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, 2020 and December 31, 2021 related to the Wisconsin Department of Health Services (DHS) BadgerCare Plus (BCP) and Supplemental Security Income (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 5 Health Plans:

- *Care4Kids Program*
- *Children's Community Health Plan, Inc.*
- *Group Health Cooperative of Eau Claire*
- *MercyCare HMO, Inc.*
- *My Choice Wisconsin Health Plan, 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.

Report on Adjusted Medical Loss Ratio

Revenue and Revenue Deductions Component

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

1. Adjust to include waived cost sharing not reported by the health plan.
2. Adjust to include community benefit expenditures (CBE) per health plan supporting documentation.

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

3. Adjust revenue reductions for taxes per health plan supporting documentation.
4. Adjust revenues to reconcile per state data.
5. Adjust to include Potentially Preventable Remission (PPR) incentive payments not captured in the MLR calculation.
6. Adjust to include Vaccine Equity Program (VEP)/ Vaccine Outreach Program (VOP) incentive payments not captured in the MLR calculation.
7. Adjust to include risk corridor recoupments per state data.

Incurred Claims Expense Component

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

1. Adjust incurred claims expense per supporting documentation for provider incentives.
2. Adjust to remove non-qualifying provider incentives payments.
3. Adjust ventilator recoupments per supporting documentation.
4. Adjust to include VEP/ VOP incentive payments per supporting documentation.
5. Adjust paid claims expenses per supporting documentation.
6. Adjust third party capitated provider expenses per supporting documentation.
7. Adjust to remove incurred but not reported (IBNR) margin.
8. Adjust to remove third party vendor administrative expenses.
9. Adjust to reclassify non-allowable incurred claims expenses to non-claims cost.

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

10. Adjust to include PPR provider incentive payments per state requirement.
11. Adjust to include Obstetrics (OB) Medical Home expenses per state data.

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 unsupported HCQI expenses.
2. Adjust to include qualifying administrative expenses to HCQI expenses per supporting documentation.

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

3. Adjust to remove non-qualifying HCQI expenses.
4. Adjust to reclassify non-allowable HCQI expenses to non-claims cost.

MLR Calculation Component

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

1. Adjust member months per state data.
2. Adjust to include credibility calculation in the adjusted MLR percentage.

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

There were no frequent adjustments to the other component.

Report on Adjusted Administrative Expenses

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

1. Adjust to actual cost based on health plan supporting documentation.
2. Adjust to remove non-allowable health plan self-reported expenses.

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

3. Adjust to remove contract deemed non-allowable administrative expense items such as lobbying, marketing, and advertising.
4. Adjust to remove 45 CFR § 75.420-475 deemed non-allowable administrative expense items such as client public relations, sponsorships, promotional items, investment trust fees.
5. Reclassify non-qualifying HCQI expenses.
6. Reclassify additional administrative expenses from incurred claims expense.

External Quality Review Protocol 5

Activity 1 – State Requirements

Note the following findings are specific to DHS or Gainwell Technologies, Inc. (fiscal agent contractor, or FAC).

1. The FAC (Gainwell) 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 does 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 appear to have a mechanism in place to ensure that all services rendered by capitated providers are submitted as encounters.
2. The health plan's applications are primarily on servers with offsite backups in the same area.
3. The health plan's optical character recognition (OCR) delegated vendor does not consistently capture all data presented on a claim.
4. The segregation of duties appears to be limited for the health plan's delegated vendor.
5. There appears to be limited oversight of health plan third-party vendors.
6. The health plan's claims processing vendor does not separate claims auditing processes and reporting by lines of business.
7. Disaster recovery testing was not performed during the measurement period.
8. The same health plan assigned internal control number (ICN) was identified on multiple, distinctly different encounters (i.e., different members, dates of service, procedures).

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

There were no frequently occurring findings related to system capabilities.

Activity 3 – Encounter Data Analysis

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

1. The health plan does not submit dental encounters.
2. The health plan-submitted sample claims data reflected an adjusted or replacement claim where the original claim was expected.
3. The health plan did not meet one or more of the required levels of timeliness for the payment of claims.
4. The health plan did not meet the 120-day requirement for the submission of encounters.

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

5. Completion percentages were at or above 100 percent.
6. Data element values were missing from the health plan-submitted sample claims data where values were expected.
7. Various key data elements had a validity, matching and accuracy, rate that was less than the 95 percent accuracy threshold.

Activity 4 – Medical Records Review

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

1. The medical records requested were submitted after the due date.

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

2. Not all of the medical records requested were submitted.
3. The medical records submitted were for members and/or dates of service that were different from the medical records requested.