

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF WISCONSIN MEDICAID
MANAGED CARE PROGRAM
POTENTIAL SAVINGS
WITH MINIMUM
MEDICAL LOSS RATIO**

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for Audit Services

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A-05-15-00040

Office of Inspector General

<https://oig.hhs.gov>

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Report in Brief

Date: June 2017

Report No. A-05-15-00040

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Private health insurers, Medicare Advantage plans, and Medicare Part D sponsors are required to spend a fixed percentage of premium dollars to provide medical services and health quality improvement activities. This percentage is known as a medical loss ratio (MLR). This report is part of a series of OIG reviews conducted to determine whether the Medicaid program could achieve savings if States required Medicaid managed care organizations (MCOs) to meet a minimum MLR standard and pay remittances if the MLR standard was not met.

Our objective was to determine the potential Medicaid program savings if Wisconsin (1) required its Medicaid managed care plans to meet a minimum MLR standard similar to the Federal standards for certain private health insurers and Medicare Advantage plans and (2) required remittances if that MLR standard was not met.

How OIG Did This Review

We reviewed 2014 cost and premium revenue data for 11 Wisconsin Medicaid managed care plans. For each plan, we determined the MLR for the same period and the amount the MCOs would have had to return to Wisconsin if the plans were required to meet MLR standards similar to the Federal standards for certain private insurers and Medicare Advantage plans.

Review of Wisconsin Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio

What OIG Found

We determined that the Wisconsin Medicaid program could have saved \$16.2 million (approximately \$9.6 million Federal share) in 2014 if Wisconsin (1) required its Medicaid managed care plans to meet the minimum MLR standard similar to the Federal standards for certain private insurers and Medicare Advantage plans and (2) required remittances when Medicaid managed care plans did not meet the MLR standard. Specifically, of the 11 managed care plans that we reviewed, we calculated MLRs for 4 plans that were less than 85 percent (the minimum MLR standard for large private insurers) during calendar year 2014.

After our review but before the issuance of our report, the Centers for Medicare & Medicaid Services (CMS) published a final rule requiring Medicaid MCOs to achieve a minimum MLR for rate-setting purposes.

What OIG Recommends and Wisconsin Comments

We recommend that Wisconsin (1) incorporate into its contracts with Medicaid MCOs the MLR standards adopted in the CMS final rule and (2) consider implementing into its Medicaid MCO contracts a remittance requirement if appropriate.

Wisconsin agreed with our recommendations and described actions that it has already taken and plans to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

A medical loss ratio (MLR) is the percentage of premium dollars an insurer spends to provide medical services and health care quality improvement activities for its members. This report is part of a series of Office of Inspector General reviews¹ conducted to determine whether the Medicaid program could have achieved savings if States had required Medicaid managed care organizations (MCOs) to meet a minimum MLR standard and pay remittances if the MLR standard was not met.

Private health insurers, Medicare Advantage plans, and Medicare Part D sponsors are required to meet Federal minimum MLR standards.² Medicare Advantage plans and Medicare Part D sponsors are required to pay remittances to the Centers for Medicare & Medicaid Services (CMS) if their MLR falls below 85 percent. Private health insurers subject to the ACA's MLR standard must provide rebates to their enrollees if their MLR falls below the appropriate percentage, whether that is either 80 or 85 percent. At the time of our review, CMS did not require States to have a minimum MLR standard for Medicaid MCOs. After our review but before the issuance of our report, CMS published its final rule requiring Medicaid MCOs to achieve a minimum MLR for rate-setting purposes. The MLR formula required by the final rule is similar to the MLR requirements for most private health insurers, Medicare Advantage plans, and Medicare Part D sponsors. In the final rule, CMS encourages States to adopt provisions that require Medicaid MCOs to pay remittances when they do not meet the MLR standard. Several States have already awarded contracts to Medicaid MCOs with MLR standards similar to those for private health insurers, Medicare Advantage plans, and Medicare Part D sponsors. Some of these contracts require MCOs to issue remittances to the appropriate Medicaid State agency if the insurers do not meet minimum MLR standards.

The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program.

