MILLIMAN REPORT

State of Wisconsin

Department of Health Services
Calendar Year 2026 Capitation Rate Development
SSI Medicaid Managed Care Program

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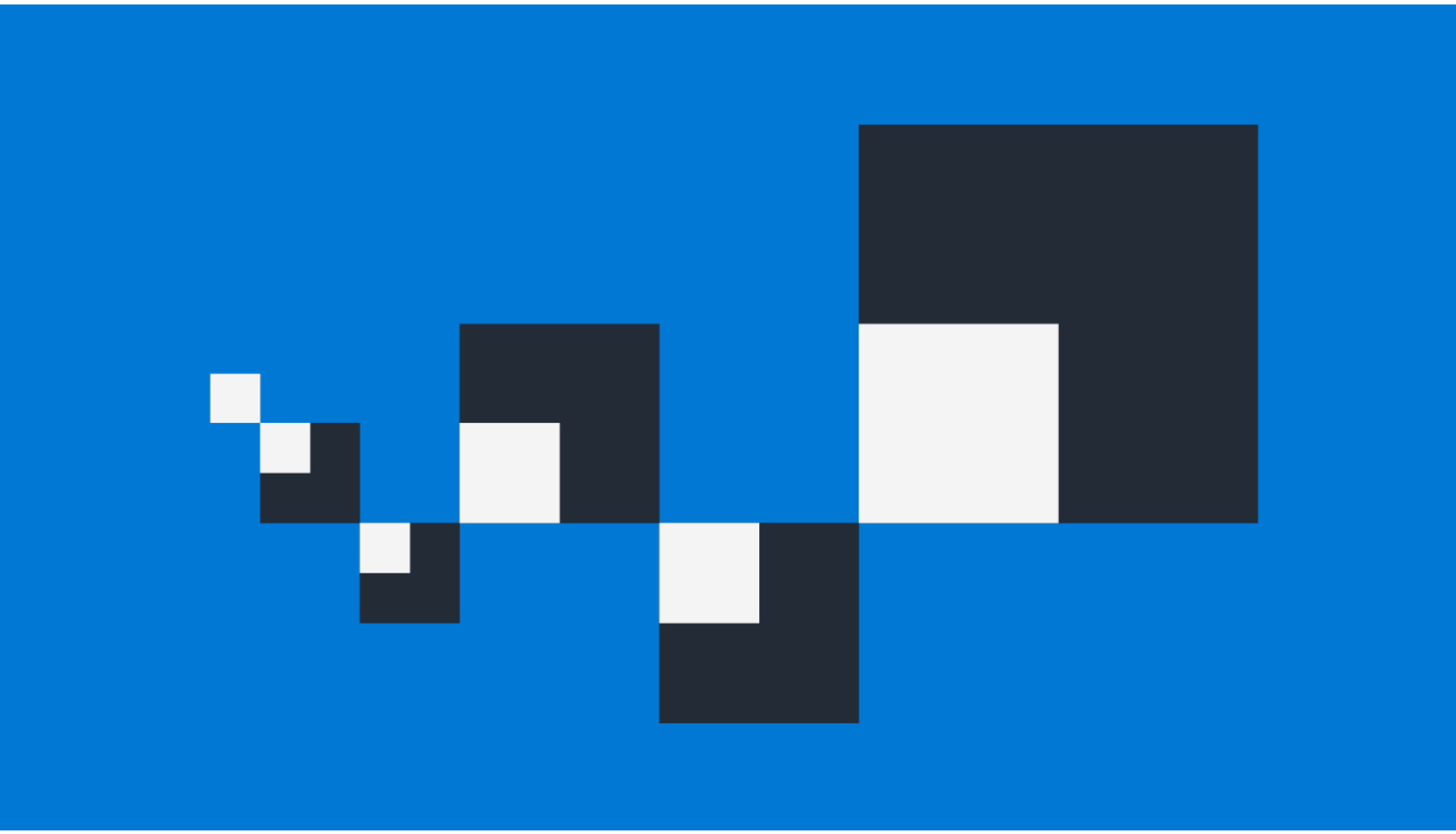
Shelly S. Brandel, FSA, MAAA
Principal and Consulting Actuary

Jill H. Brostowitz, FSA, MAAA
Principal and Consulting Actuary

Emily J. Vandermause, FSA, MAAA
Principal and Consulting Actuary



17335 Golf Parkway
Suite 100
Brookfield, WI 53045 USA
Tel +1 262 784 2250

milliman.com

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I. EXECUTIVE SUMMARY

This report documents the development of capitation rates effective January 1, 2026 through December 31, 2026 for Wisconsin's Supplemental Security Income (SSI) Medicaid managed care program.

The State of Wisconsin Department of Health Services (DHS) retained Milliman, Inc. (Milliman) to calculate, document, and certify its 2026 SSI 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.

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 2026 managed care program rating period

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

The capitation rates provided under this certification are actuarially sound for purposes of 42 CFR 438.4. 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 2026 and 2025 per member per month (PMPM) medical, dental, and chiropractic capitation rates by geographic rate region and eligibility category weighted using projected 2026 member months. The capitation rates exclude state directed payment (SDP) add-on adjustments.

Table 1A
Wisconsin Department of Health Services
Summary of Capitation Rate Changes by Region (Excluding SDPs)
Calendar Year 2025 to Calendar Year 2026
SSI Medicaid Only

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Projected 2026 Member Months							
Medical Coverage	32,513	61,702	45,753	67,147	50,993	153,099	411,207
Dental Coverage	n/a	n/a	n/a	n/a	50,993	153,099	204,092
Medical Capitation Rates							
2026 Capitation Rate	$682.05	$638.15	$675.01	$659.32	$677.98	$792.71	$711.66
2025 Capitation Rate	$670.67	$636.68	$632.11	$615.68	$616.96	$781.10	$686.75
Rate Change	1.7%	0.2%	6.8%	7.1%	9.9%	1.5%	3.6%
Dental Capitation Rates							
2026 Capitation Rate[2]	n/a	n/a	n/a	n/a	$13.31	$12.92	$13.02
2025 Capitation Rate[2]	n/a	n/a	n/a	n/a	$11.92	$11.82	$11.84
Rate Change	n/a	n/a	n/a	n/a	11.6%	9.3%	9.9%

[1] Statewide changes in capitation rates are based on projected 2026 member months.
[2] Dental capitation rates for Regions 1 to 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 SDPs)
Calendar Year 2025 to Calendar Year 2026
SSI Dual Eligible

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Projected 2026 Member Months							
Medical Coverage	20,557	36,519	27,365	33,194	29,010	79,025	225,671
Dental Coverage	n/a	n/a	n/a	n/a	29,010	79,025	108,035
Medical Capitation Rates							
2026 Capitation Rate	$84.38	$104.52	$74.69	$92.51	$94.32	$243.71	$144.73
2025 Capitation Rate	$68.23	$87.47	$63.09	$71.47	$82.57	$204.16	$120.64
Rate Change	23.7%	19.5%	18.4%	29.4%	14.2%	19.4%	20.0%
Dental Capitation Rates							
2026 Capitation Rate[2]	n/a	n/a	n/a	n/a	$6.02	$5.51	$5.65
2025 Capitation Rate[2]	n/a	n/a	n/a	n/a	$5.37	$5.64	$5.57
Rate Change	n/a	n/a	n/a	n/a	12.0%	-2.2%	1.5%

[1] Statewide changes in capitation rates are based on projected 2026 member months.
[2] Dental capitation rates for Regions 1 to 4 are not applicable, since no HMOs cover dental services in these regions.

Exhibits 15 through 17 contain more detailed comparisons summarizing the rate changes for all coverage types (medical only, medical / dental, medical / chiropractic, and medical / dental / chiropractic) separately for each Health Maintenance Organization (HMO) based on projected 2026 member months. Exhibit 22 shows the final 2026 capitation rates for each HMO, including SDPs.

Table 2 provides a high-level summary of each rate component and the impact on the overall medical capitation rate change from 2025 to 2026. The rate changes are primarily driven by updates to the base data, partially offset by benefit changes for SSI Medicaid Only and reimbursement and managed care savings compared to the 2025 rate development.

Table 2 Wisconsin Department of Health Services High-Level Summary of Medical Capitation Rate Changes between 2025 and 2026		
Rate Component	**SSI Medicaid Only**	**SSI Dual Eligible**
Updated base period encounter data	15.6%	26.0%
Reimbursement changes between base period and rating period	-6.0%	-1.8%
Benefit changes	-4.3%	1.2%
Trend changes	0.8%	0.7%
Managed care savings	-0.9%	-4.9%
Administrative load changes	0.6%	0.0%
Impact of rate cell mix on prior rates	-0.8%	0.1%
Total rate change	**3.6%**	**20.0%**

The capitation rate changes for medical services vary by region due to differences in the impact of updating the base period data, program changes, managed care savings, and rate cell mix.

For dental services, the rate changes are driven by updates to the base period data and benefit adjustments compared to the 2025 rate development.

B. CAPITATION RATE CELL STRUCTURE

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

Eligibility Categories

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

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

- **SSI Dual Eligible:** Includes SSI and MAPP members ages 19 and over who are eligible for Medicare benefits.

Rate Regions

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

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

Appendix A contains a mapping of Wisconsin counties to the six rate regions for the 2026 capitation rates.

Rate Cells

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

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

Covered Services

HMOs are responsible for providing comprehensive health care to SSI members, including hospital inpatient, hospital outpatient, professional, and other services. Prescription drugs are carved out of the capitation rates. Dental and chiropractic capitation rates are developed separately. 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 (EBPs) paid on a fee-for-service (FFS) basis outside of the capitation rates are reimbursed to the HMOs at the Medicaid fee schedule in compliance with the upper payment regulations outlined at 42 CFR §447.362. EBPs for 2026 will include:

- Dental pilot reimbursement above the Medicaid fee schedule in Brown, Marathon, Polk, and Racine Counties
- COVID-19 vaccine costs
- Long-acting reversible contraception (LARC)
- Interpreter services occurring during provider visits
- Drug testing in the outpatient substance use disorder (SUD) setting
- SSI intensive care management
- Peer support services

C. GENERAL PROGRAM INFORMATION AND HIGH-LEVEL RATE METHODOLOGY

The SSI managed care program started in Milwaukee and expanded into additional counties in 2007. DHS currently holds contracts with nine Health Maintenance Organizations (HMOs) to provide services to SSI members.

