



17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

michael.cook@milliman.com

November 14, 2023

Elizabeth Doyle, Section Manager
Long Term Care Rate Setting Section
Bureau of Rate Setting
Division Medicaid Services
1 West Wilson Street
Madison, WI 53701-0309
Sent via email: elizabeth.doyle@dhs.wisconsin.gov

Re: CY 2024 PACE Capitation Rate Report

Dear Elizabeth:

Thank you for the opportunity to assist the Wisconsin Department of Health Services (DHS) with this important project. Our report summarizes the development of the CY 2024 amount that would otherwise have been paid (AWOP) for the Program of All Inclusive Care for the Elderly (PACE) and the CY 2024 capitation rate for the PACE program.



Elizabeth, please let us know if you would like to discuss further or have any other questions.

Sincerely,

A handwritten signature in black ink that reads "Michael Cook".

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

MCC/bl

Attachment

MILLIMAN REPORT

State of Wisconsin

Department of Health Services Calendar Year 2024 Capitation Rate Development PACE Program

November 14, 2023

[Michael Cook](#), FSA, MAAA
Principal and Consulting Actuary

[Briana Botros](#), FSA, MAAA
Consulting Actuary



17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com



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Capitation Rate Development – Acute and Primary Services

- C: Projected CY 2024 Enrollment
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- H1B: June 2023 Population MCO / GSR Functional Screen Attribute Distribution – Developmentally Disabled
- H2B: June 2023 Population MCO / GSR Functional Screen Attribute Distribution – Physically Disabled
- H3B: June 2023 Population MCO / GSR Functional Screen Attribute Distribution – Frail Elderly
- I: Projections of LTC Service Costs to CY 2024 Rate Period

APPENDICES

- A: Responses to December 2015 PACE Medicaid Capitation Rate Setting Guide
- B: CY 2024 Family Care Partnership Rate report

I. EXECUTIVE SUMMARY

The Wisconsin Department of Health Services (DHS) retained Milliman to calculate and document its capitation rate development for the Program of All-Inclusive Care for the Elderly (PACE) program. This report documents the development of the January 2024 to December 2024 (CY 2024) amount that would otherwise have been paid (AWOP) and CY 2023 capitation rates for the PACE program. We developed these amounts using the methodology described in this report.

Our role is to develop the CY 2024 PACE capitation rates and demonstrate that they are below the AWOP. While these rates are not required to be certified as actuarially sound, Milliman still closely followed the at-risk rate development actuarial opinion guidance outlined by CMS and the Academy of Actuaries to ensure compliance with generally accepted actuarial practices and regulatory requirements. Specific Actuarial Standards of Practice (ASOPs) we considered include:

- ASOP No. 1 – Introductory Actuarial Standard of Practice
- ASOP No. 5 – Incurred Health and Disability Claims
- ASOP No. 12 – Risk Classification
- ASOP No. 23 – Data Quality
- ASOP No. 25 – Credibility Procedures
- ASOP No. 41 – Actuarial Communications
- ASOP No. 42 – Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims
- ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 49 – Medicaid Managed Care Capitation Rate Development and Certification
- ASOP No. 56 – Modeling
- Other applicable standards of practice

CY 2024 PACE RATE

The projected average CY 2024 capitation rate for the PACE program is \$4,500.76 per member per month (PMPM). Table 1 shows the capitation rate change from CY 2023 rate certification dated November 21, 2022 to CY 2024.

CY 2023 Rates	\$4,463.36
CY 2024 Rates	4,500.76
% Change	0.8%

Actual capitation rates by rate cell are included in Table 6 of this report.

The main drivers of this rate change are similar to those explained in Appendix B for the Family Care Partnership program. **Differences between the rate change for Family Care Partnership and PACE include:**

- There is a decrease in the actual CY 2022 base cohort LTC service costs compared to the CY 2022 costs predicted as part of CY 2023 rate development for PACE resulting in a 5.7% decrease to PACE, which is more material than the Family Care Partnership impact. While PACE uses the Partnership program as the basis for its AWOP, and therefore has the same base data, the mix of target groups is different between the programs. The PACE population is nearly all in the FE target group, which had lower 2022 results relative to what was expected than other target groups.
- There is an increase in PACE acuity resulting in a 3.4% increase to PACE capitation rates, which is more material than the Family Care Partnership impact.
- There is a decrease in PACE geographic factors compared to the increase in Family Care Partnership base data, resulting in a 1.6% decrease to PACE capitation rates.

NOTES ON REPORT STRUCTURE

This report provides a high-level overview of the “Amount that Would Otherwise have been Paid” (AWOP) development methodology. The Family Care Partnership enrollment comprise the population comparable to the PACE enrollment that is used to develop the service cost and non-service cost portions of the AWOP. Please see the CY 2024 Family Care Partnership Rate report, which is included as Appendix B to this report, for full details of the service cost and non-benefit cost projection methodologies.

We adjust the Family Care Partnership acute care and long-term care service cost projections to reflect the demographics and risk scores of the population covered under PACE in Exhibits C through I of this report. Please note, for clarity, exhibits in this report match the naming convention of exhibits in the Family Care Partnership report. This results in some exhibits appearing to be excluded from this report.

This report then applies additional services cost adjustments to reflect differences in covered benefits and MCO financial responsibility between PACE and Partnership. Finally, the report applies non-service costs, equal to the Partnership values, to develop the final AWOP rates. Final capitation rates are confirmed to be below the AWOP rates.

DATA RELIANCE AND IMPORTANT CAVEATS

Milliman prepared this report for the specific purpose of developing CY 2024 PACE AWOP and capitation rates. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of DHS. We understand this report may be shared with participating MCOs, CMS, and other interested parties. Milliman does not intend to benefit, or create a legal duty to, any third-party recipient of its work. This report should only be reviewed in its entirety.

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

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate CY 2024 PACE AWOP development and PACE capitation rate. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We used MCO financial reporting, as well as encounter, eligibility, diagnostic, and functional screen data for CY 2019, CY 2020, CY 2021, CY 2022 and June 2023, and other information provided by DHS to develop the PACE capitation rate shown in this report. We have relied upon this data and information provided by DHS for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose. Please see Appendix B for a full list of the data relied upon to develop the CY 2024 PACE AWOP development and PACE capitation.

Differences between the capitation rates and actual MCO experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. These rates may not be appropriate for all MCOs. Any MCO considering participating in PACE should consider their unique circumstances before deciding to contract under these rates.

The authors of this report are actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

II. BACKGROUND

PACE is a full-risk, fully-integrated Medicaid-Medicare managed care delivery system for the full range of LTC and acute and primary care services, which strives to foster people's independence and quality of life. PACE is a national model of care delivery for beneficiaries aged 55 and older. Participating MCOs have contracts with both the State of Wisconsin and with CMS and receive monthly capitation payments from each entity for dually eligible beneficiaries.

Eligibility for PACE is determined through the Wisconsin Long Term Care Functional Screen and detailed decision trees involving individual information about type of disability, activities of daily living, instrumental activities of daily living, and certain other medical diagnoses and health related services. All members in this program meet the Nursing Home Level of Care criteria. Enrollment in PACE is voluntary. The risk adjustment model mechanism helps to adjust rates for any differences in average member acuity over time.

PACE operates in Milwaukee County, Waukesha County, Racine County, and Kenosha County. MCOs contract with service providers to deliver all State Plan and waiver LTC services, as well as all acute care and primary care services.

The AWOP rate for the PACE program reflects costs that would have been incurred by PACE enrollees under the Family Care Partnership program (after adjustment for benefit differences) if PACE were not in existence. The covered population and benefit set are very similar between the Family Care Partnership program and the PACE program. Therefore, in this report we adjust the Family Care Partnership costs to reflect the specific characteristics of the PACE program and enrolled population. We give consideration to the unique attributes of the PACE program and covered population for the following rate setting assumptions:

- Projected enrollment
- Population acuity, as measured by the PACE population's functional status
- Projected target group distribution
- Projected Medicare eligibility distribution
- Projected age group distribution
- Service area
- Administrative allowance
- Coverage of pharmacy claims, which are not covered under the Family Care Partnership program
- Pharmacy rebate collection
- Coverage of acute and primary services for ventilator dependent members, which are carved out of the Family Care Partnership program

III. ACUTE AND PRIMARY SERVICE COST METHODOLOGY OVERVIEW

This section of the report describes the acute and primary service cost portion of the initial CY 2024 PACE AWOP development.

The methodology used to project the Family Care Partnership MCO encounter data used in the calculation of the AWOP can be outlined in the following steps. Steps 1 to 3 develop the underlying cost projections for various cohorts of the Partnership population and are unchanged from the Partnership rate development, included as Appendix B to this report. Step 4 blends these cohort projections to match the PACE-specific population demographics.

1. Extract and summarize CY 2022 MCO encounter base experience data for the Dual Eligible and Medicaid Only populations by target group for the Family Care Partnership program only. **PACE experience is not included in the base experience data.**

Exhibits A1 through A3 in Appendix B shows the summarized repriced CY 2022 Family Care Partnership MCO encounter base experience data by target group for the Dual Eligible and Medicaid only populations, respectively.

2. Further summarize CY 2022 Family Care Partnership MCO encounter base experience data by age and gender groupings.

Exhibit B1 in Appendix B shows the detailed summary of the base experience period data by age and gender groupings for each target group and Medicare eligibility status.

3. Apply adjustments to project CY 2024 services costs.

Exhibit B1 in Appendix B shows each adjustment factor by category of service; Exhibit B2 in Appendix B shows the adjusted and trended values for each target group and age / gender breakout and for each target group and Medicare eligibility status. These trends were developed from a comparable PACE-eligible population.

4. Blend the projected CY 2024 service costs into a PACE-specific projected cost based on the projected demographic distribution of CY 2024 PACE enrollees.

Exhibit C of this report shows the projected CY 2024 enrollment distribution, while Exhibits D1 to D3 of this report shows the blended PACE acute and primary service cost for the Dual Eligible, Medicaid Only, and total populations split by target group, respectively. Capitation rates will be paid separately for each target group and for Dual Eligible and Medicaid Only members, so Composite rates in Exhibits D1 and D2, as well as total population rates in Exhibit D3 are for illustrative purposes only.

Please see Section III steps 1 through 4 in Appendix B to this report for details for each of these steps.

IV. LONG-TERM CARE SERVICE COST METHODOLOGY OVERVIEW

This section of the report describes the LTC service cost portion of the initial CY 2024 PACE AWOP development.

The methodology used to calculate the LTC portion of the AWOP can be outlined in the following steps. Step 1 develops the underlying base period costs and acuity for various cohorts of the Partnership population and are unchanged from the Partnership rate development included as Appendix B to this report. Steps 2 through 4 blend these cohort costs to match the PACE-specific population geography and acuity and project the resulting costs to the contract period for each target group:

1. The LTC base data used for the AWOP development is comprised of LTC data for the Family Care Partnership program. **PACE experience is not included in the base experience data.**
2. Apply adjustments to account for the member acuity level of the PACE population using June 2023 PACE screens and the functional status acuity model developed from Family Care and Family Care Partnership experience. Note, this acuity adjustment includes consideration for a wide variety of member needs that could drive utilization of nursing facilities and other services and is much more precise than simply adjusting for differences in nursing facility utilization between Partnership and PACE.

The functional status models are shown in Exhibits G1 to G3 of Appendix B for the Developmentally Disabled, Physically Disabled, and Frail Elderly population, respectively. **PACE experience is not included in the development of these models.**

Exhibits H1B, H2B, and H3B of this report show the proportion of the June 2023 PACE enrolled population with each variable for the three functional status models used in calculating the PACE specific risk score.

Consistent with CY 2024 Family Care Partnership rate development, the PACE AWOP rate development limits the preliminary CY 2024 risk scores to a 2.0% increase or decrease from 2023 rates for each MCO and target group combination. This phases in changes to individual MCO revenues associated with changes in member assessment protocols and other potential changes over time. The bottom lines of Exhibits H1B, H2B, and H3B apply a factor to risk scores calculated from June 2023 member screens on the MCO and target group basis to limit this risk score change between years and re-normalize the risk scores. The normalization factors used to develop these exhibits are the same as those used in Appendix B.

3. Apply adjustments to the risk adjusted costs to project CY 2024 services costs for each target group. Exhibit I of this report shows adjusted and trended values for each target group and in total. The trends were developed from a comparable PACE-eligible population and are equal to those used in Appendix B. The geographic adjustment for PACE was set as the weighted average of Super Regions 3 and 4 in order to account for the unique service area covered by the PACE program. We weighted each Super Region based on the distribution of projected PACE enrollment by county as illustrated below. The factors were normalized in Partnership rate development to reflect a 1.000 program-wide average.

The PACE blend of super-regional factors is different than the Partnership blend as shown in Table 2. This single PACE geographic factor is then converted to target group-specific factors using the same adjustments as applied for Partnership rate development.

Table 2
Wisconsin Department of Health Services
Distribution of Projected PACE Enrollment

Super Region	Distribution of Projected CY 2024 PACE Enrollment	Preliminary Geographic Factor	
Super Region 3: GSR 6, 11	35.9%	1.054	
Super Region 4: GSR 8	64.1%	0.932	
PACE Total	100.0%	0.975	
	DD	PD	FE
PACE Normalized Geographic Factor	0.985	0.984	0.960

4. Blend the projected CY 2024 service costs by target group into a PACE-specific projected cost. The Composite costs are shown in the bottom section of Exhibit I and are for illustrative purposes only.

Please see Section IV steps 1 through 4 in Appendix B to this report for details for each of these steps.

V. PACE-SPECIFIC AWOP ADJUSTMENTS

This section of the report describes adjustments made to the initial AWOP rates to address benefit coverage differences between the Family Care Partnership program and the PACE program. The exhibits in this report reflect the development of an initial AWOP prior to the following additional adjustments:

- The PACE program retains financial liability for acute and primary costs for individuals with ventilator dependency, while the Family Care Partnership program does not. The acute and primary costs in Exhibit D of this report are calculated after removing members associated with ventilator dependency. Therefore, we increased the acute and primary service cost component of the acute and primary costs in Exhibit D by a factor of 1.0076 for the Dual Eligible population and 1.0259 for the Medicaid Only population to reflect the increased PACE liability. We developed this percentage as the ratio of the ventilator dependent acute and primary service costs underlying the Family Care Partnership base period data to the base period acute and primary costs shown in Exhibit A of Appendix B.
- Costs for most pharmacy services were carved out of Family Care Partnership starting in 2020; these carved-out claims were then paid on an FFS basis. The acute and primary costs in Exhibit D of this report; thus, omit most pharmacy services that will remain the liability of the PACE plan.

To estimate pharmacy expenditures for the PACE program, we relied on CY 2022 FFS pharmacy expenditures for Family Care Partnership enrollees, limited to the 55 and older population, net of rebate amounts typically collected for Medicaid-only members. DHS provided us rebate percentages of 0% for Dual Eligibles and 60% for Medicaid Only Eligibles, which we believe to be reasonable.

