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December 20, 2017

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

Re: January 1, 2018 – December 31, 2018 Rate Report and Actuarial Certification – Supplemental Security Income Program

Dear Chad:

Thank you for the opportunity to assist the Wisconsin Department of Health Services (DHS) with this important project. The attached report summarizes the development and actuarial certification of the January 1, 2018 – December 31, 2018 (CY 2018) capitation rates for the Supplemental Security Income program. We understand DHS will retroactively apply these rates to the entire CY 2018 period to replace the CY 2017 rates temporarily extended through January 2018.

❖ ❖ ❖ ❖ ❖

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

Sincerely,

Shelly Brandel

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

SSB/laa

Attachment

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2018 through December 31, 2018
SSI Medicaid Managed Care Programs

Prepared for:
Wisconsin Department of Health Services

Prepared by:
Milliman, Inc.

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December 20, 2017

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EXHIBITS (Provided in Excel)

APPENDICES

I. SUMMARY OF RESULTS AND CAVEATS

This report documents the development of capitation rates effective January 1, 2018 through December 31, 2018 for Wisconsin's Supplemental Security Income (SSI) Medicaid managed care programs.

The Wisconsin Department of Health Services (DHS) retained Milliman, Inc. (Milliman) to develop and certify its 2018 SSI capitation rates. Milliman's role is to calculate and certify actuarially sound capitation rates to comply with CMS regulations and the CMS rate setting checklist.

We provided a rate certification dated December 18, 2017 to temporarily extend the January 2017 – December 2017 capitation rates through January 2018 with the intent of retroactively adjusting the capitation rates for January 2018 once the HMOs had sufficient time to review the January 2018 – December 2018 capitation rates before signing their contract with DHS. DHS will retroactively adjust capitation rates for January 2018 to be consistent with the capitation rates included in this report.

SSI MANAGED CARE EXPANSION

Historically, managed care enrollment has been voluntary for the SSI population. As a result, a significant portion of SSI members are currently covered through the Medicaid fee-for-service (FFS) delivery system. Starting in 2018, DHS will require most SSI Medicaid Only members currently receiving benefits through the FFS program to enroll into HMOs unless they meet specific exemption criteria. The SSI expansion will be phased in during the year for counties with at least two participating HMOs, with different effective dates by region as shown in Table 1. Voluntary HMO selection will occur in the first expansion month, followed by auto-enrollment in the following month.

Table 1
SSI Medicaid Only Expansion Schedule

	Voluntary Enrollment	Auto-Enrollment
Region 1	January	February
Region 2	May	June
Region 3	February	March
Region 4	May	June
Region 5	March	April
Region 6	April	May

We developed two sets of SSI Medicaid Only capitation rates as a result of the SSI enrollment expansion (the exhibit numbers for the pre- and post-expansion capitation rates are consistent):

- The pre-expansion capitation rates cover the time period prior to SSI expansion (i.e., January 1, 2018 through April 30, 2018 for Region 2). These rates are primarily based on HMO encounter data projected to the midpoint of the pre-expansion rate period for each region.

- The post-expansion capitation rates cover the time period from SSI expansion until the end of the year (i.e., May 1, 2018 through December 31, 2018 for Region 2). These rates are based on a blend of HMO encounter data for existing HMO members and FFS data for expansion members currently enrolled in FFS.

The SSI Medicaid Only risk adjustment will also be separated into two time periods:

- The pre-expansion capitation rates include a prospective risk score adjustment, similar to prior rating periods. DHS will perform a budget neutral retrospective risk score settlement calculation using member months for the pre-expansion period only.

- The post-expansion capitation rates will not have any prospective risk score adjustments applied, since the distribution of expansion members by HMO is unknown. As a result, we will calculate risk scores for each HMO on a retrospective basis using actual member months across the entire expansion period.

A. CAPITATION RATE CHANGE

Table 2 shows a comparison of the 2018 and 2017 per member per month (PMPM) medical, dental, and chiropractic capitation rates by geographic rate region and eligibility category. Table 2D shows a PMPM comparison of the 2018 post-expansion versus 2018 pre-expansion SSI Medicaid Only capitation rates. Exhibits 14 through 16 contain more detailed comparisons summarizing the rate changes for all coverage types (medical only, medical / dental, medical / chiropractic, and medical / dental / chiropractic) separately for each Health Maintenance Organization (HMO) based on July 2017 enrollment. Exhibit 18 shows the final 2018 capitation rates, including provider access payments.

Table 2A
Summary of Capitation Rate Changes by Region (Excluding Provider Access Payments)
Calendar Year 2017 to Calendar Year 2018
SSI Medicaid Only (Pre-expansion)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Medical Capitation Rates							
2018 Capitation Rate	n/a	$461.57	$452.19	$468.91	$495.52	$627.08	$541.01
2017 Capitation Rate	n/a	$415.50	$404.96	$461.03	$470.47	$623.47	$523.15
Rate Change	n/a	11.1%	11.7%	1.7%	5.3%	0.6%	3.4%
Dental Capitation Rates							
2018 Capitation Rate[2]	n/a	n/a	n/a	n/a	$9.25	$10.34	$10.08
2017 Capitation Rate[2]	n/a	n/a	n/a	n/a	$9.37	$10.71	$10.39
Rate Change	n/a	n/a	n/a	n/a	-1.3%	-3.5%	-3.0%
Chiropractic Capitation Rates							
2018 Capitation Rate	n/a	$2.71	$4.15	$1.76	$1.20	$0.60	$1.49
2017 Capitation Rate	n/a	$2.98	$4.65	$1.83	$1.26	$0.58	$1.59
Rate Change	n/a	-9.1%	-10.8%	-3.4%	-4.7%	2.9%	-5.9%

[1] *Statewide changes in capitation rates are based on July 2017 enrollment.*
[2] *Dental capitation rates for Regions 1 through 4 are not applicable since no HMOs cover dental services in these regions.*

Table 2B Summary of Capitation Rate Changes by Region (Excluding Provider Access Payments) Calendar Year 2017 to Calendar Year 2018 SSI Dual Eligibles							
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[1]
Medical Capitation Rates							
2018 Capitation Rate	$61.24	$58.46	$63.18	$67.76	$46.75	$144.15	$100.99
2017 Capitation Rate	$75.64	$56.38	$65.43	$76.81	$48.02	$161.40	$111.19
Rate Change	-19.0%	3.7%	-3.4%	-11.8%	-2.6%	-10.7%	-9.2%
Dental Capitation Rates							
2018 Capitation Rate[2]	n/a	n/a	n/a	n/a	$9.31	$11.11	$10.72
2017 Capitation Rate[2]	n/a	n/a	n/a	n/a	$9.71	$11.46	$11.08
Rate Change	n/a	n/a	n/a	n/a	-4.2%	-3.0%	-3.2%
Chiropractic Capitation Rates							
2018 Capitation Rate	$0.59	$0.49	$0.53	$0.55	$0.18	$0.12	$0.28
2017 Capitation Rate	$0.54	$0.46	$0.81	$0.65	$0.28	$0.16	$0.32
Rate Change	9.3%	4.9%	-34.3%	-15.1%	-36.3%	-21.2%	-14.8%

[1] Statewide changes in capitation rates are based on July 2017 enrollment.

[2] Dental capitation rates for Regions 1 through 4 are not applicable since no HMOs cover dental services in these regions.

Table 2C Summary of Capitation Rate Changes (Excluding Provider Access Payments) Calendar Year 2017 to Calendar Year 2018 MAPP Medicaid Only and Dual Eligibles		
	MAPP Medicaid Only	MAPP Dual Eligible
Medical Capitation Rates		
2018 Capitation Rate	$1,094.45	$114.89
2017 Capitation Rate	$996.45	$131.27
Rate Change	9.8%	-12.5%
Dental Capitation Rates		
2018 Capitation Rate	$13.97	$8.59
2017 Capitation Rate	$15.89	$17.29
Rate Change	-12.1%	-50.3%
Chiropractic Capitation Rates		
2018 Capitation Rate	$2.80	$0.25
2017 Capitation Rate	$3.49	$0.26
Rate Change	-19.8%	-3.8%

Table 2D Summary of Capitation Rate Changes by Region (Excluding Provider Access Payments) Calendar Year 2018: Post-expansion versus Pre-expansion SSI Medicaid Only							
	Region 1[1]	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide[2]
Medical Capitation Rates							
Post-expansion Rate	$653.70	$595.37	$573.59	$565.84	$582.62	$913.89	$724.01
Pre-expansion Rate	$472.89	$461.57	$452.19	$468.91	$495.52	$627.08	$535.90
Rate Change	38.2%	29.0%	26.8%	20.7%	17.6%	45.7%	35.1%
Dental Capitation Rates							
Post-expansion Rate[3]	n/a	n/a	n/a	n/a	$8.77	$9.75	$9.51
Pre-expansion Rate[3]	n/a	n/a	n/a	n/a	$9.25	$10.34	$10.08
Rate Change	n/a	n/a	n/a	n/a	-5.2%	-5.7%	-5.6%
Chiropractic Capitation Rates							
Post-expansion Rate	$3.25	$2.43	$3.93	$1.81	$1.11	$0.64	$1.58
Pre-expansion Rate	$3.35	$2.71	$4.15	$1.76	$1.20	$0.60	$1.63
Rate Change	-3.0%	-10.3%	-5.2%	2.8%	-7.4%	7.5%	-3.2%

[1] Pre-expansion Region 1 rates are from 2017. As a result, Statewide amounts do not match Table 2A.
[2] Statewide changes in capitation rates are based on July 2017 enrollment.
[3] Dental capitation rates for Regions 1 through 4 are not applicable since no HMOs cover dental services in these regions.

