15800 Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3680

milliman.com

MEMORANDUM

March 5, 2019

To: Chad Lillethun (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

Re: Responses to Questions Regarding the BCP and SSI Financial Reporting Template

The Wisconsin Department of Health Services (DHS) retained Milliman, Inc. (Milliman) to develop, document, and certify the 2020 capitation rates for Wisconsin's BadgerCare Plus (BCP) and Supplemental Security Income (SSI) managed care programs. This memorandum provides our responses from April 25, 2018 to prior questions DHS received from the participating Medicaid Health Maintenance Organizations (HMOs) with revised responses for questions 8, 12, and 18 and updates to line number references in the template.

The questions are shown in bold italics font, followed by our response in blue text.

QUESTIONS AND ANSWERS

***Question #1*: Claims should be recorded net of the encounter based payments (e.g., SSI Care Coordination and other reimbursement made outside of the capitation), correct?**

Milliman Response: Please exclude revenue and claims for any services reimbursed by DHS on a fee-for-service basis outside of the capitation rates or maternity kick payments. If there are material amounts of these payments in the financials, please document the variances between the financial template and financial amounts in Exhibit 10.

Question #2: Where and how should any CDPS Settlement be recorded?

Milliman Response: Please include CDPS settlement amounts as positive or negative 'Capitation Revenue' in Column F of Exhibit 3.

***Question #3*: What information is required in the Coordination of Benefits column of Exhibit 4? Are subrogation dollars included in this, or total paid and cost share amounts from all other insurance entities? Where should subrogation recoveries be recorded if not in the Total Paid column?**

Milliman Response: Please include all allowed amounts paid by a third party (i.e., not paid by the member or the HMO) that reduce the HMO liability in the claims data in the 'Coordination of Benefits' (COB) column in Exhibit 4. The 'Total Paid' column in Exhibit 4 should be reported net of COB amounts. Please report subrogation recoveries and any other third party recoveries made outside of the claims system in Exhibit 5 with a claim type of 'Other' and an appropriate arrangement description (e.g., 'subrogation'). Since subrogation amounts should be estimated for the incurred year and may be recovered in future years, please include an estimate of future subrogation recoveries (based on historical experience or other information) as negative amounts in the IBNR column for 'Other Payments' line (39) in Exhibits 7 and 8.

***Question #4*: Can you provide a more detailed description of what should be included in Utilization for "visits for all other services"?**

Milliman Response: For services with visit counts, we are assuming any amounts included with the same provider on the same day would count as one visit. Utilization counts should only be reported for non-zero paid amounts.

Question #5: Where should we enter the administrative expense portion from sub-capitation payments?

Milliman Response: Please include the administrative expense portion from sub-capitation payments in the administrative expense amounts in Exhibits 7 and 8. If these amounts are reported as claims in financial statements, please document the variances between the financial template and financial amounts in the claims and administrative expense sections in Exhibit 10.

Question #6: Why is quarterly reporting required?

Milliman Response: Including quarterly results will allow us to monitor emerging claim trends and volatility of claims over time. This is especially helpful when there is a large amount of missing encounter data, and we do not know the distribution of the missing data by quarter.

Question #7: On the [Exh 3 Eligibility] tab is the capitation premium/revenue intended to be on a risk adjusted basis?

Milliman Response: Yes, capitation premium should be reported on a risk adjusted basis.

Question #8: Do we include supplemental revenue for our OB medical home/high risk pregnancy medical home?

Milliman Response: No, exclude pass-through revenue and expenses for the OB medical home / high risk pregnancy medical home from the financial template.

Question #9: Since ventilator premium recoveries are handled outside the capitation system via manual reductions to the vent reimbursement, it is very time consuming to run our capitation reports from the 820/csv files, and then manually remove the capitation payments and member months, which are actually immaterial when compared to the total member months and premium. Our preference is not do this step as the removal of the member months and capitation does not materially impact the MLR or PMPMs. Our preference is to report the premium as an offset to the ventilator reimbursement row on Exhibit 7&8 since that is how we are paid.

Milliman Response: HMOs can remove the net ventilator recoupments (i.e., claim recoupments minus premiums received) in line (40) of Exhibits 7 and 8 and not remove the member months, since there is not a material impact. Please add information to the notes section to document the deviation from this part of the instructions. It would also be helpful to provide general comments on the impact (e.g., x members were ventilator recoupments in CY 2017).

Question #10: Item #18 on the [Instructions] tab details the claim category hierarchy. We have two questions as it pertains to claims categorization: Has logic been previously provided that details how claims get categorized into the specified services?

Milliman Response: In rate development, we are using DXC's claim type definitions for the high level categories (inpatient facility, outpatient facility, etc.), rather than our Milliman *Health Cost Guidelines (HCGs)* grouper logic. DXC's definitions are provided in the encounter user guide on forwardhealth.wi.gov. Ideally, HMOs should follow DXC's definitions, if possible, for consistency when completing the financial reporting template.

