



DIVISION OF DISABILITY AND ELDER SERVICES

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Secretary

State of Wisconsin
Department of Health and Family Services

November 20, 2006

Mr. Martin E. Staehlin, F.S.A.
PricewaterhouseCoopers LLP
One North Wacker
Chicago, IL 60606

Re: Actuarial Certification of 2007 Family Care Capitation Rates

Dear Mr. Staehlin:

I, Anne Olson, Family Care Rate Setting Manager for the Wisconsin Department of Health and Family Services, hereby affirm that the data prepared and submitted to PricewaterhouseCoopers LLP for the purpose of developing 2007 Family Care capitation rates were prepared under my direction, and to the best of my knowledge and belief, are accurate and complete. This data includes:

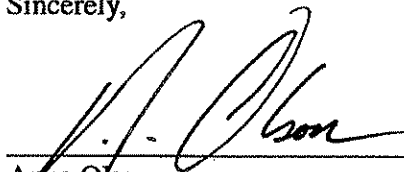
1. MA Card fee-for-service claim data files for CY 2005;
2. MA eligibility data files for CY 2005;
3. HSRS Card fee-for-service claim data files for CY 2005;
4. Functional screen information for Home and Community Based Waiver (HCBW) recipients and HCBW waitlist individuals for 2005 through August 2006;
5. Eligibility information for Family Care recipients for CY 2005;
6. Universal ID crosswalk file providing a crosswalk between Universal IDs in the LTCFS and the Recipient ID used in the eligibility file;
7. CMO encounter file containing units of service and program costs for Family Care recipients for CY 2005;
8. Wage / Fee-Based geographic factor development,

Mr. Martin E. Staehlin
November 20, 2006
Page 2

9. Fee-for-service equivalent information for potential Family Care enrollees in Kenosha and Racine counties; and
10. Current Family Care CMO reported service costs that are no longer allowable and may not receive on-going federal Medicaid match.

I further affirm that the number of eligibles, claims incurral dates, paid claim dates, paid claim amounts, summaries and related data submitted to PricewaterhouseCoopers LLP are, to the best of my knowledge and belief, accurately stated.

Sincerely,



(Name) 11/20/06 (Date)

Anne Olson
Family Care Rate Setting Manager
Department of Health and Family Services
Bureau of Long-Term Support – Managed Care Section
1 West Wilson Street, Room 518
Madison, WI 53702

Wisconsin Department of Health and Family Services
Crosswalk from CMS Rate Setting Checklist to 2007 Kenosha/Racine Family Care Report

Item	Location	Comments
AA.1.0 Overview of Ratesetting Methodology	Entire Report	
AA.1.1 Actuarial Certification	Pages 11-13	
AA.1.2 Projection of Expenditures	NA	DHFS will provide
AA.1.3 Procurement, Prior Approval and Ratesetting	NA	State Set Rates
AA.1.5 Risk contracts	NA	
AA.1.6 Limit on Payment to other providers	NA	
AA.1.7 Rate Modifications	NA	
AA.2.0 Base Year Utilization and Cost Data	Pages 4-8	
AA.2.1 Medicaid Eligibles under the Contract	NA	Data submitted by participating CMOs
AA.2.2 Dual Eligibles	NA	
AA.2.3 Spenddown	NA	
AA.2.4 State Plan Services only	NA	Data submitted by participating HMOs
AA.2.5 Services that may be covered out of contract savings	NA	
AA.3.0 Adjustments to Base Year Data	Pages 4-6	
AA.3.1 Benefit Differences	NA	No Changes in Benefits
AA.3.2 Administrative Cost Allowance Calculations	Page 9	Exhibit III-1
AA.3.3 Special Populations' Adjustments	NA	
AA.3.4 Eligibility Adjustments	NA	
AA.3.5 DSH Payments	NA	
AA.3.6 Third Party Liability	NA	
AA.3.7 Copayments, Coinsurance and Deductibles in Capitated Rates	Page 13	Exhibit III-1
AA.3.8 Graduate Medical Education	NA	
AA.3.9 FQHC and RHC Reimbursement	NA	
AA.3.10 Medical Cost / Trend Inflation	Pages 8	Exhibits II-2A, 2B, 2C & Exhibits II-3A, 3B, 3C
AA.3.11 Utilization Adjustments	NA	
AA.3.12 Utilization and Cost Assumptions	NA	
AA.3.13 Post-Eligibility Treatment of Income	NA	
AA.3.14 Incomplete Data Adjustment	Pages 4, 9	
AA.4.0 Establish Rate Category Groupings	Pages 1-2	Exhibit III-1
AA.4.1 Age	NA	
AA.4.2 Gender	NA	
AA.4.3 Locality / Region	Pages 1-2	Exhibit III-1
AA.4.4 Eligibility Categories	Pages 1-2	
AA.5.0 Data Smoothing	NA	
AA 5.1 Special Population and Assesment of the Data for Distortions	NA	
AA.5.2 Cost-neutral data smoothing adjustment	NA	
AA.5.3 Risk Adjustment	Pages 3-7	
AA.6.0 Stop Loss, Reinsurance or Risk Sharing arrangements	NA	
AA.6.1 Commercial Reinsurance	NA	
AA.6.2 Simple stop loss program	NA	
AA.6.3 Risk corridor program	NA	
AA.7.0 Incentive Arrangements	NA	

**Wisconsin Department of
Health and Family Services**

**Calendar Year 2007
Kenosha / Racine
Family Care Capitation Rates**

Prepared by:

PricewaterhouseCoopers

December 2006

December 20, 2006

Ms. Anne Olson
Family Care Rate Setting Manager
Bureau of Long-Term Support
Division of Disability and Elder Services
One West Wilson Street
Madison, WI 53701

Re: 2007 Kenosha/Racine Managed Care Capitation Rate Development for Family Care

Dear Anne:

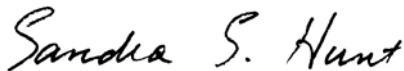
The enclosed report provides a detailed description of the methodology used to develop the 2007 Kenosha/Racine managed care capitation rates for the Family Care program effective January 1, 2007 through December 31, 2007 in Wisconsin. The methods used for calculating these costs are consistent with Centers for Medicare and Medicaid Services requirements that the capitation rates be actuarially sound and appropriate for the population covered by the program.