Table 3 provides a high level summary of each rate component and the impact on the overall medical capitation rate change from 2017 to 2018. For example, updating the reimbursement change projection factors increased the SSI Medicaid Only rates by an average of 2.0%.

Table 3 High Level Summary of Medical Capitation Rate Changes between 2017 and 2018		
Rate Component	**SSI Medicaid Only (Pre-expansion)**	**SSI Dual Eligibles**
Updated base period encounter data	0.9%	-11.3%
Reimbursement change between base period and rating period	2.0%	0.5%
Trend and other projection factor changes	1.8%	-0.4%
Impact of rate cell mix on prior rates	-1.3%	2.3%
Total rate change	**3.4%**	**-9.2%**

Differences in the pre- and post-expansion SSI Medicaid Only capitation rates (before CDPS adjustments) are driven by the impact of incorporating the FFS claims experience for members eligible for SSI expansion into the capitation rate calculations.

B. CAPITATION RATE CELL STRUCTURE

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

Eligibility Categories

We developed capitation rates for the following eligibility categories:

- **SSI Medicaid Only:** Individuals ages 19 years and older who receive SSI or SSI-related Medicaid benefits due to a disability. SSI Medicaid Only individuals are not eligible for Medicare benefits. Members may not be residing in an institution or nursing home and may not be receiving home and community based waiver benefits.
- **SSI Dual Eligibles:** Similar to SSI Medicaid Only but eligible for Medicare benefits.
- **MAPP Medicaid Only:** Low-income disabled individuals ages 18 and over that purchase Medicaid coverage through the Wisconsin Medicaid Purchase Plan (MAPP). MAPP members receive the same benefits as SSI members.
- **MAPP Dual Eligibles:** Similar to MAPP Medicaid only but eligible for Medicare benefits.

Rate Regions

SSI Medicaid Only and SSI Dual Eligible 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

MAPP Medicaid Only and MAPP Dual Eligible capitation rates do not vary by region.

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

Rate Cells

SSI capitation rates are paid separately by age category as well as rate region. Table 4 summarizes the age categories used within the SSI Medicaid Only and SSI Dual Eligibles eligibility categories. MAPP Medicaid Only and MAPP Dual Eligibles rates do not vary by age.

Table 4
Age Rate Cells for SSI Medicaid Only and SSI Dual Eligibles

Ages 19 – 39
Ages 40 – 64
Ages 65+

Covered Services

HMOs are responsible for providing comprehensive health care to SSI members, including hospital inpatient, hospital outpatient, professional, and other services. Prescription drugs are carved out of the capitation rates. Dental and chiropractic capitation rates are developed separately. Dental and chiropractic coverage are optional in all regions. We describe exclusions applied to the HMO encounter and FFS data in Sections II.B. and II.C., respectively. We also remove methadone-related claims and IMD claims for stays greater than 15 days in a given month, as described in Section III.B.

C. HIGH-LEVEL RATE METHODOLOGY

The SSI managed care program started in Milwaukee and started expanding into additional counties in 2007. DHS held contracts with 10 Health Maintenance Organizations (HMOs) to provide services to SSI members during the experience period. DHS anticipates the following changes effective January 1, 2018:

- Anthem Blue Cross Blue Shield (Anthem) is terminating its Compcare contract.
- Trilogy Health Insurance is exiting the SSI program.

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

The risk adjustment process adjusts the capitation rates for estimated differences in acuity by HMO for the SSI Medicaid Only eligibility category.

The MAPP rates are developed on a statewide basis for all ages given the small number of individuals covered by this program. The MAPP rates are not risk adjusted.

Material Changes to Rate Methodology

We made the following material changes to the 2018 rate methodology:

- Experience data sources – The 2017 rates were based on HMO encounter data and financial data from calendar years 2014 and 2015. The 2018 rates are based on more recent HMO encounter and financial data from calendar years 2015 and 2016, as well as FFS data for members eligible for SSI Medicaid Only expansion.
- Emerging financial data – We collected YTD 2017 (through April) financial data to review emerging 2017 claims and administrative expense trends.
- Methadone treatment claims – We removed methadone treatment services from the 2018 capitation rates due to uncertainty around the 2016 base period experience as a result of claim payment issues between narcotic treatment service (NTS) providers and the HMOs. DHS will reimburse methadone treatment claims on a FFS basis outside of the capitation rates for 2018. We plan to submit a future rate amendment summarizing these claim amounts. DHS intends to include methadone treatment claims in the 2019 capitation rates.

- Blending of encounter and FFS medical data (before SSI expansion) – We increased the HMO encounter data weighting used in SSI Medicaid Only Region 4 from 75% in the 2017 capitation rates to 100% in the 2018 capitation rates. We also increased the HMO encounter data weighting used for the MAPP Medicaid Only rates from 50% in the 2017 capitation rates to 100% in the 2018 capitation rates. We continue to rely fully on HMO encounter data to calculate the capitation rates in other regions.

- Risk adjustment weights for the SSI Medicaid Only population – The SSI Medicaid Only 2018 risk score adjustments are based on the custom prospective risk adjustment weights we developed for the 2017 capitation rates using the Chronic Illness and Disability Payment System plus Prescription Drug model (CDPS+Rx) with Wisconsin SSI Medicaid Only experience. For the 2017 SSI Medicaid Only capitation rates, we phased in the custom model weights by using a blend of 50% of our custom prospective weights and 50% of the prior concurrent standard model CDPS+Rx weights. The MAPP and SSI Dual Eligible rates are not risk adjusted.

- Post-expansion SSI Medicaid Only capitation rates – As noted above, DHS is expanding mandatory SSI Medicaid Only HMO enrollment in counties with two or more HMOs during 2018 based on a phase in schedule by region. We developed separate pre-expansion and post-expansion capitation rates based on the targeted phase in dates. Please see Section VI for the post-expansion SSI Medicaid Only capitation rate assumptions and methodology.

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 2018 base capitation rates by eligibility category, region and age category.

- Section IV documents the development of final HMO-specific capitation rates, including risk score adjustments, pay-for-performance (P4P) withholds, and provider access payments.

- Section V documents the projected costs for services eligible for enhanced federal funding (applies to medical capitation rates).

- Section VI provides responses to the CMS rate setting checklist.

- Section VII provides responses to the 2017-2018 CMS Medicaid Managed Care Rate Development Guide.

Exhibits 1 through 22 summarize the 2018 rate development. Appendix A provides a mapping of counties to rate regions. Appendices B and C contain details on the custom CDPS risk score model. Appendix D contains the actuarial certification.

E. IMPORTANT LIMITATIONS AND CAVEATS

We relied on several sources of HMO and FFS claims and eligibility data to develop the capitation rates in this report, including HMO encounter data, HMO financial data, FFS data, hospital inpatient and outpatient 2018 re-pricing data, and other supporting information from DHS. **We did not audit any of the base data sources**, but we did assess the data for reasonableness.

We relied on DHS for the collection and processing of the HMO encounter data, the accuracy of the FFS data, and the inpatient and hospital outpatient 2018 re-pricing data. We relied on the HMOs to provide accurate financial data to DHS. If the data used is inadequate or incomplete, the results will be likewise inadequate or incomplete.

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

Our report is intended for the internal use of DHS to develop 2018 SSI Medicaid managed care 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 the report describes the base data development and the blending of the various data sources described in this report. In general, the base data used to calculate the 2018 capitation rates reflects the most current credible available data from DHS and the HMOs.

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

- Exhibit 1: Medical (for HMO encounter and FFS claims separately)
- Exhibit 7: Dental
- Exhibit 11: Chiropractic

A. BASE DATA SOURCES

The data sources used in the 2018 rate development are listed and described below:

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

2. **HMO Financial Data** – Participating HMOs were required to submit CY 2015, CY 2016, and YTD April 2017 financial data to DHS. The financial data included the following information by eligibility category, region and calendar year:

   - Member months.
   - Total revenue including capitation payments and other sources.
   - Claim payments to providers, including FFS claim payments, payments made to sub-capitated providers, provider risk sharing and incentive payments, and other payments made outside the FFS claims system.
   - Administrative costs.
   - Additional information on payments made to related parties.
   - A certification from the HMO attesting the data is accurate, complete and truthful.
   - A reconciliation to HMO financial statements.

   We used the financial data to calculate missing data adjustments to apply to the encounter data payments, develop adjustments to reflect claims paid outside of FFS claims systems, analyze historical trends, and develop the administrative cost allowances included in the capitation rates. We also used financial data to develop the dental capitation rates in Regions 5 and 6. We believe the HMO financial data is a more accurate summary of historical dental claims due to under-reporting of dental encounter data due to the prevalence of subcapitation.

3. **Fee-For-Service (FFS) Data** – Includes claims paid by DHS on a FFS basis. We used FFS data as the basis for developing capitation rates for dental services in Regions 1 to 4 and chiropractic services in all regions. We also used FFS data to develop the post-expansion SSI Medicaid Only capitation rates for medical, dental, and chiropractic services.

