

**Wisconsin Department of
Health and Family Services**

**Contract Period 2008
Family Care Capitation Rates for Expansion Regions**

Prepared by:

PricewaterhouseCoopers

January 2008

January 28, 2008

Mr. Thomas Lawless
Financial Management and Business Services Section Chief
Division of Long-Term Care - Office of Family Care Expansion
One West Wilson Street
Madison, WI 53701

Re: 2008 Family Care Managed Care Capitation Rate Development for Expansion Regions

Dear Tom:

The enclosed report provides a detailed description of the methodology used to develop the 2008 Family Care managed care capitation rates for Expansion Regions 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

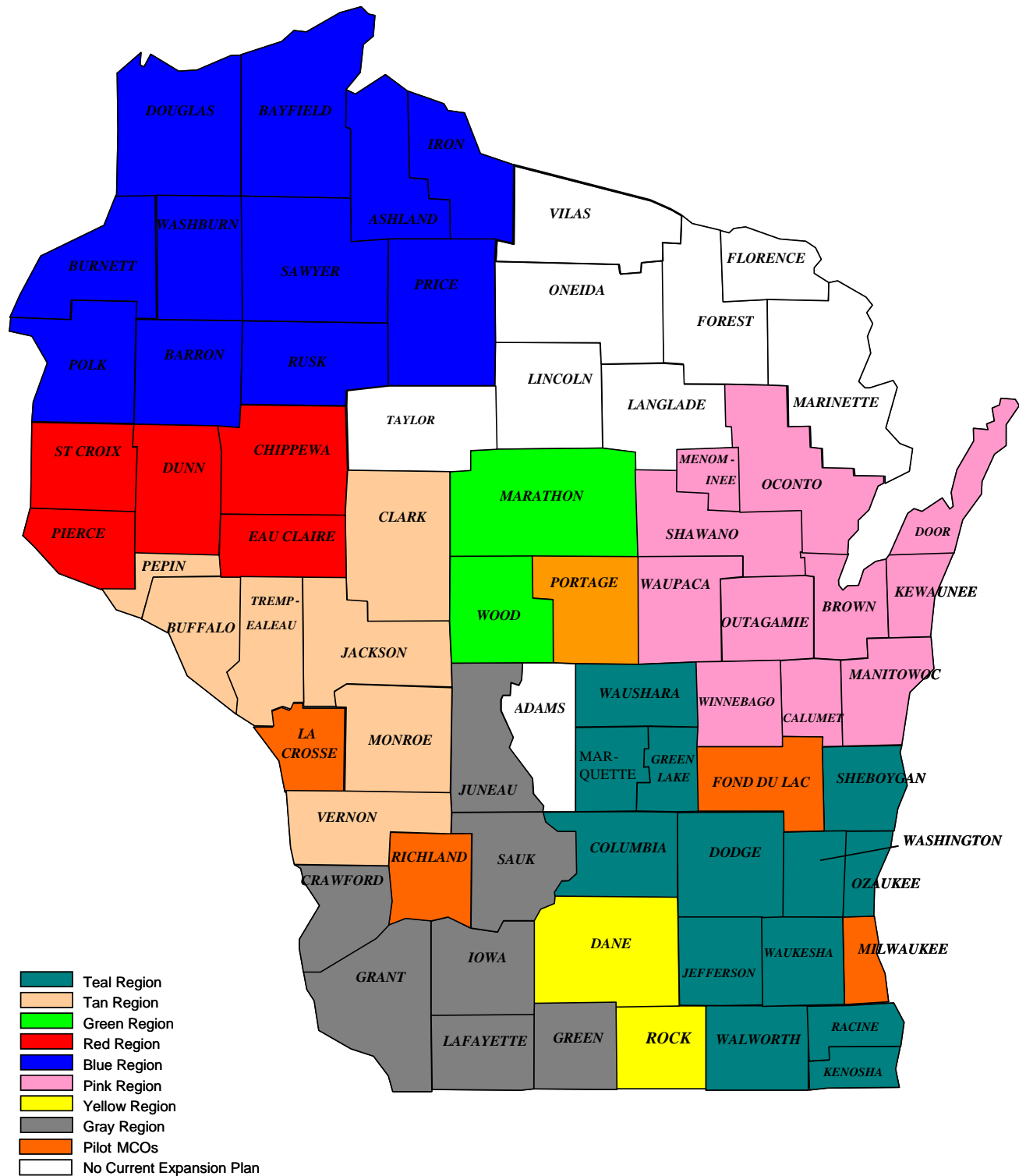
Exhibit I-1	Summary of 2006 Actual Experience by County; Nursing Home Level of Care
Exhibit I-2	Summary of 2006 Actual Experience by County; Non-Nursing Home Level of Care
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I. EXECUTIVE SUMMARY

This report describes the methodology used to develop monthly capitation payments for Family Care Expansion Regions. 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. The following table shows the MCOs that are currently participating in the Family Care program.