We reviewed historical pharmacy experience, gross of rebates, for CY 2019, CY 2021, and CY 2022 in order to develop our pharmacy trend as seen in Table 3A. Note, in CY 2019, pharmacy services were included in the Family Care Partnership program, so we estimated the amount to be carved out based on a list of NDCs provided by DHS. We trended the CY 2022 base pharmacy claims to CY 2024 using a 5.00% annual trend. This annual trend assumption is also comparable to pharmacy trends realized in other Medicaid managed care programs in recent years.

Table 3A Wisconsin Department of Health Services AWOP Pharmacy Trends					
	CY 2019 FCP Carved Out	CY 2021 FFS FCP	2022 FFS FCP	Annual CY 2021 / CY 2019	Annual CY 2022 / CY 2021
Dual Eligible	\$18.57	\$5.33	\$4.54	-46.4%	-14.7%
Medicaid Only	\$849.26	\$1,018.63	\$1,096.64	9.5%	7.7%
Total Population	\$80.98	\$81.46	\$86.59	0.3%	6.3%

This projection process resulted in an addition of pharmacy expenditures of \$40.97 PMPM related to services covered under PACE, but not under Family Care Partnership.

Table 3B Wisconsin Department of Health Services AWOP Pharmacy Adjustment						
	CY 2024 Projected Exposure Months – PACE	CY 2022 Pharmacy PMPM	Rebate Percentage	CY 2022 Pharmacy Net of Rebates	Trend Adjustment	CY 2024 Pharmacy Projection PMPM
Dual Eligible	5,781	\$4.54	0%	\$4.54	1.1025	\$5.01
Medicaid Only	470	\$1,096.64	60%	\$438.66	1.1025	\$483.62
Blended Experience	6,250	\$86.59	57.09%	\$37.16	1.1025	\$40.97

- Costs for certain substance abuse disorder (SUD) services are carved out of Family Care Partnership and are paid outside of the Medicaid managed care capitation rate on an FFS basis but should be included in AWOP development. The acute and primary costs in Exhibit D of this report, thus, omit these services. We relied on CY 2022 experience provided by DHS to quantify this amount, which had no utilization in CY 2022.

We trended these CY 2022 claims to CY 2024 using a 5.00% annual trend from 2022 to 2024, as shown by Table 4 below. This annual trend assumption aligns with the annual trend applied to other A&P services underlying AWOP development. This resulted in an estimate of substance abuse expenditures of \$0.00 PMPM related to eligible services covered under FFS that are added to the AWOP.

Table 4
Wisconsin Department of Health Services
AWOP SUD Adjustment

	CY 2024 Projected Member Months – PACE	CY 2022 SUD FFS Experience PMPM	CY 2022 to CY 2024 Trend Adjustment	CY 2024 SUD Projection PMPM
Dual Eligible	5,781	\$0.00	1.1025	\$0.00
Medicaid Only	470	\$0.00	1.1025	\$0.00
Total Population	6,250	\$0.00	1.1025	\$0.00

- The 2022-2024 Wisconsin biennial budget includes additional funding to Family Care Partnership MCOs to distribute to direct care workforce (DCW) providers and the estimated total for CY 2024 is \$8.8 million. This additional funding resulted in an increase of approximately \$185.32 PMPM in Appendix B, which we also add to AWOP development.
- For CY 2024 Family Care Partnership rate development we assume 100% of the capitation withhold is expected to be earned back by the MCOs. Therefore, we apply the same adjustment in the PACE AWOP development.

VI. NON-SERVICE COST ALLOWANCE

This section of the report describes the development of the non-service cost allowance for the initial CY 2024 PACE AWOP development. Non-service expense loads and resulting capitation rates are equal to the values used for Family Care Partnership capitation.

ADMINISTRATIVE COST ALLOWANCE

In order to develop administrative costs, DHS and Milliman reviewed Family Care Partnership program experience from plan reported financial summaries for CY 2022. We set overall CY 2024 administrative costs based on the CY 2022 administrative cost PMPM level with two years of 4.0% annual trend applied, which is comparable to recent Employment Cost Index calculations published by the Bureau of Labor Statistics. This trend adjustment considers the high levels of inflation and wage growth seen in early 2023 at 5% trend for CY 2022 to CY 2023 and the expectation of the return to the historical average in 2024 at 3% trend from CY 2023 to CY 2024. **PACE experience was not included in the development of the administrative costs.**

Please see Section V in Appendix B to this report for additional details regarding the administrative cost model.

Targeted Risk Margin / Contribution to Reserves

We include an explicit targeted margin of 2.0% of the AWOP, less costs that would not have otherwise been paid through Partnership for PACE eligible members, to account for risk margin and cost of capital. We believe that this margin is appropriate given the predictability of expenses under the program and margins included for similar programs nationally.

Final PACE AWOP

Table 5 below shows the final PACE AWOP calculation for each target group and Medicare eligibility status. The CY 2024 blended AWOP for the PACE program is \$4,686.08.

Table 5
Wisconsin Department of Health Services
Final AWOP Calculation

AWOP Component	Dual Eligible			Exhibit Reference
	DD	PD	FE	
PMPM				
Acute Care Costs – Starting	\$133.52	\$229.19	\$132.39	Exhibit D1
× FFS Vent Adjustment	1.0076	1.0076	1.0076	
+ FFS Pharmacy Adjustment	\$5.01	\$5.01	\$5.01	
+ FFS SUD Adjustment	\$0.00	\$0.00	\$0.00	
Acute Care Costs – Final	\$139.55	\$235.95	\$138.41	
Long Term Care Costs -- Starting	\$4,785.51	\$4,473.06	\$3,659.33	Exhibit I, Column (E)
× Non-Return of Withhold	1.0000	1.0000	1.0000	
+ DCW Adjustment	\$185.32	\$185.32	\$185.32	
Long Term Care Costs -- Final	\$4,970.83	\$4,658.38	\$3,844.65	
Administrative Allowance	\$244.50	\$244.50	\$244.50	Appendix B, Exhibit J1, Column (D)
Target Margin	\$105.38	\$100.95	\$82.37	2% of Final AWOP less DCW and FFS Adj.
Final AWOP	\$5,460.26	\$5,239.78	\$4,309.93	
Medicaid Only				
PMPM				
AWOP Component	DD	PD	FE	Exhibit Reference
Acute Care Costs – Starting	\$1,804.97	\$1,556.70	\$1,178.53	Exhibit D2
× FFS Vent Adjustment	1.0259	1.0259	1.0259	
+ FFS Pharmacy Adjustment	\$483.62	\$483.62	\$483.62	
+ FFS SUD Adjustment	\$0.00	\$0.00	\$0.00	
Acute Care Costs – Final	\$2,335.25	\$2,080.56	\$1,692.62	
Long Term Care Costs -- Starting	\$4,785.51	\$4,473.06	\$3,659.33	Exhibit I, Column (E)
× Non-Return of Withhold	1.0000	1.0000	1.0000	
+ DCW Adjustment	\$185.32	\$185.32	\$185.32	
Long Term Care Costs -- Final	\$4,970.83	\$4,658.38	\$3,844.65	
Administrative Allowance	\$244.50	\$244.50	\$244.50	Appendix B, Exhibit J2, Column (D)
Target Margin	\$139.49	\$128.05	\$103.72	2% of Final AWOP less DCW and FFS Adj.
Final AWOP	\$7,690.07	\$7,111.49	\$5,885.49	

PACE CAPITATION RATE DEVELOPMENT

Table 6 below shows the CY 2024 capitation rate for each combination of target group and Medicare eligibility status. These values are less than the AWOP amounts shown in Table 5 above to be in compliance with the rate requirements of 42 CFR 460.182. We adjust each AWOP for the following issues to develop the final capitation rates:

- We remove the portion of the AWOP rate associated with the DCW directed payment, since PACE providers are not subject to directed payments
- We add back any adjustment made to the AWOP for Partnership non-return of withhold, since there is no withhold program for PACE
- We make no adjustment for the portion of the AWOP rate associated with FFS SUD services, since PACE providers are financially responsible for these services

November 14, 2023

This report assumes that the reader is familiar with the State of Wisconsin's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the PACE program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 6			
Wisconsin Department of Health Services			
Capitation Rate Development			
Dual Eligible PMPM			
	DD	PD	FE
Final AWOP - Dual Eligible	\$5,460.26	\$5,239.78	\$4,309.93
- DCW Adjustment	(\$185.32)	(\$185.32)	(\$185.32)
+ Impact of AWOP Withhold	\$0.00	\$0.00	\$0.00
Capitation Rate - Dual Eligible	\$5,274.94	\$5,054.46	\$4,124.61
Medicaid Only PMPM			
	DD	PD	FE
Final AWOP - Medicaid Only	\$7,690.07	\$7,111.49	\$5,885.49
- DCW Adjustment	(\$185.32)	(\$185.32)	(\$185.32)
+ Impact of AWOP Withhold	\$0.00	\$0.00	\$0.00
Capitation Rate - Medicaid Only	\$7,504.75	\$6,926.17	\$5,700.17

Additional rate reductions from each AWOP are not necessary since the basis of the AWOP rates already reflects experience from a mature managed care program. Documentation of compliance with the December 2015 PACE Medicaid Rate Setting Guide is included as Appendix A. The PACE rates are prospective in nature and do not include any retrospective adjustments or incentives.

November 14, 2023

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EXHIBITS

(Provided in Excel Format Only)

State of Wisconsin Department of Health Services
CY 2024 Capitation Rate Development for PACE Program

November 14, 2023

This report assumes that the reader is familiar with the State of Wisconsin's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the PACE program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

APPENDIX A

Responses to December 2015 PACE Medicaid Capitation Rate Setting Guide

State of Wisconsin Department of Health Services
CY 2024 Capitation Rate Development for PACE Program

November 14, 2023

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APPENDIX A

Responses to December 2015 PACE Medicaid Capitation Rate Setting Guide

1. AWOP Development
 - a. The acute and primary portion of the AWOP is developed separately for Medicare and Medicaid-only eligibles. The long-term care portion of the AWOP is developed separately by target group (physically disabled, developmentally disabled, and frail elderly).
 - b. The AWOP is developed prospectively for the calendar year and does not include any retrospective adjustments or incentives.
 - c. The AWOP is developed from recent managed care data and is adjusted in many ways to reflect the population enrolled in PACE.
2. Rate Development
 - a. The rate development is consistent with the process outlined in the State Plan and is nominally lower than the rate that would have been paid had PACE individuals been enrolled in Family Care Partnership.
 - b. Capitation rates will be paid prospectively on a PMPM basis and reflect the same level of rate category grouping as the AWOP.
 - c. Capitation rates will be paid prospectively for the twelve-month contract period beginning January 1, 2024 and ending December 31, 2024.
 - d. Capitation rates are lower than the AWOP. The PACE program has no incentive arrangements. Information on projected enrollment is included in this report.

APPENDIX B

CY 2024 Family Care Partnership Report

State of Wisconsin Department of Health Services
CY 2024 Capitation Rate Development for PACE Program

November 14, 2023

This report assumes that the reader is familiar with the State of Wisconsin's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the PACE program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.



17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

michael.cook@milliman.com

November 14, 2023

Elizabeth Doyle, Section Manager
Long Term Care Rate Setting Section
Bureau of Rate Setting
Division Medicaid Services
1 West Wilson Street
Madison, WI 53701-0309
Sent via email: elizabeth.doyle@dhs.wisconsin.gov

Re: CY 2024 Family Care Partnership Capitation Rate Report

Dear Elizabeth:

Thank you for the opportunity to assist the Wisconsin Department of Health Services (DHS) with this important project. Our report summarizes the development of CY 2024 capitation rates for Wisconsin's Family Care Partnership program.



Elizabeth, please let us know if you would like to discuss further or have any other questions.

Sincerely,

A handwritten signature in black ink that reads "Michael Cook". The signature is fluid and cursive.

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

MCC/crl

Attachments

MILLIMAN REPORT

State of Wisconsin

Department of Health Services Calendar Year 2024 Capitation Rate Development for Family Care Partnership Program

November 14, 2023

[Michael Cook](#), FSA, MAAA
Principal and Consulting Actuary

[Briana Botros](#), FSA, MAAA
Consulting Actuary



17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com



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I. EXECUTIVE SUMMARY

This report documents the development of the January 2024 to December 2024 (CY 2024) capitation rates for Wisconsin's Family Care Partnership program. The Wisconsin Department of Health Services (DHS) retained Milliman to calculate, document, and certify its capitation rate development. The capitation rates developed in this report reflect only the Medicaid liability and exclude Medicare liability for Dual Eligible members. We developed the capitation rates using the methodology described in this report.

Our role is to certify that the CY 2024 Family Care Partnership capitation rates produced by the rating methodology are actuarially sound to comply with Centers for Medicare and Medicaid Services (CMS) regulations. We developed actuarially sound capitation rates using published guidance from the American Academy of Actuaries (AAA), CMS, and federal regulations to ensure compliance with generally accepted actuarial practices and regulatory requirements. Specific Actuarial Standards of Practice (ASOPs) we considered include:

- ASOP No. 1 – Introductory Actuarial Standard of Practice
- ASOP No. 5 – Incurred Health and Disability Claims
- ASOP No. 12 – Risk Classification
- ASOP No. 23 – Data Quality
- ASOP No. 25 – Credibility Procedures
- ASOP No. 41 – Actuarial Communications
- ASOP No. 42 – Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims
- ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 49 – Medicaid Managed Care Capitation Rate Development and Certification
- ASOP No. 56 – Modeling
- Other applicable standards of practice

CY 2024 CAPITATION RATES

The statewide average gross capitation rate for CY 2024 is \$4,815.10 for the Family Care Partnership population. Table 1 shows the statewide gross capitation rate change from the CY 2023 rate recertification dated September 19, 2023 to the CY 2024 capitation rates.

CY 2023 Rates	\$4,775.43
CY 2024 Rates	\$4,815.10
% Change	0.8%

The 0.8% increase in gross capitation rates from CY 2023 to CY 2024 can be broken down as follows:

- 3.3% decrease due to the actual CY 2022 base cohort LTC service costs compared to the CY 2022 costs predicted as part of CY 2023 rate development. The projection of CY 2022 costs in CY 2023 rate development included trend and programmatic rate increase estimates.

- 0.4% increase due to the difference in projected enrollment by target group from CY 2023 to CY 2024. Specifically, projected enrollment for the higher-cost DD target group increased by approximately 6.8%, and projected enrollment for the lower-cost PD target group decreased by approximately 1.4%.
- 0.1% increase due to projected acuity differences relative to CY 2023 rates.
- 0.4% increase due to the update of geographic factors from CY 2023 to CY 2024.
- 1.4% decrease due to differences in the CY 2022 to CY 2023 LTC trends estimated in CY 2023 rate setting compared to those used in CY 2024 rate setting.
- 0.5% increase due to the restatement of legislated changes in CY 2022 and CY 2023 nursing home reimbursement and personal care.
- 1.6% increase due to application of nursing home reimbursement and personal care to project CY 2023 to CY 2024.
- 1.3% increase due to the application of LTC service cost trends to project CY 2023 costs to CY 2024.
- 1.3% increase due to the application of LTC acuity trend to project CY 2023 acuity to CY 2024.
- 1.4% decrease due to the update of A&P base period data from CY 2021 to CY 2022.
- 0.3% increase due to the increase in the projection of Medicaid-only enrollment from CY 2023 to CY 2024; the proportion of Medicaid-only enrollees is projected to increase from 27.9% in 2023 to 29.2% in 2024.
- 0.1% decrease due to differences in the CY 2022 to CY 2023 A&P trends estimated in CY 2023 rate setting compared to those used in CY 2024 rate setting.
- 0.6% increase due to the application of CY 2023 to CY 2024 A&P trends.
- 0.1% increase due to application of Hospital Behavioral Health Increase to project CY 2022 to CY 2024.
- 0.5% increase due to the differences in the administrative loads as a percent of the capitation rates from CY 2023 to CY 2024.

