

**NETWORK HEALTH PLAN
BadgerCare Plus (BCP)/
Supplemental Security Income
(SSI)
Wisconsin Medicaid Managed
Care Programs**

Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the Calendar Year Ended December 31, 2023
Paid through April 30, 2024



**MYERS AND
STAUFFER^{LC}**
CERTIFIED PUBLIC ACCOUNTANTS



Table of Contents

■ Table of Contents	1
■ Independent Accountant's Report	2
■ Adjusted Medical Loss Ratio for the Calendar Year Ended December 31, 2023 Paid through April 30, 2024	3
■ Schedule of Adjustments for the Calendar Year Ended December 31, 2023	4



State of Wisconsin
Department of Health Services
Madison, Wisconsin

Independent Accountant's Report

We have examined the accompanying Adjusted Medical Loss Ratio of Network Health Plan (health plan) for the calendar year ended December 31, 2023. The health plan's management is responsible for presenting the Medical Loss Ratio in accordance with the criteria set forth in 42 Code of Federal Regulations (CFR) § 438.8 and other applicable federal guidance (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Adjusted Medical Loss Ratio is in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratio. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the Adjusted Medical Loss Ratio, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements related to our engagement.

The accompanying Adjusted Medical Loss Ratio was prepared from information contained in the Medical Loss Ratio for the purpose of complying with the criteria, and is not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the Adjusted Medical Loss Ratio is presented in accordance with the criteria, in all material respects, and the Adjusted Medical Loss Ratio meets or exceeds the Centers for Medicare & Medicaid Services (CMS) requirement of 85 percent for the calendar year ended December 31, 2023.

This report is intended solely for the information and use of the Department of Health Services, Milliman, and the health plan and is not intended to be and should not be used by anyone other than these specified parties.

Myers and Stauffer LC
Kansas City, Missouri
January 28, 2026



NETWORK HEALTH PLAN **ADJUSTED MEDICAL LOSS RATIO**

Adjusted Medical Loss Ratio for the Calendar Year Ended December 31, 2023 Paid Through April 30, 2024

Adjusted Medical Loss Ratio for the Calendar Year Ended December 31, 2023 Paid Through April 30, 2024				
Line #	Line Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
1. Medical Loss Ratio Numerator				
1.1	Incurred Claims	\$ 142,663,660	\$ (346,743)	\$ 142,316,917
1.2	Activities that Improve Health Care Quality	\$ 4,798,951	\$ (1,043,743)	\$ 3,755,208
1.3	MLR Numerator	\$ 147,462,610	\$ (1,390,486)	\$ 146,072,124
1.4	Non-Claims Costs (Not Included in Numerator)	\$ 18,238,312	\$ -	\$ 18,238,312
2. Medical Loss Ratio Denominator				
2.1	Premium Revenue	\$ 176,215,086	\$ (7,663,180)	\$ 168,551,906
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	\$ 592,663	\$ -	\$ 592,663
2.3	MLR Denominator	\$ 175,622,423	\$ (7,663,180)	\$ 167,959,243
3. MLR Calculation				
3.1	Member Months	747,005	-	747,005
3.2	Unadjusted MLR	84.0%	3.0%	87.0%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	84.0%	3.0%	87.0%
4. Remittance				
4.1	Contract Includes Remittance Requirement	No		No
4.2	State Minimum MLR Requirement	85.0%		85.0%

**The Non-Claims Costs line has not been subjected to the procedures applied in the examination, including testing for allowability of expenses or appropriate allocation to the Medicaid line of business. Adjustments identified during the course of the examination were not tested to determine any impact on Non-Claims Costs. Accordingly, we express no opinion on the Non-Claims Costs line.*

Note: The amounts reflected within the MLR calculation on line 1.3 contain a variance due to rounding.



Schedule of Adjustments

During the course of the engagement, we identified the following adjustments.

Adjustment #1 – To adjust provider incentive payments per health plan supporting documentation

The health plan reported provider incentive payments for the medical loss ratio (MLR) reporting period. It was determined the health plan amounts reported were overstated, attributed to capturing estimated payments that were ultimately not earned and paid to providers for the MLR reporting period. An adjustment was proposed to reduce provider incentive payments per health plan supporting documentation. The provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	Line Description	Amount
1.1	Incurred Claims	(\$236,535)

Adjustment #2 – To remove non-qualifying care coordination expenses per health plan supporting documentation

The health plan reported provider care coordination expenses within provider incentive payments for the MLR reporting period. Based on the provider contracts, the health plan pays a per-member per-month amount to specific providers for performing care coordination services. Since the services are considered health care quality improvement (HCQI) activities in nature and were not tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards, the amounts did not qualify as provider incentive payments. Additionally, documentation from the contracted provider was not submitted to properly test for qualifying HCQI expenses. An adjustment was proposed to remove the non-qualifying care coordination expenses per health plan supporting documentation. The provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	Line Description	Amount
1.1	Incurred Claims	(\$73,455)



Adjustment #3 – To remove non-qualifying HCQI/HIT expenses per health plan supporting documentation

The health plan reported HCQI and health information technology (HIT) expenses based on salaries and benefits, vendor costs, and overhead costs. It was determined the health plan included non-qualifying expenses based on federal guidance and expenses unrelated to the MLR reporting period. An adjustment was proposed to remove non-qualifying salaries, benefits, vendor costs, and overhead and expenses not related to the MLR reporting period. The HCQI/HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	Line Description	Amount
1.2	Activities that Improve Health Care Quality	(\$1,043,743)

Adjustment #4 – To adjust ventilator recoupments per health plan supporting documentation

The health plan reported ventilator recoupments for the MLR reporting period. Supporting documentation demonstrated amounts reported were understated due to the exclusion of additional paid amounts identified during the paid through period. An adjustment was proposed to increase the ventilator recoupment amount per health plan supporting documentation. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	Line Description	Amount
1.1	Incurred Claims	(\$36,753)

Adjustment #5 – To adjust revenues per state data

The health plan reported revenue amounts that did not reflect payments received for its members applicable to the covered dates of service for the MLR reporting period. An adjustment was proposed to report the revenues per state data for capitation, maternity, encounter based payments, earned withholds, and other revenue payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2). The health plan completed the MLR based on the template instructions.

Proposed Adjustment		
Line #	Line Description	Amount
2.1	Premium Revenue	(\$290,332)



Adjustment #6 – To adjust the risk corridor settlement per state data

A risk corridor was contractually in effect for the MLR reporting period. The final risk corridor calculation occurred subsequent to the filing of the MLR. An adjustment was proposed to reflect revenues for the final risk corridor calculation per state data. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2).

Proposed Adjustment		
Line #	Line Description	Amount
2.1	Premium Revenue	(\$7,372,848)