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

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

Material Changes to Rate Methodology

The 2026 capitation rate methodology is generally consistent with the 2025 rate methodology. We made the following material changes to the 2025 rate methodology:

- Experience data sources –2026 rates are based on calendar year 2024 HMO encounter, HMO financial, and FFS data. 2025 rates were based on calendar year 2023 except SSI Dual Eligible medical rates also used 2022 experience to help smooth out significant fluctuations in claim costs between 2022 and 2023.

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 2026 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)
- Section VI provides responses to the CMS rate setting checklist
- Section VII provides responses to the 2025 – 2026 CMS Medicaid Managed Care Rate Development Guide

Exhibits 1 through 26 summarize the 2026 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 Federal Medical Assistance Percentage (FMAP) identification criteria. Appendix E contains the actuarial certification.

E. DATA RELIANCE AND IMPORTANT CAVEATS

The information contained in this report has been prepared for DHS for the purpose of developing 2026 capitation rates for the SSI Medicaid program. It may not be appropriate, and should not be used, for other purposes. This report has been prepared solely for DHS and their consultants and advisors. It is our understanding the information in this report will be shared with CMS and may be utilized in a public document. 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. To the extent this information is provided to third parties, 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 provided by DHS and the participating HMOs, including eligibility data, FFS claims data, HMO encounter data, HMO financial data, program changes, and other supporting information. We accepted this information without audit, but reviewed the information for general reasonableness and validated the HMO encounter data to HMO reported financial data. If the information 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 deviates from expected experience due to many different factors, including the unwinding of the public health emergency (PHE).

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, 2025.

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 2026 capitation rates reflects the most current credible available data from DHS and the HMOs.

The following exhibits summarize the base data and adjustments by region for all age categories combined (separate exhibits are provided by eligibility category):

- Exhibit 1A: Medical – SSI Medicaid Only
- Exhibit 1B: Medical – SSI Dual Eligible
- Exhibit 7A: Dental – SSI Medicaid Only
- Exhibit 7B: Dental – SSI Dual Eligible
- Exhibit 12A: Chiropractic – SSI Medicaid Only
- Exhibit 12B: Chiropractic – SSI Dual Eligible

A. BASE DATA SOURCES

The primary data sources used in the 2026 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 2023, CY 2024 and YTD March 2025 financial data to DHS. The financial data included the following information by eligibility category, region, and calendar year:

    a. Member months.

    b. Total revenue including capitation payments and other sources.

    c. Claim payments to providers, including FFS claim payments, payments made to sub-capitated providers, and other payments made outside the FFS claims system, including overpayments to providers not already reflected in the FFS claim payments.

    d. Administrative costs.

    e. Additional information on payments made to related parties.

    f. A certification from the HMO attesting the data is accurate, complete, and truthful.

    g. 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 the prevalence of sub-capitation.

3. **FFS Data** – Includes claims paid by DHS on a FFS basis. We used FFS data as the basis for developing capitation rates for dental services in Regions 1 through 4 and chiropractic services in all regions.

DHS and Milliman went through an extensive data validation process to review all HMO data included in the 2026 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.

We 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 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 2026 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	2024	Early May 2025[1]
HMO Financial Data	2024	April 2025
HMO Emerging 2025 Financial Data	YTD March 2025	June 2025
FFS Data	CY 2024	Early May 2025

[1] *Encounter data files received from DHS on May 21, 2025; paid through date differs 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 calendar years 2022 through early May 2025. As noted above, we used 2024 encounter data to develop the adjusted base medical period costs. We summarized the encounter data using the methodology described in the following sections.

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

Excluded Claims

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

1. **Claims incurred outside of 2024:** We excluded claims for services provided outside of the period January 1, 2024 through December 31, 2024.

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 provided to the HMOs for these members. Therefore, these claims are excluded from the base data used to develop the capitation rates, along with the corresponding member months from the same time period.

5. **EBPs:** We excluded EBPs, because DHS reimbursed the HMOs for these claims outside of the capitation rates.

6. **Dental claims in Regions 1 through 4:** We excluded claims based on the dental criteria in Region 1 through Region 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 no HMOs covered chiropractic services during the base period for the SSI program.

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 base period experience. We developed separate capitation rates for medical coverage, dental services, and chiropractic services. Any classified claims not identified as dental or chiropractic services as medical coverage.

Dental

Encounters with procedure codes from D0120 – D9999 were identified as dental services and carved out from the base data. HMOs are 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 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 Service or Setting (ILOS)

The SSI Medicaid program covered an ILOS called “Sub-Acute Psychiatric Community-Based Psychiatric and Recovery Center Services” (Sub-Acute Psychiatric ILOS) during the 2024 base period, which will be removed effective January 1, 2026. These services were defined in Section IV.B.13 of the HMO contract. The benefit was limited to short term residential (non-hospital residential treatment program) for behavioral health. Sub-acute community based clinical treatment could have been used in lieu of inpatient psychiatric hospitalization during the base period. This benefit was cost effective since the required reimbursement of $450 per diem was much lower than the average SSI Medicaid Only inpatient psychiatric cost per day. We applied a benefit adjustment to replace this experience with the per diem cost for inpatient psychiatric services, as described in Section III.B.

Effective January 1, 2025, the SSI program allows HMOs to cover medically tailored meals and nutritional counseling as an optional ILOS. There is no 2024 experience for this benefit described in Section III.B.

The SSI program also allows HMOs to provide IMD benefits in lieu of inpatient psychiatric and substance abuse admissions. Reimbursement adjustments for IMDs are documented in Section III.A and benefit adjustments are documented in Section III.B.

Service Category Assignment

We relied on the claim type (and category of service for FQHC / RHC) in the encounter files provided by DHS to assign broad categories of service (hospital inpatient, hospital outpatient, professional, FQHC / RHC, and other services). We identified IMD, hospice, personal care, Indian health services, zero copay preventive services, and family planning services based on criteria provided by DHS. We then used Milliman's *Health Cost Guidelines*™ (*HCG*) 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 2024 base data before projecting costs to the 2026 rating period.

Missing Data Adjustment (Encounter Data)

We developed 2024 medical missing data adjustments for each HMO 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 reported IBNR and using encounter data re-priced at the Medicaid fee schedule for some sub-capitation arrangements). 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. 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.

Table 5 summarizes the medical missing data adjustments by eligibility category and region. 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. We applied higher missing data adjustments for the SSI Dual Eligible population, since we observed a larger variance between the HMO paid amounts in the encounter data and the financial data for Medicare crossover claims.

Table 5
Wisconsin Department of Health Services
2024 Missing Data Adjustments for Medical Services

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
SSI Medicaid Only	1.031	1.033	1.031	1.047	1.035	1.035
SSI Dual Eligible	1.128	1.138	1.129	1.146	1.130	1.135

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 Factors

We first applied completion factors to the 2024 encounter data using the HMO reported incurred but not reported (IBNR) amounts in the financial data and reviewed the results for reasonableness compared to the observed lags in the encounter data. We then reduced the inpatient facility IBNR for estimated ventilator recoupments not yet reflected in the encounter data based on historical cost patterns.

Table 6 summarizes the completion factors applied to the base 2024 claims before and after we apply the ventilator recoupment adjustments.

Table 6
Wisconsin Department of Health Services
2024 Completion Factors

	Hospital Inpatient				
	Before Ventilator Recoupment Adjustment	Ventilator Recoupment Adjustment	After Ventilator Recoupment Adjustment	Other Medical and Chiropractic	Dental
SSI Program	1.018	-0.038	0.980	1.009	1.000

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 gross of member cost sharing by broad service category and region to develop provider contracting adjustments that reflect average HMO contracting levels relative to Medicaid fees.

Table 7 summarizes the provider contracting adjustments applied to the SSI Medicaid Only re-priced Medicaid paid amounts in the encounter data. We did not apply provider contracting adjustments to the SSI Dual Eligible population.

Table 7
Wisconsin Department of Health Services
Provider Contracting Adjustments
SSI Medicaid Only

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

III. PROJECTED 2026 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 2026 capitation rates by eligibility category, region, and age category before risk adjustment, P4P withholds, and SDPs are applied.

The following exhibits summarize the development of projected 2026 claim costs:

- Exhibit 2A: Medical – SSI Medicaid Only
- Exhibit 2B: Medical – SSI Dual Eligible
- Exhibit 7A: Dental – SSI Medicaid Only
- Exhibit 7B: Dental – SSI Dual Eligible
- Exhibit 12A: Chiropractic – SSI MA Only
- Exhibit 12B: Chiropractic – SSI Dual Eligible

A. REIMBURSEMENT CHANGES

Generally, 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, specified level I oral and maxillofacial procedures in the hospital outpatient setting provided under deep sedation, 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 incorporate changes to the Medicaid fee schedule into their payments to providers. Therefore, we applied reimbursement adjustments to the SSI Medicaid Only experience consistent with projected Medicaid fee schedule changes between the base period and the rating period. We are not aware of any other anticipated fee changes other than the items mentioned in this section.

During the 2024 base period, the HMOs could provide coverage for the Sub-Acute Psychiatric ILOS reimbursed at $450 per diem. DHS removed this benefit for 2026 and we applied corresponding benefit adjustments as described in Section III.B.

Table 8 shows the overall projected claims impact across all services for each reimbursement change (excluding the SDPs described in Section IV.C).

Table 8
Wisconsin Department of Health Services
Overall Projected Claims Impact for Reimbursement Adjustments

Reimbursement Adjustment	SSI Medicaid Only Medical	SSI Dual Eligible Medical
Hospital Inpatient Re-Pricing / Part A Cost Sharing	0.0%	0.5%
Hospital Outpatient Re-Pricing	1.2%	n/a
Home Health Skilled Nursing	0.0%	n/a
Hospice	0.0%	n/a
Institution for Mental Disease	0.1%	n/a
Opioid Treatment	0.2%	n/a
Personal Care	0.2%	1.1%
Private Duty Nursing	0.0%	0.0%
Skilled Nursing Facility	0.2%	n/a
Part B Medicare Cost Sharing	n/a	4.1%
Total	**1.9%**	**5.6%**

Because the reimbursement changes for the SSI Dual Eligible population are primarily impacted by changes in the Medicare Part A and Part B deductible amounts and Medicare trends affecting Part B member coinsurance, rather than changes to Medicaid fee schedules, we applied reimbursement trends to the SSI Dual Eligible population related to expected changes in Medicare cost sharing for all service categories for medical coverage except personal care and "Payments Made Outside Encounter Data."