Question #11: Is the hierarchical ordering intended to be rolled up at a claim level or can claims be split out at a claim line level?

Milliman Response: Hierarchical ordering can be done at a claim line level, if reporting can be done at a claim line level and is appropriate.

Question #12: Could you please provide a definition of Non-State Plan Service?

Milliman Response: These are claims for services not covered under the HMO's contract (Non-State Plan Services do not include in-lieu of services or encounter based payments). In-lieu of services should be included in other covered claim categories. Encounter based payments should be excluded from the template (other than 'Narcotic Treatment Services' reported for informational purposes), except to show any differences between the reported template and financial amounts in Exhibit 10.

Question #13: The template requires IBNR to be reported in many components. Our membership is not large enough to develop reliable IBNR estimates at that detail level. Slicing and dicing our data at that finite level is not credible.

Milliman Response: The template provides flexibility to enter IBNR consistently with how the reserves are developed. For example, if only one IBNR bucket is developed, it would be reasonable to use the same IBNR percentage adjustment across all service categories. Alternatively, the IBNR factor could be varied by service category and / or eligibility category as appropriate based on the reserving methodology. We agree reserve credibility should be considered in determining how IBNR is calculated.

Question #14: Our Provider incentives are not attributable to members and cannot be broken out in the categories except through an allocation method. Additionally the amounts will likely be estimates versus actual paid.

Milliman Response: In order to include these payments into the base encounter data, we need provider incentive payments to be allocated by eligibility category and region. The template provides the flexibility for HMOs to determine the best way to allocate these payments using member months, total claims, or various other criteria depending on the details of the provider contracting arrangements. We understand the amounts reported may be estimates. Additionally, line (38) in Exhibits 7 and 8 allows HMOs to enter amounts not yet paid by eligibility category if appropriate for provider incentive payments.

Question #15: Our subrogation vender currently does not provide us with the information at this level.

Milliman Response: Please allocate the total subrogation amounts by a reasonable method (e.g., claim dollars) and document the methodology in the notes section.

Question #16: Please provide more detail around the Health Insurer Fee (HIF) and the expectation of how it should be populated for this template? More specifically, is the HIF that is being requested for CY 2014 the amount that was paid in 2014?

Milliman Response: HIF should be reported for the amount paid in each calendar year in the HIF rows in both the revenue and administrative expenses sections.

Question #17: We are not required to prepare an MLR report/Supplemental Health Care Exhibit in accordance with cited CFRs, thus we do not track "MLR qualified Care Coordination and Case Management" or "MLR Qualified Taxes and Fees". Additional, we follow GAAP but GAAP does not require that we track expenses as "Sales and Marketing", "Direct Expense", "Indirect Expense", "HIF Fee", or "Other". So we will use our best estimates to essentially create a third system of accounting (Statutory, GAAP, this DHS MLR report), but we would like the certification modified to state that the expense categories represent our best estimate of what the MLR directions are requesting since our current systems of accounting and reporting do not and are not required to track expenses in this manner.

Milliman Response: Please populate data for the administrative expense categories using the instructions provided in the template and include any deviations in the Notes tab. The certification includes the disclosures in the Notes tab and should be sufficient documentation.

Question #18: Are the Dental Fee-for-Service limited to payments to dentists, or any provider using the listed D codes?

Milliman Response: Dental experience should include any providers using D0120 - D9999 procedure codes and should only be reported if the HMO provides dental coverage.

Question #19: How are Maternity Delivery fee-for-service payments supposed to be defined? Can you please provide the criteria?

Milliman Response: For BadgerCare Plus Standard members, a claim is identified as maternity if it includes one of the following DRG codes with a non-zero re-priced Medicaid paid amount, which triggers a maternity kick payment:

- MS–DRG codes effective until January 1, 2017: 765, 766, 767, 768, 774, and 775
- APR-DRG codes effective January 1, 2017: 540, 541, 542, and 560

For members with one of the DRG codes listed above with a non-zero re-priced Medicaid paid amount, we assign claims with the following codes with service dates within nine months before, or two months after, the delivery date as maternity-related costs for purposes of the maternity kick payment development:

- Revenue codes: 0110 – 0539, 0560 – 0569, 0610 – 0649, or 0660 – 0999
- Procedure codes: 01958 – 01961, 01967 – 01968, 59000 – 59899, or 76801 – 76828

Note: We re-classify any maternity claims reported for Childless Adults (CLA) or SSI members as base claims since DHS does not pay maternity kick payments for these eligibility categories.

CAVEATS AND LIMITATION ON USE

This memorandum is intended to help DHS answer questions from the participating HMOs about the financial template to be used for the 2020 BCP and SSI capitation rate development. 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 to use for rate development and future MLR reporting. The HMOs are accountable for reporting their financial results in compliance with the template instructions and MLR requirements (once applicable), as well as keeping appropriate documentation supporting their financial data submission.

This memorandum 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 memorandum 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.

We are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

The terms of Milliman's contract with DHS effective January 1, 2015 apply to this memorandum and its use.

SSB/JHB/jf