CONSIDERATION OF THE BAYOU HEALTH TRANSPARENCY REPORT

DEPARTMENT OF HEALTH AND HOSPITALS
STATE OF LOUISIANA

INFORMATIONAL AUDIT
ISSUED AUGUST 13, 2014

LOUISIANA LEGISLATIVE AUDITOR
1600 NORTH THIRD STREET
POST OFFICE BOX 94397
BATON ROUGE, LOUISIANA 70804-9397

LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

FIRST ASSISTANT LEGISLATIVE AUDITOR
AND STATE AUDIT SERVICES
PAUL E. PENDAS, CPA

DIRECTOR OF FINANCIAL AUDIT
THOMAS H. COLE, CPA

LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

August 13, 2014

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:

This informational audit report provides the results of our procedures on the Act 212 reporting to the Senate and House committees on health and welfare by the Department of Health and Hospitals. Our objectives were to evaluate the reliability and consistency of the information reported in the *Bayou Health Transparency Report* and to provide additional information and analysis regarding that report. Management's response is included in Appendix A to 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 the Department of Health and Hospitals for their assistance.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/ch

DHH ACT 212 REPORTING 2014

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Consideration of the Bayou Health Transparency Report
Department of Health and Hospitals

August 2014

Audit Control # 80140104

Introduction

Act 212 of the 2013 Regular Session required the Louisiana Department of Health and Hospitals (DHH) to submit an annual report to the Louisiana Legislature on the Medicaid Bayou Health program. DHH was instructed to submit the report beginning January 1, 2014, and annually thereafter, to the Senate and House committees on health and welfare. The Act detailed information required for inclusion.

DHH submitted its Act 212 reporting on January 2, 2014, as the *Bayou Health Transparency Report*, a 23-page report divided into 24 sections. The submission also provided supplemental data, referred to as a data book, located on the DHH website at new.dhh.louisiana.gov/index.cfm/page/1750.

Upon review of the transparency report, we noted the following:

- The transparency report covers only July 2012 through June 2013 and did not cover the first five months of the Bayou Health program--February 2012 through June 2012.

- The report did not provide comparable data between the new Bayou Health services data and the prior legacy (pre-Bayou Health) Medicaid data. For example, the data chart in Section 7, Number of Claims Denied or Reduced, is not useful since the legacy Medicaid amount is not accumulated using comparable criteria.

- The report included global assertions about Bayou Health cost savings and improved outcomes that were not required by Act 212, but support was not provided for these assertions.

- Data provided in the report is primarily self-reported by the Bayou Health plans. DHH did not provide documentation of validation or verification by DHH personnel of this self-reported data.

- DHH sanctioned one health plan one time for failure to provide the required percentage of general health plan paid claims data. However, two of the three health plans had numerous months where they failed to meet the requirement for claims data submission.

- One health plan reported 257,665 non-emergency claims paid to non-network providers totaling $31.5 million. This self-reported data is inconsistent with data reported by the other health plans, with no explanation for the significant data outliers.

- Act 212 required DHH to provide audited financial statements for each health plan. While the report listed a section as audited financial statements, no audited financial statements were included.

- The transparency report included mathematical errors and inconsistencies between the various report sections and the supplemental data provided.

Based on our initial review, two objectives were identified for this report:

OBJECTIVE 1: To evaluate the reliability and consistency of the information reported in the Transparency Report, including the following areas: Reporting Period Used; Use of Pre-Bayou Health Medicaid Data; Validity of Global Assertions on Savings and Health Outcomes; Reliability and Sources of Data Reported; Mathematical Accuracy; and Consistency Between Data in the Report and the Supplemental Data Book.

OBJECTIVE 2: To provide additional information and analysis regarding the Transparency Report.

Appendix A contains DHH's response to this report, Appendix B contains a list of concerns and issues noted by section, Appendix C includes compilation of validated encounter claims information, and Appendix D provides our scope and methodology.

Bayou Health Background

In 2012, DHH launched an overhaul of its legacy Medicaid system for delivery of acute care services resulting in the state's first managed care system for residents enrolled in Medicaid known as 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.

Three entities operate as prepaid health plans in Bayou Health:

- Amerigroup
- AmeriHealth Caritas (formerly known as LaCare)
- Louisiana Healthcare Connections

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.

While the Shared Savings Health Plan "pre-processes" claims, the state continues final processing and pays provider claims through DHH's fiscal intermediary, Molina.

Two entities operate as shared savings health plans in Bayou Health:

- Community Health Solutions of Louisiana
- UnitedHealthcare Community Plan of Louisiana

OBJECTIVE 1: Reliability and Consistency

Reporting Period Used

The transparency report submitted by the Department of Health and Hospitals (DHH) covers July 2012 through June 2013. As noted on page 3 of the transparency report, Bayou Health began in February 2012. Since the initial transparency report only covers July 2012 through June 2013, the first five months of managed care are not included in this Act 212 reporting.

The first five months would provide some evidence of the quality of the transition to Bayou Health in areas including but not limited to Section 6, Percentage of Clean Clams Paid for Providers and Average Number of Days to Pay; Section 7, Number of Claims Denied or Reduced; and Section 8, Number and Dollar Value of Claims paid to Non-Network Providers.

> **Recommendation 1:** DHH should consider additional reporting that would include the initial five months of Bayou Health.
>
> **Management's Response:** DHH management noted that the inclusion of the first five months of the Bayou Health implementation would provide an inequitable and unbalanced picture of the program. See Appendix A, pages 2-3 and 6.
>
> **Additional Comments:** Reporting for the first five months would provide some evidence of the quality of the implementation of Bayou Health.

Use of Pre-Bayou Health Medicaid Data

Pre-Bayou Health (or legacy) Medicaid information included in the transparency report did not consider "carve outs".[1] Total Medicaid data was accumulated including services that were not shifted to the Bayou Health Plans. Act 212 requested Medicaid data for the period "prior to the date of services initially being provided under Bayou Health." Comparable data appears to have been the intent of the act. DHH confirmed that it did not consider the carve outs in any of the Medicaid data for the time prior to Bayou Health.

This lack of comparability renders most comparisons of Bayou Health data to legacy Medicaid data skewed and not useful. For example, the data chart in Section 7, Number of Claims Denied or Reduced, is not accurate since the legacy Medicaid amount is not accumulated using comparable criteria. Though DHH personnel told us the Medicaid data warehouse was used, no supporting documentation was provided for how the legacy Medicaid data was determined for denied claims.

> **Recommendation 2:** Future reporting should consider carve outs so that data presented is comparable.

[1] Carve outs are services that DHH did not transfer to the health plans. Initially this included Pharmacy, Dental, Specialized Behavioral Health, Hospice, Targeted Case Management, Personal Care Services, and all Nursing Facility Services. Some of these services have been shifted to the health plans since implementation.

Management's Response: DHH management noted that it used the best data available and was not able to provide pre-Bayou Health data in the same specifications of Act 212. DHH management will consider carve outs in future Act 212 reporting. See Appendix A, pages 3 and 6.

Additional Comments: In the Transparency Report Section 7, Number of Claims Denied or Reduced, DHH provided a disclaimer that data compiled for legacy Medicaid and the new Bayou Health was not comparable. However, the data was presented in a comparable manner. DHH has provided no explanation for reporting 20,955,404 claims denied through legacy Medicaid when the data book noted approximately 6.5 million denied claims.