Please note, the sum of the rate change drivers may not equal the total rate change, because the change drivers are calculated as multiplicative factors. The product of “one plus” each change driver equals “one plus” the total rate change.

The change in gross capitation rates for the DD, PD, and FE target groups is -4.3%, +8.8%, and -2.3%, respectively. The rate change by target group differs from the composite change due to differing base period data changes and target group-specific service cost and acuity trend values, and the varying impact of provider rate increases.

Projected CY 2024 expenditures split between federal and state liability are included in Exhibit L.

COVID-19 CONSIDERATIONS IN CY 2024 RATE DEVELOPMENT

The COVID-19 pandemic and determination of a public health emergency (PHE) have impacted health care costs significantly since March 2020. The impact of the COVID-19 pandemic and PHE on CY 2024 capitation rates is difficult to predict due to the evolving nature of the pandemic. To develop our best estimates of future costs, we considered a wide array of potential impacts based on information from publicly available sources, internal Milliman research, and MCO feedback. The program continues to include a risk corridor around target medical loss ratios to provide financial protection to the state and MCOs.

We applied the following methodological changes to reflect the impact of the COVID-19 pandemic on projected CY 2023 expenditures:

- Without the presence of the pandemic, Milliman would have used CY 2020 to CY 2022 experience to estimate trends to apply to CY 2022 experience to project it to a CY 2024 level. Due to the COVID-19 pandemic, CY 2020 costs were significantly depressed relative to CY 2019 levels, and thus we reverted to the three years of experience excluding the pandemic (CY 2019, CY 2021, and CY 2022) to estimate service cost trends.
- Claims for Adult Day Activities, Home Care, Transportation, and Vocational remained lower during the initial months of CY 2022, after which they appeared to stabilize at a higher level relative to those initial months. We applied scaling factors to adjust experience in these service categories incurred during early CY 2022 to reflect levels observed later in CY 2022, which are expected to continue through CY 2024.

The capitation rates do not currently include explicit provisions for expected vaccination administration fees or other costs related to COVID-19 in CY 2024 above CY 2022 levels. Should costs prove to be material and in excess of any continuing utilization decreases in CY 2024, we will consider revising capitation rates.

We made no other explicit adjustment for the PHE, since the 2022 experience utilization is generally consistent with pre-pandemic levels. For the categories of service not fully recovered to pre-pandemic levels, we either adjusted in the base data to reflect increases during 2022, or we still do not expect significant increases in 2024 relative to 2022.

METHODOLOGY CHANGES FROM CY 2023 RATES

This section describes significant methodology changes from the CY 2024 capitation rate methodology.

FCP Base Data

We are using the FCP LTC data directly as base data in rate setting this year. We reviewed a comparison of the FCP financials compared to encounters for CY 2022 and determined the data was substantially complete and appropriate for use in rate development after applying the adjustments outlined in Section IV of this report.

Risk Score Change Limits

In order to phase in changes to individual MCO revenues associated with changes in member assessment protocols and other potential changes, the preliminary CY 2024 risk scores are limited to a 2.0% increase or decrease from 2023 rates for each MCO and target group combination. We apply a factor to risk scores calculated from June 2023 member screens on the MCO and target group basis to limit this risk score change between years and re-normalize the risk scores on the projected CY 2024 enrollment.

Service Area Changes

Effective January 1, 2023, MCWHP began operations in GSR 9 and 13. We make the following assumptions in developing the various acute care and LTC costs for these regions:

- Exhibits D1 to D3 develop the acute and primary service cost based on the statewide average of the existing service areas and projected enrollment for MCWHP GSRs 9 and 13.
- Exhibits H1, H2, and H3 develop each target group risk score based on the statewide average for the existing service areas for CY 2022 and actual June 2023 snapshot enrollment.
- Exhibit I shows adjusted and trended values for each target group and in total. For the new service areas, we assume the following for each adjustment:
 - Columns D1 through D3 are based on the target group specific average.
 - Column D4 is based on the Geographic development by Super Region for GSR 9 and 13.
 - Columns D5 and D6 are based on the target group specific average.
- Exhibit J1 to J3 assumes the same PMPM administrative and percentage margin load as statewide.

DATA RELIANCE AND IMPORTANT CAVEATS

Milliman prepared this report for the specific purpose of developing CY 2024 Family Care Partnership capitation rates. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of DHS. We understand this report may be shared with participating MCOs, CMS, and other interested parties. Milliman does not intend to benefit, or create a legal duty to, any third party recipient of its work. This report should only be reviewed in its entirety.

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

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate CY 2024 capitation rates for Family Care Partnership. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We used MCO financial reporting, as well as encounter, eligibility, diagnostic, and functional screen data for CY 2019 through, CY 2022 and June 2023, and other information provided by DHS to develop the Family Care Partnership capitation rates shown in this report. We have relied upon this data and information provided by DHS for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose. Please see Appendix B for a full list of the data relied upon to develop the CY 2024 Family Care Partnership capitation rates.

Differences between the capitation rates and actual MCO experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. These rates may not be appropriate for all MCOs. Any MCO considering participating in Family Care Partnership should consider their unique circumstances before deciding to contract under these rates.

Michael Cook is an actuary for Milliman, member of the American Academy of Actuaries, and meets the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of his knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

II. BACKGROUND

Family Care Partnership is a full-risk, fully-integrated Medicaid-Medicare managed care delivery system for the full range of LTC and acute and primary care services, which strives to foster people's independence and quality of life. While most pharmacy services are carved out of the capitation rate, a small portion of pharmacy products are still included. Participating MCOs have contracts with both the State of Wisconsin and with CMS and receive monthly capitation payments from each entity for dually eligible beneficiaries. All of the dual enrollees in Family Care Partnership are in plans operating as Fully integrated Dual Eligible Special Needs Plans (FIDE-SNP).

Since 1999, Family Care Partnership has served people ages 18 and older with physical disabilities, people with intellectual / developmental disabilities, and frail elders, with the specific goals of:

- Improving quality of health care and service delivery, while containing costs
- Reducing fragmentation and inefficiency in the existing health care delivery system
- Increasing the ability of people to live in the community and participate in decisions regarding their own health care

Eligibility for Family Care Partnership is determined through the Wisconsin Long Term Care Functional Screen and detailed decision trees involving individual information about type of disability, activities of daily living, instrumental activities of daily living, and certain other medical diagnoses and health related services. All members in this program meet the Nursing Home Level of Care criteria. Enrollment in Family Care Partnership is voluntary. The risk adjustment model mechanism helps to adjust rates for any differences in average member acuity over time.

In 2024 the state will be comprised of 13 distinct GSRs for rate setting and other purposes, which are grouped into seven distinct Geographic Service Regions (GSRs), consistent with the Family Care program definitions, for rate setting and other purposes. However, the Family Care Partnership program is not operated in all counties within each GSR.

III. ACUTE AND PRIMARY SERVICE COST METHODOLOGY OVERVIEW

This section of the report describes the acute and primary service cost portion of the CY 2024 Family Care Partnership capitation rate methodology.

The methodology used to project the MCO encounter data underlying the calculation of the capitation rates can be outlined in the following steps:

1. Extract and summarize CY 2022 MCO encounter base experience data for the Dual Eligible and Medicaid Only populations by target group.
2. Further summarize CY 2022 MCO encounter base experience data by age and gender groupings.
3. Apply IBNR and other adjustments to project CY 2024 services costs.
4. Blend the projected CY 2024 service costs into a MCO / GSR specific projected cost.

Each of the above steps is described in detail below.

STEP 1: EXTRACT AND SUMMARIZE REPRICED ENCOUNTER BASE EXPERIENCE DATA

In this step we summarize the MCO encounter experience for CY 2022 by MCO / GSR and service category for the populations enrolled in the Family Care Partnership program.

Exhibits A1 and A2 show the summarized repriced CY 2022 MCO acute and primary base experience data by target group for the Dual Eligible and Medicaid only populations, respectively. Exhibit A3 shows repriced CY 2022 MCO encounter base experience data in composite.

Please see Appendix A for a map showing the counties included in each GSR.

Base Data

We received detailed MCO encounter claims data from DHS for claims with dates of service between January 2021 and December 2022 with dates of payment through February 2023. This encounter data includes both services for which Medicaid is the primary payer, as well as costs associated with Medicare cost sharing and expenditures related to coordination of benefits between Medicaid and Medicare.

We reviewed and summarized the data and compared to plan financial reporting and previous rate reports for accuracy and completeness. We did not identify any material concerns with the quality or availability of the data with respect to total claims in aggregate and detailed summaries by category of service.

Under the contract between DHS and the MCOs, the MCOs are not ultimately liable for acute and primary service costs, reimbursed up to the FFS fee schedule, for members meeting certain criteria associated with ventilator dependency. Therefore, we excluded all base period acute and primary costs for members identified using the same criteria.

Costs for most pharmacy services will be carved out of the Family Care Partnership program for CY 2024. The encounter data used to develop the acute and primary portion of the capitation rates excludes most pharmacy costs, including physician administered drugs, since these claims were reimbursed on an FFS basis in CY 2022 and will continue to be reimbursed on an FFS basis in CY 2024.

The base data used in capitation rate setting is net of historical recoveries of provider overpayments.

There are no in lieu of services provided to FCP enrollees in the base data or expected for the contract period.

It is our understanding that the base experience data complies with requirements of 438.602(i) in that no claims paid by an MCO to a provider outside of the United States are included in the base period data.

The CY 2024 rate methodology relies on CY 2022 MCO encounter data for all MCO / GSR combinations.

Target Group Assignment

The capitation rates rely on a member's classification into one of three target groups: Developmentally Disabled (DD), Physically Disabled (PD), and Frail Elderly (FE). Each Family Care Partnership enrollee is assigned a target group based on information collected using Long-Term Care Functional Screens (LTCFS), administered to program participants at least annually. The assigned target group is only valid for the period covered by the screen. Therefore, individuals could potentially change target groups at each screening.

For members in the PD or FE target groups as defined by LTCFS, we calculated the age for each member as of the first day of each enrollment month; thus, a member could be defined as PD in their most recent functional screen but would be assigned to the FE target group once achieving age 65. Based on this new age calculation, we transitioned a small number of members from FE members to the PD target group (if their calculated age was 64 or below) or from the PD target group to the FE target group (if their calculated age was 65 or above).

The base data shown in Exhibit A1 through A3 reflects this target group assignment.

STEP 2: SUMMARIZE CY 2022 MCO ENCOUNTER DATA BY AGE AND GENDER GROUPINGS

In this step we further summarize the base period experience data for both the Dual Eligible and Medicaid Only populations by age and gender category. The age / gender classification is used as a form of risk adjustment for both populations as described in Step 4 below. Because of the small number of Frail Elderly Medicaid Only beneficiaries, we do not project their service costs separately by age and gender.

Exhibit B1 shows the detailed summary of the base experience period data by age and gender groupings for each target group and Medicare eligibility status.

STEP 3: APPLY IBNR ASSUMPTIONS AND OTHER ADJUSTMENTS TO PROJECT CY 2024 SERVICE COSTS

In this step we apply an adjustment to the base period costs to account for outstanding service cost liability and to reflect differences between the base period encounter data and the projected CY 2024 Family Care Partnership program service costs. Each adjustment factor is explained in detail below.

Exhibit B1 shows each adjustment factor by category of service; Exhibit B2 shows the adjusted and trended values for each target group and age / gender breakout for each target group and Medicare eligibility status.

IBNR Adjustment

Due to the small enrollment base and amount of claim runout available to us, we developed a single completion factor of 1.0464. We developed this IBNR factor using all acute and primary data service categories except for pharmacy, which we assume is complete given two months of runout. We apply this factor consistent with this development to all service categories excluding pharmacy.

We used Milliman's *Claim Reserve Estimation Workbook (CREW)* to calculate the completion factor used for the CY 2022 data. *CREW* calculates incurred but not reported (IBNR) reserve estimates using the lag completion method.

The lag method reflects the historical average lag between the time a claim is incurred and the time it is paid. In order to measure this average lag, claims are separated by month of incurral and month of payment. Using this data, historical lag relationships are used to estimate ultimate incurred claims (i.e., total claims for a given incurral month after all claims are paid) for a specific incurral month based on cumulative paid claims for each month.

Service Cost, Utilization, and Acuity Trend from CY 2022 to CY 2024

We used trend rates to project the CY 2022 baseline cost data to the CY 2024 contract period, to reflect changes in provider payment levels, average service utilization and mix, and changes in member acuity. Separate trends were not developed for utilization, unit cost, and acuity. Milliman and DHS reviewed the following information to determine the annual trend rates:

- Historical encounter data experience
- Budgeted provider rate increases
- Known policy changes that may impact utilization patterns
- Industry experience for other comparable Medicaid programs

We reviewed experience trends for the Family Care Partnership program in recent years as the primary support for trend development. Due to the impact of COVID-19 on claim costs in CY 2020, it is included for informational purposes only. We used experience from CY 2017 through CY 2019 and CY 2021 to CY 2022 to determine A&P service cost trends. Given the large variances in experience trends, we did not feel comfortable using those trends at the category of service level. Instead, we used an overall trend rate of 5.0% applied to all services, consistent with historical experience for the Family Care Partnership programs.

Please see Exhibit M for a summary of historical A&P service cost trends from CY 2017 through CY 2019 and CY 2021 to CY 2022.

Treatment of IMD Costs

Effective July 5, 2016, federal regulation requires rate development to include special treatment for costs associated with stays in an Institution for Mental Diseases (IMD) for individuals between ages 21 and 64. We identified one IMD stay of over 15 days during CY 2022 for individuals in this age range. All experience for this member during this month was excluded from the base data as part of Step 1.

We observed 11 IMD stays of 15 days and under for Medicaid Only individuals in this age range during 2022, totaling approximately \$63,000. CMS requires IMD utilization for these stays to be based on the unit costs for State plan services. To be consistent with this requirement, we applied a unit cost adjustment factor of 0.80 to encounter base period IMD claims based on a comparison of the historical average cost per day for inpatient psychiatric stays and IMD stays for the comparable Medicaid Only population served under the SSI Medicaid managed care program.

