88 unit cost adjustment to HMO encounter base period IMD claims based on the ratio of the historical average cost per day for inpatient psychiatric and substance abuse stays to IMD stays using 2019 encounter data re-priced to 2021.

Personal Care

The Medicaid fee schedule for personal care services (procedure codes T1019 and 99509) increased by 2% effective July 1, 2018, and an additional 14.4% effective January 1, 2020. DHS re-priced all personal care claims incurred during 2018 to the current rate effective January 1, 2020. DHS estimated the impact of these fee schedule changes to be a 15.2% increase for 2018 claims. We applied reimbursement factors to the “Other - Personal Care“ service category to reflect the increase applicable to each year.

Professional Evaluation and Management

The Medicaid fee schedule for specific professional evaluation and management services increased effective January 1, 2020 by either 33% or 6% depending on the provider type, specialty type, and procedure code. We applied reimbursement adjustments to the applicable detailed service categories within the broad service categories of professional and FQHC / RHC. We understand the industry is making some structural changes to these codes in 2021, which could potentially impact future costs. We did not make any adjustments because the potential impact of the changes are not known, including whether the changes may increase or decrease costs.

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.

Electroencephalography (EEG) monitoring

The Medicaid fee schedule includes new CPT codes for EEG monitoring effective January 1, 2020 to bill only the technical component compared to current codes to bill only the professional component or the combined technical and professional components. We did not apply any adjustments because the impact is anticipated to be immaterial due to the low volume of total EEG services in the base period experience.

Skilled Nursing Facility

The Medicaid fee schedule for skilled nursing facility services increased 2.2% effective July 1, 2020. We did not apply any adjustments because the impact is anticipated to be immaterial due to the low volume of these services in the base period experience.

B. PROGRAM CHANGES

Benefit Changes

IMD Utilization Adjustment

IMD services are routinely provided by HMOs in lieu of inpatient psychiatric admissions. Consistent with CMS rate setting requirements, we adjusted the HMO encounter base period utilization to exclude IMD stays of more than 15 days within a given month. For example, if a member was in an IMD for 20 days in one month, we excluded all 20 days for that month. These adjustments are shown in the benefit adjustment column of Exhibit 2 in the ”Hospital Inpatient IMD” service category.

We also applied minor adjustments at the service category level to reflect the impact of removing the member months and non-IMD claims for members with over 15 days in an IMD for a given month. The composite impact of these adjustments rounded to 1.000 in each eligibility category and region for medical and maternity coverage.

Removal of Synagis Administration

DHS removed the coverage of administering the Synagis drug effective October 1, 2020 identified by the CPT code 90378. We applied benefit adjustments in the "Professional Other" and "FQHC / RHC Other" service categories in Exhibit 2 for the BCP Standard program, with a composite medical impact across all services of less than 0.1% in all eligibility categories and regions.

Addition of Coverage for Telehealth Services

New telehealth services were added during 2020 for physician-to-physician consultations and remote monitoring. We assume these services will offset reductions in in-person visits and related services. As a result, we did not apply an explicit adjustment to reflect the new telehealth services.

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 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 applied adjustments for the following member cost sharing changes:

- BCP Standard: Removed member copays for the following specific child subset for the entire rate year:
  - Continuously eligible newborns with incomes over 150% FPL (medical status codes 7W and 9H)
  - Children under age 1 with incomes over 150% FPL (medical status codes 7N, 9F, and 9G)
  - Children in the separate CHIP program (medical status codes BG, C3, 9K, 9L, and 9Z)
  - Children in the Medicaid-Expansion CHIP program (medical status code 99)
- BCP CLA: Added member copays for non-emergent visits to the emergency room in for the entire rate year. We assumed 25% of emergency room visits would be considered non-emergency related based on Exhibit 3 of the article https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5754025/.

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 11. We developed the trend assumptions based on historical trends, Medicaid industry trends, and actuarial judgment.

Table 11
Wisconsin Department of Health Services
Annual Trend Factors Assumed

	BCP Standard	BCP Childless Adults
Hospital Inpatient	0%	1%
Hospital Outpatient	3%	3%
Professional and Other	1%	0%
Dental	4%	2%

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

As part of our trend analysis, we reviewed historical trends from 2017 to 2019 in the HMO encounter and financial data by eligibility category, region, and broad category of service, removing the impact of facility and professional reimbursement changes over this period. Table 12 summarizes the historical HMO encounter utilization and case mix trends excluding the impact of reimbursement changes.

Table 12
Wisconsin Department of Health Services
Historical Annual 2017 to 2019 Medical Utilization and Case Mix Trends

	BCP Standard			BCP Childless Adults		
	Utilization	Case Mix[1]	Combined	Utilization	Case Mix[1]	Combined
2017 to 2018						
Hospital Inpatient	-1.8%	0.3%	-1.5%	-2.0%	2.5%	0.5%
Hospital Outpatient	1.3%	1.1%	2.5%	2.1%	4.0%	6.2%
Professional	1.9%	-0.7%	1.2%	1.6%	-1.8%	-0.2%
2018 to 2019						
Hospital Inpatient	0.2%	-3.2%	-2.9%	-1.9%	3.8%	1.8%
Hospital Outpatient	6.9%	-0.3%	6.6%	2.7%	2.1%	4.8%
Professional	2.3%	-0.2%	2.1%	2.3%	-1.6%	0.7%
Average 2017 to 2019						
Hospital Inpatient	-0.8%	-1.4%	-2.2%	-2.0%	3.2%	1.1%
Hospital Outpatient	4.1%	0.4%	4.5%	2.4%	3.0%	5.5%
Professional	2.1%	-0.4%	1.7%	1.9%	-1.7%	0.2%

[1] *Case mix trend is the change in the PMPM re-priced at 2020 fees after excluding the impact of utilization change.*

- **Hospital Inpatient:** We assumed an annual hospital inpatient trend of 0% for BCP Standard and 1% BCP CLA. The BCP Standard utilization and case mix combined trends were negative over the 2-year period from 2017 to 2019, and we do not expect the negative trend to continue. The BCP CLA utilization and case mix combined annual trend from 2017 to 2019 was about 1%, consistent with our assumption for the 2021 capitation rates.