Validity of Global Assertions on Savings and Health Outcomes

During our review of the transparency report, we noted certain global assertions regarding savings and health outcomes. On page 5 of the report, although not required by Act 212, DHH made the following assertions:

- *"Already, DHH has seen a cost savings over what the state would have spent in absence of managed care."* We could not find the supporting data for this assertion in the report. Upon our request, DHH provided support for savings in neonatal intensive care unit (NICU) days and the shared savings payments to one of the two shared savings model health plans. While DHH presents the NICU reductions of days as a savings, a decrease in NICU days would not provide a cost savings under the three Prepaid Plans since the health plans are paid a capitated rate that is not directly tied to services provided. The two areas of savings noted by DHH are a small portion of the expenses that would need to be considered to show whether or not DHH has achieved an overall cost savings because of Bayou Health managed care. To make an accurate determination of managed care savings, the following expense areas at a minimum would have to be accumulated and presented for both legacy Medicaid and the current Bayou Health program: all claims for comparable services considering all carve outs; all DHH payroll expense and related benefits for those employees working on Medicaid; and all contracts for Medicaid related services for support, development, implementation, and monitoring.

- *"DHH has observed marked improvements in the quality of care delivered under Bayou Health."* We could not find the supporting data for this assertion in the report. Upon our request, DHH provided some support for improvements using its Bayou Health Incentive Measure Interim Tracking. However, the DHH evidence of improvement included tracking five metrics that showed inconsistent results. For two metrics, none of the five health plans met pre-Bayou Health baselines and only one metric was met by all health plans.

Recommendation 3: DHH should maintain support for all assertions included in the annual report.

Management Response: DHH management noted that support was provided to the auditors for the two global assertions. For savings, prepaid plans offered guaranteed up-front savings through capitation rates and interim savings have been identified for the Shared Savings Model. For improvements in the quality of care, five key measures are being tracked that support the assertion. See Appendix A, pages 3 and 6-7.

Additional Comments: For the global assertion regarding savings, management provides two components; however, these components represent only a portion, as noted in our report, of what would need to be considered to determine global savings in Bayou Health. For the global assertion of improved quality of care, the five key measures noted in the response have inconsistent results as explained in our report.

Reliability and Source of Data Reported

During our review, we specifically inquired about the sources of data used to compile the transparency report. At least 17 of the 24 (71%) sections were compiled totally or partially using self-reported data from the health plans. DHH has not provided any documentation to show how it verified or validated the self-reported health plan data for this report. DHH has contracted with a firm to validate completeness and accuracy of claims submission, but this process will not be completed until the fall of 2014.

In Section 11, Medical Loss Ratio, the amounts reported are totally self-reported data by the health plans, with no evidence provided by DHH on how amounts were verified or validated. The same is true for Section 7, Denied or Reduced Claims, and Section 8, Number and Dollar Value of Claims Paid to Non-Network Providers.

Individual sections in the transparency report and supplemental data book do not always identify the source(s) used. The report includes a bibliography, but it appears to be incomplete and does not reference applicable report sections for each source used.

We reviewed data in the report, the supplemental data book, and any additional data provided by DHH. While it is true DHH requires and receives a large number of monthly, quarterly, and annual reports from the health plans, it appears the plans may not have known DHH's expectations for the data to be reported. Reports from the plans were inconsistent and disclaimers were used. One such disclaimer reads as follows:

> *This report was based on Louisiana Healthcare Connections' understanding of the current report specifications provided by DHH. The report programming is still under review, thus any changes may result in resubmission of the report. This report should not be used for comparative purposes until all reporting format and specifications have been finalized.*

DHH has indicated that no consideration of the disclaimers was given when compiling data for comparative presentation in the transparency report.

DHH reported to us:

> *All reporting is received by a Health Plan Manager (HPM) assigned to a specific plan model (either Prepaid or Shared Savings), who ensures each report meets timeliness requirements and is the appropriate deliverable with all the necessary components. The HPM then assigns the report to a Subject Matter Expert (SME) for a second-level review. The SME analyzes the data contained in the report for reasonableness and accuracy of submission and determines if the report is compliant or non-compliant. If there are compliance issues, Bayou Health staff works with the Health Plan to resolve issues through corrective action planning.*

DHH provided us with a list of health plan managers and subject matter experts with some information about reports reviewed by these individuals. We interviewed four subject matter experts regarding their procedures for verification or validation. The subject matter experts noted that most of their efforts were reviews for contract compliance. They also noted that they accepted health plan company certifications that data reported was complete and accurate. No specific procedures were noted or documentation provided to show how health plan self-reported data was validated or verified. We also requested listings of instances of noncompliance regarding health plan report submissions. None were provided.

DHH included its own information disclaimer on page 5 of the transparency report noting:

> *In some cases the data is self-reported from the health plans, and in these cases the Department has worked diligently to ensure consistency in how data is captured and reported, though some discrepancies may still exist.*

DHH also noted on page 5 of the transparency report:

> *For future reports, the Department is working to streamline how information is reported back from the health plans to the program and is exploring the option of contracting with an outside auditing firm to review and verify this self-reported information.*

Recommendation 4: In future reports, DHH should verify or audit the self-reported data.

Management Response: DHH management did not concur and noted that it has an extensive internal validation process, and a CPA firm has been contracted to begin independent verification for future Act 212 reporting. See Appendix A, pages 3-4 and 7.

Additional Comments: We requested support from DHH management regarding how DHH verified or validated the self-reported health plan data. Although management's response includes a description of a process, DHH has not provided any documentation to show how it verified or validated the self-reported health plan data for this report. The four subject matter experts we interviewed noted that they accepted health plan company certifications that data reported was complete and accurate. No

specific procedures were noted or documentation provided to show how health plan self-reported data was validated or verified. We also requested from management and the four subject matter experts listings of instances of noncompliance regarding health plan report submissions. None were provided.

We did receive an email on April 9, 2014, from the Medicaid Director that included the following excerpt which contradicts an extensive internal validation process:

> *…We had to use the best available information we had. With the window of time to complete a project of this magnitude and no budget for external resources we used what we could get. In hindsight, we probably should have had more disclaimers in our report. We realized at the time that it had weaknesses and that is why we were already working in December of 2013 to engage Myers & Stauffer to assist us in validation of the data for the 2014 report that is due to the legislature 1/1/15….*

Later in the same email, the Medicaid Director further characterizes the data as being "marginally legitimate."

Mathematical Accuracy

In eight of the 12 (67%) sections that presented numerical data, we noted mathematical errors. Examples of the errors noted are totals that are not added correctly as in Section 3, Total and Monthly Average Number of Members, where the total was incorrect and understated by 2,001 members. In the supplemental data book for Section 3, none of the totals or cross-totals were correct.

Inconsistencies in Data

In six of the 15 (40%) sections that presented data, we identified inconsistencies between report data and the supplemental data book information. For example, in Section 7, Denied or Reduced Claims, the report chart showed approximately 21 million denied claims for legacy Medicaid. However, the data book only showed approximately 6.5 million, a variance of 223%. In Section 3, Total and Average Number of Members, one of five (20%) data elements did not agree with the supplemental data book. In Section 8, Number and Dollar Value of Claims Paid to Non-Network Providers, two of 12 (17%) data elements did not agree with the supplemental data book.

