



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

milliman.com

## MEMORANDUM

March 16, 2016

From: Shelly Brandel

To: Mr. Chad Lillethun  
Deputy Director, Bureau of Fiscal Management

Re: **Responses to HMO Financial Reporting Template Questions**

At your request, we are providing the Wisconsin Department of Health Services (DHS) with answers to questions from Medicaid Health Maintenance Organizations (HMOs) in response to the draft financial reporting template provided on February 1, 2016. The financial reporting template will be used to collect HMO financial data for participating BadgerCare Plus and SSI HMOs.

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

### QUESTIONS AND ANSWERS

**Question #1: We are concerned that 30 days is not enough time to complete this report (paid claims to 5/31, due date 7/1). We would like at least 60 days to complete.**

The Department will likely add a process to the contract which will allow an HMO to request an extension beyond the 7/1 due date. However, an extension would be unlikely to extend beyond 30 days. At this time it is unlikely the run out date of 5/31 will change. Extensions could delay draft rates.

**Question #2: The reporting periods seem to be duplicative. Is there a reason we are resubmitting 2014 and 3 quarters of 2015 data (other than the new Milliman layout)?**

We are asking for more detailed data (e.g., region, claim category, and incurred quarter) to refine our calculation of missing data and other encounter data adjustments. The updated template also provides HMOs the opportunity to re-state their 2014 data based on more updated information (e.g., additional time for claim runoff).

**Question #3: Why is quarterly reporting required?**

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 (the 2016 rates included factors around 10%), and we do not know the distribution of the missing data by quarter.

**Question #4: Should we exclude Benchmark costs/members from the financial data?**

Yes, all Benchmark experience should be excluded.

**Question #5: On the [Exh 3 Eligibility] tab is the capitation premium/revenue intended to be on a risk adjusted basis?**

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

**Question #6: Do we include supplemental revenue for our OB medical home/high risk pregnancy medical home?**

Yes, this should be included in the "other operating revenue" line (6) in Exhibits 7 and 8.

**Question #7: 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.**

HMOs can remove the net ventilator recoupments (i.e., claim recoupments minus premiums received) in row 39 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 and y members were ventilator recoupments in CY2014 and CY2015).

**Question #8: *Total utilization should be optional for the first year. We understand the need for inpatient admissions and deliveries, but question the need for visit counts for all other services.***

We would be comfortable with the HMOs excluding visit counts in their financial reporting. We agree inpatient admissions and deliveries should be the most helpful and most consistently reported, so please include this information in the financial data.

**Question #9: On [Exh 4 FFS Claims] is there a standardized method for recording utilization for services that typically have unit counts rather than visits, i.e., blood factor? Would two units of blood factor equal one visit or two visits?**

The intention for the visit counts is to collect utilization information and make it as meaningful as possible while combining multiple services together. For services with visit counts, we are assuming any amounts included with the same provider on the same day would count as one visit. In your example, the two units of blood along with any other claims from the same provider on the same day would be included together as one visit.

**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?**

In rate development, we are using Hewlett Packard's (HP's) claim type definitions for the high level categories (inpatient facility, outpatient facility, etc.) rather than our Milliman *Health Cost Guidelines (HCGs)* grouper logic. HP's definitions are provided in the encounter user guide on [forwardhealth.wi.gov](http://forwardhealth.wi.gov). Ideally, HMOs should follow HP'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?**

Hierarchical ordering can be done at a claim line level, if you are able to do so and it is appropriate.

**Question #12: Has the definition of maternity services changed from last year?**

We are evaluating the current maternity definition, which may be revised before the final template is released in April.

**Question #13: Can Maternity be clarified for both revenue and claims? We are assuming maternity revenue is the kick payment only, and not the capitation payments for pregnant women. In prior years, there were unique rate cells for pregnant standard, and initially thought that is what "BCP Standard Maternity" referred to, however this is no longer the case. Additionally, we would like clear, straightforward definitions of "BCP Standard Maternity – Hospital Inpatient" and "BCP Standard Maternity – Other". Ideally, we would like a straightforward list of IP DRGs, DX codes (ICD 9 and 10) and professional CPT codes to include, without any significant qualifiers. While this may not be a perfect split of the claims, we need to set up our reporting without too many complications.**

Maternity revenue should only include the kick payment. "BCP Standard Maternity – Hospital Inpatient" are inpatient facility claims based on DHS' current maternity logic. "BCP Standard Maternity – Other" are all other claims based on DHS' current maternity logic. We are reviewing the maternity logic and may recommend a simpler definition to DHS.