Part A Services (SSI Dual Eligible Only)

We applied a two-year trend factor of 1.064 from 2024 to 2026 to reflect the actual Medicare Part A deductible increases of 2.7% from 2024 to 2025 and 3.6% from 2025 to 2026.

Part B Services (SSI Dual Eligible Only)

We applied a two-year trend factor of 1.097 from 2024 to 2026 based on the actual Medicare Part B deductible increases of 7.1% from 2024 to 2025 and 10.1% from 2025 to 2026 applied to 45% of the Part B claims and an assumed annual trend of 1.5% from 2024 to 2026 for other Part B cost sharing.

We did not apply any of the other Medicaid reimbursement adjustments in this section to the SSI Dual Eligible population, except for personal care services not covered by original Medicare.

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

Hospital Inpatient Re-Pricing Adjustments

We re-priced the base period hospital inpatient claims, excluding skilled nursing facility (SNF), to the inpatient Medicaid reimbursement rates effective January 1, 2026 and used this data to calculate the impact of reimbursement changes on the 2024 hospital inpatient claims by eligibility category and region. Table 9 summarizes the hospital inpatient re-pricing adjustments for 2026 fee changes (prior to the "other reimbursement adjustments" described below) applied to the base period encounter hospital inpatient claims for the SSI Medicaid Only population.

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

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
SSI Medicaid Only	1.015	1.046	1.031	0.959	1.003	0.995

The variation by eligibility category, region, and coverage type is driven by differences in the mix of hospitals and APR-DRG codes, as well as an increase to the outlier payment threshold.

Hospital Outpatient Re-Pricing Adjustments

Similar to hospital inpatient claims, we re-priced the base period hospital outpatient claims, excluding hospice, to the Medicaid fees effective January 1, 2026 to calculate the impact of reimbursement changes between the base period and the contract period.

Table 10 summarizes the hospital outpatient re-pricing adjustments for 2026 fee changes applied to the base encounter hospital outpatient claims for the SSI Medicaid Only population.

Table 10
Wisconsin Department of Health Services
SSI Medicaid Only
Hospital Outpatient Re-Pricing Adjustments (Excluding Hospice)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
SSI Medicaid Only	1.024	1.038	1.040	1.056	1.052	1.093

The variation by eligibility category, region, and coverage type is driven by differences in the mix of hospitals and services.

Other Reimbursement Adjustments

We applied reimbursement adjustments for changes to other Medicaid fee schedules as described in this section.

Home Health Skilled Nursing

We applied reimbursement factors to the "Other - Other" service category to reflect an increase of 21.6% to procedure code 99600 based on changes to the Medicaid fee schedule effective January 1, 2026.

Hospice

We applied reimbursement factors to the "Hospital Outpatient - Hospice" service category to reflect an average estimated increase of 9.6% based on changes to the Medicaid fee schedule effective each October.

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 unit cost adjustment of 1.026 to HMO encounter base period IMD claims based on the ratio of the historical average cost per day for inpatient psychiatric stays to IMD stays using 2024 encounter data re-priced to 2026.

Opioid Treatment

We applied reimbursement factors to the "Professional - Substance Abuse" service category to reflect an increase of 32.1% to procedure code H0020 with modifier code U1 based on the change to the Medicaid fee schedule effective January 1, 2026.

Personal Care

We applied reimbursement factors to the "Other - Personal Care Services" service category to reflect an increase to procedure code T1019 of 2.1% effective January 1, 2026.

Private Duty Nursing

We applied reimbursement factors to the "Other – Other" service category to reflect an increase to procedure code S9123 of 65.7% effective January 1, 2026.

Skilled Nursing Facility

We applied reimbursement factors to the "Hospital Inpatient - Skilled Nursing Facility" service category to reflect an average estimated increase of 17.3% based on changes to the Medicaid fee schedule effective each July.

Other Fee Schedule Changes

DHS updated the fee schedule for other miscellaneous procedure codes with an average combined increase of less than 0.1%, including increases of 170% and 202% to procedure codes H0004 and T1006, respectively, for behavioral health counseling services effective August 1, 2024. We did not apply reimbursement adjustments for these changes due to immateriality.

B. PROGRAM CHANGES

Benefit Changes

We applied benefit adjustments as described in this section, with the overall projected claims impact across all services for each benefit change summarized in Table 11.

Table 11
Wisconsin Department of Health Services
Overall Projected Claims Impact for Benefit Adjustments

Benefit Adjustment	SSI Medicaid Only Medical	SSI Dual Eligible Medical	SSI Medicaid Only Dental[1]	SSI Dual Eligible Dental[1]
Concurrent Services	0.0%	0.0%	n/a	n/a
Continuous Glucose Monitoring	0.4%	0.1%	n/a	n/a
Criteria Change for SSI Ventilator Recoupments	1.2%	0.0%	n/a	n/a
Institute for Mental Disease	-0.5%	0.0%	n/a	n/a
Intensive Outpatient Services	0.0%	0.0%	n/a	n/a
Removal of Sub-Acute Psychiatric ILOS	0.2%	n/a	n/a	n/a
Peer Recovery Support Services	0.0%	0.1%	n/a	n/a
Dental Sedation	n/a	n/a	0.3%	0.0%
Dental Therapists	n/a	n/a	0.3%	0.2%
Replacing Salzmann Orthodontic Index with Automatic Qualifiers	n/a	n/a	0.0%	0.0%
Nitrous Oxide	n/a	n/a	0.0%	0.0%
Periodontal Maintenance	n/a	n/a	0.5	0.3%
Total	**1.4%**	**0.2%**	**1.1%**	**0.5%**

[1]*The projected claims impact of benefit changes on the dental capitation rates reflect impacts to HMO regions 5 and 6 only.*

Concurrent Services

Effective December 1, 2025, HMOs can reimburse providers for outpatient mental health support for members who also receive Residential Substance Use Disorder (RSUD) treatment. We applied benefit adjustments to the "Professional – Psychiatric" service category based on DHS' estimated HMO impact for the BCP and SSI programs.

Continuous Glucose Monitoring (CGM)

We applied benefit adjustments to the "Other – Durable Medical Equipment" service category to reflect the prior EBP experience included in the capitation effective January 1, 2025. We based these benefit adjustments on the 2024 EBP experience.

Criteria Change for SSI Ventilator Recoupments

Effective January 1, 2025, the criteria for determining SSI ventilator recoupments changed from 4 to 30 days to align with the BCP criteria. We applied benefit adjustments of 1.032 for SSI Medicaid Only and 1.001 for SSI Dual Eligibles to the hospital inpatient service categories based on analyzing claims for members with ventilator recoupments. Because the exact number of days that each member spent on a ventilator was not available from the claims data, we used the inpatient days for members with ventilator recoupments as a reasonable proxy for ventilator days. In addition, if the inpatient facility claim indicated the member was deceased, we assumed the member's claims would remain eligible for ventilator recoupment under the 2026 criteria.

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 is less than 0.1% for each eligibility category and region.

Intensive Outpatient (IOP) Services

Effective March 1, 2025, HMOs began covering 9 to 19 hours per week of intensive outpatient services for psychiatric and substance abuse. We applied benefit adjustments to the “Professional – Psychiatric” and “Professional – Substance Abuse” service categories in Exhibit 2 based on DHS’ analysis of 2023 and 2024 experience for OP SUD and day treatment services (HCPCS code H2012).

Removal of Sub-Acute Psychiatric ILOS

Effective January 1, 2026, DHS removed the Sub-Acute Psychiatric ILOS. As a result, we applied benefit adjustments to remove these claims from the “Professional - Psychiatric“ and “Professional – Substance Abuse” service categories, and we re-priced the experience using the average 2026 inpatient psychiatric per diem and moved the claims to the “Hospital Inpatient – Psychiatric” and “Hospital Outpatient – Substance Abuse” service categories.

Peer Recovery Support Services

Effective November 1, 2025, HMOs will cover services provided by Peer Recovery Coaches (PRCs), who are individuals with lived experience that have survived addiction, with HCPCS code H0038. PRCs provide peer support to members and open discussion, in tandem with normal treatment from mental health professionals. We applied benefit adjustments to the ”Professional – Substance Abuse” service category in Exhibit 2 based on DHS’ estimated HMO impact for the BCP and SSI programs.

Dental Sedation

Effective January 1, 2026, the maximum allowable dental sedation units for procedure codes D9222, D9223, D9239, and D9243, will increase from four to ten with an updated unit cost of $238. In addition, a case management fee will be covered for members with special needs. We applied benefit adjustments in Exhibit 9 based on DHS’ estimated HMO impact for the BCP and SSI programs.

Dental Therapists

Effective January 1, 2026, dental therapists will be covered as a new provider type with the same Medicaid fee schedule as dentists. We applied benefit adjustments in Exhibit 9 based on DHS’ estimated HMO impact for the BCP and SSI programs.

Replacing Salzmann Orthodontic Index with Automatic Qualifiers

Effective September 30, 2025, DHS replaced the Salzmann Orthodontic Index with automatic qualifiers to reduce the administrative burden for providers. This change is expected to increase coverage for a small population of members that were previously denied under the Salzmann Score guidelines. We did not apply any benefit adjustments because we expect the impact to be immaterial for the SSI program.

Nitrous Oxide

Effective January 1, 2026, HMOs will cover the use of nitrous oxide in tandem with dental sedation. We applied benefit adjustments in Exhibit 9 based on DHS’ estimated impact HMO impact for the BCP and SSI programs.

Periodontal Maintenance

Effective January 1, 2026, HMOs will cover up to three units of periodontal maintenance annually using procedure code D4910 compared to only covering one unit previously. We applied benefit adjustments in Exhibit 9 based on DHS’ estimated HMO impact for the BCP and SSI programs.