Recommendation 5: In future reports, DHH should ensure that all amounts are mathematically accurate and resolve inconsistencies between report data and the supplemental data book information.

Management's Response: DHH considers the data book to be the official response to the Act 212 request. Management noted that with several exceptions, the math in the data book was accurate. Management also noted that there were transcription errors in

the narrative as well, but this handful of human-level errors is not reflective of the quality of the report as a whole. See Appendix A, pages 6-7.

Additional Comments: During our procedures, the report titled "Bayou Health Transparency Report - Report Prepared in Response to Act 212 of the 2013 Regular Session," which listed the data book as an addendum in the table of contents, was consistently referred to as the primary report and the data book as supplementing information.

Statements included in the *Bayou Health Transparency Report* (or narrative as it is referred to in DHH's response) also indicated that this report was the official response. The Transparency Report's Executive Summary includes the following:

> *This report outlines responses to the request made by the legislature in Act 212 relative to Bayou Health management and performance.*

In the original email providing us the Act 212 reporting, DHH's Chief of Staff, on January 2, 2014, stated the following:

> *This is being sent to the health and welfare committees and posted on our website right now. The reports are attached. The supplementing data can be found at the below links.*

The report attached in the email was the *Bayou Health Transparency Report* and the supplementing data linked to the data book on the DHH website.

DHH was informed of all errors and inconsistencies that our auditors identified during our procedures. Eight of the 12 (67%) sections that presented numerical data had mathematical errors. Six of the 15 (40%) sections that presented data had inconsistencies between report data and the supplemental data book information.

OBJECTIVE 2: Opportunities for Additional Information

Transparency Report - Section 17: Sanctions

Section 17.5.4.12 of the Bayou Health Pre-Paid health plan contracts requires the health plans to submit 95% of their general encounter data at least monthly to DHH.

Section 17 of the *Bayou Health Transparency Report* details sanctions levied by DHH against a health plan. One plan, AmeriHealth Caritas (formerly known as LaCare), was sanctioned a monetary penalty of $240,000 in June 2013 for noncompliance with the above general encounter data submission requirement.

The encounter claim reports provided to us by DHH noted many instances of noncompliance with the 95% requirement by Amerigroup and AmeriHealth Caritas (formerly known as LaCare). However, DHH only sanctioned one health plan on one occasion for general encounter data submission. See Appendix C.

NOTE: Pharmacy claim encounter data submission is also required but is not addressed in our consideration since pharmacy services were not included in the Bayou Health program until November 2013. We concentrated on the general encounter data for this report. One sanction of $170,000 was assessed on AmeriHealth Caritas (formerly known as LaCare) for lack of pharmacy encounter data according to that program's requirements.

> **Recommendation 6:** DHH should consider further sanctions for the lack of submission of encounter data.
>
> **Management's Response:** DHH management did not agree with our report for this section. Management noted that there were two sanctions for incomplete submission of encounter data: one for general encounter claims and one for pharmacy encounter claims. Management also noted that the department makes the decision to fine based on aspects provided in the contracts. See Appendix A, pages 4-5 and 7.
>
> **Additional Comments:** Our report included the general encounter claims sanction and the pharmacy encounter claims sanction. However, as shown in Appendix C, DHH did not issue sanctions for 18 other instances of noncompliance.

Complete and Timely Encounter Data

Encounter data, as defined by the contracts, includes claims paid by the health plan for services delivered to enrollees through the health plan during a specified reporting period. DHH collects and uses this data for many reasons such as federal reporting, rate setting, risk adjustment, service verification, managed care quality improvement program, utilization patterns and access to care, DHH hospital rate setting, and research studies.

The importance of valid and timely encounter data was pointed out by DHH prior to implementation of Bayou Health. In a *Making Medicaid Better Newsletter* dated December 8, 2011, the subject of encounter data was discussed. The newsletter quotes the then DHH Secretary:

> *We have made it very clear from the start (based on lessons learned from other states) that Plans must submit timely and accurate encounter data on a monthly basis to our Fiscal Intermediary. We have built stiff monetary penalties for failure to do so into the contracts. Some states are still not getting valid encounter data from their Medicaid managed care plans, in some cases many years after implementation.*

DHH engaged another contractor to analyze Bayou Health encounter data submitted by the prepaid health plans to DHH's fiscal intermediary, Molina, and complete a comparison of the encounters to cash disbursement journals provided by each prepaid health plan. DHH requested the contractor to estimate the percentage of each health plan's paid encounter claims that appear to be included in Molina's database. This comparison should show the amount of encounter data submitted to DHH in comparison to expenses on the health plans' books.

The contractor's encounter claim reports are provided to DHH bimonthly. The reports provided are cumulative and begin with February 2012. However, it appears no validation of encounter data was performed until the February 2013 report. DHH did not provide us any reports for 2012. As noted above, the reports provided by DHH noted many instances of noncompliance with the 95% requirement by Amerigroup and AmeriHealth Caritas (formerly known as LaCare).

Since the encounter data submitted by the health plans does not appear to be complete, DHH is without an important tool that would allow it to verify the health plans' self-reported data. As noted above, the Act 212 Transparency Report is largely based on self-reported health plan data.

It is also important to note that under the pre-paid health plans, providers are not required to be enrolled Louisiana Medicaid providers to participate. Without complete encounter data, DHH cannot be certain which providers are providing services to the state's Medicaid recipients and that these providers are comparable to the providers under the Shared Savings model or traditional legacy Medicaid.

Recommendation 7: DHH should ensure that it collects and verifies all encounter data timely since encounters are a primary tool to ensure accurate service delivery and payment information from the health plans.

Management's Response: DHH management noted that it remains dedicated to improving the collection and validation of encounter claims as demonstrated by the contract with Myers & Stauffer. See Appendix A, page 8.

Quality Management Strategy

DHH was required by federal regulations to develop and maintain a written strategy for assessing and improving the quality of managed care services offered by all managed care organizations. DHH's current Louisiana Quality Management Strategy, dated November 2011, notes that it is a comprehensive plan incorporating monitoring, assessment, coordination and ongoing quality improvement processes to continually improve Medicaid/Children's Health Insurance Program care and services.

Prior to launch and implementation of managed care in Louisiana Medicaid, DHH was required by federal managed care regulations (CFR 42 §438.202) to:

- develop a written strategy;
- obtain recipient and public comment on that strategy;
- ensure plan compliance with standards established;
- conduct periodic reviews to evaluate effectiveness of the strategy, including updating the strategy periodically, as needed;
- submit to CMS the initial strategy and a copy of the revised strategy whenever significant changes are made; and
- provide regular reports on the implementation and effectiveness of the strategy.

The strategy must include contract provisions that incorporate federal managed care standards, procedures that assess the quality and appropriateness of care and services furnished under the contracts, procedures that monitor and evaluate plan compliance with standards, and arrangements for annual external quality reviews.

An excerpt from the November 2011 Quality Management Strategy for Bayou Health noted:

> *The Louisiana Quality Management Strategy (QMS) is a comprehensive plan incorporating monitoring, assessment, coordination and ongoing quality improvement processes to continually improve Medicaid/Children's Health Insurance Program (CHIP) care and services. The QMS is a vehicle to communicate the vision, goals and monitoring strategies addressing issues of health care quality, timely access and efficiency.*

At the drafting of the strategy, DHH recognized the importance of the strategy. We are aware of at least one expected deliverable that was not met. For the annual external quality reviews, the strategy notes that encounter data will be validated. Encounter data validation was not included as a testing category in the annual external quality review.