Family Care Current MCOs		
MCO	Implementation Date	Covered Counties
Fond du Lac	Pilot MCO	Fond du Lac
La Crosse	Pilot MCO	La Crosse
Milwaukee	Pilot MCO	Milwaukee
Portage	Pilot MCO	Portage
Richland	Pilot MCO	Richland
Community Care	Jan. 1, 2007	Kenosha and Racine

The State has been continuing the effort to expand the Family Care program outside of the current service areas. The expansion plan that DHFS has provided categorizes the State into eight regions; each region being comprised of multiple counties. MCOs will not expand to all counties in their region at the same time. The map below provides the regional configuration for the Family Care program.



Rates are calculated for the Nursing Home (NH) and Non-Nursing Home (non-NH) level of care populations. The NH level of care capitation rates are separately developed for the five expansion MCOs: Care Wisconsin, Community Care, Community Health Partnership (CHP), Community Care of Central Wisconsin (CCCW), and Southwest Care Management Organization (SCMO). For a current Family Care provider that is expanding coverage to additional counties, the non-NH expansion capitation rate is equivalent to the current pilot MCO capitation rate. For those providers who are not currently participating in the Family Care program, a program-wide non-NH level of care capitation rate applies to all providers.

The implementation dates for various MCOs as well as the counties to which they are expanding coverage to are detailed below.

Family Care Expansion Details		
MCO	Implementation Date	Expansion Counties
Care Wisconsin	Mar. 1, 2008	Columbia, Dodge, Green Lake, Jefferson, Marquette Washington, Waukesha, & Waushara
Community Care	Feb. 1, 2008	Ozaukee, Sheboygan, Washington, & Waukesha
CHP	May 1, 2008	Chippewa, Dunn, Eau Claire, Pierce, & St. Croix
CCCW	Aug. 1, 2008	Marathon & Wood (Pilot MCO = Portage)
SCMO	Oct. 1, 2008	Sauk (Pilot MCO = Richland)

Noted in the above table, CCCW and SCMO are currently participating in the Family Care program in Portage and Richland counties, respectively. As a result, for the contract period effective from Aug. 1, 2008 through Dec. 31, 2008, for CCCW and from Oct. 1, 2008 through Dec. 31, 2008 for SCMO, the capitation rates for these two providers will be calculated using a blend of the following two rates:

1. Current capitation rate for the pilot MCO effective for calendar year 2008, as detailed in the Family Care Capitation Report provided to CMS dated December 21, 2007.
2. Capitation rate developed for those individuals eligible to enroll in expansion counties not currently participating in the Family Care program.

For expansion regions, there is no readily available managed care claim experience that could be used for rate development. As a result, the capitation rates for expansion regions are developed based on encounter data reported from the five pilot MCOs for calendar year 2006. The five pilot

MCOs are Fond du Lac, La Crosse, Milwaukee, Portage, and Richland. The implementation date for Community Care was January 1, 2007. Therefore Community Care has no corresponding claims experience that can be used for the calendar year 2006 data period.

The rates are based on the five pilot MCOs' encounter data, with adjustments for variation in functional status as measured by each recipient's Long-Term Care Functional Screen (LTCFS) based on eligibles from specific expansion regions. The encounter data is adjusted to remove costs of non-state plan services and the waiver services contained in the baseline claims experience that were not cost effective in comparison with their in-lieu-of substitute service. Baseline experience data is adjusted for trend, recognizing changes in utilization, cost, technology, and the different timing of an MCO's implementation date. An allowance is also made for administrative costs and prospective risk margin, and the claims data is adjusted to account for incomplete claims.

Nursing Home Level of Care Functional Status Model

The NH level of care rates are based on a regression model of functional status developed from the five pilot MCOs' experience for calendar year 2006. 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:

- SNF level of care for the elderly
- Type of developmental disability for the disabled, if any
- Number of the following IADLs: meal preparation; medical management; money management; telephone usage; transportation and employment
- ADLs and their levels of help
- Interaction terms among various ADLs
- Behavioral indicators
- Medication management

Since there remains a material difference in the per member per month costs among regions that is not fully explained by that model, 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 managed care claims experience. An annual trend of 3.6% for the Elderly population, and 1.9% for the Disabled population, was developed using managed care claim and eligibility data, which measures the annual mix, cost, and utilization trend. The expected mix of Elderly and Disabled expansion participants is used to determine the two-year trend rates for each MCO.

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 expenses and reasonable risk charges.

