



DIVISION OF LONG TERM CARE

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Jim Doyle
Governor

Kevin R. Hayden
Secretary

State of Wisconsin
Department of Health and Family Services

December 20, 2007

Mr. Martin Staehlin, FSA
Ms. Jinn-Feng Lin, FSA MAAA
PricewaterhouseCoopers LLP
One North Wacker
Chicago, IL 60606

RE: 2008 Family Care, Family Care Partnership, and PACE Capitation Rates

I, Tom Lawless, Financial 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 2008 Family Care, Family Care Partnership, and PACE capitation rates were prepared under my direction, and to the best of my knowledge and belief, are accurate and complete. These data include:

1. MA Card fee-for-service claim data files for 2004 through 2006, including record layouts, for the nursing home and home and community-based waiver populations,
2. MA eligibility data files for 2004 through 2006, including record layouts, for the nursing home and home and community-based waiver populations,
3. HSRS fee-for-service claim data files for 2004 through 2006, including record layouts,
4. A data file containing a crosswalk of HSRS service categories by SPC code,
5. Final FY 2008 and FY 2009 MA provider rate increases,
6. Final CY 2007 Family Care capitation rates,
7. Functional screen information for Family Care and Family Care Partnership members, as well as for home and community-based waiver and wait list clients in regions of the state to which the program is anticipated to expand,
8. Eligibility information for Family Care and Family Care Partnership members,

9. Universal ID crosswalk file providing a crosswalk between Universal IDs in the LTCFS and the Recipient ID used in the eligibility file,
10. CMO encounter file containing units of service and program costs for Family Care members,
11. Cost sharing amounts PMPM separately for the Family Care MA-eligible and non-MA eligible populations,
12. Projected Family Care enrollment months for CY2008 and CY 2009 in light of the program's anticipated expansion,
13. Potential contracting agencies and anticipated start dates in regions of the state to which the program is expected to expand,
14. Financial information submitted by current contractors to the Department of Health and Family Services, as summarized by the Department, and
15. Departmental policy with respect to ICF-MR relocation funding and the per member per month calculations in support of an appropriate capitation rate adjustment, by MCO.

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,



Tom Lawless, Section Chief
Fiscal & Business Management Services



DIVISION OF LONG TERM CARE

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Jim Doyle
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State of Wisconsin
Department of Health and Family Services

December 18, 2007

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

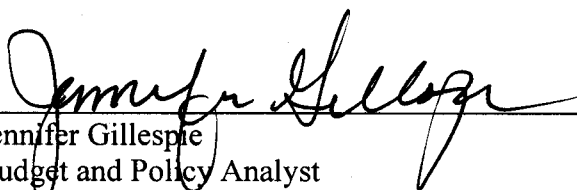
Re: Actuarial Certification of 2008 Family Care Capitation Rates

Dear Mr. Staehlin:

I, Jennifer Gillespie, Budget and Policy Analyst for the Wisconsin Department of Health and Family Services, hereby affirm that the following data prepared and submitted to PricewaterhouseCoopers LLP for the purpose of developing the wage / fee-based geographic factor for 2008 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. BLS wage data;
2. Metropolitan statistical areas (MSA) for Wisconsin counties;
3. Residential service costs;
4. Institutional service costs;

Sincerely,

 _____ (Name) 12/18/07 (Date)
Jennifer Gillespie
Budget and Policy Analyst
Department of Health and Family Services
Division of Long-Term Care - Office of Family Care Expansion
1 West Wilson Street, Room 518
Madison, WI 53702

Wisconsin Department of Health and Family Services
Crosswalk from CMS Rate Setting Checklist to 2008 Family Care Report

Item	Location	Comments
AA.1.0 Overview of Ratesetting Methodology	Entire Report	
AA.1.1 Actuarial Certification	Pages 16-18	
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 4-12	
AA.2.1 Medicaid Eligibles under the Contract	NA	Data submitted by participating health plans
AA.2.2 Dual Eligibles	NA	
AA.2.3 Spenddown	NA	
AA.2.4 State Plan Services only	NA	Data submitted by participating health plans
AA.2.5 Services that may be covered out of contract savings	NA	
AA.3.0 Adjustments to Base Year Data	Pages 4, 6, & 8-12	
AA.3.1 Benefit Differences	NA	No Changes in Benefits
AA.3.2 Administrative Cost Allowance Calculations	Page 14	Exhibit III-1a
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 14	Exhibit III-1a
AA.3.8 Graduate Medical Education	NA	
AA.3.9 FQHC and RHC Reimbursement	NA	
AA.3.10 Medical Cost / Trend Inflation	Pages 13	
AA.3.11 Utilization Adjustments	Page 6, & 11-12	
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	
AA.4.0 Establish Rate Category Groupings	Pages 1-3	Exhibit III-1a, III-1b, and III-2
AA.4.1 Age	NA	
AA.4.2 Gender	NA	
AA.4.3 Locality / Region	Pages 1-3	Exhibit III-1a, III-1b, and III-2
AA.4.4 Eligibility Categories	Pages 1-3	
AA.5.0 Data Smoothing	Page 8, 9	
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 6-12	
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 2008
Family Care Capitation Rates**