The development of these rates was overseen by Sandra Hunt, Principal, and Martin Staehlin, Lead Actuary.

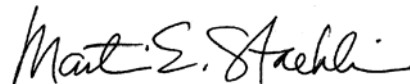
Please call Sandra Hunt at 415-498-5365 or Marty Staehlin at 312-298-3689 if you have any questions regarding these rates.

Very truly yours,

PricewaterhouseCoopers LLP



By: Sandra S. Hunt, M.P.A.
Principal



Martin Staehlin, F.S.A., M.A.A.A.
Managing Director

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SUMMARY OF EXHIBITS

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Exhibit-I-2	Functional Screen Regression Model of 2005 PMPM
Exhibit I-3	Summary of Proportion of CMO Population with Rating Characteristics
Exhibit II-1	Annual Eligibility Summary – Comprehensive
Exhibit II-2A	Development of Projected Trends – Comprehensive – Total
Exhibit II-2B	Development of Projected Trends – Comprehensive – Elderly
Exhibit II-2C	Development of Projected Trends – Comprehensive – Disabled
Exhibit II-3A	Annual PMPM Summary – Comprehensive – Total
Exhibit II-3B	Annual PMPM Summary – Comprehensive – Elderly
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I. EXECUTIVE SUMMARY

This report describes the methodology used to develop monthly capitation payments for Family Care for Calendar Year 2007. This program is sponsored by the State of Wisconsin Department of Health and Family Services and covers long-term care (LTC) services previously provided through the Medicaid State Plan, the Medicaid Home and Community Based Waivers (Waiver), and the Community Options Program (COP). Primary and acute medical services are not covered by Family Care.

Rates are calculated for the Comprehensive and Intermediate populations residing in Kenosha and Racine, who are eligible for the Family Care program. The rates are based on CMO specific encounter data, with adjustments for variation in functional status as measured by each recipient's Long-Term Care Functional Screen (LTCFS). Baseline experience data is adjusted for trend, recognizing changes in utilization, cost, technology and functional status that are expected between the 2005 data period and the 2007 contract period. An allowance is also made for administrative costs, prospective risk margin, and the claims data is adjusted to account for incomplete claims.

Functional Status Model

The rates are based on a regression model of functional status developed from the current five CMO-reported experience for calendar year 2005. The five current participating CMOs are Fond du Lac, La Crosse, Milwaukee, Portage, and Richland. Regression is a statistical technique that produces an estimate of the effect of each factor individually on the cost for an individual. The final model uses the following "functional" measures to develop the capitation rates:

- County
- SNF level of care for the elderly
- Type of developmental disability for the disabled, if any
- Number of IADLs
- ADLs and their levels of help
- Interaction terms among various ADLs
- Behavioral indicators
- Medication management

The county values from the regression model recognize county-to-county cost differences that are not explained by the other factors in the model. Variation in county experience results from differences in provider fee levels, resource availability, potentially incomplete data, CMO management and other factors. There remains a material difference in the per member per month costs among counties that is not fully explained by that model. Consequently, an adjustment is made to the results of the regression model to account for the differences in costs by geography for a market basket of LTC services.

Trend was developed separately for the Elderly and Disabled populations based on an analysis of fee-for-service claims experience. The two-year trend of 8.1% for the Elderly population, and 4.0% for the Disabled population, was developed using FFS claim and eligibility data; which measures the annual mix and utilization trend. Additionally, the Wisconsin Legislature has approved a 2.8% rate increase for nursing homes in State Fiscal Year 2007. For the two-year trend period we have calculated a two-year trend rate of 8.2% for the Elderly population, and 4.1% for the Disabled population. The current mix of Elderly and Disabled participants is used to determine the two-year trend rates for Kenosha/Racine.

An additional adjustment was made to the rates to account for MA-specific cost sharing. Finally, the rates include an allowance for health plan administrative expense and reasonable profit levels.

Disclaimer

In performing this analysis, we relied on data and other information provided by the State. We have not audited or verified this data or other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and believe the data appear to be reasonable for this rate development. If there are material errors or omissions in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual results depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis.

This report is intended to assist the State in developing Family Care capitation rates. It may not be appropriate for other uses. PricewaterhouseCoopers does not intend to benefit and assumes no duty or liability to other parties who receive this work. This report should only be reviewed in its entirety. It assumes the reader is familiar with Family Care, the Wisconsin Medicaid long-term care and Waiver programs, and managed care rating principles.

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

II. FUNCTIONAL SCREEN METHODOLOGY

This section of the report details the development and statistical validity of a risk adjustment methodology appropriate to meet the State's needs and comply with CMS requirements as specified in its checklist titled "The Financial Review Documentation for At-Risk Capitated Contracts Ratesetting."

To appropriately reflect the relative risk of enrollees in the Family Care program, a regression model was developed that measures differences in utilization of services based on functional status. A Family Care-specific model was developed because available risk assessment and risk adjustment models were deemed to be a poor fit for measuring differences in expected Long Term Care costs among enrollees. Available models are largely designed to estimate the need for acute care services, and do not take into account such factors as frailty and the need for assistance with activities of daily living. Through use of a regression model we are able to measure the independent and combined effects of specific cost drivers for the services and population covered by this program.