Non-Nursing Home Level of Care Functional Status Model

In prior capitation rate reports, the non-NH and NH level of care populations were combined and an aggregate MA Comprehensive rate was developed. For 2008, a new rate development methodology is being used to calculate the capitation rates for those individuals that do not meet a nursing home level of care criteria.

The non-NH level of care rates are based on the five pilot MCOs' reported experience for calendar year 2006. The non-NH level of care rates are developed using a functional status based model that stratifies claims experience based on an individual's level of need, using their sum of ADLs and IADLs. The ADLs and IADLs are each separated into "low" and "high" levels of need. A "low" level of need corresponds to an individual that has an ADL/IADL count of two or less. A "high" level of need corresponds to an individual that has an ADL/IADL count of three or more. The rates are developed based on four distinct cohorts:

- Low IADL and low ADL level of need,
- Low IADL and high ADL level of need,
- High IADL and low ADL level of need, and
- High IADL and high ADL level of need

For example, assume an individual requires bathing assistance (ADL), dressing assistance (ADL), and medication management (IADL). This individual has an ADL count of two and an IADL count of one. Therefore the claim and eligibility experience of this individual are bucketed into the "low" ADL and "low" IADL level of need cohort.

Similar to the NH level of care rate development, the non-NH rates are adjusted for trend and an administrative allowance.

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.

I. DATA SOURCES

A first step in developing capitation rates is identifying the data that will be used for the calculations. The CMS regulations call for use of data that is appropriate for the population to be covered by the program. Those regulations also indicate it is CMS' intent that the data be no more than five years old. A number of sources of data may be considered appropriate including:

- Fee-for-service data for the Medicaid population in the geographic area to be covered by managed care plans;
- Health plan encounter data for their Medicaid population;
- Health plan encounter data for other populations, with appropriate adjustments to reflect utilization patterns of Medicaid enrollees;
- For some components of the analysis, health plan financial data;
- For some components of the analysis, data from other Medicaid programs.

Per capita costs are developed separately for the Waiver and Waitlist populations and for those individuals that meet a nursing home level of care criteria and those that do not. Managed care eligibility and claims experience data from the five pilot Wisconsin MCOs for calendar year 2006 is used to establish baseline costs. In addition to claims and eligibility data, functional screen data were provided by the State. To correct for missing functional screen data, 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.

Each recipient's cost for 2006 was matched to their corresponding eligible days. Therefore a cost PMPM was determined for each eligibility group as the total payments divided by total eligibility days times 30.41667 (the average number of days in a month).

Claims Experience

The claims data covers dates of service for calendar year 2006 with run out through July 2007. 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 0.06% was made to the claims data. IBNR claims have been estimated using standard actuarial methods.

Functional Status Information

All recipients were given health status and functional screens annually prior to 2006 or at the point of Family Care enrollment during 2006. 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.

To appropriately reflect the relative risk of enrollees in the Family Care program, a risk assessment 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. A description of each risk assessment model is contained in the NH and non-NH rate development sections of the report.

II. NH LEVEL OF CARE FUNCTIONAL SCREEN METHODOLOGY

This section of the report details the development and statistical validity of a risk adjustment methodology used to calculate the Nursing Home level of care baseline per capita costs.

Base Data

Aggregate 2006 claims are \$224,174,359, and the exposure months totaled 108,330, resulting in a PMPM of \$2,069.36 for the NH level of care population. Exhibit I-1A shows the experience by eligibility group and category of service for the NH population. 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.

Non State Plan Services Adjustment

In the prior year's rate development, costs for guardianship services were included in the encounter data submitted by the health plans. Guardianship is a non-state plan service that does not have a comparable service covered under Wisconsin's state plan services. Therefore the costs of these services needed to be removed. Since we were unable to directly identify the costs associated with guardianship services, the exclusion of these costs was based on MCOs' self-reported experience.

The calendar year 2006 encounter data used to develop the 2008 rates includes a code to identify all non-state plan services. Using this code, the costs associated with the non-state plan services have been removed from the base rate data.

An additional non-state plan service included in the calendar year 2006 data is non-covered residential care services. Non-covered residential care services are provided in-lieu-of nursing home stays for nursing home eligible enrollees. A cost effectiveness analysis was completed for the non-residential care services. A service is cost effective if the cost of providing that service is less than or equal to the cost of its in-lieu-of substitute. We have utilized the data to determine the cost of residential care and the comparable institutional care which would be utilized by a proportion of those currently using residential care. The results of our analysis show that non-covered residential care is a cost effective substitute for nursing home stays, therefore no adjustment to the data was made.