Prepared by:

PricewaterhouseCoopers

December 2007

December 21, 2007

Mr. Thomas Lawless
Family Care Rate Setting Manager
Division of Long-Term Care
One West Wilson Street
Madison, WI 53701

Re: 2008 Managed Care Capitation Rate Development for Family Care

Dear Tom:

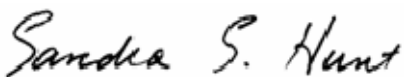
The enclosed report provides a detailed description of the methodology used to develop the 2008 managed care capitation rates for the Family Care program effective January 1, 2008 through December 31, 2008 in Wisconsin. The methods used for calculating these costs are consistent with Centers for Medicare 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
Exhibit I-3	Summary of 2006 Actual Experience by County (All Recipients)
Exhibit-II-1	Functional Screen Regression Model of 2006 PMPM; NH Level of Care - Fond du Lac, La Crosse, Milwaukee, Portage, and Richland
Exhibit-II-2	Functional Screen Regression Model of 2006 PMPM; NH Level of Care - Community Care
Exhibit II-3	Summary of Proportion of CMO Population with Rating Characteristics
Exhibit III-1a	Development of the 2008 Preliminary Rates; Nursing Home and Non-Nursing Home Level of Care
Exhibit III-1b	Development of the 2008 Final Rates; After Adjustment for ICF-MR Relocations
Exhibit III-2	Development of the 2008 Final Rates; Non-MA

I. EXECUTIVE SUMMARY

This report describes the methodology used to develop monthly capitation payments for Family Care for Calendar Year 2008. 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 Nursing Home (NH) and Non-Nursing Home (non-NH) level of care populations. Both rates are separately developed for the six participating CMOs: Fond du Lac, La Crosse, Milwaukee, Portage, Richland, and Community Care (Kenosha and Racine counties). The implementation date for the Community Care CMO was January 1, 2007. Since the base data used in the capitation rate development consists of CY 2006 encounter data, Community Care did not have any claims experience that could be factored into the rate development. As a result, the application of certain process steps differs between the five pilot CMOs (Fond du Lac, La Crosse, Milwaukee, Portage, and Richland) and Community Care. If no distinction is made, a consistent methodology is used between all six participating CMOs.

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). 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 functional status that are expected between the 2006 data period and the 2008 contract period. 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 pilot county NH level of care rates are based on a regression model of functional status developed from CMO-reported 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:

- 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. Although the regression model yields county parameters, there remains a material difference in the per member per month costs among counties that is not fully explained by that model. Consequently, we blended the results of the regression model with measures of differences in costs by geography for a market basket of LTC services.

The Community Care NH level of care rate is based on a regression model developed from the claims experience of the five pilot CMOs. Since Community Care is operated in counties that are distinct from the five pilot counties, the County variable in the regression is omitted. Similarly, an adjustment is made to account for the differences in cost between the Community Care counties and the five pilot counties.

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 current mix of Elderly and Disabled participants is used to determine the two-year trend rates for each County.

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 CMO-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.

The capitation rates are developed separately 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 CMOs for calendar year 2006 is used to establish baseline costs for both populations. 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. IBNR adjustments are made by CMO across both eligibility categories: Fond du Lac data was increased by 0.26%, La Crosse by 0.10%, Milwaukee by 0.02%, Portage by 0.03%, Richland by 0.04%, and Community Care by 0.06%. 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 county, target 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 CMO 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 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 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 CMO for the NH population in 2006. To better assess the prospective cost in a county, we used the functional screens active in August 2007 for the Family Care population enrolled in each county in 2006. This risk adjustment technique is discussed in further detail later in the report.

Regression Modeling Details

The calendar year 2006 NH data for the five pilot CMOs (Fond du Lac, La Crosse, Milwaukee, Portage, and Richland) is used as the basis to develop a regression model. Using this data, two ordinary least squares linear regression models are created to relate monthly costs to recipient functional characteristics; one model is developed for the five pilot CMOs and another for the Community Care CMO.