Missing Data Adjustment

We developed a missing data adjustment in aggregate across all MCOs for CY 2022 based on a comparison of the total paid amounts in the encounter data and the total MCO liability in the financial data, excluding pharmacy and including IBNR estimates. We based this missing data adjustment on only experience for acute and primary claims. We combined FFS and sub-capitated claim payments together to develop the missing data adjustments, since the encounter data does not consistently and completely identify FFS versus sub-capitated claims separately. Therefore, the missing data adjustment reflects the impact of missing encounters (including sub-capitated claims), as well as encounters that were submitted, but not accepted by the DHS system edits. The only sub-capitated arrangement is for dental services for one MCO, so the value of sub-capitated claims is very small as a percentage of total costs. DHS has carefully reviewed the discrepancies between encounter and financial data and believes the costs missing from the encounter data represent valid costs for rate development. We have no concerns with the results of the DHS review.

After accounting for IBNR, the financial to encounter data difference was less than 1%, and therefore, we do not make an adjustment for missing data in FCP A&P.

Hospital Behavioral Health Increase

Effective January 1, 2024, DHS is implementing an increase to reimbursement rates for inpatient hospital services provided in a behavioral health unit of a general medical and surgical hospital.

Based on a claim level review of a similar population, inpatient hospital service costs for the Medicaid only population in the Family Care Partnership program are expected to increase by 2.4% for these services.

STEP 4: BLEND PROJECTED SERVICE COSTS BY TARGET GROUP

In this step we blend the projected CY 2024 service costs for each target group, Medicare eligibility status, and age / gender grouping based on the projected CY 2024 target group membership. Exhibit C shows the projected CY 2024 enrollment distribution while Exhibits D1 to D3 show the blended acute and primary service cost by MCO / GSR / Target Group for the Dual Eligible, Medicaid Only, and total populations, respectively.

The age / gender and target group breakout is used as a form of risk adjustment for both the Dual Eligible and Medicaid Only population, since the costs can materially differ among these demographic groups.

IV. LONG-TERM CARE SERVICE COST METHODOLOGY OVERVIEW

This section of the report describes the CY 2024 Family Care Partnership capitation rate methodology for the Long-Term Care portion of the rate.

The methodology used to calculate the LTC portion of the capitation rates can be outlined in the following steps:

1. Extract and summarize CY 2022 MCO encounter base experience data for the FCP LTC benefit package by target group.
2. Apply IBNR assumptions and other adjustments to project CY 2024 services costs.
3. Calculate MCO / GSR specific risk adjusted base rates using June 2023 screens and the functional status acuity model relativities.
4. Apply adjustments to the risk adjusted base rates to project CY 2024 services costs for each MCO / GSR combination and target group.
5. Blend the projected CY 2024 service costs, including allowances for non-benefit costs, by target group into an MCO / GSR specific projected cost.

Each of the above steps is described in detail below.

STEP 1: EXTRACT AND SUMMARIZE ENCOUNTER BASE EXPERIENCE DATA

In this step the MCO encounter experience for CY 2022 is summarized by MCO / GSR and service category for the FCP LTC population.

DHS and Milliman performed a substantial review of the CY 2022 experience. For most service categories, CY 2022 experience rebounded to pre-pandemic levels. However, certain service categories did not stabilize until the later months of CY 2022. We thus elected to use CY 2022 data for the purposes of CY 2024 rate setting with adjustments for select service categories (detailed in Step 2 below).

Exhibit E shows the summarized CY 2022 MCO encounter base experience data by MCO / GSR combination and target group.

Base Data

We received detailed MCO encounter claims data from DHS for claims with dates of service between January 2021 and December 2022 with dates of payment through February 2023. This data reflects payments net of any third-party liability. These costs are also gross of member cost share / patient liability, as DHS adjusts capitation payments to MCOs for each member to reflect that particular member's cost share (also known as Post Eligibility Treatment of Income).

We believe the encounter data is of appropriate quality and completeness to use as the primary basis for developing actuarially sound rates for the Wisconsin Family Care Partnership program. We reviewed the data and validated both provider service and case management expenditures against financial statements for accuracy and completeness of the data provided. We ultimately included a missing data adjustment as a result of this review as outlined later in this section.

The base period data includes only those individuals actually enrolled in the Wisconsin Family Care Partnership program, so no adjustment for retroactive eligibility periods is needed. The base experience data also excludes 0.06% of total expenses for which there is not a corresponding member eligibility record. No member supplemental room and board expenses are included in the base data. The base data used in capitation rate setting is net of historical recoveries of provider overpayments.

The CY 2024 rate methodology relies on CY 2022 MCO encounter data for all MCOs in all GSRs.

There are no in lieu of services provided to FCP enrollees in the base data or expected for the contract period.

MCOs provided attestations that the base experience data complies with requirements of 438.602(i) in that no claims paid by an MCO to a provider outside of the United States are included in the base period data.

Target Group Assignment

The FCP capitation rates rely on a member's classification into one of three target groups: Developmentally Disabled, Physically Disabled, and Frail Elderly. Each Family Care Partnership enrollee is assigned a target group based on information collected using LTCFS, administered to program participants at least annually. The assigned target group is only valid for the period covered by the screen. Therefore, individuals could potentially change target groups at each screening.

For members in the PD or FE target groups as defined by LTCFS, we calculated the age for each member as of the first day of each enrollment month; thus, a member could be defined as PD in their most recent functional screen but would be assigned to the FE target group once achieving age 65. Based on this age calculation, we transitioned a small number of members from FE members to the PD target group (if their calculated age was 64 or below) or from the PD target group to the FE target group (if their calculated age was 65 or above).

The experience summaries shown in Exhibit E reflects this target group assignment.

Case Management Expenditures

Case management expenditures are included in the base cohort data as a service cost, consistent with contract terms. The case management expenses are trued up to financial statements due to the difficulty in properly and completely reporting full service cost information in the encounter data format.

Table 2 below shows the CY 2022 encounter data to financial statement reconciliation adjustment for case management expenditures.

Table 2 Wisconsin Department of Health Services Family Care Partnership Encounter Data to Financial Statement Reconciliation Adjustment For Case Management Services	
MCO	CY 2022
MCWHP	36.28%
CCHP	1.71%
iCare	5.39%

**Adjustments are negative when case management reported in financials are less than the case management amounts included in encounters.*

Non-Covered Services Adjustments

We removed approximately 0.97% of expenditures for services not covered under the Family Care Partnership benefit set from the base data. This includes any payments made for member supplemental room and board expenses not included in the Institutional or Residential categories of service. No services were provided in lieu of a covered service for the FCP LTC population.

Sub-Capitated Services

The base data includes sub-capitated services for one MCO that contracts for sub-capitated services for Transportation with a vendor unrelated to the MCO. However, the encounters for this service were substantially incomplete, and we included costs in the base data from the financial reporting instead.

STEP 2: APPLY IBNR ASSUMPTIONS AND OTHER BASE DATA ADJUSTMENTS

IBNR

We used Milliman's *Claim Reserve Estimation Workbook (CREW)* to calculate the incurred but not reported (IBNR) adjustment factors shown in Table 3 below. We developed Completion factors (CFs) by MCO in aggregate across all service types due to the small magnitude of the adjustments, using experience data for the FCP LTC population. *CREW* calculates incurred but not reported (IBNR) reserve estimates by blending two different estimation methods: the lag completion method and the projection method.

The lag method reflects the historical average lag between the time a claim is incurred and the time it is paid. To measure this average lag, claims are separated by month of incurral and month of payment. Using this data, historical lag relationships are used to estimate ultimate incurred claims (i.e., total claims for a given incurral month after all claims are paid) for a specific incurral month based on cumulative paid claims for each month.

The projection method develops estimates for incurred claims in recent incurral months by trending an average base period incurred cost per unit to the midpoint of the incurred month at an assumed annual trend rate and applying an additional factor to account for the seasonality of claim costs and the differing number of working days between months. The base period is chosen by selecting a group (usually 12) of recent consecutive months for which the lag completion method provides reasonable results.

The lag completion and projection methods are combined to produce the final incurred claim estimate. Final incurred claim estimates are calculated as a weighted average of these two methods. Because of the amount of claim runoff available in the encounters, no weight is placed on the projection method results.

Exhibit N provides additional detail on the calculation of the IBNR adjustments applied to each MCO's CY 2022 experience data. This exhibit includes CY 2022 provider services paid through February 2023, estimated incurred claims and outstanding liability, and the implied IBNR adjustment factor for each incurred month. Table 3 below shows the cumulative IBNR adjustment applied to the CY 2022 experience data. While our IBNR calculation accounts for outstanding provider service costs, in practice the adjustment factor is applied to both provider service costs and case management; as such, the adjustment factors shown in Table 3 are slightly dampened from those underlying Exhibit N to account for the proportion of base period experience attributable to case management to avoid double counting.

Because of the unusual provider payment patterns in recent time periods, we use the completion factors developed for the remaining FCP MCOs in aggregate to complete one of the MCO's CY 2022 claims.

Table 3 Wisconsin Department of Health Services Family Care Partnership Program LTC IBNR Adjustment Factors	
MCO	IBNR Factor
MCWHP	1.0180
CCHP	1.0187
iCare	1.0182

COVID-19 Impacted Services Adjustment

For the FCP LTC population, claims in the Adult Day Activities, Home Care, Transportation, and Vocational service categories claims remained lower during the initial months of CY 2022, after which they appeared to stabilize at a higher level relative to those initial months. We thus performed the following steps to increase these claims incurred during early CY 2022 to levels observed later in CY 2022, as shown by Exhibit O:

-
- A. We determined the first month in CY 2022 during which services stabilized:
 1. For the DD population:
 - i. June for Adult Day Activities.
 - ii. March for Home Care.
 - iii. August for Vocational services.
 2. For the PD population:
 - i. July for Home Care services.
 - ii. March for Vocational services.
 3. For the FE population:
 - i. February for Adult Day Activities.
 - ii. July for Home Care services.
 - iii. March for Transportation services.
 - B. We compared the costs in the months prior to these stabilized months (the “low claim period”) to months including and following these months (the “high claim period”).
 - C. We calculated the increase in the low claim period to the high claim period after consideration for seasonality seen prior to the PHE.
 - D. We calculated the aggregate factor across all CY 2022 claims, including the factor calculated by Step C applied to claims incurred during the low claim period during CY 2022 blended with a 1.00 factor applied to claims incurred during the high claim period during CY 2022.

Exhibit F shows the application of the results from Step D above to the proportion of CY 2022 claims in these service categories blended with a 1.00 factor for all other service categories.

Missing Data and Nursing Home Accrual Adjustment

We developed a missing data adjustment in aggregate across all MCOs for CY 2022 based on a comparison of the total paid amounts in the encounter data and the total MCO liability in the financial data, including IBNR estimates. This missing data adjustment represents FCP LTC encounters that were submitted, but not accepted by the DHS system edits and estimates of the retrospective nursing home rate increase amounts reported in MCO financials, but not yet reflected in encounters or in the typical claim payment patterns underlying the IBNR factors. This was limited to not exceed financials and the total MCO liability reported in the financial data, including IBNR estimates. DHS has carefully reviewed the discrepancies between encounter and financial data and believes the costs missing from the encounter data represent valid costs for rate development. We have no concerns with the results of the DHS review.

Through these data adjustments, we increase the encounter data to reflect the retrospective nursing home rate increase amounts reported by MCOs and missing sub-capitated encounters (as described below) in Exhibit F. Other than these issues and IBNR, we deemed the base data as substantially complete.

Sub-Capitation Adjustment

The only sub-capitated arrangement is for transportation services for one MCO. We increase the encounter data to reflect the full amount of the sub-capitation arrangement from the financial data in Exhibit F.

Case Management Associated with Medicare Services Adjustment

We developed a data adjustment for CY 2022 to remove the portion of case management associated with managing Medicare-covered services. We estimate the portion of costs to remove based on the portion of the total revenue associated with Medicare revenue reported in the financial data. We decrease the encounter data to reflect only the amount of case management applicable to managing Medicaid services in Exhibit F.

STEP 3: CALCULATE MCO / GSR SPECIFIC RISK ADJUSTED BASE RATE USING JUNE 2023 ENROLLMENT AND THE FUNCTIONAL STATUS ACUITY MODEL RELATIVITIES

For CY 2024 rate setting, Milliman developed the FCP regression models using individuals' functional status to predict costs from MCO-reported experience for CY 2021 and CY 2022. This model is a budget-neutral risk adjustment, which is used to adjust the data to better reflect the acuity of the population covered under each MCO / GSR relative to the base data cohort. We used two years of combined Family Care and FCP data in order to improve the credibility and stability of the models. We developed risk weights for each of the three target groups independently using the corresponding population's functional screen, claim, and eligibility data. Wisconsin's LTCFS system provided the member level detail underlying each model.

The attached Exhibits G1 through G3 show the FCP functional status acuity models for the DD, PD, and FE populations, respectively. 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.

Table 4 below provides a high-level comparison between the CY 2023 and CY 2024 models for each target group:

Table 4			
Wisconsin Department of Health Services			
Family Care Partnership			
Comparison of CY 2023 and CY 2024 Functional Status Models			
Family Care Partnership			
	Developmentally Disabled	Physically Disabled	Frail Elderly
CY 2024 R ²	+43.7%	+43.0%	+34.0%
CY 2023 R ²	+43.8%	+42.9%	+34.9%
R ² Percentage Change	-0.1%	+0.1%	-0.9%

The "Proportion with Variable" statistics shown in Exhibit G represent the proportion of the base cohort target group population identified with each variable used in the regression model. This is identified directly from a review of an individual's functional screen. It is calculated as "Number of individuals with condition" divided by "Number of individuals in the target group base cohort."

The "Statewide Estimate" in Exhibit G represents the estimated incremental dollar cost associated with each variable for the entire target group base data cohort. The values are the result of the multivariable linear regression exercise.

The product of the statewide estimate and the proportion with variable equals the "incremental increase" value. The sum of the incremental increase values equals the total PMPM target group base data cohort cost. For example, the sum of the incremental increase values on Exhibit G1 is \$4,313.91, which is equal to the completed DD base data cost shown on Exhibit F.

Exhibits H1A, H2A, and H3A develop the restated base period costs for each MCO / GSR combination, as modeled by the functional status acuity model. The acuity model is normalized to be budget neutral across all base data GSRs. Therefore, the CY 2022 costs for each target population base data cohort are unaffected in total.

Exhibits H1B, H2B, and H3B develop the final composite risk score as modeled by the functional status acuity model using the June 2023 FCP population enrollment. For credibility purposes, each MCO / GSR / target group combination with fewer than 100 members enrolled in June 2023 will use a blend of the MCO-specific regression results and the regression results for the entire GSR / target group combination. We calculate the credibility-adjusted regression result using the following formulas:

$$\text{Adjusted Regression Result} = \text{Credibility\%} \times \text{MCO / GSR / TG Risk Score} + (1 - \text{Credibility\%}) \times \text{GSR / TG Risk Score}$$

$$\text{Credibility\%} = \text{MIN} \left[\sqrt{\frac{\text{June Enrollment}}{100}}, 100\% \right]$$

MCOs with 100 members or more enrolled in a particular GSR and target group in June 2023 are considered fully credible.

