# Summary of Adjustments and Findings

## Background

This document presents an overview of findings and adjustments reported during the performance of the HMO Financial Reporting Examination of Exhibit 7 and 8 and External Quality Review (EQR) Protocol 4 engagements for the calendar years ended December 31, 2016 and December 31, 2017 related to the Wisconsin Department of Health Services (DHS) BadgerCare Plus and SSI managed care programs. Myers and Stauffer LC is contracted by DHS to perform the engagement per the request for bid (RFB) and contract number RFB S-0720 Division of Medicaid Services (DMS)-18.

**HMO Financial Reporting Examination of Exhibit 7 and 8:**

Wisconsin Financial Reporting Memorandums and Centers for Medicare & Medicaid Services (CMS) federal guidance are utilized for the financial reporting examination engagement. Guidance specific to the medical loss ratio (MLR) is included below:

https://www.ecfr.gov/cgi-bin/text-idx?SID=e45ec878432b9e3203ccbeab7b5084b5&mc=true&node=se42.4.438_18&rgn=div8

**EQR Protocol 4:**

Centers for Medicare & Medicaid Services (CMS) federal guidance is utilized for the EQR Protocol 4 engagement included below:

https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-4.pdf

## HMO Financial Reporting Examination of Exhibits 7 and 8

- **Revenue Component**

*The adjustments listed below were infrequently required for the health plans examined during the engagement.*

1. Adjust provider access payments to agree with state data.
2. Add Health Insurer Fee (HIF) revenues not reported by the health plan.
3. Adjust other revenues to agree with health plan's documentation.
4. Adjust waived member cost sharing to agree with the health plan's supporting documentation.

- **Clinical Expense Component**

*The adjustments listed below were infrequently required for the health plans examined during the engagement.*

1. Reclassify interest expense on paid claims and to administrative expense.

2. Remove incurred but not reported (IBNR) margin from Fee-For-Service medical expense.

3. Adjust ventilator recoupments to the health plan's supporting documentation for the correct time period.

4. Remove duplicated claims payments to providers in medical expenses that were not reversed by the health plan.

5. Reclassify medical expenses reported as other medical identified as Healthcare Quality Improvement (HCQI) expense.

*The adjustments listed below were frequently required for the health plans examined during the engagement.*

6. Adjust medical vendors' expense reported on a per member-per month (PMPM) basis to actual claims incurred. Administrative cost and profit for related medical vendors should not be reported as medical cost.

7. Remove non-allowable HCQI items such as related party profit, utilization management, and unsupported unpaid claims adjustment expense.

- **Administrative Expense Component**

*The adjustments listed below were infrequently required for the health plans examined during the engagement.*

1. Remove duplicated expenses related to HIF and sales reported in administrative expense.

2. Adjust to health plan's supporting documentation to correct misreported expense amounts.

3. Adjust HIF expenses not reported by the health plan.

4. Reclassify administrative expenses claimed as provider incentives in medical expense.

5. Remove HIF related taxes from the tax reporting line. HIF for the MLR calculation is not included, therefore, related taxes should also be excluded.

*The adjustments listed below were frequently required for the health plans examined during the engagement.*

6. Adjust to remove non-allowable administrative expense items such as non-Medicaid markets, lobbying, charitable contributions, regulatory fines and penalties, marketing, and advertising.

7. Adjust to reflect administrative expenses at actual cost.

8. Remove related party profit and unsupported related party administrative expense.

- **Other Information Component**

*The adjustments listed below were infrequently required for the health plans examined during the engagement.*

1. Adjust BadgerCare Plus (BCP) standard deliveries to the state's data.

***DHS Response to the HMO Financial Reporting Examination of Exhibit 7 and 8:***

DHS is reviewing individual HMO audit results and may reach out to the plans to discuss any required changes.

# External Quality Review Protocol 4

- **Activity 1 – State Requirements**

*Note the following findings are specific to DHS or DXC (fiscal agent contractor, or FAC).*

1. DXC currently only sends member information to the health plans twice a month.

2. The Wisconsin companion guide for dental encounters (837D) does not require the submission of the claim health plan paid date on dental encounters.