Data Preparation

Managed care eligibility and claims experience data from the five Wisconsin CMOs for calendar year 2005 is used to establish baseline costs for the rate development. In addition to claims and eligibility data, exposure and functional screen data were provided by the State. Each recipient's cost for 2005 was matched to their corresponding eligible days. Cost PMPM was determined as the total payments divided by total eligibility days times 30.41667 (the average number of days in a month).

To run a regression model, it is essential that all data fields are populated. To correct for missing data, we used certain decision rules. Specifically, where gender is missing from the eligibility or claims file, the recipient is assumed to be female; however, gender is not a rating variable. For elements of the functional screen, missing values were assumed to have a value of "0". In other words, we assumed that the individual did not have the characteristic addressed by the question unless it was affirmatively reported.

Claims Experience

Aggregate 2005 claims used for the statistical analysis are \$200,786,633, and the exposure months totaled 107,024, resulting in a PMPM of \$1,876.09 for the Medical Assistance (MA) comprehensive population. Exhibit I-1A shows this experience by target group and category of service. Based on discussions with DHFS staff, we understand that reported costs are prior to any participant cost sharing and net of any third party liability.

The claims data covers dates of service for calendar year 2005 with run out through July 2006. These data must be adjusted to reflect claims that were Incurred But Not Reported (IBNR) in order to “complete” the starting claims database. An IBNR adjustment of 0.1% was made to the claims data. IBNR claims have been estimated using standard actuarial methods.

The calendar year 2005 claims data is further adjusted to exclude expenditures that do not match the allowable definition of state plan services. In other words, all non-state plan service costs are excluded from the base data. Expenditures are excluded unless they fit into one of the new s. 1915 (b) (3) waiver service definitions or one of the other service definitions in the Family Care s. 1915 (c) waivers or the State Plan services included in the benefit. The most common expenditure that did not match is support for consumers' room and board. These excluded services account for an estimated aggregate claim amount of \$2,779,800, and thus have been excluded from the calendar year 2007 capitation rate development.

The remainder of this section summarizes the methodology used to develop the proposed payment rates. The results include the regression analysis conducted on the CMO calendar year 2005 encounter data and the functional measures reported from the screens conducted by the Resource Centers and CMOs.

Sample Size and 2006 Model Validation

There were 11,273 MA Comprehensive enrollees in the Family Care program during 2005 that had eligible claims during the year. The experience of this entire population is used for designing the risk adjustment methodology, except for that portion of the population described in the section titled "Carve-Outs," below.

Using the 2005 data, an analysis was performed to validate the statistical significance of the variables used in the prior year's model. The results showed that the variables included in the prior model were appropriate, and the same variables were retained in the current model; the parameter values were calibrated to match the most recent experience.

Carve-Outs

Any recipients that were not eligible for Medical Assistance and those not eligible for comprehensive care were excluded from the risk adjustment and rate setting process. These groups constituted less than 5% of the Family Care population in 2005.

Functional Status Information

All recipients were given health status and functional screens annually prior to July 1, 2005 or at the point of Family Care enrollment during 2005. Such information is readily available on the

State's administrative system and is expected to continue to be available while the Family Care program is in effect.

The health status and functional screens collect the following information on recipients:

- Type of living situation, level of care (e.g., skilled nursing)
- The presence of a developmental disability
- The level of assistance for each instrumental activity of daily living (i.e., IADLs)
- The level of assistance for each activity of daily living (i.e., ADLs)
- The presence of one of 64 diagnosis groups, summarized into 10 diagnostic classes
- The use of medications and the level of assistance required to correctly administer them
- The frequency of certain health related services (e.g., pain management, TPN, dialysis, etc.)
- The levels of communication, memory, and cognition
- The presence and extent of certain behaviors (wandering, self-injurious, offensive, etc.)

Legal and administrative information is also collected but not used for risk adjuster development.

All screeners are trained by the State to ensure that the screens are administered consistently.

Approach to Rate Development

Estimated costs PMPM are determined for recipients based on each recipient's IADL count, specific levels of ADL assistance needed, the presence of certain behavioral problems, detail on medication assistance provided, the level of care provided, the type of developmental disability (if any), certain combinations of ADLs, and geographic region. Monthly screen information of the cost period (calendar year 2005) is used, resulting in a concurrent risk adjustment model.¹

Linear least squares regression was used to model the effects of the above factors in predicting costs PMPM. The overall cost estimate for a recipient is determined by summing the coefficients for the factors applicable to the recipient, and adding the regression intercept. This method essentially results in an individual rate for each recipient rather than categorizing them into mutually exclusive groups, as would be done with other approaches to rate development.

Exhibit I-2 shows the results of the regression analysis. The R-squared of the risk adjustment model is approximately 40%. This value is similar to, but somewhat higher than the R-squared

¹ Note: risk adjustment models are typically termed "concurrent" or "prospective". A concurrent model measures expected costs in the current period based on claims and screening data for the current period. A prospective model measures expected costs in a subsequent period based on claims and screening data for a current period. The choice of whether to use a concurrent or prospective model depends on a number of factors, including the stability of the population. For the Family Care population, we believe a concurrent model is appropriate, although a prospective model is not expected to yield materially different results for this program, given the limited turn-over of the population.

value for many concurrent physical health models. The high predictive power results in part from use of a concurrent model, and in part from the fact that use of LTC services is more persistent on average than use of acute health care services.