OBJECTIVE

Our objective was to determine potential Medicaid program savings if the Wisconsin Department of Health Services (State agency) (1) required its Medicaid managed care plans to meet a minimum MLR standard similar to the Federal standards for certain private health insurers and Medicare Advantage plans and (2) required remittances if that MLR standard was not met.

¹ See Appendix A for related Office of Inspector General reports.

² Patient Protection and Affordable Care Act, P.L. No. 111-148 (Mar. 23, 2010), and amending provisions of the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively known as the ACA.

BACKGROUND

The Medicaid Program

The Medicaid program pays for medical assistance for certain individuals and families with low income and resources (Title XIX of the Social Security Act). The Federal and State Governments jointly fund and administer the program. CMS administers the program at the Federal level. In Wisconsin, the State agency administers the Medicaid program.

Minimum Medical Loss Ratio for Medicaid Managed Care Organizations

CMS published a final rule on May 6, 2016, that requires Medicaid MCOs to achieve a minimum MLR of at least 85 percent, effective July 1, 2017.³ CMS implemented an MLR calculation for Medicaid MCOs similar to the Federal standards for most private health insurers, Medicare Advantage Plans, and Medicare Part D sponsors. The MLR calculation for Medicaid MCOs includes some variations to account for differences in the Medicaid program and population, for example, long-term services and supports or other services specific only to Medicaid and covered under the State plan. Under the final rule, States are required to use the 85-percent MLR as they develop capitation rates, and an MLR is one tool that can be used to assess whether capitation rates are appropriately set. Appropriately set capitation rates help to ensure adequate payments are made to provide services to beneficiaries, rather than to pay for administrative expenses. MCOs are also required to calculate and report their MLR to the State Medicaid agencies. CMS did not require Medicaid State agencies to implement remittances for MCOs that fail to meet MLR standards. However, CMS provided States the flexibility to require remittances from MCOs and encouraged States to implement contract provisions for remittances when the minimum MLR standard is not met.

Wisconsin's Medicaid Managed Care Program

Under Wisconsin's Medicaid managed care program, the State agency pays contracted MCOs fixed capitated payments to provide enrollees with Medicaid-covered services. In calendar year (CY) 2014, 1,032,183 Medicaid beneficiaries in Wisconsin were enrolled in Medicaid managed care plans.⁴ Of this number, 938,309 people were enrolled in 18 BadgerCare Plus managed

³ 81 Fed. Reg. 27498 (May 6, 2016). Medicaid MCOs must calculate MLRs effective July 1, 2017, and must achieve a minimum MLR of at least 85 percent effective July 1, 2019.

⁴ Wisconsin Medicaid managed care plans included the BadgerCare Plus plans (Standard, Benchmark, and Childless Adult), Medicaid Supplemental Security Income Program (including the Medicaid Purchase Plan), Children Come First and Wrap Around Milwaukee, and Long-Term Care plans (Family Care, Family Care Partnership, Program of All-Inclusive Care for the Elderly, and Care4Kids). We limited the scope of our review to the BadgerCare Plus and Family Care managed long-term care plans.

care plans,⁵ which offer comprehensive health services covered under the Medicaid State Plan and 44,669 people were enrolled in 7 Family Care managed long-term care plans,⁶ which offer certain services to the aged, chronically ill, or disabled.

Appendix B contains a detailed description of Wisconsin's Medicaid managed care coverage types, and Appendix C contains the MLR standard for Medicaid MCOs.

During CY 2014, the State agency claimed Medicaid reimbursement for payments made to MCOs totaling \$2,613,790,873 (\$1,548,577,742 Federal share). Of this amount, payments made to the 18 BadgerCare Plus managed care plans and 7 Family Care managed long-term care plans totaled \$955,830,493 (\$572,736,309 Federal share)⁷ and \$1,282,339,254 (\$754,735,932 Federal share), respectively.

