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MEMORANDUM

April 19, 2016

To: Krista Willing and Bryan Hoeft (Wisconsin Department of Health Services)

From: Shelly Brandel, Jill Brostowitz, and John Meerschaert (Milliman)

cc: All HMOs Participating in BadgerCare Plus and SSI Medicaid Managed Care Programs

Re: **Financial Reporting Request for 2017 Rate Setting**

As discussed during Wisconsin Medicaid HMO contractor meetings, the Department of Health Services (DHS) is requiring all HMOs participating in the Wisconsin Medicaid BadgerCare Plus (BCP) and Supplemental Security Income (SSI) managed care programs to submit historical financial information for services provided during Calendar Years (CY) 2014 and 2015 with payments through May 31, 2016. This information will be used to support the 2017 rate setting process in various ways:

- Validating the CY 2014 and 2015 encounter data submitted to DHS and estimate 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 consider whether they should be included in the capitation rate setting base data
- Analyzing historical HMO administrative costs and develop 2017 administrative cost targets

The enclosed file, entitled "WI BCP Financial Template Version 1.0.xlsb", is the template the HMOs should use to report member months, revenue, payments to providers for medical services, and administrative costs for services provided during CY 2014 and 2015. The file contains an instructions tab for directions on completing the template.

The completed report should be submitted via email to DHS (DHSDHCAABFM@dhs.wisconsin.gov) by July 1, 2016.

KEY UPDATES FROM THE PRELIMINARY VERSION

We provided a draft financial reporting template to the HMOs at the February HMO technical call. We made the following changes to the draft template as a result of comments provided by the HMOs and discussion with DHS:

1. We removed Federally Qualified Health Center (FQHC) as a separate service category in Exhibits 4, 7, and 8, and any FQHC claims should be reported within other claim categories (e.g., professional) in these exhibits. We also added the "FQHC" tab for HMOs to report the subset of FQHC paid claims by incurred quarter.
2. We added the "Exhibit 9 Checks" tab for HMOs to validate the data they entered in Exhibits 3, 4, and 5 before providing the file to DHS to avoid resubmissions. If any amount in the "checks" column is non-zero, the data will likely need to be re-entered.

We also made other minor changes to wording, formats, and presentation of information throughout the reporting template.

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 in detail 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

The “Version” tab will be used to track each version of the file used.

Trade Secret

The “Trade Secret” tab is the non-disclosure of trade secret language from the HMO contract with DHS, which is shown in the file for reference.

Instructions

The “Instructions” tab provides general directions for completing the file and high level information about each tab.

Notes

The “Notes” 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. In subsequent years, the dates on this tab can be updated to reflect future reporting time periods.

FQHC

The “FQHC” tab contains tax identification numbers used to identify claim payments to FQHC providers. Enter claims paid for 2014 and 2015 incurred quarters excluding any incurred but not reported (IBNR) amounts.

Exhibit 1 Certification

The “Exh 1 Certification” 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. Exhibit 1 can be signed and submitted 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.

Exhibit 2 Definitions

The “Exh 2 Definitions” tab shows the valid field values that can be pasted into the green columns in Exhibits 3, 4, and 5 (rather than selecting each drop down box). Drop dox boxes show the valid entries and check the data entered. Invalid entries will be shaded in red.

Exhibit 3 Eligibility

In the “Exh 3 Member Months” tab, 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.

Exhibit 4 Fee-For-Service Claims

In the “Exh 4 FFSClaims” tab, enter incurred year fee-for-service claims utilization 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.

Exhibit 5 Sub-capitation and Other Claims

In the “Exh 5 SubCapOtherClaims” tab, enter incurred year payments to sub-capitated providers, risk sharing and / or provider incentive payments, and other payments made outside the claims system by various groupings. The Arrangement Number field should be used to differentiate different provider arrangements. The same arrangement number can be used multiple times to report payments by quarter, eligibility category, region, etc. as appropriate.

Exhibit 6 Related Party

In the “Exh 6 RelatedParty” tab, enter related party information by vendor name, affiliation, arrangement description, payment methodology, and amount by incurred year quarter for fee-for-service claims, sub-capitated claims, provider risk sharing and incentives, other provider payments, administrative expense, and other expenses. A related party is an entity that is associated with the HMO by any form of common, privately held ownership, control, or investment.

Exhibit 7 Summary of Newer Base Year

The “Exh 7 SumNewerBaseYear” tab summarizes the incurred year information for the most recent year reported (i.e., CY 2015) based on the information entered in Exhibits 3 through 5. There are also several areas on this tab for HMOs to enter financial information.

Exhibit 8 Summary of Older Base Year

The “Exh 8 SumOlderBaseYear” tab summarizes the incurred year information for the older year reported (i.e., CY 2014) based on the information entered in Exhibits 3 through 5. Similar to Exhibit 7, there are also several areas on this tab for HMOs to enter financial information.

Exhibit 9 Checks

The “Exh 9 Checks” 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.

QUESTION AND ANSWER FILE

In response to HMO questions on the draft financial template provided to DHS on February 1, 2016, we provided a question and answer document on March 16, 2016 which can also be referenced when completing the template.



CAVEATS AND LIMITATION ON USE

This memorandum and the attached exhibit are intended to be used by DHS and the participating HMOs to collect financial information to be used for the 2017 capitation rate development. This information may not be appropriate for other purposes. This letter should not be provided to anyone other than DHS or the participating HMOs without Milliman's prior written consent.

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.

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 letter assumes that the reader is familiar with the Wisconsin Medicaid program and managed care encounter data processing and reporting.

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

SSB/laa

Attachment in Excel