Reports on the quality management strategy could provide additional information on areas reported in the Act 212 Transparency Report.

Recommendation 8: DHH should follow its quality management strategy since information and reporting from the strategy would assist the department with future reports to the Legislature.

Management's Response: DHH management agreed and noted that it will continue to follow the quality management strategy in addition to updating the strategy as the Bayou Health program evolves. See Appendix A, page 8.

Transparency Report - Section 11: Medical Loss Ratio

Bayou Health plans are required as part of their contracts to track their medical loss ratio, which is defined as the percentage of the per member per month payments received by the health plans from DHH that is used to pay medical claims from providers, approved quality improvements, and approved information systems costs. The medical loss ratio must not be less than 85%. If the medical loss ratio falls below 85%, the health plans are required to repay the difference to DHH.

The Medical Loss Ratio Report used to determine whether a refund is due to DHH is required to be submitted by prepaid health plans no later than June 1, 2014. In the interim, DHH provided data sheets in the data book using preliminary medical loss ratio data for the three applicable pre-paid health plans.

Upon review of the data book, we identified that the medical loss ratio worksheets are self-reported by the health plans and appear to be based on data as of December 30, 2012. The health plans are reporting medical loss ratios at or exceeding 96%, which indicates the health plans are spending virtually all of their per member per month payments on claims payments and allowed plan expenses.

The calculation includes consideration of a "premium tax." The premium tax is a tax levied on managed care premiums that is paid to the state of Louisiana through the Department of Insurance. Amendment 1 to the prepaid health plan contracts included revising the per member per month rates to adjust for the inclusion of the premium tax. By statute, these tax collections from the prepaid health plans are deposited in the Medical Assistance Trust Fund.

While there is no requirement for DHH to issue payments to the health plans based on medical loss ratios of 96% or higher, the ratios could factor into future per member per month rate increases.

DHH would have a valuable resource in verifying medical expenses reported by the health plans if encounter data submitted by the health plans was complete and validated.

Recommendation 9: For future reports, DHH should ensure complete and timely encounter data is received to assist in validating self-reported health plan information on medical loss ratio.

Management's Response: DHH management noted its efforts through its contractor to validate encounter claims and the medical loss ratio reported by each health plan. See Appendix A, pages 4 and 8-9.

Transparency Report - Section 8: Number and Dollar Value of Claims Paid to Non-Network Providers by Type

As reported, a key Bayou Health objective is to ensure adequate access to appropriate care in the appropriate setting. All health plans are required to provide emergency services without requiring prior authorization and to reimburse for treatment of emergency medical conditions at 100% of the Medicaid rate regardless of whether the provider is in or out of the health plan's network.

This section reports more than 565,000 total provider claims for emergency services paid to non-network providers totaling more than $61 million. Upon review, there are several errors in the report chart and in the narrative. The total number of claims should be 596,463 for emergency and non-emergency services. DHH did not provide an explanation for the inconsistency between the other health plans and the large number and dollar amount of non-emergency claims for Louisiana Healthcare Connections. Of the $42.8 million paid for out of network non-emergency services, $31.5 million (74%) consisted of 257,665 claims from just one plan, Louisiana Healthcare Connections. DHH provided no documentation on how significant outliers in self-reported data were researched and explained.

Since this section was compiled using self-reported health plan data, reliable encounter data would provide the claim detail for medical service expenses incurred by the health plans.

Recommendation 10: For future reports, DHH should ensure that the data presented is accurate and supported. Also, DHH should receive complete and timely encounter data to assist in validating self-reported health plan information and assessing service network adequacy.

Management's Response: DHH management noted it continually assesses the adequacy of health plan networks. Management further noted that it found no evidence that the number of out-of-network claims by Louisiana Healthcare Connections indicated barriers to access for Medicaid recipients. See Appendix A, pages 5 and 9.

Additional Comments: DHH did not provide documentation on how significant inconsistencies and outliers were researched and addressed for the Act 212 reporting.

Transparency Report - Section 15: Annual Audited Financial Statements

DHH reported that audited financial statements for each plan were included in the supplemental data book. Any audited financial statements must include an independent auditor's opinion. The data book includes only self-reported plan data using DHH provided templates and does not include audited financial statements.

Upon inquiry regarding this section, we were provided parent company financial statements and agreed-upon procedures reports. The parent financial statement audits do not provide detailed information for the Louisiana plan and the agreed-upon procedures reports do not contain an auditor's opinion.

Audited financial statements that speak specifically to Louisiana plans would allow for verification of certain self-reported health plan data, such as medical loss ratio (Section 11). No audited financial statements are included in the transparency report.

In response to our audit work, DHH has now placed audited financial statements from the parent companies for each health plan in the data book. DHH has also included agreed-upon procedures reports for each health plan that specifically address the auditors' work for Louisiana Medicaid. We have not reviewed these reports or considered the adequacy of the procedures performed.

Recommendation 11: For future reports, DHH should provide the audited financial statements required by Act 212 of 2013 Regular Session.

Management's Response: DHH management noted an error in posting the response to Act 212 online. Management further noted updates were made to the online documents and the complete financial statements are now available. See Appendix A, pages 5 and 9.

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

July 23, 2014

Daryl G. Purpera, CPA
Legislative Auditor
1600 North Third Street
Post Office Box 94397
Baton Rouge, Louisiana 70804-9397

Re: LLA Informational Audit of 2013 Bayou Health Transparency Report (Act 212)

Dear Mr. Purpera:

We have carefully reviewed the Louisiana Legislative Auditor (LLA) informational audit relative to the Bayou Health Transparency Report that was submitted to the legislature in January 2014 as required by Act 212 of the 2013 Louisiana Legislative Session.

As you and your staff know, Medicaid is a difficult and complex program in the midst of a massive modernization and improvement initiative. In the last five years we have undertaken significant transformative reform efforts to improve the provision of health care services for over a quarter of our state's population, including the implementation of Bayou Health in 2012.

The Bayou Health Transparency Report represents an unprecedented compilation and publication of Medicaid data, much of which was not collected or reported on for our legacy Medicaid program. Considering that Act 212 was signed into law less than seven months before the first annual report became due, we had a very narrow window of time to identify existing sources for the required data, extract and analyze the data, and prepare the report. It required hundreds of hours of staff time to compile and report in a manner dictated by Act 212 and our team did a commendable job.

We support your office's intent to aid the legislature in its evaluation of the program and improve our future reporting efforts, an effort that has already begun. Despite the enormous resources deployed by your office in the creation of this informational report, it does not paint a complete picture. As requested, we are providing DHH's response to the issues and recommendations. You will note that, while we appreciate the efforts of the LLA to improve our programs and operations, the Department continues to disagree with the basis of many of the findings.

