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January 6, 2017

Ms. Krista Willing
Director
Bureau of Fiscal Management
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
One West Wilson Street
P.O. Box 309
Madison, WI 53701-0309

**Re: January 2016 BadgerCare Plus Capitation Rate Report**

Dear Krista:

The attached report contains January 2016 capitation rates for Wisconsin's BadgerCare Plus Medicaid managed care program. The January 2016 capitation rate development is identical to the February through December 2016 rate development documented in our report dated December 22, 2016, except for the annual trends being applied to a contract period midpoint of January 15, 2016 compared to a midpoint of July 15, 2016 in the February through December 2016 capitation rate development.

As additional background, DHS initially extended the Calendar Year 2015 capitation rates (developed by PricewaterhouseCoopers) through January 2016. The attached rate report and actuarial certification contains amended capitation rates effective for the one-month period from January 1, 2016 through January 31, 2016. DHS will adjust the January 2016 capitation payments on a retroactive basis from the original basis (2015) to the January 2016 rates in the attached report.

Sincerely,

Shelly Brandel

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

SSB/kal

Attachment

# State of Wisconsin
# Capitation Rate Development
# January 1, 2016 through January 31, 2016
# BadgerCare Plus Standard and Childless Adult Programs

Prepared for:
**Wisconsin Department of Health Services**

Prepared by:
**Milliman, Inc.**

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January 6, 2017

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# I. SUMMARY OF RESULTS AND CAVEATS

This report documents the development of capitation rates effective January 1, 2016 through January 31, 2016 (herein referred to as the "January 2016" or "2016" capitation rates) for Wisconsin's BadgerCare Plus (BCP) Standard and Childless Adult (CLA) programs.

The Wisconsin Department of Health Services (DHS) retained Milliman, Inc. (Milliman) to develop and certify its January 2016 BCP capitation rates. Milliman's role is to calculate and certify actuarially sound capitation rates to comply with CMS regulations and the CMS rate setting checklist.

The January 2016 capitation rate development is identical to the February through December 2016 rate development documented in our report dated December 22, 2016, except for the annual trends being applied to a contract period midpoint of January 15, 2016 compared to a midpoint of July 15, 2016 in the February through December 2016 capitation rate development. Please refer to our report dated December 22, 2016 for the development of BCP capitation rates for the period February through December 2016.

## A. CAPITATION RATE COMPARISON

Table 1 shows a comparison of the January 2016 and calendar year 2015 per member per month (PMPM) medical and dental capitation rates and maternity kick payments by geographic rate region and eligibility category. A more detailed comparison summarizing the rate changes for all coverage types (medical only, medical / dental, medical / chiropractic, and medical / dental / chiropractic) for each HMO based on August 2015 enrollment is shown in Exhibits 18 through 20. Exhibit 22 shows the final January 2016 capitation rates, including provider access payments.

**Table 1A**
**Summary of Capitation Rate Changes by Region (Excluding Provider Access Payments)**
**Calendar Year 2015 to January 2016**
**BadgerCare Plus Standard**

| | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 | Region 6 | Statewide[1] |
|---|---|---|---|---|---|---|---|
| **Medical Capitation Rates** | | | | | | | |
| 2016 Capitation Rate | $129.09 | $105.55 | $113.21 | $109.46 | $106.44 | $115.71 | $113.27 |
| 2015 Capitation Rate | $137.48 | $102.05 | $112.05 | $107.48 | $106.33 | $116.81 | $113.63 |
| Rate Change | -6.1% | 3.4% | 1.0% | 1.8% | 0.1% | -0.9% | -0.3% |
| **Maternity Kick Payments** | | | | | | | |
| 2016 Kick Payment | $6,184.43 | $4,480.67 | $5,131.05 | $5,012.63 | $4,496.81 | $5,248.11 | $5,086.73 |
| 2015 Kick Payment | $6,402.56 | $4,303.36 | $4,705.44 | $5,079.66 | $4,530.29 | $5,056.39 | $4,984.89 |
| Kick Payment Change | -3.4% | 4.1% | 9.0% | -1.3% | -0.7% | 3.8% | 2.0% |
| **Dental Capitation Rates** | | | | | | | |
| 2016 Capitation Rate | n/a | n/a | n/a | n/a | $7.39 | $6.24 | $6.58 |
| 2015 Capitation Rate | n/a | n/a | n/a | n/a | $7.00 | $6.78 | $6.85 |
| Rate Change | n/a | n/a | n/a | n/a | 5.5% | -8.1% | -4.0% |
| **Chiropractic Capitation Rates** | | | | | | | |
| 2016 Capitation Rate | $2.11 | $1.17 | $1.85 | $1.11 | $0.80 | $0.27 | $1.05 |
| 2015 Capitation Rate | $3.35 | $2.33 | $2.98 | $1.87 | $1.10 | $0.31 | $1.72 |
| Rate Change | -37.0% | -50.0% | -37.7% | -40.6% | -26.9% | -13.9% | -38.8% |

[1] *Statewide changes in medical and dental capitation rates are based on August 2015 enrollment; statewide changes in maternity kick payments are based on deliveries by region from November 2013 through October 2014.*

| Table 1B<br>Summary of Capitation Rate Changes by Region (Excluding Provider Access Payments)<br>Calendar Year 2015 to January 2016<br>Childless Adults | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Region 1** | **Region 2** | **Region 3** | **Region 4** | **Region 5** | **Region 6** | **Statewide[1]** |
| **Medical Capitation Rates** | | | | | | | |
| 2016 Capitation Rate | $310.29 | $266.52 | $243.62 | $255.99 | $306.53 | $276.94 | $276.19 |
| 2015 Capitation Rate | $322.68 | $259.31 | $266.31 | $283.58 | $279.26 | $277.23 | $280.20 |
| Rate Change | -3.8% | 2.8% | -8.5% | -9.7% | 9.8% | -0.1% | -1.4% |
| **Dental Capitation Rates** | | | | | | | |
| 2016 Capitation Rate | n/a | n/a | n/a | n/a | $7.29 | $6.43 | $6.64 |
| 2015 Capitation Rate | n/a | n/a | n/a | n/a | $6.86 | $7.01 | $6.97 |
| Rate Change | n/a | n/a | n/a | n/a | 6.3% | -8.2% | -4.7% |
| **Chiropractic Capitation Rates** | | | | | | | |
| 2016 Capitation Rate | $3.05 | $2.96 | $3.32 | $2.28 | $1.42 | $0.55 | $1.84 |
| 2015 Capitation Rate | $6.08 | $4.78 | $5.34 | $3.86 | $2.45 | $0.92 | $3.17 |
| Rate Change | -49.9% | -38.0% | -37.7% | -40.8% | -42.2% | -40.0% | -41.8% |

[1] *Statewide changes in medical and dental capitation rates are based on August 2015 enrollment; statewide changes in maternity kick payments are based on deliveries by region from November 2013 through October 2014.*

## B. CAPITATION RATE CELL STRUCTURE

The January 2016 rate cell structure is the same as the rate cell structure used for the 2015 rates.

### Eligibility Categories

We developed capitation rates for the following eligibility categories:

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

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

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

April 1, 2014. The newly-covered CLA population began enrollment into managed care on July 1, 2014.

### Rate Regions

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

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

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

### Rate Cells

The capitation rates are paid separately by age / gender category as well as rate region. Table 2 summarizes the age / gender categories used within each eligibility category.

**Table 2**
**Age / Gender Rate Cells by Eligibility Category**

| BCP Standard | BCP Childless Adults |
|---|---|
| Age 0 | n/a |
| Ages 1-5 | |
| Ages 6-14 | |
| Ages 15-20 Female | Ages 19-34 Female |
| Ages 21-34 Female | |
| Ages 35-44 Female | Ages 35-44 Female |
| Ages 45+ Female | Ages 45+ Female |
| Ages 15-20 Male | Ages 19-34 Male |
| Ages 21-34 Male | |
| Ages 35-44 Male | Ages 35-44 Male |
| Ages 45+ Male | Ages 45+ Male |

### Covered Services

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

## C. HIGH LEVEL RATE METHODOLOGY

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

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

The risk adjustment process adjusts the capitation rates for estimated differences in acuity levels by HMO for the BCP Standard eligibility category. The CLA capitation rates are not risk adjusted due to the significant rate of growth of this population during 2014 and the limited amount of base period data available (a large proportion of this population became newly eligible for Medicaid as of April 1, 2014 and did not begin enrollment into managed care until July 1, 2014).

## Material Changes to Rate Methodology

DHS' prior actuarial vendor developed the calendar year 2015 capitation rates for the BadgerCare Plus program. Material changes to the rate methodology include:

- Base data sources – The 2015 rates were based on HMO encounter data from fiscal years 2011 and 2012. The January 2016 rates are based on more recent HMO encounter data from calendar years 2013 and 2014.