Addition of Coverage in the Pharmacy Setting

Effective July 1, 2024 DHS allowed HMOs to enroll pharmacists as Medicaid providers to provide certain medical services including vaccinations. In addition, DHS expanded the list of vaccines that can be administered in the pharmacy setting for members ages 19 to 64 from the COVID-19, influenza, and hepatitis A vaccines to all vaccines

recommended by the Advisory Committee on Immunization Practices (ACIP). The HMOs will be responsible for these services in 2026, except for COVID-19 vaccinations reimbursed as an EBP.

We assumed no material impact for this change due to the following reasons:

- We assumed medical services provided by pharmacists in the future will replace medical services currently covered by other providers.
- We assumed a low prevalence of vaccines will be administered in a pharmacy, similar to what we have observed for the hepatitis A vaccine. We also reviewed the cost of covering influenza vaccines in the pharmacy setting using 2023 FFS experience, which was immaterial, and observed a low volume of 2024 HMO claims provided in the pharmacy setting.

Disenrollment of Incarcerated Members

Effective January 1, 2025, DHS disenrolls a member who is incarcerated for at least 30 days retroactive to the day prior to the month in which the member was incarcerated. We did not apply a benefit adjustment because we expect the impact to be immaterial based on our analysis of 2023 experience.

Ketamine Infusion

Effective January 1, 2025, HMOs cover intravenous ketamine infusion therapy and monitoring for treatment-resistant major depressive disorder or suicidality. We did not apply a benefit adjustment because we expect the impact to be immaterial based on our review of DHS' analysis. The ketamine drug costs are carved out of the HMO coverage.

Meals ILOS

Effective January 1, 2025, HMOs may cover medically tailored meals and nutritional counseling as an optional ILOS. The benefit includes fresh or frozen prepared meals medically tailored by a registered dietitian for members with diabetes or cardiovascular disease who have been discharged from the hospital within the last 90 days. HMOs may authorize eligible members every 12 weeks to receive up to two meals per day and an initial evaluation and periodic nutrition counseling by a registered dietician. We assumed the cost of this ILOS will be budget neutral for 2026 with offsetting cost reductions for emergency room and hospital inpatient services. In addition, we expect further reductions in emergency and hospital inpatient costs in future years based on research cited by CalAIM in https://www.dhcs.ca.gov/Documents/MCQMD/CA-ILOS-Evidence-Library-Executive-Summary-August-2021.pdf.

C. TREND

The annual trend assumptions (excluding Medicaid reimbursement changes) are shown in Table 12. We developed the trend assumptions based on historical trends, emerging 2025 claims information, Medicaid industry trends, and actuarial judgment.

Table 12
Wisconsin Department of Health Services
Projected Annual Trend Factors

	2024 to 2026	
	SSI Medicaid Only	SSI Dual Eligible
Hospital Inpatient	1%	1%
Hospital Outpatient	3%	3%
Professional and Other	3%	3%
Dental	5%	5%

Below is a summary of annualized trend assumptions relative to the 2025 rate development:

- Hospital Inpatient, Hospital Outpatient, and Dental: We applied hospital utilization trends from 2024 to 2026 consistent with the assumptions in the 2025 rate development.

- Professional and Other: Based on higher observed trends from 2023 to 2024, we increased the projected professional utilization trends by 1%.

We chose to apply the same projected trends by broad service category to each eligibility category in the BCP and SSI programs, acknowledging the uncertainty with estimating the normalized historical claim trends for large membership changes and understanding that future trends will differ from historical trends (e.g., a high trend may follow a low trend and vice versa).

Table 13 shows the annual 2022 to 2024 historical claims PMPM trends normalized for program and concurrent risk score changes in the HMO medical encounter and financial data by eligibility category and broad category of service.

Table 13
Wisconsin Department of Health Services
Historical 2022 to 2024 Claims PMPM Trends
Normalized for Program and Concurrent Risk Score Changes

	2022 to 2024 Annualized Claims PMPM Trends	
	SSI Medicaid Only	**SSI Dual Eligible[1]**
Hospital Inpatient	3.2%	4.9%
Hospital Outpatient	2.2%	9.3%
Professional	1.3%	7.5%
Dental[2]	8.1%	2.1%

[1] SSI Dual Eligible Claims were not normalized for risk score changes.
[2] Dental trends are based on financial data in Regions 5 and 6 and normalized using Medical concurrent risk score changes.

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

D. MANAGED CARE SAVINGS

We applied managed care savings adjustments to personal care services in Regions 5 and 6, as shown in Table 14, to reduce HMO outlier costs in the base experience. Based on discussion with DHS, we compared the difference in 2024 costs PMPMs between the outlier HMO and the average of the other HMOs by eligibility category and region and removed 75% of the excess costs.

Table 14
Wisconsin Department of Health Services
Managed Care Savings Adjustments Applied to 2024 Personal Care Services

	Managed Care Savings	
	Region 5	**Region 6**
SSI Medicaid Only	0.761	0.743
SSI Dual Eligible	0.707	0.804

E. ADMINISTRATIVE COST AND RISK MARGIN ALLOWANCE

The following exhibits add the administrative cost and risk margin allowance to the projected 2026 claim costs by eligibility category and region:

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

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

The 2026 administrative cost allowances to apply as a percentage of the capitation rates are 12.0% for SSI Medicaid Only and 13.0% for SSI Dual Eligible, with a 0.5% increase for SSI Medicaid Only and no change for SSI Dual Eligible from the percentage loads used for the 2025 capitation rates.

Table 15 shows the development of the projected 2026 BCP and SSI combined administrative cost target of $34.37 PMPM based on the 2024 financial data provided by the HMOs.

Table 15
Wisconsin Department of Health Services
Administrative Cost PMPM
BCP and SSI Programs Combined

A	2024 HMO Financial Administrative Costs PMPM [1]	$30.76
B	Annual Inflation Trend Applied to 2024 PMPM	4.0%
C	Enrollment Mix Change	1.011
D	Indirect Administrative PMPM Increase Due to Membership Reduction	$0.73
E = A*(1+B)^2*C+D	Target Projected 2026 Administrative Cost PMPM	$34.37

[1] Excludes HMO costs greater than 120% of the average administrative cost adjusted for the mix of membership by eligibility category.

We applied the following adjustments:

- Assumed a 4% annual inflation trend based on recent BCP and SSI administrative cost trends and a review of trends from the Bureau of Labor statistics related to health insurance.
- Applied a factor of 1.011 to reflect the impact of projected enrollment mix changes by eligibility category, reflecting a relatively lower portion of BCP members in 2026 compared to 2024.
- Increased indirect administrative costs by $0.73 PMPM due to the projected 10% decrease in member months between 2024 and 2026. We assumed 50% of reported indirect costs are related to fixed costs that will not vary with membership changes.

We then developed the administrative allowances as a percentage of capitation for each eligibility category to be consistent with the target projected PMPM across the BCP and SSI programs and all coverages. HMOs generally allocated their administrative costs by eligibility category in their financial reporting using simplified methods, such as member months, claims, or revenue. As a result, we grouped HMOs by their participating eligibility categories to estimate administrative costs by eligibility category.

Table 16 summarizes the administrative cost and risk margin assumptions applied to the medical, dental, and chiropractic rates.

Table 16
Wisconsin Department of Health Services
2026 Administrative Cost and Risk Margin Assumptions
Medical, Dental, and Chiropractic Capitation Rates

Administrative Cost Components	SSI Medicaid Only	SSI Dual Eligible
Direct Costs	4.4%	5.8%
Indirect Costs	4.5%	5.6%
Care Coordination	1.1%	1.4%
Licensing and Regulatory Fees	0.0%	0.0%
Sales and Marketing	0.0%	0.2%
Total Administrative Cost Allowance	**10.0%**	**13.0%**
Risk Margin Allowance	2.0%	2.0%
Administrative Cost / Risk Margin Allowance	**12.0%**	**15.0%**

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 2026 statewide administrative allowance for medical services is $73.07 PMPM for SSI Medicaid Only and $18.88 PMPM for SSI Dual Eligible, as shown in Exhibit 3 based on the base period demographic mix by rate cell and region.

The SSI capitation rates exclude any provision for federal or state income taxes or state premium taxes, since HMOs are expected to pay any of these applicable taxes out of the risk margin included in the capitation rates. We reviewed historical medical loss ratio (MLR) qualified taxes and fee amounts in the HMO financial reporting and did not observe any material reported amounts.

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

F. ALLOCATION OF BASE CAPITATION RATES BY RATE CELL

The 2026 SSI MA Only and SSI Dual Eligible base capitation rates are allocated by rate cell using the cost relativities among age bands based on statewide data. The regional rates by eligibility category are based on region specific total costs, but the relationships between age bands were standardized to statewide relativities.

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

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

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

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

2. **Normalize statewide rate cell factors to 1.0 by region and eligibility category:** For each region and eligibility category, the statewide rate cell factors are normalized so the rates by rate cell produce the overall capitation rate by region and eligibility category based on the member months in the base data used for rate development.

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

G. HMO-SPECIFIC DENTAL UTILIZATION ADJUSTMENT

The 2026 SSI Medicaid Only dental capitation rates include HMO-specific adjustments to compensate HMOs with higher utilization, while still providing funding to HMOs with lower dental utilization to provide an incentive to provide increased dental services. The adjustments are budget neutral across the HMOs by eligibility category and region based on projected membership and reflect 75% of the difference between each HMO's 2024 HMO encounter data re-priced to the Medicaid fee schedule relative to the average cost for HMOs included in the adjustment calculation. We used the encounter data re-priced to the Medicaid fee schedule to reflect utilization and service mix differences between the HMOs but not differences in negotiated dental reimbursement. The adjustments are shown in Exhibit 10 and applied in Exhibit 11. This methodology is consistent with the development of the 2025 capitation 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 2024 encounter data re-priced to the Medicaid fee schedule compared to the projected member months. We selected a 75% 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.

We did not apply HMO-specific dental relativities to the SSI Dual Eligible dental rates due to inconsistent base data cost relativities due to small volumes for some HMOs.

H. POTENTIAL RETROACTIVE RATE AMENDMENTS

We do not anticipate any future retroactive rate amendments to be applied to the 2026 capitation rates.