Bienville Building • 628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone #: 888/342-6207 • Fax #: 225/342-9508 • *WWW.DHH.LA.GOV*
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LLA Issue #1: *The transparency report covers only July 2012 through June 2013 and did not cover the first five months of the Bayou Health Program; February 2012 through June 2012.*

DHH Response: The program was not fully implemented statewide until June 2012. As Act 212 does not stipulate when the reporting period should begin, DHH made the decision to align the report with the fiscal year to provide the most accurate information possible. The focus of Act 212 is on an **annual** report with the due date of the first day of the calendar year. DHH considered several factors when selecting State Fiscal Year (SFY) 13 as the reporting period:

- The Bureau of Health Services Financing (BHSF) has historically conducted Medicaid reporting by SFY (for example, the Medicaid Annual Reports produced and published by BHSF are based on SFY). Providing the Act 212 response based on SFY was consistent with historic reporting and aggregation of data.
- In the absence of a requirement to provide data from the program's inception, DHH considered it important to provide more recent data.

In addition, the inclusion of data from those first five months of Bayou Health (February through June 2012) would distort the performance of both the program and individual Health Plans and lead to wrong conclusions about its success. This is due to the following reasons:

- Data could not be compared across regions during the startup period as Bayou Health was geographically phased in over five months with service start dates of February 1, 2012; April 1, 2012; and June 1, 2012.
- Claims data during the transition period is skewed by contractual requirements. To ensure continuity of care during the transition from fee-for-service Medicaid to managed care, Bayou Health Plans were contractually required to make payments to out-of-network providers. According to Section 6.29.1 in Exhibit E of the Bayou Health Prepaid contract (found here: http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/CCNPrepaid04112011_FINAL.pdf) the Health Plans were required to continue the coordination of medically necessary services during the transition for a period up to ninety (90) calendar days; and Health Plans were prohibited from denying authorization of such services "solely on the basis that the provider is a non-contract provider." Payments made during the transition are not representative of ongoing payments to out-of-network providers.
- There was volatility in Health Plan assignment among members. Members were able to change Health Plans for any reason in the first 90 days of the program, per Section 11.6.2 of the Bayou Health Prepaid contract (see link above). Because of the staggered roll out we had three initial months of experience and three 90 day periods in which there was major movement of membership between Health Plans.
- Because of the volatility in the beginning months of Bayou Health enrollment, our actuary did not recommend that monthly capitation payments begin to be risk adjusted until the fourth month of operations. Actuaries recommended that the

initial month of experience in each of the three implementations be disregarded in calculating shared savings.

LLA Issue #2: *The report did not provide comparable data between the new Bayou Health services data and the prior legacy (pre-Bayou Health) Medicaid data. For example, the data chart in Section 7, Number of Claims Denied or Reduced, is not useful since the legacy Medicaid amount is not accumulated using comparable criteria.*

DHH Response: DHH provided the best data possible within the bounds of the Act. The data utilized in the response was based on the specifications of Act 212. DHH was not able to provide pre-Bayou Health data in the same specifications, as it was not collected and reported in that manner. For example, there is a full class of "optional" enrollees in Bayou Health that could not be properly categorized in the pre-Bayou Health data. DHH pulled the most applicable data to provide for comparison to the specific criteria outlined in Act 212.

Regarding the concerns with Section 7, DHH followed Act 212 specifications in its response. Pre-Bayou Health (legacy Medicaid) data was collected from the claims data warehouse maintained by our fiscal intermediary Molina. Claim denial reasons captured in legacy Medicaid claims processing differ from the claim denial reasons required to be reported by Act 212, which was signed into law in June 2013, more than a year after the Bayou Health program was implemented. Legacy Medicaid claims processing logic for denial reasons could not be altered retroactively, making an "apples to apples" comparison to Bayou Health Act 212 requirements for Bayou Health impossible.

LLA Issue #3: *The report included global assertions about Bayou Health cost savings and improved outcomes that were not required by Act 212, but support was not provided for these assertions.*

DHH Response: Support of the global assertion relative to savings realized was provided to the LLA following review of the draft report on May 16, 2014. Details regarding the remaining concerns found in Recommendation #3 are addressed below with that recommendation.

LLA Issue #4: *Data provided in the report is primarily self-reported by the Bayou Health Plans. DHH did not provide documentation of validation or verification by DHH personnel of this self-reported data.*

DHH Response: This is not an accurate finding. In fact, DHH provided extensive information regarding the process for reviewing self-reported data from the Bayou Health plans. DHH maintains an effective internal validation process, described below, and has additionally contracted with a CPA firm to begin independent verification.

- All Health Plan reported data submitted as part of regular reporting must accompany an attestation, signed by the Health Plan's chief officer in Louisiana, asserting that the report is accurate, true and complete. Any inaccuracies found in

the reporting may be subject to monetary penalties and/or administrative sanctions, as outlined in the Health Plan's contract.

- All reporting is received by a Health Plan Manager (HPM) assigned to a specific plan model (either Prepaid or Shared Savings), who ensures each report meets timeliness requirements and is the appropriate deliverable with all the necessary components. The HPM then assigns the report to a Subject Matter Expert (SME) for a second-level review. The SME analyzes the data contained in the report for reasonableness and accuracy of submission and determines if the report is compliant or non-compliant. If there are compliance issues, Bayou Health staff will work with the Health Plan to resolve issues through corrective action planning.

DHH has contracted with the CPA firm Myers & Stauffer to independently verify the completeness and accuracy of encounter data submitted by Managed Care Organizations (MCOs) to the state. Specifically, Myers & Stauffer is charged with applying the procedures specified in *CMS External Quality Review Protocol 4: Validation of Encounter Data Reported by MCO* (document previously provided to the LLA) to Bayou Health Prepaid Plans. Their work is being completed in two phases, validating first completeness and then accuracy. Completeness, assessed through bimonthly reconciliations of plan cash disbursement journals to encounter data submissions, was verified for all plans as of February 2014. An assessment of accuracy is in progress, with preliminary findings expected in fall 2014. This timeline is consistent with other states' experience.

LLA Issue #5: *DHH sanctioned one Health Plan one time for failure to provide the required percentage of general Health Plan paid claims data. However, two of the three Health Plans had numerous months where they failed to meet the requirement for claims data submission.*

DHH Response: DHH does not agree with this finding. Financial penalties were actually assessed and withheld from capitation payments for Amerihealth Caritas on **two** separate occasions: $170,000 for pharmacy encounter data and $240,000 for general encounter data for a total of $410,000.

DHH's contract allows the Department to fine Health Plans when necessary and the financial penalties that have been assessed (and not assessed) in relation to encounter data reporting are appropriate. DHH's contracts with the Health Plans specify the factors that are to be considered when determining whether financial penalties should be assessed. DHH weighs each factor and applies the available penalties accordingly. According to Section 20.2.2 of Exhibit E in the Bayou Health contract, the following aspects are to be considered:

- The duration of the violation;
- Whether the violation (or one that is substantially similar) has previously occurred;
- The CCN's history of compliance;

- The severity of the violation and whether it imposes an immediate threat to the health or safety of the Medicaid members; and
- The "good faith" exercised by the CCN in attempting to stay in compliance.

Submission of accurate and complete encounter data requires extensive testing between the Health Plan and the Medicaid fiscal intermediary and we were told by our actuary that, based on their experience in other state Medicaid managed care programs, it would take at least one year and probably two years to work out all of the issues in transmitting encounter data between Health Plans and a Medicaid fiscal intermediary. Therefore, our experience and the performance of our other Health Plans is within the normal expectation of a new managed care program and financial penalties related to these expected startup issues would not be appropriate.