- **Hospital Outpatient:** We assumed an annual hospital outpatient trend of 3% for BCP Standard and BCP CLA. The historical BCP Standard trends have been slightly higher than 3% but we expect future trends to be closer to the results observed in the BCP CLA experience.

- **Professional and Other:** We assumed an annual physician trend of 1% for BCP Standard and 0% for BCP CLA. This assumption is based mainly on the historical physician utilization and case mix combined trends from 2017 to 2019 shown in Table 12. 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 4% for BCP Standard and 2% for BCP CLA. We considered 2017 to 2019 dental trends for HMO financial data in regions 5 and 6, as shown in Table 13. We assumed higher trends than experienced from 2017 to 2019 due to continued efforts to improve member access to dental services.

Table 13
Wisconsin Department of Health Services
Annual 2017 to 2019 PMPM HMO Financial Data Dental Trends

	BCP Standard	BCP Childless Adults
2017 to 2018	1.3%	-3.7%
2018 to 2019	3.8%	-3.4%
Average 2017 to 2019	2.6%	-3.6%

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 *2018 Actuarial Report on the Financial Outlook for Medicaid*. The projected trends in this report are lower on average than the results in the prior year's OACT report. We projected the BCP provider reimbursement trends 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 14, which includes reimbursement changes.

Table 14
Wisconsin Department of Health Services
Summary of Projected National Medicaid Benefit Annual Expenditures per Enrollee
Table 22 of the 2018 Actuarial Report on the Financial Outlook for Medicaid
Published by the CMS Office of the Actuary

	Children		Adults*	
Federal Fiscal Year	**Projected Medicaid Cost per Enrollee**	**Annual Trend**	**Projected Medicaid Cost per Enrollee**	**Annual Trend**
2017	$3,836	n/a	$5,616	n/a
2018	$3,911	2.0%	$5,482	-2.4%
2019	$4,052	3.6%	$5,664	3.3%
2020	$4,238	4.6%	$5,918	4.5%
2021	$4,442	4.8%	$6,198	4.7%
Average Projected Annual Trend		**3.7%**		**2.5%**

**Adults exclude aged and disabled.*

D. BLENDING OF 2021 PROJECTED CLAIMS BY YEAR

For all eligibility categories and regions, we weighted the 2021 claim projections from 2018 and 2019 experience based on the member month volume in each period.

E. ADMINISTRATIVE COST AND RISK MARGIN ALLOWANCE

The following exhibits add the administrative cost and risk margin allowance to the projected 2021 claim costs by eligibility category and region:

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

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

We developed the administrative allowances in the 2021 capitation rates based on the 2018 and 2019 financial data provided by the HMOs. HMOs generally allocated their administrative costs 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 costs by eligibility category and projected costs from the combined 2018 and 2019 experience to 2021 using a 1.6% annual trend. Table 15 summarizes the administrative cost and risk margin assumptions applied to the medical, dental, and chiropractic rates.

Table 15
Wisconsin Department of Health Services
2021 Administrative Cost and Risk Margin Assumptions
Medical, Dental, and Chiropractic Capitation Rates

Administrative Cost Components	BCP Standard	BCP Childless Adults
Direct Costs	6.7%	5.4%
Indirect Costs	6.3%	4.9%
Care Coordination	1.9%	1.5%
Licensing and Regulatory Fees	0.1%	0.0%
Sales and Marketing	0.5%	0.2%
Total Administrative Cost Allowance	**15.5%**	**12.0%**
Risk Margin Allowance	2.0%	2.0%
Administrative Cost / Risk Margin Allowance	**17.5%**	**14.0%**

We also considered the following two additional items affecting administrative costs, which we project to offset each other during 2021:

- Increased costs due to CMS interoperability rule: We assumed an increase of about $0.70 PMPM based on the new interoperability requirements assuming the CMS primary estimate of about $1.58 million per HMO, an allocation of 30% Medicaid, and projected 2021 member months (based on annualized July 2020 membership). CMS guidance on the interoperability rule can be found in https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index.

- Reduced fixed costs due to higher membership: We assumed a reduction in fixed costs PMPM of about $0.70 PMPM based on assuming 50% of reported indirect costs are related to fixed costs that will not vary with membership changes and a member month growth of about 16% from 2019 to 2021.

Table 16 summarizes the historical 2018 and 2019 administrative costs PMPM submitted by the HMOs and projected 2021 administrative costs PMPM used in the development of the administrative allowances for the BCP and SSI programs combined across all coverages.

Table 16
Wisconsin Department of Health Services
Administrative Cost PMPM
BCP and SSI Programs Combined

2018 HMO Financial Data	$24.04
2019 HMO Financial Data	$26.46
Average 2018 and 2019 HMO Financial Data	$25.25
Projected 2021	$26.30

The 2021 BCP capitation rates exclude any provision for federal or state income taxes or state premium taxes, since HMOs are expected to pay any of these applicable taxes out of the risk margin included in the capitation rates. We reviewed historical MLR qualified taxes and fee amounts (excluding the health insurer fee reimbursed outside of the capitation for applicable experience years and taxes) in the HMO financial reporting 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 2021 statewide administrative allowance for medical services is $20.15 PMPM for BCP Standard and $38.74 PMPM for CLA 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.