In order to phase in changes to individual MCO revenues associated with changes in member assessment protocols and other potential changes, the bottom lines of Exhibits D1B, D2B, and D3B limit the preliminary 2024 risk scores to a 2.0% increase or decrease from 2023 rates for each MCO and target group combination. We apply a factor to risk scores calculated from June 2023 member screens on the MCO and target group basis to limit this risk score change between years and then re-normalize the risk scores on the projected CY 2024 enrollment.

STEP 4: APPLY ADJUSTMENTS TO THE RISK ADJUSTED BASE RATE TO PROJECT CY 2024 SERVICE COSTS

In this step, we apply adjustment factors to reflect differences between the base period encounter data and the projected CY 2024 Family Care Partnership program service costs. Each adjustment is explained in detail below.

Exhibit I shows adjusted and trended values for each target group and in total.

Service Cost Trend from CY 2022 to CY 2024

Service cost trend rates were used to project the CY 2022 baseline cost data to the CY 2024 contract period, to reflect changes in provider payment levels and changes in average service utilization and mix. This requires application of 24 months of trend from the midpoint of the baseline cost period to the contract period.

To assist in developing these trend rate projections, we analyzed monthly Family Care Partnership MCO encounter data from CY 2019 through 2022 encounter data, excluding CY 2020 in several different ways using data consistent with the Family Care Partnership MCO / GSR combinations included in base data development. Due to the impact of COVID-19 and public health emergency on CY 2020 costs, we do not use PMPM trends between CY 2019 to CY 2020 or CY 2020 to CY 2021 for CY 2024 rate setting.

To consistently compare experience across all years of the trend study we adjusted member target groups determined via screens collected before June 2019 to match the target group automation algorithm in place beginning in June 2019. Additionally, to ensure we are not double counting any program change adjustments in trends, we have repriced all claims to a December 2022 level to account for the following programmatic changes already reflected in rates:

- CY 2020 to CY 2022 FFS nursing home rate changes
- DME FFS rate changes
- Personal Care FFS rate changes
- 2021 HCBS Increase
- 2022 ARPA Increase
- 2022 Budget Increases

All trends described below are inclusive of this claim repricing.

Results of the Family Care Partnership trend analysis are shown in Exhibit P1. Due to the small size and incompleteness of the encounter data in Family Care Partnership in 2019 and 2021, as well as the size of the calculated negative service cost trends and high acuity trends, we use the acuity and cost trends summarized for the Family Care population. Given the significant similarity of covered populations, benefits, provider reimbursement, and geography between the Family Care and Family Care Partnership populations, we believe the Family Care trend rates are the most appropriate to use for the Family Care Partnership population.

Exhibit P2 summarizes the results of our CY 2019 through 2022 encounter data, excluding CY 2020 trend analysis for the Family Care population. Based on this analysis, we selected trends of 1.8%, 1.4%, and 1.1% for the DD, PD, and FE target groups, respectively. The annualized acuity-adjusted service cost trends between 2019 to 2021 continue to be negative, as CY 2021 costs did not rebound fully to pre-pandemic levels and are not representative of future costs. The annualized trends between 2021 to 2022 include the impact of the claim costs further rebounding from the COVID-19 pandemic and are higher than we would expect to continue from 2022 to 2024. We note, the FE target group shows these same patterns though not as significantly as the DD and PD target groups. Therefore, we use 50% of the annualized trend between 2021 to 2022 for DD and PD and 75% for FE.

Table 5 illustrates the service cost trend values implemented for the CY 2024 rate development split between utilization and unit cost trends for each target group. DHS performed an analysis of residential and institutional reimbursement rates over time to develop the unit cost projections. Other services did not realize unit cost changes that materially impact total costs outside of program changes that are accounted for separately. Utilization trends are then calculated to arrive at the targeted PMPM trend after the unit cost emerging experience adjustment described in the previous paragraph. This analysis supports the idea that substantially all recent service cost trend is associated with increases in provider unit costs. We believe that increased utilization rates are reflected in the acuity trend addressed in the next section of this report.

Table 5 Wisconsin Department of Health Services Family Care Partnership Annual Trend Rates by Targe Group			
Target Group	Utilization Trend	Unit Cost Trend	PMPM trend
Developmentally Disabled	0.00%	1.80%	1.80%
Physically Disabled	0.00%	1.40%	1.40%
Frail Elderly	0.00%	1.10%	1.10%

Acuity Trend from CY 2022 to CY 2024

In addition to the above service cost trends, which determine historical cost increases on a risk-neutral basis, we also apply acuity trends to CY 2022 experience to reflect expected population acuity changes from CY 2022 to CY 2024. In order to be consistent with our selection of service cost trends net of acuity, as well as our concerns about the high acuity trends in the Family Care Partnership trend study, we used the same acuity trends as used for the Family Care program.

To develop these acuity trends, we analyzed annual risk scores from CY 2019 through 2022, excluding CY 2020 for each target group independently. We used these risk scores to calculate the annual trend from CY 2019 through 2022, excluding CY 2020, as shown in Exhibit P2. The selected annual trends, shown in Table 6 below, will be used to acuity trend CY 2022 to CY 2024.

Table 6 Wisconsin Department of Health Services Family Care Partnership Annual Acuity Trend Rates by Target Group	
Target Group	Annual Acuity Trend
Developmentally Disabled	1.10%
Physically Disabled	2.40%
Frail Elderly	1.00%

Because the service cost trends in the previous section are net of changes in member acuity, there is no double-counting between the service cost and acuity trends.

Geographic Adjustment

The functional status acuity model does not include a consideration for the difference in service costs associated with providing care in different regions of the state. Therefore, we developed geographic factors based on an analysis of CY 2022 plan performance relative to the costs projected using the regression model and rate setting assumptions. CY 2019 through CY 2021 costs were materially impacted by the public health emergency and due to the small size and incompleteness of the encounter data, are excluded from this analysis. The results of this analysis are shown in Exhibit Q and are applied on Exhibit I. The methodology to calculate the geographic factors is as follows:

1. We summarize actual Family Care Partnership experience by MCO / GSR combination using MCO encounter data for each of CY 2022. The following adjustments are made to MCO encounter data, consistent with the treatment in rate development:

- a. Services covered outside of the capitation rate are excluded, such as supplemental net member room and board expenses.
 - b. Case management expenses, which are historically underreported in the MCO encounter data, are adjusted to match the values reported in the MCO's financial data.
 - c. An adjustment has been made to the reported amounts to reflect our estimate of incurred but not reported (IBNR) claims.
2. We normalized the actual to expected results, such that within each given year of data used for the geographic factor analysis, all base data GSRs aggregate to a 1.0 actual to expected ratio.
 3. The preliminary geographic adjustment factor is calculated as the ratio of actual and expected costs. The projected costs serve as a form of "risk adjustment" to account for differences in target group, member acuity and other issues between GSRs that are already accounted for in MCO payment and should not be part of the geographic factor calculations. Exhibit Q shows this calculation for each GSR.
 4. The 2024 geographic adjustment factor is calculated as the average of 1) the ratio of actual and projected Family Care Partnership costs for CY 2022 and 2) the geographic factors developed for the 2023 rate setting. In this way, the revenue distribution change across GSRs caused by moving to directly using Family Care Partnership experience in the geographic factors is spread out over two years. Note, the geographic factors developed in 2023 rate setting relied on Family Care data for all GSRs except GSR 12 and are reweighted to reflect CY 2022 FCP experience.
 5. For GSR 13 only, we give 100% weight to the CY 2023 rate setting result because operations in GSR 13 do not begin until January 1, 2023.
 6. As part of capitation rate development, we scale the preliminary geographic factors to maintain budget neutrality relative to the Family Care Partnership MCO / GSR combinations used in base data development. This budget neutrality adjustment will be performed separately for each target group. Table 7 below shows the normalization factor applied to the preliminary geographic adjustment factors by target group.

Target Group	Normalization Factor
Developmentally Disabled	0.9906
Physically Disabled	0.9914
Frail Elderly	1.0161

To increase the credibility of this calculation and to limit the maximal market share achieved by a single MCO, the geographic factors for certain GSRs are calculated as the combination of results across several GSRs. These combinations are referred to as "Super Regions" in Exhibit Q.

Nursing Home Rate Adjustment

The Wisconsin biennial budgets direct DHS to provide a 14.1% rate increase for SFY 2022, an additional 23.1% increase for SFY 2023, and an additional 23.4% increase for SFY 2024. Based on historical rate increases and guidance from DHS, we assume an additional 3.0% increase for SFY 2025. We applied an adjustment specific to each target group and GSR based on the proportion of service costs for nursing home services in CY 2022. Table 8 shows the calculation of this adjustment, which is included in Exhibit I.

Table 8
Wisconsin Department of Health Services
Family Care Partnership
Nursing Home Rate Adjustment

GSR	Percentage of Nursing Home Cost in CY 2022			Adjustment Factor		
	DD	PD	FE	DD	PD	FE
GSR 3	7.3%	36.6%	32.8%	1.0260	1.1332	1.1190
GSR 5	13.5%	22.3%	19.9%	1.0482	1.0802	1.0716
GSR 6	19.7%	20.0%	37.1%	1.0708	1.0720	1.1350
GSR 8	12.0%	12.8%	19.2%	1.0430	1.0459	1.0688
GSR 9	11.3%	12.8%	19.9%	1.0405	1.0458	1.0715
GSR 10	6.8%	16.1%	14.2%	1.0241	1.0577	1.0507
GSR 11	5.8%	10.2%	15.7%	1.0207	1.0364	1.0563
GSR 12	11.1%	10.4%	18.1%	1.0396	1.0370	1.0650
GSR 13	11.3%	12.8%	19.9%	1.0405	1.0458	1.0715

Personal Care Rate Adjustment

DHS increased fee-for-service personal care rates from \$20.80 per hour in CY 2022 to \$23.44 per hour in CY 2023, and \$24.51 per hour in CY 2024. Personal care costs represented between 1.23% and 2.74% of base period costs across the three target groups. Applying these rate increases to these portions of the cost results in adjustments of 0.25%, 0.47%, and 0.21% for the DD, PD, and FE target groups, respectively. This adjustment is made in Exhibit I.

STEP 5: BLEND PROJECTED SERVICE COSTS BY TARGET GROUP

In this step we blend the projected CY 2023 MCO / GSR service costs for each target group based on the composite projected CY 2023 target group membership. The blended costs are reflected in the bottom section of Exhibit I. However, these blended service costs are for illustrative purposes only, since the capitation payment system pays separate capitation rates for each target group.

V. NON-SERVICE COST ALLOWANCE

This section of the report describes the development of the non-service cost allowance for the CY 2024 Family Care Partnership capitation rate. Non-service expense loads and resulting capitation rates are shown in Exhibits J1 through J3. Exhibits K1 through K3 restate the components of the MCO / GSR capitation rates net of withhold. However, the blended rates in Exhibits J and K are for illustrative purposes only, since the program information technology started paying separate capitation rates for each target group in 2022.

ADMINISTRATIVE COST ALLOWANCE

In order to develop administrative costs, DHS and Milliman reviewed program experience from plan reported financial summaries for CY 2022. We set overall CY 2024 administrative costs based on the CY 2022 administrative cost PMPM level with two years of 4.0% annual trend applied, which is comparable to recent Employment Cost Index calculations published by the Bureau of Labor Statistics. This trend adjustment considers the high levels of inflation and wage growth seen in early 2023 at 5% trend for CY 2022 to CY 2023 and the expectation of the return to the historical average in 2024 at 3% trend from CY 2023 to CY 2024.

This results in an overall CY 2024 administrative load of \$244.50 PMPM for Family Care Partnership.

TARGETED RISK MARGIN / CONTRIBUTION TO RESERVES

We include an explicit 2.0% targeted margin to account for risk margin and cost of capital. We believe that this margin is appropriate given the predictability of expenses under the program, the existence of a permanent risk corridor mechanism, and margins included for similar programs nationally. All of the 0.5% P4P withhold is expected to be returned to MCOs as described in Section VI of this report.

VI. OTHER RATE CONSIDERATIONS

All calculations and actual and potential adjustments outlined in this section have been developed in accordance with generally accepted actuarial principles and practices.

RISK CORRIDOR

For CY 2024 Family Care Partnership will continue to have a risk corridor mechanism to mitigate the uncertainty associated with the unique ownership and operational circumstances that some MCOs in this program face. The risk corridor will address variances in costs for all services other than care management. The pricing assumptions in this report create an average target risk corridor loss ratio of 84.5%, excluding care management, based on the following components:

- Average administrative allowance of 5.1%
- Average care management load of 8.4%:
 - DD target group – 6.8%
 - PD target group – 7.9%
 - FE target group – 10.7%
- Margin of 2.0%

MCO / GSR-specific administrative allowance and care management loads will be developed to match actual target group mix, LOC mix and pricing assumptions made in rate development. Note, the actual rate development MLR including covered care management services is well above the 85% minimum required under federal regulation.

DHS and each MCO will share the marginal financial risk of actual results above or below the target risk corridor loss ratio as shown in the table below.

Variance from Target	Average Loss Ratio Claims Corridor	MCO Share of Gain / Loss in Corridor	DHS Share of Gain / Loss in Corridor
< -6.0%	< 78.5%	0%	100%
-6.0% to -2.0%	78.5% to 82.5%	50%	50%
-2.0% to +2.0%	82.5% to 86.5%	100%	0%
+2.0% to +6.0%	86.5% to 90.5%	50%	50%
> +6.0%	> 90.5%	0%	100%

The risk corridor settlement will occur after the CY 2024 rate year has ended and enough time has passed to collect and validate CY 2024 encounter data and financial data with sufficient run-out. We anticipate performing an initial settlement no earlier than four months after the rate year has ended and a final settlement no earlier than nine months after the rate year has ended.

Only medical benefit services costs, as defined in the contract and this report, other than care coordination, will be included in the numerator of the loss ratio calculation for the risk corridor program. Care coordination, quality improvement, and other non-medical benefit service costs will not be included in the numerator of the loss ratio calculation, consistent with the development of the target risk corridor target loss ratio. All capitation revenue, assuming 100% return of withhold, will be included in the denominator of the loss ratio calculation, other than any incentive payments earned.

Consistent with contract expectations, DHS expects reimbursement made for medical benefit services should be at market-based levels and should incent efficient and high-quality care. As such, DHS reserves the right to review encounters and other information associated with such payments and adjust the risk corridor calculation as necessary to reflect those expectations.

WITHHOLDS AND INCENTIVES

The total value of incentives outlined in this section will not exceed 5% of total capitation received by any Family Care Partnership MCO.

Pay for Performance Withhold and Incentive

Beginning in CY 2018, DHS implemented pay for performance (P4P) in the Family Care Partnership program. For CY 2024, DHS intends to withhold 0.5% of each MCO's gross capitation rate. MCOs will be allowed to earn back the withhold based on their performance on the following metrics:

1. MCOs that complete an interest inventory for community connections with cohort sampling at 90% (+/-5%) confidence level will earn back 0.10% withheld from the capitation. If the MCO meets the interest inventory standard, it is eligible to earn back 0.10% withheld from the capitation for having outcome and completed follow up activity for 90% of assessed members that are interested or may be interested. MCOs that complete quarterly data reporting on key performance indicators and summarizing study / act phases of Plan-Do-Study-Act will earn back 0.05% withheld from the capitation.