**Question #14: Could you please provide a definition of Non-State Plan Service?**

These are claims for services not covered under the HMO's contract, which do not include in-lieu of services.

**Question #15: The template requires IBNR to be reported in 40 components. There are 4 lines of business (BC+, CLA, SSI MA Only, SSI Duals). There are 10 Fee-For-Services claim categories. 4 lines of business times 10 claim categories results in 40 IBNR buckets. 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.**

The template provides flexibility to enter your IBNR consistently with how your reserves are developed. For example, if you have only 1 IBNR bucket, you could use the same IBNR percentage adjustment across all service categories. Alternatively, you can vary the IBNR factor by service category and/or eligibility category as appropriate based on your reserving methodology. We agree reserve credibility should be considered in determining how IBNR is calculated.

**Question #16: Is there a minimum FQHC reimbursement/payment amount for IBNR reporting? Our payments are not extensive. Could the actuary set an amount where, if HMOs don't reimburse FQHCs for that amount of services on an annual basis, then no IBNR reporting for FQHCs is necessary?**

FQHC is being removed as a separate category in Exhibit 4, and any FQHC claims will be reported within other claim categories (e.g., professional). We will be adding columns to the FQHC tab for HMOs to report the subset of FQHC paid claims by incurred calendar year (excluding IBNR).

**Question #17: Our Provider incentives are not attributable to members and cannot be broken out in the categories except through an allocation method. Additionally 2015 will likely be estimates versus actual paid.**

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, Row (37) in Exhibits 7 and 8 allows HMOs to enter amounts not yet paid by eligibility category if appropriate for provider incentive payments.

**Question #18: Our subrogation vender currently does not provide us with the information at this level.**

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

**Question #19: Item #16 on the [Instructions] tab contains administrative costs. 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?**

HIF should be reported for the amount paid in each calendar year.

**Question #20: 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.**

Please populate data for the administrative expense categories as best you can using the instructions provided in the template and include any deviations in the Notes tab. Your certification includes your disclosures in the Notes tab and should be sufficient documentation.

**Question #21: Is there a minimum MLR calculation for Wisconsin? Line 2 of the template mentions a minimum but a percentage is not provided.**

There is not currently a minimum MLR for Wisconsin Medicaid, but we are calculating the amount for reference. President Obama’s FY 2017 budget includes establishing a 2017 MLR of 85% for Medicaid and CHIP (see page 62): <https://www.whitehouse.gov/sites/default/files/omb/budget/fy2017/assets/budget.pdf>.

**Question #22: Can you clarify what is meant by audit? Specifically, what would be audited and how long should we keep this information?**

Auditing details have not yet been determined. However, DHS reserves the right to audit information, which should be kept for a minimum of 5 years.



## **CAVEATS AND LIMITATIONS ON USE**

I, Shelly S. Brandel, am a Principal and Consulting Actuary for Milliman. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

This letter is intended for the internal use of the Wisconsin Department of Health Services and it should not be distributed, in whole or in part, to any external party without the prior written permission of Milliman. This letter can be shared with the participating Wisconsin Medicaid HMOs. We do not intend this information to benefit any third party even if we permit the distribution of our work product to such third party.

This letter is designed to help DHS answer questions from HMOs about the financial reporting template that will be used to collect BadgerCare Plus and SSI HMO financial data. This information may not be appropriate, and should not be used, for other purposes.

In preparing this information, we relied on information provided by DHS about the Wisconsin BadgerCare Plus / SSI program. 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 Consulting Services Agreement with DHS effective January 1, 2015 apply to this letter and its use.



Please call Jill Brostowitz, John Meerschaert or me at (262) 784-2250 if you have any questions.

JHB/JDM/SSB:laa

cc: Brian Hoeft, DHS  
John Meerschaert, Milliman  
Jill Brostowitz, Milliman