IV. FINAL HMO-SPECIFIC CAPITATION RATES

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

These adjustments are summarized in the following exhibits:

- Exhibit 6A: Medical – SSI Medicaid Only
- Exhibit 6B: Medical – SSI Dual Eligible
- Exhibit 11A: Dental – SSI Medicaid Only
- Exhibit 11B: Dental – SSI Dual Eligible
- Exhibit 22A: Final HMO-Specific Capitation Rates by Type of Coverage – SSI Medicaid Only
- Exhibit 22B: Final HMO-Specific Capitation Rates by Type of Coverage – SSI Dual Eligible

A. RISK SCORE ADJUSTMENTS

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

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

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

This section describes the development of the risk adjustment system that will be used to risk adjust payments for the 2026 SSI Medicaid Only capitation rates.

Exhibit 5A summarizes the risk score adjustments applied to the base 2026 capitation rates to calculate HMO-specific risk-adjusted 2026 SSI Medicaid Only medical capitation rates (before P4P withholds and SDPs).

CDPS Risk Score Model Overview

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

- CDPS is a diagnostic classification system that Medicaid programs can use to make health-based capitated payments for TANF and disabled Medicaid beneficiaries. CDPS uses ICD-10 diagnostic codes to assess risk and assigns each member to one or more of 56 possible medical condition categories from 19 major diagnostic categories. Each member is also assigned to one of 11 age / gender categories. Most 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 39 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 7.2 for the 2026 capitation rates.

In addition to the standard CDPS+Rx condition categories, we added a housing insecurity variable to the risk weight model used to develop risk scores. The housing insecurity variable is determined by a member receiving the ICD-10 codes of Z59.0, Z59.00, Z59.01, Z59.02, Z59.1, Z59.10, Z59.11, Z59.12, Z59.19, Z59.81, Z59.811, or Z59.812 during the assessment period, which indicates homelessness, inadequate housing, or housing insecurity. The prevalence of housing insecurity is likely understated in the data. However, our analysis shows that individuals with insecure housing 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.

We developed prospective risk weight models for the SSI Medicaid Only population, which used 2022 diagnoses to predict 2023 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 model calibrated to the SSI Medicaid Only population has an R-squared measure of 22.8%, which is comparable to typical prospective model predictive powers for comparable Medicaid populations.

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

Attachment C shows the mapping of the risk categories from the standard to the custom CDPS+Rx models. For purposes of developing risk weights, we combined severity levels for several of the CDPS+Rx standard risk categories to ensure a logical relationship between the risk weights and the severity level or in situations where individual categories did not provide additional statistical predictive ability.

Risk Adjustment Methodology and Data

The risk scores shown in Exhibit 5A are based on 2024 FFS claims and HMO encounter claims for HMO members from the encounter data extracts submitted to DHS by the HMOs.

Each scored individual receives a demographic relative cost weight and disease or housing insecurity categories depending on that individual’s claim records.

- We used version 7.2 of the CDPS+Rx model to assign individuals to a demographic category and disease categories based on their diagnostic information and pharmacy utilization during 2024

- 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, 2025, and is used for demographic classification
- Similar to the diagnostic conditions, housing insecurity is indicated by an HMO encounter or FFS medical claim diagnoses in the assessment period using the ICD-10 codes listed earlier in this section

For each member, the weights for all disease categories assigned are combined with their demographic, housing insecurity information, and the model intercept to calculate a total individual risk score under the custom prospective model. Scored members are assigned to the SSI Medicaid Only population and each HMO using capitation enrollment data provided by DHS for July 2025.

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 risk weight 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 with Housing Insecurity] x [Housing Insecurity 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]

To ensure budget neutrality, the risk scores are normalized within each combination of rate cell and region within the SSI Medicaid Only population by dividing each individual HMO's 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.

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

Risk Adjustment Implementation Considerations

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

- Membership threshold for scoring a member – Risk adjustment methods typically use 12 months of historical data to assess risk. For members with less than 12 months of eligibility in that historical period, a determination is needed as to how to handle their risk assessment. We used a minimum of six months of eligibility for risk scoring.
- Treatment of non-scored members – Individuals with too short of an eligibility span to assess their risk are often assigned risk based on their age and gender and / or based on some portion of the risk assessed in the capitated plan's population with full eligibility. We assumed that non-scored members of an HMO have a risk score equal to that HMO's rate cell average risk score within a given combination of region and eligibility category.
- Normalization by rate cell within each region and eligibility category – Risk adjustment is intended to measure the relative risk of populations enrolled by HMOs to develop capitation rate adjustments by HMO that are budget neutral. HMO risk factors are normalized to be budget neutral for each rate cell within each region for the SSI Medicaid Only population based on July 2025 enrollment.
- Credibility adjustments – Risk scores developed for small populations may not be credible due to the inherent variability of risk scores. For HMOs with fewer than 50 scored members in a given rate cell within a given combination of each region and eligibility category, the normalized HMO risk score was set to 1.000, since the risk score result is not considered to be a credible measure of estimated future morbidity.

Potential Risk Score Adjustments Based on Actual Membership

As noted above, we developed 2026 risk score adjustments for each HMO based on their July 2025 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 (using the same risk scores by member developed from 2024 experience) if we observe material mix changes due to the actual 2026 member months compared to the July 2025 enrollment.

B. PAY-FOR-PERFORMANCE (P4P) WITHHOLDS

A P4P withhold of 2.5% of the entire medical capitation payment (prior to risk adjustment and SDPs) applies to SSI Medicaid Only for the entire 2026 rate year. There are no P4P withholds for SSI Dual Eligible for any coverage types and no SSI Medicaid Only P4P withholds on dental or chiropractic rates. The purpose of the withhold is to incentivize HMOs to meet or exceed performance targets.

Based on historical withhold payment data from DHS, SSI HMOs have earned back an average of 70% of the P4P withhold from 2020 to 2023 in aggregate and 41% for 2024. DHS removed the withhold criteria attributed to each HMO's specific performance improvement plan (PIP) in 2024, which we understand was more achievable than other measures, compared to 0% in 2020, 1.5% in 2021 and 2022, and 0.75% in 2023. For 2026, we understand DHS is replacing the prior asthma criteria with a more achievable measure and some HMOs were close to the threshold for earning larger amounts back. We are not aware of any other material changes expected to the P4P criteria for 2026. generally based on HEDIS scores achievable by HMOs. Additionally, the 2% risk margin included in the capitation rates is sufficient to cover the average portion of withholds not earned back by the HMOs in aggregate based on historical results and the 2026 criteria. As a result, we are certifying the rates gross of the withhold, and also certifying the entire amount of the withhold is reasonably achievable for a given HMO. Exhibit 6A shows the SSI Medicaid Only medical capitation rates gross and net of P4P withholds.

C. STATE DIRECTED PAYMENTS

Provider Access Payments

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

The provider access payments will be made under a 438.6(c) preprint for 2026 that DHS will submit to CMS, and we reviewed the preprint for consistency with the 2026 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. HMOs will pay add-on amounts per inpatient discharge and outpatient visit of $12,076 for inpatient acute and rehabilitation hospitals, $937 for outpatient acute and rehabilitation hospitals, $4,114 for inpatient critical access hospitals, and $627 for outpatient critical access hospitals. After the 2026 rating period is complete, DHS will submit an amended rate certification with the final add-on amounts and restated access payment rates based on actual claims experience with sufficient claims run-out.

Table 17 shows the projected CY 2026 HMO funding amounts by eligibility category.

Table 17
Wisconsin Department of Health Services
Projected 2026 Provider Access Payment Funding

	BCP Standard	BCP CLA	SSI Medicaid Only	Total
Inpatient Acute and Rehabilitation	$452,890,308	$166,924,374	$68,911,665	$688,726,348
Outpatient Acute and Rehabilitation	$867,760,464	$385,004,919	$139,697,015	$1,392,462,398
Inpatient Critical Access	$9,876,884	$2,710,891	$908,726	$13,496,501
Outpatient Critical Access	$116,683,001	$45,602,862	$12,298,884	$174,584,746
Total	$1,447,210,657	$600,243,046	$221,816,290	$2,269,269,993

We allocated the funding amounts by eligibility category and then by HMO based on the total projected 2026 admissions (inpatient access payments) or visits (outpatient access payments). We then calculated a fixed PMPM amount for each HMO by eligibility category to add to the 2026 capitation rates.

The methodology used to calculate the 2026 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 and long term acute care (LTAC) facilities.

2. **Project 2026 Utilization:** We projected the utilization PMPM by HMO, eligibility category, region, and rate cell to 2026.

   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 base data and program change utilization adjustments in Exhibits 1 and 2. For other rate cells with less than 250 member months, we set the projected utilization PMPM to the regional average projected utilization PMPM across all HMOs for the eligibility category.

   We converted the projected utilization PMPM to total projected utilization counts based on the projected 2026 member months by rate cell.

3. **Calculate Provider Access Payment Rates:** We allocated the total provider access payments by HMO based on the projected utilization and calculated the provider access payments PMPM by dividing the total allocated provider access payments by the total projected 2026 member months.

   The provider access payments are calculated for each HMO with credible membership. New HMOs, if applicable, will receive the average regional PMPM. Exhibit 18A summarizes the 2026 provider access payments PMPM. Exhibits 18B through 18E show the projected utilization, projected average 2026 monthly membership, and projected 2026 provider access payment dollars by HMO and region for each type of provider access payment.

Ambulance Payments

DHS will provide funding to promote access for Medicaid individuals to ambulance. This funding is included in the capitation rates for the SSI Medicaid Only population. The SSI Dual Eligible population is not eligible for ambulance SDPs.

The ambulance SDPs will be made under a 438.6(c) preprint for 2026 that DHS will submit to CMS, and we reviewed the preprint for consistency with the 2026 rate certification. After the 2026 rating period is complete, DHS will submit documentation to CMS summarizing the total amount of ambulance SDPs by rate cell.

The HMOs will pay qualified ambulance providers an add-on fee per trip that will vary for emergency vs. non-emergency trips (based on HCPCS codes) and the provider's location (Milwaukee vs. outside of Milwaukee), as shown in Exhibit 19. Milwaukee providers will be funded at 20% of the add-on fee for non-Milwaukee providers and non-emergency transports will be funded at 50% of the add-on fee for emergency transports.

Table 18 shows the projected 2026 HMO funding amounts by eligibility category for the BCP and SSI programs.

