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MEMORANDUM

February 22, 2023

To: Grant Cummings (Wisconsin Department of Health Services)

From: Jill Brostowitz and Emily Vandermause (Milliman)

cc: All HMOs Participating in BadgerCare Plus and SSI Medicaid Managed Care Programs
Shelly Brandel (Milliman)

Re: Financial Template for 2024 Rate Setting and 2021 Medical Loss Ratio Reporting

The Wisconsin Department of Health Services (DHS) retained Milliman, Inc. (Milliman) to provide actuarial services for Wisconsin's BadgerCare Plus (BCP) and Supplemental Security Income (SSI) managed care programs. This memo summarizes the changes we made to the HMO financial reporting template in version 8.0. HMOs will use this template to report their financial results for services provided in 2021 and 2022 and paid through April 30, 2023. **This first financial reporting submission is due to DHS by May 29, 2023.**

Similar to prior years, we plan to use the financial information in various ways, including:

- Validating the 2021 and 2022 encounter data submitted to DHS and estimating missing data adjustments for each HMO, if needed
- Quantifying the amount of sub-capitation payments, provider risk sharing and settlement payments, and other types of payments not included in the encounter data files, and considering whether they should be included in the capitation rate setting base data
- Analyzing historical HMO administrative costs and developing 2024 administrative cost targets
- Reviewing 2021 and 2022 historical margins and 2024 projected medical loss ratios (MLRs) for reasonableness
- Calculating the final 2021 and preliminary 2022 risk corridor settlements

DHS also plans to use the 2021 results from this submission for 2021 MLR reporting to CMS.

HMOs will complete this template again later in the year to report financial results for year-to-date (YTD) services provided through March 31, 2023 and paid through June 30, 2023. **This second financial reporting submission is due to DHS by July 31, 2023.** We plan to use the 2023 information to review emerging claim trends, administrative expenses, and margins, for consideration in the 2024 capitation rate development.

The completed templates should be submitted to DHS via email (**DHSDMSBRS@dhs.wisconsin.gov**) by the required dates.

CHANGES FROM VERSION 7.0

1. Removed the Health Insurer Fee (HIF) from Exhibits 7, 8, and 11
2. Added "Other Incentive Revenue" in line (12) of Exhibits 7 and 8 to report HMO incentive revenue other than amounts for the Potentially Preventable Re-admissions (PPR) program, Vaccine Outreach Program (VOP), or Vaccine Equity Program (VEP) such as the Obstetric Medical Home incentive. Please include descriptions and amounts of "other incentive" revenue reported in line (12) in the text box at the bottom of the exhibit.

3. Added "Interpreter Services During Provider Services" as a category under administrative expenses in line (69) of Exhibits 7 and 8.

4. Clarified in the instructions tab that grant revenue and any expenses related to grant revenue should be excluded completely from the template. HMOs should only enter these amounts in Exhibit 10 if needed to reconcile to financials.

5. Updated minor wording and formatting.

We emphasize the following items:

1. Exhibit 3 revenue should exclude provider access payments, pay-for-performance (P4P) settlements, and amounts for services reimbursed by DHS outside of the capitation rates or maternity kick payments. Provider access payments, P4P settlements, and revenue outside of capitation should be reported directly in Exhibits 7 and 8. **Do not report any estimated receivable or liability related to the DHS risk corridor settlement in Exhibits 3, 7, or 8, but include as a reconciliation item in Exhibit 10, as needed.**

2. Claims related to narcotic treatment services should be entered in Exhibits 4 and 5, as in the past, but all other encounter-based payments (EBPs) should only be entered in Exhibits 7 and 8 (line 51).

3. HMOs should report the names of provider entities in column D of Exhibit 5 for all arrangements including PPR bonus incentives.

4. We expect revenue for EBPs should equal claims for EBPs in most cases, since HMOs should report both revenue and expense amounts by service year. **If you are unable to track or reasonably allocate expenses specifically related to the EBP for SSI Care Management, include the EBP revenue for this service as a proxy for its expenses in line (51) of Exhibit 7 and 8 and also remove this same amount from the administrative expenses reported in Exhibit 7 and 8. Please disclose any allocation methods or use of the proxy method.**

5. Ensure the enhanced reimbursement from the dental pilot is excluded from the dental claims reported in Exhibits 4 and 5 and attest in Exhibit 1 that the amounts are excluded, if applicable.

6. HMOs should include estimated ultimate subrogation and audit recoveries for the service year based on historical recoveries by service year and member months in the reported service year.

7. If any administrative expenses were incurred directly related to the VOP or VEP program in 2021, report the amount in line (81) of Exhibit 8 and describe and disclose the amount specific to VOP or VEP in row 136.

