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, 2019 and December 31, 2020 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:

Centers for Medicare & Medicaid Services federal guidance is utilized for this examination engagement. Guidance specific to the MLR, 42 Code of Federal Regulations (CFR) § 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:

Wisconsin Financial Reporting Instructions and Centers for Medicare & Medicaid Services federal guidance are utilized for this review engagement. Guidance specific to administrative expenses, 45 CFR § 75.420-475, 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

Contract Year 4 Health Plans:

- *Anthem Blue Cross and Blue Shield of Wisconsin*
- *Group Health Cooperative of South Central Wisconsin*
- *Independent Care Health Plan*
- *Managed Health Services Insurance Corporation*
- *Molina Healthcare of Wisconsin, Inc.*

[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.

- *Network Health Plan*

Report on Adjusted Medical Loss Ratio

- ***Revenue Component***

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

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

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

2. Adjust revenue reductions for taxes to health plan supporting documentation.
3. Adjust revenues to reconcile per state data.
4. Adjust to include Potentially Preventable Remission (PPR) incentive payments not captured in the MLR calculation per Exhibit 11.

- ***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 for provider incentives.
2. Adjust ventilator recoupments to health plan supporting documentation.
3. Adjust to include PPR provider incentive payments.
4. Adjust to remove incurred but not reported (IBNR) expenses reported based on inappropriate methodology.
5. Adjust to remove non-allowable medical expenses and reclassify to non-claims cost.

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

There were no frequent adjustments to the clinical expense component.

- ***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 HCQI expense to health plan supporting documentation.

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

2. Adjust to remove non-qualifying HCQI expenses and reclassify to non-claims cost.

Other Component

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

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 component.

Information Only Component

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

1. Reclassify non-allowable expenses to non-claims cost.

Report on Adjusted Administrative Expenses

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

1. Adjust to remove unsupported administrative expenses.

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

2. Adjust to remove contract deemed non-allowable administrative expense items such as lobbying, charitable contributions, marketing, and advertising.
3. Adjust to remove 45 CFR § 75.420-475 deemed non-allowable administrative expense items such as litigation settlements, client public relations, sponsorships, promotional items, investment trust fees, and alcohol.
4. Reclassify non-qualifying HCQI expenses.
5. Reclassify additional administrative expenses from medical expense.
6. Adjust to remove non-allowable health plan self-reported 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 only reworks/corrects encounters rejected/denied by the FAC that are over $1,000.
2. The health plan manually tracks denied encounters and communicates their status via email.
3. There appears to be limited oversight or validation of changes made in the enrollment system.

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

4. There appears to be limited oversight of the health plan's delegated vendors' encounter submissions. The data is passed through to the FAC with minimal checks and/or validation.

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. Place of service values within the encounter data reflected values that were different from the claims sample data.
3. Tooth numbers within the claims sample and/or encounter data were missing.
4. The health plan did not meet one or more of the required levels of timeliness for the payment of claims.
5. The health plan did not meet one or more of the encounter submission requirements for encounter claims.

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

6. There were missing health plan paid date values in the encounter data.
7. Various key data elements had a validity, matching and accuracy, rate of less than 100 percent.

Activity 4 – Medical Records Review

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

1. Validation rates for the tested or usable medical records were below the 95 percent threshold.
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 of the medical records requested were submitted.