- HMO financial data – As part of the January 2016 rate setting process, we collected HMO financial data for the first time and used this information to validate the encounter data and develop missing data adjustments, incorporate payments made to providers outside of the claims system, develop provider contracting adjustments, and develop 2016 administrative cost allowance targets. The HMO financial data was not available for the 2015 rate development.

- Statewide rate cell factors – We used statewide data to allocate the regional capitation rates by rate cell. Previously, the capitation rates for each rate cell were developed based on the base data for each rate cell.

- Hospital re-pricing adjustments – The 2015 hospital inpatient and hospital outpatient re-pricing adjustments were developed separately for critical access hospitals and other hospitals on a statewide basis regardless of eligibility category. In the January 2016 rate development, we calculated hospital inpatient and hospital outpatient re-pricing adjustments that vary by eligibility category, region, and claim type (i.e., base medical coverage versus maternity) using detailed encounter data re-priced to the 2016 Medicaid fee schedule to recognize regional hospital reimbursement differences.

- CLA rate setting – The 2015 CLA rates were based on a blend of data sources since encounter data for the CLA expansion population was not yet available. The January 2016 capitation rates are based on CLA encounter data for the period April through December 2014, with adjustments to reflect the estimated impact of pent-up demand wear-off and seasonality.

- BCP Standard risk adjustment – The 2015 risk scores by HMO were normalized by regional groupings (i.e., the final risk score adjustments were the same for Regions 1 through 4 and Regions 5 and 6). The January 2016 risk scores were normalized separately for each region (i.e., the weighted average risk score across all HMOs within a given region is 1.000). We also excluded lab, radiology, and durable medical equipment claims to eliminate false positive indicators, and we used a minimum of six months of eligibility (instead of three months) to assign risk scores to individuals to reduce the bias towards lower risk scores for new members.

## 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 January 2016 base capitation rates by eligibility category, region, and age / gender category.
- Section IV documents the development of final HMO-specific capitation rates, including risk score adjustments, pay-for-performance (P4P) withholds, and provider access payments.
- Section V documents the projected costs for services eligible for enhanced federal funding (applies to medical capitation rates and maternity kick payments).
- Section VI provides responses to the CMS rate setting checklist.
- Section VII provides responses to the 2016 CMS Medicaid rate setting guide.

Exhibits 1 through 26 summarize the January 2016 rate development. Appendix A contains our actuarial certification which applies to the January 2016 contract period.

### IMPORTANT LIMITATIONS AND CAVEATS

We relied on several sources of HMO and fee-for-service (FFS) claims and eligibility data to develop the capitation rates in this report, including HMO encounter data, HMO financial data submissions, detailed FFS data, inpatient and outpatient facility 2016 repricing data, and other supporting information from DHS. **We did not audit any of the base data sources**, but we did assess the data for reasonableness.

We relied on DHS for the collection and processing of the HMO encounter data, the accuracy of the FFS data, and the inpatient and outpatient facility 2016 repricing data. We relied on the HMOs to provide accurate financial data as certified by the HMO. If the data used is inadequate or incomplete, the results will be likewise inadequate or incomplete.

Differences between the capitation rates and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

Our report is intended for the internal use of DHS to develop January 2016 BadgerCare Plus capitation rates. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. It should only be reviewed in its entirety.

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

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

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

# II. BASE DATA DEVELOPMENT

This section of our report describes the base data development and the blending of the various data sources described in this report. In general, the base data used to calculate the January 2016 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 / gender categories combined:

- Exhibit 1A: Medical Only – BCP Standard
- Exhibit 1B: Medical Only – CLA
- Exhibit 7: Maternity – BCP Standard
- Exhibit 10A: Dental – BCP Standard
- Exhibit 10B: Dental – CLA
- Exhibit 15A: Chiropractic – BCP Standard
- Exhibit 15B: Chiropractic – CLA

## A. BASE DATA SOURCES

The data sources used in the January 2016 rate development are listed and described below:

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

2. **HMO Financial Data** – Participating HMOs were required to submit calendar year (CY) 2013 and CY 2014 financial data to DHS. The financial data included the following information by eligibility category, region, and calendar year:

   - Total member months and maternity deliveries eligible for kick payments.
   - Total claim payments to providers, including FFS claim payments, payments made to sub-capitated providers, provider risk sharing and incentive payments, and other payments made outside the FFS claims system.
   - Total administrative costs (this information was reported in total across all eligibility categories).
   - Additional information on payments made to related parties.
   - A certification from the HMO attesting the data is accurate, complete and truthful.

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

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

DHS and Milliman went through an extensive data validation process to review all HMO data included in the January 2016 rate setting methodology. DHS collected monthly encounter reporting from each HMO to monitor the quality of encounter data submissions. After this process was complete, DHS forwarded the data to Milliman.

Milliman also reviewed the encounter data and financial data. We provided data summaries to all participating HMOs and held one-on-one conference calls with many HMO representatives to present the HMO-specific summaries, discuss data questions, and solicit feedback. After receiving answers to our questions and several data resubmissions from the HMOs, we released base data summaries on September 24, 2015 (with updates provided on October 21, 2015) for HMO review and comment. Additionally, we held a meeting on November 19, 2015 to explain the base data and solicit feedback from the HMOs.

Table 3 summarizes the base data time period and midpoint for the data sources shown in Table 2.

**Table 3**
**Base Data Time Periods**

| Data Source | Data Time Period Used | Paid Through | Data Midpoint |
|---|---|---|---|
| HMO Encounter Data | CY 2013 and CY 2014 | July 2015[1] | January 1, 2014 |
| HMO Financial Data | CY 2013 and CY 2014 | July 2015 | January 1, 2014 |
| FFS Data | CY 2013 and CY 2014 | June 2015 | January 1, 2014 |

*[1] Encounter data files received from DHS on August 6, 2015; paid through date may differ by HMO.*

## B. HMO ENCOUNTER DATA PROCESSING METHODOLOGY

### HMO Encounter Data Submission

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

The encounter data provided to Milliman includes services provided during calendar years 2012 through 2014. As noted above, we used 2013 and 2014 encounter data to develop the base period costs. We summarized the 2013 and 2014 encounter data using the methodology described in the following sections.

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

## Excluded Claims

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

1. **Claims incurred outside of CY 2013 and CY 2014:** We excluded claims for services provided outside of the period January 1, 2013 through December 31, 2014. Incurral dates for hospital inpatient claims are assigned based on the admission date.

2. **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.

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

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

5. **Physician administered drugs:** We excluded claims for physician administered drugs since these claims are reimbursed on a FFS basis by DHS. The definition of physician administered drugs is consistent with the changes effective January 1, 2015 and is summarized as follows:

   Professional claims for physician administered drugs (based on the DHS list provided as of 1/1/2015) are paid under FFS. The HMOs are at risk for the administrative expense component of physician administered drugs. HMOs are also at risk for drugs dispensed in certain places of service such as hospital inpatient and hospital outpatient settings. HMOs are at risk for some ESRD provider claims based on CPT code.

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

7. **Financial Indicator "N" claims:** We excluded claims with a Financial Indicator of "N" which were flagged by DHS as not having any payment made by the HMO (this excludes sub-capitated claims).

8. **Excluded HMOs:** Based on our review of the HMO encounter data in comparison to average results across all HMOs, HMO financial data, and other information, we determined the encounter data for several HMOs was not reliable. Therefore, the claims and member months for these plans were excluded from the HMO encounter base data to produce a more credible result. This adjustment resulted in excluding approximately 4% of total member months in the base period experience statewide, with the largest impact in Region 4. The impact by eligibility category and region are shown in Table 4.

| Table 4<br>Percentage of Member Months Removed from Base Data due to Excluded HMOs | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Region 1** | **Region 2** | **Region 3** | **Region 4** | **Region 5** | **Region 6** | **Statewide** |
| BadgerCare Plus Standard | 0.0% | 0.0% | 0.0% | 24.0% | 0.2% | 0.2% | 4.3% |
| Childless Adults | 0.0% | 0.4% | 0.0% | 26.2% | 1.7% | 3.3% | 5.7% |

## Included Claims

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

We confirmed with DHS that the re-priced Medicaid paid and HMO paid amounts in the encounter data and financial data excluded any additional enhanced payments made to providers due to the Affordable Care Act (ACA). The enhanced payments to PCPs ended on December 31, 2014, therefore the January 2016 capitation rates should exclude the historical cost of these enhanced payments.