DHS and Milliman went through an extensive data validation process to review all HMO data included in the 2018 rate setting methodology. DHS collected monthly encounter reporting from each HMO to monitor the quality of encounter data submissions. After this process was complete, DHS forwarded the data to Milliman.

Milliman also reviewed the encounter data and financial data. We provided data summaries to all participating HMOs along with a list of HMO-specific data questions. We had one-on-one conference calls with some HMO representatives to discuss the HMO-specific summaries and data questions. After receiving answers to our questions and a few data resubmissions from the HMOs, we released base data summaries on September 7, 2017 for HMO review and comment. Additionally, DHS presented the information to the HMOs on September 28, 2017 to explain the base data and solicit feedback from the HMOs.

Table 5 summarizes the base data time periods for the various data sources.

Table 5
Base Data Time Periods

Data Source	Data Time Period Used	Paid Through Date
HMO Encounter Data	CY 2015 and CY 2016	May 2017[1]
HMO Financial Data	CY 2015 and CY 2016	April 2017
HMO Emerging 2017 Financial Data	YTD April 2017	June 2017
FFS Data	CY 2015 and CY 2016	June 2017

[1] Encounter data files received from DHS on May 25, 2017; paid through date may differ by HMO

B. HMO ENCOUNTER DATA PROCESSING METHODOLOGY

HMO Encounter Data Submission

Participating HMOs are required to submit encounters for Medicaid covered services to DHS on a periodic basis. DHS, along with their contracted data processing vendor, DXC Technology, performs a re-pricing analysis on the encounter data records and assigns re-priced Medicaid allowed and paid amounts for accepted encounter records. The encounter records also include HMO paid amounts in addition to the re-priced Medicaid paid amounts. We included HMO paid amounts from the encounter data for accepted records only to develop missing data adjustments and provider contracting adjustments, thereby excluding any potential duplicate rejected claims.

The encounter data provided to Milliman includes services incurred during calendar years 2014 through 2016. As noted above, we used 2015 and 2016 encounter data to develop the base period costs. We summarized the 2015 and 2016 encounter data using the methodology described in the following sections.

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

Excluded Claims

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

1. **Claims incurred outside of CY 2015 and CY 2016**: We excluded claims for services provided outside of the period January 1, 2015 through December 31, 2016.

2. **Financial Indicator "N" claims:** We excluded claims with a Financial Indicator of "N" which were flagged by DHS as not having any payment made by the HMO.

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

4. **Ventilator dependent claims**: The HMOs are not at risk for claims for ventilator dependent members. DHS retroactively reimburses the HMOs for claims incurred and recoups premiums provided to the 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 based on criteria provided by DHS since these professional claims are reimbursed on a FFS basis by DHS.

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

7. **Non-covered chiropractic claims:** We excluded chiropractic claims for HMOs that did not cover chiropractic services in 2015 or 2016 (only one HMO elected to cover chiropractic services over this period).

Included Claims

The total amounts after excluding the claims and member months listed above represent the encounter data used to develop the base period experience. We developed separate capitation rates for medical coverage, dental services, and chiropractic services. Any included claims not identified as dental or chiropractic services were classified as medical coverage.

Dental

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

Chiropractic

Encounters with Category of Service code 60 (chiropractic) were identified as chiropractic services. Only one HMO elected to cover chiropractic services during the base period.

Medical "Payments Made Outside Encounter Data"

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

In Lieu of Services

SSI Medicaid Only covers an in lieu of service called "Sub-Acute Psychiatric Community-Based Psychiatric and Recovery Center Services". The services are defined in Section IV.B.12 of the HMO contract. The benefit is limited to behavioral health: short term residential (non-hospital residential treatment program). Sub-acute community based clinical treatment may be used in lieu of inpatient psychiatric hospitalization. The benefit is reimbursed at $450 per diem. This benefit is cost effective since it is much lower than the SSI Medicaid only inpatient psychiatric cost per day.

The SSI Medicaid program allows HMOs to provide Institution for Mental Disease (IMD) benefits in lieu of inpatient psychiatric admissions. Reimbursement adjustments for IMDs are documented in Section III.A, and benefit adjustments are documented in Section III.B.

Service Category Assignment

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

C. FFS DATA PROCESSING METHODOLOGY

We used FFS data for HMO members to develop capitation rates for dental services in Regions 1 to 4 and chiropractic services (since credible encounter data is not available). We summarized dental and chiropractic FFS claims (using the service criteria above) for members enrolled in HMOs during the base period. We also used FFS data to develop the post-expansion SSI Medicaid Only rates (in combination with the HMO encounter data for existing HMO members).
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 IMDs
    - Members receiving home and community based waiver services
    - Members enrolled in HMOs
    - Members in an HMO exemption status (other than HIV / AIDS, methadone and SSI opt out)
    - Members with a non-SSI Medical Status code

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

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

D. ADJUSTMENTS TO THE BASE DATA

This section discusses the adjustments we made to the base 2015 and 2016 data before projecting costs to the 2018 rating period. These adjustments are shown in the following exhibits:

- Exhibit 1: Medical
- Exhibit 7: Dental
- Exhibit 11: Chiropractic

Missing Data Adjustment (Encounter Data)

DHS has required contracted HMOs to submit encounter data files to be used for Medicaid managed care rate setting for many years. DHS system edits originally implemented in 2012 resulted in lower rates of accepted claims that have continued to improve over time.

We developed missing data adjustments for each HMO and calendar year based on a comparison of the total HMO paid amounts in the encounter data and the total FFS and sub-capitated claim payments reported in the HMO financial data (excluding IBNR with similar claims run-out to the encounter data as shown in Table 5). We combined FFS and sub-capitated claim payments together to develop the missing data adjustments since the encounter data does not consistently identify FFS versus sub-capitated claims separately. Therefore, the missing data adjustments reflect the impact of missing encounters (including sub-capitated claims), as well as encounters that were submitted but not accepted by the DHS system edits.

Table 6 summarizes the medical 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 6 Missing Data Adjustments Applied to HMO Encounter Data (Medical Services)						
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
SSI Medicaid Only						
2015	1.037	1.034	1.035	1.048	1.029	1.026
2016	1.036	1.043	1.034	1.064	1.047	1.034
SSI Dual Eligibles						
2015	1.042	1.037	1.038	1.046	1.026	1.024
2016	1.030	1.036	1.027	1.040	1.036	1.022
MAPP Medicaid Only						
2015	1.037	1.030	1.034	1.048	1.029	1.032
2016	1.042	1.045	1.037	1.079	1.056	1.052
MAPP Dual Eligibles						
2015	1.039	1.034	1.036	1.034	1.026	1.022
2016	1.024	1.031	1.019	1.049	1.042	1.024

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

Completion Factor (Encounter and FFS Data)

Table 7 summarizes the completion factors applied to base 2016 claims to adjust for incurred but not reported (IBNR) claims as of the claim submission date. CY 2015 claims are assumed to be complete since there are approximately 17 months of claims runout.

Table 7 2016 Completion Factors				
	HMO Encounter Claims		**Fee-For-Service Claims**	
	Hospital Inpatient	**Other Services**	**Hospital Inpatient**	**Other Services**
SSI / MAPP Medicaid Only	1.017	1.003	1.044	1.009
SSI / MAPP Dual Eligibles	1.008	1.002	1.062	1.007

We calculated the encounter claims completion factors based on reported IBNR amounts in the HMO financial data, and reviewed the resulting factors for reasonableness. We developed the FFS completion factors based on FFS claim lag patterns.

Provider Contracting Adjustment (Encounter and FFS Data)

The base encounter data reflects the re-priced Medicaid paid amounts assigned by DHS to each encounter. We compared the total HMO paid amounts to the re-priced Medicaid paid amounts by broad service category and region to develop provider contracting adjustments that reflect average HMO contracting levels relative to Medicaid fees across the two years of base period experience data. Regions 5 and 6 include counties around the Milwaukee area, where some providers require higher reimbursement to participate in the Medicaid program. Table 8 summarizes the provider contracting adjustments applied to the SSI / MAPP Medicaid Only re-priced Medicaid paid amounts in the encounter data. The SSI / MAPP Dual Eligibles do not have provider contract adjustments applied.

Table 8 Provider Contracting Adjustments						
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Hospital Inpatient	1.01	1.01	1.01	1.01	1.03	1.03
Hospital Outpatient	1.00	1.00	1.00	1.00	1.08	1.08
Professional	1.00	1.00	1.00	1.00	1.01	1.01
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

Managed Care Savings Factors (FFS Data)

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

- Hospital inpatient = 0.85
- Hospital outpatient = 0.89
- Professional = 0.96
- Personal Care = 0.96 (i.e., the “Other” category)
- Other = 0.89

In applying the managed care savings adjustments, we assumed it would take the HMOs approximately three months to realize the savings. We also assumed 35% of the HMO expansion eligible members would voluntarily choose an HMO in the first expansion month followed by auto-enrollment into an HMO in the next month for the remaining members based on historical HMO enrollment patterns provided by DHS. Therefore, the managed care savings adjustments shown in Exhibit 2 represent a blend of 1.00 factors applied for the first voluntary month of partial expansion (35% of the expansion enrollment) and the first three months of SSI expansion after auto-enrollment, and the managed care factors above for the remaining expansion months. For example, the Region 2 post-expansion SSI Medicaid Only rates are effective from May 1, 2018 through December 31, 2018. Therefore, the blended managed care factor of 91.8% for hospital inpatient in Region 2 is calculated as (3.35 months * 1.00 + 4 months * 0.85) divided by 7.35 total expansion months.

