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 for the calendar year (CY) 2022 and Encounter Data Validation (EDV) engagements for the state fiscal year (SFY) 2022. These engagements were conducted on seven managed care entities (MCE), operating as One Care and/or Senior Care Options plans, under contract with MassHealth during the reporting periods. Myers and Stauffer LC was contracted by the Executive Office of Health and Human Services (EOHHS) to perform the engagement.

Report on Adjusted Medical Loss Ratio

The Centers for Medicare & Medicaid Services (CMS) federal guidance is utilized for the examination of the Senior Care Options Medicaid-Only Adjusted Medical Loss Ratio. Guidance specific to the MLR, 42 Code of Federal Regulations (CFR) § 438.8, is included below:

Electronic Code of Federal Regulations National Archives

During the reporting period, the One Care plans operated as Medicare-Medicaid Plan (MMP) pursuant to Section 1115A of the Social Security Act and held three-way contracts between CMS, EOHHS, and the One Care plans. The Massachusetts Section 1115A demonstration and the One Care MLR Reporting Instructions were utilized, in addition to the above federal guidance, for the examination of the One Care Adjusted Medical Loss Ratio.

Report on Encounter Data Validation

The Encounter Data Validation evaluated the accuracy, truthfulness, and completeness of the data submitted by the SCO and One Care plans and contained within the EOHHS MassHealth Data Warehouse.

Contract Year 2 MCEs

- Boston Medical Center Health Plan, Inc. dba WellSense Health Plan Senior Care Options
- Commonwealth Care Alliance, Inc. One Care and Senior Care Options
- Fallon Community Health Plan, Inc. Senior Care Options
- Senior Whole Health, LLC Senior Care Options
- Tufts Health Public Plans, Inc. One Care
- Tufts Associated Health Maintenance Organization, Inc. Senior Care Options
- UnitedHealthcare Insurance Company One Care and Senior Care Options

Report on Adjusted Medical Loss Ratio

Incurred Claims Component

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

1. Adjust vendor incurred claims to the amount incurred by the vendor for claims paid to providers per vendor supporting documentation.
2. Adjust pharmacy incurred claims to reconcile amounts incurred by the pharmacy benefit manager (PBM) for claims paid to pharmacies, rebates, transaction fees, and effective rate reimbursement guarantees per PBM supporting documentation.
3. Adjust provider incentive payments to reconcile per MCE supporting documentation.

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

4. Adjust allocation between Medicaid and Medicare expenses to reconcile per MCE supporting documentation.
5. Remove administrative expenses, including management fees, that do not meet the definition of incurred claims or health care quality improvement (HCQI) activities per MCE supporting documentation.
6. Adjust to include additional American Rescue Plan Act payments per MCE supporting documentation.
7. Reclassify expenses between incurred claims and HCQI, as appropriate, per MCE supporting documentation.
8. Remove reinsurance premiums and recoveries as reinsurance was not a requirement per MCE contract.
9. Adjust incurred claims to reconcile per MCE supporting documentation, addressing duplicated expenses and expenses not correctly associated with the appropriate line of business.
10. Adjust to offset deductions from incurred claims, such as coordination of benefits recoveries, claims recoveries, and unpaid provider withhold expenses, per MCE supporting documentation.
11. Remove patient payments per MCE supporting documentation.
12. Remove One Care Medicare low income subsidy (LICS) expenses per MCE supporting documentation.
13. Adjust capitated provider expenses to remove non-qualifying and unsupported expenses and reconcile per MCE or provider supporting documentation.

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

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

1. Remove non-qualifying HCQI/HIT expenses per MCE supporting documentation.

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

2. Reclassify expenses between incurred claims and HCQI, as appropriate, per MCE supporting documentation.
3. Adjust HCQI/HIT expenses to reconcile per MCE supporting documentation

Revenue and Revenue Deductions Component

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

1. Adjust premium revenue to reconcile per state data.
2. Adjust revenue to reflect the final Senior Care Options risk share settlement per state data.

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

3. Adjust One Care Medicare revenue per MCE supporting documentation.
4. Remove One Care Medicare LICS revenue per MCE supporting documentation.

The One Care modified examination reports contained the following data caveat.

5. The One Care program integrated Medicaid and Medicare benefits for dually eligible enrollees under the Section 1115A authority, which required a combined Medicaid and Medicare MLR calculation. EOHHS provided data to validate the accuracy of the Medicaid revenue. However, no comparable third-party data source was available for Medicare revenue, and MCE data was utilized. A risk corridor calculation with CMS was contractually required for the reporting period. Since the calculation has not yet been finalized by CMS, the risk corridor amount reported within the MLR was based on an estimate provided by the MCE. The impact resulting from the finalized risk corridor calculation and the MCE's Medicare revenue is unknown.

Member Months Component

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

There were no frequent adjustments to the member months component.

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

1. Adjust member months per state data.

Encounter Data Validation

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

1. The MCE did not meet the 60 day requirement of 99 percent for the payment of claims.

2. Encounter completion percentages exceeded 100 percent when compared to MCE-submitted cash disbursement paid amounts.
3. Encounter completion percentages exceeded 100 percent when compared to MCE-submitted MLR claims lag paid amounts for January 2022 through June 2022.
4. Encounter data element values did not agree with the MCE-submitted sample claim values (i.e. Billed Charges, Service/Rendering Provider Taxonomy, Surgical Procedure Codes, Former Internal Control Numbers (ICNs), MCE Paid Amount, and MCE Paid Date).

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

5. The MCE did not meet the 30 day requirement of 90 percent for the payment of claims.
6. Encounter completion percentages were below the 95 percent threshold when compared to MCE-submitted sample claim counts.
7. Encounter completion percentages were below the 95 percent threshold when compared to MCE-submitted sample claim paid amounts.
8. Encounter completion percentages were below the 95 percent threshold when compared to MCE-submitted cash disbursement paid amounts.