Administrative Cost / Risk Margin Allowance for Maternity Kick Payments

We applied an administrative cost allowance of 5% and risk margin allowance of 2% for the maternity kick payments. The 2021 statewide administrative cost allowance for maternity kick payments is about $324 per delivery or about $29 PMPM assuming there are 11 months of eligibility per delivery (including two months post-delivery).

We do not have actual administrative costs for maternity kick payments because the HMOs do not track administrative costs specific to maternity services. However, we included the administrative costs for maternity kick payments in our aggregate administrative cost projection to ensure we did not over-project administrative costs by including administrative costs in the maternity kick payments.

F. ALLOCATION OF BASE CAPITATION RATES BY RATE CELL

The 2021 base capitation rates are allocated by rate cell using the cost relativities among age bands based on statewide data. The regional rates by eligibility category are based on region specific total costs, but the relationships between age bands were standardized to statewide relativities.

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

- Exhibit 4A: Medical – BCP Standard
- Exhibit 4B: Medical – BCP CLA
- Exhibit 11A: Dental – BCP Standard
- Exhibit 11B: Dental – BCP CLA
- Exhibit 15A: Chiropractic – BCP Standard
- Exhibit 15B: Chiropractic – BCP CLA

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

- **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.

- **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 for rate development.

- **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 2021 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 costs 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 2020 membership and reflect 50% of the difference between each HMO's dental claims PMPM relative to the average cost for HMOs included in the adjustment calculation. The adjustments are shown in Exhibit 12 and applied in Exhibit 13. We increased the HMO specific dental utilization adjustment from 25% in the 2020 capitation rates to 50% in the 2021 capitation rates because large dental cost variations between HMOs continue to exist and appear to be relatively consistent over time based on our analysis of the base data. As a result, the HMOs who provide higher access to dental services will receive more capitation relative to other HMOs in the 2021 rates compared to the 2020 rates.

Similar to risk adjustment, the base dental capitation rates are based on aggregate experience, and we apply budget neutral adjustments to the final rates to reflect the relative dental utilization of each HMO, as measured by the base period claims experience, compared to the projected member months. We selected a 50% credibility weight such that the rates are appropriately adjusted to reflect higher / lower capitation rates associated with higher / lower base period dental utilization, but the credibility weight is lower than 100% since the base period claims experience is not a perfect measure of the future relativity of dental utilization by HMO.

H. POTENTIAL RETROACTIVE RATE AMENDMENTS

We do not anticipate any future retroactive rate amendments to be applied to the 2021 capitation rates.

IV. FINAL HMO-SPECIFIC CAPITATION RATES

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

These adjustments are summarized in the following exhibits:

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

A. RISK SCORE ADJUSTMENTS

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

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

Risk adjustment models 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 2021 BCP Standard and CLA capitation rates.

Exhibit 5 summarizes the risk score adjustments applied to the base 2021 capitation rates to calculate HMO-specific risk-adjusted 2021 BCP medical capitation rates (before P4P withholds and provider access payments).

CDPS Risk Score Model Overview

The BCP risk adjustment process uses the Chronic Illness and Disability Payment System plus Prescription Drug (CDPS+Rx) model structure developed by The University of California – San Diego (UCSD). UCSD developed three models, as described below.

- CDPS is a diagnostic classification system that Medicaid programs can use to make health-based capitated payments for TANF and disabled Medicaid beneficiaries. CDPS uses ICD-10 diagnostic codes to assess risk and assigns each member to one or more of 58 possible medical condition categories from 19 major diagnostic categories. Each member is also assigned to one of 11 age / gender categories. All of the 19 major diagnostic categories are "hierarchic" categories in that only the single most severe diagnostic category within the major category is counted. Single counting within major categories is intended to avoid encouraging a proliferation of different diagnoses reported for a single disease process just to increase payment.

- MRX is a pharmacy based risk adjustment model that may be used to adjust capitated payments to capitated plans that enroll Medicaid beneficiaries. The MRX model assigns each member to one or more of 45 medical

condition categories based on the prescription drugs used by each member and to one of 11 age / gender categories.

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

CDPS, MRX, and CDPS+Rx are widely used in the Medicaid industry because they are designed specifically for the Medicaid population. We used the structure of version 6.4 for the 2021 capitation rates.

In addition to the standard CDPS+Rx condition categories, we added two new types of variables to the 2021 risk weight model: variables to account for the member duration within the assessment period for scored members with less than a full year of enrollment, and a variable to indicate member homelessness, as detailed below:

- The duration categories reflect the potential under-reporting of diagnostic categories for scored members with fewer than 12 months of enrollment. These members would on average accrue additional NDCs and diagnoses with a full 12 months of enrollment, so the duration categories compensate for any missing conditions.

- The homelessness variable is determined by a member receiving the "Z59.0" ICD-10 code during the assessment period. The prevalence of homelessness is likely understated in the data. However, our analysis shows that homeless individuals are associated with higher claims cost in all programs. Therefore, we believe it is appropriate to include this variable in the risk score weights.

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 2021 capitation rates, we developed separate prospective risk weight models for the BCP Standard and CLA populations, which used 2017 to 2018 diagnoses to predict 2018 to 2019 costs. These custom risk weight models, which we will refer to as the "custom prospective models," reflect Wisconsin's specific covered benefits, eligibility rules, provider reimbursement, and practice patterns.