Consistent with the development of the prior year's model, the first regression model is developed by including county variables in the regression. Since the base data consists of the five pilot CMOs, this model will be used to calculate the average PMPM cost for the five corresponding counties.

However, Community Care does not have any managed care experience in the calendar year 2006 data period, because their implementation date was January 2007. As a result, a second regression model is needed to develop costs for Community Care. This second model uses the aggregate experience of the five pilot CMOs. After removing the county variables, the health status parameter values have been recalibrated based on the aggregate CMO experience. Therefore, the only difference between the two models is the inclusion of the county variables. All other health status and functional screen information is consistent between the two regression models.

For each model, 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.

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.

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 thirty two variables to predict cost. The variables are separated into the following seven classes: region, 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 five pilot CMOs and Exhibit II-2 shows the final statistical model for the Community Care CMO. The models each explain approximately 40% of the variation in the data. Each 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 \$75.96 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.

County Factors

The county values developed by the regression for the five pilot CMOs represent differences in costs by county that are not explained by other variables in the model. The county estimates represent differences due to historical costs by county, and can result from a variety of factors, including CMO management, provider fee levels, resource availability, potentially incomplete data and others. 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 separately developed factors based on the relative wage levels and fees paid in the five CMO 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 for all CMOs combined. This process estimates the potential costs faced by the CMOs.

We averaged these relative values with the county factors from the regression model. The table below shows the combined effects of this adjustment.

Family Care County Effect Adjustment		
	Regression Values PMPM	Adjusted Values PMPM
Fond du Lac	(\$420.97)	(\$300.16)
La Crosse	(51.27)	(139.67)
Milwaukee	0.00	34.52
Portage	149.04	(1.92)
Richland	149.71	(37.88)
Composite	0.00	0.00

Additionally, we have developed factors based on the wage levels and fees paid in the Community Care CMO counties. The relative wage and fee levels were aggregated using the relative costs for these services and compared with the relative wage and fee levels of the five pilot CMOs. The potential costs faced by Community Care were on average 0.60% lower than the five pilot CMOs. To account for this difference in wage and fee levels, the baseline per capita costs for Community Care were decreased by a factor of 0.9940.

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 updated functional screen information as of August 2007. This August 2007 data was applied to the regression coefficients to derive costs by CMOs. Exhibit II-3 shows the distribution of the population by CMO 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 estimated costs only measure a change in the

proportion of individuals with a given characteristic from the two periods: calendar year 2006 and August 2007. As a result, using the updated functional screen data does not have a direct impact on the aggregate baseline costs. This approach quantifies a relative change in acuity between the plans, and thus shifts expected costs among counties. 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 county, 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 CMO so that consumers can learn skills to provide their own personal care that would otherwise have to be purchased by a CMO. 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 is done on a CMO basis: Fond du Lac claims decreased by \$34,109, La Crosse by \$37,465, Milwaukee by \$47,886, Portage by \$25,949, and Richland by \$9,642.

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 2006 encounter data and the functional measures reported from the screens conducted by the Resource Centers and CMOs.

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 CMO, the CMO'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. A similar methodology is used for all CMOs. However, the Community Care CMO currently enrolls only a small number of non-NH eligibles. As a result of the limited number of enrollees, the PMPM cost for Community Care is calculated using the five pilot CMOs experience.

	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

To better assess the prospective cost in a county, we used the functional screens active in August 2007 for the Family Care population enrolled in each county in 2006.

IV. TREND DEVELOPMENT

Trend rates are used to project the 2006 baseline cost data beyond the base cost period to the 2008 contract period.

Trend was developed separately for the Elderly and Disabled populations. The two-year trend of 7.3% for the Elderly population, and 3.8% 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 CMO.

County Name	Two-Year Trend
Fond du Lac	5.3%
La Crosse	5.1%
Milwaukee	7.3%
Portage	5.4%
Richland	5.6%
Community Care	6.5%

V. PER CAPITA COST DEVELOPMENT

In summary, the 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 CMO 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 two years 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 CMO 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 CMOs are subject to greater risk fluctuations, risk margins were determined based on the size of the population enrolled in each CMO. The following table summarizes the administrative / risk allowance for each CMO.

	Admin/Risk Rate
Fond du Lac	5.75%
La Crosse	5.75%
Milwaukee	5.35%
Portage	5.75%
Richland	12.25%
Community Care	5.75%

5. Non-MA PMPM costs were calculated for each CMO 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 CMO were adjusted to include an administrative allowance, as discussed in point 4 above.