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

III. PROJECTED 2018 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 2018 base capitation rates by eligibility category, region, and age category before risk adjustment, P4P withholds, and provider access payments are applied.

The following exhibits summarize the development of projected 2018 claim costs:

- Exhibit 2: Medical
- Exhibit 7: Dental
- Exhibit 11: Chiropractic

A. REIMBURSEMENT CHANGES

Generally, the HMOs are not required to pay the Medicaid fee schedule with a few exceptions such as emergency institutional and federally qualified health center (FQHC) claims. However, most HMOs reimburse providers at the Medicaid fee schedule or at a percentage of the Medicaid fee schedule. In these instances, they would be required to apply changes to the Medicaid fee schedule as appropriate. Therefore, we applied reimbursement adjustments to the experience consistent with projected Medicaid fee schedule changes. We are not aware of any other material anticipated fee changes other than the items mentioned in this section.

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

Hospital inpatient claims, excluding skilled nursing facility (SNF), were re-priced by DHS to the inpatient rates effective January 1, 2018. We used this detailed re-pricing data, provided by DHS, to calculate the impact of reimbursement changes on the historical 2015 and 2016 hospital inpatient claims. Since the re-pricing impact varies by hospital, the rating adjustments are applied by eligibility category, year, and region to reflect the expected changes based on the historical volume of claims by hospital. Table 9 summarizes the hospital inpatient re-pricing adjustments for 2018 fee changes (prior to the 'other reimbursement adjustments' described below) applied to both the base HMO encounter and FFS claims hospital inpatient claims.

Table 9
Hospital Inpatient Re-Pricing Adjustments (excluding Skilled Nursing Facility)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
HMO Encounter Data						
2015	1.128	1.139	1.239	1.163	1.293	1.147
2016	1.100	1.098	1.224	1.081	1.151	1.116
Post-expansion FFS Data						
2015	1.004	1.147	1.153	1.216	1.232	1.159
2016	1.088	1.130	1.158	1.095	1.160	1.127

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

Similar to hospital inpatient claims, DHS provided re-priced hospital outpatient claims, excluding hospice, based on fees effective January 1, 2018. Table 10 summarizes the HMO encounter hospital outpatient re-pricing adjustments for 2018 fee changes (prior to the 'other reimbursement adjustments' described below) applied to both the base HMO encounter and FFS hospital outpatient claims.

Table 10
Hospital Outpatient Re-Pricing Adjustments (excluding Hospice)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
HMO Encounter Data						
2015	0.998	1.031	0.945	1.042	1.029	1.003
2016	0.915	0.959	0.851	0.974	0.984	0.933
Post-expansion FFS Data						
2015	1.024	1.023	0.997	0.997	1.058	0.998
2016	0.926	1.013	0.862	0.924	1.015	0.980

Other Reimbursement Adjustments

Hospice (Encounter and FFS Data)

The Medicaid fee schedule for hospice claims changed on January 1, 2016 and October 1, 2016. DHS estimated the impact of these fee schedule increases to be an 8.8% increase for 2015 claims and a 3.6% increase for 2016 claims. We reviewed DHS' calculations and applied these reimbursement factors to hospice claims for all eligibility categories and regions to reflect the estimated increase in Medicaid reimbursement.

Behavioral Health

Medicaid fees for specific behavioral health services are projected to increase by 28.4% between the experience period and the contract period based on information provided by DHS. We applied reimbursement factors based on the proportion of these behavioral health claims to total claims in the "Hospital Outpatient Psychiatric / Substance Abuse", "Professional Other", and "FQHC" service categories.

Personal Care

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

Ambulatory Surgery Center (ASC)

The ASC provider access payments for BCP Standard were discontinued as of October 1, 2017, and Medicaid funding for ASCs is expected to increase 19.0% between the experience period and the contract period based on information provided by DHS. We applied reimbursement factors based on the proportion of these ASC claims to total claims in the "Professional Other" service category.

IMD

We applied a 1.10 unit cost adjustment to HMO encounter base period IMD claims for the SSI and MAPP Medicaid Only eligibility categories based on a comparison of the historical average cost per day for inpatient psychiatric stays and IMD stays. This adjustment does not apply for dual eligibles.

ICD-9 to ICD-10 Conversion

DHS contracts with Navigant to set hospital rates on an annual basis. Navigant performed an analysis showing the conversion from ICD-9 to ICD-10 diagnosis codes (effective October 1, 2015) increased inpatient Medicaid reimbursement by approximately 5% due to casemix differences. Therefore, we applied a 1.05 unit cost adjustment to 2015 hospital inpatient claims (excluding SNF) to reflect this impact.

B. PROGRAM CHANGES

Benefit Changes (Encounter Data)

IMD Utilization Adjustment

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

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

Methadone Treatment Claim Removal

DHS will reimburse the cost of methadone treatment on a FFS basis outside the capitation rates in 2018, as mentioned in Section I.C. Therefore, we removed these services from the base period experience. These adjustments are shown in the benefit adjustment column of Exhibit 2 in the 'Professional Other' service category.

C. TREND

The annual trend assumptions (excluding Medicaid reimbursement changes and ICD-10 impact) are shown in Table 11. We developed the trend assumptions based on historical trends, Medicaid industry trends, and actuarial judgment.

Table 11 Annual Trend Factors		
	SSI / MAPP Medicaid Only	**SSI / MAPP Dual Eligibles**
Hospital Inpatient (Annual)	4.0%	2.0%
Hospital Outpatient (Annual)	4.0%	4.0%
Professional and Other (Annual)	2.0%	2.0%
Dental Regions 5 and 6 (2015 to 2016)	13.1%	1.0%
Dental Regions 5 and 6 (2016 to 2017)	5.0%	5.0%
Dental Regions 5 and 6 (2017 to 2018)	5.0%	5.0%
Dental FFS Claims (Annual)	5.0%	5.0%

Table 12 shows the number of months trended between the experience and rating period midpoints for pre-expansion versus post-expansion based on region. The number of months differ by region because each region has a different expansion effective date.

Table 12 SSI Medicaid Only Months of Trend					
		Number of Months Between Experience and Rating Period Midpoints			
	Expansion Effective Date	**Pre-Expansion**		**Post-Expansion**	
		2015	**2016**	**2015**	**2016**
Region 1	January	N/A	N/A	36.0	24.0
Region 2	May	32.0	20.0	38.0	26.0
Region 3	February	30.5	18.5	36.5	24.5
Region 4	May	32.0	20.0	38.0	26.0
Region 5	March	31.0	19.0	37.0	25.0
Region 6	April	31.5	19.5	37.5	25.5

As part of our trend analysis, we reviewed historical trends from 2014 to 2016 in the HMO encounter data, HMO financial data (including emerging 2017 experience, and FFS data by eligibility category, region, and broad category of service. We also reviewed historical hospital inpatient and outpatient trends from 2014 to 2016 re-priced to 2018 Medicaid fees to remove the impact of annual reimbursement changes.

- Hospital Inpatient: The historical SSI Medicaid Only utilization trends were relatively flat between 2014 and 2016. However, the annual hospital inpatient PMPM trends have been about 6% each year from 2014 and 2016, implying increases in the case mix intensity. Hospital inpatient utilization trends for SSI Dual Eligibles have generally been negative. We assumed annual hospital inpatient utilization trends of 4% and 2% for SSI Medicaid Only and SSI Dual Eligibles, respectively.

- Hospital Outpatient: The historical hospital outpatient PMPM trends were flat to negative for 2014 to 2015. The 2015 to 2016 trend was about 3% and 4% for SSI Medicaid Only and SSI Dual Eligibles in the HMO encounter data, respectively. The 2015 to 2016 trend was higher in the FFS data. We assumed an annual hospital outpatient trend of 4% for both populations.

- Professional and Other: The historical SSI professional PMPM trends were flat to negative from 2014 to 2016. There were not any significant changes in professional Medicaid fees between 2014 and 2016 and, therefore, we did not apply any re-pricing adjustments for this analysis. We assumed an annual trend of 2% for professional and other services since we do not expect the flat to negative trends to continue.

- Dental Regions 5 and 6: We observed material increases in dental claims for HMO members in SSI Medicaid Only Regions 5 and 6 due to increased access to dental services. Therefore, we set the 2015 to 2016 trend assumptions based on the actual aggregate historical dental claim PMPM trend in the HMO financial data. We considered the emerging 2017 financial dental data in Regions 5 and 6 to project the 5% annual dental trend from 2016 to 2018 for Regions 5 and 6. We assumed annual 2016 to 2018 dental trends of 5%. Historical FFS trends for SSI Medicaid Only members in Regions 1 through 4 varied materially by region. We assumed an annual dental trend of 5% for FFS claims.

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

We also reviewed the claim trends summarized in Table 13 from the CMS Office of the Actuary (OACT) in the *2016 Actuarial Report on the Financial Outlook for Medicaid*. This report projects future Medicaid per enrollee cost trends will be higher than historical trends and states the higher trends are, in part, due to anticipated higher provider reimbursement. We projected the SSI Medicaid provider reimbursement trends and ICD-10 impact separately from the remainder of the claim trend. As a result, our remaining claim trend projection is expected to be lower than OACT's total claim trend projected in Table 13.