R-squared measures the variability in a data set accounted for by the statistical model. R-squared values for regression models vary from 0% to 100%, with 100% indicating a model that explains all the variation in a particular data set. The custom prospective regression models calibrated to the BCP Standard and BCP CLA populations have R-squared measures of 13.0% and 14.8%, respectively, which is comparable to typical prospective model predictive powers for comparable Medicaid populations.

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

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

Risk Adjustment Methodology and Data

The risk scores shown in Exhibit 5 are based on 2019 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, a duration cost weight based on the months of enrollment, and disease or homelessness categories depending on that individual's claim records.

- We used version 6.4 of the CDPS+Rx model to assign individuals to a demographic category and disease categories based on their diagnostic information and pharmacy utilization during 2019.
- We excluded diagnostic codes from laboratory, radiology, DME, and medical supplies claims to avoid including false positive diagnostic indicators for tests run on individuals and equipment and supplies used.
- The recipient age and gender is calculated as of July 1, 2020, and is used for demographic classification.
- Similar to the diagnostic conditions, homelessness is indicated by an HMO encounter or FFS medical claim diagnoses in the assessment period – specifically the "Z59.0" ICD-10 code - but is not a standard CDPS+Rx variable.
- The duration variables indicate the number of unique enrollment months a member had in the assessment period across any managed care HMO or FFS coverage.

For each member, the weights for all disease categories assigned are combined with their demographic, duration, and homelessness information and the model intercept to calculate a total individual risk score under the custom prospective model. Scored members are assigned to the BCP Standard and CLA populations and to each HMO using capitation enrollment data provided by DHS for July 2020.

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 for a member with two diagnostic conditions is provided below:

(Model Intercept
+ [Scored Member Months in Demographic Bucket] x [Demographic Bucket Risk Weight]
+ [Scored Member Months in Duration Bucket] x [Duration Bucket Risk Weight]
+ [Scored Member Months with Homelessness] x [Homelessness Risk Weight]
+ [Scored Member Months with Condition #1] x [Condition #1 Risk Weight]
+ [Scored Member Months with Condition #2] x [Condition #2 Risk Weight])
/ [Total HMO Scored Member Months]
= [Unnormalized Risk Score]

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

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

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

Risk Adjustment Implementation Considerations

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

- Membership threshold for scoring a member – Risk adjustment methods typically use 12 months of historical data to assess risk. For members with less than 12 months of eligibility in that historical period, a determination is needed as to how to handle their risk assessment. We used a minimum of 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 2020) member months.

- Credibility adjustments – Risk scores developed for small populations may not be credible due to the inherent variability of risk scores. For HMOs with fewer than 50 scored members in a given rate cell within a given combination of region and eligibility category, the normalized HMO risk score was set to 1.000 since the risk score result is not considered to be a credible measure of estimated future morbidity.

- HMOs with large enrollment growth or a lower percentage of scored members – Two HMOs (Trilogy and Independent Care) have a lower percentage of BCP Standard scored members than other HMOs. Therefore, we assigned partial (50%) credibility to the calculated BCP Standard normalized risk scores for these HMOs.

Retrospective Risk Score Adjustment

In addition to the risk scores being budget neutral on a prospective basis (based on July 2020 enrollment), DHS will perform a risk score settlement calculation to ensure risk scores are budget neutral on a retrospective basis based on actual 2021 enrollment by HMO.

Potential Risk Score Adjustments Based on Actual Membership

As noted above, we developed 2021 risk score adjustments for each HMO based on their July 2020 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 2019 experience) if we observe material changes in enrollment between 2020 and 2021.

B. PAY-FOR-PERFORMANCE (P4P) WITHHOLDS

A P4P withhold of 2.5% of the entire medical capitation payment (prior to risk adjustment and provider access payments) applies to BCP Standard for the entire 2021 rate year. There are no P4P withholds for BCP CLA for any coverage types and no BCP Standard P4P withholds on the maternity kick payment, dental, or chiropractic rates. The purpose of the withhold is to incentivize HMOs to meet or exceed performance targets and achieve HMO specific performance improvement plans.

Based on historical withhold payment data from DHS, BCP HMOs have earned back at least 74% of the P4P withhold from 2011 to 2019 in aggregate. We understand DHS will potentially increase the proportion of the withhold criteria attributed to each HMO's specific performance improvement plan, which is anticipated to result in the same or higher future withhold returns. We are not aware of any significant changes expected for the 2021 withhold returns, and, therefore, we believe the P4P withholds are reasonably achievable by the HMOs during the 2021 contract period.

C. QUALITY INCENTIVE PAYMENTS

DHS implemented a potentially preventable re-admissions (PPR) incentive payment program in 2018. The maximum incentive payment to any HMO may not be more than 5% of their capitation rate consistent with Medicaid managed care regulations. The HMOs earned about $2.2 million in 2018 and 3.7 million in 2019 of the $9 million potential incentive for each year, which represented less than 0.3% of total BCP capitation payments. HMOs are required to share 85% of their earned incentive with providers. There are no PPR incentives paid to providers in the base experience used for rate development.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

Provider Access Payments

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

The provider access payments will be made under a 438.6(c) preprint for 2021 that DHS submitted to CMS (but is not yet approved) and the arrangement is consistent with this 2021 rate certification. After the 2021 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 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 2021 payments are based on admissions and visits for claims paid in December 2020).

Table 17 shows the SFY 2021 (July 2020 through June 2021) funding amounts for HMOs in total and the projections for BCP Standard versus SSI Medicaid Only.