Approach to NH 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 issues, 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 2006) is used, resulting in a concurrent risk adjustment model.¹

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

Ordinary 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 II-1 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 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 2006 functional status indices, the regression model estimates a baseline cost by MCO for the NH population in 2006. To better assess the prospective cost in a region, we used the functional screens active in August 2007 for the Family Care population eligible to be enrolled in each expansion region in 2008. The population / functional screens were identified using the March 2007 county specific HCBS Waiver and Waitlist individuals provided by DHFS.

Regression Modeling Details

As the expansion counties do not have any managed care experience in the calendar year 2006 data period, the calendar year 2006 NH data for the five pilot MCOs (Fond du Lac, La Crosse, Milwaukee, Portage, and Richland) is used as the basis to develop a regression model. Using this 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 2006 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:

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.

- 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 seven 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 II-1 shows the final statistical model for the expansion MCOs. The model explains approximately 40% of the variation in the data. The model has a mean of \$2,069 PMPM.

The average effect of each variable shows how the aggregate cost PMPM are allocated among individual characteristics in the population. For example, referring to Exhibit II-1, the model attributes \$68.93 PMPM of the aggregate PMPM (\$2,069) 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.

Factors to Reflect County Economic Differences

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.

We developed factors based on the relative wage levels and fees paid in the current five pilot MCO counties and for all expansion counties. We 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 MCOs and the expansion counties.

The potential costs faced by the expansion regions were calculated relative to the current five pilot MCOs. To account for the difference in wage and fee levels, the baseline per capita costs for the expanding MCOs are adjusted by the factors provided in the following table. For example,

CCCW's factor of 0.996 means that the potential costs faced by CCCW were on average 0.40% lower than the five pilot MCOs.

MCO	Wage Factor
Care Wisconsin	0.999
Community Care	1.004
CHP	1.000
CCCW	0.996
SCMO	0.982

Application of the Model

The regression model was developed using 2006 cost and functional screen data. To determine expected costs for the contract period, we obtained functional screen information as of August 2007 for the Waiver and Waitlist populations. This August 2007 data was applied to the regression coefficients to derive costs by MCO. Exhibit II-2 shows the distribution of the population by MCO, population type, and functional measure used to calculate the final base rates.

Using August 2007 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. NON-NURSING HOME LEVEL OF CARE

This section of the report details the development and statistical validity of a risk adjustment methodology used to calculate the Non-Nursing Home level of care baseline per capita costs.

Base Data

Aggregate 2006 claims are \$4,530,599, and the exposure months totaled 7,147, resulting in a PMPM of \$633.91 for the non-NH level of care population. However, an adjustment to the base data costs needs to be made to remove certain waiver services costs. The section below provides a complete description of the costs that were removed. Exhibit I-2 shows the experience by target group and category of service for the Non-NH population after adjusting the baseline experience; the adjusted aggregate PMPM is \$612.22. Based on discussions with DHFS staff, we understand that the non-nursing home level of care population is not subject to cost sharing.

Waiver Services Cost Adjustment

The non-NH populations' calendar year 2006 claims data is further adjusted to remove costs of the of waiver services that were not cost effective in comparison with their in-lieu-of substitute service.

A cost effectiveness analysis was completed for each waiver service. A service is cost effective if the cost of providing that service is less than or equal to the cost of its in-lieu-of substitute. The two significant services that waiver services are "in-lieu-of" are personal care and transportation services. PwC consulted with DHFS on the appropriate measure of personal care for a majority of the waiver services including daily living skills training, day services, adult day care, supportive home care, and residential services. For example, daily living skills training is purchased by a MCO so that consumers can learn skills to provide their own personal care that would otherwise have to be purchased by a MCO. For those services that were cost effective no adjustment to the data was made. However, some waiver services were determined to not be cost effective; consequently we have removed the additional costs incurred as a result of providing a service that is partially cost effective.

Some waiver services were not explicitly included in the cost effectiveness analysis because they do not have a comparable service under Wisconsin's state plan services. For example, the waiver service supported employment may avoid occupational and physical therapy costs in the future by keeping individuals' minds and bodies active through employment. It may also reduce the need for personal care if individuals are at home all day rather than employed, however it does not have a comparable state plan service. Consequently we have removed the entire cost for those services that do not have a comparable state plan service.

The exclusion of costs for waiver services that are not cost effective or that do not have a comparable state plan service resulted in a claims decrease of \$155,051.

The remainder of this section summarizes the methodology used to develop the proposed payment rates. The results include the regression analysis conducted on the MCO calendar year 2006

encounter data and the functional measures reported from the screens conducted by the Resource Centers and MCOs.