3. The payment of interest on claims paid late by the health plans does not appear to be consistent. The contract between DHS and health plan does not contain specific language related to the payment of interest by the health plan to providers.

4. The DHS requirement regarding encounter volume only contains criteria around variances greater than 10 percent lower than expected volume.

5. Contract language is unclear related to the dates utilized in calculating pricing percentage requirement.

6. Contract language is unclear related to the date utilized in assessing the encounter data submission timeliness requirement.

7. Contract language related to audit requirements does not identify specific criteria regarding the timeliness of audit information.

- **Activity 2 – MCO's Capability**

*The findings listed below were infrequently identified for the health plans reviewed during the engagement.*

1. Information related to a member's third party liability (TPL) is not being communicated to DHS when the health plan receives the information in the course of business.

2. The health plan does not have a formal HIPAA check policy or procedure.

3. The health plan is unable to distinguish claims by line of business related to its claim audit process.

4. Health plan provider specialty definitions do not correspond to DHS' definitions.

5. The health plan does not always correct a claim in the claim system if an encounter is adjusted and the update would not change the payment of the claim.

6. The health plan makes mass claims adjustments but does not make individual adjustments to premiums its processing system.

7. The health plan does not have a formal method of tracking encounter adjustment information interdepartmentally.

8. The health plan uses a manual process for pricing DRG claims, editing claims and processing the claim through the encounter system.

9. Encounter edits are being performed without the claim adjusted through the claims system.

10. The health plan has an overall enrollment audit process, however, there are no established enrollment audit procedures specific to BadgerCare Plus.

11. The health plan uses DHS reporting to calculate the premiums reported in the Financial Template.

12. Health plan personnel indicated the FAC is not sending the encounter response file consistently in a timely manner.

13. Health plan personnel indicated that for dual eligible members' encounters, where Medicare paid zero dollars, the FAC was denying the encounter with a denial reason code which specified the encounter should be submitted as Medicaid only and not as a dual eligible member.

14. Health plan personnel indicated dual members that had more than one service on an encounter and one or all of the services were not covered by Medicare, the Medicare non-covered lines have to be pulled out and submitted as a Medicaid only claim on a separate encounter.

*The findings listed below were frequently identified for the health plans reviewed during the engagement.*

15. The health plan does not have a formal process for tracking claim processing aging or encounter aging within its systems.

16. The health plan does not have a formal duplicate process established to verify duplicated encounters.

17. There is limited oversight and validation of subcontractor encounter submissions for the health plan subcontractors. Often, the data is passed through to the FAC with minimal checks for completion or subsequent validation by the health plan.

- **Activity 3 – Encounter Data Analysis**

*The findings listed below were infrequently identified for the health plans reviewed during the engagement.*

1. Cash Disbursements Journal (CDJ) data was not submitted for dental service type for the one or more of the selected sample months.

*The findings listed below were frequently identified for the health plans reviewed during the engagement.*

2. There were missing values for the plan paid date or the data element was populated with a default date of 01/01/1900 within all service types.

3. Encounter data for selected sample months was missing, attributing to completion percentages of less than 100 percent.

4. Surplus encounters, encounters for which there was not a corresponding CDJ claim submission, were identified across all service types in the FAC encounter data.

5. Various key data elements within all service types had a validity, matching and accuracy rates of less than 100 percent.

6. The Service/Rendering Provider Specialty Code in the sample claims data represented the Service/Rendering Provider type, attributing to lower accuracy rates between the encounter data and the claims data.

7. Service/Rendering Provider Specialty Code was not always populated in the sample claims data.

- **Activity 4 – Medical Records Review**

*The findings listed below were frequently identified for the health plans reviewed during the engagement.*

1. Not all medical records were submitted due to lack of response from its providers.

2. Medical records received did not contain the necessary documentation to support the tested element, attributing to lower accuracy rates for certain service types.

3. Medical records received were illegible, therefore deemed unusable, attributing to lower accuracy rates for certain service types.

## ***DHS Response to the External Quality Review (EQR) Protocol 4 engagement:***

DHS is addressing the audit findings by reviewing potential contract changes, working with the FAC on possible modifications and reaching out to the HMOs if necessary.