Table 17
Wisconsin Department of Health Services
Projected 2021 Provider Access Payment Funding

	BCP Standard	SSI Medicaid Only	Total
Inpatient acute and rehabilitation	$229,858,839	$36,264,525	$266,123,364
Outpatient acute and rehabilitation	$185,652,531	$32,084,767	$217,737,298
Inpatient critical access	$3,586,214	$223,453	$3,809,667
Outpatient critical access	$2,801,970	$315,030	$3,117,000

We do not anticipate the provider access payments to the HMOs will change from the amounts included in the 2021 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 2021 admissions (inpatient access payments) or visits (outpatient access payments) based on the base period experience, adjusted to reflect the impact of missing data. We then calculated a fixed PMPM amount for each HMO by program to add to the 2021 capitation rates.

The methodology used to calculate the 2021 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 2021 Utilization Mix**: We projected the mix of utilization PMPM by HMO, eligibility category, region, and rate cell to 2021.

   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 for that rate cell with missing data adjustment across all HMOs.

   We converted the adjusted utilization PMPM to total utilization counts based on the projected 2021 member months by rate cell (based on annualized July 2020 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 2021 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 20A summarizes the 2021 provider access payments PMPM. Exhibits 20B through 20E show the adjusted utilization, July 2020 membership, and projected 2021 provider access payment dollars by HMO and region for each type of provider access payment.

Exhibit 21 shows the final 2021 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 submitted 438.6(c) preprints to CMS for 2021 provider access payments, dental services, and sub-acute psychiatric community-based psychiatric and recovery center services, and these preprints are not yet approved. These 2021 preprint arrangements are consistent with this 2021 rate certification and also consistent with the prior 2020 preprint arrangements approved by CMS.

E. RISK MITIGATION (RISK CORRIDOR)

The BCP and SSI programs will have a combined two-way risk corridor mechanism for 2021 to mitigate the significant uncertainty outside of HMO control related to the ongoing COVID-19 pandemic. The risk corridor will address variances in the ratio of claim costs divided by capitation (before P4P withholds are applied) and maternity kick payments. We will calculate a composite target loss ratio (LR) for each HMO at the end of the year using the pricing LRs by eligibility

category and coverage type shown in Table 18 weighted by the mix of each HMO's actual capitation and maternity kick payments by rate cell.

Table 18
Wisconsin Department of Health Services
Combined BCP and SSI Programs
2021Target Loss Ratios

	Pricing Loss Ratio	
	Medical, Dental, and Chiropractic	**Maternity**
BCP Standard	82.5%	93.0%
BCP Childless Adults	86.0%	n/a
SSI Medicaid Only	88.5%	n/a
SSI Dual Eligibles	86.5%	n/a

DHS and each HMO will share the marginal financial risk of actual results above or below the LR target as shown in Table 19.

Table 19
Wisconsin Department of Health Services
Risk Corridor for the Combined BCP and SSI Programs

	Gain / Loss in Corridor	
Variance from Target LR	**HMO Share**	**DHS Share**
< -6.0%	0%	100%
-6.0% to -2.0%	50%	50%
-2.0% to +2.0%	100%	0%
+2.0% to +6.0%	50%	50%
> 6.0%	0%	100%

The risk corridor settlement will occur after the 2021 contract period has ended and enough time has passed to collect and validate 2021 experience. We anticipate performing an initial settlement using 2021 contract year HMO financial reporting data with four months of claim runout and a final settlement using data with sixteen months of claim runout.

Only benefit costs for covered services, as applicable and defined in the contract and this report, will be included in the numerator of the LR calculation for the risk corridor program. All capitation revenue including maternity kick payments, gross of P4P and net of provider access payments, will be included in the denominator of the LR calculation.

Consistent with contract expectations, DHS expects reimbursement made for covered services should be at market-based levels and should incent efficient and high quality care. As such, DHS reserves the right to review encounter data and other information associated with such payments and adjust the risk corridor calculation as necessary to reflect those expectations.

Any payment or recoupment amount from the risk corridor will be included in the denominator of the federal medical loss ratio (MLR) for purposes of submitting CY 2021 MLR calculations to CMS.

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 2021 capitation rates for services eligible for enhanced FMAP. There are no services eligible for enhanced FMAP in the dental or chiropractic capitation rates.

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

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

A. SERVICES ELIGIBLE FOR ENHANCED FMAP

Appendix D includes a summary of the criteria 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.

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

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

- **Project 2021 claim costs**:

  - Preventive Services: The projected 2021 medical cost PMPM for zero copay preventive services is developed in Exhibit 2 (medical capitation rates). We did not identify any zero copay preventive services in the maternity kick payment base experience.

  - Family Planning Services: The projected 2021 medical cost PMPM for family planning services is developed in Exhibit 2 (medical capitation rates) and Exhibit 7 (maternity kick payments).

  - IHS: The projected 2021 medical cost PMPM for IHS services is developed in Exhibit 2 (medical capitation rates) and Exhibit 7 (maternity kick payments).

  Please refer to Section II for a discussion of the base period data and adjustments and Section III for the assumptions used to project the base period experience to 2021.

- **Add administrative cost and margin allowance**: The administrative cost and margin allowance is added to the projected claim costs in Exhibit 22 (medical capitation rates) and Exhibit 26 (maternity kick payments). The administrative cost and margin allowance added to the services eligible for enhanced FMAP is the same as the allowance added to the total medical capitation rate and maternity kick payments and is summarized in Section III.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 23 (preventive services), Exhibit 24 (family planning), and Exhibit 25 (IHS). This methodology is described in detail in Section III.F. This step does not apply for the maternity kick payments since these payments do not vary by rate cell.