We adjusted the NH and non-MA sets of 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 and non-NH 2008 capitation rates. Exhibit III-2 shows the development of the non-MA 2008 capitation rates.

VI. 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 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.

DHFS provided PwC with a listing of all relocations that were known as of November 2007. For each individual who has been relocated from an ICF-MR to a community based setting, DHFS provided the monthly estimated cost of the care plan and the MCO in which the individual is enrolled. Using this data, we calculated 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.

In Exhibit III, Exhibit III-1(a) displays capitation rates prior to ICF-MR adjustment. Exhibit III-1(b) shows the number of ICF-MR enrollees by plan, the average care cost per month, and the resulting adjusted capitation rates.

VII. STOP-LOSS IMPACT ON PER CAPITA COST DEVELOPMENT

DHFS will offer stop-loss reinsurance coverage on individual claims that exceed \$175,000. This section discusses the development of the of the stop-loss reinsurance rate for 2008. DHFS will cover 90% of the claims above the stop-loss attachment point of \$175,000 for the rate indicated.

Calendar years 2004, 2005, and 2006 incurred claims paid through July 2007 were used as the base data. Claims were completed (Incurred but Not Reported adjustment) and trended to Calendar Year 2008. An annual claim amount per enrollee was calculated and the \$175,000 claim threshold or attachment point was valued. DHFS will cover 90% of the cost above the attachment point.

In theory, the calculation assumes budget neutrality for the claim cost. A risk margin is added to the base claim cost. Claims above an attachment point are inherently volatile (because of the low frequency and high amount of the claims). A 10% risk margin was added to the base claim cost as a balance between protection for DHFS and a reasonable premium for the CMOs participating. The rate to be deducted from the monthly cap rate paid to the two participating plans is indicated in the following chart:

	Stop-Loss at \$175,000
Net Premium	\$ 4.95
Risk Margin	\$ 0.55
Gross Premium	\$ 5.50

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 and resulting rate change versus the 2007 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
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 Family Care capitation rates for calendar year 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 calendar year 2008.

To the best of my information, knowledge and belief, for the period from January 1, 2008 to December 31, 2008, 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 21, 2007

Date

Exhibits

**Wisconsin Department of Health and Family Services
CY 2008 Family Care Capitation Rate Development**

**Summary of 2006 Actual Experience by County
Nursing Home Level of Care**

	Fond du Lac		La Crosse		Milwaukee		Portage		Richland		All Counties	
	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled
Exposure Months	5,054	5,387	6,953	10,169	67,601	194	5,043	4,394	1,699	1,836	86,350	21,980
Adaptive Equipment	30.60	40.43	60.70	74.14	71.25	152.69	51.61	59.50	47.94	53.48	66.42	61.92
Adult Day Activities	25.10	205.51	28.62	121.83	68.66	143.58	23.10	155.40	0.17	85.57	58.87	146.21
Case Management	244.95	329.74	293.80	335.99	296.32	397.06	271.39	300.44	363.95	374.14	292.99	331.08
Community At Large	-	-	-	-	-	-	-	-	-	-	-	-
Room and Board	(258.10)	(192.94)	(137.90)	(148.96)	(148.52)	(94.02)	(245.64)	(149.99)	(76.70)	(88.56)	(158.34)	(154.41)
Family Support Funding	-	-	-	-	-	-	-	-	-	-	-	-
Habilitation / Health	11.02	12.81	20.10	53.34	12.36	10.94	9.43	19.36	21.47	52.56	12.91	36.17
Home Care	128.30	330.92	146.49	286.64	488.70	639.20	357.69	921.55	573.78	558.81	434.08	450.28
Home Health Care	24.16	40.52	129.25	203.76	100.64	222.50	8.50	18.18	10.69	5.92	91.32	110.29
Housing	0.01	1.54	1.11	5.87	3.11	0.93	2.14	4.11	9.38	3.13	2.83	4.18
Institutional	243.25	82.13	575.36	151.63	382.60	145.47	400.76	155.26	870.40	154.76	400.63	135.53
Member Tracking	-	-	-	-	-	-	-	-	-	-	-	-
Other	7.67	12.92	2.19	5.43	15.92	15.02	0.97	1.83	5.21	11.53	13.25	7.14
Residential Care	1,301.50	1,072.08	649.81	879.81	663.04	650.85	1,047.89	1,009.61	500.49	652.30	718.61	931.85
Respite Care	4.48	21.53	24.62	62.62	3.42	-	5.60	60.81	3.78	47.74	5.32	50.39
Transportation	16.42	73.68	20.53	86.58	41.55	41.49	26.93	63.41	19.23	18.41	37.09	72.69
Vocational	<u>12.92</u>	<u>200.92</u>	<u>9.86</u>	<u>219.56</u>	<u>10.69</u>	<u>56.63</u>	<u>13.22</u>	<u>205.80</u>	<u>5.04</u>	<u>215.96</u>	<u>10.79</u>	<u>210.50</u>
Total	1,792.29	2,231.78	1,824.55	2,338.24	2,009.72	2,382.32	1,973.59	2,825.28	2,354.82	2,145.74	1,986.77	2,393.83
Composite PMPM	2,019.05		2,129.64		2,010.79		2,370.17		2,246.23		2,069.36	