HOW WE CONDUCTED THIS REVIEW

We reviewed CY 2014 cost and premium revenue data for 11 Wisconsin Medicaid managed care plans (9 BadgerCare Plus plans and 2 Family Care managed long-term care plans). During this period, the total amount of Medicaid premium revenue earned by these plans was \$830,079,962.⁸ For each plan, we determined the MLR for the same period and the amount the MCOs would have had to return to the State agency if the plans were required to meet MLR standards similar to those for private insurers and Medicare Advantage plans. We used the MLR formula applicable to private health insurers and Medicare Advantage plans.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix D contains the details of our audit scope and methodology.

⁵ BadgerCare Plus managed care plans provide beneficiaries with full Medicaid eligibility a comprehensive benefits package that includes inpatient and outpatient hospital services, emergency care, pharmacy services, home health services, and hospice care.

⁶ Family Care managed long-term care plans provide beneficiaries with any service or support that a person needs due to age, disability, or chronic illness that limits the ability to perform everyday tasks including nursing facility services, personal care services, home health services, therapies, disposable medical supplies, and durable medical equipment.

⁷ This amount includes capitated payments made to MCOs for BadgerCare Plus Standard, Benchmark, and Childless Adult enrollees.

⁸ The premium revenue included \$556,859,199 of BadgerCare Plus and \$273,220,763 of Family Care payments.

FINDING

We determined that the Wisconsin Medicaid program could have saved \$16,239,025 (approximately \$9,558,695 Federal share) in CY 2014 if the State agency (1) required its Medicaid managed care plans to meet the MLR standard similar to the Federal standards for certain private health insurers and Medicare Advantage plans and (2) required remittances when Medicaid managed care plans did not meet the MLR standard. Specifically, of the 11 managed care plans that we reviewed, we calculated MLRs for 4 plans that were less than 85 percent (the minimum MLR standard for large private insurers) during CY 2014.

SOME PLANS HAD A MEDICAL LOSS RATIO OF LESS THAN 85 PERCENT

We determined that four of Wisconsin's Medicaid managed care plans had MLRs of less than 85 percent during CY 2014. All four plans with MLRs less than 85 percent were BadgerCare Plus managed care plans.

We calculated that the Wisconsin Medicaid program could have saved \$16,239,025 (approximately \$9,558,695 Federal share) during CY 2014 if the State agency had required its Medicaid managed care plans to meet MLR standards for private health insurers and Medicare Advantage plans and required the plans to issue remittances to the State agency when they did not meet the standards. These standards, with the exception of issuing remittances, have since been established for Medicaid MCOs in the CMS final rule.⁹

Appendix E contains the results of our calculation of the MLR for the selected plans using the formula applicable to private health insurers and Medicare Advantage plans, the results of our calculation of potential remittances if the plans did not meet an 85-percent minimum MLR standard, and potential Medicaid program savings if the State agency had required its Medicaid managed care plans to meet an 85-percent minimum MLR standard and issue remittances to the State agency if the standards were not met.

RECOMMENDATIONS

We recommend that the State agency:

- incorporate into its contracts with Medicaid MCOs the MLR standards adopted in the CMS final rule and
- consider implementing into its Medicaid MCO contracts a remittance requirement if appropriate (while the CMS final rule did not require States to collect remittances from MCOs, CMS encouraged States to implement this type of provision).

⁹ The standards give States some flexibility in implementing the MLR requirements that may affect application of the formula.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations. The State agency stated that it has already reviewed the MLR requirements in the final Medicaid rule and described actions that it has taken to calculate MLR results well in advance of the Federal MLR reporting requirements. Additionally, the State agency stated that it will be important to look at the potential financial impact to MCOs, the quality of health for members, and the overall impact to the program when it considers implementing a remittance requirement into its Medicaid MCO contracts.