If the MCO meets all three of the withhold standards, it is eligible to receive up to an additional 0.20% incentive for completing stakeholder and community related activities. The MCO will receive 0.10% for quarterly Stakeholder Advisory Council Committee and one residential provider meeting, 0.05% for quarterly local provider stakeholder collaboration committee meetings in each GSR, and 0.05% for Community Readiness assessment in each GSR.

2. MCOs that maintain between 80% and 89% of their current competitive integrated employment rate will earn back 0.125% withheld from the capitation. MCOs that maintain between 90% and 100% of their current competitive integrated employment rate will earn back 0.25% withheld from the capitation.

MCOs will earn an incentive of 0.05% of the capitation if they increase the number of members in competitive integrated employment by between 2.0% and 3.9% and an incentive of 0.1% if they increase the number of members by at least 4.0%.

Based on past performance and expectations under measure revisions, DHS and Milliman assume all of the 0.5% withhold will be returned to MCOs under the pay for performance terms, assuming no material changes to the program are made. These capitation rates are certified as being actuarially sound assuming that all of the 0.5% withhold is returned.

Assisted Living Quality Incentive Payment

MCOs may receive incentive payments of no more than 0.1% of the total capitation received for each member residing in assisted living facilities that meet one of three performance benchmarks. The amount of the incentive payment depends on which of the three performance benchmarks the facility meets:

1. Licensed for three years, compliant with Home and Community-Based Services settings rule, and with no enforcement actions or substantiated complaints for three years.
2. Licensed for three years, compliant with Home and Community-Based Services settings rule, and with no enforcement actions or substantiated complaints for three years; has a rate of less than three falls with injury per 1,000 occupied bed days and is a member of the Wisconsin Coalition for Collaborative Excellence in Assisted Living in good standing.
3. Collectively increasing the statewide average of assisted living facilities and have at least one member residing in the setting and be a member of the Wisconsin Coalition for Collaborative Excellence in Assisted Living with a membership status of new member, regular member, or gold member.

Transition Incentive Payment

DHS may provide a one-time incentive payment to the Family Care Partnership MCO for each MCO member who is relocated from an institution into a community setting consistent with federal Money Follows the Person (MFP) guidelines, contingent on the availability of federal MFP funding.

ALTERNATIVE PAYMENT ARRANGEMENTS

The following describes alternative payment arrangements in the Family Care Partnership program. Additional documentation of these arrangements is provided in our response to the CMS Medicaid Managed Care Rate Development Guide in Appendix D.

We certify that the Family Care Partnership capitation rates, including these alternative payment arrangements, are actuarially sound.

Maximum Provider Fee Schedule

Per the contract between DHS and the participating MCOs, State Plan services provided under the Family Care Partnership benefit package are subject to a maximum fee schedule established by the state. The use of this maximum fee schedule promotes efficient and cost-effective care by controlling the growth in Medicaid expenditures. Most providers of State Plan services are subject to the maximum fee schedule, though MCOs have the ability to exceed the limit when necessary for executing a reimbursement contract. This arrangement does not include a separately distributed directed payment. DHS will submit a §438.6(c) pre-print proposal for an alternative payment arrangement to implement the maximum fee schedule for CMS approval. We built the maximum fee schedule into rates in a manner consistent with the §438.6(c) payment arrangement.

We developed the base data and Partnership experience adjustment discussed in Sections III and IV of this report using historical Family Care and Partnership experience, which reflects the long-standing maximum fee schedule arrangement and approved exceptions. We expect no material change to the total value of exceptions made over the maximum fee schedule, which was \$0 for 2022 base data. We used this base data to develop rates for all regions, including expansion regions. No further adjustment to provider reimbursement levels is made as part of rate development.

Direct Care Workforce

Wisconsin Statute §49.45(47m) directs DHS to make payments for CY 2024 services to Family Care Partnership MCOs to distribute to direct care workforce (DCW) providers. DHS will estimate the value of these payments for CY 2024 for the final certification. The 2022 to 2024 Wisconsin biennial budget includes additional funding for these providers and the estimated total for CY 2024 is \$146 million of which \$8.8 million is estimated to be allocated to Family Care Partnership. These payments will be made retrospectively after the conclusion of the rate year and are intended to be consistent with an §438.6(c) payment arrangement, which has not been submitted. Providers of the following services are eligible for these payments:

- Providers of adult day care services
- Daily living skills training
- Habilitation services
- Residential care
- Respite care provided outside of a nursing home
- Supported employment
- Prevocational employment
- Vocational futures planning
- Supportive home care

Exhibit R includes a preliminary estimate of the allocation of total DCW funding for each MCO / GSR combination. We allocated the total funding between the Family Care NH LOC, Family Care Non-NH LOC and FCP programs and between MCO / GSR combinations within each program using actual CY 2022 MCO expenditures. We then developed PMPM values using projected CY 2024 MCO / GSR enrollment.

HCBS Provider Rate Increase – Effective June 2021

Effective June 1, 2021, DHS is requiring MCOs participating in Family Care Partnership to increase provider reimbursement rates for certain home and community-based services. This increase is 4.24% for eligible providers. No explicit adjustment was necessary as part of this certification since our base data reflects this increase. We certify that these capitation rates are actuarially sound and are intended to be consistent with a forthcoming §438.6(c) payment arrangement. This increase is in addition to the funding provided to providers through the DCW arrangement described previously.

ARPA Provider Rate Increase – Effective January 2022

Effective January 1, 2022, DHS is requiring MCOs participating in Family Care Partnership to increase provider reimbursement rates by 5% for certain home and community-based services. No explicit adjustment was necessary as part of this certification since our base data reflects this increase. We certify that these capitation rates are actuarially sound and are intended to be consistent with a forthcoming §438.6(c) payment arrangement. This increase is in addition to the funding provided to providers through the DCW arrangement described previously.

EXHIBITS A through D
Capitation Rate Development – Acute and Primary Services
(Provided in Excel Format Only)

State of Wisconsin Department of Health Services
Calendar Year 2024 Capitation Rate Development for Family Care Partnership Program

November 14, 2023

This report assumes that the reader is familiar with the State of Wisconsin's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the Family Care Partnership program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

EXHIBITS E through I
Capitation Rate Development – Long Term Care Services
(Provided in Excel Format Only)

State of Wisconsin Department of Health Services
Calendar Year 2024 Capitation Rate Development for Family Care Partnership Program

November 14, 2023

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EXHIBITS J through K
Capitation Rate Development – Capitation Rates
(Provided in Excel Format Only)

State of Wisconsin Department of Health Services
Calendar Year 2024 Capitation Rate Development for Family Care Partnership Program

November 14, 2023

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EXHIBIT L
Expenditure Projection
(Provided in Excel Format Only)

State of Wisconsin Department of Health Services
Calendar Year 2024 Capitation Rate Development for Family Care Partnership Program

November 14, 2023

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EXHIBITS M through R
Assumption Development Support
(Provided in Excel Format Only)

State of Wisconsin Department of Health Services
Calendar Year 2024 Capitation Rate Development for Family Care Partnership Program

November 14, 2023

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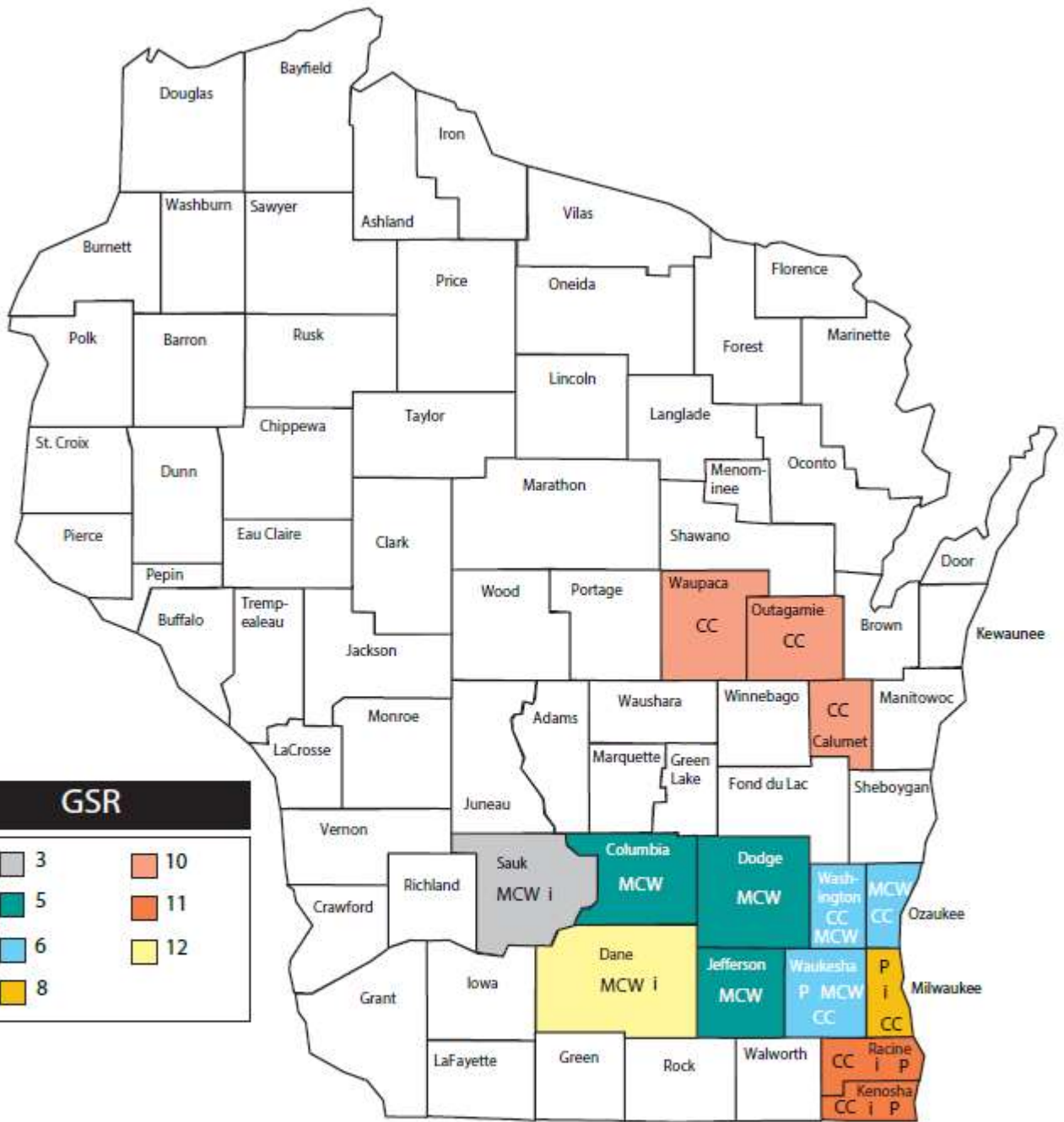
APPENDIX A

Geographical Service Region Map

State of Wisconsin Department of Health Services
Calendar Year 2024 Capitation Rate Development for Family Care Partnership Program

November 14, 2023

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GSR

3	10
5	11
6	12
8	

MCO

- MCW My Choice Wisconsin
- CC Community Care, Inc.
- i iCare
- P PACE (Community Care, Inc.)

APPENDIX B

Actuarial Certification of CY 2024 Wisconsin Family Care Partnership Capitation Rates

State of Wisconsin Department of Health Services
Calendar Year 2024 Capitation Rate Development for Family Care Partnership Program

November 14, 2023

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17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

michael.cook@milliman.com

November 14, 2023

**Wisconsin Department of Health Services
Capitated Contracts Ratesetting
Actuarial Certification
CY 2024 Family Care Partnership Program Capitation Rates**

I, Michael Cook, am associated with the firm of Milliman, Inc., am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion.

I was retained by the Wisconsin Department of Health Services (DHS) to perform an actuarial certification of the Family Care Partnership program capitation rates for calendar year (CY) 2024 for filing with the Centers for Medicare and Medicaid Services (CMS).

I reviewed the calculated capitation rates and am familiar with the following regulation and guidance:

- The requirements of 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7.
- CMS "Appendix A, PAHP, PIHP, and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting dated November 10, 2014."
- 2023 to 2024 Medicaid Managed Care Rate Development Guide.
- Actuarial Standard of Practice 49.

The payment rates, methodology, data, and assumptions used to calculate the January 1, 2024 through December 31, 2024 rates are documented in this report to DHS, of which this certification is a part.

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

In my opinion, the payment rates identified above are actuarially sound, as defined in 42 CFR §438.4, including that they:

1. Have been developed in accordance with generally accepted actuarial principles and practices and Actuarial Standards of Practice.
2. Are appropriate for the populations to be covered and the services furnished.
3. Meet the relevant actuarial requirements of 42 CFR §438.4(b).

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

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted managed care organization's situation and experience. These capitation rates may not be appropriate for all health plans. Any health plan considering participating in the Family Care Partnership program should consider their unique circumstances before deciding to contract under these rates.



This Opinion assumes the reader is familiar with the Wisconsin Medicaid program, Family Care Partnership programs, and actuarial rating techniques. The Opinion is intended for the State of Wisconsin and the 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.

A handwritten signature in black ink that reads 'Michael Cook'. The signature is written in a cursive style with a large, looping 'M' and 'C'.

Michael Cook
Member, American Academy of Actuaries

November 14, 2023



RELIANCE LETTER

Tony Evers
Governor



DIVISION OF MEDICAID SERVICES

1 WEST WILSON STREET
PO BOX 309
MADISON WI 53701-0309

Kirsten Johnson
Secretary

State of Wisconsin
Department of Health Services

Telephone: 608-266-8922
Fax: 608-266-1096
TTY: 711

November 3, 2023

Michael Cook, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
17335 Golf Parkway, Suite 100
Brookfield, WI 53045

RE: Data Reliance for Actuarial Certification of CY 2024 Family Care, Family Care Partnership, and PACE Capitation Rates

Dear Michael:

I, Grant Cummings, Director, Bureau of Rate Setting, hereby affirm that the listings and summaries prepared and submitted to Milliman, Inc. for the development of the CY 2024 Family Care, and 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 listings and summaries include:

1. Health Plan encounter data files containing claims information on capitated plan assignment, detailed service category, target group, geographic indicators, and demographic indicators for calendar years (CYs) 2017 through 2022 for the Family Care, Family Care Partnership, and PACE programs.
2. Fee-for-service, Waitlist, and Waiver data files containing claims information on detailed service category, geographic indicators, and demographic indicators for CYs 2017 through 2022 for the Family Care and Family Care Partnership programs.
3. Long Term Care Functional Screen (LTCFS) data extracts through June 2023 for the Family Care, Family Care Partnership, and PACE programs, and data files containing a list of non-victim incidents by member.
4. Data files containing enrollment information on capitated plan assignment, program and target group, geographic indicators, and demographic indicators (including ventilator-dependent members, tribal members, and other distinguishing characteristics) for CY 2017 through 2022, and January 2023 through June 2023 for the Family Care, Family Care Partnership, and PACE programs.
5. Data file containing IMD claims for Family Care Partnership members.
6. Personal Care Assistance (PCA) fee schedules from CY 2022 through CY 2024, including definitions of covered PCA services.
7. Nursing Home Rate Increases from SFY 2022 to SFY 2024.
8. Data file containing a list of screens impacted by changes to the target group automation algorithm.
9. Data files containing claims and enrollment information for the acute and primary portion of the Family Care Partnership and PACE programs.
10. Data files containing estimated monthly enrollment projections for CY 2024 in total and by health plan, geographic indicator, Medicare status, and target group for the Family Care, Family Care Partnership, and PACE programs.