**Wisconsin Department of Health and Family Services
CY 2008 Family Care Capitation Rate Development**

**Summary of 2006 Actual Experience by County
Non-Nursing Home Level of Care**

	Fond du Lac		La Crosse		Milwaukee		Portage		Richland		All Counties	
	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled
Exposure Months	293	444	525	2,005	2,841	-	136	473	170	259	3,966	3,181
Adaptive Equipment	16.68	33.15	34.64	43.86	29.28	-	21.62	43.23	60.55	28.30	30.14	41.00
Adult Day Activities	7.46	3.11	1.43	8.05	14.05	-	17.56	4.84	-	31.17	11.41	8.77
Case Management	245.02	375.89	217.92	270.90	261.67	-	148.98	351.24	205.63	431.16	248.37	310.55
Community At Large	-	-	-	-	-	-	-	-	-	-	-	-
Room and Board	(3.70)	-	(11.71)	(2.73)	(5.20)	-	-	-	(21.25)	(16.82)	(6.46)	(3.09)
Family Support Funding	-	-	-	-	-	-	-	-	-	-	-	-
Habilitation / Health	6.32	14.98	1.41	43.61	7.43	-	1.13	15.31	1.04	73.08	6.06	37.81
Home Care	121.79	99.63	95.95	90.98	285.77	-	131.94	174.56	121.46	102.74	236.19	105.57
Home Health Care	36.06	23.03	14.52	10.32	35.69	-	-	1.94	0.10	5.84	30.16	10.49
Housing	-	-	0.29	6.35	0.92	-	0.37	0.65	-	1.02	0.71	4.18
Institutional	-	-	-	-	-	-	-	-	-	-	-	-
Member Tracking	-	-	-	-	-	-	-	-	-	-	-	-
Other	1.95	2.48	0.06	2.43	7.43	-	0.51	1.56	6.35	5.26	5.76	2.54
Residential Care	489.31	-	23.08	18.33	25.63	-	-	2.06	93.54	113.61	61.63	21.11
Respite Care	-	-	0.19	2.14	-	-	-	-	-	0.52	0.03	1.39
Transportation	12.00	45.04	4.75	16.04	27.29	-	9.98	19.81	10.95	32.12	21.88	21.96
Vocational	-	17.02	-	5.08	-	-	-	7.09	-	16.45	-	7.98
Total	932.90	614.34	382.54	515.38	689.96	-	332.08	622.29	478.37	824.45	645.87	570.26
Composite PMPM	741.04		487.82		689.96		557.28		687.26		612.22	