The State agency's comments are included in their entirety as Appendix F.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Review of California Medicaid Managed-Care Program Potential Savings With Minimum Medical Loss Ratio</i>	<u>A-09-15-02025</u>	1/13/2017
<i>Review of South Carolina’s Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio</i>	<u>A-04-16-06191</u>	12/21/2016
<i>Review of Massachusetts Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio</i>	<u>A-01-15-00505</u>	11/30/2016
<i>The Medicaid Program Could Have Achieved Savings if Oregon Had Applied Medical Loss Ratio Standards Similar to Those Established by the Affordable Care Act</i>	<u>A-09-15-02033</u>	4/12/2016
<i>The Medicaid Program Could Have Achieved Savings if New York Applied Medical Loss Ratio Standards Similar to Those Established by the Affordable Care Act</i>	<u>A-02-13-01036</u>	10/20/2015

APPENDIX B: WISCONSIN'S MEDICAID MANAGED CARE COVERAGE TYPES

BADGERCARE PLUS

BadgerCare Plus is a health care coverage program for low-income Wisconsin residents comprising children, pregnant women, and adults with or without dependent children. During 2014, there were three BadgerCare Plus plans: the Standard Plan, Benchmark Plan, and Childless Adult Plan. Beneficiaries receive a comprehensive benefits package, including inpatient and outpatient hospital services, emergency care, pharmacy services, home health services, and hospice care.

Standard Plan

The Standard Plan became effective February 1, 2008, and provides Medicaid services for families with income at or below 200 percent of the Federal Poverty Level (FPL).

Benchmark Plan

The Benchmark Plan, which ended March 31, 2014, provided Medicaid services to all previously noncovered children, to certain previously noncovered pregnant women, and to certain self-employed adults with an income of up to 300 percent of the FPL. This plan had higher copayments than the Standard Plan and limited some coverage of benefits.

Childless Adult Plan

The Childless Adult Plan provides Medicaid services comparable to those provided by the Standard Plan to adults who do not have any children under the age of 19 in their care and whose income does not exceed 200 percent of the FPL. Effective April 1, 2014, the Childless Adult Plan became limited to the population with income of less than or equal to 100 percent of the FPL.

MEDICAID SUPPLEMENTAL SECURITY INCOME

Supplemental Security Income (SSI) is a monthly cash benefit plan paid by the Federal Social Security Administration and State agency to people in financial need who are 65 years old or older or people of any age who are blind or disabled and residents of Wisconsin. Beneficiaries who are approved for the SSI plan are automatically qualified for Medicaid. For beneficiaries who also have Medicare, the State agency pays out-of-pocket Medicare costs, such as Medicare premiums, deductibles, and copayments. (This plan was not included in the scope of our review.)

The Medicaid Purchase Plan

The Medicaid Purchase Plan provides health care for people who work and have disabilities. This plan allows adults with significant disabilities to earn more income and maintain higher asset levels without risking their health or long-term care coverage. Depending on the beneficiary's income, a premium payment may be required for this health care coverage. (This plan was not included in the scope of our review.)

CHILDREN COME FIRST AND WRAP AROUND MILWAUKEE

The Children Come First Plan started in Dane County in 1993, and the Wrap Around Milwaukee Plan started in Milwaukee County in 1997, to provide behavioral health services to children with severe emotional disturbances in home and community settings rather than in residential treatment centers and inpatient psychiatric hospitals. A child must be a Medicaid recipient and have a severe emotional disturbance to be eligible. (These plans were not included in the scope of our review.)

LONG-TERM CARE

Managed long-term care assists elderly, blind, or disabled individuals who require health and long-term-care services, such as personal care, housekeeping, or nursing. Long-term care is provided in people's homes, in residential care facilities or group homes, in nursing facilities, and in the workplace. Long-term care includes any service or support that a person needs because of age, disability, or chronic illness that limits the ability to perform everyday tasks; these services and support include nursing facility services, personal care services, home health services, therapies, disposable medical supplies, and durable medical equipment.

Within the managed long-term care program, there are four types of plans: Family Care, Family Care Partnership, Program of All-Inclusive Care for the Elderly (PACE), and Care4Kids. All plans accept Medicaid.

Family Care

Family Care provides long-term care services for people who are elderly, blind, or disabled. Family Care started in 1999 and has since expanded nearly statewide. Family Care integrates home and community-based services, institutional care (such as nursing home care), medical personal care, and home health. Family Care does not pay for health care costs such as hospital stays, emergency room visits, medications, or doctor visits. Family Care participants use Medicare and Medicaid to purchase these health care services.