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

### Maternity

Encounters that meet the following criteria are identified as services covered by the maternity kick payment. We identified completed deliveries using the following criteria:

- Diagnosis code of 650, 65221, 65222, 64421, or 65421
- Diagnosis code beginning with 6695, 6696, 6697, or V27
- Diagnosis code beginning with 650-669 where the fifth digit is a 1 or 2
- Diagnosis code beginning with 640 or 670 where the fifth digit is a 1 or 2
- MS-DRG equal to 765, 766, 767, 768, 774, or 775

Additional inpatient, outpatient, and professional / other maternity services are also carved out and identified as follows:

- Inpatient Claims (Claim Type = “A,” “I,” or “L”):
  - Revenue code of 0110-0539, 0560-0569, 0610-0649, or 0660-0999 and primary diagnosis code beginning with 630-634 or 640-676 or V22-V242
  - MS-DRG equal to 765, 766, 767, 768, 774, or 775
  - Revenue code of 0112, 0122, 0132, 0142, 0512, 0232, or 0720-0729

- Outpatient Claims (Claim Type = "C" or "O"):
  - Revenue code of 0110-0539, 0560-0569, 0610-0649, or 0660-0999 and primary diagnosis code beginning with 630-634 or 640-676 or V22-V242
  - Revenue code of 0720, 0721, 0722, 0723, 0724, or 0729
  - Procedure code of 59400-59410, 59510-59515, 59610-59622, 59000-59350, 59412-59430, 59812-59899, or 59525
- Professional / All Other Claims (Claim Type = "M," "B," or "H"):
  - Revenue code of 0110-0539, 0560-0569, 0610-0649, or 0660-0999 and primary diagnosis code beginning with 630-634 or 640-676 or V22-V242
  - Procedure code of 59000-59830, 59866-59899, MCD01-MCD04, G9005-G9006, G9001-G9002, G9009-G9012, MCM01-MCM11, 01958-01960, 01961, 01967, 01968, or 76801-76828
  - Procedure code of 99201-99440, 90801-90899, 92002-92014, 97001-97004, D0120-D0170, H0001-H0030, IHC01-IHC11, CMS01, FQH01, FQ600, G0363, IH500, M0064, Q0034, RHC01, RH555, 90471, 99499, or 9500M-9600M AND primary diagnosis code beginning with 630-634 or 640-676
  - Procedure code of 99201-99440, 90801-90899, 92002-92014, 97001-97004, D0120-D0170, H0001-H0030, IHC01-IHC11, CMS01, FQH01, FQ600, G0363, IH500, M0064, Q0034, RHC01, RH555, 90471, 99499, or 9500M-9600M AND primary diagnosis code of V22-V242

We re-classified any maternity claims for CLA members as part of the medical data since DHS only pays maternity kick payments for the BCP Standard eligibility category.

We included maternity claims for completed pregnancies only by limiting the delivery dates to the time period from November 2013 through October 2014.

### Dental

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

### Chiropractic

Chiropractic: Encounters with procedure codes of W9010 or 98940-98942 were identified as chiropractic services.

## Service Category Assignment

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

## C. FFS DATA PROCESSING METHODOLOGY

The FFS data was used to develop capitation rates for chiropractic services since very few of the HMOs were contracted to cover these services in the base period and therefore credible encounter data is not available. Most of the data exclusions in the encounter data section apply to the FFS data as well, with the exception of excluded HMOs which was not applicable for the FFS data. In addition to the encounter data adjustments, we applied the following adjustments to the FFS data:

1. Excluded populations

    - Patients residing in ICF/MR or Alternative Mental Health Service facilities
    - Members receiving home and community based waiver services
    - Members enrolled in HMOs
    - Members in an HMO exemption status

2. Excluded services (not covered by the capitation rate)

    - Targeted case management
    - School-based services
    - Prenatal care coordination
    - Community Support Program
    - Crisis intervention services
    - Prescription drugs

## D. ADJUSTMENTS TO THE BASE DATA

This section discusses the adjustments we made to the base 2013 and 2014 data before projecting costs to the January 2016 rating period. These adjustments are shown in the following exhibits:

- Exhibit 1A: BCP Standard – Medical
- Exhibit 1B: CLA – Medical
- Exhibit 7: BCP Standard – Maternity
- Exhibit 10A: BCP Standard – Dental
- Exhibit 10B: CLA – Dental
- Exhibit 15A: BCP Standard – Chiropractic
- Exhibit 15B: CLA – Chiropractic

### Missing Data Adjustment (Encounter Data)

DHS has required contracted HMOs to submit encounter data files for many years to be used for Medicaid managed care rate setting. However, there were significant changes to the system and edits during 2012, which has resulted in lower rates of accepted claims. We identified several issues with the 2013 and 2014 encounter data files:

- Encounter data submissions may not be complete (i.e., some encounters may not have been submitted to DHS).

- Encounters may have been submitted but did not pass the DHS system edits, resulting in encounters with a “denied” status that could not be re-priced even though the records may have represented valid encounters.

- Encounter data typically does not include payments made to providers outside the claim adjudication system, such as quality incentives or distribution of withhold payments, provider risk sharing settlements, or other miscellaneous claim payments. Excluding these amounts could understate or overstate the total payments from HMOs to providers.

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

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

**Table 5**
**Missing Data Adjustments Applied to HMO Encounter Data**

| | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 | Region 6 |
|---|---|---|---|---|---|---|
| **BadgerCare Plus Standard** | | | | | | |
| Medical – CY 2013 | 1.062 | 1.068 | 1.049 | 1.126 | 1.075 | 1.077 |
| Medical – CY 2014 | 1.075 | 1.065 | 1.057 | 1.120 | 1.126 | 1.129 |
| Dental – CY 2013[1] | n/a | n/a | n/a | n/a | 1.071 | 1.070 |
| Dental – CY 2014[1] | n/a | n/a | n/a | n/a | 1.132 | 1.138 |
| Maternity[2] | 1.000 | 1.000 | 1.000 | 1.121 | 1.000 | 1.000 |
| **Childless Adults** | | | | | | |
| Medical – CY 2014 | 1.074 | 1.069 | 1.060 | 1.111 | 1.089 | 1.088 |
| Dental – CY 2014[1] | n/a | n/a | n/a | n/a | 1.090 | 1.094 |

[1] *Dental capitation rates are only calculated in Regions 5 and 6.*

[2] *Maternity claims are generally assumed to be complete in the encounter data since we identify completed pregnancies directly in the encounter data. A missing data adjustment is applied in Region 4 due to known issues with the inpatient encounter data reporting in this region.*

## Completion Factor (Encounter and FFS Data)

We applied completion factors to allow for incurred but not reported (IBNR) claims as of the data submission date. We reviewed claims lag patterns in the FFS data to establish the IBNR adjustments since the HMO encounter data did not include reliable claim payment date information. Table 6 summarizes the completion factors applied to the base data. The CY 2013 data is assumed to be complete since there are approximately 18 months of claims runout.

**Table 6**
**Completion Factors**

| Eligibility Category | Calendar Year 2013 | | Calendar Year 2014 | |
|---|---|---|---|---|
| | Inpatient Facility | Other Services | Inpatient Facility | Other Services |
| BCP Standard | 1.000 | 1.000 | 1.038 | 1.013 |
| Childless Adults | 1.000 | 1.000 | 1.047 | 1.016 |

## Provider Contracting Adjustment (Encounter Data)

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

**Table 7**
**Provider Contracting Adjustments**

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

## Dental Re-Pricing Adjustment (Encounter Data)

The CY 2013 re-priced Medicaid paid amounts PMPM for dental services in the BCP Standard eligibility category were significantly higher than the CY 2014 re-priced Medicaid paid amounts, while the HMO paid amounts PMPM did not show the same pattern. Based on our analysis and discussion with DHS, we determined the 2013 dental re-priced Medicaid paid amounts were overstated due to a re-pricing issue with orthodontic services during 2013. To address this issue, we applied a dental re-pricing adjustment of 0.607 and 0.580 to the 2013 BCP Standard dental re-priced Medicaid paid amounts in Regions 5 and 6, respectively, to adjust the 2013 re-priced Medicaid paid amounts PMPM based on the 2013 HMO paid amounts PMPM compared to the 2014 re-priced paid Medicaid amounts PMPM and the 2014 HMO paid amounts PMPM.

# III. PROJECTED JANUARY 2016 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 January 2016 base capitation rates by eligibility category, region and age / gender category before risk adjustment, P4P withholds, and provider access payments are applied.