When used with the 2005 functional status indices, the regression model estimates a baseline cost by CMO for 2005. To better assess the prospective cost in a county, we used the functional screens active in August 2006 for the Family Care population eligible to be enrolled in Kenosha and Racine counties. The population / functional screens were identified using the March 2006 Kenosha and Racine HCBS Waiver and Waitlist individuals provided by DHFS.

Regression Modeling - Details

Using calendar year 2005 MA Comprehensive data, an ordinary least squares linear regression model is created to relate monthly costs to recipient functional characteristics. The unit of analysis is the recipient month. That is, the monthly 2005 cost and the recipient's corresponding functional screen constitute one observation. The statistical analyses weigh experience in proportion to each recipient's days of eligibility.

Modeling proceeds in a stepwise manner, starting with variables that explain the most variation and incrementally adding variables that have a marginally decreasing effect on improving the model's R-squared value and increasing the model's overall predictive capacity. Note also that all predictor variables are coded as binary, (i.e., having a value of "0" or "1".) Thus, a recipient either has a particular characteristic or they do not. With this approach we avoid forcing a relationship upon the variables, such as doubling the expected costs for an individual with twice as many ADLs as another individual.

When considering variables to include in the model, we used the following criteria:

- Variables are included in the model if they show a 5% level of significance.
- Variables are excluded if, when included, multicollinearity is present. That is, when an additional variable is included it shows a strong linear relationship among one or more of the other variables.
- Variables are excluded to simplify the model if including them only marginally increases model fit.

With a baseline model established, the effects of interaction are considered. Interaction terms are important since the effect of, for example, a bathing ADL requiring assistance with a dressing ADL requiring assistance, may be greater or less than the sum of these effects modeled individually.

The final regression model consists of twenty eight variables to predict cost. The variables are separated into the following six classes: level of care, IADLs, specific ADLs, interactions, behavioral, and medication use. The estimated impact on the cost for each variable is shown along with its significance (i.e., p-value), relative contribution in explaining the variation (i.e., Incremental Partial R²) and the proportion of the population with the characteristic.

Exhibit I-2 shows the final statistical model. The model explains approximately 40% of the variation in the data. The model has a mean of \$1,876 PMPM

The average effect of each variable shows how the aggregate cost PMPM are allocated among individual characteristics in the population. For example, the model attributes \$52.17 PMPM of the aggregate PMPM (\$1,876) to IADL-5. Thus to derive the average PMPM cost for a given population, one would cross-multiply all regression parameter estimates by the proportion of the population with the respective characteristic.

County Factors

The intent of using the county experience factors is to recognize differences in costs that cannot be explained directly by the regression model, and to provide stability to funding for the Family Care program.

The State developed factors based on the relative wage levels and fees paid in the current five participating CMO counties and for Kenosha / Racine counties. They used wage data collected by the State / Federal government, and reported by the U.S. Bureau of Labor Statistics, for occupations involved in providing care: registered nurses, social workers, home health aides, personal care / home care aides and personal care / service. Average fees paid by Medicaid for nursing home and residential care days were also reviewed. The relative wage and fee levels were aggregated using the relative costs for these services. This process estimates the potential costs faced by the current CMOs and the expansion counties.

The potential costs faced by Kenosha and Racine counties were on average 0.28% higher than the current five participating CMOs. To account for this difference in wage and fee levels, the baseline per capita costs for Kenosha / Racine were increased by a factor of 1.0028.

Application of the Model

The regression model was developed using 2005 cost and functional screen data. To determine expected costs for the contract period, we obtained updated functional screen information as of August 2006. Exhibit I-3 shows the distribution of the population by target group, population type, and functional measure used to calculate the final base rates.

Using August 2006 functional screen data provides a snapshot of the estimated average cost for each of the counties at a point in time. The most recent functional screen information is used to better assess the relative prospective cost in a county.

III. FEE-FOR-SERVICE TREND DEVELOPMENT

Trend rates are used to project the 2005 baseline cost data beyond the base cost period to the 2007 contract period.

Trend was developed separately for the Elderly and Disabled populations. The two-year trend of 8.1% for the Elderly population, and 4.0% for the Disabled population, was developed using FFS Medicaid Management Information System (MMIS) and Human Services Reporting System (HSRS) claim and eligibility data from calendar years 2002 through 2005. The trend over this period includes annual mix and utilization trend. To derive final trend rates, the mix / utilization component is adjusted for estimated fee increases over calendar years 2006 and 2007. The Wisconsin Legislature, outside of the biennial budget process, has approved a 2.8% rate increase for nursing homes in State Fiscal Year 2007. The adjusted two-year trend rates of 8.2% (4.0% annually) for the Elderly population and 4.0% (2.0% annually) for the Disabled population is used to project baseline per capita costs to the contract period. The current mix of Elderly and Disabled participants is used to determine the two-year trend rates for each County.

Exhibit II-1 shows the eligible days for each year from 2001 to 2005 for both the Elderly and Disabled fee-for-service populations. The proportion of the population that is Disabled has remained flat or increased each year since 2000 (except 2002) for both MMIS and HSRS eligibility.

The following table summarizes the trend.

County Name	Two-Year Trend
Kenosha / Racine	5.28%

The two-year trend accounts for both the change in costs within each population and the change in the mix of eligibles by population.

Exhibits II-2A, II-2B, and II-2C contain the development of the projected annual trends from 2005 to 2007 for the Total, Elderly, and Disabled comprehensive populations, respectively.

Exhibits II-3A, II-3B, and II-3C summarize the comprehensive per member per month (PMPM) costs and average annual trends from 2001 to 2005 for the Total, Elderly, and Disabled populations, respectively. The trends are based on experience from non-Family Care counties only.