- **Apply P4P withholds:** The BCP Standard P4P withhold of 2.5% is applied to the capitation rates by rate cell in Exhibit 23 (preventive services), Exhibit 24 (family planning), and Exhibit 25 (IHS). This step does not apply to the BCP CLA capitation rates or the BCP Standard maternity kick payments 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 17 through 19 show the expected rate change from the 2020 to 2021 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 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 BCP Medicaid managed care program 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 BCP HMO has been excluded from the base data. The payment rates provided under the contract are for Medicaid-eligible individuals only.

AA.2.2 – DATA SOURCES

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

AA.3.0 – ADJUSTMENTS TO BASE YEAR DATA

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

AA.3.1 – BENEFIT DIFFERENCES

The base data used to calculate the capitation rates only includes services covered under the managed care contract and the 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 15.

AA.3.3 – SPECIAL POPULATION ADJUSTMENTS

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

AA.3.4 – ELIGIBILITY ADJUSTMENTS

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

AA.3.5 – THIRD PARTY LIABILITY (TPL)

The HMOs are responsible for the collection of any TPL recoveries. As such, the HMO encounter data already includes the impact of TPL recoveries. 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. Managed care enrollment is mandatory for BCP. The base utilization and cost data for the capitation rates includes HMO encounter data, HMO financial data, and FFS data. The blending of each claim projection by base period year is discussed in Section III.D.

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 BCP program excludes members and services subject to this type of patient liability.

AA.3.15 – INCOMPLETE DATA ADJUSTMENT

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

AA.3.16 – PRIMARY CARE RATE ENHANCEMENT

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

AA.5.0 – DATA SMOOTHING

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

- The methodology uses two years of base data to smooth random fluctuation that occurs on a year-to-year basis.
- Capitation rates are first set by eligibility category and region in Exhibit 3 (medical), Exhibit 10 (dental), and Exhibit 15 (chiropractic). Statewide cost relationships are then used to develop statewide rate cell factors within each eligibility category, which are applied on a cost-neutral basis to convert the region capitation rates into capitation rates by rate cell and region in Exhibit 4 (medical), Exhibit 11 (dental), and Exhibit 16 (chiropractic).

AA.5.1 – COST-NEUTRAL DATA SMOOTHING ADJUSTMENT

Exhibit 4 (medical), Exhibit 11 (dental), and Exhibit 16 (chiropractic) demonstrate the rate cell factors are cost neutral in each individual region. Please see Section III.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 BCP Standard and CLA medical capitation rates are risk adjusted using an actuarially sound CDPS + Rx methodology. Please refer to Section IV.A for a description of the risk adjustment methodology.

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

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

AA.6.1 – COMMERCIAL REINSURANCE

DHS does not require entities to purchase commercial reinsurance.

AA.6.2 – SIMPLE STOP LOSS PROGRAM

None.

AA.6.3 – RISK CORRIDOR PROGRAM

The 2021 rates will include a two-way risk corridor as described in Section IV.E.

AA.7.0 – INCENTIVE ARRANGEMENTS

DHS has an incentive arrangement for 2021 as described in Section IV.C. The HMO contract does not permit the incentive payment for any HMO to be more than 5% of their capitation rate.

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

DHS has not implemented HMO incentive payments related to EHRs for the 2021 contract period.

VII. RESPONSES TO 2020 THROUGH 2021 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, 2021 through December 31, 2021.
- Actuarial rate certification – See Appendix E.
- Final capitation rates – Please refer to Exhibit 6 (medical capitation rates), Exhibit 8 (maternity kick payments), Exhibit 13 (dental capitation rates), and Exhibit 16 (chiropractic capitation rates) for the final capitation rates. Exhibit 21 summarizes the final capitation rates for each coverage option (Medical only, Medical and Dental, Medical and Chiropractic, or All Services).
- Rate ranges – Not applicable.
- Program descriptions – See Section I.B.
- MLR – The projected BCP MLR for 2021 is greater than 85%. There is no minimum MLR or remittance provision in place for the BCP 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 17 to 19.
- Material changes to capitation rate methodology – See Section I.C.

2. Data

- Service data sources – See Sections II.A through II.C.
- Validation and quality adjustments – See Section II.D.
- Changes in data sources – Base period HMO encounter and financial data was updated from calendar years 2017 and 2018 to calendar years 2018 and 2019.
- Potential future data improvements – As described in Section II.D, we applied missing data adjustments to the encounter data. DHS anticipates missing data adjustments will continue to decrease going forward as encounter data improves over time.
- Other data adjustments – See Section II.D.
- Blending of data sources – See Section III.D.
- 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:
  - 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, along with the member months and non-IMD claims for these members. Adjustments were also applied to remove coverage for Synagis administration and to reflect member cost sharing changes.
- 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 2021 capitation rates. The base period data is net of these recoveries, with a total of $13.9 million collected in 2019 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 – Not applicable.
- Final projected benefit costs – See Exhibit 3 (medical capitation rates), Exhibit 8 (maternity kick payments), Exhibit 10 (dental capitation rates), and Exhibit 15 (chiropractic capitation rates).
- Conditions of any litigation to which the state is subjected – 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.
- We estimate the aggregate cost impact of program changes deemed immaterial to be less than 0.1% of capitation.

4. Special Contract Provisions Related to Payment

- Incentive Arrangements – See Section IV.C
- Withhold Arrangements – See Section IV.B
- Risk Sharing – See Section IV.E
- Delivery System and Provider Payment Initiatives – See Section IV.D

  – DHS submitted the following preprints for 2021 state directed payments similar to the arrangements for the 2020 preprints:

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

    These arrangements are incorporated into the base capitation rates.