The following exhibits summarize the development of projected January 2016 claim costs:

- Exhibit 2A: BCP Standard – Medical
- Exhibit 2B: CLA – Medical
- Exhibit 8: BCP Standard – Maternity
- Exhibit 10A: BCP Standard – Dental
- Exhibit 10B: CLA – Dental
- Exhibit 15A: BCP Standard – Chiropractic
- Exhibit 15B: CLA – Chiropractic

## A. REIMBURSEMENT CHANGES

### Inpatient Facility Re-Pricing Adjustment

Inpatient facility claims, excluding skilled nursing facility, were re-priced by DHS to the inpatient rates effective January 1, 2016. We used this detailed re-pricing data, provided by DHS, to calculate the impact of reimbursement changes on the historical 2013 and 2014 inpatient facility claims (excluding nursing facility). Since the re-pricing impact varies significantly by hospital, the rating adjustments are applied by eligibility category, year, and region to reflect the expected changes based on the historical volume of claims by hospital. Table 8 summarizes the inpatient facility re-pricing adjustments applied to the base encounter data.

**Table 8**
**Inpatient Facility Re-Pricing Adjustments**

| | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 | Region 6 |
|---|---|---|---|---|---|---|
| **BadgerCare Plus Standard** | | | | | | |
| Medical – CY 2013 | 1.009 | 1.008 | 1.025 | 1.038 | 0.974 | 1.076 |
| Medical – CY 2014 | 1.001 | 0.995 | 1.010 | 1.018 | 0.954 | 1.048 |
| Maternity[1] | 1.013 | 0.993 | 0.994 | 0.966 | 1.039 | 1.005 |
| **Childless Adults** | | | | | | |
| Medical – CY 2013 | n/a | n/a | n/a | n/a | n/a | n/a |
| Medical – CY 2014 | 0.957 | 0.983 | 0.980 | 0.992 | 0.902 | 1.005 |

[1] *Maternity claims are for claims related to deliveries from November 2013 through October 2014*

### Outpatient Facility Re-Pricing Adjustment

Similar to the inpatient claims, DHS provided re-priced outpatient facility claims, excluding hospice, based on the fees effective January 1, 2016. DHS moved to HMO outpatient reimbursement based on Enhanced Ambulatory Patient Groupings (EAPGs) effective January 1, 2015.

Table 9 summarizes the outpatient facility re-pricing adjustments applied to the base encounter data.

| Table 9<br>Outpatient Facility Reimbursement Adjustments | | | | | | |
|---|---|---|---|---|---|---|
| | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 | Region 6 |
| **BadgerCare Plus Standard** | | | | | | |
| Medical – CY 2013 | 1.029 | 0.894 | 1.041 | 1.028 | 0.963 | 0.816 |
| Medical – CY 2014 | 0.981 | 0.896 | 0.985 | 0.994 | 1.003 | 0.812 |
| Maternity[1] | 0.640 | 0.755 | 0.912 | 0.841 | 0.793 | 0.782 |
| **Childless Adults** | | | | | | |
| Medical – CY 2013 | n/a | n/a | n/a | n/a | n/a | n/a |
| Medical – CY 2014 | 1.330 | 1.202 | 1.279 | 1.281 | 1.302 | 1.117 |

[1] *Maternity claims are for claims related to deliveries from November 2013 to October 2014*

### Hospice Reimbursement Adjustment

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

## B. PROGRAM CHANGES

### Benefit Changes

#### Alternative Mental Health Services

Alternative Mental Health Services (AMHS) are routinely provided by HMOs in lieu of inpatient psychiatric admissions.

We separated AMHS claims into those less than or equal to 30 days versus those greater than 30 days in the base data summaries. AMHS stays over 30 days are not covered by Medicaid and, therefore, the benefit adjustment for these services are set to zero.

Per DHS, AMHS and inpatient psychiatric services are reimbursed at the same Medicaid rate. Therefore, no unit cost adjustments for AMHS services 30 days or less were required.

#### Removal of Copayments for Certain Preventive Services

Member copayments were removed from certain preventive services effective April 1, 2014. We developed benefit adjustments for these "$0 Copay Preventive Services" by analyzing the impact of removing the member copayments in the base encounter data. Table 10 summarizes the benefit adjustments for these services:

| Table 10<br>Zero Copay Preventive Services Unit Cost Adjustments | | | | |
|---|---|---|---|---|
| | BadgerCare Plus Standard | | Childless Adults | |
| Service Category | CY 2013 | CY 2014 | CY 2013 | Apr-Dec 2014 |
| Outpatient Facility | 1.009 | 1.010 | n/a | 1.009 |
| Professional | 1.005 | 1.002 | n/a | 1.001 |

### Eligibility Changes

Change in Enrollment Exemption Policy for Members Receiving Methadone Treatment

Currently, members receiving methadone treatment can receive an exemption to enroll into FFS instead of an HMO for the BCP Standard and CLA programs. Effective January 1, 2016, DHS will no longer allow exemptions from HMO enrollment solely due to methadone treatment. However, DHS will not actively enroll members already exempted solely for methadone treatment back into the HMOs before their renewal dates.

We analyzed the average risk score for the FFS members receiving methadone treatment compared to the average risk score for HMO enrolled members. We assumed 30% of the currently exempted FFS members would voluntarily move to HMO enrollment in 2016. Based on this analysis, we applied a 1.001 factor to the BCP Standard projected claims to reflect the estimated impact of enrolling a higher proportion of members receiving methadone treatment in 2016. This adjustment was applied to all service categories, except "Payments Made Outside Encounter Data."

We performed a similar analysis for the CLA eligibility category and determined the estimated impact on this population was not significant and, therefore, no adjustment was necessary.

Change in Enrollment Exemption Policy for Individuals with HIV / AIDS

Currently, members diagnosed with HIV / AIDS can receive an exemption to enroll into FFS instead of an HMO for the BCP Standard and CLA programs. Similar to the methadone adjustment, we analyzed the average risk score for FFS members with HIV / AIDS compared to the average risk score for the HMO enrolled population. Based on this analysis, we determined the estimated impact of no longer allowing HMO exemptions for individuals solely based on being diagnosed with HIV / AIDS was not significant and, therefore, no adjustment was necessary.

## C. CLA ADJUSTMENTS

CLA Durational Adjustment

Prior to April 1, 2014, the BCP CLA program provided Medicaid services to childless adults with income at or below 200 percent of the FPL, but enrollment was capped. Effective April 1, 2014, the CLA program was expanded to include all childless adults with incomes less than 100 percent of the FPL, including members previously enrolled in other Medicaid programs as well as individuals not previously eligible for Medicaid benefits. Benefit coverage in the CLA plan was aligned with the BCP Standard plan benefits effective April 1, 2014. The newly covered CLA population began enrollment into managed care on July 1, 2014. CLA enrollment increased significantly from April through December 2015.

The 2015 CLA capitation rates included a 5.5% upward adjustment for newly eligible CLA enrollees for assumed pent-up demand. Because we used actual CLA experience data to develop the January 2016 rates, it was necessary to estimate the pent-up demand embedded in the experience data and make a downward adjustment to the rates. We estimated durational utilization factors by performing an analysis that reviewed quarterly costs for the CLA population by quarter of entry into the program. For example, we reviewed monthly costs for the population that enrolled in April through June 2014 separately from enrollees entering the program from July through September 2014. We defined pent-up demand as an entry month cohort having higher average PMPM expenses in initial quarters relative to enrollment quarters of longer duration relative to program entry.

Based on our analysis, we assumed pent-up demand was higher during the quarter of initial enrollment and decreased by 5% for each of the two following quarters of enrollment.

Table 11 summarizes the development of the 0.95 durational adjustment applied to the base period CLA claim costs. We assigned each individual included in the base period experience to one of the three enrollment categories shown below. We also estimated the distribution of CLA member months by enrollment category for January 2016 and calculated the difference in the average pent-up demand factor for the base period compared to the contract period.

**Table 11**
**CLA Durational Utilization Adjustment**

| | | Distribution of Member Months | |
|---|---|---|---|
| **Quarter of CLA Enrollment** | **Estimated Durational Factor** | **Base Period (April through December 2014) – *Actual*** | **Contract Period (January 2016) – *Estimated*** |
| 1 | 1.00 | 47% | 10% |
| 2 | 0.95 | 32% | 10% |
| 3+ | 0.90 | 21% | 80% |
| Average Pent-Up Demand Factor | | 0.963 | 0.915 |

Durational Adjustment: 0.915 / 0.963 = 0.950

### CLA Seasonality Adjustment

The CLA base period experience is from the period April through December 2014. Since this is less than a full calendar year of experience, we analyzed historical incurred claims PMPM for 2012 and 2013 for services provided during April through December compared to the full calendar year. Based on this analysis, we applied a seasonality adjustment of 1.023 to the CLA base period claims.

## D. TREND

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

- Inpatient facility = 1%
- Outpatient facility = 4%
- Professional and Other = 2%
- Dental = 4%

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

As part of our trend analysis, we reviewed historical trends from 2012 to 2014 in the HMO encounter and FFS data by eligibility category, region, and broad category of service.

- Inpatient facility utilization trends have generally been negative to flat in both the encounter and FFS data, although we observed positive utilization trend in the FFS data for the BCP Standard eligibility category. Based on our analysis, we assumed an inpatient facility utilization trend of 1% per year.