2021 MLR REPORTING

HMOs need to ensure their MLR reporting complies with 42 CFR 438.8 and all other CMS guidance. We continue to emphasize the following items:

1. Ensure sub-capitation amounts in the "MLR Paid Amount" of Exhibit 5 comply with the CMS bulletin dated May 15, 2019 (https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf). See excerpts from this guidance in the instructions tab of the financial template.

2. Include 2021 final pay-for-performance (P4P) settlements in Exhibit 8 to include in MLR reporting.

3. Include any other HMO incentive revenue in line (12) of Exhibit 8 that is not already captured in line (10) as PPR incentive Revenue or in line (11) as VOP or VEP Incentive Revenue. All HMO incentive revenue should be excluded from MLR reporting.

4. Report waived member cost sharing as appropriate in Exhibit 8 where cost sharing is intentionally not collected.

5. Include descriptions of any methodologies used to allocate expenditures between product lines or eligibility categories in the bottom of Exhibit 8 as required for MLR reporting.

6. Report the best estimate of incurred but not reported (IBNR) amounts without any margin and estimated future subrogation and audit recoveries.

7. Compare GAAP financial statements in Exhibit 10 to explain differences by component with only a minor amount remaining for unexplained differences (i.e., less than 0.5%).

8. Correct any items we identified during our review of the financial templates used for 2023 rate development and 2020 MLR reporting.

GENERAL INFORMATION

The financial reporting template is an Excel-based file that should be completed by each HMO and submitted to DHS. The template includes several tabs, each of which are described below.

Throughout the template, input cells are shaded in green with blue text. All other areas of the template are locked and cannot be modified.

Version

This tab is used to track each version of the file used.

Trade Secret

This tab is the non-disclosure of trade secret language from the HMO contract with DHS, which is shown in the file for reference.

Instructions

This tab provides general directions for completing the file and high-level information about each tab.

Notes

This tab can be used to add notes regarding any exhibit. It also contains the preparer's information and assigns the reporting period for the other tabs. If reporting a partial year, enter the period in the format "YTD XX/XX/XXXX" (e.g., YTD 03/31/2023 for the second reporting submission) in the "Older Incurred Year" row. If only reporting one year in the model, leave the "Newer Incurred Year" blank.

Exhibit 1: Certification

This tab includes input cells for the HMO name and a certification statement that must be signed by the plan CEO or CFO. Signatures can be handled in two ways. HMOs may sign and submit Exhibit 1 electronically in PDF format separately from the Excel file. Alternatively, the Exhibit 1 tab may contain an electronic signature with only that tab password protected.

The tab also includes attestation boxes applicable for HMOs that report dental claims, certain MLR qualified expenses in Exhibits 7 or 8, and earn PPR incentives. Please use the comment box to describe the criteria used to determine any PPR incentives paid to providers.

Exhibit 2: Definitions

This tab shows the valid field values that can be copied and pasted (not cut and pasted) into the green columns in Exhibits 3, 4, and 5 (rather than selecting each drop down box). Drop down boxes show the valid entries and check the data entered. Invalid entries will be shaded in red.

Exhibit 3: Eligibility

Enter incurred year member month and premium data by various groupings. For maternity kick payments, HMOs should enter the number of deliveries rather than the number of member months. Please exclude revenue and membership information for ventilator-dependent members. Please also exclude revenue for provider access payments, P4P

settlements, and amounts for services reimbursed by DHS outside of the capitation rates in Exhibits 3 and report in Exhibits 7 and 8. **Do not report any estimated receivable or liability related to the DHS risk corridor settlement in Exhibits 3, 7, or 8, but include as a reconciliation item in Exhibit 10, as needed.**

Exhibit 4: Fee-For-Service Claims

Enter incurred year fee-for-service claims utilization, COB, and paid amounts by various groupings. Incurred year is the service year of the claim regardless of the paid year. Payments made to sub-capitated providers should be excluded from this tab. All payments should be reported net of third party liability recoupments. Payments made to related parties should be identified separately from payments made to other providers. Narcotic treatment services are the only EBPs that should be included in Exhibit 4. Claims for all other EBPs should be entered in line (51) of Exhibits 7 and 8.

Exhibit 5: Sub-capitation and Other Claims

Enter incurred year payments and COB to sub-capitated providers, risk sharing and / or provider incentive payments, and other payments made outside the claims system by various groupings. “Other Provider Incentives” should include provider incentives related to covered Medicaid benefits and should exclude provider incentives related to the initiatives for PPR, VOP, or VEP, which have separate Payment Types.