Table 13
Summary of Projected National Medicaid Benefit Expenditures per Enrollee
Table 19 of the 2016 Actuarial Report on the Financial Outlook for Medicaid
Published by the CMS Office of the Actuary

	Aged		Disabled	
Federal Fiscal Year	Projected Medicaid Cost per Enrollee	Annual Trend	Projected Medicaid Cost per Enrollee	Annual Trend
2015	$14,323	n/a	$19,478	n/a
2016	$14,451	0.9%	$20,082	3.1%
2017	$14,939	3.4%	$20,934	4.2%
2018	$15,617	4.5%	$21,877	4.5%
Average Projected Annual Trend		**2.9%**		**3.9%**

D. BLENDING OF 2018 PROJECTED CLAIMS BY YEAR

For all eligibility categories and regions, we weighted the 2018 claim projections from 2015 and 2016 experience based on the member month volume in each period.

E. BLENDING EXHIBITS AND ADMINISTRATIVE COST AND MARGIN ALLOWANCE

The following exhibits combine the results of the detailed claim cost projections by eligibility category, region, and delivery system (FFS and HMO encounter data). After blending, we added an administrative cost and margin allowance to the blended 2018 claim costs:

- Exhibit 3: Medical
- Exhibit 8: Dental
- Exhibit 12: Chiropractic

FFS / Encounter Data Blending Percentages

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

Dental and Chiropractic Capitation Rates (Pre-expansion)

The dental rates for all eligibility categories are based on 100% HMO financial data in Regions 5 and 6 and 100% FFS data in other regions. The MAPP statewide capitation rates are based only on Regions 5 and 6 since there is currently no dental coverage in other regions. The chiropractic rates are based on 100% FFS data since very few of the HMOs provided chiropractic coverage during the base period and therefore credible encounter data is not available.

Post-expansion SSI Medicaid Only Capitation Rates

The post-expansion capitation rates are based on a blend of HMO encounter data and FFS data. We projected the 2018 post-expansion member months from each source based on July 2017 HMO / FFS enrollment. We made the following assumptions in our member month projection based on discussion with DHS:

- 35% of FFS members would enroll in HMOs during the first month of expansion based on the July 2017 distribution of members by HMO.
- The remaining 65% of members would be automatically enrolled in an HMO in the second month of expansion, with an equal number of members distributed to each HMO participating in a region.

Exhibit 3 shows the projected 2018 member months and resulting FFS blending weights for each region.

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

We developed the administrative allowances in the 2018 capitation rates based on the 2015 and 2016 financial data provided by the HMOs. The assumptions for SSI Dual Eligibles and pre-expansion SSI Medicaid Only members are unchanged from the prior rate development.

The administrative allowance in the post-expansion capitation rates is lower than pre-expansion as a percentage of capitation but results in a similar administrative allowance PMPM.

Table 14 summarizes the administrative cost and margin assumptions applied to the medical, dental, and chiropractic rates, which use the same percentages within each population.

Table 14
2018 Administrative Cost and Margin Assumptions
Medical, Dental, and Chiropractic Capitation Rates

Administrative Cost Components	SSI Dual Eligibles and Pre-expansion SSI Medicaid Only	Post-expansion SSI Medicaid Only
Direct Expenses	6.0%	4.6%
Indirect Expenses	4.0%	2.8%
Care Coordination	1.9%	1.5%
Sales and Marketing	0.1%	0.1%
Total Administrative Cost Allowance	12.0%	9.0%
Margin Allowance	2.0%	2.0%
Administrative Cost / Margin Allowance	14.0%	11.0%

The 2018 SSI capitation rates exclude any provision for taxes, fees, or assessments. HMOs are expected to pay any applicable federal or state taxes out of the margin included in the capitation rates. DHS required the HMOs to report licensing and fees separately from income tax and health insurer provider fee (HIF) amounts in their financial data. These amounts were primarily for Office of the Commissioner of Insurance (OCI) fees and some community benefit expenses, and represent an immaterial cost of approximately $0.02 PMPM.

The administrative loads are higher on a percentage basis than are typically used in other states because Wisconsin carves out prescription drugs from the capitation rates, resulting in a lower medical cost. On average, the projected 2018 statewide administrative allowance for medical services is $65.75 PMPM for pre-expansion SSI Medicaid Only, $65.47 PMPM for post-expansion SSI Medicaid Only, $12.21 for SSI Dual Eligibles, $134.70 for MAPP Medicaid Only, and $13.79 for MAPP Dual Eligibles, as shown in Exhibit 3 based on the base period demographic mix by rate cell and region. The resulting PMPM administrative loads are consistent with Wisconsin HMO reported experience.

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

F. ALLOCATION OF BASE CAPITATION RATES BY RATE CELL

The 2018 SSI MA Only and SSI Dual Eligibles base capitation rates are allocated by rate cell using the cost relativities among age bands based on statewide data. The regional rates by eligibility category are based on region specific total costs, but the relationships between age bands were standardized to statewide relativities.

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

- Exhibit 4: Medical
- Exhibit 9: Dental
- Exhibit 13: Chiropractic

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

1. **Develop statewide rate cell factors**: For each eligibility category, type of coverage, and rate cell, we calculated the statewide projected costs by rate cell and calculated the relativity PMPM to the overall costs PMPM. We maintained the same statewide rate cell factors for the SSI Medicaid Only population for the pre- and post-expansion rate periods.

2. **Normalize statewide rate cell factors to 1.0 by region and eligibility category**: For each region and eligibility category, the statewide rate cell factors are normalized so the rates by rate cell produce the overall capitation rate by region and eligibility category based on the member months in the base data used in the 2018 rate calculation.

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

G. POTENTIAL RETROACTIVE RATE AMENDMENTS

Health Insurer Provider Fee

Plan reimbursement for costs related to the Affordable Care Act (ACA) HIF have historically been developed outside of the rate development. The base period experience excludes HIF payments. CMS did not impose HIF for the 2017 capitation rates. If CMS reinstates the HIF for 2018, we will file a retroactive amendment to the capitation rates.

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

We plan to file a retroactive rate amendment for HMO encounter-based payments paid on a FFS basis outside of the capitation rates, such as methadone treatment claims and care coordination.

IV. FINAL HMO-SPECIFIC CAPITATION RATES

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

These adjustments are summarized in the following exhibits:

- Exhibit 6: Medical
- Exhibit 18: 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 risk adjust payments for the 2018 SSI Medicaid Only capitation rates.

Exhibit 5A summarizes the risk score adjustments applied to the base 2018 capitation rates to calculate HMO-specific risk-adjusted 2018 SSI Medicaid Only medical capitation rates (before P4P withholds and provider access payments).

CDPS Risk Score Model Overview

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

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

- CDPS 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 58 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.

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

CDPS, MRX, and CDPS+Rx are widely used in the Medicaid industry because they are designed specifically for the Medicaid population. We used the structure of version 6.0, which was originally free for states and capitated plans to download.

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.

Prior to the 2017 capitation rate development, the SSI Medicaid Only capitation rates were risk adjusted based on the standard CDPS+Rx concurrent risk score weights applied prospectively. For the 2017 rate development, we developed custom CDPS+Rx risk weights based on historical Wisconsin Medicaid SSI Medicaid Only plan experience from 2013 and 2014 to project 2014 and 2015 costs. The custom risk weights reflect Wisconsin's specific covered benefits, eligibility rules, provider reimbursement, and practice patterns. We will refer to this as the "custom prospective model". We continue to use these custom weights for the 2018 SSI Medicaid Only risk score adjustments.

R-squared measures the variability in a data set accounted for by the statistical model. R-squared values for regression models vary from 0% to 100%, with 100% indicating a model that explains all the variation in a particular data set. The custom prospective regression model calibrated to the SSI Medicaid Only population has an R-squared measure of 23%, which is comparable to typical prospective model predictive powers for comparable Medicaid populations.

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

Attachment C shows the mapping of the risk categories from the standard to the custom CDPS+Rx models. We combined standard categories where the individual categories did not provide additional statistical predictive ability (for example, we combined the eye very low and low categories).

For the 2017 SSI Medicaid Only rates, we blended the new and prior models, assigning 50% weight to each model, to phase in the impact of the model change on HMO capitation rates. For the 2018 SSI Medicaid Only rates, we used 100% of the custom model weights.

Risk Adjustment Methodology and Data (Pre-expansion Rates)

The risk scores shown in Exhibit 5A are based on 2016 FFS claims and HMO encounter claims for HMO members 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 2016. 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, 2017 and is used for demographic classification. 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 under the custom prospective model. Scored members are assigned to the SSI Medicaid Only population and each HMO using capitation data provided by DHS for July 2017.

For each HMO, the unnormalized risk scores 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 provided 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] = [Unnormalized Risk Score]*

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

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

SSI Medicaid Only ages 65+ rate cell is not risk adjusted due to low membership in this rate cell.

SSI Dual Eligible, MAPP Medicaid Only, and MAPP Dual Eligible populations are not risk adjusted.

Risk Adjustment Implementation Considerations

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

- *Membership threshold for scoring a member* – Risk adjustment methods typically use 12 months of historical data to assess risk. For members with less than 12 months of eligibility in that historical period, a determination is needed as to how to handle their risk assessment. We used a minimum of 6 months of eligibility for risk scoring.