LLA Issue #6: *One Health Plan reported 257,655 non-emergency claims paid to non-network providers totaling $31.5 million. This self-reported data is inconsistent with data reported by the other Health Plans, with no explanation for the significant data outliers.*

DHH Response: DHH has found no evidence that the number of out-of-network claims by LHC indicates barriers to access for Medicaid recipients and has no impact on state cost. It is within the scope of the Bayou Health Plan contract to allow members to access non-network providers, as long as the Health Plan has met the contractual terms for network adequacy. Managed care allows for differing network models to allow a Health Plan the flexibility to manage access and care to best suit the needs of its members and providers, and there is no expectation that all Health Plan networks will look alike.

DHH uses numerous tools that provide an accurate assessment of network adequacy and allow us to monitor plan networks for any gaps in coverage. These include quarterly submission of GEOAccess maps that reflect actual provider coverage of actual members (sample GEOAccess maps were provided to LLA), the annual CAHPS survey (included as part of Section 14 of the Act 212 report) and the internal complaints tracker used by Bayou Health member services to assess any member problems (samples provided to LLA). LHC's provider network is comparable in size to the other two plans, which is further illustrated in Section 2 of the Act 212 response.

LLA Issue #7: *Act 212 required DHH to provide audited financial statements for each Health Plan. While the report listed a section as audited financial statements, no audited financial statements were included.*

DHH Response: DHH posted the full financial report from all five Health Plans as part of the response to Section 15 of Act 212. There was an error with the creation of the PDF posted online and the embedded audit documents were not converted properly. DHH has updated the online documents and verified that both the audits for the parent company (Schedule W for Shared Savings, Schedule Y for Prepaid) and the Louisiana Bayou Health Plan (Schedule X for Shared Savings, Schedule Z for Prepaid) are now visible when opening the file.

LLA Issue #8: *The transparency report included mathematical errors and inconsistencies between the various report sections and the supplemental data provided.*

DHH Response: As we have previously explained, DHH provided an official response to Act 212 in the form of a data book that contained 23 separate elements that followed the specifications of the legislative request and an accompanying narrative that provided context and explanation of the information contained in the data book. **DHH considers the data book to be the official response to the Act 212 request.** The narrative was supplemental. With several exceptions we have been able to confirm, the math in the data book was accurate. There were transcription errors in the creation of the supplemental narrative as well, but DHH feels this handful of human-level errors is not reflective of the quality of the report as a whole. To avoid future issues, DHH will incorporate a thorough editorial review process that will analyze the entire report.

Recommendation #1: *DHH should consider additional reporting that would include the initial five months of Bayou Health.*

DHH Response: The inclusion of the initial five months of Bayou Health implementation would provide an inequitable and unbalanced picture of the program. A detailed response to this recommendation is outlined in DHH's response to LLA Issue #1.

Recommendation #2: *Future reporting should consider carve outs so that data presented is comparable.*

DHH Response: The data utilized in the response was based on the specifications of Act 212. However, DHH will incorporate carve outs where appropriate in future reporting.

Recommendation #3: *DHH should maintain support for all assertions included in the annual report.*

DHH Response: In the Act 212 supplemental narrative, DHH provided nine examples of how Bayou Health was improving health care for Medicaid recipients. Of those, LLA expressed concern over two of those examples, listed below. DHH supporting data, previously provided to LLA, is also provided below.

- *Act 212 Narrative Language:* "Already, DHH has seen a cost savings over what the state would have spent in absence of managed care." *DHH Supporting Data:* Prepaid plans offer guaranteed up-front savings through the actuarial process of establishing their capitation rates. The other most direct demonstration of cost savings for DHH is found in the actuarial determination of interim savings in the Shared Savings Model. As noted in the Interim Savings Determination for Program Year 1 reports prepared by DHH's actuary, Mercer, Community Health Solutions (CHS) and UnitedHealthcare (UHC) achieved a combined savings of $12.5 million in the first year of Bayou Health implementation (February 2012 – December 2012). Per the Shared Savings contract, Health Plans may receive 60%

of the savings determined for the period, with DHH keeping 40%. Savings payments based on the interim determination are limited to 75% of this 60%. To date, DHH has made interim payments to CHS and UHC totaling $5,629,271 ($4,519,201 to CHS and $1,110,070 to UHC).

- *Act 212 Narrative Language:* "DHH has observed marked improvements in the quality of care delivered under Bayou Health." *DHH Supporting Data:* Improvements to quality since Bayou Health implementation are identified in the subsequent assertions from the transparency report (decreased NICU hours, inpatient hospital stays, care management, etc.). At the time the report was written, this global assertion was very much supported by the performance of the five Plans in quality measurement year 2013 against the pre-Bayou Health baseline in the five key measures that DHH was tracking. With more than four months of additional experience still pending for claims run out, baseline performance had already been exceeded by some plans for some of the five measures.

Recommendation #4: *In future reports, DHH should verify or audit the self-reported data.*

DHH Response: DHH has an extensive internal validation process in place, as previously demonstrated to LLA. Additionally, DHH has taken steps to provide additional levels of verification to future reporting for Act 212 through its contract with Myers & Stauffer, beginning with the January 2015 submission.

Recommendation #5: *In future reports, DHH should ensure that all amounts are mathematically accurate and resolve inconsistencies between report data and the supplemental data book information.*

DHH Response: With several exceptions we have been able to confirm, the math in the Act 212 official response (the data book) was accurate. There were transcription errors in the conversion from the data book to the narrative that led to some inconsistencies, but DHH believes these human-level errors are not reflective of the quality of the report as a whole. DHH is incorporating additional editorial steps for future Bayou Health Transparency Reports to ensure a multi-tiered review process for all content, including the review of any math and data compilation.

Recommendation #6: *DHH should consider further sanctions for the lack of submission of encounter data.*

DHH Response: The assessment of financial penalties has been appropriate in keeping with the factors to be taken into consideration determine monetary sanctions. A detailed response to this recommendation is outlined in DHH's response to LLA Issue #5.

Recommendation #7*: DHH should ensure that it collects and verifies all encounter data timely since encounters are a primary tool to ensure accurate service delivery and payment information from the Health Plans.*

DHH Response: DHH recognizes the complexities of the encounter collection task and the transition to a managed care environment, and remains dedicated to improving our collection and validation of encounter data. This is demonstrated by our contract with Myers & Stauffer as well as through internal controls put in place to improve collection. This includes the requirement that Prepaid Bayou Health Plans submit encounter data submission reports weekly for dedicated claims staff to monitor, analyze and validate the data and remediate any inconsistencies between the Health Plans and the Fiscal Intermediary.

Recommendation #8: *DHH should follow its quality management strategy since information and reporting from the strategy would assist the department with future reports to the Legislature.*

DHH Response: DHH agrees and continues to do so. But DHH also recognizes the need to update its quality management strategy as the program evolves, as it was originally completed in 2011 prior to Bayou Health implementation. Quality management and improvement is in continuous development and DHH's strategy continues to be guided through the efforts of the Bayou Health Quality Committee, which advises DHH on best practices, provider relations, ongoing quality improvement measures and recommendations for changes. The agency also continues to focus available resources on quality improvement, including:

- A recent business reorganization of Medicaid that included the creation of quality improvement team within the Medicaid Managed Care Program.
- Leveraging federal grant resources ($2 million) to drive quality improvement in the Managed Care Program.
- Filling a key position in quality care this fiscal year dedicated to the revision and management of the quality management strategy.