Family Care Partnership

Family Care Partnership began in 1996 and is a full-benefit plan that covers health care and long-term support services for people who are elderly or disabled. Services are provided in the

member's home or in a setting of his or her choice. Family Care Partnership provides participants in 14 counties with services similar to Family Care, except Family Care Partnership also covers acute and primary care services. (This plan was not included in the scope of our review.)

Program of All-Inclusive Care for the Elderly

A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. Beneficiaries receive a comprehensive benefits package, including care management, inpatient and outpatient hospital services, physician services, home health care, personal care, adult day care, durable medical equipment, and transportation services. PACE plans receive a capitated payment from both Medicaid and Medicare. (This plan was not included in the scope of our review.)

Care4Kids

Care4Kids was launched January 1, 2014, in six counties in Wisconsin and offers comprehensive and coordinated health services for children and youth in foster care. Benefits include health screening and assessments, all Medicaid-covered benefits, dental and vision care, routine check-ups, services of a health care coordinator, and a comprehensive health care plan tailored to the child's individual needs. (This plan was not included in the scope of our review.)

APPENDIX C: THE MEDICAL LOSS RATIO STANDARDS FOR MEDICAID MANAGED CARE ORGANIZATIONS

CMS published a final rule on May 6, 2016, that requires Medicaid MCOs to calculate, report, and use an MLR to develop capitation rates. The final rule requires that the capitation rates for MCOs be set so as to achieve a minimum MLR of at least 85 percent.¹⁰ The MLR calculation for Medicaid MCOs is similar to the Federal standards for most private health insurers, Medicare Advantage plans,¹¹ and Medicare Part D sponsors.¹²

The MLR is the sum of an MCO's incurred claims, expenditures for activities that improve health care quality, and possibly limited expenditures for fraud prevention activities¹³ divided by premium revenue adjusted for Federal or State taxes and licensing or regulatory fees and accounting for net adjustments for risk corridors or risk adjustment. According to CMS, the calculation is the same general calculation as the one established in 45 CFR § 158.221 for private insurers, with differences as to what is included in the numerator and the denominator to account for differences in the Medicaid program and population.

The formula for calculating the MLR under the final rule is:

$$\frac{\text{(Incurred Claims + Expenditures for Activities that Improve Health Care Quality)}^{14}}{\text{(Premium Revenue}^{15} - \text{Taxes} - \text{Licensing and Other Regulatory Fees)}}$$

The CMS final rule proposes that States may impose a remittance requirement in accordance with State requirements if an MCO fails to meet the minimum MLR. Although the rule does not

¹⁰ 81 Fed. Reg. 27498, 27521 (May 6, 2016).

¹¹ 42 CFR part 422.

¹² 42 CFR part 423.

¹³ CMS noted in the final rule that it was premature to adopt a standard for incorporating fraud prevention activities in the MLR for Medicaid since these expenses are not included in the current regulations on the MLR in the private insurance market. CMS further stated that fraud prevention activities should be aligned across programs. Therefore, the final rule stated that regulations related to incorporating fraud prevention activities in the MLR calculation will specify that MCO expenditures on activities related to fraud prevention as adopted for the private insurance market at 45 CFR part 158 would be incorporated into the Medicaid MLR calculation in the event the private insurance market MLR regulations are amended.

¹⁴ The definition of activities that improve health care quality encompasses activities related to service coordination, case management, and activities supporting States' goals for community integration of individuals with more complex needs, such as individuals using long-term services and supports.

¹⁵ Payments by States to MCOs for one-time, specific life events of enrollees—events that do not receive separate payments in the private market or Medicare Advantage—would be included as premium revenue. Typical examples of these include maternity “kick-payments,” where payments to MCOs are made at the time of delivery to offset the cost of prenatal, postnatal, and labor and delivery costs for an enrollee.

require States to collect remittances from MCOs, CMS encourages States to implement these types of financial contract provisions. Section 1.B.1.c.(3) of the final rule addresses the treatment of any Federal share of such remittances.¹⁶

¹⁶ 81 Fed. Reg. 27498, 27532 (May 6, 2016).