- *Treatment of non-scored members* – Individuals with too short of an eligibility span to assess their risk are often assigned risk based on their age and gender and / or based on some portion of the risk assessed in the capitated plan's population with full eligibility. We assumed that non-scored members of an HMO have a risk score equal to that HMO's rate cell average risk score within a given combination of region and eligibility category.

- *Normalization by rate cell within each region and eligibility category* – Risk adjustment is intended to measure the relative risk of populations enrolled by HMOs to develop capitation rate adjustments by HMO that are budget neutral. HMO risk factors are normalized to be budget neutral for each rate cell within each region and eligibility category based on projected (i.e., July 2017) member months.

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

- *Adjustments to ICD-10 Mapping* – In subsequent updates to the CDPS mapping, UCSD corrected the condition category mappings of several ICD-10 codes. To account for this, we made the following technical adjustments to the CDPS version 6.0 mappings:

  – The following ICD-10 code is now being mapped to PSYL: F329.

  – The following ICD-10 diagnosis codes are now being mapped to DIA1M:E1051, E1052, E1059, E10618, E10620, E10621, E10622, E10628, E10630, E10638, E10649, E1065, E1069, E108.

  – The following ICD-10 code is now being mapped to DIA1H:E10641.

Pre-expansion Retrospective Risk Score Adjustment

In addition to the risk scores being budget neutral on a prospective basis (based on July 2017 enrollment), DHS will perform a risk score settlement calculation on the pre-expansion rates to ensure risk scores are budget neutral on a retrospective basis based on actual 2018 enrollment by HMO.

Potential Risk Score Adjustments Based on Actual Membership (Pre-expansion Rates)

As noted above, we developed 2018 risk score adjustments for each HMO based on their July 2017 enrollment. Historically, risk scores have been established prospectively for each calendar year with no midyear adjustments. DHS will consider an update to average risk scores (i.e., using the same risk scores by member developed from 2016 experience) if we observe material changes in enrollment between 2017 and 2018.

Risk Adjustment Methodology and Data (Post-expansion Rates)

For the 2018 post-expansion SSI Medicaid Only capitation rates, the initial risk scores are set to 1.000 since we do not know how SSI expansion will impact enrollment for specific HMOs. In order to more accurately reflect the expected morbidity differences due to the population actually enrolled in each HMO after the SSI expansion occurs, we will apply a retrospective risk score adjustment to the 2018 post-expansion SSI Medicaid Only capitation rates (using prospective risk score weights). The risk scores used in this approach will be calculated using eligibility and claims data from calendar year 2016 with similar logic to the 2018 pre-expansion SSI Medicaid Only risk scores (e.g., members would only receive a risk score if they had a minimum of six months of Medicaid eligibility in 2016 and non-scored members would receive the average risk score of members scored in their specific HMO, rate cell, region, and eligibility category subject to credibility).

B. PAY-FOR-PERFORMANCE WITHHOLDS

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

Based on historical withhold payment data from DHS, SSI HMOs have earned back at least 77% of the P4P withhold from 2011 to 2015 in aggregate. At this time, we are not aware of any significant changes in the withhold quality measures that would impact 2018 withhold payouts. Additionally, the 2% margin allowance would be sufficient to cover a significant decrease in withhold earn back. Therefore, we are comfortable that the capitation rates included in this report are actuarially sound net of the P4P withholds.

C. QUALITY INCENTIVE PAYMENTS

DHS anticipates implementing a potentially preventable re-admissions (PPR) incentive payment program for 2018. The maximum incentive payment to any HMO may not be more than 5% of their capitation rate.

D. PROVIDER ACCESS PAYMENTS

DHS provides funding to promote access for Medicaid individuals to acute care, rehabilitation, and critical access hospitals. This funding is included in the capitation rates for the SSI and MAPP Medicaid Only populations. The SSI and MAPP Dual Eligible populations are not eligible for provider access payments in 2018.

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 provider access payment funding amounts for the BadgerCare Plus (BCP) and SSI programs combined are appropriated in the Wisconsin state budget on a State Fiscal Year (SFY) basis. For SFY 2018 (July 2017 through June 2018), the funding amounts for HMOs in total and the projections for BCP Standard versus SSI and MAPP Medical Only are shown in Table 15.

Table 15 Projected 2018 Provider Access Payment Funding			
	BCP Standard	SSI and MAPP Medicaid Only	Total
Inpatient acute and rehabilitation	$193,647,465	$36,253,552	$229,901,017
Outpatient acute and rehabilitation	$153,389,475	$34,711,357	$188,100,832
Inpatient critical access	$3,736,394	$262,549	$3,998,943
Outpatient critical access	$2,922,711	$349,152	$3,271,863

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

We allocated the funding amounts to BCP Standard versus SSI and MAPP Medicaid Only (pre-expansion and post-expansion combined) and then by HMO based on total projected 2018 admissions (inpatient access payments) or visits (outpatient access payments). We then calculated a fixed PMPM amount for each HMO by program to add to the 2018 capitation rates.

The methodology used to calculate the 2018 provider access rate adjustments is summarized in the following steps:

1. **Summarize Historical Utilization**: We summarized the total HMO encounter base period (2015 and 2016) utilization PMPM by HMO, eligibility category, region, and rate cell for providers eligible to receive provider access payments. The utilization counts are admissions for inpatient access payments and visits for outpatient access payments. DHS provided a list of National Provider Identification (NPI) codes for facilities eligible for each type of provider access payment.

2. **Project 2018 Utilization**: We projected the base period utilization PMPM by HMO, eligibility category, region, and rate cell to 2018.

   For rate cells with at least 250 member months in the base period, the projected 2018 utilization PMPM is calculated as the base period utilization multiplied by the missing data adjustment. For other rate cells with less than 250 member months, we developed the projected 2018 utilization PMPM based on the regional average base period utilization PMPM with missing data adjustment across all HMOs.

   We converted the projected 2018 utilization PMPM to total utilization counts based on the projected 2018 member months by rate cell.

3. **Calculate Provider Access Payment Rate Adjustments:** We allocated the total provider access payments by HMO based on the projected 2018 utilization and calculated the provider access payments PMPM by dividing the total allocated provider access payments by the total projected 2018 member months (including SSI Medicaid Only expansion).

   The provider access payment add-ons are calculated for each HMO with credible membership. New HMOs will receive the average regional PMPM adjustment. The SSI Medicaid Only capitation rates will have the same provider access payments PMPM applied for both pre-expansion and post-expansion. Exhibit 17 in the pre-expansion exhibits summarizes the 2018 SSI and MAPP Medicaid Only provider access payments.

Exhibit 18 shows the final 2018 capitation rates by HMO and type of coverage, including CDPS, P4P, and provider 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, family planning services, and services provided to Native Americans or Alaskan Native members at facilities officially recognized as Indian Health Services (IHS) facilities. This section of the report documents the development of the 2018 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 19A: Overall FMAP capitation rates (preventive services)
- Exhibit 19B: Overall FMAP capitation rates (family planning services)
- Exhibit 19C: Overall FMAP capitation rates (IHS)
- Exhibit 20: FMAP capitation rates by rate cell (preventive services)
- Exhibits 21: FMAP capitation rates by rate cell (family planning services)
- Exhibits 22: FMAP capitation rates by rate cell (IHS)

A. SERVICES ELIGIBLE FOR ENHANCED FMAP

The preventive, family planning, and IHS eligible for enhanced FMAP are each identified separately using criteria provided by DHS. We assigned the categories in the hierarchical order of family planning, preventive, and IHS so no services are double counted. The preventive services enhanced FMAP does not apply to SSI and MAPP Dual Eligibles.

B. METHODOLOGY USED TO DEVELOP FMAP PORTION OF CAPITATION PAYMENTS

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

- **Project 2018 claim costs**:
  - Preventive Services: The projected 2018 medical cost PMPM for zero copay preventive services is developed in Exhibit 2. For post-expansion SSI, the encounter and FFS projections are blended in Exhibit 19A.
  - Family Planning Services: The projected 2018 medical cost PMPM for family planning services is developed in Exhibit 2. For post-expansion SSI, the encounter and FFS projections are blended in Exhibit 19B.
  - IHS: We calculated the proportion of IHS claims included in the FQHC base experience and applied this proportion to the projected 2018 FQHC claims developed in Exhibit 2.

  Please refer to Section II for a discussion of the base period data and adjustments and Section III for the assumptions used to project the base period data to 2018.

- **Add administrative cost and margin allowance**: The administrative cost and margin allowance is added to the projected claim costs in Exhibit 19A (preventive services), Exhibit 19B (family planning), and Exhibit 19C (IHS). The administrative cost and margin allowance added to the services eligible for enhanced FMAP is the same as the allowance added to the total medical capitation rate and is summarized in Section III.E.

- **Allocate regional capitation rates by rate cell**: The medical capitation rates are allocated by rate cell based on statewide rate cell factors normalized to the base period mix of member months by rate cell in each region. These calculations are shown in Exhibit 20 (preventive services), Exhibits 21 (family planning), and Exhibits 22 (IHS). This methodology is described in detail in Section III.F. This step is not applicable for the MAPP rates since these rates do not vary by rate cell.

- **Apply P4P withholds:** The SSI Medicaid Only P4P withhold of 2.5% is applied to the capitation rates by rate cell in Exhibit 20 (preventive services), Exhibits 21 (family planning), and Exhibits 22 (IHS). The MAPP Medicaid Only P4P withhold is applied in Exhibit 19A (preventive services), Exhibit 19B (family planning), and Exhibit 19C (IHS) since these rates do not vary by rate cell. P4P withholds do not apply to the SSI Dual Eligible and MAPP Dual Eligible rates.