Approach to Non-NH Rate Development

The non-NH level of care rates are developed using a functional status based model that stratifies claims experience based on an individual's level of need, using their sum of ADLs and IADLs. The ADLs and IADLs are each separated into "low" and "high" levels of need. A "low" level of need corresponds to an individual that has an ADL/IADL count of two or less. A "high" level of need corresponds to an individual that has an ADL/IADL count of three or more. The rates are developed based on four distinct cohorts:

- Low IADL and low ADL level of need,
- Low IADL and high ADL level of need,
- High IADL and low ADL level of need, and
- High IADL and high ADL level of need

For example, assume an individual requires bathing assistance (ADL), dressing assistance (ADL), and medication management (IADL). This individual has an ADL count of two and an IADL count of one. Therefore the claim and eligibility experience of this individual are bucketed into the "low" ADL and "low" IADL level of need cohort.

Estimated costs PMPM are calculated by combining the claim and eligibility data for all individuals that correspond to a given cohort. The table below provides the cost PMPM for the four cohorts. To calculate rates for a MCO, the MCO's enrollees are bucketed into the four levels of need cohorts. The distribution of enrollees is then used to calculate a weighted average of the PMPM costs across the four cohorts. Only a small number of the non-NH Family Care population are eligible to be enrolled by an expansion MCO. As a result of the limited number of enrollees, the PMPM cost for the expanding MCOs is calculated using the aggregate five pilot MCOs experience. The aggregate baseline PMPM cost is \$612.22.

	Functional Based PMPM
Low IADL, Low ADL	\$ 536.50
Low IADL, High ADL	\$ 634.85
High IADL, Low ADL	\$ 726.54
High IADL, High ADL	\$ 1,166.72

For a current Family Care provider that is expanding coverage to additional counties, the non-NH expansion capitation rate is equivalent to the current pilot MCO capitation rate. For those providers who are not currently participating in the Family Care program, a program-wide non-NH level of care capitation rate applies to all providers.

IV. TREND DEVELOPMENT

Trend rates are used to project the 2006 baseline cost data beyond the base cost period to the midpoint of the 2008 contract period. The effective trend will be developed by using member months to weight the various populations (i.e., existing, waiver or waitlist) according to the most current information regarding the expansion plans of the specific providers.

Trend was developed separately for the Elderly and Disabled populations. The annual trend of 3.6% for the Elderly population, and 1.9% for the Disabled population, was developed analyzing Family Care encounter claim and eligibility data from calendar years 2004 through 2006. The trend over this period includes annual mix, fee increases, and utilization trend. The following table summarizes the trend by each expansion MCO.

Provider	Contract Period Trend
Care Wisconsin	5.4%
Community Care	5.3%
CHP	5.2%
CCCW	6.0%
SCMO	6.1%

V. RATE DEVELOPMENT FOR CURRENT VERSUS NEW MCOs

The capitation rate development process will differ depending on each MCO's current status. Specifically there are different methods for:

- A provider that is not currently participating in the Family Care program, and
- A current Family Care managed care provider that is expanding coverage to additional counties.

For a provider that is not currently participating in the Family Care program, a single rate will be developed for the 2008 contract period. The effective period for the capitation rate will begin on the first county's anticipated start date and span through December 31, 2008. For example, CHP anticipates expanding to Chippewa in May, Dunn in June, Pierce in July, St. Croix in September, and Eau Claire in November. One composite capitation rate will be calculated for CHP effective May 1, 2008 through December 31, 2008. Per capita costs will be calculated for each county based on the individuals eligible to enroll in the county. Additionally, based on a county's date of implementation, the base period per capita costs are trended to the midpoint of the county's contract period based. Since the size of the eligible population may differ by county, the average capitation rate for the contract period will be based on the estimated distribution of eligible lives by region. The effective contract periods for providers that are not currently participating in the Family Care program are provided in the following table.

Provider	Contract Period
Care Wisconsin	Mar. 1, 2008 - Dec. 31, 2008
Community Care	Feb. 1, 2008 - Dec. 31, 2008
CHP	May. 1, 2008 - Dec. 31, 2008

The second consideration is the development of a capitation rate where a provider is currently participating in the Family Care program. CCCW and SCMO currently participate in the Family Care program in Portage and Richland counties, respectively. For these two providers, two capitation rates will be calculated; one rate for the MCO currently operating that is effective from January 1, 2008 through the first expansion county's implementation date, and another rate effective from the first implementation date through December 31, 2008. Note that the capitation rate for the MCOs currently operating is contained in the Family Care Capitation Report submitted to CMS dated December 21, 2007.

Effective August 1, 2008, CCCW will expand coverage to Marathon County and effective October 1, 2008 SCMO will expand coverage to Sauk County. Therefore a new capitation rate will be calculated for each provider using a blend of the pilot MCO capitation rate and the expansion

county rate at the date of each MCOs expansion. The weighted average provider capitation rate will be calculated using actual managed care enrollment and the estimated enrollment in the expansion counties. Based on conversations with DHFS, we have assumed that after a county's date of implementation, the Waiver and Waitlist populations will be enrolled evenly over a six month and twenty four month coverage period, respectively. We have assumed no selection bias will occur within a county.