**Wisconsin Department of Health and Family Services
CY 2008 Family Care Capitation Rate Development**

**Summary of 2006 Actual Experience by County
NH and Non-NH Level of Care**

	Fond du Lac		La Crosse		Milwaukee		Portage		Richland		All Counties	
	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled
Exposure Months	5,347	5,831	7,478	12,174	70,443	194	5,179	4,867	1,869	2,095	90,316	25,161
Adaptive Equipment	29.84	39.88	58.87	69.15	69.56	152.69	50.82	57.92	49.09	50.36	64.82	59.28
Adult Day Activities	24.14	190.09	26.71	103.09	66.45	143.58	22.95	140.77	0.16	78.85	56.79	128.84
Case Management	244.95	333.26	288.48	325.27	294.92	397.06	268.16	305.38	349.54	381.19	291.03	328.48
Community At Large	-	-	-	-	-	-	-	-	-	-	-	-
Room and Board	(244.14)	(178.24)	(129.04)	(124.88)	(142.74)	(94.02)	(239.17)	(135.42)	(71.66)	(79.69)	(151.67)	(135.28)
Family Support Funding	-	-	-	-	-	-	-	-	-	-	-	-
Habilitation / Health	10.76	12.97	18.79	51.74	12.16	10.94	9.22	18.97	19.61	55.09	12.61	36.38
Home Care	127.95	313.29	142.94	254.42	480.52	639.20	351.75	849.00	532.62	502.43	425.39	406.70
Home Health Care	24.81	39.19	121.20	171.91	98.02	222.50	8.28	16.60	9.72	5.91	88.63	97.67
Housing	0.01	1.42	1.05	5.95	3.02	0.93	2.09	3.78	8.52	2.87	2.74	4.18
Institutional	229.90	75.87	534.98	126.66	367.17	145.47	390.20	140.18	791.19	135.63	383.03	118.40
Member Tracking	-	-	-	-	-	-	-	-	-	-	-	-
Other	7.36	12.13	2.04	4.94	15.58	15.02	0.96	1.80	5.31	10.75	12.92	6.56
Residential Care	1,256.93	990.38	605.82	737.93	637.33	650.85	1,020.28	911.75	463.46	585.70	689.76	816.71
Respite Care	4.24	19.89	22.91	52.66	3.28	-	5.45	54.90	3.44	41.90	5.09	44.20
Transportation	16.18	71.50	19.43	74.96	40.97	41.49	26.48	59.18	18.47	20.10	36.42	66.28
Vocational	<u>12.21</u>	<u>186.91</u>	<u>9.17</u>	<u>184.24</u>	<u>10.25</u>	<u>56.63</u>	<u>12.87</u>	<u>186.50</u>	<u>4.58</u>	<u>191.30</u>	<u>10.31</u>	<u>184.90</u>
Total	1,745.14	2,108.53	1,723.35	2,038.04	1,956.49	2,382.32	1,930.34	2,611.30	2,184.07	1,982.40	1,927.88	2,163.29
Composite PMPM	1,934.70		1,918.30		1,957.66		2,260.24		2,077.49		1,979.17	

Wisconsin Department of Health and Family Services
CY 2008 Family Care Capitation Rate Development

Functional Screen Regression Model of 2006 PMPM
Nursing Home Level of Care

Variable	Estimate	p-Value	Incremental Partial R2	Proportion with Variable	Incremental Increase
Intercept (Grid Component)	762.24	0.0001			762.24
County (Grid Component)					
Richland	149.71	0.0001	0.00038	0.0326	4.89
La Crosse	(51.27)	0.0001	0.00018	0.1581	(8.10)
Fond du Lac	(420.97)	0.0001	0.00003	0.0964	(40.57)
Portage	149.04	0.0001	0.00337	0.0871	12.98
DD/NH Level of Care (Grid Component)					
Vent Dependent	2,744.64	0.0001	0.00309	0.0008	2.33
DD1A	1,502.38	0.0001	0.01882	0.0121	18.19
DD1B	2,365.98	0.0001	0.08898	0.0257	60.77
DD2	923.13	0.0001	0.03281	0.1179	108.87
SNF	331.48	0.0001	0.08240	0.2560	84.87
Number of IADLs (Grid Component)					
IADL_3	76.73	0.0001	0.01294	0.1895	14.54
IADL_4	258.08	0.0001	0.00002	0.3327	85.87
IADL_5	310.94	0.0001	0.03680	0.2443	75.96
IADL_6	1,154.60	0.0001	0.04166	0.0320	36.97
Specific ADLs / Equipment Used (Add-On)					
Bathing_2	332.11	0.0001	0.03111	0.4966	164.92
Dressing_2	96.76	0.0001	0.01147	0.2832	27.40
Eating_2	113.29	0.0001	0.00294	0.0890	10.08
Toileting_1	222.50	0.0001	0.00050	0.1835	40.83
Toileting_2	331.78	0.0001	0.00787	0.1929	63.99
Transfer_2	329.94	0.0001	0.00187	0.1792	59.13
Interaction Terms (Add-On)					
Bathing_Equip_Dressing	158.56	0.0001	0.00148	0.4746	75.26
Transfer_Equip_Mobility	316.80	0.0001	0.00159	0.0724	22.93
Bathing_Equip_Eating	79.92	0.0001	0.00023	0.2064	16.50
Behavioral Variables (Add-On)					
Communication_3	178.92	0.0001	0.00043	0.0402	7.20
Cognition_3	37.91	0.0186	0.00047	0.1524	5.78
Resistive	134.24	0.0001	0.00176	0.0540	7.25
Injury	407.58	0.0001	0.00208	0.0285	11.60
Offensive_1-2	335.42	0.0001	0.00176	0.1056	35.41
Offensive_3	1,109.43	0.0001	0.00278	0.0080	8.86
Medication Use (Add-On)					
Meds_2A	287.37	0.0001	0.00027	0.2235	64.23
Meds_2B	554.98	0.0001	0.00462	0.4117	228.47