APPENDIX D: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the total amounts recorded on the MCOs' general ledgers for premium revenue, medical expenses, activities that improve health care quality, and Federal and State taxes and licensing and regulatory fees for nine BadgerCare Plus managed care plans and two Family Care managed long-term care plans for CY 2014.¹⁷ During this period, the total amount of Medicaid premium revenue earned by these plans was \$830,079,962.¹⁸

During CY 2014, the State agency claimed Medicaid reimbursement for payments made to 18 BadgerCare Plus managed care plans and 7 Family Care managed long-term care plans totaling \$955,830,493 (\$572,736,309 Federal share) and \$1,282,339,254 (\$754,735,932 Federal share), respectively.

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS) file for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to the State's claim for reimbursement in the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).

We did not review the overall internal control structure of the State agency or the Wisconsin Medicaid program. Rather, we reviewed only those controls related to our objective. We did not verify the accuracy of all cost and premium revenue information provided by the MCOs.

We performed fieldwork at the State agency's office in Madison, Wisconsin, and at MCOs' offices throughout Wisconsin from July 2015 through April 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements;
- held discussions with CMS officials to obtain information regarding Wisconsin's Medicaid managed care program;

¹⁷BadgerCare Plus MCOs are required to submit an MLR report quarterly. Family Care MCOs are required to submit audited year-end financial statements annually. Both BadgerCare Plus and Family Care MCOs are required to submit service utilization information.

¹⁸ The premium revenue comprised \$556,859,199 of BadgerCare Plus and \$273,220,763 of Family Care payments.

- held discussions with State agency officials to gain an understanding of the State agency’s policies and procedures for overseeing and administering its Medicaid managed care program;
- reconciled Medicaid managed care payments included on Form CMS-64 to the State’s MMIS for the quarter ended March 31, 2014;
- obtained from the State agency a summary of capitated payments made to MCOs contracted with the State agency during CY 2014;
- obtained from the State agency Medicaid Managed Care MLR reports for all BadgerCare Plus managed care plans and Financial Statement Summaries for all Family Care managed long-term-care plans;
- selected for review 9 of the 18 BadgerCare Plus managed care plans and 2 of the 7 Family Care managed long-term-care plans and:
 - obtained from the MCOs total amounts recorded on their plans’ general ledgers for cost and premium revenue;¹⁹
 - obtained from the MCOs supporting documentation (e.g., general ledger account summaries and actuarial estimates and opinions) for the cost and premium revenue elements, as well as an explanation of how these amounts were derived;
 - verified a judgmental sample of incurred medical expenses;²⁰
 - verified earned premium revenue;²¹
 - used the financial data obtained from the MCOs to compute the MLR, using the formula applicable to private health insurers and Medicare Advantage plans;

¹⁹ Specifically, we obtained the total amounts recorded on the plans’ general ledgers for premium revenue, medical expenses, activities that improve health care quality, and Federal and State taxes and licensing and regulatory fees.

²⁰ We selected 1 month during the audit period and verified certain medical expenses to the general ledger and supporting documentation (e.g., invoices).

²¹ We obtained total capitated payments made to the plans by the State agency and compared those amounts to the plans’ earned premium revenue.

- calculated the remittance²² that would have been issued to the State agency and determined the potential Medicaid program savings if the State agency had required the plan to meet a minimum MLR standard and issue a remittance to the State agency if the standard was not met; and
- discussed our audit results with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

²² The ACA-established formula for calculating the rebate is (premium revenue – taxes – licensing and regulatory fees) × (the applicable MLR standard – the insurer’s calculated MLR).

**APPENDIX E: MEDICAL LOSS RATIOS FOR WISCONSIN'S MEDICAID
MANAGED CARE PLANS AND POTENTIAL PROGRAM SAVINGS**

Plan	MLR²³	Potential Medicaid Program Savings²⁴	Federal Share of Potential Medicaid Program Savings²⁵
BadgerCare Plus			
MMC-1	94.2%	-	-
MMC-2	80.6%	\$1,290,340	\$759,526
MMC-3	83.2%	2,281,652	1,343,037
MMC-4	72.5%	6,194,115	3,646,011
MMC-5	76.3%	6,472,918	3,810,121
MMC-6	88.1%	-	-
MMC-7	91.0%	-	-
MMC-8	87.7%	-	-
MMC-9	85.5%	-	-
Subtotal		16,239,025	9,558,695
Family Care			
MLTC-1	98.9%	-	-
MLTC-2	91.8%	-	-
Subtotal		-	-
Total		\$16,239,025	\$9,558,695

Note: Shaded areas indicate those plans that did not meet a minimum MLR of 85 percent.