11. Data dictionary files for the encounter, enrollment, and LTCFS files for the Family Care, Family Care Partnership, and PACE programs, including definitions of low and high activities of daily living, and instrumental activities of daily living, definitions of base and expansion cohorts, data files containing a mapping of functional screen fields to cost weight variables, and data files containing a mapping of services to broad categories of service.
12. Mapping file summarizing the consolidation and expansion of MCO/GSRs for CY 2024 relative to CY 2023 .
13. Mapping file summarizing the MCO ID to MCO / GSR crosswalk.
14. CY 2017 through 2022 financials and CY 2019 through CY 2021 IBNR actual to expected analysis for health plans participating in the Family Care, Family Care Partnership, and PACE programs.
15. CY 2022 financial accruals related to the Nursing Home Rate Increase for health plans participating in the Family Care, Family Care Partnership, and PACE programs.
16. Health Plan encounter data files containing claims information on CY 2022 Institutional and Residential encounters with runout through June 30, 2023 for the Family Care program.
17. Information and analysis regarding paid provider unit cost trends.
18. An estimate for expenses related to the Office of the Commissioner of Insurance's (OCI's) financial oversight function.
19. A data file containing lists of allowed and dis-allowed services under managed care and estimates of pharmacy rebates for the Family Care, Family Care Partnership, and PACE programs.
20. A summary of non-covered claims to be reclassified as covered.
21. Information and direction regarding the goals of the PACE rate development.
22. Information regarding the covered services for PACE rate development.
23. Information and direction regarding the Pay for Performance and incentive payment mechanisms for the Family Care and Family Care Partnership programs, including expectations around withhold return.
24. Results of analyses performed by DHS regarding the fiscal impact of legislative and policy changes for the Family Care, Family Care Partnership, and PACE programs.
25. Estimated impacts of legislated increases in FFS reimbursement rates for certain services as part of the 2023-2025 biannual state budget.
26. Information and direction regarding Directed Payments for the Family Care and Family Care Partnership programs, including Maximum Provider Fee Schedule, and Direct Care Workforce.
27. Any other items provided to Milliman to support the 2024 rate development not mentioned above for the Family Care, Family Care Partnership, and PACE programs.

I affirm that the above information and any other related data submitted to Milliman, Inc. are, to the best of my knowledge and belief, accurately stated.

Sincerely,



Grant Cummings
Director, Bureau of Rate Setting
Wisconsin Department of Health Services

APPENDIX C

CMS Rate Setting Checklist Issues

State of Wisconsin Department of Health Services
Calendar Year 2024 Capitation Rate Development for Family Care Partnership Program

November 14, 2023

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APPENDIX C

Rate Setting Checklist

This section of the report lists each item in the November 10, 2014 CMS checklist and discusses how DHS addresses each issue and / or directs the reader to other parts of this report. CMS uses the rate setting checklist to review and approve a state's Medicaid capitation rates.

AA.1.0 – Overview of Rates Being Paid Under the Contract

The calendar year (CY) 2024 managed care organization (MCO) capitation rates are developed using 2022 Wisconsin Medicaid long term care (LTC) MCO encounter data for the MCO eligible population, along with other information. DHS sets rates by MCO and Geographical Service Area (GSR).

Please refer to Sections II to VI of this report for background on the program and more details around the rate development.

AA.1.1 – Actuarial Certification

The Actuarial Certification of the CY 2024 capitation rates is included as Appendix B of this report. The CY 2024 Wisconsin LTC Medicaid care management 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.

AA.1.2 – Projection of Expenditures

Exhibit L includes a projection of total expenditures and Federal-only expenditures based on Projected CY 2024 MCO enrollment and CY 2024 capitation rates. We used a 60.66% FMAP rate to calculate the Federal expenditures.

AA.1.3 – Risk Contracts

The Wisconsin Family Care Partnership program meet the criteria of a risk contract.

AA.1.4 – Modifications

The rates documented in this report are the initial capitation rates for the CY 2024 Wisconsin Medicaid LTC managed care contracts.

Note: There is no AA.1.5 on the Rate Setting Checklist

AA.1.6 – Limit on Payment to Other Providers

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

AA.1.7 – Risk and Profit

The CY 2024 Family Care Partnership capitation rates include a targeted margin of 2.0% for risk, profit, and contribution to reserves. We believe that this margin is appropriate given low service cost trends and the predictability of expenses under the program.

AA.1.8 – Family Planning Enhanced Match

DHS does not claim enhanced match for family planning services for the population covered under this program.

AA.1.9 – Indian Health Service (IHS) Facility Enhanced Match

DHS does not claim enhanced match for Indian Health Services for the population covered under this program.

AA.1.10 – Newly Eligible Enhanced Match

The Wisconsin Family Care Partnership program does not cover the newly eligible Medicaid population. Therefore, none of the recipients are eligible for the enhanced Federal match under Section 1905(y).

APPENDIX C

Rate Setting Checklist

AA.1.11 – Retroactive Adjustments

The CY 2024 rates documented in this report are the initial capitation rates for the CY 2024 Wisconsin Medicaid LTC managed care contracts and do not contain any retroactive adjustments.

AA.2.0 – Based Only Upon Services Covered Under the State Plan

The CY 2024 rate methodology relies on CY 2022 MCO encounter data for the Family Care and Family Care Partnership programs as the primary data sources. Only State Plan and waiver services that are covered under the Wisconsin Family Care Partnership contract have been included in the rate development.

Please refer to the Non-Covered Services portion of Section IV of this report for more details.

AA.2.1 – Provided Under the Contract to Medicaid-Eligible Individuals

The capitation rate development methodology relies on data that includes only those eligible and currently enrolled in the Wisconsin Family Care and Family Care Partnership program and does not include experience for individuals not eligible to enroll in these programs.

AA.2.2 – Data Sources

The CY 2024 capitation rates are developed using Wisconsin Medicaid MCO encounter, eligibility, and functional screen data for CY 2022 for the MCO eligible population as the primary data source.

Please refer to Section III to IV of this report for more details.

AA.3.0 – Adjustments to Base Year Data

All adjustments to the base year data are discussed in Section III to IV of this report. In addition, each item in the checklist is addressed in items AA.3.1 through AA.3.17 below.

AA.3.1 – Benefit Differences

The base data used to calculate the capitation rates has been adjusted to only include services covered under the Medicaid care management program contract.

AA.3.2 – Administrative Cost Allowance Calculations

The MCO capitation rates include explicit administrative allowances by MCO. Please see Section V of the report for more details regarding the administrative cost calculation.

AA.3.3 – Special Populations' Adjustments

The CY 2024 capitation rates methodology does not include an adjustment for special populations as the base MCO encounter data used to calculate the capitation rates is consistent with the Wisconsin Family Care Partnership program population.

AA.3.4 – Eligibility Adjustments

The base MCO encounter data reflects experience for time periods where members were enrolled in a Family Care Partnership MCO.

AA.3.5 – Third Party Liability (TPL)

The managed care organizations are responsible for the collection of any TPL recoveries. The MCO encounter data is reported net of TPL recoveries; therefore, no adjustment was necessary.

AA.3.6 – Indian Health Care Provider Payments

The MCOs are responsible for the entirety of the IHC payments, which are fully reflected in encounters.

APPENDIX C

Rate Setting Checklist

AA.3.7 – DSH Payments

DSH payments are not included in the capitation rates.

AA.3.8 – FQHC and RHC Reimbursement

The MCOs are responsible for the entirety of the FQHC and RHC payments, which are fully reflected in encounters.

AA.3.9 – Graduate Medical Education (GME)

GME payments are included as part of the hospital reimbursement formula. Therefore, the base data used in the capitation rate calculation includes GME payments. Separate FFS payments are not made to hospitals for members covered under managed care.

AA.3.10 – Copayments, Coinsurance, and Deductibles in Capitated Rates

The Wisconsin Family Care Partnership program does not include member cost sharing, so no adjustment to base period experience for this issue is required.

AA.3.11 – Medical Cost / Trend Inflation

Trend rates from CY 2022 to CY 2024 were developed by rate category and type of service for Family Care Partnership eligible services and individuals using historical MCO encounter data from January 2019 to December 2022, excluding CY 2020 and actuarial judgment.

The trend rates and inflation factors represent the expected change in per capita cost between CY 2022 and CY 2024, net of acuity changes.

Please see Section III to IV and Exhibit P for more details on the trend development.

AA.3.12 – Utilization Adjustments

Utilization trend is included in AA.3.11.

AA.3.13 – Utilization and Cost Assumptions

The CY 2024 capitation rates use an actuarially sound risk adjustment model to adjust the rates for each participating MCO in a particular GSR in order to reflect the acuity of enrolled members. Acuity adjustments were applied independently from the unit cost and utilization trend adjustments.

AA.3.14 – Post-Eligibility Treatment of Income (PETI)

Capitation rates are developed gross of patient liability, and DHS adjusts capitation paid for each member to reflect that individual's specific patient liability. Encounter payment amounts are gross of patient liability, so no adjustment to the data is necessary for this issue.

AA.3.15 – Incomplete Data Adjustment

The capitation rates include an adjustment to reflect IBNR claims and a missing data adjustment to acute and primary claims. Please refer to Section III and IV of this report for more information on the IBNR assumptions and the missing data adjustment factor.

We apply an adjustment to true up care management expenditures to financial statements due to the difficulty in properly and completely collecting this information in the encounter data reporting format. Please refer to Section IV of this report for more information on the development of these adjustment factors.

AA.3.16 – Primary Care Rate Enhancement

Acute and primary care base data is comprised of claims paid after January 1, 2018, and would not reflect the impact of the primary care rate enhancement.

APPENDIX C

Rate Setting Checklist

AA.3.17 – Health Homes

Not applicable.

AA.4.0 – Establish Rate Category Groupings

Please refer to Sections III to IV of this report.

AA.4.1 – Eligibility Categories

Target populations for individuals meeting the nursing home level of care requirement are defined in Step 1 of Section III and Section IV.

AA.4.2 – Age

Age is not used for rate category groupings outside of the Target Population assignment.

AA.4.3 – Gender

Gender is not used for rate category groupings.

AA.4.4 – Locality / Region

Geographic regions are defined in Appendix A.

AA.4.5 – Risk Adjustments

Acuity adjustment models are described in Section IV.

AA.5.0 – Data Smoothing

We did not perform any data smoothing.

AA.5.1 – Cost-Neutral Data Smoothing Adjustment

We did not perform any data smoothing.

AA.5.2 – Data Distortion Assessment

Our review of the base MCO encounter data did not detect any material distortions or outliers.

AA.5.3 – Data Smoothing Techniques

We determined that a data smoothing mechanism resulting from data distortions was not required.

AA.5.4 – Risk Adjustments

The LTC component of the CY 2024 capitation rates use an actuarially sound risk adjustment model based on a functional screen to adjust the rates for each participating MCO. Please see Section III and IV of this report. The risk adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices.

AA.6.0 – Stop Loss, Reinsurance, or Risk Sharing Arrangements

Not applicable.

AA.6.1 – Commercial Reinsurance

DHS does not require entities to purchase commercial reinsurance.

APPENDIX C

Rate Setting Checklist

AA.6.2 – Stop-Loss Program

The CY 2024 capitation rates do not feature a stop-loss program.

AA.6.3 – Risk Corridor Program

The CY 2024 capitation rates will feature a risk corridor as described in Section VI of this report.

AA.7.0 – Incentive Arrangements

Please see Section VI of the rate report.

AA.7.1 – Electronic Health Records (EHR) Incentive Payments

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

APPENDIX D

CMS Medicaid Managed Care Rate Development Guide

State of Wisconsin Department of Health Services
Calendar Year 2024 Capitation Rate Development for Family Care Partnership Program

November 14, 2023

This report assumes that the reader is familiar with the State of Wisconsin's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DHS to set CY 2024 capitation rates for the Family Care Partnership program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

APPENDIX D

Response to 2023 to 2024 Managed Care Rate Development Guide

I. MEDICAID MANAGED CARE RATES

1. General Information

A. Rate Development Standards

- i. A single capitation rate, rather than a range of rates, is developed for each rate cell.
- ii. The rate certification included herein is for the calendar year (CY) 2024 contract period. The previous certification was for the CY 2023 contract period.
- iii. This rate certification includes all of the items required in the rate development guide.
 - a. The rate certification is included in Appendix B.
 - b. The final and certified capitation rates for all rate cells and regions can be found in Exhibit K.
 - c. The descriptions of the Family Care Partnership program can be found in Sections I and II of this report.

The following directed payment arrangements apply to CY 2024. Additional documentation of these arrangements is included below in Section I.4.D of this rate setting guide.

- Maximum Provider Fee Schedule
 - Direct Care Workforce
 - Home and Community Based Services Provider Rate Increase (effective June 2021)
 - American Rescue Plan Act Provider Rate Increase (effective January 2022)
- iv. Differences in capitation rates for the covered population are based on valid rate development standards and are not based on the rate of Federal financial participation associated with the covered population. This was evaluated for the entire managed care program and includes all managed care contracts for all covered populations.
 - v. Each rate cell is developed independently to be actuarially sound and does not cross-subsidize payments for another rate cell.
 - vi. The effective dates of changes to the Medicaid program are consistent with the assumptions used to develop the capitation rates.
 - vii. The target rate development MLR for the CY 2024 rates is 92.9%. As such, the capitation rates are developed such that MCOs can reasonably achieve a federal MLR of greater than 85%.
 - viii. A single capitation rate, rather than a range of rates, is developed for each rate cell.
 - ix. A single capitation rate, rather than a range of rates, is developed for each rate cell.
 - x. The rate certification submission does demonstrate that the capitation rates were developed using generally accepted actuarial practices and principles and are consistent with the regulatory requirements.
 - a. All adjustments to the capitation rates reflect reasonable, appropriate, and attainable costs.
 - b. No adjustments to the rates are performed outside of the initial rate setting process beyond those outlined in Sections III and VI of the report.
 - c. The final contracted rates in each cell match the capitation rates in the certification.
 - xi. The capitation rates included in this submission are certified for all time periods in which they are effective. No rates for a previous time period are used for a future time period.

APPENDIX D

Response to 2023 to 2024 Managed Care Rate Development Guide

- xii. The capitation rates were developed to account for the direct and indirect impacts of the COVID-19 public health emergency. Section I of this report contains detailed information about the COVID-19 considerations for the CY 2024 rate development.
- xiii. This rate certification conforms to the procedure for rate certifications and for rate and contract amendments. The CY 2024 rates documented in this report are the initial capitation rates for the CY 2024 Wisconsin Medicaid LTC managed care contracts.