Wisconsin Department of Health and Family Services
CY 2008 Family Care Capitation Rate Development

Family Care Based Functional Screen Regression Model of 2006 PMPM
Nursing Home Level of Care: Community Care

Variable	Estimate	p-Value	Incremental Partial R2
Intercept (Grid Component)	746.06	0.0001	
DD/NH Level of Care (Grid Component)			
Vent Dependent	2,713.38	0.0001	0.00299
DD1A	1,495.38	0.0001	0.01939
DD1B	2,347.24	0.0001	0.09032
DD2	876.04	0.0001	0.02846
SNF	320.24	0.0001	0.08150
Number of IADLs (Grid Component)			
IADL_3	76.30	0.0001	0.01271
IADL_4	249.99	0.0001	0.00009
IADL_5	283.29	0.0001	0.03882
IADL_6	1,072.60	0.0001	0.03976
Specific ADLs / Equipment Used (Add-On)			
Bathing_2	330.45	0.0001	0.03209
Dressing_2	102.60	0.0001	0.01199
Eating_2	119.48	0.0001	0.00313
Toileting_1	226.38	0.0001	0.00056
Toileting_2	331.26	0.0001	0.00791
Transfer_2	327.33	0.0001	0.00179
Interaction Terms (Add-On)			
Bathing_Equip_Dressing	165.48	0.0001	0.00159
Transfer_Equip_Mobility	314.52	0.0001	0.00154
Bathing_Equip_Eating	77.20	0.0001	0.00021
Behavioral Variables (Add-On)			
Communication_3	162.00	0.0001	0.00043
Cognition_3	75.74	0.0001	0.00075
Resistive	166.55	0.0001	0.00199
Injury	411.86	0.0001	0.00209
Offensive_1-2	314.27	0.0001	0.00152
Offensive_3	1,089.26	0.0001	0.00267
Medication Use (Add-On)			
Meds_2A	302.78	0.0001	0.00018
Meds_2B	554.44	0.0001	0.00463

Wisconsin Department of Health and Family Services CY 2008 Family Care Capitation Rate Development

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

Variable	Fond Du Lac	La Crosse	Milwaukee	Portage	Richland	Community Care
Disability or Nursing Home						
Vent Dependent	0.1%	0.0%	0.1%	0.1%	0.0%	0.2%
DD1A	1.0%	2.8%	1.0%	1.9%	2.1%	1.0%
DD1B	5.3%	7.4%	0.8%	7.2%	5.5%	6.6%
DD2	30.0%	20.9%	5.3%	18.3%	21.7%	42.2%
SNF	23.0%	20.1%	30.0%	20.5%	16.8%	12.7%
Instrumental Activities of Daily Living						
IADL_3	15.2%	17.6%	20.0%	15.7%	21.4%	10.9%
IADL_4	32.0%	29.2%	41.3%	28.5%	26.6%	30.9%
IADL_5	32.1%	21.9%	21.8%	30.6%	24.8%	33.4%
IADL_6	10.0%	7.8%	0.7%	6.7%	5.2%	14.3%
Activities of Daily Living						
Bathing_2	45.4%	38.2%	54.9%	50.5%	33.0%	51.5%
Dressing_2	26.2%	20.2%	34.1%	26.4%	19.3%	33.8%
Eating_2	9.4%	7.5%	9.7%	11.0%	6.7%	17.4%
Toileting_1	17.6%	15.9%	19.6%	17.1%	15.9%	20.4%
Toileting_2	20.6%	15.7%	21.7%	20.5%	15.9%	22.9%
Transfer_2	18.2%	13.8%	20.1%	19.9%	9.8%	19.3%
Interaction Terms						
Bathing_Equip_Dressing	40.6%	37.8%	54.5%	45.1%	31.8%	38.1%
Transfer_Equip_Mobility	9.0%	12.3%	11.8%	12.7%	8.3%	13.3%
Bathing_Equip_Eating	21.9%	19.7%	21.8%	26.9%	15.3%	21.0%
Behavioral Variables						
Communication_3	5.3%	4.0%	3.7%	6.2%	2.8%	9.7%
Cognition_3	14.6%	13.2%	15.9%	19.9%	14.7%	27.0%
Resistive	4.1%	4.8%	5.7%	7.2%	6.7%	8.6%
Injury	4.0%	2.5%	2.1%	3.4%	2.8%	7.9%
Offensive_1-2	16.0%	12.2%	8.2%	14.6%	13.5%	23.4%
Offensive_3	1.0%	3.3%	0.4%	1.4%	0.6%	1.2%
Medication Use						
Meds_2A	17.8%	19.1%	22.5%	19.7%	28.4%	21.0%
Meds_2B	49.1%	38.1%	45.2%	39.8%	29.7%	49.6%