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

    - All BCP Standard rates cells are impacted by these payments. These payments do not apply to BCP CLA.
    - The BCP Standard provider access payment PMPM is shown in Column C of Exhibit 20A. The amounts vary by each HMO but are the same for each provider access payment type across all regions and rate cells. Any new HMOs would receive the PMPM amounts in the New HMOs section at the bottom of this exhibit by region. The HMO impact of the provider access payment by region and rate cell is the difference between Exhibit 21A and Exhibit 17A.
    - Refer to Section IV.D for a description of the data, assumptions, and methodologies.
    - The payment arrangement is consistent with the 2021 preprint information, (and the 2020 preprint information except for updated funding amounts).
    - The 2021 provider access payments are included in this rate certification.

  - There are no other directed payments in the BCP program that are not addressed in this rate certification.
  - There are no requirements regarding the reimbursement rates the HMOs must pay to any providers other than the arrangements disclosed in Section IV.D.

- Pass-through payments – Not applicable.

5. Projected Non-Benefit Costs

- Assumptions used to project non-benefit costs do not vary based on the rate of federal financial participation associated with the covered populations.
- Administrative costs and provision for margin – See Section III.E.
- Health Insurer Fee treatment – Not applicable for 2021 and excluded from the base experience.

- Historical administrative costs reported by HMOs – See Table 16 in Section III.E.

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 BCP is not a primarily long-term care service program.

SECTION III. NEW ADULT POPULATION CAPITATION RATES

Introduction

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

1. Data

Milliman used detailed HMO encounter data for 2018 and 2019 for rate development for all individuals, along with 2018 and 2019 supplemental financial data, as described in Section II.

Since the 2016 rating period, the CLA rates have been based on encounter data. The rate setting data and methodology have largely been consistent over time and are described in Section II.

2. Projected Benefit Costs

See section III for a summary of rate adjustments applied to project benefit costs to the contract period.

3. Projected Non-Benefit Costs

See Section III.E for the development of projected administrative costs and contribution to surplus. The assumption is based on 2018 and 2019 health plan financial reporting.

4. Final Certified Rates or Rate Ranges

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

5. Risk Mitigation Strategies

The 2021 rates are risk adjusted. Please refer to section IV.A of the rate report.

DHS' contract with the HMOs will include risk sharing corridors as described in Section IV.E to address future claims uncertainty due to the COVID-19 pandemic No other risk corridors, minimum loss ratios, reinsurance, high cost risk pools, or other mechanisms are incorporated into the CLA capitation rates.

2021 RATE EXHIBITS

(Provided In Excel)

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2021 through December 31, 2021
BadgerCare Plus Standard And Childless Adult Programs