The “Paid Amount” column should only include claims expenses and should exclude any administrative expenses included in the sub-capitation payments. The “MLR Paid Amount” will be used for MLR reporting purposes to report claims paid to sub-capitated providers. As noted earlier, the “MLR Paid Amount” column should reflect amounts for sub-capitated providers in compliance with the CMS bulletin dated May 15, 2019 (https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf). The “MLR Paid Amount” column should equal the “Paid Amount” column for other payment types in Exhibit 5 (i.e., risk sharing, provider incentives, and other). Each arrangement should be given a consistent number for all incurred quarters so the detail can by summarized by each unique arrangement across different time periods. In addition, HMOs should provide informative descriptions in the “arrangement description” column. Similar to Exhibit 4, narcotic treatment services are the only EBPs that should be included in Exhibit 5. Claims for all other EBPs should be entered in line (51) of Exhibits 7 and 8.

Enter any paid PPR provider incentives as of the date you submit the template (rather than through the date specified in the template for all other claims), with any unpaid PPR provider incentives estimated in the IBNR columns in Exhibits 7 and 8. The PPR provider incentives are currently only applicable to the BCP program. Indicate the provider entity who received PPR and other incentives in the Entity column of Exhibit 5 (column D).

Exhibit 6: Related Party

Enter related party information by vendor name, affiliation, arrangement description, payment methodology, and amount by incurred quarter for fee-for-service claims, sub-capitated claims, provider risk sharing and incentives, other provider payments, administrative expenses, and other expenses. Enter any sub-capitated claims consistent with the “Paid Amount” column in Exhibit 5. A related party is an entity that is associated with the HMO by any form of common, privately held ownership, control, or investment. Please review the checks in rows 24 and 35 and make corrections if they do not match the amounts in the rows above them.

Exhibit 7: Summary of Newer Base Year

This tab summarizes the incurred year information for the most recent year reported (based on the information entered in Exhibits 3 through 5) when two years of experience are reported in the financial template. There are also several areas on this tab for HMOs to enter financial information.

Exhibit 8: Summary of Older Base Year

This tab summarizes the incurred year information for the older year reported (based on the information entered in Exhibits 3 through 5) when two years of experience are reported in the financial template. Similar to Exhibit 7, there are also several areas on this tab for HMOs to enter financial information. This tab also summarizes the partial year of experience when “YTD XX/XX/XXXX” is entered in cell B6 of the Notes tab.

Exhibit 9: Checks

This tab includes formulas to verify the data entered into Exhibits 3, 4, and 5 is consistent. Any non-zero check amounts on this tab indicate invalid entries into one or more of the input exhibits and should be addressed before submitting the completed template to DHS.

Exhibit 10: Reporting Comparison to Financials

Financial reporting amounts by service dates should be comparable to audited financial statements with material differences explained between claim, administrative expense, member month, and revenue amounts. Records supporting the amounts in this file should be kept for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later, based on Medicaid regulation. We provided a standard template in the "Exh 10 Fin Compare Std" tab HMOs may use to complete this information. If HMOs prefer to provide the comparison in their own format, please use the blank tab called "Exh 10 Fin Compare Custom." When using this template to report early partial incurred year results, these Exhibit 10 tabs should not be completed, and the "Exh 10 Fin Compare Std" tab will be shaded out.

Exhibit 11: MLR

This tab uses the information from other tabs to calculate the adjusted MLR and summarize the key components required for MLR reporting. Milliman may adjust the final MLR amounts reported to CMS to include any risk corridor settlements in the denominator or other adjustments, as appropriate.

CAVEATS AND LIMITATION ON USE

This memorandum and the attached financial reporting template are intended to be used by DHS and the participating HMOs to collect financial information to be used for the BadgerCare Plus and SSI 2024 capitation rate development and 2021 MLR reporting. This information may not be appropriate for other purposes. We designed the template to provide the HMOs with flexibility to report various financial reporting components for capitation rate development and MLR reporting. The HMOs are accountable for reporting their financial results in compliance with the template instructions and MLR requirements, as well as keeping appropriate documentation supporting their financial data submission.

This memo should not be provided to anyone other than DHS or the participating HMOs without Milliman's prior written consent. This information should not be relied upon by anyone other than DHS. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This memo assumes that the reader is familiar with the Wisconsin Medicaid program and managed care encounter data processing and reporting.

In preparing this information, we relied on information provided by DHS. We accepted this information without audit but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate.

The terms of Milliman's contract with DHS effective January 1, 2020, apply to this memo and its use.

JHB/EJV/laa

Financial Template (Provided in Excel)