VI. CMS RATE SETTING CHECKLIST ISSUES

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

AA.1.0 – OVERVIEW OF RATE SETTING METHODOLOGY

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

AA.1.1 – ACTUARIAL CERTIFICATION

Appendix D includes the actuarial certification.

AA.1.2 – PROJECTION OF EXPENDITURES

Exhibits 14 through 16 show the expected rate change from the 2017 to 2018 capitation rates by eligibility category, HMO, and rate cell excluding provider access payments. The post-expansion SSI Exhibits 14 through 16 show the change in the post-expansion SSI 2018 capitiation rates compared to the pre-expansion SSI 2018 capitation rates.

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

The 2018 capitation rates in this report are the initial rates for the contract period. As noted in Section I, DHS will retroactively adjust the capitation rates for January 2018, temporarily based on the January 2017 – December 2017 capitation rates extended to January 2018, to be consistent with the capitation rates in this report.

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

AA.1.6 – LIMIT ON PAYMENT TO OTHER PROVIDERS

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

AA.1.7 – RISK AND PROFIT

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

AA.1.8 – FAMILY PLANNING ENHANCED MATCH

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

AA.1.9 – INDIAN HEALTH SERVICE FACILITY ENHANCED MATCH

DHS will claim enhanced match for services provided to Native Americans or Alaskan Native members at facilities officially recognized as IHS facilities and the administrative and margin associated with the delivery of these services for the population covered under this program in 2018. Please refer to Section V of this report for the development of capitation rates for services eligible for enhanced match.

AA.1.10 – NEWLY ELIGIBLE ENHANCED MATCH

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

AA.1.11 – RETROACTIVE ADJUSTMENTS

Please see response to Section AA.1.4. Any future retroactive capitation adjustments will be limited to a maximum period of two years.

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

The Medicaid base data includes only State Plan services covered by the SSI Medicaid managed care program, including Medicare crossover benefits, and IMD experience (with adjustments) and “Sub-Acute Psychiatric Community-Based Psychiatric and Recovery Center Services” which are covered in lieu of inpatient psychiatric admissions.

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

Data for populations not eligible to enroll in a SSI Medicaid 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 14.

AA.3.3 – SPECIAL POPULATION ADJUSTMENTS

The base data used to calculate the capitation rates is consistent with the managed care population. The post-expansion SSI rate development includes FFS base period experience for members who would have been eligible for expansion during the base period based on the HMO expansion criteria. 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. No adjustments were necessary.

AA.3.11 – MEDICAL COST TREND INFLATION

Please refer to Section III.C of this report.

AA.3.12 – UTILIZATION ADJUSTMENTS

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

AA.3.13 – UTILIZATION AND COST ASSUMPTIONS

The base data for all capitation rates is appropriate for the populations to be covered. Starting in 2018, DHS will require SSI Medicaid Only members currently receiving benefits through the FFS program to enroll in managed care unless they meet specific exemption criteria. The SSI expansion will be phased in during the year by region. As such, we developed separate capitation rates for the pre-expansion and post-expansion time periods for each region.

The base utilization and cost data for the capitation rates include HMO encounter data, supplemented with HMO financial data, and FFS data. The pre-expansion rates are primarily based on HMO encounter data projected to the midpoint of the pre-expansion rate period for each region. The post-expansion rates are based on a blend of HMO encounter data for existing HMO members and FFS data for expansion members currently enrolled in FFS.

The FFS data is adjusted to the average acuity of the HMO population and has managed care savings factors applied based on the SSI expansion phase-in schedule. The blending of the data sources is discussed in Sections III.D and III.E.

The dental rates in regions 1 through 4 are based on FFS data since HMOs do not currently cover dental services in those regions. Chiropractic rates in all regions are based on FFS data since very few HMOs were contracted to cover chiropractic services during the base period, and therefore, credible HMO encounter data is not available.

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

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

AA.3.15 – INCOMPLETE DATA ADJUSTMENT

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

AA.3.16 – PRIMARY CARE RATE ENHANCEMENT

The 2015 and 2016 base period data excludes enhancements to payment rates made to primary care providers, which expired on December 31, 2014. Therefore, no adjustments were necessary.

AA.3.17 – HEALTH HOMES

The Wisconsin Department of Health Services has a health home pilot for members with AIDS / HIV who receive services provided through the AIDS Resource Center of Wisconsin (ARCW). Effective January 1, 2016, members enrolled in this health home pilot program were no longer required to disenroll from Medicaid managed care HMOs. This change is not anticipated to have a material impact on the 2018 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

The capitation rates do not vary by gender.

AA.4.4 – LOCALITY / REGION

Please refer to Section I.B of this report.

AA.4.5 – RISK ADJUSTMENT

The SSI Medicaid Only pre-expansion medical capitation rates are risk adjusted using an actuarially sound CDPS + Rx prospective risk score adjustment methodology. The post-expansion capitation rates are not risk-adjusted prospectively since the distribution of expansion members by HMO is unknown. A retrospective risk score adjustment will be made based on actual enrollment after the SSI expansion occurs.

The SSI Dual Eligible and all MAPP rates will not be risk adjusted.

Please refer to Section IV.A for a description of the risk adjustment methodology.

AA.5.0 – DATA SMOOTHING

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

- The methodology uses two years of base data to smooth random fluctuation that occurs on a year-to-year basis.
- Capitation rates are first set by eligibility category and region in Exhibit 3 (medical), Exhibit 8 (dental), and Exhibit 12 (chiropractic). Statewide cost relationships are then used to develop statewide rate cell factors within each eligibility category, which are applied on a cost-neutral basis to convert the region capitation rates into capitation rates by rate cell and region in Exhibit 4 (medical), Exhibit 9 (dental), and Exhibit 13 (chiropractic).

AA.5.1 – COST-NEUTRAL DATA SMOOTHING ADJUSTMENT

Exhibit 4 (medical), Exhibit 9 (dental), and Exhibit 13 (chiropractic) demonstrate the rate cell factors are cost neutral in each individual region. Please see Section III.F for additional details.

AA.5.2 – DATA DISTORTION ADJUSTMENT

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

AA.5.3 – DATA SMOOTHING TECHNIQUES

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

AA.5.4 – RISK ADJUSTMENT

The SSI Medicaid Only eligibility category is risk adjusted using an actuarially sound CDPS + Rx methodology. The post-expansion capitation rates are not risk-adjusted prospectively since the distribution of expansion members by HMO is unknown. A retrospective risk score adjustment will be made based on actual enrollment after the SSI expansion occurs.

The SSI Dual Eligible and all MAPP 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

DHS is implementing an incentive arrangement for 2018 as described in Section IV.C. The HMO contract will not permit the incentive payment for any HMO to be more than 5% of their capitation rate.

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

DHS has not implemented incentive payments related to EHRs for the 2018 contract period.

VII. RESPONSES TO 2017-2018 CMS MANAGED CARE RATE SETTING GUIDE

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

- Rate period – The capitation rates are in effect for the twelve month period from January 1, 2018 through December 31, 2018.
- Actuarial rate certification – See Appendix D.
- Final capitation rates – Please refer to Exhibit 6 (medical capitation rates), Exhibit 10 (dental capitation rates), and Exhibit 13 (chiropractic capitation rates) for the final capitation rates. Exhibit 18 summarizes the final capitation rates, including provider access payments.
- Rate ranges – Not applicable.
- Program descriptions – See Section I.B.
- Federal Medical Assistance Percentage – The assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards and do not vary based on the rate of Federal financial participation associated with the covered populations.
- Cross-subsidies – Payments from one rate cell are not cross-subsidized by payments from any other rate cell.

2. Data

- Service data sources – See Sections II.A through II.C.
- Validation and quality adjustments – See Section II.D.
- Changes in data sources – Base period HMO encounter and financial data was updated from calendar years 2014 and 2015 to calendar years 2015 and 2016.
- Potential future data improvements – As described in Section II.D, we applied missing data adjustments to the encounter data. DHS anticipates missing data adjustments will continue to decrease going forward as encounter data improves over time.
- Other data adjustments – See Section II.D.
- Blending of data sources – See Sections III.D and III.E.

3. Projected Benefit Costs and Trends

- Assumptions used to project benefit costs do not vary based on the rate of federal financial participation associated with the covered populations.
- Changes in covered services and benefits.

  - Various legislative and program changes effective between the base period and contract period – See Section III.B. The costs associated with IMD stays of more than 15 days within a given month were removed from the base data, and we considered the impact of removing the member months and non-IMD claims for members with over 15 IMD days in an IMD for a given month from the 2018 capitation rates and determined the impact was not material.