**Wisconsin Department of Health and Family Services
CY 2008 Family Care Capitation Rate Development**

Development of the 2008 Preliminary Rates

Nursing Home Capitation Rate Development

County	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 Rates
Fond du Lac	2,126.80	5.75%	5.3%	2,376.99	52.82	2,324.17
La Crosse	2,049.66	5.75%	5.1%	2,284.56	65.92	2,218.64
Milwaukee	2,043.84	5.35%	7.3%	2,317.38	96.82	2,220.56
Portage	2,256.76	5.75%	5.4%	2,523.52	48.93	2,474.58
Richland	2,020.38	12.25%	5.6%	2,431.28	70.50	2,360.78
Community Care	2,689.44	5.75%	6.5%	3,040.00	82.67	2,957.33

Non-Nursing Home Capitation Rate Development

County	Total Statistical Model 2006 PMPM Inc IBNR	Admin/Risk Rate	Two-Year Trend	2008 Gross Non-NH Rates	2008 Ave. Cost Sharing PMPM	Preliminary 2008 Rates
Fond du Lac	618.91	5.75%	5.3%	691.71	-	691.71
La Crosse	588.65	5.75%	5.1%	656.11	-	656.11
Milwaukee	639.02	5.35%	7.3%	724.55	-	724.55
Portage	595.85	5.75%	5.4%	666.28	-	666.28
Richland	592.89	12.25%	5.6%	713.47	-	713.47
Community Care	612.67	5.75%	6.0%	689.33	-	689.33

**Wisconsin Department of Health and Family Services
CY 2008 Family Care Capitation Rate Development**

Development of the 2008 Final Rates; After Adjustment for ICF-MR Relocations

Nursing Home Capitation Rate Development

County	Preliminary 2008 Rates	Total Annual ICF-MR Funding Including Admin	ICF-MR Member Months	ICF-MR 2008 Rates	Final CY 2008 Capitation Rates	Final CY 2007 Capitation Rates	Percentage Change
Fond du Lac	2,324.17	-	-	-	2,324.17	2,308.49	0.7%
La Crosse	2,218.64	494,661	48	10,305.44	2,238.09	2,243.37	-0.2%
Milwaukee	2,220.56	-	-	-	2,220.56	2,130.92	4.2%
Portage	2,474.58	331,019	36	9,194.98	2,496.02	2,554.34	-2.3%
Richland	2,360.78	-	-	-	2,360.78	2,335.41	1.1%
Community Care	2,957.33	-	-	-	2,957.33	2,670.23	10.8%

Non-Nursing Home Capitation Rate Development

County	Preliminary 2008 Rates	Total Annual ICF-MR Funding Including Admin	ICF-MR Member Months	ICF-MR 2008 Rates	Final CY 2008 Capitation Rates	Final CY 2007 Capitation Rates	Percentage Change
Fond du Lac	691.71	-	-	-	691.71	691.35	0.1%
La Crosse	656.11	-	-	-	656.11	691.35	-5.1%
Milwaukee	724.55	-	-	-	724.55	691.35	4.8%
Portage	666.28	-	-	-	666.28	691.35	-3.6%
Richland	713.47	-	-	-	713.47	691.35	3.2%
Community Care	689.33	-	-	-	689.33	691.35	-0.3%

**Wisconsin Department of Health and Family Services
CY 2008 Family Care Capitation Rate Development**

Development of the 2008 Final Rates; Non-MA

Non-MA Capitation Rate Development

County	Total Statistical Model 2006 PMPM Inc IBNR	Admin/Risk Rate	Two-Year Trend	2008 Gross Nursing Home Rates	2008 Ave. Cost Sharing PMPM	Final 2008 Capitation Rates
Fond du Lac	2,025.67	5.75%	5.3%	2,263.96	718.72	1,545.24
La Crosse	1,625.32	5.75%	5.1%	1,811.59	402.66	1,408.94
Milwaukee	1,683.08	5.35%	7.3%	1,908.34	390.37	1,517.96
Portage	1,951.06	5.75%	5.4%	2,181.67	150.00	2,031.67
Richland	1,437.97	12.25%	5.6%	1,730.42	76.52	1,653.90