Summary of Adjustments and Findings

Background

This document presents an overview of findings and adjustments reported during the performance of the Medical Loss Ratio (MLR) Examination, Administrative Expenses Review, and External Quality Review (EQR) Protocol 4 engagements for the calendar years ended December 31, 2017 and December 31, 2018 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.

Report on Adjusted Medical Loss Ratio - Exhibit 7 and 8:

Wisconsin Financial Reporting Memorandums and Centers for Medicare & Medicaid Services federal guidance are utilized for this examination engagement. Guidance specific to the MLR, 42 Code of Federal Regulations § 438.8, is included below:

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

Report on Adjusted Administrative Expenses - Exhibit 7 and 8:

Wisconsin Financial Reporting Memorandums and Centers for Medicare & Medicaid Services federal guidance are utilized for this review engagement. Guidance specific to administrative expenses, 45 Code of Federal Regulations § 75 Subpart E, is included below:

https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75#sp45.1.75.e

EQR Protocol 4:

Centers for Medicare & Medicaid Services 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

Report on Adjusted Medical Loss Ratio - 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. Adjust waived member cost sharing to agree with the health plan's supporting documentation.

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

3. Add revenues related to programs reimbursed outside of the capitation including Dental Pilot, Supplemental Security Income Care Coordination, Long-Acting Reversible Contraceptives, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome, and Narcotic Treatment Services (2018 only) and other payments to agree with state data.

Clinical Expense Component

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

1. Adjust medical expense keying errors to health plan's supporting documentation.
2. Adjust maternity medical expenses to align with the dates of services within the reporting period.
3. Adjust ventilator recoupments to the health plan's supporting documentation for the reporting period.
4. Remove unsupported medical expenses.
5. Remove non-allowable taxes reported.
6. Adjust provider incentives to actual paid amounts.
7. Adjust third party medical expenses to actual claims paid for the reporting period.

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

8. Add medical claims expense incurred for programs reimbursed outside of the capitation (associated with revenue component number 3).
9. Reclassify MLR qualifying expense reported as administrative expenses (Healthcare Quality Improvement and Community Benefit Expenditures).

Other Information Component

The adjustments listed below were infrequently required for the health plans examined during the engagement and are informational only.

1. Add Health Insurer Fee revenue and expense not reported by the health plan.

DHS Response to the Report on Adjusted Medical Loss Ratio - Exhibit 7 and 8:

DHS added contract language clarifying which expenses qualify for MLR. DHS is also reviewing individual HMO audit results and may reach out to the plans to discuss any other required changes.

Report on Adjusted Administrative Expenses - Exhibits 7 and 8

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

1. Adjust allocation of expenses based on supporting documentation.
2. Adjust to reflect administrative expenses at actual cost.
3. Remove unsupported administrative expenses.

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

4. Adjust to remove non-allowable administrative expense items such as non-Medicaid markets, lobbying, charitable contributions, marketing, and advertising.
5. Reclassify MLR qualifying expense reported as administrative expenses (Healthcare Quality Improvement and Community Benefit Expenditures).

DHS Response to the Report on Adjusted Administrative Expenses - Exhibit 7 and 8:

DHS added contract language specifying administrative expenses that are not allowable for consideration when setting the administrative portion of the capitation rate. The contract language around MLR qualifying expense was also adjusted.

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 payment of interest on claims paid late by the health plans does not appear to be consistent. The contract between DHS and the health plan does not contain specific language related to the payment of interest by the health plan to providers.
3. The DHS requirement regarding encounter volume only contains criteria around variances greater than 10 percent lower than expected volume.

4. Contract language is unclear related to the benchmark utilized in calculating pricing percentage requirement.

5. Contract language related to audit requirements does not identify specific criteria regarding the timely submission of audit documentation.

- *Activity 2 – MCO's Systems Capability*

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

1. The health plan does not split out claim metrics by program.

2. The health plan does not reprocess claims for retroactive eligible members and relies on the provider to contact the health plan requesting the reprocessing of a claim.

3. The health plan has not successfully submitted any dental encounters.

4. The health plan manually loads encounter data from its claims management vendor.

5. The health plan does not have a formal process to verify duplicate encounters. The health plan does not search for current ICN number on adjustments.

6. The health plan backs up all data but does not have a formal data archiving process.

7. There are no formal procedures in place for auditing and reconciling enrollment files. The health plan relies on claim audits for identifying issues.

8. The health plan does not have a formal process for claim examiner audits after the initial training and achievement of 100 percent accuracy or audits only two percent of its claims volume.

9. Although each subcontractor has a disaster recovery plan, there is no health plan oversight of these individual plans to ensure the subcontractor's ability to fully restore the health plan's operations in an acceptable amount of time.

10. There does not appear to be oversight of the vendor that processes paper claims.

11. Changes in processes implemented by a third party vendor are not vetted through the health plan. These changes, which may affect members, could potentially be implemented without the health plan's knowledge.

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

12. There is no formal process in place for reconciling encounters to financial data.

13. There is no workflow tool in place for tracking claims adjustments, processing notes and encounter corrections and revisions. If the assistance of another department is required, the health plan uses electronic mail to communicate claim information.

14. A risk area was identified regarding staffing and/or the segregation of duties for many operational tasks.

15. There is limited health plan oversight and validation of subcontractor encounter data submissions. Subcontractor encounter data is passed through to the FAC with minimal checks for completion and edits for 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. The health plan identified transactions where the cash disbursements journal (CDJ) paid date differed from the FAC paid date, due to the health plan's system lag between paid date and check date.

2. The health plan was unable to provide a reconciliation comparing CDJ data and encounter data, including itemized reconciling amounts to account for variances between data sources.

3. Member months derived from the member enrollment data extract provided by the FAC was were 10 percent lower than member month values reported by DHS.

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

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

5. Surplus encounters, potential duplicates and replacements were identified in the FAC encounter data that were not present in the CDJ samples, attributing to completion percentages greater than 100 percent.

6. There were missing health plan paid date values in the encounter data.

7. Various key data elements within the claims sample and/or encounter data were not populated attributing to accuracy percentages of less than 100 percent.

8. Various key data elements had a validity, matching and accuracy, rate of less than 100 percent.

9. Service/Rendering Provider data within the claims sample and/or encounter data was the same as the billing provider data.

10. The health plan did not meet one or more of the required levels of timeliness of claim payments for encounter claims.

11. The health plan did not meet one or more of the encounter submission requirements for encounter claims.

- *Activity 4 – Medical Records Review*

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

1. A significant number of dental records were not submitted.

2. Medical records received did not contain the necessary documentation to support the tested element(s), attributing to lower accuracy rates.

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

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

4. Validation rates for the tested or usable medical records were at or above the 95 percent threshold.

DHS Response to the External Quality Review 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.