Recommendation #9: *For future reports, DHH should ensure complete and timely encounter data is received to assist in validating self-reported Health Plan information on medical loss ratio.*

DHH Response: As noted in LLA Issue #4, DHH has contracted with the CPA firm Myers & Stauffer to independently verify the completeness and accuracy of encounter data submitted by MCOs to the State. For additional details on the scope of this contract, see LLA Issue #4.

Myers & Stauffer will also conduct an independent audit of the annual Medical Loss Ratio (MLR) reports. The MLR reporting year is calendar year, and the first MLR report required under the contract is for the second calendar of the contract, which is CY13. The

CY13 report is due to DHH by June 1, 2014. DHH will make the audit results public within 60 calendar days of finalization of the audit.

Recommendation #10: *For future reports, DHH should ensure that data presented is accurate and supported. Also, DHH should receive complete and timely encounter data to assist in validating self-reported Health Plan information and assessing service network adequacy.*

DHH Response: DHH agrees that it should continue to provide accurate and supported data as has always been our chief objective. The data included in the official Act 212 response was subject to an internal validation process and is supported by volumes of additional documentation that DHH has supplied to LLA. As noted in LLA Issue #4 and Recommendation #9, DHH's relationship with Myers & Stauffer will further address the concerns for accurate, timely and supported data.

DHH is continually assessing the adequacy of the Health Plan networks through a variety of tools and reports, as illustrated in the response to LLA Issue #6. The ratio of network to out-of-network providers as a standalone assessment is not an accurate depiction of network adequacy or access to care.

Recommendation #11: *For future reports, DHH should provide the audited financial statements required by Act 212 of 2013 Regular Session.*

DHH Response: As noted in LLA Issue # 7, there was an error made when posting the response to Act 212 online. DHH has made updates to the online documents and the complete financial statements are now available.

We appreciate the opportunity to again respond to the issues and concerns raised by LLA. As the public and the legislature deserve an objective and fair assessment, it is our hope that this response will augment and provide additional context to LLA's report and assist in providing an accurate and complete assessment of the inaugural Bayou Health Transparency Report.

Sincerely,

J. Ruth Kennedy
Medicaid Director

JRK/PDL

APPENDIX B: LIST OF CONCERNS AND ISSUES NOTED BY SECTION

Section	Title	Source Information	Self-Reported Data Used	DHH Verified Self-Reported Data
1	COORDINATED CARE NETWORK NAME AND SERVICE AREA	**DID NOT LIST**	NO	N/A
2	TOTAL PROVIDERS BY HEALTH PLAN, GSA AND SPECIALTY	DATABOOK & BIBLIOGRAPHY	**YES**	**NO**
3	TOTAL AND MONTHLY AVERAGE NUMBER OF MEMBERS ENROLLED IN EACH NETWORK BY ELIGIBILITY GROUP	DATABOOK & BIBLIOGRAPHY	NO	N/A
4	CONTINUOUS PHONE ACCESS PROVIDED BY PCPS	BIBLIOGRAPHY	**YES**	**NO**
5	PERCENTAGE OF REGULAR AND EXPEDITED SERVICE AUTHORIZATION REQUESTS	BIBLIOGRAPHY	**YES**	**NO**
6	PERCENTAGE OF CLEAN CLAIMS PAID FOR PROVIDERS AND AVERAGE NUMBER OF DAYS TO PAY	BIBLIOGRAPHY	**YES**	**NO**
7	NUMBER OF CLAIMS DENIED OR REDUCED BY EACH COORDINATED CARE NETWORK BY REASON	DATABOOK & BIBLIOGRAPHY	**YES**	**NO**
8	NUMBER AND DOLLAR VALUE OF CLAIMS PAID TO NON-NETWORK PROVIDERS BY TYPE	**DID NOT LIST**	**YES**	**NO**
9	NUMBER OF MEMBERS WHO CHOSE THEIR NETWORK VERSUS AUTOENROLLED MEMBERS	DATABOOK & BIBLIOGRAPHY	NO	N/A
10	TOTAL PAYMENTS AND AVERAGE PER MEMBER PER MONTH (PMPM) FOR EACH COORDINATED CARE NETWORK	DATABOOK & BIBLIOGRAPHY	NO	N/A
11	MEDICAL LOSS RATIOS FOR COORDINATED CARE NETWORKS AND RELATED REFUNDS	**DID NOT LIST**	**YES**	**NO**
12	COMPARISON OF HEALTH OUTCOMES BETWEEN HEALTH PLANS AND TO MEDICAID PRIOR TO BAYOU HEALTH	DATABOOK	**YES**	**NO**
13		**DID NOT LIST**	NO	N/A
14	MEMBER AND PROVIDER SATISFACTION SURVEYS FOR EACH BAYOU HEALTH PLAN	BIBLIOGRAPHY	**YES**	**NO**
15	ANNUAL AUDITED FINANCIAL STATEMENTS FOR COORDINATED CARE NETWORKS	**DID NOT LIST**	**YES**	**NO**
16	TOTAL SAVINGS TO THE STATE FOR EACH SHARED-SAVINGS COORDINATED CARE NETWORK	**DID NOT LIST**	NO	N/A
17	NARRATIVE OF SANCTIONS LEVIED BY DHH AGAINST A COORDINATED CARE NETWORK	**DID NOT LIST**	NO	N/A
18	GRIEVANCES, APPEALS, STATE FAIR HEARINGS BY NUMBER OF MEMBERS PER COORDINATED CARE NETWORK INCLUDING REVERSALS	BIBLIOGRAPHY	**YES**	**NO**
19	DATA REGARDING TYPES OF SERVICES PROVIDED, LOCATIONS, TYPES OF CARE AND PRESCRIPTION BENEFITS	BIBLIOGRAPHY	**YES**	**NO**
20		BIBLIOGRAPHY	**YES**	**NO**
21		BIBLIOGRAPHY	**YES**	**NO**
22		**DID NOT LIST**	**YES**	**NO**
23		**DID NOT LIST**	**YES**	**NO**
24	ANY OTHER METRIC OR MEASURE THAT DHH DEEMS APPROPRIATE FOR INCLUSION IN THE REPORT	**DID NOT LIST**	**YES**	**NO**