- We also reviewed historical outpatient facility claim PMPM trends from 2013 to 2014 using claims re-priced to 2016 Medicaid fees (2012 data was not available re-priced to 2016) to remove the impact of reimbursement changes. The HMO encounter trend was negative; however, the FFS trend was over 10%. The utilization trend assumption of 4% per year reflects an overall shift towards hospital outpatient services in the healthcare system.

- Historical trends for professional services (including chiropractic services) were negative or flat in the encounter data and about 6% in the FFS data. There were not any significant changes in Medicaid fees between 2012 and 2014 and therefore no re-pricing adjustments were required for this analysis. We assumed an annual trend of 1% for professional and other services.

- Dental trends were 2% to 3% in the encounter data, and FFS dental trends were variable. We assumed an annual dental trend of 4%.

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

## E. ADMINISTRATIVE COST AND MARGIN ALLOWANCE

The following exhibits add the administrative cost and margin allowance to the projected January 2016 claim costs by eligibility category and region:

- Exhibit 3: Medical
- Exhibit 9: Maternity
- Exhibit 11: Dental
- Exhibit 16: Chiropractic

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

The administrative allowances in the January 2016 capitation rates were developed as a percentage of revenue based on the 2013 and 2014 financial data provided by the HMOs. Table 12 summarizes the administrative cost and margin assumptions applied to the medical, dental, and chiropractic rates.

**Table 12**
**Administrative Cost and Margin Assumptions**
**Medical, Dental, and Chiropractic Capitation Rates**

| | BadgerCare Plus Standard | Childless Adults |
|---|---|---|
| *2016 Administrative Cost Components:* | | |
| Direct Expenses | 7.5% | 6.0% |
| Indirect Expenses | 5.0% | 4.0% |
| Care Coordination | 3.0% | 2.3% |
| Sales and Marketing | 0.5% | 0.2% |
| Total Administrative Cost Allowance | 16.0% | 12.5% |
| Margin Allowance | 2.0% | 2.0% |
| 2016 Administrative Cost / Margin Allowance | 18.0% | 14.5% |
| 2015 Administrative Cost / Margin Allowance | 14.0% | 12.0% |
| Change from 2015 to 2016 | 4.0% | 2.5% |

The 2016 administrative allowance is based on actual 2013 and 2014 administrative expenses reported by the HMOs across all eligibility categories in the supplemental financial data. We also examined the administrative costs reported by eligibility category in the year-to-date 2015 Medical Loss Ratio (MLR) reports through June 2015 provided by DHS. The margin allowance is 2% of capitation for all rate cells.

The recommended administrative loads are higher on a percentage basis than are typically used in other states because Wisconsin carves out prescription drugs from the capitation rates, resulting in a lower medical cost. On average, the rate year statewide administrative allowance for medical services is $18.63 PMPM for BCP Standard and $37.37 PMPM for CLA as shown in Exhibit 3 based on the base period demographic mix by rate cell and region. The resulting PMPM administrative loads are comparable to those used in other states and are consistent with Wisconsin HMO reported experience.

### Administrative Cost / Margin Allowance for Maternity Kick Payments

We applied an administrative cost allowance of 5% and margin allowance of 2% for the maternity kick payments. The rate year statewide administrative cost allowance for maternity kick payments is about $254 per delivery or about $28 PMPM when there are nine months of eligibility per delivery.

## F. ALLOCATION OF BASE CAPITATION RATES BY RATE CELL

The January 2016 base capitation rates are allocated by rate cell using the cost relativities among age and gender bands based on statewide data. The regional rates by eligibility category are based on region specific total costs, but the relationships between age and gender bands were standardized to statewide relativities.

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

- Exhibit 4A: BCP Standard – Medical
- Exhibit 4B: CLA – Medical
- Exhibit 12A: BCP Standard – Dental
- Exhibit 12B: CLA – Dental
- Exhibit 17A: BCP Standard – Chiropractic
- Exhibit 17B: CLA – Chiropractic

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

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

2. **Normalize statewide rate cell factors to 1.0 by region and eligibility category:** For each region and eligibility category, the statewide rate cell factors must be normalized so that the rates by rate cell will produce the overall capitation rate by region and eligibility category based on the member months in the base data used in the January 2016 rate calculation. The sum product of the statewide rate cell factors and the member months in each rate cell were divided by the total member months by region and eligibility category to determine the normalization factor used to create the regional rate cell factors.

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

Demographic shifts from the base data period to the January 2016 rate period will be appropriately reflected through the rate cell specific rates.

### DENTAL UTILIZATION ADJUSTMENT

The BCP Standard dental HMO encounter claims PMPM in Regions 5 and 6 has historically varied significantly by HMO. The 2015 dental capitation rates included HMO-specific utilization adjustments to compensate HMOs with higher than average utilization, while still providing funding to the HMOs with lower dental costs to provide an incentive to increase utilization. Based on our review of the 2013 and 2014 encounter data, we determined similar adjustments were appropriate.

The dental utilization adjustments were calculated for HMOs with significant membership in Regions 5 and 6 in the base period. The adjustments are budget neutral across these HMOs and reflects 25% of the difference between each HMO's dental claims PMPM relative to the average cost for HMOs included in the adjustment calculation. The adjustments are shown in Exhibit 13.

No adjustment was made for the CLA population since there is not enough base data available to make an assessment of historical dental cost patterns by HMO.

## G. HEALTH INSURER PROVIDER FEE

Plan reimbursement for costs related to the Affordable Care Act Health Insurer Provider Fee (HIF) will be developed outside this rate development. The payment will be developed separately for each HMO, dependent upon the HIF liability reported by the HMO.

# IV. FINAL HMO-SPECIFIC CAPITATION RATES

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

These adjustments are summarized in the following exhibits:

- Exhibit 6A: BCP Standard – Medical
- Exhibit 6B: CLA – Medical
- Exhibit 14A: BCP Standard – Dental
- Exhibit 14B: CLA – Dental
- Exhibit 22A: BCP Standard – Final HMO-Specific Capitation Rates by Type of Coverage
- Exhibit 22B: CLA – Final HMO-Specific Capitation Rates by Type of Coverage

## A. RISK SCORE ADJUSTMENTS

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

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

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

This section describes the development of the risk adjustment system that will be used to provide HMOs with risk adjusted payments for the January 2016 BCP Standard capitation rates.

Exhibit 5A summarizes the risk score adjustments applied to the base January 2016 capitation rates to calculate HMO specific risk adjusted January 2016 BCP Standard medical capitation rates (before P4P withholds and provider access payments).

As noted earlier, the CLA rates are not being risk adjusted for 2016 due to the significant rate of growth of this population during 2014 and the limited amount of base period data available (a large proportion of this population became newly eligible for Medicaid as of April 1, 2014 and did not begin enrollment into managed care until July 1, 2014). We developed preliminary risk score information for the CLA population based on partial year 2014 FFS and encounter data; but based on our review of these results, we determined they were not credible for purposes of 2016 risk adjustment.

### CDPS Risk Score Model Overview

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

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

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

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

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

Risk adjustment can be implemented in one of two ways:

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

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

Historically, DHS has used concurrent risk score weights for BCP Standard risk adjustment. DHS is continuing the concurrent risk adjustment method for 2016 and intends to implement a fully prospective risk adjustment methodology for 2017.

## Risk Adjustment Methodology and Data

The risk scores shown in Exhibit 5A are based on 2014 fee-for-service (FFS) claims and HMO encounter claims from the encounter data extracts submitted to DHS by the HMOs.

We used version 6.0 of the CDPS+Rx model to assign individuals to a demographic category and disease categories based on their diagnostic information and pharmacy utilization during the study period. Each scored individual receives a demographic relative cost weight and can have multiple disease categories assigned depending on that individual's health status. The recipient age and gender is calculated as of July 1, 2014 and is used for demographic classification. The standard CDPS+Rx cost weights reflecting a prescription drug carve-out were used, reflecting that all prescription drugs are paid through FFS, and not included in the capitation rate paid to the HMOs. In addition, the pregnancy complete diagnostic classification was removed from the model as all delivery costs are paid through a non-risk adjusted delivery kick payment. All diagnostic codes from laboratory, radiology, and DME claims were excluded to avoid including false positive diagnostic indicators for tests run on individuals.

For each member, the weights for all of the disease categories assigned are combined with their demographic information to calculate a total individual risk score. Scored members are assigned to the BCP Standard population and each HMO using capitation data provided by DHS for August 2015.

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

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

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

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

The final HMO rates are calculated by applying each HMO's applicable Budget Neutral Plan Factor by eligibility category and region to the effective medical capitation rates. New HMOs will receive capitation rates based on 1.000 risk scores.