Exhibit II-4 shows the Intermediate rate for 2007. At this time there are very few recipients in this rate category. Based on the limited data available, the 2006 Family Care Intermediate rate appears to be sufficient for covering CMO Intermediate costs. Consequently, the rates from the prior year have been used as a basis for the Kenosha / Racine Intermediate capitation rate.

IV. PER CAPITA COST DEVELOPMENT

In summary, the 2007 per capita costs were developed as described below.

1. Determine functional status based costs using the 2005 CMO reported experience and functional screens as outlined in Section II. These cost estimates are adjusted to reflect an estimate for IBNR using payments through July 2006.
2. Exclude disallowed services that were included in the 2005 encounter data.
3. Project adjusted 2005 costs two years using the annualized Elderly and Disabled fee-for-service trend rates discussed in Section III.
4. Divide the projected rates by a target administration rate to develop a capitation rate. We used a factor of 6.25% for Kenosha / Racine county. The 6.25% factor is based on a review of CMO reported administrative costs in 2005 and year-to-date 2006.
5. Divide the projected rates by 1 minus a risk margin rate. The risk adjustment made to Kenosha / Racine was 2.0%. A risk margin is provided to accommodate the adverse effects of volatility in delivery care patterns. The risk margin was determined based on the size of the Kenosha and Racine HCBS Waiver and Waitlist individuals at August 2006.
6. We adjusted the rates for cost-sharing to produce preliminary net rates from the gross cost projection. The estimate is based on the most recent Family Care data available and will be adjusted to actual individually calculated cost share amounts at the end of the contract year.

Exhibit III-1 shows the projection of rates to 2007, the cost-sharing adjustment, and the calculation of capitation rates.

V. FINAL CAPITATION RATES

The Wisconsin Department of Health and Family Services determined the final 2007 capitation rates for the Family Care program. Exhibit III-1 illustrates the 2007 capitation rates.

The 2007 per capita costs developed in this report are within a reasonable range of rates for the Family Care population, as defined by reasonable ranges on several important assumptions including annual trend rates and appropriate administrative loadings, among others.

VI. ACTUARIAL CERTIFICATION

Following is our actuarial certification for the 2007 capitation rates

**Actuarial Certification of
Proposed 2007 Family Care Capitated Rates
State of Wisconsin Department of Health and Family Services**

I, Martin E. Staehlin, am associated with the firm of PricewaterhouseCoopers. I am a member of the American Academy of Actuaries and meet its Qualification Standards to certify as to the actuarial soundness of the 2007 capitation rates developed for the Medicaid managed care programs known as Family Care. I have been retained by the Wisconsin Department of Health and Family Services (DHFS) to perform an actuarial certification of the Family Care capitation rates for calendar year 2007 for filing with the Centers for Medicare and Medicaid Services (CMS). I have reviewed the capitation rates developed by DHFS and am familiar with the Code of Federal Regulations, 42 CFR 438.6(c) and the CMS "Appendix A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting."

I have examined the actuarial assumptions and actuarial methods used by DHFS in setting the capitation rates for calendar year 2007.

To the best of my information, knowledge and belief, for the period from January 1, 2007 to December 31, 2007, the capitation rates offered by DHFS are in compliance with 42 CFR 438.6(c), with respect to the development of Medicaid managed care capitation rates. The attached actuarial report describes the rate development methodology used by DHFS. I believe that the capitation rates have been 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. The capitation rates are based solely on the projected costs for State Plan services.

In making my opinion, I have relied upon the accuracy of the underlying enrollment, encounter, and other data and summaries prepared by DHFS and the participating contracted CMOs. A copy of the reliance letter received from DHFS is attached and constitutes part of this opinion. I reviewed the data for reasonableness; however, I performed no independent verification and take no responsibility as to the accuracy of these data.

The proposed actuarially sound rates shown are a projection of future events. It may be expected that actual experience will vary from the values shown here. Actuarial methods, considerations, and analyses used in developing the proposed capitation rates conform to the appropriate Standards of Practice promulgated from time to time by the Actuarial Standards Board.

The capitation rates may not be appropriate for any specific CMO. Each CMO will need to review the rates in relation to the benefits provided. The CMOs should compare the rates with their own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract

with the State. The CMO may require rates above, equal to, or below the proposed actuarially sound capitation rates.

This Opinion assumes the reader is familiar with the Family Care program, 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.



Martin E. Staehlin

Member, American Academy of Actuaries

December 20, 2006

Date

Exhibits

**Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development**

Summary of 2005 Actual Experience (MA Comprehensives Only)

	All Counties	
	Elderly	Disabled
Exposure Months	83,221	23,803
Adaptive Equipment	63.17	64.60
Adult Day Activities	56.49	173.40
Case Management	268.87	299.33
Community At Large	-	-
Room and Board	(146.78)	(129.03)
Family Support Funding	-	-
Habilitation / Health	8.97	43.36
Home Care	313.28	509.79
Home Health Care	183.84	113.23
Housing	0.98	2.61
Institutional	348.57	131.81
Member Tracking	-	-
Other	9.02	4.37
Residential Care	628.18	718.09
Respite Care	3.40	46.23
Transportation	34.33	55.92
Vocational	9.56	171.80
Total	1,781.87	2,205.52
Composite PMPM	1,876.09	

Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development

Functional Screen Regression Model of 2005 PMPM
Comprehensive MAs Only

Variable	Estimate	p-Value	Incremental Partial R2	Proportion with Variable	Incremental Increase
Intercept (Grid Component)	659.63	0.0001			659.63
DD/NH Level of Care (Grid Component)					
Vent Dependent	3,199.42	0.0001	0.00438	0.0008	2.60
DD1A	1,259.97	0.0001	0.01918	0.0119	14.97
DD1B	1,787.08	0.0001	0.07472	0.0252	45.03
DD2	906.56	0.0001	0.04170	0.1147	104.00
SNF	273.32	0.0001	0.07815	0.2339	63.93
Number of IADLs (Grid Component)					
IADL_3	23.85	0.0793	0.00940	0.1905	4.54
IADL_4	171.93	0.0001	0.00031	0.3533	60.74
IADL_5	227.71	0.0001	0.02832	0.2291	52.17
IADL_6	1,096.94	0.0001	0.04524	0.0335	36.79
Specific ADLs / Equipment Used (Add-On)					
Bathing_2	273.27	0.0001	0.03632	0.4764	130.18
Dressing_2	84.74	0.0001	0.01407	0.2752	23.32
Eating_2	96.46	0.0001	0.00371	0.0833	8.04
Toileting_1	179.84	0.0001	0.00076	0.1677	30.16
Toileting_2	382.24	0.0001	0.01158	0.1813	69.32
Transfer_2	239.32	0.0001	0.00113	0.1666	39.86
Interaction Terms (Add-On)					
Dressing_Toileting	114.72	0.0001	0.00183	0.4491	51.52
Bathing_Equip_Dressing	128.18	0.0001	0.00106	0.4352	55.78
Transfer_Equip_Mobility	390.27	0.0001	0.00210	0.0686	26.76
Bathing_Equip_Eating	68.66	0.0001	0.00033	0.1891	12.98
Behavioral Variables (Add-On)					
Communication_2	54.00	0.0008	0.00020	0.1062	5.74
Communication_3	174.63	0.0001	0.00079	0.0374	6.53
Cognition_3	76.16	0.0001	0.00074	0.1468	11.18
Resistive	168.32	0.0001	0.00213	0.0563	9.47
Injury	360.61	0.0001	0.00221	0.0460	16.57
Offensive_1-2	332.70	0.0001	0.00272	0.1104	36.72
Offensive_3	739.02	0.0001	0.00119	0.0067	4.95
Medication Use (Add-On)					
Meds_2A	370.06	0.0001	0.00049	0.2060	76.22
Meds_2B	559.46	0.0001	0.00940	0.3870	216.53

Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development

Functional Screen Regression Model of 2005 PMPM
Kenosha / Racine Rate Development

Variable	Elderly		Disabled	
	Waiver	Waitlist	Waiver	Waitlist
Intercept (Grid Component)				
DD/NH Level of Care (Grid Component)				
Vent Dependent	0.0%	0.5%	0.6%	0.3%
DD1A	0.3%	0.0%	1.9%	2.1%
DD1B	0.5%	0.5%	10.4%	5.6%
DD2	8.4%	0.0%	56.9%	23.6%
SNF	19.0%	26.9%	7.4%	15.3%
Number of IADLs (Grid Component)				
IADL_3	13.3%	24.1%	8.9%	21.5%
IADL_4	44.8%	37.7%	21.9%	25.7%
IADL_5	26.1%	15.6%	38.4%	15.6%
IADL_6	2.2%	0.5%	22.9%	6.3%
Specific ADLs / Equipment Used (Add-On)				
Bathing_2	66.6%	48.6%	51.2%	27.8%
Dressing_2	38.0%	25.5%	36.8%	20.8%
Eating_2	11.7%	7.5%	22.3%	11.1%
Toileting_1	19.8%	17.9%	19.8%	13.5%
Toileting_2	18.5%	15.1%	26.8%	13.5%
Transfer_2	18.8%	17.0%	19.7%	16.0%
Interaction Terms (Add-On)				
Dressing_Toileting	57.9%	42.9%	51.0%	29.2%
Bathing_Equip_Dressing	64.1%	36.8%	27.7%	21.2%
Transfer_Equip_Mobility	13.3%	2.4%	13.7%	4.5%
Bathing_Equip_Eating	26.6%	16.0%	17.2%	11.1%
Behavioral Variables (Add-On)				
Communication_2	7.3%	5.2%	24.3%	14.6%
Communication_3	3.3%	0.9%	13.7%	8.0%
Cognition_3	16.0%	11.3%	32.7%	12.2%
Resistive	4.6%	2.4%	11.9%	4.5%
Injury	1.6%	0.9%	18.9%	7.6%
Offensive_1-2	9.2%	5.7%	33.7%	9.0%
Offensive_3	0.5%	0.0%	1.1%	1.4%
Medication Use (Add-On)				
Meds_2A	20.4%	24.5%	21.1%	19.8%
Meds_2B	48.1%	37.7%	53.1%	22.6%

**Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development**

Annual Eligibility Summary - Comprehensive

MMIS					
	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005
Eligible Days					
Elderly	2,483,998	2,788,771	2,846,144	2,432,879	2,812,556
Disabled	<u>3,494,177</u>	<u>3,836,186</u>	<u>4,064,471</u>	<u>3,866,419</u>	<u>4,303,426</u>
Total MMIS Days	5,978,175	6,624,957	6,910,615	6,299,298	7,115,982
Percent of Total					
Elderly	41.55%	42.09%	41.19%	38.62%	39.52%
Disabled	<u>58.45%</u>	<u>57.91%</u>	<u>58.81%</u>	<u>61.38%</u>	<u>60.48%</u>
Total	100.00%	100.00%	100.00%	100.00%	100.00%

HSRS					
	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005
Eligible Days					
Elderly	2,384,493	2,709,290	2,778,035	2,400,872	2,553,224
Disabled	<u>3,458,033</u>	<u>3,791,008</u>	<u>4,030,851</u>	<u>3,871,545</u>	<u>4,200,672</u>
Total MMIS Days	5,842,526	6,500,298	6,808,886	6,272,417	6,753,896
Percent of Total					
Elderly	40.81%	41.68%	40.80%	38.28%	37.80%
Disabled	<u>59.19%</u>	<u>58.32%</u>	<u>59.20%</u>	<u>61.72%</u>	<u>62.20%</u>
Total	100.00%	100.00%	100.00%	100.00%	100.00%

**Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development**

Development of Projected Trends; Comprehensive - Total

MMIS							
	2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM	2006-2007 Reimbursement Trend	2006-2007 Mix / Utilization Trend	Projected 2007 PMPM
Nursing Facility	86.83	0.0%	2.6%	89.10	1.4%	2.6%	92.72
MR Centers	42.30	0.0%	2.6%	43.41	0.0%	2.6%	44.55
MR Facilities	1.11	0.0%	2.6%	1.14	0.0%	2.6%	1.17
Home Care	467.74	0.0%	2.6%	479.99	0.0%	2.6%	492.57
Case Management	0.87	0.0%	2.6%	0.89	0.0%	2.6%	0.91
Other ⁽¹⁾	<u>57.40</u>	0.0%	2.6%	<u>58.90</u>	0.0%	2.6%	<u>60.44</u>
MMIS Total	656.24			673.44			692.36

HSRS							
	2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM	2006-2007 Reimbursement Trend	2006-2007 Mix / Utilization Trend	Projected 2007 PMPM
Habilitation	8.51	0.0%	3.2%	8.78	0.0%	3.2%	9.06
Home Care	506.78	0.0%	3.2%	522.84	0.0%	3.2%	539.41
Residential	813.72	0.0%	3.2%	839.51	0.0%	3.2%	866.11
Case Management	172.48	0.0%	3.2%	177.94	0.0%	3.2%	183.58
Other ⁽²⁾	638.50	0.0%	3.2%	658.74	0.0%	3.2%	679.61
Cost Sharing	<u>(13.20)</u>	0.0%	3.2%	<u>(13.62)</u>	0.0%	3.2%	<u>(14.05)</u>
HSRS Total	2,126.78			2,194.19			2,263.73
Total MMIS & HSRS	2,783.03			2,867.63			2,956.09
Two-Year Trend							6.2%
Annual Trend				3.0%			3.1%

**Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development**

Development of Projected Trends; Comprehensive - Elderly

MMIS							
	2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM	2006-2007 Reimbursement Trend	2006-2007 Mix / Utilization Trend	Projected 2007 PMPM
Nursing Facility	171.03	0.0%	0.9%	172.57	1.4%	0.9%	176.56
MR Centers	5.07	0.0%	0.9%	5.11	0.0%	0.9%	5.16
MR Facilities	0.16	0.0%	0.9%	0.16	0.0%	0.9%	0.16
Home Care	255.47	0.0%	0.9%	257.77	0.0%	0.9%	260.09
Case Management	0.60	0.0%	0.9%	0.61	0.0%	0.9%	0.62
Other ⁽¹⁾	<u>39.89</u>	0.0%	0.9%	<u>40.25</u>	0.0%	0.9%	<u>40.61</u>
MMIS Total	472.22			476.47			483.20

HSRS							
	2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM	2006-2007 Reimbursement Trend	2006-2007 Mix / Utilization Trend	Projected 2007 PMPM
Habilitation	5.22	0.0%	5.1%	5.48	0.0%	5.1%	5.76
Home Care	390.95	0.0%	5.1%	410.89	0.0%	5.1%	431.84
Residential	584.94	0.0%	5.1%	614.77	0.0%	5.1%	646.12
Case Management	160.26	0.0%	5.1%	168.44	0.0%	5.1%	177.03
Other ⁽²⁾	176.38	0.0%	5.1%	185.37	0.0%	5.1%	194.83
Cost Sharing	<u>(23.22)</u>	0.0%	5.1%	<u>(24.41)</u>	0.0%	5.1%	<u>(25.65)</u>
HSRS Total	1,294.52			1,360.54			1,429.93

Total MMIS & HSRS	1,766.74			1,837.01			1,913.13
Two-Year Trend							8.3%
Annual Trend				4.0%			4.1%

**Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development**

Development of Projected Trends; Comprehensive - Disabled

MMIS							
	2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM	2006-2007 Reimbursement Trend	2006-2007 Mix / Utilization Trend	Projected 2007 PMPM
Nursing Facility	31.79	0.0%	2.7%	32.65	1.4%	2.7%	34.00
MR Centers	66.64	0.0%	2.7%	68.44	0.0%	2.7%	70.29
MR Facilities	1.74	0.0%	2.7%	1.78	0.0%	2.7%	1.83
Home Care	606.47	0.0%	2.7%	622.84	0.0%	2.7%	639.66
Case Management	1.04	0.0%	2.7%	1.06	0.0%	2.7%	1.09
Other ⁽¹⁾	<u>68.84</u>	0.0%	2.7%	<u>70.70</u>	0.0%	2.7%	<u>72.61</u>
MMIS Total	776.51			797.48			819.48
HSRS							
	2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM	2006-2007 Reimbursement Trend	2006-2007 Mix / Utilization Trend	Projected 2007 PMPM
Habilitation	10.51	0.0%	1.8%	10.70	0.0%	1.8%	10.89
Home Care	577.19	0.0%	1.8%	587.58	0.0%	1.8%	598.15
Residential	952.77	0.0%	1.8%	969.92	0.0%	1.8%	987.38
Case Management	179.90	0.0%	1.8%	183.14	0.0%	1.8%	186.43
Other ⁽²⁾	919.38	0.0%	1.8%	935.93	0.0%	1.8%	952.78
Cost Sharing	<u>(7.11)</u>	0.0%	1.8%	<u>(7.23)</u>	0.0%	1.8%	<u>(7.37)</u>
HSRS Total	2,632.64			2,680.03			2,728.27
Total MMIS & HSRS	3,409.16			3,477.51			3,547.75
Two-Year Trend							4.1%
Annual Trend				2.0%			2.0%

**Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development**

Annual PMPM Summary; Comprehensive - Total

MMIS PMPM						
	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	2002 - 2005 Trend
Nursing Facility	96.52	101.78	95.64	82.66	86.83	-5.16%
MR Centers	12.92	9.59	16.71	11.12	42.30	63.98%
MR Facilities	13.58	13.89	12.78	4.86	1.11	-56.88%
Home Care	406.04	395.36	407.07	467.00	467.74	5.76%
Case Management	1.70	1.55	1.39	0.30	0.87	-17.69%
Other ⁽¹⁾	<u>70.14</u>	<u>70.41</u>	<u>70.23</u>	<u>70.55</u>	<u>57.40</u>	<u>-6.58%</u>
MMIS Total	600.89	592.58	603.81	636.49	656.24	3.46%

HSRS PMPM						
	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	2002 - 2005 Trend
Habilitation	5.88	6.51	7.21	9.35	8.51	9.33%
Home Care	644.61	610.78	590.61	544.39	506.78	-6.03%
Residential	620.54	667.32	708.56	762.46	813.72	6.83%
Case Management	147.52	154.16	162.17	157.22	172.48	3.81%
Other ⁽²⁾	460.87	485.01	524.93	625.26	638.50	9.60%
Cost Sharing	<u>(9.06)</u>	<u>(10.60)</u>	<u>(11.89)</u>	<u>(11.21)</u>	<u>(13.20)</u>	<u>7.60%</u>
HSRS Total	1,870.35	1,913.18	1,981.59	2,087.47	2,126.78	3.59%

**Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development**

Annual PMPM Summary; Comprehensive - Elderly

MMIS PMPM						
	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	2002 - 2005 Trend
Nursing Facility	182.93	181.99	174.49	174.77	171.03	-2.05%
MR Centers	-	0.07	3.92	-	5.07	322.31%
MR Facilities	4.10	2.33	5.60	2.32	0.16	-58.87%
Home Care	222.73	209.65	216.72	258.84	255.47	6.81%
Case Management	1.61	1.32	1.09	0.26	0.60	-22.91%
Other ⁽¹⁾	<u>48.24</u>	<u>47.66</u>	<u>49.49</u>	<u>53.39</u>	<u>39.89</u>	<u>-5.76%</u>
MMIS Total	459.61	443.00	451.30	489.58	472.22	2.15%

HSRS PMPM						
	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	2002 - 2005 Trend
Habilitation	2.96	3.15	3.86	5.90	5.22	18.33%
Home Care	423.26	403.97	401.74	414.74	390.95	-1.09%
Residential	349.00	436.86	489.51	555.09	584.94	10.22%
Case Management	127.94	134.19	146.03	143.29	160.26	6.10%
Other ⁽²⁾	131.67	135.87	146.12	169.22	176.38	9.09%
Cost Sharing	<u>(12.44)</u>	<u>(16.52)</u>	<u>(18.65)</u>	<u>(19.06)</u>	<u>(23.22)</u>	<u>12.02%</u>
HSRS Total	1,022.40	1,097.51	1,168.61	1,269.18	1,294.52	5.66%

**Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development**

Annual PMPM Summary; Comprehensive - Disabled

MMIS PMPM						
	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	2002 - 2005 Trend
Nursing Facility	35.09	43.47	40.42	24.71	31.79	-9.90%
MR Centers	22.10	16.52	25.66	18.11	66.64	59.18%
MR Facilities	20.31	22.30	17.81	6.45	1.74	-57.30%
Home Care	536.35	530.37	540.37	597.99	606.47	4.57%
Case Management	1.76	1.72	1.59	0.33	1.04	-15.56%
Other ⁽¹⁾	<u>85.71</u>	<u>86.95</u>	<u>84.75</u>	<u>81.34</u>	<u>68.84</u>	<u>-7.49%</u>
MMIS Total	701.33	701.32	710.61	728.94	776.51	3.45%

HSRS PMPM						
	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	2002 - 2005 Trend
Habilitation	7.75	8.77	9.43	11.42	10.51	6.20%
Home Care	786.48	749.93	716.01	622.10	577.19	-8.36%
Residential	794.59	822.38	854.00	886.77	952.77	5.03%
Case Management	160.08	167.60	172.89	165.56	179.90	2.39%
Other ⁽²⁾	671.87	719.92	776.46	898.62	919.38	8.49%
Cost Sharing	<u>(6.89)</u>	<u>(6.61)</u>	<u>(7.41)</u>	<u>(6.50)</u>	<u>(7.11)</u>	<u>2.43%</u>
HSRS Total	2,413.87	2,461.98	2,521.39	2,577.97	2,632.64	2.26%

**Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development**

2007 Intermediate Capitation Rate

	Intermediate Composite Rate
Target Group	2007 Rate
Statewide	\$691.35

**Wisconsin Department of Health and Family Services
CY 2007 Kenosha/Racine Family Care Capitation Rate Development**

Development of the 2007 Final Rates; Kenosha / Racine

County	Adjusted Total Statistical 2005 PMPM*	Admin Rate	Risk Rate	Two-Year Trend	2007 Gross Rates
Kenosha / Racine	2,364.34	6.25%	2.00%	5.28%	2,713.04

County	2007 Ave. Cost Sharing PMPM	Final 2007 Capitation Rate
Kenosha / Racine	42.81	2,670.23

*Only State plan services were included.