Table 18
Wisconsin Department of Health Services
Projected 2026 Ambulance SDP Funding

	BCP Standard	BCP Childless Adults	SSI Medicaid Only	Total
Ambulance	$4,974,072	$4,460,092	$2,245,571	$11,679,734

We used the following methodology to calculate the 2026 ambulance SDPs:

1. **Summarize Historical Trips:** We summarized 2024 trips to qualified ambulance providers (based on the list of NPIs provided by DHS) by eligibility category, region, provider location, and emergency vs. non-emergency trips. We excluded SSI dual eligible experience since their claims will not qualify for ambulance SDP add-on fees.

2. **Project 2026 Trip Counts:** We projected 2026 trip counts by adjusting the 2024 trips for projected utilization trend and member month changes anticipated between 2024 and 2026.

3. **Calculate Ambulance SDP Rate Adjustments:** We allocated the total ambulance funding by eligibility category and region based on the projected 2026 distribution of ambulance trips and calculated the projected 2026 ambulance add-on fees PMPM by dividing by the total projected 2026 member months.

We also included a 2% risk margin in the capitation payment since the HMOs will be at risk for the ambulance SDP.

Exhibit 19 shows the development of the projected 2026 ambulance SDP PMPMs by region based on 2024 membership mix. Exhibit 20 shows the allocation of the 2026 ambulance SDP by region and rate cell.

University of Wisconsin Medical Foundation (UWMF) Payments for Professional Services

DHS will provide funding for qualified UWMF professional services to incentivize appropriate preventive treatment to pediatric and adult members and to improve overall health outcomes by applying uniform percentage increase (UPI) payments of 346% for BCP and 364% for SSI Medicaid Only to the claim payments to adjust UWMF's reimbursement to be no higher than the grandfathered 2025 UWMF SDP preprint funding, resulting in total projected UWMF payments below the estimated average commercial rate (ACR) reimbursement as demonstrated in the 2026 preprint.

The UWMF SDP will be made under a 438.6(c) preprint for 2026 that DHS will submit to CMS, and we reviewed the preprint for consistency with this rate certification. After the 2026 rating period is complete, DHS will submit an amended rate certification with restated UWMF capitation rates based on actual experience with sufficient claims run-out and consider updates to the UPIs if needed.

Table 19 shows the projected 2026 HMO funding amounts by eligibility category for the BCP and SSI programs.

Table 19
Wisconsin Department Of Health Services
Projected 2026 UWMF Professional SDP Funding

	BCP Standard	BCP Childless Adults	SSI Medicaid Only	Total
UWMF	$52,581,785	$29,673,341	$8,843,204	$91,098,330

We used the following methodology to calculate the 2026 UWMF SDP adjustments:

1. **Summarize Historical UWMF Professional Claims PMPM:** We summarized 2024 HMO paid claims PMPM for UWMF professional services by eligibility category, region, service category and HMO excluding claims paid as secondary to other coverage or for SSI Dual Eligible members.

2. **Project 2026 UWMF Professional Claims PMPM at 2026 Medicaid Fees:** We projected the 2026 claims PMPM for UWMF professional services by eligibility category, region, and HMO by adjusting the 2024 HMO paid claims PMPM for the appropriate base data and rate adjustments in Exhibits 1 and 2 by service category.

3. **Project 2026 UWMF SDP Claims:** We calculated the 2026 UWMF SDP as the projected 2026 UWMF Professional claims at the UPIs by program in Step 2). If an HMO had less than 250 members months for a given eligibility category and region, we set the HMO's SDP PMPM for the eligibility category and region equal to the average HMO SDP PMPM for the eligibility category and region.

4. **Calculate UWMF SDP Rates by Rate Cell:** We developed UWMF SDP rates by rate cell based on statewide rate cell factors normalized to the base period mix of member months by rate cell in each region as shown in Exhibit 21.

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
- Specified level I oral and maxillofacial procedures in the hospital outpatient setting provided under deep sedation (EAPG 367; Procedure code: 41899, modifier U2)
- Out of network emergency services

We did not include any capitation rate adjustments for these services, except for the deep sedation, since the base data used for rate development reflects the Medicaid fee schedules for all other claims. The adjustment for the deep sedation is included in the hospital outpatient re-pricing adjustments.

Exhibit 22 shows the final 2026 capitation rates by HMO and type of coverage, including applicable CDPS, P4P, and SDP adjustments.

D. RISK MITIGATION (RISK CORRIDOR)

The BCP and SSI programs will have a combined two-way risk corridor mechanism for 2026 to mitigate the significant uncertainty outside of HMO control related to the unwinding of the COVID-19 pandemic, consistent with the arrangement in effect since 2021. The risk corridor will address variances in the ratio of claim costs divided by capitation (before P4P withholds are applied) and BCP Standard 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 20 weighted by the mix of each HMO's actual capitation and maternity kick payments by rate cell.

Table 20
Wisconsin Department of Health Services
Combined BCP and SSI Programs
2026 Target Loss Ratios

	Pricing Loss Ratio		
	Medical, Dental, and Chiropractic	Maternity	Ambulance SDP
BCP Standard	82.0%	93.0%	98.0%
BCP Childless Adults	86.0%	n/a	98.0%
SSI Medicaid Only	88.0%	n/a	98.0%
SSI Dual Eligible	85.0%	n/a	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 21.

Table 21 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 2026 contract period has ended and enough time has passed to collect and validate 2026 experience. We anticipate performing an initial settlement using 2026 contract year HMO financial reporting data with four months of claim runout and a final settlement using data with sixteen or more 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 net of provider access payments and UWMF SDPs. The denominator of the LR calculation will include all capitation revenue, including BCP Standard maternity kick payments, gross of P4P withholds and net of provider access payments and UWMF SDPs.

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 MLR for purposes of submitting CY 2026 MLR calculations to CMS.

Related Party Expenses

The 2025-2026 HMO contract with DHS requires additional consideration for payments made to related party providers:

a. Related party expenses reported in the numerator must not be materially above the fee-for-service reimbursement rate for services provided, multiplied by the average provider contracting adjustment from the capitation rate development.

b. This requirement may be waived at the sole discretion of the Department if the HMO can demonstrate both that:

   i. The reimbursement rates to the related party for the services in question do not exceed the rates paid to entities that are not related for the same or similar services, and

   ii. A material percentage of its expenditures for the services in question are being paid to entities that are not related.

c. This requirement may be waived at the sole discretion of the Department if the provider can demonstrate that:

   i. The reimbursement rates do not exceed the rates that the provider receives from entities that are not related parties.

   ii. A material percentage of its reimbursement for the services in question are being received from entities that are not related.

d. Related party is defined as any type of arrangement with an entity that is associated with the HMO through any form of common, privately-held ownership, control, or investment.

V. CAPITATION RATES FOR ENHANCED FMAP SERVICES

DHS will receive enhanced FMAP for certain preventive services provided without member copayments, family planning services, services provided to Native Americans or Alaskan Native members at facilities officially recognized as Indian Health Services (IHS) facilities during 2026.

This section of the report documents the development of the 2026 capitation rates for preventive, family planning, and IHS 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 23: Overall FMAP capitation rates
- Exhibit 24: FMAP capitation rates for SSI Medicaid Only rate cells (preventive services)
- Exhibit 25A: FMAP capitation rates for SSI Medicaid Only rate cells (family planning services)
- Exhibit 25B: FMAP capitation rates for SSI Dual Eligible rate cells (family planning services)
- Exhibit 26: FMAP capitation rates for SSI Medicaid Only rate cells (IHS)

A. SERVICES ELIGIBLE FOR ENHANCED FMAP

Appendix D includes a summary of the criteria DHS used to identify services eligible for enhanced FMAP in the base experience. 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

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

- **Project 2026 claim costs:**
  - Preventive Services: The projected 2026 medical cost PMPM for zero copay preventive services is developed in Exhibit 2.
  - Family Planning Services: The projected 2026 medical cost PMPM for family planning services is developed in Exhibit 2.
  - IHS: The projected 2026 medical cost PMPM for IHS services is developed in Exhibit 2.

  Please refer to Section II for a discussion of the base period data and adjustments and Section III for the assumptions used to project the base period experience to 2026.
- **Add administrative cost and margin allowance:** The administrative cost and margin allowance is added to the projected claim costs in Exhibit 23. The administrative cost and margin allowance added to the services eligible for enhanced FMAP is the same as the allowance added to the total medical capitation rate and is summarized in Section III.E.
- **Allocate regional capitation rates / medical costs 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 24 (preventive services), Exhibit 25 (family planning), and Exhibit 26 (IHS. This methodology is described in detail in Section III.F.
- **Apply P4P withholds (if applicable):** The SSI Medicaid Only P4P withhold of 2.5% is applied to the capitation rates by rate cell in Exhibit 24 (preventive services), Exhibit 25 (family planning), and Exhibit 26 (IHS). This step does not apply to the SSI Dual Eligible capitation rates, since these payments are not subject to the P4P withhold.

VI. CMS RATE SETTING CHECKLIST

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

AA.1.0 – OVERVIEW OF RATE SETTING METHODOLOGY

Please refer to Sections I through V of the report for a description of the rate setting methodology.

AA.1.1 – ACTUARIAL CERTIFICATION

Appendix E includes the actuarial certification.

AA.1.2 – PROJECTION OF EXPENDITURES

Exhibits 15 through 17 show the expected rate change from the 2025 to 2026 capitation rates by eligibility category, HMO, and rate cell excluding SDPs.

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 SSI Medicaid managed care program, including Medicare crossover benefits, IMD (with adjustments), Sub-Acute Psychiatric ILOS covered in lieu of inpatient psychiatric admissions (not applicable for 2026), and medically tailored meals and nutritional counseling in lieu of future emergency department visits and inpatient admissions.

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

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

AA.2.2 – DATA SOURCES

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

AA.3.0 – ADJUSTMENTS TO BASE YEAR DATA

All adjustments to the base year data are discussed in Sections II through 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 ILOS 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 Tables 15 and 16.

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)

The State does not make HMO GME payments directly to providers.

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

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

AA.3.11 – MEDICAL COST TREND INFLATION

Please refer to 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 SSI Medicaid Only with few exemptions. The base utilization and cost data for the capitation rates includes HMO encounter data, HMO financial data, and FFS data.