B. Appropriate Documentation

- i. The actuary is certifying CY 2024 capitation rates.
- ii. We believe that the attached report properly documents all the elements included in the rate certification and provides CMS enough detail to determine that regulatory standards are met.

Please see Sections I, III, IV, and V of this report for the following details:

- Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources
 - Assumptions made, including any basis or justification for the assumption
 - Methods for analyzing data and developing assumptions and adjustments
- iii. Service cost projection assumptions used in rate development do not differ by managed care organization. Capitation rates differ by MCO based on the MCO admin load, LTC risk score, and demographic mix.
 - iv. A single capitation rate, rather than a range of rates, is developed for each rate cell.
 - v. We detail within our responses in this guide the section of our report where each item described in the 2023 to 2024 Medicaid Managed Care Rate Development Guide can be found.
 - vi. All differences in the assumptions, methodologies, and factors used to develop capitation rates for covered populations comply with 42 C.F.R. § 438.4(b)(1), are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and do not vary with the rate of FFP associated with the covered populations.
 - vii. All services and populations included in this rate certification are subject to the regular state Federal Medical Assistance Percentage (FMAP).
 - viii. Relative to the previous rating period, please see Section I of this report for the following details:
 - a. A comparison of the final certified rates in the prior certification.
 - b. A description of material changes to the capitation rate development process.
 - c. The capitation rates in the previous rating period were not adjusted by a *de minimis* amount.
 - ix. Section VI of the report documents the only known future amendments to these rates for final direct care workforce payments.
 - x. Section I includes documentation of the COVID-19 considerations and related unwinding considerations in the CY 2024 rate development.

2. Data

A. Rate Development Standards

- i. The rate development process follows CMS rate development standards related to base data.

APPENDIX D

Response to 2023 to 2024 Managed Care Rate Development Guide

- a. DHS provided Milliman with validated encounter data and financial reports for at least the three most recent and complete years prior to the rating period. Managed care plans and DHS have provided detailed financial reporting data for CY 2019, CY 2020, CY 2021, and CY 2022 to the state's actuaries for this and prior year rate development.
- b. The rate development methodology uses current MCO encounter data. Sections III and IV include documentation of the CY 2022 base data period used to develop the CY 2024 Family Care capitation rates.
- c. The base data used is derived from the Medicaid population served under the Family Care and Family Care Partnership programs.
- d. The CY 2024 rate calculation uses CY 2022 base data, which is within the CMS three-year requirement.

B. Appropriate Documentation

- i. Milliman did request and receive a full claims and enrollment database from DHS. Acute and primary care data is summarized in Exhibit A and long term care data is summarized in Exhibit E. DHS provided detailed financial reporting data for CY 2022 and encounter data for CY 2018 through CY 2022 to the state's actuaries for this year's rate development.
- ii. A detailed description of the data used in the rate development methodology can be found in Sections III to IV of this report. Sections III to IV also include comments on the availability and quality of the data used for rate development.
 - a. The CY 2024 capitation rates for the Family Care Partnership program are developed using CY 2022 encounter data, financial data, and other information.
 - b. DHS and Milliman went through an extensive data validation process to review all capitated plan data included in the CY 2024 rate setting methodology. DHS internally reviews encounter data submissions and notifies plans of corrections necessary to allow for records to be accepted. Milliman reviewed the encounter and financial data.

The capitated plan financial data, encounter and FFS data, are all of very high quality and appropriate for use in rate development.
 - c. All base data is specific to the populations that will be covered under the CY 2024 Family Care Partnership capitation rates.
 - d. The rate documentation methodology does not use a data book separate from what is shown in the report.
- iii. The rate certification and attached report thoroughly describe any material adjustments, and the basis for the adjustments, that are made to the data. Please see Section III and IV of this report for more details.

3. Projected Benefit Costs

A. Rate Development Standards

- i. The final capitation rates shown in Exhibit K are based only upon services described in 42 CFR 438.3(c)(1)(ii) and 438.3(e).
- ii. Each projected benefit cost trend assumption is reasonable and developed in accordance with generally accepted actuarial principles and practices using actual experience of the Medicaid population. Please refer to Sections III and IV of this report for the details.
- iii. Please refer to Sections III and IV of this report for the details related to the treatment of in-lieu of services (ILOS). There are no ILOS services in the base data or expected for the contract period.

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- iv. There are no ILOS services in the base data or expected for the contract period.
- v. See Step 3 of Section III of this report for details related to the treatment of IMD costs.

B. Appropriate Documentation

- i. The various Exhibits included in this report document the final projected benefit costs by relevant level of detail and is consistent with how the State makes payments to the plans.
- ii. Please refer to Sections III to IV of this report for the methodology and assumptions used to project contract period benefit costs from the base period to CY 2024. Section I of the report highlights key methodological changes since the previous rate development. The base period costs used in rate development are net of these overpayments.
- iii. The rate certification includes a section on projected benefit cost trends in compliance with 42 CFR §438.7(b)(2). See Step 3 and 4 of Section III and Step 3 and 4 of Section IV for details related to the development of projected benefit cost trends.
- iv. This certification does not include additional services deemed by the state to be necessary to comply with the parity standards of the Mental Health Parity and Addiction Equity Act.
- v. There are no ILOS in the base data or expected for the contract period.
- vi. Since the rate development base data reflects actual program experience, no adjustment for retrospective eligibility periods is necessary.
- vii. Section I documents the impact on projected costs for all material changes to covered benefits or services since the last rate certification. Impacts for all such changes are included in Sections III and IV.
- viii. Sections III and IV of the rate certification includes an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment for each change related to covered benefits or services for CY 2024.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

The pay for performance, the member relocation incentive payment, and the assisted living quality incentive payment are described in Section VI of the report. These incentives will not exceed 5% of the certified rates, and we made no adjustment for the incentive payments in rate development. The rate certification includes a description of the incentive arrangement. See Section VI of the report.

B. Risk Sharing Mechanism

The pay for performance withhold is described in Section VI of the report. The rate certification includes a description of the withhold arrangement. See Section VI of the report.

C. Risk Sharing Mechanism

The functional screen risk adjustment has been developed in accordance with generally accepted actuarial principles and practices and is cost neutral to the state in total.

The CY 2024 capitation rates will feature a risk corridor as described in Section VI of this report.

The rate certification includes a description of the risk sharing mechanisms. See Section IV of the report for the functional screen risk adjustment and Section VI for the risk corridor mechanism.

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D. State Directed Payments

Information for each of the state directed payments is outlined in the tables below. Please see Section VI of the rate report for additional documentation of these arrangements.

Control Name of the State Directed Payment	Type of Payment (See (i)(A) below)	Brief Description (See (i)(B) below)	Is the payment included as a rate adjustment or separate payment term? (See (ii) and (iii) below)
Over MA FFS: WI_Fee_HCBS6_New_202 30101-20231231	Maximum fee schedule	State Plan services provided under the Family Care Partnership benefit package are subject to a maximum fee schedule established by the state.	Rate adjustment (base data reflects the long-standing maximum fee schedule arrangement)
DCW: WI_Fee_HCBS5_New_202 30101-20231231	Uniform increase for network providers that provide particular services under the contract	DHS will distribute an amount to the MCOs proportional to the total encounter-reported expenditures for eligible providers. This payment will then be passed through to eligible providers.	Separate payment term; Interim estimate included in this certification
HCBS Increase: WI_Fee_HCBS4_New_202 30101-20231231	Uniform increase for network providers that provide particular services under the contract	Effective June 1, 2021, DHS is requiring MCOs participating in Family Care Partnership to increase provider reimbursement rates for certain home and community-based services. This increase is 4.24% for eligible providers.	Rate adjustment (Base data reflects the existing uniform increase for the network provider arrangement).
ARPA Increase: WI_Fee_HCBS3_New_202 30101-20231231	Uniform increase for network providers that provide particular services under the contract	Effective January 1, 2022, DHS is requiring MCOs participating in Family Care Partnership to increase provider reimbursement rates for certain home and community-based services. This increase is 5.0% for eligible providers.	Rate adjustment (Base data reflects the existing uniform increase for the network provider arrangement).

DHS will submit 438.6€ preprints to CMS for 2024 for each of the payments included in the table above. The 2024 preprints will be consistent with the prior preprints approved by CMS. There are no other directed payments in these programs that are not addressed in this certification.

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Additional information for state directed payments included as rate adjustments is outlined in the table below.

Control Name of the State Directed Payment	Rate Cells Affected (See (A) below)	Impact (See (B) below)	Description of the Adjustment (See (C) below)	Confirmation the Rates are Consistent with the Preprint (See (D) below)	For Maximum Fee Schedules, Provide the Information Requested (E) Below
Over MA FFS: WI_Fee_HCBS6 _New_2023010 1-20231231	All rate cells	Reflected in Base Data summarized in Exhibit A	The maximum fee schedule is a long-standing arrangement, which was in effect during the base data period. Please refer to Section VI of the rate certification for additional information.	The fee schedule is consistent with the preprint.	MCOs have the ability to exceed the limit when necessary for executing a reimbursement contract. We expect no material change to the value of exceptions made over the maximum fee schedule relative to the base data, so no adjustments were made.
HCBS Increase: WI_Fee_HCBS4 _New_2023010 1-20231231	All rate cells	Reflected in Base Data summarized in Exhibits A and E	The arrangement was in effect during the base data period. Please refer to Section VI of the rate certification for additional information.	This rate increase is consistent with the preprint.	Not applicable.
ARPA Increase: WI_Fee_HCBS3 _New_2023010 1-20231231	All rate cells	Reflected in Base Data summarized in Exhibits A and E	The arrangement was in effect during the base data period. Please refer to Section VI of the rate certification for additional information.	This rate increase is consistent with the preprint.	Not applicable.

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The table below documents additional information for the state directed payments incorporated into the initial rate certification as a separate payment term.

Control Name of the State Directed Payment 26	Aggregate Amount Included in the Certification (See (A) below)	Statement that the Actuary is Certifying the Separate Payment Term (See (B) below)	The Magnitude on a PMPM Basis (See (C) below)	Confirmation the Rate Development is Consistent with the Preprint (See (D) below)	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (As applicable; see (E) below)
DCW: WI_Fee_HC BS5_New_2 0230101-20231231	The aggregate amount of the payment applicable to the rate certification is \$146 million, of which \$8.8 million is estimated to be allocated to Family Care Partnership.	Confirmed.	Implemented as a PMPM Add-On. The values specific to each rate cell are an estimate at this time. Capitation rates will be updated to reflect realized payments. Please refer to Section VI of the rate certification for additional information.	This rate development is consistent with the preprint.	After the rating period is complete, the state will submit documentation to CMS that incorporates the total amount of the state directed payment specific to each rate cell into the rate certification's rate cell-specific capitation rate consistent with the distribution methodology.

E. Pass-Through Payments

The CY 2024 capitation rate methodology does not include any pass-through payments.

5. Projected Non-Benefit Costs

A. Rate Development Standards

- i. The development of the non-benefit component of the CY 2024 rates is compliant with 42 CFR §438.5(e) and includes reasonable, appropriate, and attainable expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital. Please see Sections III, IV, and V.
- ii. The non-benefit costs included in the CY 2024 capitation rates are developed as a per member per month for common categories of administrative expenses. Please see Section V for additional detail on how the administrative component is calculated.

B. Appropriate Documentation

- i. Please refer to Section V of this report for a detailed description of the data and methodology used to develop of the projected non-benefit costs included in the capitation rates. The report includes a description of changes made since the last rate development.
- ii. The projected non-benefit costs include appropriate consideration for administrative costs, taxes, licensing and regulatory fees, other assessments and fees, contribution to reserves, risk margin, and cost of capital.

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- iii. Historical costs serve as the basis for projected administrative load as described in Section V of this report. The table below summarizes current and historical administrative costs by MCO.

FCP MCOs receive capitation funding from Medicare that includes funds for administrative expenses. We assume that 37% of reported FCP administrative expenses are attributable to Medicare based on the relativity of Medicare and Medicaid service costs for the FCP program.

Wisconsin Department of Health Services Comparison of CY 2022 and CY 2024 Administrative PMPMs			
HMO	Year Ending December 31, 2022		Difference
	CY2024 Medicaid Admin PMPM	Financials PMPM	
iCare	\$244.50	\$208.56	\$35.95
MCWHP	\$244.50	\$246.70	-\$2.20
CCHP- FCP	\$244.50	\$217.13	\$27.37

6. Risk Adjustment

A. Rate Development Standards

- i. The functional screen and risk adjustment detailed in Sections III and IV of the report are used for explaining costs of services covered under the contract for defined populations across MCOs.
- ii. The risk adjustment models have been developed in accordance with generally accepted actuarial principles and practices and cost neutral to the state in total.

B. Appropriate Documentation

- i. The functional screen and risk adjustment processes are detailed in Sections III and IV of the report.
- ii. Section VI of the report documents the various retrospective risk adjustment mechanisms.
- iii. The rate certification and supporting documentation do specifically include a description of any changes that are made to risk adjustment models since the last rating period and documentation that the risk adjustment model is budget neutral in accordance with 42 CFR §438.5(g).

7. Acuity Adjustment

A. Rate Development Standards

- i. Section IV of this report documents the use of acuity trends separate from benefit utilization and unit cost trends to consider the change in acuity for the Family Care Partnership population.

B. Appropriate Documentation

- i. The rate certification includes a description of the acuity trend adjustment. This adjustment is developed according with generally accepted actuarial principles and practices.

II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

1. Managed Long-Term Services and Supports

- A. The information included in Section I is applicable to both the acute and primary care and long-term care component of the capitation rates.
- B. Rate Development Standards.
 - i. The Wisconsin Family Care Partnership program's capitation rates blend costs for individuals in all settings of care.

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C. Appropriate Documentation.

- i. Sections I to IV of this report address the following items:
 - a. The structure of the capitation rates and rate cells or rating categories.
 - b. The structure of the rates and the rate cells, and the data, assumptions, and methodology used to develop the rates in light of the overall rate setting approach.
 - c. Any other payment structures, incentives, or disincentives used to pay the MCOs.
 - d. The expected effect that managing LTSS has on the utilization and unit costs of services.
 - e. Any effect that the management of this care is expected to have within each care setting and any effect in managing the level of care that the beneficiary receives.
- ii. Please refer to Section V of this report for a detailed description of the data and methodology used to develop the projected non-benefit costs included in the capitation rates. The report includes a description of changes made since the last rate development.
- iii. The Wisconsin Family Care Partnership capitation rates presented in this report are based entirely on historical MCO encounter data and financial experience.
- iv. Please refer to Sections III and IV for a description of the data sources used to develop the assumptions used for rate setting.

III. NEW ADULT GROUP CAPITATION RATES

This certification does not include rates for the new adult group under 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

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milliman.com

CONTACTS

Michael C. Cook
michael.cook@milliman.com

Briana Botros
briana.botros@milliman.com

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milliman.com

CONTACT

Michael Cook
michael.cook@milliman.com

Briana Botros
briana.botros@milliman.com