BAYOU HEALTH TRANSPARENCY REPORT FOLLOW-UP

DEPARTMENT OF HEALTH AND HOSPITALS STATE OF LOUISIANA

INFORMATIONAL REPORT
ISSUED SEPTEMBER 9, 2015

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September 9, 2015

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Charles E. "Chuck" Kleckley,
Speaker of the House of Representatives

Dear Senator Alario and Representative Kleckley:

We performed a follow-up to our August 2014 informational audit on the first *Bayou Health Transparency Report* issued by the Department of Health and Hospitals (DHH) on January 2, 2014. Our objectives were to evaluate the reliability and consistency of the information DHH reported in its second *Bayou Health Transparency Report*, issued on December 31, 2014, and provide additional information and analysis regarding the report. The scope of our audit was significantly less than an audit conducted in accordance with *Government Auditing Standards*. I hope this report will assist you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of DHH for their assistance.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

AHC:WDG:EFS:aa

BAYOU HEALTH TRANSPARENCY FOLLOW-UP 2015

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Bayou Health Transparency Report Follow-up
Department of Health and Hospitals

September 2015

Audit Control # 80150101

Introduction

Act 212 of the 2013 Regular Session requires the Louisiana Department of Health and Hospitals (DHH) to submit an annual report on the Medicaid Bayou Health program to the Louisiana Legislature. DHH submitted its first annual Act 212 report on January 2, 2014, as the *Bayou Health Transparency Report* (transparency report). In response, we conducted an audit to evaluate and report on the reliability of the information presented in the transparency report.

In our prior informational audit report, *Consideration of the Bayou Health Transparency Report*, issued in August 2014, we noted that the transparency report did not include the first five months of Bayou Health operations; did not provide comparable data between Bayou Health services data and the prior legacy (pre-Bayou Health) Medicaid data; included global assertions about Bayou Health cost savings and improved outcomes that were not supported in the report; included primarily self-reported data from the Bayou Health plans without verification or validation of the data; did not include audited financial statements; and provided sections of the report with mathematical errors and inconsistencies between the report and supplemental data.

The second DHH *Bayou Health Transparency Report* was submitted to the Legislature on December 31, 2014, and placed on DHH's website.[1] The report included 23 sections with narratives, amounts and tables, and links to appendices on the DHH website.

Our objectives for this follow-up audit were:

1) **Evaluate the second *Bayou Health Transparency Report* for the reliability and consistency of the information reported in the transparency report.**

2) **Provide additional information and analysis regarding the transparency report.**

Overall, we found that DHH addressed many of our prior recommendations and produced a more reliable report. However, we noted some continuing issues that DHH needs to address further including unreported periods, self-reported data, unaudited and unadjusted amounts in the Medicaid Loss Ratio reports, and not including audited financial statements.

Appendix A contains DHH's response to this report, and Appendix B provides our scope and methodology. Appendix C is background on Bayou Health; Appendix D is a listing of Myers and Stauffer findings; and Appendix E is the Myers and Stauffer survey document.

[1] http://new.dhh.louisiana.gov/index.cfm/page/2086

Objective 1: Reliability and Consistency

Overall, we found that DHH addressed many of our prior recommendations and produced a more reliable report. However, there are some issues that DHH needs to address further. These areas, along with the improvements DHH made, are outlined below.

In the second annual transparency report, DHH duplicated six months of the prior report (January 2013 through June 2013).

Reporting Period Used

The first annual transparency report submitted by DHH on January 2, 2014, covered July 2012 through June 2013 (Fiscal Year 2013), leaving Bayou Health operations for February 2012 through June 2012 unreported.

The second annual transparency report submitted to the Legislature on December 31, 2014, covered January 2013 through December 2013. This reporting period duplicated six months of the prior report (January 2013 through June 2013). For 29 months of Bayou Health operations (February 2012 through December 2014), DHH has reported data for only 18 months. While Act 212 did not specify a reporting period, reporting for all possible months of Bayou Health operation would provide more information for stakeholders to consider.

The department noted that as it continued to collaborate with all of the internal and external parties involved in the collection, validation, and production of the report, it was determined that the timeframe used produced the best quality of data.

Act 212 only required comparison of Bayou Health data to Legacy Medicaid in the initial report. For this report, DHH did not include comparative legacy (pre-Bayou Health) Medicaid data, except in Section 12, Health Outcomes.

