# 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) Validation of Encounter Data (Protocol 5[1]) engagements for the calendar years ended December 31, 2018 and December 31, 2019 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 Instructions 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 Instructions 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 5:

Centers for Medicare & Medicaid Services federal guidance is utilized for the EQR Protocol 5 engagement included below:

https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.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 revenues to reconcile per state data.
  2. Adjust waived member cost sharing to health plan supporting documentation.

[1] The original contract between DHS and Myers and Stauffer states “Protocol 4”. In 2019, CMS updated the EQRO protocols and the encounter data validation is now referred to as Protocol 5.

3. Adjust to include PPR incentive revenues not captured in the MLR calculation per Exhibit 11.
4. Adjust revenue reductions to health plan supporting documentation.
5. Adjust for incorrect classification of expenses related to revenues deductions between template lines.

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

6. Adjust to include Health Insurer Fee revenue and expense not reported by the health plan.

### *Clinical Expense Component*

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

1. Adjust medical expense to health plan supporting documentation.
2. Adjust ventilator recoupments to health plan supporting documentation.
3. Adjust related party medical expenses to reasonable cost.
4. Adjust to remove unsupported medical expenses.
5. Reclassify amounts claimed as administrative cost to medical expense.

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

6. Reclassify non-allowable medical expenses.

### *Health Care Quality Improvement (HCQI) Expense Component*

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

1. Adjust to remove non-qualifying HCQI expenses.

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

2. Reclassify administrative expenses to HCQI expenses.

### *Other Information Component*

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

1. Adjust member months per state data.

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

There were no frequent adjustments to the other information component.

## 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 health plan supporting documentation.
2. Adjust to reflect administrative expenses at actual cost.
3. Adjust to remove unsupported administrative expenses.
4. Adjust to include additional administrative expenses not reported.
5. Adjust classification of expense based on incorrect reporting of taxes.

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

6. Adjust to remove non-allowable administrative expense items such as lobbying, charitable contributions, marketing, and advertising.
7. Reclassify expenses between HCQI qualifying expenses and administrative expenses.

## External Quality Review Protocol 5

### *Activity 1 – State Requirements*

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

1. The FAC (DXC) currently 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 related to the benchmark used in calculating pricing percentage requirements is unclear.
5. Contract language related to audit requirements do not identify specific criteria regarding the timeliness of audit documentation.

### *Activity 2 – Systems Capability*

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

1. The health plan does not have a formal audit program to ensure that claims examiners maintain acceptable levels of accuracy beyond the initial training period.
2. The health was unable to provide certain requested data element values, as the system was no longer online.
3. The health plan does not have a notification process in place alerting them that expected third party vendor files have not been received.
4. The health plan does not submit denied claims as encounters.
5. The health plan tracks development changes for the claims system user interface, and does not track changes to the production and reporting databases.
6. The health plan's claims system contains simulated user accounts set up for training and testing purposes.

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

7. Certain tasks, processes and/or functions are performed and/or tracked manually.

### *Activity 3 – Encounter Data Analysis*

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

1. Encounter data for selected sample months was missing, attributing to completion percentages of less than 100 percent.
2. Service/Rendering Provider data within the claims sample and/or encounter data was the same as the billing provider data.
3. The health plan indicated that they have 45 days from the date of receipt to pay or deny a claim.

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

4. Surplus encounters, potential duplicates and replacements were identified in the FAC encounter data that were not present in the CDJ and claims samples, attributing to completion percentages greater than 100 percent.
5. There were missing health plan paid date values in the encounter data.
6. Various key data elements within the claims sample and/or encounter data were not populated attributing to accuracy percentages of less than 100 percent.
7. Various key data elements had a validity, matching and accuracy, rate of less than 100 percent.

8. 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.*

There were no infrequent findings identified for Activity 4 - medical records review.

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

1. Not all of the medical records requested were submitted.
2. Validation rates for the tested or usable medical records were below the 95 percent threshold.
3. Medical records received did not contain the necessary documentation to support the tested element(s), attributing to lower accuracy rates.