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 engagements for the calendar year (CY) 2022 for the four health plans under review and state fiscal year (SFY) 2022 for the two county programs 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:

The 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/2023-eqr-protocols.pdf

Contract Year 6 Health Plans and County Programs Reviewed:

Health Plans:

- *Dean Health Plan, Inc.*
- *Quartz Health Benefit Plans Corporation*
- *Security Health Plan of Wisconsin, Inc.*
- *UnitedHealthcare Community Plan of Wisconsin*

County Programs:

- *Children Come First (Dane County)*
- *Wraparound Milwaukee (Milwaukee County)*

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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.

There were no infrequent adjustments to the revenues and revenue deductions component.

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

1. Adjust revenue reductions for taxes per health plan supporting documentation or audited financial statements.
2. Adjust revenues to reconcile per state data.
3. 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 to remove non-qualifying provider incentives payments.
2. Adjust ventilator recoupments per supporting documentation.
3. Adjust related party global capitation arrangements.
4. Adjust to remove third party vendor administrative expenses.
5. Adjust incurred claims for third party liability payments.
6. 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.

7. Adjust incurred claims expenses per supporting documentation.

Health Care Quality Improvement (HCQI)/Health Information Technology (HIT) Expense Component

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

There were no infrequent adjustments to the HCQI/HIT component.

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

1. Adjust to remove non-qualifying HCQI/HIT expenses.

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MLR Calculation Component

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

There were no infrequent adjustments to the other component.

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

1. Adjust member months per state data.

Report on Adjusted Administrative Expenses

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

1. Adjust administrative expenses based on health plan supporting documentation.
2. Reclassify additional administrative expenses from incurred claims expense.
3. Reclassify non-qualifying taxes to administrative expense.
4. 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.

5. Adjust to remove contract deemed non-allowable administrative expense items such as lobbying, marketing, and advertising.
6. Adjust to remove 45 CFR § 75.420-475 deemed non-allowable administrative expense items such as client public relations, sponsorships, and promotional items.
7. Reclassify non-qualifying HCQI expenses.

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 currently sends member information to the health plans twice per month.
2. The payment of interest on claims paid late by the health plans to providers does not appear to be consistent. The contracts between DHS and the health plans do not contain specific language related to the payment of interest by the health plan to providers.

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3. The contract 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

There were no findings related to system capabilities of the health plans.

Activity 3 – Encounter Data Analysis

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

1. The health plan's encounter completion percentage, was below the 95 percent threshold when compared to health plan-submitted cash disbursement journal (CDJ) paid amounts.
2. Key data elements had a validity, matching and accuracy, rate that was less than the 95 percent accuracy threshold.
3. The health plan did not meet one or more of the required levels of timeliness for the payment of claims.

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

4. Encounter completion percentages were below the 95 percent threshold when compared to health plan-submitted sample claim counts.
5. Encounter completion percentages were at or above 100 percent when compared to health plan-submitted sample claim paid amounts.
6. Data element values were missing from the health plan-submitted sample claims data where values were expected and/or encounter data element values did not agree with the health plan-submitted sample claim value (i.e., former original claim internal control number (ICN), Medicaid Management Information System (MMIS) ICN, service provider National Provider Identifier (NPI) and taxonomy).
7. The health plan did not meet the required level of timeliness for the submission of encounters.

Activity 4 – Medical Records Review

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

1. The validity rate of the medical records tested was below the 95 percent threshold.

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

2. Less than 95 percent of the medical records requested were submitted.
3. Validity issues were primarily related to the member's date of birth missing from the medical record, and diagnosis codes and/or revenue codes not supported by the documentation submitted.