Use of Pre-Bayou Health Medicaid Data

DHH only reported legacy Medicaid data in Section 12, Health Outcomes. In each of the cases where legacy Medicaid was included in this second report, the department presented one of its HEDIS® measures.[2] Historically, DHH has captured and reported HEDIS® measures for Medicaid. We did not audit the legacy Medicaid statistics presented, but note little risk with this reporting. DHH annually collects and reports these measures following HEDIS® requirements.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a widely-used set of performance measures maintained by the National Committee for Quality Assurance.

DHH did not include unsupported global assertions in this second transparency report.

Validity of Global Assertions on Savings and Health Outcomes

In the prior audit, DHH reported global assertions on savings and health outcomes that were not supported in the report. No global assertions were included this year.

The validation efforts used in this second transparency report resulted in significant improvement over the self-reported data presented in the first report.

Reliability of Data Reported

In our prior informational audit, we noted a majority of the report sections were compiled totally or partially using self-reported data from the health plans. The health plan reports contained disclaimers that were not addressed by the department. DHH was not able to provide documentation to show how it verified or validated the self-reported health plan data for the report. In addition, the audit also noted sources of reported information were not always identified.

For its second transparency report, DHH contracted with Myers and Stauffer[3] for assistance with verification procedures related to the transparency report. Contract deliverables included:

- Develop queries to pull the encounter data necessary for appropriate response by the department and analyze the results of the queries.
- Evaluate the completeness and accuracy of self-reported data from the health plans where encounter data cannot be used.
- Evaluate completeness and accuracy of reports submitted by the health plans that contain information required for the transparency report.

Myers and Stauffer reviewed the reports and documents provided by DHH and determined the method it would use to verify the information provided in the reports. Myers and Stauffer's procedures included using fee for service or encounter claims data from the Medicaid claims system and a survey developed by Myers and Stauffer for completion by the health plans for items where existing data could not be used. The survey was used to verify how data was tracked and monitored, whether definitions were appropriate, and any other pertinent information.

Myers and Stauffer provided DHH with a draft report on October 31, 2014, with three recommendations. In one of the recommendations, Myers and Stauffer noted:

[3] Myers and Stauffer LC, Certified Public Accountants

> "*We would propose that DHH consider including in future validation activities the following tasks: trace a sample of the report items back to the source data at the health plan level, and evaluate documented procedures and methodologies used by the health plans to report the Act 212 items to ensure adherence to DHH policies and guidelines*."

We reviewed the survey and survey findings prepared by Myers and Stauffer as part of the verification process for the Transparency Report sections 4-8, 12, 14, and 18. As part of our review, we observed instances where Myers and Stauffer noted that sufficient documentation was not provided and/or plan attestation statements were not provided. See Appendix D for a list of Myers and Stauffer findings and Appendix E for survey questions. While some survey findings are listed, Myers and Stauffer noted that for the majority of its verification results, the procedures appeared reasonable.

Even though Myers and Stauffer noted in its report to DHH that additional verification and validation procedures could be performed, we consider the validation efforts used in this second transparency report to be significant improvement over the self-reported data presented in the first report.

The current year transparency report contained mathematical errors in Section 23 of the primary report and in the Section 3 Appendix.

Mathematical Accuracy

In our prior informational audit, we noted mathematical errors in numerical data presented in the report and supplemental data book. In the current audit, a supplemental databook was not presented. The report contains figures and tables in the body of the report and references to thirty-two appendices. We noted mathematical errors in three (37%) of the eight linked appendices that included calculations.

In Appendix XXX and Appendix XXXI (Section 23, Pharmacy Benefits), two of the health plans, Amerigroup (AMG) and AmeriHealth Caritas (AHC), provided reports that included mathematical errors, causing the related transparency report section to be misstated on one of three line items. Per DHH, for the table in Section 23, the amount reported for Unduplicated Claims Received should be the sum of the next two report lines, Unduplicated Claims Paid and Unduplicated Claims Denied. For the two health plans noted above, adding lines 2 and 3 does not equal line 1. See Exhibit 1. Any of the amounts for AMG and AHC could be incorrect. Since the amounts reported came directly from the health plan reports in Appendices XXX and XXXI, the transparency report included incorrect amounts for either Line 1, Line 2, or Line 3.

Exhibit 1

Table 23: Total Claims for Pharmacy Benefits in Calendar Year, by Plan				
		AMG	**AHC**	**LHC**
Line 1	Unduplicated Claims Received	$3,543,995	$2,896,939	$2,243,066
Line 2	Unduplicated Claims Paid	2,061,987	1,922,693	$1,721,403
Line 3	Unduplicated Claims Denied	832,937	755,545	521,663
Line 4	Line 2 plus Line 3	2,894,924	2,678,238	$2,243,066
Line 5	**Variance from Line 1**	**($649,071)**	**($218,701)**	**None**
Source: DHH *Bayou Health Transparency Report* Section 23 table and auditors' calculations.				