The dental rates in Regions 1 to 4 are based on FFS data, since HMOs do not currently cover dental services in those regions. Chiropractic rates in all regions are based on FFS data, since no HMO was contracted to cover chiropractic services during the base period for SSI, and therefore, no SSI HMO encounter data is available.

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

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

AA.3.15 – INCOMPLETE DATA ADJUSTMENT

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

AA.3.16 – PRIMARY CARE RATE ENHANCEMENT

The 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 DHS has a health home pilot for members with AIDS / HIV who receive services provided through the AIDS Resource Center of Wisconsin (ARCW). Effective January 1, 2016, members enrolled in this health home pilot program were no longer required to disenroll from Medicaid managed care HMOs.

AA.4.0 – ESTABLISH RATE CATEGORY GROUPINGS

Please refer to Section I.B of this report.

AA.4.1 – ELIGIBILITY CATEGORIES

Please refer to Section I.B of this report.

AA.4.2 – AGE

Please refer to Section I.B of this report.

AA.4.3 – GENDER

The capitation rates do not vary by gender.

AA.4.4 – LOCALITY / REGION

Please refer to Section I.B of this report.

AA.4.5 – RISK ADJUSTMENT

The SSI Medicaid Only medical capitation rates are risk adjusted using an actuarially sound CDPS+Rx methodology. The SSI Dual Eligible rates will not be risk adjusted. Please refer to Section IV.A for a description of the risk adjustment methodology.

AA.5.0 – DATA SMOOTHING

The medical capitation rate methodology uses the following smoothing technique:

- Capitation rates are first set by eligibility category and region in Exhibit 3 (medical), Exhibit 8 (dental), and Exhibit 13 (chiropractic). Statewide cost relationships are then used to develop statewide rate cell factors within each eligibility category, which are applied on a cost-neutral basis to convert the region capitation rates into capitation rates by rate cell and region in Exhibit 4 (medical), Exhibit 9 (dental), and Exhibit 14 (chiropractic).

AA.5.1 – COST-NEUTRAL DATA SMOOTHING ADJUSTMENT

Exhibit 4 (medical), Exhibit 9 (dental), and Exhibit 14 (chiropractic) demonstrate the rate cell factors are cost neutral in each individual region. Please see Section III.F for additional details.

AA.5.2 – DATA DISTORTION ADJUSTMENT

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

AA.5.3 – DATA SMOOTHING TECHNIQUES

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

AA.5.4 – RISK ADJUSTMENT

The SSI Medicaid Only medical capitation rates are risk adjusted using an actuarially sound CDPS+Rx methodology. The SSI Dual Eligible rates will not be risk adjusted. Please refer to Section IV.A for a description of the risk adjustment methodology.

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

DHS' contract with the HMOs does not include any provisions for stop loss, reinsurance, or risk sharing arrangements other than the risk corridor described in AA.6.3.

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 2026 rates will include a two-way risk corridor as described in Section IV.D.

AA.7.0 – INCENTIVE ARRANGEMENTS

None.

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

DHS has not implemented HMO incentive payments related to EHRs for the 2026 contract period.

VII. RESPONSES TO 2025 THROUGH 2026 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, 2026 through December 31, 2026.
- Actuarial rate certification – See Appendix E.
- HMOs participating in the SSI program are required to offer a Dual Eligible Special Needs Plan (D-SNP). SSI Dual Eligible members can be enrolled in original Medicare or a Medicare Advantage plan.
- Final capitation rates – Please refer to Exhibit 6 (medical capitation rates), Exhibit 11 (dental capitation rates), and Exhibit 14 (chiropractic capitation rates) for the final capitation rates before SDPs. Exhibit 22 summarizes the final capitation rates for each coverage option (Medical only, Medical and Dental, Medical and Chiropractic, or All Services) including SDPs.
- Rate ranges – Not applicable.
- Program descriptions – See Section I.B.
- MLR – We projected an aggregate 2026 federal MLR greater than 85% for each HMO in the BCP and SSI programs. There is no minimum MLR or remittance provision in place for the SSI program.
- Federal Medical Assistance Percentage – The assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards and do not vary based on the rate of Federal financial participation associated with the covered populations.
- Cross-subsidies – Payments from one rate cell are not cross-subsidized by payments from any other rate cell.
- Rate change from prior period – See Section I.A. and Exhibits 15 to 17.
- Material changes to capitation rate methodology – See Section I.C.
- COVID-19 pandemic and unwinding impacts:
  - Enrollment: DHS projects 2026 member months will be 1.0% lower for SSI Medicaid Only and 1.1% lower for the SSI Dual Eligible population than 2024 member months, which includes the impact of member redeterminations.
  - Pandemic specific costs anticipated during 2026: We did not make any explicit adjustments related to the unwinding of the PHE for the 2026 capitation rates because we anticipate minimal population acuity changes from 2024 to 2026. As mentioned in Section I.B., costs for COVID-19 vaccines will be covered as EBPs in 2026.
  - Risk mitigation: DHS will continue a combined BCP and SSI two-way risk corridor mechanism for 2026 to mitigate the significant uncertainty related to the unwinding of the PHE, similar to the arrangement from 2021 through 2025, as described in Section IV.D.

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, HMO financial, and FFS data were updated from calendar year 2023 (and 2022 for SSI Dual Eligible) to calendar year 2024.
- Other data adjustments – See Section II.D.
- Blending of data sources – Not applicable.
- Data reliance – Please refer to the actuarial certification included as Appendix E 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.
- 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.

  ILOS – See the list of 2026 ILOS services in Section II.B, which only includes IMD and the meals ILOS effective January 1, 2025 described in Section III.B. The projected 2026 SSI ILOS Cost Percentage (excluding short-term stays in an IMD) is 0.7% calculated as the projected SSI ILOS cost of $3,884,219 divided by the projected SSI total capitation of $561,053,747.
- 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 during 2024 as part of their financial template submission and included these recoveries to develop the 2026 capitation rates.

- Changes in covered services and benefits – There were no benefit changes between the base period and contract period other than the covered service changes described in Section III.B.
- Other adjustments – Not applicable.
- Final projected benefit costs – See Exhibit 3 (medical capitation rates), Exhibit 8 (dental capitation rates), and Exhibit 13 (chiropractic capitation rates) before SDP add-ons.
- Conditions of any litigation to which the state is subjected – Not applicable.
- 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 – Not applicable
- Withhold Arrangements – See Section IV.B
- Risk Sharing – See Section IV.D
  - The risk sharing arrangement is consistent with pricing assumptions used in capitation rate development
  - The risk sharing arrangement will not result in a remittance / payment or receivable if calculated based on pricing assumptions used in capitation rate development (i.e., if projected claims are equal to projected claims, the risk sharing remittance / payment will be $0)
- State Directed Payments – See Section IV.C

DHS will submit 438.6(c) preprints to CMS for each SDP utilized by the SSI program and described in the following table:

Control name of the state directed payment	Type of payment	Brief description	Is the payment included as a rate adjustment or separate payment term?
Provider Access Payments	Uniform dollar	Eligible facilities are paid access fees by the HMOs for eligible inpatient and outpatient utilization.	Separate payment term included in capitation rates – see Exhibit 18.
Ambulance Payments	Uniform dollar	Eligible providers are paid access fees by the HMOs for eligible trips.	Rate adjustment included in capitation rates – see Exhibits 19 and 20.
UWMF Payments for Professional Services	Uniform Percentage Increase	HMOs pay UWMF an additional uniform percentage increase for professional claims below the average commercial rates for their top 5 carriers compared to the Medicaid fee schedule.	Separate payment term included in capitation rates – see Exhibit 21.

These 2026 preprint arrangements are consistent with this 2026 rate certification. The preprints are also consistent with the 2025 preprint arrangements, not yet approved by CMS, except for updated funding amounts.

The following table includes details for the SDP incorporated as a rate adjustment:

Control name of the state directed payment	Rate cells affected	Impact	Description of the adjustment	Confirmation the rates are consistent with the preprint	For maximum fee schedules, provide the information requested in (E) below
Ambulance Payments	All SSI Medicaid Only rate cells	See the PMPM amounts in Exhibits 19 and 20 and the projected aggregate amounts in Table 18.	DHS provides funding to promote access for Medicaid individuals to ambulance services.	Confirmed	Not applicable

The following table includes details for the SDP incorporated as a separate payment term:

Control name of the state directed payment	Aggregate amount included in the certification	Statement that the actuary is certifying the separate payment term	The magnitude on a PMPM basis	Confirmation the rates are consistent with the preprint	Confirmation that the state and actuary will submit required documentation at the end of the rating period
Provider Access Payments	Refer to Table 17	Confirmed	Refer to Exhibit 18A	Confirmed	Confirmed
UWMF Payments for Professional Services	Refer to Table 19	Confirmed	Refer to Exhibit 21	Confirmed	Confirmed

  - Refer to Section IV.C for a description of the data, assumptions, and methodologies.
  - There are no other directed payments in the SSI 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 here and in Section IV.C.

- 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.
- Historical administrative costs reported by HMOs – See Table 15 in Section III.E.

6. Risk Adjustment

- See Section IV.A and Exhibits 5A and 6A.

7. Acuity Adjustments

- Not applicable.