To adjust for any risk selection that may occur once enrollment begins, the State will retroactively adjust rates for variation in measured health status for two contract periods after the date of implementation. The risk variation will be measured based on the regression model (with the functional screen data from those people that have enrolled in a plan) that we include as shown in Exhibit I-2.

VI. PER CAPITA COST DEVELOPMENT

In summary, the contract period 2008 per capita costs were developed as described below.

1. Determine functional status based costs for the NH and non-NH populations using the 2006 pilot MCO reported experience and functional screens as outlined in Section II and III. These cost estimates are adjusted to reflect an estimate for IBNR using payments through July 2007,
2. Exclude costs for waiver services that were not fully cost effective or did not have a comparable state plan service that were included in the 2006 encounter data for the non-NH population.
3. Project adjusted 2006 costs to the appropriate midpoint of the contract period using the annualized Elderly and Disabled trend rates discussed in Section IV.
4. Divide the projected rates by an administration / risk allowance to develop a capitation rate. The administrative allowance was developed based on a review of MCO reported administrative costs in 2006 and year-to-date 2007. The risk allowance is provided to accommodate the adverse effects of volatility in delivery care patterns. Since smaller MCOs are subject to greater risk fluctuations, risk margins were determined based on the size of the population enrolled in each MCO. The following table summarizes the administrative / risk allowance for each MCO.

	Admin/Risk Rate
Care Wisconsin	5.75%
Community Care	5.75%
CHP	5.75%
CCCW	5.75%
SCMO	12.25%

5. For those providers that are currently participating in the Family Care program, a blended capitation rate is calculated for a contract period starting at the expansion MCO's first implementation date through December 31, 2008, as discussed in Section V.
6. Non-MA PMPM costs were calculated for each MCO using the 2006 cost and eligibility data. The 2006 costs were projected to the calendar year 2008 contract period using the trend rate discussed in Section IV. The projected costs by MCO were adjusted to include an administrative allowance, as discussed in point 4 above.

We adjusted the NH 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 development of the NH level of care capitation rates. Exhibit III-2 shows the non-NH level of care capitation rates.

VII. IMPACT OF ICF-MR RELOCATIONS ON PER CAPITA COST DEVELOPMENT

DHFS oversees the administration of Wisconsin's ICF/MR restructuring initiative. This initiative facilitates the relocation of an individual from an Intermediate Care Facility for the Mentally Retarded (ICF-MR) to the community via enrollment in a Family Care managed care organization (MCO). Through DHFS oversight, the relocation is designed to be accomplished in a setting appropriate for the individual being relocated and cost-effective for the Family Care Program. The Office of Family Care Expansion (OFCE) at DHFS reviews and approves a relocation plan submitted by an MCO when the plan meets the following criteria: 1) it places the individual in the least restrictive community setting; 2) it meets his or her long-term needs; and 3) it is cost effective relative to the cost of institutional services.

Neither the historical fee-for-service costs or the estimated care plan costs for these individuals are included in the base data used to estimate the per capita costs for the Family Care expansion population. Additionally, the care plan costs for the ICF-MR enrollees are extraordinarily high compared to the average for all Family Care enrollees, and an adjustment to the base costs is needed.

Upon identification of relocating ICF-MR enrollees, DHFS will provide PwC with a listing of all relocations. For each individual who has been relocated from an ICF-MR to a community based setting, DHFS will provide the monthly estimated cost of the care plan and the MCO in which the individual is enrolled. Using this data, we will calculate an adjustment to the base capitation rates for the MCOs with new ICF-MR enrollees.

The process is appropriate for the managed care model utilized in Wisconsin as it meets the cost of relocating an individual in the short term while providing strong incentives to develop a more cost-effective care plan over time. As the transition to community-based care proceeds, the costs of serving the ICF-MR population will become embedded in the historical data.

VIII. FINAL CAPITATION RATES

The Wisconsin Department of Health and Family Services determined the final 2008 capitation rates for the Family Care program. Exhibits III-1 and III-2 illustrate the 2008 capitation rates.

The 2008 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.

IX. ACTUARIAL CERTIFICATION

Following is our actuarial certification for the 2008 capitation rates

**Actuarial Certification of
Proposed 2008 Family Care Capitated Rates for Expansion Regions
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 2008 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 Expansion Family Care capitation rates for contract period 2008 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 contract periods within calendar year 2008.