In Appendix III (Section 3, Members Enrolled), while the Totals added across the rows are correct, none of the Totals added down the columns are correct. However, the mathematical errors do not misstate the report, since the totals are not presented in the report.

Consistency

The prior audit noted instances of inconsistency between the report and supplemental data. We again noted instances of supporting documentation not matching amounts reported in the report and/or referenced appendices. However, none of the identified inconsistencies materially misstated the report.

Objective 2: Additional Information

During our review of the transparency report, we identified additional information on the following topics: medical loss ratio, audited financial statements, and new legislation.

For Section 11, Medical Loss Ratio (MLR), DHH reported unaudited and unadjusted amounts in the MLR reports since audited reports were not available on the date the report was provided to legislators. However, DHH posted audited calendar year 2013 MLR reports to the website when first available on March 9, 2015.

Medical Loss Ratio Reporting

MLR reports the percentage of Medicaid per member per month revenue that the health plans spend on claim payments and other allowed expenses. The health plans are required to maintain a MLR of at least 85%. DHH contracts with Myers and Stauffer to conduct annual audits of the MLR reports submitted by the health plans.

Audited calendar year 2013 MLR reports were posted to DHH's website[4] on March 9, 2015, as required. While the final audits of MLR reports show all plans met the 85% requirement, a decreasing adjustment of AmeriGroup's expenses and percentage was made as part of the Myers and Stauffer MLR report audit.

There were no audits of calendar year 2012 MLR reports for any of the three plans. The plan contracts allow for the plans to defer reporting revenues from enrollees with less than 12 months experience with the plans until the next MLR reporting year. AmeriHealth Caritas, exercising the deferral option, reported two years (February 2012 - December 2013) of revenue and expenses in their 2013 MLR report. The deferred amounts from calendar year 2012 were not scheduled correctly as deferred from a prior year in the plan's MLR calculation. The department responded that they will ask for correction.

Louisiana Healthcare Connection and AmeriGroup did not report any deferred experience from calendar 2012 in their calendar 2013 reports, thus calendar year 2012 reports have not been audited for either of these health plans.

[4] http://dhh.louisiana.gov/index.cfm/page/2142

Section 15 of the report did not include audited financial statements as required. However, as of June 1, 2015, the links in Section 15 for Appendices XXIII through XXVII appropriately included audited financial statements of the parent companies and agreed-upon procedures for the Louisiana operations.

Audited Financial Statements

In the transparency report, Section 15 references Appendices XXIII through XXVII for audited financial statements of the plans. Initially, the appendices included DHH required worksheets but did not include audited financial statements. After our inquiries, the department also provided audited financial statements for the parent companies and agreed-upon procedures for the Louisiana operations. A similar situation occurred in the prior audit. DHH noted issues with its website when loading certain files.

Act 158 of the 2015 Regular Session restructured the annual required reporting for Bayou Health.

New Legislation

Act 158 will allow DHH, in some instances, to report statistics and performance measures that DHH is already required to collect and report for federal oversight or national statistics gathering. According to DHH, the revised reporting will provide better information with less production time from Medicaid staff and contractors. For the current report, DHH contracted with Myers and Stauffer and Louisiana State University to assist in the validation of report data and the compilation of the report with more than $52,000 expended at June 30, 2015.

In addition, the act changes future transparency reporting as it requires DHH to report by fiscal year (July 1 - June 30), with the report submitted by June 30 every year for the previous fiscal year, except for those measures that require reporting of health outcomes by calendar year. The next required report would cover fiscal year 2015 data (July 1, 2014 - June 30, 2015), leaving Bayou Health operations for January 2014 through June 2014 unreported.

Recommendation

DHH should continue improving its annual *Bayou Health Transparency Report* to assist the department and the Legislature in future decision-making regarding Medicaid and Bayou Health. DHH should also consider the recommendations from Myers and Stauffer to further verify and validate self-reported plan data.

APPENDIX A: MANAGEMENT'S RESPONSE

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

August 31, 2015

Daryl G. Purpera, Legislative Auditor
Louisiana Legislative Auditor
1600 North 3rd Street
Baton Rouge, LA 94397

Dear Mr. Purpera:

SUBJECT: Bayou Health Transparency Report Follow-Up

The outstanding attestation statements noted in Appendix D, Listing of Myers and Stauffer findings, of the *Bayou Health Transparency Report Follow-Up* informational report have been provided to the Department.