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

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

SECTION III. NEW ADULT POPULATION CAPITATION RATES

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

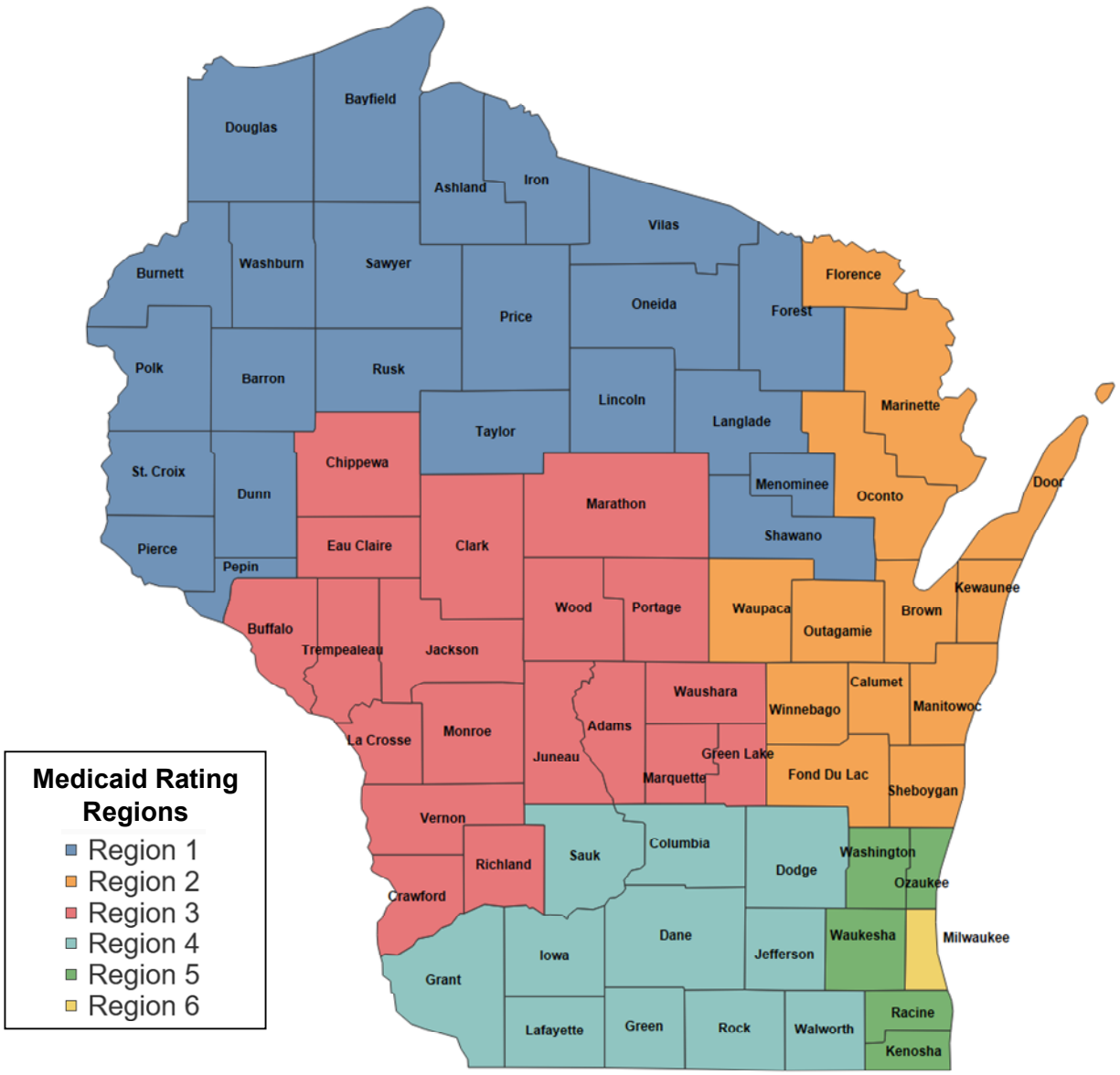
2026 RATE EXHIBITS
(Provided In Excel)

State of Wisconsin Department of Health Services
Calendar Year 2026 Capitation Rate Development
SSI Medicaid Managed Care Program

December 10, 2025

APPENDIX A

Mapping of Wisconsin Counties to Medicaid Rate Regions



APPENDIX B
Custom Risk Model Weights
(Provided In Excel)

APPENDIX C
Custom Risk Model Category Mapping
(Provided In Excel)

APPENDIX D

Enhanced FMAP Identification Criteria

APPENDIX D

ENHANCED FMAP IDENTIFICATION CRITERIA

We identified the family planning services, 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
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

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**
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
99394	5047	N/A
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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

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**
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
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

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**
45350	5048	33
45355	5048	33
45378	5048	33
45379	5048	33
45380	5048	33
45381	5048	33
45382	5048	33
45383	5048	33
45384	5048	33
45385	5048	33
45386	5048	33
45387	5048	33
45388	5048	33
45389	5048	33
45390	5048	33
45392	5048	33
45393	5048	33
45398	5048	33
76705	5048	33
76770	5048	33
76775	5048	33
76977	5048	33
77051	5048	33
77052	5048	33
77055	5048	33
77056	5048	33
77078	5048	33
77079	5048	33
77080	5048	33
77081	5048	33
77082	5048	33
80055	5048	33
80061	5048	33
80422	5048	33
82270	5048	33
82274	5048	33
82465	5048	33
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

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**
86701	5048	33
86702	5048	33
86703	5048	33
86704	5048	33
86705	5048	33
86706	5048	33
86900	5048	33
86901	5048	33
87070	5048	33
87081	5048	33
87086	5048	33
87088	5048	33
87340	5048	33
87341	5048	33
87389	5048	33
87390	5048	33
87534	5048	33
87535	5048	33
87536	5048	33
87590	5048	33
87591	5048	33
87592	5048	33
87850	5048	33
92002	5048	33
92004	5048	33
92012	5048	33
92014	5048	33
92587	5048	33
96040	5048	33
96150	5048	33
96151	5048	33
96152	5048	33
96153	5048	33
96154	5048	33
99174	5048	33
99201	5048	33
99202	5048	33
99203	5048	33
99204	5048	33
99205	5048	33
99211	5048	33
99212	5048	33
99213	5048	33
99214	5048	33
99215	5048	33
G0204	5048	33
G0206	5048	33

APPENDIX E

Actuarial Certification

This report assumes the reader is familiar with the State of Wisconsin's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set 2026 capitation rates for the SSI Medicaid managed care program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This report should only be reviewed in its entirety.

State of Wisconsin Department of Health Services
Calendar Year 2026 Capitation Rate Development
SSI Medicaid Managed Care Program

December 10, 2025

17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA

Tel +1 262 784 2250

milliman.com

December 10, 2025

Wisconsin Department of Health Services
SSI Medicaid Managed Care Program
January through December 2026 Capitation Rates
Actuarial Certification

We, Shelly Brandel, Jill Brostowitz, and Emily Vandermause, are Principals and Consulting Actuaries with the firm of Milliman, Inc. We are members of the American Academy of Actuaries and meet its Qualification Standards for Statements of Actuarial Opinion. We have been retained by the Wisconsin Department of Health Services (DHS) to perform an actuarial certification of the SSI Medicaid managed care program capitation rates for January through December 2026 for filing with the Centers for Medicare and Medicaid Services (CMS). We reviewed the calculated capitation rates and are 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 2025-2026 Medicaid Managed Care Rate Development Guide, and Actuarial Standard of Practice (ASOP) 49.

To the best of our information, knowledge, and belief, the 2025 SSI capitation rates offered by DHS are in compliance with the relevant requirements of § CFR 438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7.

The attached actuarial report describes the capitation rate setting methodology.

In our 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.

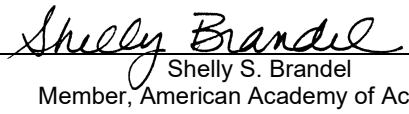
In making our opinion, we relied upon the accuracy of the underlying records, data summaries, and calculations prepared by DHS, as well as encounter data and financial data summaries prepared by the participating HMOs. A copy of the reliance letter received from DHS is attached and constitutes part of this opinion. We did not audit the data and calculations, but did review them for reasonableness and consistency and did not find material defects. In other respects, our examination included such review of the underlying assumptions and methods used and such tests of the calculations as we 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 our opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

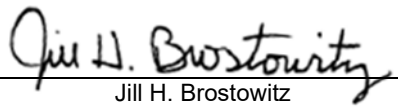
It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted HMO's situation and experience.

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



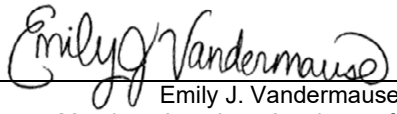
Shelly S. Brandel
Member, American Academy of Actuaries

December 10, 2025



Jill H. Brostowitz
Member, American Academy of Actuaries

December 10, 2025



Emily J. Vandermause
Member, American Academy of Actuaries

December 10, 2025

November 14, 2025

Ms. Jill H. Brostowitz, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
17335 Golf Parkway, Suite 100
Brookfield, WI 53045

RE: January 1, 2026 through December 31, 2026 Wisconsin Medicaid BadgerCare Plus and Supplemental Security Income (SSI) Managed Care Rate Development Data Reliance Letter

Dear Jill:

I, Krista Willing, Assistant Administrator for Systems, Fiscal, and Operations 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 2026 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 2026 capitation rate development, including:
   a. Fee-for-service claim data
   b. HMO encounter data
   c. Eligibility data
   d. 2025 and 2026 APR-DRG and per diem payment rates and parameters for the Wisconsin Medicaid FFS program
   e. 2025 and 2026 EAPG and non-EAPG outpatient facility payment rates and parameters for the Wisconsin Medicaid FFS program

2. Other supporting data, including:
   a. HMO financial data
   b. Projected 2026 member months
   c. 2026 provider access payment funding and criteria
   d. 2026 ambulance state directed payment funding and criteria
   e. University of Wisconsin Medical Foundation's 2024 professional commercial rates for its top 5 commercial payers and criteria for its state directed payment
   f. Historical performance withhold returns and quality incentive payments
   g. Information regarding program changes including Medicaid fee schedule changes
   h. Details regarding the scope of HMO covered services and eligible recipients
   i. Identification of claims eligible for enhanced federal match
   j. 2026 directed payment preprints submitted to CMS
   k. Other computer files and clarifying correspondence

Milliman relied on DHS for the collection and re-pricing of the FFS and encounter data to the Medicaid fee schedule amount at the time of each incurred claim. Milliman relied on the HMOs to provide accurate financial data as certified by the HMOs. Milliman did not audit the data, but assessed the data for reasonableness.

Signature

Krista Willing
Print Name

Assistant Administrator for Systems, Fiscal and Operations
Title

11/14/2025
Date

For more information about Milliman, please visit us at:

milliman.com

Solutions for a world at risk™

Milliman leverages deep expertise, actuarial rigor, and advanced technology to develop solutions for a world at risk. We help clients in the public and private sectors navigate urgent, complex challenges—from extreme weather and market volatility to financial insecurity and rising health costs—so they can meet their business, financial, and social objectives. Our solutions encompass insurance, financial services, healthcare, life sciences, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Shelly S. Brandel
shelly.brandel@milliman.com

Jill H. Brostowitz
jill.brostowitz@milliman.com

Emily J. Vandermause
emily.vandermause@milliman.com