## Risk Adjustment Implementation Considerations

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

- *Membership threshold for scoring a member* – Risk adjustment methods typically use 12 months of historical data to assess risk. For members with less than 12 months of eligibility in that historical period, a determination is needed as to how to handle their risk assessment. We used a minimum of 6 months of eligibility for risk scoring.
- *Treatment of non-scored members* – Individuals with too short of an eligibility span to assess their risk are often assigned risk based on their age and gender and / or based on some portion of the risk assessed in the capitated plan's population with full eligibility. We assumed that non-scored members of an HMO have a risk score equal to that HMO's regional average risk score.
- *Normalization by region* – 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 in total. HMO risk factors are normalized to be budget neutral for each region based on projected (i.e., August 2015) member months.

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

- *New HMOs* – Two HMOs (Trilogy and Independent Care) lack sufficient data to develop credible risk scores due to low enrollment. Therefore, their risk scores are set to the average HMO risk score for each region.

## B. PAY-FOR-PERFORMANCE WITHHOLDS

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

Based on historical withhold payment data from DHS, BCP HMOs have earned back at least 74% of the P4P withhold from 2011 to 2013 in aggregate. We are not aware of any significant changes in the withhold quality measures that would impact future withhold payouts. Additionally, the 2% margin allowance would be sufficient to cover a significant decrease in withhold earnback. Therefore, we are comfortable that the capitation rates included in this report are actuarially sound net of the P4P withholds.

## C. PROVIDER ACCESS PAYMENTS

DHS provides funding to promote access for Medicaid individuals to acute care, rehabilitation, and critical access hospitals. This funding is included in the capitation rates for the BCP Standard population. An annual reconciliation is completed to ensure that the total funding allocated in the budget is fully expended. The CLA population is not currently eligible for access payments.

The provider access payments are intended to reimburse providers based on Medicaid utilization. Therefore, the payment amounts per service do not vary based on acuity or provider billed charges. The total access payment funding amounts for the BCP and SSI programs combined are appropriated in the Wisconsin state budget on a State Fiscal Year (SFY) basis. For SFY 2016 (July 2015 through June 2016), the funding amounts for HMOs are as follows:

- Inpatient acute: $235,814,870
- Outpatient acute: $192,939,439
- Inpatient critical access: $4,424,260
- Outpatient critical access: $3,619,849
- Ambulatory Surgical Center (ASC): $5,520,522

The total access payment funding amounts are allocated to each program (BCP and SSI) and then by HMO based on total projected 2016 admissions (inpatient access payments) or visits (outpatient and ASC access payments) and converted to a fixed PMPM amount per HMO added to the January 2016 capitation rates.

The methodology used to calculate the January 2016 provider access rate adjustments is summarized in the following steps:

1. **Summarize Historical Utilization:** We summarized the total base period (2013 and 2014) utilization PMPM by HMO, region, and rate cell for providers eligible to receive access payments. The utilization counts are admissions for inpatient access payments and visits for outpatient and ASC access payments. DHS provided a list of National Provider Identification (NPI) codes for facilities eligible for each type of access payment. We summarized historical discharges for inpatient acute and critical access hospital payments and visits for outpatient acute hospital, critical access hospital, and ASC payments.

2. **Project 2016 Utilization:** We projected the base period utilization PMPM by HMO, region and rate cell to 2016 using the adjustment factors that would materially impact utilization:

   - Missing data adjustments
   - Completion factors
   - Utilization trends

   For rate cells with at least 250 member months in the base period, the projected 2016 utilization PMPM is calculated as the base period utilization multiplied by the adjustments listed above. For other rate cells with less than 250 member months, the projected 2016 utilization PMPM is developed based on the regional average base period utilization PMPM across all HMOs. We also made adjustments to HMO-specific results that appeared to be outliers based on encounter data under-reporting issues or low enrollment.

   The projected 2016 utilization PMPM is converted to total utilization counts based on the projected 2016 member months by rate cell (i.e., the August 2015 enrollment by rate cell multiplied by 12).

3. **Calculate Access Payment Rate Adjustments:** We allocated the total access payments by HMO based on the projected 2016 utilization and calculated the access payment rate adjustments PMPM by dividing the total allocated access payments by the total projected 2016 member months.

   The access payment add-ons are calculated for each HMO with credible membership. For new HMOs or HMOs with low membership, the average regional PMPM adjustment will be paid. Exhibit 21 summarizes the 2016 access payments.

The provider access payment adjustments included in the January 2016 capitation rates are based on the total SFY 2016 funding amounts. DHS will ensure total access payments do not exceed the amount appropriated in the state budget for SFY 2016. Exhibit 22 shows the final January 2016 capitation rates by HMO and type of coverage, including CDPS, P4P, and access payments.

# V. CAPITATION RATES FOR ENHANCED FMAP SERVICES

DHS receives enhanced Federal Medical Assistance Percentage (FMAP) for certain preventive services provided without member copayments and for family planning services. This section of the report documents the development of the January 2016 capitation rates for services eligible for enhanced FMAP. There are no services eligible for enhanced FMAP in the dental or chiropractic capitation rates.

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

- Exhibit 23: Base January 2016 FMAP capitation rates
- Exhibit 24: FMAP capitation rates by rate cell (preventive services)
- Exhibit 25: FMAP capitation rates by rate cell (family planning services)
- Exhibit 26: FMAP maternity kick payments

## A. SERVICES ELIGIBLE FOR ENHANCED FMAP

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

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

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

- **Project January 2016 claim costs:**

  - Preventive Services: The projected January 2016 professional medical cost PMPM (from Exhibit 2) is multiplied by the projected portion of those services eligible for enhanced FMAP. We did not identify any zero copay preventive services in the maternity kick payment base experience.

  - Family Planning Services: The projected January 2016 family planning services PMPM is developed in Exhibit 2 (medical capitation rates) and Exhibit 8 (maternity kick payments).

  Please refer to Section II for a discussion of the base period data and adjustments and Section III for the assumptions used to project the base period experience to January 2016.

- **Add administrative cost and margin allowance:** The administrative cost and margin allowance is added to the projected claim costs in Exhibit 23 (medical capitation rates) and Exhibit 26 (maternity kick payments). The administrative cost and margin allowance added to the services eligible for enhanced FMAP is the same as the allowance added to the total medical capitation rate and maternity kick payments and is summarized in Section III.E.

- **Allocate regional capitation rates by rate cell:** The medical capitation rates are allocated by rate cell based on statewide rate cell factors normalized to the base period mix of member months by rate cell in each region. These calculations are shown in Exhibit 24 (preventive services) and Exhibit 25 (family planning). This methodology is described in detail in Section III.F. This step does not apply for the maternity kick payments since these payments do not vary by age or gender.

- **Apply P4P withholds:** The P4P withhold of 2.5% is applied to the capitation rates by rate cell in Exhibit 24 (preventive services) and Exhibit 25 (family planning). This step does not apply for the maternity kick payments since these payments are not subject to the P4P withhold.

# VI. CMS RATE SETTING CHECKLIST ISSUES

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

### AA.1.0 – OVERVIEW OF RATE SETTING METHODOLOGY

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

### AA.1.1 – ACTUARIAL CERTIFICATION

Appendix A includes the actuarial certification.

### AA.1.2 – PROJECTION OF EXPENDITURES

Exhibits 18 through 20 show the expected rate change from the 2015 capitation rates to the January 2016 capitation rates by eligibility category, HMO, and rate cell excluding access payments.

### AA.1.3 – RISK CONTRACTS

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

### AA.1.4 – RATE MODIFICATIONS

This report is an amendment to the original January 2016 capitation rates. DHS initially extended the Calendar Year 2015 capitation rates through January 2016. The January 2016 capitation rate development in this report is identical to the February through December 2016 rate development documented in our report dated December 22, 2016 except for the annual trends being applied to a contract period midpoint of January 15, 2016 compared to a midpoint of July 15, 2016 in the February through December 2016 capitation rate development. DHS will adjust the January 2016 capitation payments on a retroactive basis from the original basis to the January 2016 rates in this report.

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

### AA.1.6 – LIMIT ON PAYMENT TO OTHER PROVIDERS

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

### AA.1.7 – RISK AND PROFIT

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

### AA.1.8 – FAMILY PLANNING ENHANCED MATCH

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

### AA.1.9 – INDIAN HEALTH SERVICE FACILITY ENHANCED MATCH

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

### AA.1.10 – NEWLY ELIGIBLE ENHANCED MATCH

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

### AA.1.11 – RETROACTIVE ADJUSTMENTS

As noted in Item AA.1.4 above, the January 2016 rates documented in this report are amended rates and will be applied retroactively to adjust the original January 2016 capitation payments. Any future retroactive capitation adjustments will be limited to a maximum period of two years.