APPENDIX B: LIST OF CONCERNS AND ISSUES NOTED BY SECTION

Section	Title	Comparative Legacy Medicaid Data[3] Requested	Comparative Legacy Medicaid Data Presented	Report and/or Databook Mathematically Accurate	Data in Report and Databook Match	DHH Provided with Adequate[1] Support
1	COORDINATED CARE NETWORK NAME AND SERVICE AREA	NO	N/A	N/A	YES	N/A
2	TOTAL PROVIDERS BY HEALTH PLAN, GSA AND SPECIALTY	**YES**	**NO**	N/A	YES	NO
3	TOTAL AND MONTHLY AVERAGE NUMBER OF MEMBERS ENROLLED IN EACH NETWORK BY ELIGIBILITY GROUP	NO	N/A	**NO**	**NO**	YES
4	CONTINUOUS PHONE ACCESS PROVIDED BY PCPS	NO	N/A	**NO**	YES	NO
5	PERCENTAGE OF REGULAR AND EXPEDITED SERVICE AUTHORIZATION REQUESTS	**YES**	**NO**	**NO**	**NO**	NO
6	PERCENTAGE OF CLEAN CLAIMS PAID FOR PROVIDERS AND AVERAGE NUMBER OF DAYS TO PAY	**YES**	**NO**	**NO**	**NO**	NO[2]
7	NUMBER OF CLAIMS DENIED OR REDUCED BY EACH COORDINATED CARE NETWORK BY REASON	**YES**	**NO**	N/A	**NO**	NO
8	NUMBER AND DOLLAR VALUE OF CLAIMS PAID TO NON-NETWORK PROVIDERS BY TYPE	NO	N/A	**NO**	**NO**	NO[2]
9	NUMBER OF MEMBERS WHO CHOSE THEIR NETWORK VERSUS AUTOENROLLED MEMBERS	NO	N/A	YES	YES	YES
10	TOTAL PAYMENTS AND AVERAGE PER MEMBER PER MONTH (PMPM) FOR EACH COORDINATED CARE NETWORK	NO	N/A	N/A	**NO**	**NO[2]**
11	MEDICAL LOSS RATIOS FOR COORDINATED CARE NETWORKS AND RELATED REFUNDS	NO	N/A	YES	YES	**NO**
12	COMPARISON OF HEALTH OUTCOMES BETWEEN HEALTH PLANS	NO	N/A	N/A	N/A	**NO**
13	AND TO MEDICAID PRIOR TO BAYOU HEALTH	**YES**	**NO**	**NO**	YES	**NO**
14	MEMBER AND PROVIDER SATISFACTION SURVEYS FOR EACH BAYOU HEALTH PLAN	NO	N/A	N/A	YES	**NO**
15	ANNUAL AUDITED FINANCIAL STATEMENTS FOR COORDINATED CARE NETWORKS	NO	N/A	N/A	N/A	**NO**
16	TOTAL SAVINGS TO THE STATE FOR EACH SHARED-SAVINGS COORDINATED CARE NETWORK	NO	N/A	YES	YES	YES
17	NARRATIVE OF SANCTIONS LEVIED BY DHH AGAINST A COORDINATED CARE NETWORK	NO	N/A	N/A	YES	YES
18	GRIEVANCES, APPEALS, STATE FAIR HEARINGS BY NUMBER OF MEMBERS PER COORDINATED CARE NETWORK INCLUDING REVERSALS	NO	N/A	YES	N/A	**NO**
19	DATA REGARDING TYPES OF SERVICES PROVIDED, LOCATIONS, TYPES OF CARE AND PRESCRIPTION BENEFITS	NO	N/A	N/A	N/A	**NO[2]**
20		NO	N/A	**NO**	N/A	**NO[2]**
21		NO	N/A	**NO**	N/A	**NO[2]**
22		**YES**	**NO**	N/A	N/A	**NO[2]**
23		NO	N/A	N/A	N/A	**NO[2]**
24	ANY OTHER METRIC OR MEASURE THAT DHH DEEMS APPROPRIATE FOR INCLUSION IN THE REPORT	NO	N/A	N/A	N/A	**NO**
		6 YES	**6 NO**	**8 NO**	**6 NO**	**8 NO SUPPORT PROVIDED (NO[2])**
						11 INADEQUATE SUPPORT
			100%	**67%**	**40%**	**83%**

[1] The definition of adequate support for this report includes, but is not limited to, support that is mathematically correct, ties to the report/databook, is for the appropriate time period, consistent time periods (when presented as comparative), did not include a plan disclaimer, and was not solely plan reported data.

[2] Indicates DHH did not provide source data and/or was unresponsive to inquiries on source data.

[3] Act 212 requests Medicaid data for the period prior to the date of services initially being provided under Bayou Health.

APPENDIX C: COMPILATION OF VALIDATED ENCOUNTER CLAIMS

DHH requires the health plans to submit 95% of their encounter claims on a monthly basis. Months highlighted in the chart note where the health plans are not in compliance. (See Section 17 - Sanctions on pages 10-13 of this report for discussion of encounter claims.)

However, DHH sanctioned only one plan on only one occasion for noncompliance with Section 17.5.4.12 of the contract. In a letter issued by DHH on June 18, 2013, to LaCare, DHH states, *"LaCare appears to have submitted approximately 76 percent of their non-pharmacy encounter data for this period, with a cumulative monthly range between 3 percent and 77 percent."* (See percentages highlighted in blue.)

	Amerigroup		LHC		AmeriHealth (LaCare)	
	% of Monthly Claims	*% of Cumulative Total*	*% of Monthly Claims*	*% of Cumulative Total*	*% of Monthly Claims*	*% of Cumulative Total*
February 2012	91.70%	91.70%	103.49%	103.49%	3.64%	3.64%
March 2012	90.71%	90.88%	106.47%	105.88%	42.92%	38.09%
April 2012	90.60%	90.73%	100.79%	103.06%	67.78%	57.76%
May 2012	92.18%	91.40%	99.80%	101.20%	79.09%	69.06%
June 2012	95.30%	92.90%	98.77%	100.37%	91.90%	77.65%
July 2012	99.55%	94.97%	99.37%	100.05%	74.57%	76.49%
August 2012	95.43%	95.10%	98.69%	99.61%	73.85%	75.77%
September 2012	97.75%	95.64%	97.11%	99.11%	64.59%	73.63%
October 2012	97.99%	96.02%	99.87%	99.27%	70.91%	73.01%
November 2012	97.68%	96.28%	93.28%	98.17%	45.08%	67.45%
December 2012	99.05%	96.75%	92.59%	97.10%	52.25%	64.97%
January 2013	92.43%	96.14%	99.07%	97.39%	84.19%	67.50%
February 2013	69.57%	93.07%	75.30%	94.83%	41.48%	64.92%
Instances of Noncompliance	6	6	3	0	13	13
% error	**46%**	**46%**	**23%**	**0%**	**100%**	**100%**
min	69.57%	90.73%	75.30%	94.83%	3.64%	**3.64%**
max	99.55%	96.75%	106.47%	105.88%	91.90%	**77.65%**

% of monthly claims - the monthly percentage difference between the cash disbursement journal dollars and the encounter claims dollars
% of cumulative total - the cumulative percentage difference between the cash disbursement journal dollars and the encounter claims dollars
Cash Disbursements Journal - Payments for a given month reported by a prepaid health plan to DHH
Encounter Data - Encounter submissions for a given month

Source: Myers & Stauffer Comparison of Managed Care Organization Encounter Claims to Cash Disbursements (aka Encounter Data Validation Reports) - May 17, 2013.

APPENDIX D: SCOPE AND METHODOLOGY

We conducted procedures for this informational audit to provide information to the Legislature on the Act 212 Reporting received from DHH on January 2, 2014, and titled *Bayou Health Transparency Report*. The scope of our audit was significantly less than an audit conducted in accordance with *Government Auditing Standards*. The objectives were the following:

OBJECTIVE 1: To evaluate the reliability and consistency of the information reported in the Transparency Report to include the following areas:

- Reporting period used
- Use of pre-Bayou Health Medicaid data
- Validity of global assertions on savings and health outcomes
- Reliability and sources of data reported
- Mathematical accuracy
- Consistencies between data in the report and the supplemental data book

OBJECTIVE 2: To provide additional information and analysis regarding that report.

To achieve our objectives, we performed the following steps:

- 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 supplemental data book.
- 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 the DHH's answers and additional documentation, if any, as well as other information and understanding we have accumulated through our audits of DHH.