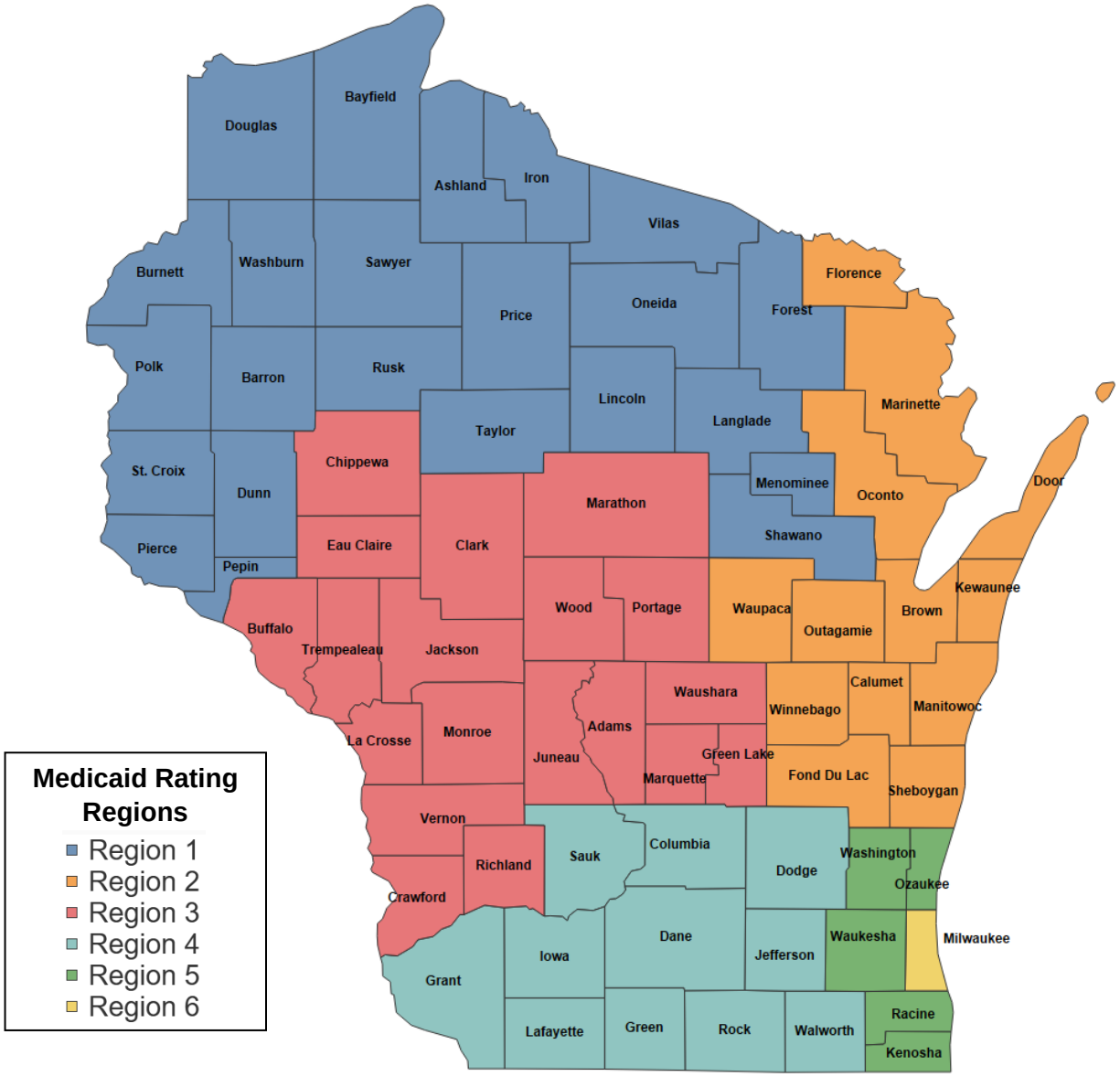
November 24, 2020

APPENDIX A

Mapping of Wisconsin Counties to Medicaid Rate Regions

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2021 through December 31, 2021
BadgerCare Plus Standard And Childless Adult Programs

November 24, 2020



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 2021 capitation rates for the BadgerCare Plus Standard and Childless Adults programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

APPENDIX B

Custom Risk Model Weights

(Provided In Excel)

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2021 through December 31, 2021
BadgerCare Plus Standard And Childless Adult Programs

November 24, 2020

APPENDIX C

Custom Risk Model Category Mapping

(Provided In Excel)

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2021 through December 31, 2021
BadgerCare Plus Standard And Childless Adult Programs

November 24, 2020

APPENDIX D

Enhanced FMAP Identification Criteria

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2021 through December 31, 2021
BadgerCare Plus Standard And Childless Adult Programs

November 24, 2020

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. 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
87623	5047	N/A
87624	5047	N/A
87625	5047	N/A
87806	5047	N/A
87810	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**
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
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

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**
99394	5047	N/A
99395	5047	N/A
99396	5047	N/A
99397	5047	N/A
99401	5047	N/A
99402	5047	N/A
99403	5047	N/A
99404	5047	N/A
99406	5047	N/A
99407	5047	N/A
99408	5047	N/A
99409	5047	N/A
99411	5047	N/A
99412	5047	N/A
A4281	5047	N/A
A4282	5047	N/A
A4283	5047	N/A
A4284	5047	N/A
A4285	5047	N/A
A4286	5047	N/A
E0602	5047	N/A
E0603	5047	N/A
E0604	5047	N/A
G0123	5047	N/A
G0124	5047	N/A
G0141	5047	N/A
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

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**
44402	5048	33
44403	5048	33
44404	5048	33
44405	5048	33
44406	5048	33
44407	5048	33
44408	5048	33
45330	5048	33
45331	5048	33
45332	5048	33
45333	5048	33
45334	5048	33
45335	5048	33
45337	5048	33
45338	5048	33
45339	5048	33
45340	5048	33
45341	5048	33
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

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**
77079	5048	33
77080	5048	33
77081	5048	33
77082	5048	33
80055	5048	33
80061	5048	33
80422	5048	33
82270	5048	33
82274	5048	33
82465	5048	33
82728	5048	33
82947	5048	33
82948	5048	33
82950	5048	33
82951	5048	33
82952	5048	33
83020	5048	33
83021	5048	33
83700	5048	33
83701	5048	33
83704	5048	33
83718	5048	33
83721	5048	33
84030	5048	33
84443	5048	33
84478	5048	33
85025	5048	33
86592	5048	33
86593	5048	33
86689	5048	33
86701	5048	33
86702	5048	33
86703	5048	33
86704	5048	33
86705	5048	33
86706	5048	33
86900	5048	33
86901	5048	33
87070	5048	33
87081	5048	33
87086	5048	33
87088	5048	33
87340	5048	33
87341	5048	33
87389	5048	33
87390	5048	33
87534	5048	33
87535	5048	33
87536	5048	33
87590	5048	33

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**
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

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

shelly.brandel@milliman.com

November 24, 2020

Wisconsin Department of Health Services
BadgerCare Plus Standard and Childless Adults Medicaid Managed Care Programs
January – December 2021 Capitation Rates
Actuarial Certification

I, Shelly S. Brandel, am associated with the firm of Milliman, Inc. and am a member of the American Academy of Actuaries and meet its Qualification Standards for Statements of Actuarial Opinion. I have been retained by the Wisconsin Department of Health Services (DHS) to perform an actuarial certification of the BadgerCare Plus (BCP) Standard and Childless Adults program capitation rates for January through December 2021 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 2020 - 2021 Medicaid Managed Care Rate Development Guide, and Actuarial Standard of Practice (ASOP) 49.

To the best of my information, knowledge, and belief, the 2021 BCP 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 S. Brandel
Member, American Academy of Actuaries

November 24, 2020

Tony Evers
Governor

Andrea Palm
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF MEDICAID SERVICES

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November 23, 2020

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 M. Nerad, Director, 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 2021 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 2021 capitation rate development, including:

    a. Fee-for-service claim data
    b. HMO encounter data
    c. Eligibility data
    d. Hospital inpatient and outpatient facility 2021 re-pricing data

2. Other supporting data, including:

    a. Monthly identification of ventilator-dependent members
    b. HMO financial data
    c. 2021 provider access payment funding amounts
    d. Historical performance withhold payments
    e. Information regarding program changes effective prior to December 31, 2021 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. 2021 directed payment preprints submitted to CMS
    i. Other computer files and clarifying correspondence

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

Signature

Benjamin M. Nerad

Print Name

Director, Bureau of Rate Setting, DHS

Title

November 23, 2020

Date

For more information about Milliman, please visit us at:

milliman.com

Milliman

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property and casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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