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

The Medicaid base data includes only State Plan services covered by the BadgerCare Plus Medicaid managed care program.

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

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

### AA.2.2 – DATA SOURCES

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

### AA.3.0 – ADJUSTMENTS TO BASE YEAR DATA

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

### AA.3.1 – BENEFIT DIFFERENCES

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

### AA.3.2 – ADMINISTRATIVE COST ALLOWANCE CALCULATIONS

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

### AA.3.3 – SPECIAL POPULATION ADJUSTMENTS

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

### AA.3.4 – ELIGIBILITY ADJUSTMENTS

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

### AA.3.5 – THIRD PARTY LIABILITY (TPL)

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

### AA.3.6 – INDIAN HEALTH CARE PROVIDER PAYMENTS

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

### AA.3.7 – DSH PAYMENTS

DSH payments are not included in the capitation rates.

### AA.3.8 – FQHC AND RHC REIMBURSEMENT

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

### AA.3.9 – GRADUATE MEDICAL EDUCATION (GME)

GME payments are excluded from the base data.

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

The base data reflects appropriate cost sharing provisions. An adjustment was made to the base experience to reflect member copayments removed from certain preventive services effective April 1, 2014, as described in Section III.B. No other adjustments were necessary.

### AA.3.11 – MEDICAL COST TREND INFLATION

Please refer to Section III.D of this report.

### AA.3.12 – UTILIZATION ADJUSTMENTS

Please refer to Sections III - IV of this report.

### AA.3.13 – UTILIZATION AND COST ASSUMPTIONS

The base utilization and cost data for the capitation rates is mainly HMO encounter data, with the exception of chiropractic services which are based on FFS data since very few HMOs were contracted to cover chiropractic services during the base period and therefore credible HMO encounter data is not available.

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

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

### AA.3.15 – INCOMPLETE DATA ADJUSTMENT

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

### AA.3.16 – PRIMARY CARE RATE ENHANCEMENT

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

### AA.3.17 – HEALTH HOMES

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

### AA.4.0 – ESTABLISH RATE CATEGORY GROUPINGS

Please refer to Section I.B of this report.

### AA.4.1 – ELIGIBILITY CATEGORIES

Please refer to Section I.B of this report.

### AA.4.2 – AGE

Please refer to Section I.B of this report.

### AA.4.3 – GENDER

Please refer to Section I.B of this report.

### AA.4.4 – LOCALITY / REGION

Please refer to Section I.B of this report.

### AA.4.5 – RISK ADJUSTMENT

The BadgerCare Plus Standard medical capitation rates are risk adjusted using an actuarially sound CDPS + Rx methodology. The CLA rates will not be risk adjusted. Please refer to Section IV.A for a description of the risk adjustment methodology.

## AA.5.0 – DATA SMOOTHING

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

- The methodology generally uses two years of base data to smooth random fluctuation that occurs on a year-to-year basis, although this was not possible in the CLA eligibility category since less than a full year of encounter data was available for newly eligible CLA individuals.

- Capitation rates are first set by eligibility category and region in Exhibit 3 (medical), Exhibit 11 (dental), and Exhibit 16 (chiropractic). Statewide cost relationships are then used to develop statewide rate cell factors within each eligibility category, which are applied on a cost-neutral basis to convert the region capitation rates into capitation rates by rate cell and region in Exhibit 4 (medical), Exhibit 12 (dental), and Exhibit 17 (chiropractic).

A dental utilization adjustment is also applied to the dental capitation rates to reflect significant variation in historical dental encounter costs PMPM by HMO within the BCP Standard eligibility category. Please refer to Section III.G for discussion of the dental utilization adjustment and Exhibit 13 for the calculation of the adjustment.

## AA.5.1 – COST-NEUTRAL DATA SMOOTHING ADJUSTMENT

Exhibit 4 (medical), Exhibit 12 (dental), and Exhibit 17 (chiropractic) demonstrate the rate cell factors are cost neutral in each individual region. Exhibit 13 demonstrates the dental utilization adjustment is cost neutral. Please see Sections III.F and III.G for additional explanation of these adjustments.

## AA.5.2 – DATA DISTORTION ADJUSTMENT

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

## AA.5.3 – DATA SMOOTHING TECHNIQUES

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

## AA.5.4 – RISK ADJUSTMENT

The BadgerCare Plus Standard medical capitation rates are risk adjusted using an actuarially sound CDPS + Rx methodology. The CLA rates will not be risk adjusted. Please refer to Section IV.A for a description of the risk adjustment methodology.

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

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

## AA.6.1 – COMMERCIAL REINSURANCE

DHS does not require entities to purchase commercial reinsurance.

### AA.6.2 – SIMPLE STOP LOSS PROGRAM

None.

### AA.6.3 – RISK CORRIDOR PROGRAM

None.

### AA.7.0 – INCENTIVE ARRANGEMENTS

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

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

DHS has not implemented incentive payments related to EHRs for the January 2016 contract period.

# VII. RESPONSES TO 2016 CMS MANAGED CARE RATE SETTING GUIDE

## SECTION I. MEDICAID MANAGED CARE RATES

### 1. General Information

- Rate certification – See Appendix A.
- Final capitation rates – Please refer to Exhibit 6 (medical capitation rates), Exhibit 9 (maternity kick payments), Exhibit 14 (dental capitation rates), and Exhibit 17 (chiropractic capitation rates) for the final capitation rates excluding access payments. Exhibit 22 summarizes the final capitation rates, including access payments.
- Program descriptions – See Section I.B.

### 2. Data

- Service data sources – See Sections II.A through II.C.
- Validation and quality adjustments – See Section II.D.
- Changes in data sources – Base period HMO encounter data was updated from fiscal year 2011 - 2012 (July 2010 – June 2012) to calendar years 2013 - 2014. HMO financial data was also collected for the first time.
- Potential future data improvements – As described in Section II.D, we applied missing data adjustments to the encounter data. DHS anticipates missing data adjustments will decrease going forward as encounter data improves over time.
- Other data adjustments – See Section II.D.

### 3. Projected Benefit Costs and Trends

- Changes in covered services and benefits
  - Various legislative and program changes effective between the base period and contract period – See Section III.B.
  - CLA durational and seasonality adjustments – See Section III.C.
- Projected benefit cost trends
  - Trends excluding reimbursement changes – See Section III.D.
  - Legislative reimbursement changes between the base period and contract period – See Section III.A.

- Other adjustments
  - Dental utilization adjustment – See Section III.G.
  - Alternative Mental Health Services (AMHS) in lieu of inpatient psychiatric admissions – See Section III.B.
- Final projected benefit costs – See Exhibit 3 (medical capitation rates), Exhibit 9 (maternity kick payments), Exhibit 11 (dental capitation rates), and Exhibit 16 (chiropractic capitation rates).
- Conditions of any litigation to which the state is subjected – Not applicable; no impact on rates.

### 4. Pass-Through Payments

- Pass-through payments – See Section IV.C.

### 5. Projected Non-Benefit Costs

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

### 6. Rate Range Development

- Assumption variation for rate range endpoints – Not applicable.

### 7. Risk and Contractual Provisions

- Risk adjustment – See Section IV.A and Exhibits 5 and 6.
- Withholds – See Section IV.B, Exhibit 6 (medical capitation rates), and Exhibit 14 (dental capitation rates).
- Incentives, MLR requirements, reinsurance requirements – None.

### 8. Other Rate Development Considerations

- Federal Medical Assistance Percentage (FMAP) – DHS receives enhanced FMAP for family planning services and certain preventive services provided without member copayments. See Section V and Exhibits 23 through 26.
- Final certified rates – See Exhibit 6 (medical capitation rates), Exhibit 9 (maternity kick payments), Exhibit 14 (dental capitation rates), and Exhibit 17 (chiropractic capitation rates). Exhibit 22 summarizes the final capitation rates, including access payments by type of coverage.
- Area and rate cell relativity factors – See Section III.F, Exhibit 4 (medical capitation rates), Exhibit 12 (dental capitation rates), and Exhibit 17 (chiropractic capitation rates).
- Enhanced hospital and GME payments – Not applicable.

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

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

## SECTION III. NEW ADULT POPULATION CAPITATION RATES

### Introduction

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

### 1. Data

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

### 2. Projected Benefit Costs

See Section III for a summary of rate adjustments applied to project benefit costs to the contract period and specifically Section III.C for the adjustments to remove the impact of pent-up demand wear-off and seasonality. In projecting 2014 benefit costs to January 2016, we examined high level HMO financial results for 2015 through June as well as FFS data for the CLA eligibility category. However, we did not directly incorporate this information into rate development.