The Department acknowledges that Medical Loss Ratio data reported by Bayou Prepaid Plans for calendar year 2012 were not audited as required by the Louisiana Administrative Code. The required audits will be completed by February 28, 2016.

Should you have questions regarding this letter, please contact Jen Steele, Medicaid Deputy Director, at (337) 354-5750 or jen.steele@la.gov.

Sincerely,

J. Ruth Kennedy
Medicaid Director

JRK/jls

c: Pam Diez
Kathy Kliebert
Jeff Reynolds
Jen Steele

APPENDIX B: SCOPE AND METHODOLOGY

We performed a follow-up to our August 13, 2014, informational audit on the first *Bayou Health Transparency Report* issued by the Department of Health and Hospitals (DHH) on January 2, 2014. Our objectives were to evaluate the second *Bayou Health Transparency Report* issued on December 31, 2014, to determine the reliability and consistency of the information reported; and to provide additional information and analysis regarding the transparency report. The scope of our procedures was significantly less than an audit conducted in accordance with *Government Auditing Standards*. To achieve our objectives, we performed the following steps:

- Followed-up on the issues and recommendations from the prior informational audit.
- Met with DHH personnel and performed certain procedures to obtain an understanding of the Act 212 reporting and supporting documentation.
- Reviewed each section of the report for mathematical accuracy and consistency between the report and the supporting data.
- Worked to determine the source of data presented.
- Presented our preliminary review results and questions to DHH, requesting any additional information DHH could provide.
- Considered DHH's answers and additional documentation, if any, as well as other information and understanding we have accumulated through our audits of DHH.

APPENDIX C: BACKGROUND

The Department of Health and Hospitals (DHH) privatized acute care services in Medicaid in February 2012 under the name Bayou Health. Two separate Medicaid managed care models were developed: a "Prepaid" model and a "Shared Savings" model.

Prepaid Model

The Prepaid Health Plan model provides for a traditional, risk-bearing managed care organization. Prepaid health plans must establish networks of providers to cover the full range of Medicaid services, including primary, secondary, and hospital care. Providers are not required to be enrolled Louisiana Medicaid providers to participate. The health plan receives a monthly capitation fee for each member enrolled to provide core benefits and services, with utilization management and claims payment handled directly by the health plan. Amerigroup, AmeriHealth Caritas (formerly known as LaCare), and Louisiana Healthcare Connections operated as prepaid health plans from February 2012 through January 2015.

Shared Savings Model

The Shared Savings Plan model provides for an enhanced primary care case management organization, which incorporates many of the features historically associated with a managed care organization. A Shared Savings Health Plan's provider network consists of primary care physicians only, and all providers must also be enrolled in Louisiana Medicaid. The Shared Savings Health Plan is expected to coordinate specialty care and hospital care with providers enrolled in the Medicaid provider network. The health plan receives a monthly fee for each enrolled member to provide enhanced management services, with the opportunity to share in any savings to the state that result from the improved coordination of care. From February 2012 through January 2015, Community Health Solutions of Louisiana and UnitedHealthcare Community Plan of Louisiana operated as shared savings health plans in Bayou Health.

Beginning February 1, 2015, DHH signed five new contracts for Bayou Health for February 2015 through January 2018, with all operating under the prepaid model.

Maximum Contract Amounts	
AmeriGroup	$1,964,731,789
AmeriHealth	1,964,731,789
Louisiana Healthcare Connections	1,964,731,789
UnitedHealthcare	1,964,731,789
Aetna Better Health	1,964,731,789
Total	**$9,823,658,945**

Source: Contract documents provided by DHH and DHH website http://dhh.louisiana.gov/index.cfm/page/1763

APPENDIX D: MYERS AND STAUFFER RESULTS

Myers and Stauffer (MSLC) provided the Department of Health and Hospitals (DHH) with a draft of the second *Bayou Health Transparency Report* on October 31, 2014, and follow-up survey results on December 16, 2014. The second transparency report was provided to the legislature on December 31, 2014. On January 7, 2015, after the report was submitted, MSLC provided an additional update to survey results. Below is the summary of findings provided to DHH in December 2014.