²³ We rounded insurers' MLRs in accordance with Federal regulations (45 CFR § 158.221 and 42 CFR §§ 422.2400-2480).

²⁴ To calculate the potential Medicaid program savings, we multiplied the potential program savings by the percent of the MCO's revenue that was funded 100 percent by Medicaid.

²⁵ The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program (section 1903(d)(3)(A) of the Social Security Act). To determine the approximate Federal share of potential program savings, we multiplied the Medicaid potential program savings by 59.06 percent for 9/12th of the year (the Federal Medicaid assistance percentage applied to payments to Medicaid managed care organizations in Wisconsin for January 1, 2014, through September 30, 2014) and by 58.27 percent for 3/12th of the year (the Federal Medicaid assistance percentage applied to payments to Medicaid managed care organizations in Wisconsin for October 1, 2014, through December 31, 2014).

APPENDIX F: STATE AGENCY COMMENTS



State of Wisconsin
Department of Health Services
Scott Walker, Governor
Linda Seemeyer, Secretary

April 21, 2017

Ms. Sheri L. Fulcher
Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan Avenue, Suite 1360
Chicago, IL 60601

Re: Report No: A-05-15-00040

Dear Ms. Fulcher:

This letter sets forth the comments of the Wisconsin Department of Health Services (WIDHS) regarding the U.S. Department of Health and Human Services (DHHS), Office of Inspector General's (OIG) draft report entitled *Review of Wisconsin Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio*, Report No: A-05-15-00040, dated March 21, 2017 (hereinafter, "Draft").

The Draft report makes two recommendations:

DHHS OIG Recommendation:

Incorporate into its contracts with Medicaid Managed Care Organizations (MCOs) the Medical Loss Ratio (MLR) standards adopted in the CMS final rule.

WIDHS Response:

The WIDHS has welcomed the OIG audit of our Medicaid Managed Care Program's MLRs. The OIG audit was performed on 2014 Medicaid experience. At the time the 2014 capitation rates were developed WIDHS, did not collect detailed financial data from the Medicaid MCOs. As a result, it was difficult to validate the base period encounter data used for rate setting or measure historical MLR results for consideration in rate development.

Starting in 2016, WIDHS required plans to report financial data. As a result, WIDHS is now able to ensure the base period encounter data used for rate setting is consistent with the actual reported financial data for each MCO. In addition to base data validation, the financial data can also be used to measure historical financial results for

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each MCO and in aggregate across all Medicaid MCOs for each rate setting eligibility category.

WIDHS concurs with the OIG's recommendation and has already reviewed the MLR requirements in the final Medicaid rule and adjusted the financial reporting template to allow WIDHS to calculate MLR results using the MLR definition included in the final rule. This will allow WIDHS to calculate MLR results well in advance of the federal MLR reporting requirements for calendar year contracts to report calendar year 2018 MCO experience to CMS by the end of 2019.

DHHS OIG Recommendation:

Consider implementing into its Medicaid MCO contracts a remittance requirement if appropriate (while the CMS final rule did not require States to collect remittances from MCOs, CMS encouraged States to implement this type of provision).

WIDHS Response:

As OIG notes in its recommendation, the CMS final rule did not require States to collect remittances from MCOs, though CMS encouraged States to implement this type of provision. WIDHS agrees with OIGs recommendation to *consider* implementing a remittance requirement into its Medicaid MCO contracts if it is deemed appropriate. As WIDHS considers this action, it will be important to look at the potential financial impact to MCOs, the quality of health for members, and the overall impact to the program.

Thank you for the opportunity to comment.

Sincerely,

\Linda Seemeyer\

Linda Seemeyer
Secretary