### 3. Projected Non-Benefit Costs

See Section III.E for the development of projected administrative costs and contribution to surplus. The starting point for this assumption was 2013 and 2014 health plan financial reporting and year-to-date quarter 2 2015 medical loss ratio reports.

### 4. Final Certified Rates or Rate Ranges

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

Overall, the medical CLA rates decreased by 1.4% statewide. The rate changes were driven largely by using April – December 2014 HMO encounter data to develop the January 2016 rates. The 2015 rates were based on a blend of data sources since encounter data for the expansion population was not available. Additionally, the 2015 capitation rates included an adjustment for estimated pent-up demand, while the January 2016 capitation rates include an adjustment to remove the estimated pent-up demand included in the base period experience. See Exhibits 18B to 20B for a comparison of 2015 and January 2016 capitation rates.

## 5. Risk Mitigation Strategies

The January 2016 CLA rates are not risk adjusted, although DHS intends to implement risk adjustment in the 2017 rate development if appropriate. Please refer to section IV.A of the rate report.

No risk corridors, minimum loss ratios, reinsurance, high cost risk pools, or other mechanisms will be incorporated.

# January 2016 Rate Exhibits

# (Provided in Excel Format)

This material assumes that the reader is familiar with the State of Wisconsin's Medicaid program, Wisconsin Medicaid benefits, and rate setting principles. The material was prepared solely to provide assistance to DHS to set January 2016 capitation rates for the BadgerCare Plus Standard and Childless Adults programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

**Wisconsin Department of Health Services**
Capitation Rate Development January 1, 2016 – January 31, 2016
BadgerCare Plus Standard and Childless Adults Programs

January 6, 2017

# Appendix A

# Actuarial Certification

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Principal and Consulting Actuary

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**January 6, 2017**

**Wisconsin Department of Health Services**
**BadgerCare Plus Standard and Childless Adults Medicaid Managed Care Programs**
**January 2016 Capitation Rates**
**Actuarial Certification**

I, Shelly S. Brandel, am associated with the firm of Milliman, Inc. and am a member of the American Academy of Actuaries and meet its Qualification Standards for Statements of Actuarial Opinion. I have been retained by the Wisconsin Department of Health Services (DHS) to perform an actuarial certification of the January 2016 BadgerCare Standard and Childless Adults program capitation rates for filing with the Centers for Medicare and Medicaid Services (CMS). I reviewed the calculated capitation rates and am familiar with the Code of Federal Regulations, 42 CFR 438.6(c) and the CMS "Appendix A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting."

I examined the actuarial assumptions and actuarial methods used in setting the capitation rates for January 2016. To the best of my information, knowledge and belief, for the period from January 1, 2016 through January 31, 2016, the capitation rates offered by DHS are in compliance with 42 CFR 438.6(c). The attached actuarial report describes the capitation rate setting methodology.

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

In making my opinion, I relied upon the accuracy of the underlying records, data summaries, and calculations prepared by DHS, as well as encounter data and financial data summaries prepared by the participating HMOs. A copy of the reliance letter received from DHS is attached and constitutes part of this opinion. I did not audit the data and calculations but did review them for reasonableness and consistency and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary.

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

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

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

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

Shelly S. Brandel
Member, American Academy of Actuaries

January 6, 2017

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Scott Walker
Governor

Linda Seemeyer
Secretary

**State of Wisconsin**

Department of Health Services

December 21, 2016

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

**RE: January, 2016 Wisconsin Medicaid BadgerCare Plus and Supplemental Security Income (SSI) Managed Care Rate Development Data Reliance Letter**

Dear Shelly:

I, Krista Willing Director of Bureau of Fiscal Management for the Wisconsin Department of Health Services (DHS), hereby affirm that the data prepared and submitted to Milliman, Inc. (Milliman) for the purpose of certifying Wisconsin Medicaid BadgerCare Plus and Supplemental Security Income (SSI) rate development for 2016 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, 2016 capitation rate development, including:
   a. Fee-for-service claim, HMO Encounter and Eligibility data
   b. Hospital inpatient and outpatient facility 2016 re-pricing data

2. Other supporting data, including:
   a. Monthly identification of ventilator-dependent members
   b. HMO financial data and medical loss ratio reports
   c. SFY 2016 provider access payment funding amounts
   d. HMO corrective action reports and Historical performance withhold payments
   e. Information regarding program changes effective prior to December 31, 2016
   f. Details regarding the scope of HMO covered services and eligible recipients
   g. Other computer files and clarifying correspondence

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

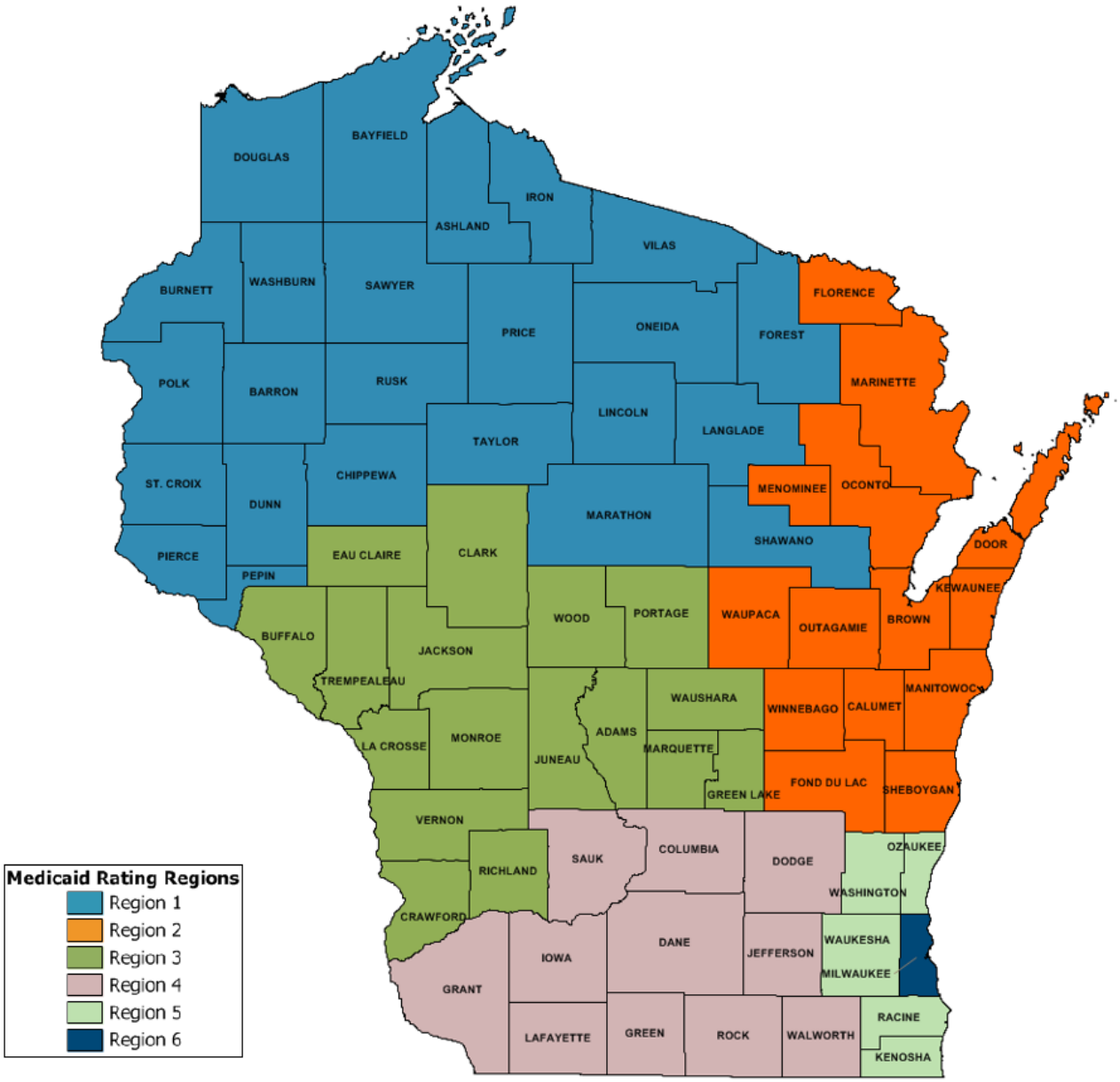
Sincerely,

Krista Willing

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

# Appendix B

# Mapping of Wisconsin Counties to Medicaid Rate Regions




This material assumes that the reader is familiar with the State of Wisconsin's Medicaid program, Wisconsin Medicaid benefits, and rate setting principles. The material was prepared solely to provide assistance to DHS to set January 2016 capitation rates for the BadgerCare Plus Standard and Childless Adults programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

**Wisconsin Department of Health Services**
Capitation Rate Development January 1, 2016 – January 31, 2016
BadgerCare Plus Standard and Childless Adults Programs