To the best of my information, knowledge and belief 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 MCOs. 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 MCO. Each MCO will need to review the rates in relation to the benefits provided. The MCOs should compare the rates with their own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The MCO 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

January 28, 2008
Date

Exhibits

Wisconsin Department of Health and Family Services
Contract Period 2008 Family Care Expansion Capitation Rate Development

Summary of 2006 Actual Experience
Nursing Home Level of Care

	All Pilot MCOs	
	Elderly	Disabled
Exposure Months	86,350	21,980
Adaptive Equipment	\$66.42	\$61.92
Adult Day Activities	58.87	146.21
Case Management	292.99	331.08
Community At Large	-	-
Room and Board	(158.34)	(154.41)
Family Support Funding	-	-
Habilitation / Health	12.91	36.17
Home Care	434.08	450.28
Home Health Care	91.32	110.29
Housing	2.83	4.18
Institutional	400.63	135.53
Member Tracking	-	-
Other	13.25	7.14
Residential Care	718.61	931.85
Respite Care	5.32	50.39
Transportation	37.09	72.69
Vocational	10.79	210.50
Total	\$1,986.77	\$2,393.83
Composite PMPM	\$2,069.36	

Wisconsin Department of Health and Family Services
Contract Period 2008 Family Care Expansion Capitation Rate Development

Summary of 2006 Actual Experience
Non-Nursing Home Level of Care

	All Pilot MCOs	
	Elderly	Disabled
Exposure Months	3,966	3,181
Adaptive Equipment	\$30.14	\$41.00
Adult Day Activities	11.41	8.77
Case Management	248.37	310.55
Community At Large	-	-
Room and Board	(6.46)	(3.09)
Family Support Funding	-	-
Habilitation / Health	6.06	37.81
Home Care	236.19	105.57
Home Health Care	30.16	10.49
Housing	0.71	4.18
Institutional	-	-
Member Tracking	-	-
Other	5.76	2.54
Residential Care	61.63	21.11
Respite Care	0.03	1.39
Transportation	21.88	21.96
Vocational	-	7.98
Total	\$645.87	\$570.26
Composite PMPM	\$612.22	

Wisconsin Department of Health and Family Services
Contract Period 2008 Family Care Expansion Capitation Rate Development
Family Care Based Functional Screen Regression Model of 2006 PMPM

Variable	Estimate	p-Value	Incremental Partial R2	Proportion with Variable	Incremental Increase
Intercept (Grid Component)	746.06	0.0001			746.06
DD/NH Level of Care (Grid Component)					
Vent Dependent	2,713.38	0.0001	0.00299	0.0008	2.29
DD1A	1,495.38	0.0001	0.01939	0.0121	18.03
DD1B	2,347.24	0.0001	0.09032	0.0256	60.05
DD2	876.04	0.0001	0.02846	0.1175	102.90
SNF	320.24	0.0001	0.08150	0.2550	81.67
Number of IADLs (Grid Component)					
IADL_3	76.30	0.0001	0.01271	0.1887	14.40
IADL_4	249.99	0.0001	0.00009	0.3314	82.85
IADL_5	283.29	0.0001	0.03882	0.2433	68.93
IADL_6	1,072.60	0.0001	0.03976	0.0319	34.20
Specific ADLs / Equipment Used (Add-On)					
Bathing_2	330.45	0.0001	0.03209	0.4946	163.44
Dressing_2	102.60	0.0001	0.01199	0.2821	28.94
Eating_2	119.48	0.0001	0.00313	0.0886	10.59
Toileting_1	226.38	0.0001	0.00056	0.1828	41.38
Toileting_2	331.26	0.0001	0.00791	0.1921	63.63
Transfer_2	327.33	0.0001	0.00179	0.1785	58.43
Interaction Terms (Add-On)					
Bathing_Equip_Dressing	165.48	0.0001	0.00159	0.4727	78.23
Transfer_Equip_Mobility	314.52	0.0001	0.00154	0.0721	22.67
Bathing_Equip_Eating	77.20	0.0001	0.00021	0.2056	15.87
Behavioral Variables (Add-On)					
Communication_3	162.00	0.0001	0.00043	0.0401	6.49
Cognition_3	75.74	0.0001	0.00075	0.1518	11.50
Resistive	166.55	0.0001	0.00199	0.0538	8.95
Injury	411.86	0.0001	0.00209	0.0284	11.68
Offensive_1-2	314.27	0.0001	0.00152	0.1052	33.05
Offensive_3	1,089.26	0.0001	0.00267	0.0080	8.67
Medication Use (Add-On)					
Meds_2A	302.78	0.0001	0.00018	0.2226	67.40
Meds_2B	554.44	0.0001	0.00463	0.4100	227.33

Wisconsin Department of Health and Family Services
Contract Period 2008 Family Care Expansion Capitation Rate Development

Summary of Proportion of MCO Population with Rating Characteristics
Nursing Home Level of Care