Section	Type of MSLC Verification	MSLC Survey Findings in December 2014
Section 1	N/A1	
Section 2	None	
Section 3	None	
Section 4	Survey	LHC* did not provide an attestation statement. United** may be monitoring compliance every other year rather than annually.
Section 5	Survey	LHC did not provide sufficient documentation for MSLC verification, and an attestation statement was not provided. United did not provide supporting documentation sufficient for MSLC verification.
Section 6	Survey P	LHC did not provide an attestation statement.
Section 7	Survey P	AHC*** may include claims counted more than once for 2013. LHC did not provide an attestation statement.
Section 8	Survey P	Amerigroup and LHC may not have included revenue codes 450-459. LHC did not provide sufficient documentation for MSLC verification, and an attestation statement was not provided.
Section 9	Third Party	
Section 10	None	
Section 11	None	
Section 12	Survey P	Documentation appears reasonable.
Section 13	N/R	
Section 14	Survey	LHC did not provide sufficient documentation for MSLC verification, and an attestation statement was not provided.
Section 15	Third Party	
Section 16	Third Party	
Section 17	None	
Section 18	Survey	LHC did not provide an attestation statement.
Section 19	Query	
Section 20	Query	
Section 21	Query	

Section	Type of MSLC Verification	MSLC Survey Findings in December 2014 (continued)
Section 22	None	
Section 23	None	
Section 24	Third Party	

*LHC - Louisiana Healthcare Connections
**United - UnitedHealthcare Community Plan of Louisiana
***AHC - AmeriHealth Caritas

N/A1 - No data to verify.
N/R - Not reported. Act 212 only required Section 13 in the first annual report.
Survey P - Survey provided to Pre-Paid plans only.

Type of Validation:
Survey - MLSC validated using survey. See Appendix C for survey questions.
None - Self-reported or MARS Data Warehouse. No verification by MLSC.
Query - MLSC validated by query and/or reviewing DHH's query from MARS Data Warehouse.
Third Party - Data provided by third party, data calculated by third party, or data audited by third party.

Source: Compiled by legislative auditors from Myers and Stauffer surveys.

APPENDIX E: MYERS AND STAUFFER SURVEY QUESTIONS

Attachment B

Louisiana Department of Health and Hospitals
Bayou Health
Act 212 Reporting
Survey for MCO Self Reported Items
9/10/2014

Report Reference Number	Report Elements	Questions	MCO Response
4	The percentage of primary care practices that provide verified continuous phone access with the ability to speak with a primary care provider clinician within 30 minutes of member contact, for each MCO (current Plan calls for 95%).	a. How were these results obtained?	
		b. How are the results verified/validated?	
		c. What are the plans for improvement?	
5	The percentage of regular and expedited service authorization requests processed within the time frames specified by the contract for each MCO.	a. What is your definition of a regular authorization request?	
		b. What is your definition of an expedited authorization request?	
		c. How are prior authorizations monitored and tracked?	
		d. How are reports generated and what types of reports are generated?	
6	Percent of clean claims paid within 30 days and average days to pay.	a. Provide the definition used for clean claims.	
		b. Provide the report criteria for the results.	
7	The number of claims denied or reduced by each MCO for each of the following reasons:	For each denial reason, (1) is the denial auto-adjudicated or a manual denial, and (2) explain any tracking or auditing that is performed to ensure the denial is accurate.	
	a. Lack of documentation to support medical necessity	a. Please provide the criteria for the denial	
	b. Prior authorization was not on file	b. Please provide the criteria for the denial	
	c. Member has other insurance that must be filled first	c. Please provide the criteria for the denial	
	d. Claim was submitted after filing deadline	d. Please provide the criteria for the denial	
	e. Service was not covered by the MCO	e. Please provide the criteria for the denial	
	f. Due to process, procedure, notification, referrals, or any other required administrative function of a MCO.	f. Please provide the criteria for the denials.	
8	The number and dollar value of all claims paid to non-network providers by claim type, categorized by emergency services and non-emergency services for each MCO, by GSA.	a. If applicable, please explain how this report was generated (i.e., assumptions made, data utilized, criteria, etc.).	
12	Comparison of health outcomes.	a. Please provide the criteria utilized to report these results.	
		b. Provide the quality assurance measures used to ensure the results are accurate.	
14	A copy of the member and provider satisfaction survey report for each MCO.	a. How are Children with Chronic Conditions (CCC) determined?	
		b. What approach was used to obtain the results?	
18	The number of members, broken down by each MCO, who file a grievance or appeal, and the number of members who accessed the State fair hearing process, and the number and percentage of grievances or appeals that reversed or otherwise resolved a decision in favor of the member.	a. Provide your definition of a grievance.	
		b. Provide your definition of an appeal.	
		c. How are grievances/appeals tracked? If software is used, please provide the name of the software. If manually, please describe the process.	
		d. What controls are in place to make sure nothing is missed and that numbers are accurate? (Any checks and balances in place?)	

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