- Projected benefit cost trends.
  - Annual trend assumptions excluding Medicaid FFS reimbursement changes – See Section III.C.
  - Medicaid reimbursement changes between the base period and contract period – See Section III.A.
- In-lieu-of services – See Section II.B.
- IMD services – Reimbursement adjustments for IMDs are documented in Section III.A, and benefit adjustments are documented in Section III.B
- Mental Health Parity and Addiction Equity Act – No additional services were necessary to add to the program to achieve compliance with the act.
- Other adjustments.
  - Managed care factor adjustments applied to FFS data – See Section II.D.
- Final projected benefit costs – See Exhibit 3 (medical capitation rates), Exhibit 8 (dental capitation rates), and Exhibit 12 (chiropractic capitation rates).
- Retrospective eligibility periods
  - HMOs are not responsible for claims incurred during retroactive eligibility periods. If there are claims for retrospective disenrollment periods, these claims are excluded from the base period encounter data since there is no corresponding eligibility record in the eligibility data. No explicit data adjustment is made to the capitation rates to reflect the impact of claim payments made for retroactively disenrolled members. However, the missing data adjustments add these costs into the base data.
- Conditions of any litigation to which the state is subjected – Not applicable; no impact on rates.

4. Special Contract Provisions Related to Payment

- Incentive arrangements – See Section IV.C
- Withhold arrangements – See Section IV.B
- Risk sharing – Not applicable.
- Delivery system and provider payment initiatives – Not applicable.
- Pass-through payments – Not applicable.

5. Projected Non-Benefit Costs

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

6. Risk Adjustment and Acuity Adjustments

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

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

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

SECTION III. NEW ADULT POPULATION CAPITATION RATES

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

2018 Rate Exhibits

(Provided in Excel Format)

This material assumes the reader is familiar with the State of Wisconsin's Medicaid program, Wisconsin Medicaid benefits, and rate setting principles. The material was prepared solely to provide assistance to DHS to set 2018 capitation rates for the SSI Medicaid managed care programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2018 through December 31, 2018
SSI Medicaid Managed Care Programs

December 20, 2017

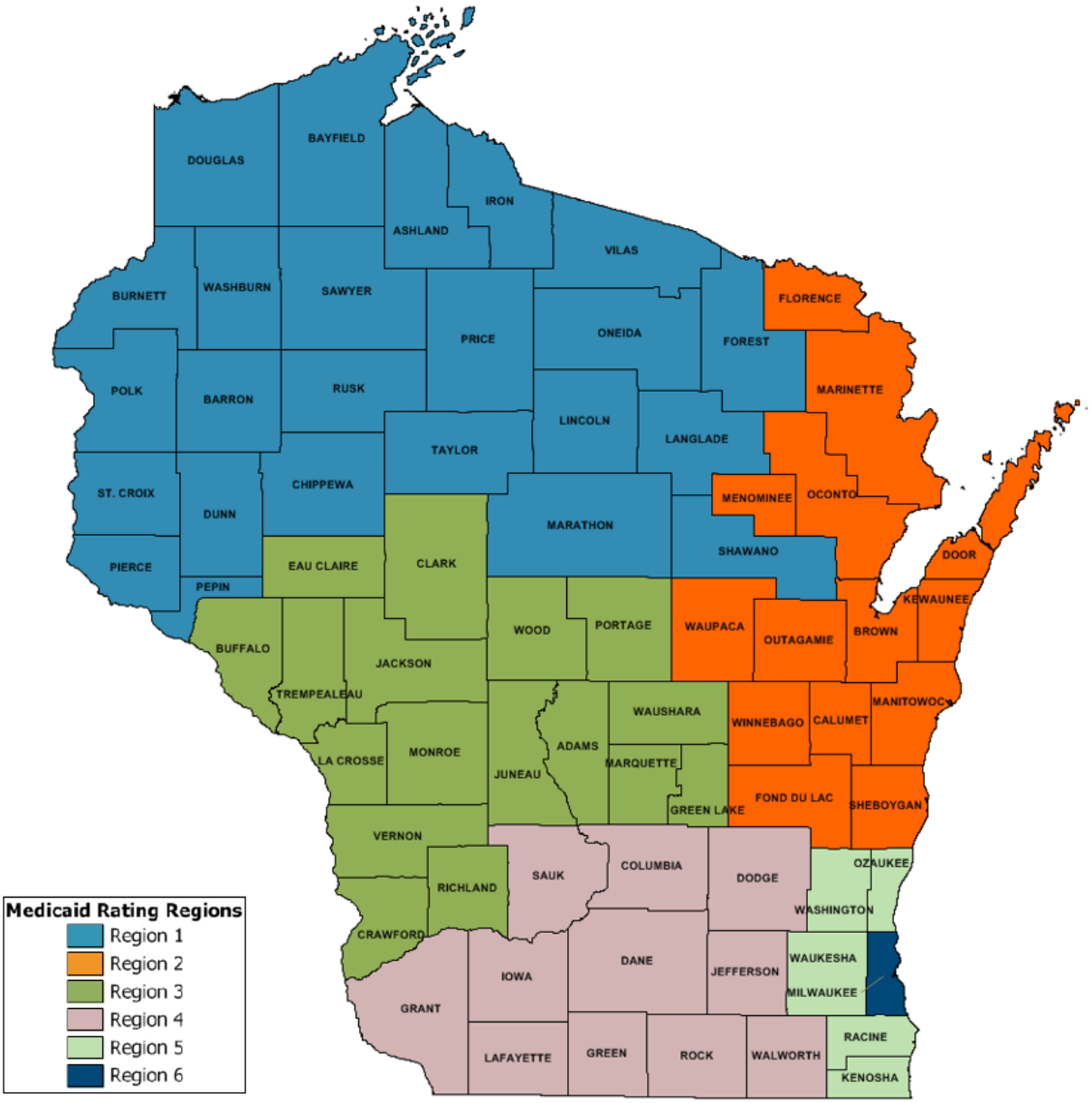
Appendix A

Mapping of Wisconsin Counties to Medicaid Rate Regions

This material assumes the reader is familiar with the State of Wisconsin's Medicaid program, Wisconsin Medicaid benefits, and rate setting principles. The material was prepared solely to provide assistance to DHS to set 2018 capitation rates for the SSI Medicaid managed care programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2018 through December 31, 2018
SSI Medicaid Managed Care Programs

December 20, 2017



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Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2018 – December 31, 2017
SSI Medicaid Managed Care Programs

December 20, 2017

Appendix B

Custom Risk Model Weights

(Provided in Excel Format)

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2018 through December 31, 2018
SSI Medicaid Managed Care Programs

December 20, 2017

Appendix C

Custom Risk Model Category Mapping

(Provided in Excel Format)

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2018 through December 31, 2018
SSI Medicaid Managed Care Programs

December 20, 2017

Appendix D

Actuarial Certification

This material assumes the reader is familiar with the State of Wisconsin's Medicaid program, Wisconsin Medicaid benefits, and rate setting principles. The material was prepared solely to provide assistance to DHS to set 2018 capitation rates for the SSI Medicaid managed care programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Wisconsin Department of Health Services
Capitation Rate Development
January 1, 2018 through December 31, 2018
SSI Medicaid Managed Care Programs

December 20, 2017

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December 20, 2017

Wisconsin Department of Health Services
SSI Medicaid Managed Care Programs
January – December 2018 Capitation Rates
Actuarial Certification

I, Shelly S. Brandel, am associated with the firm of Milliman, Inc. and am a member of the American Academy of Actuaries and meet its Qualification Standards for Statements of Actuarial Opinion. I have been retained by the Wisconsin Department of Health Services (DHS) to perform an actuarial certification of the SSI Medicaid managed care program capitation rates for January – December 2018 for filing with the Centers for Medicare and Medicaid Services (CMS). I reviewed the calculated capitation rates and am familiar with the relevant requirements of 42 CFR 438, the CMS "Appendix A, PAHP, PIHP, and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting", the 2017-2018 Medicaid Managed Care Rate Development Guide, and Actuarial Standard of Practice (ASOP) 49.

To the best of my information, knowledge, and belief, the 2018 SSI capitation rates offered by DHS are in compliance with the relevant requirements of § CFR 438.3(c), 438.3(e), 438.4 (excluding paragraphs (b)(3),(b)(4) and (b)(9)), 438.5, 438.6, and 438.7 (excluding paragraph (c)(3)).

The attached actuarial report describes the capitation rate setting methodology.

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

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

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

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

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

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

Shelly Brandel

Shelly S. Brandel
Member, American Academy of Actuaries

December 20, 2017

Scott Walker
Governor

Linda Seemeyer
Secretary

State of Wisconsin

Department of Health Services

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December 6, 2017

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

RE: January 1, 2018 through December 31, 2018 Wisconsin Medicaid BadgerCare Plus and Supplemental Security Income (SSI) Managed Care Rate Development Data Reliance Letter

Dear Shelly:

I, Chad Lillethun, Director of the 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 2018 were prepared under my direction, and to the best of my knowledge and belief are accurate and complete. This includes the following information supporting the rate development:

1. Data files supporting the January – December 2018 capitation rate development, including:
   a. Fee-for-service claim, HMO Encounter, and Eligibility data
   b. Hospital inpatient and outpatient facility 2018 re-pricing data

2. Other supporting data, including:
   a. Monthly identification of ventilator-dependent members
   b. HMO financial data and Historical performance withhold payments
   c. 2018 provider access payment funding amounts
   d. Information regarding program changes effective prior to December 31, 2018
   e. Details regarding the scope of HMO covered services and eligible recipients
   f. Identification criteria for services eligible for enhanced federal match
   g. Identification of SSI members eligible for HMO expansion
   h. SSI target dates and enrollment assumptions for HMO expansion
   i. Other computer files and clarifying correspondence

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

Sincerely,

Chad Lillethun, Director
Bureau of Fiscal Management
Division of Health Care Access & Accountability