Variable	Care Wisconsin	Community Care	CHP	CCCW	SCMO
Disability or Nursing Home					
Vent Dependent	0.4%	0.3%	0.4%	0.0%	0.1%
DD1A	2.9%	3.1%	5.0%	1.6%	1.4%
DD1B	6.7%	5.8%	10.4%	11.0%	5.6%
DD2	39.1%	38.6%	48.3%	28.2%	33.5%
SNF	6.3%	5.3%	7.8%	13.9%	9.6%
Instrumental Activities of Daily Living					
IADL_3	12.2%	12.2%	9.8%	13.2%	16.1%
IADL_4	30.2%	31.3%	23.3%	28.9%	28.8%
IADL_5	31.3%	32.1%	37.9%	30.2%	23.0%
IADL_6	14.8%	13.5%	17.6%	16.2%	15.7%
Activities of Daily Living					
Bathing_2	52.4%	50.0%	51.4%	58.9%	44.6%
Dressing_2	29.1%	28.0%	31.8%	34.7%	20.7%
Eating_2	16.2%	15.9%	24.3%	19.8%	10.2%
Toileting_1	18.5%	16.3%	17.5%	23.1%	21.4%
Toileting_2	20.8%	20.7%	25.5%	26.7%	12.0%
Transfer_2	16.7%	15.7%	19.9%	22.0%	10.2%
Interaction Terms					
Bathing_Equip_Dressing	32.6%	30.4%	33.0%	43.7%	32.2%
Transfer_Equip_Mobility	10.8%	9.2%	12.6%	14.2%	10.3%
Bathing_Equip_Eating	18.9%	18.3%	22.4%	31.2%	15.1%
Behavioral Variables					
Communication_3	8.2%	7.4%	8.7%	8.8%	4.8%
Cognition_3	23.0%	20.0%	28.7%	25.5%	14.1%
Resistive	9.1%	9.9%	14.8%	10.0%	4.3%
Injury	7.9%	8.9%	11.1%	7.7%	4.8%
Offensive_1-2	21.8%	21.8%	29.3%	25.6%	16.2%
Offensive_3	0.8%	0.7%	1.1%	2.3%	1.4%
Medication Use					
Meds_2A	24.2%	26.1%	19.1%	20.6%	20.5%
Meds_2B	44.6%	40.4%	52.7%	55.5%	40.3%

**Wisconsin Department of Health and Family Services
Contract Period 2008 Family Care Expansion Capitation Rate Development**

Development of the 2008 Final Nursing Home Rates

Current MCO	Contract Period	Final 2008 Capitation Rates
Portage (CCCW)	Jan 1, 2008 - July 31, 2008	\$2,496.02
Richland (SCMO)	Jan 1, 2008 - Sept. 30, 2008	\$2,360.78

Expanding MCO	Contract Period	Total Statistical Model 2006 PMPM Inc IBNR	Admin/Risk Rate	Two-Year Trend	2008 Gross Nursing Home Rates	2008 Ave. Cost Sharing PMPM	Preliminary 2008 Capitation Rates
Care Wisconsin	Mar. 1, 2008 - Dec. 31, 2008	\$2,617.69	5.75%	5.4%	\$2,927.85	\$82.67	\$2,845.19
Community Care	Feb. 1, 2008 - Dec. 31, 2008	\$2,552.06	5.75%	5.3%	\$2,850.42	\$82.67	\$2,767.75
CHP	May 1, 2008 - Dec. 31, 2008	\$2,980.15	5.75%	5.2%	\$3,327.61	\$82.67	\$3,244.95
CCCW	Preliminary Rate	\$2,817.27	5.75%	6.0%	\$3,169.10	\$82.67	\$3,086.43
SCMO	Preliminary Rate	\$2,298.94	12.25%	6.1%	\$2,779.19	\$82.67	\$2,696.52

MCO	Contract Period	Final 2008 Capitation Rates
Care Wisconsin	Mar. 1, 2008 - Dec. 31, 2008	\$2,845.19
Community Care	Feb. 1, 2008 - Dec. 31, 2008	\$2,767.75
CHP	May 1, 2008 - Dec. 31, 2008	\$3,244.95
CCCW	Aug. 1, 2008 - Dec. 31, 2008	\$2,750.43
SCMO	Oct. 1, 2008 - Dec. 31, 2008	\$2,450.36

Wisconsin Department of Health and Family Services
Contract Period 2008 Family Care Expansion Capitation Rate Development

Development of the 2008 Final Non-Nursing Home and Non-MA Rates

	Non-Nursing Home Capitation Rate
Care Wisconsin	\$689.33
Community Care	\$689.33
CHP	\$689.33
CCCW	\$666.28
SCMO	\$713.47