



An Audit Report on

**HealthSpring Life and Health Insurance  
Company, Inc., a Medicaid STAR+PLUS  
Managed Care Organization**

February 2017  
Report No. 17-025



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## Overall Conclusion

HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) controls over its financial reporting process provided reasonable assurance that the \$601.3 million in medical claims and prescription drug claims that HealthSpring paid in fiscal year 2015 for the Medicaid STAR+PLUS managed care program (STAR+PLUS) were accurately reported on its financial statistical reports to the Health and Human Services Commission (Commission).

However, the salaries, other medical expenses, bonuses, allocated corporate costs, and professional services costs that HealthSpring reported on its financial statistical reports for fiscal year 2015 were not compliant with the Commission's contract requirements. Those costs were approximately \$53.8 million. Specifically:

- **Unallowable Costs** - Auditors identified approximately \$3.8 million in unallowable costs. HealthSpring (1) reported bonuses paid by its affiliate companies and (2) included advertising costs, charitable donations, non-STAR+PLUS affiliate company expenses, employee events expense, gifts, and stock options in its reported allocated corporate costs on its financial statistical reports. The Commission's Medicaid program requirements specify that those costs are unallowable and, therefore, should not be reported on the financial statistical reports. In addition, \$163,977 in reported professional services costs were for costs incurred in fiscal year 2014.
- **Questioned Costs** - Auditors identified approximately \$34.0 million in questioned salaries, other medical expenses (service coordinator salaries), and professional services costs. HealthSpring did not prepare certifications or personnel activity reports that the Commission requires to show that its reported salaries, approximately \$33.7 million, were for services that supported STAR+PLUS. In addition, HealthSpring could not provide

### Background Information

HealthSpring Life and Health Insurance Company, Inc. (HealthSpring) provides acute care services plus long-term care services and support (LTSS) by integrating primary care, pharmacy services, and LTSS for individuals who are age 65 or older or have a disability through services delivered through Medicaid STAR+PLUS managed care program (STAR+PLUS) in three service delivery areas in Texas. Those service delivery areas are: Tarrant service delivery area, Hidalgo service delivery area, and Northeast Medicaid rural service areas (see Appendix 3 for additional information on those service delivery areas).

From September 1, 2014, through August 31, 2015, HealthSpring received payments from the Health and Human Services Commission (Commission) that totaled \$713.7 million. Approximately \$601.3 million of that amount paid for medical claims and prescription drug claims for 62,828 people enrolled in STAR+PLUS.

Source: The Commission.

This audit was conducted in accordance with Texas Government Code, Sections 321.0131, 321.0132, and 321.013(k)(2).

For more information regarding this report, please contact John Young, Audit Manager, or Lisa Collier, First Assistant State Auditor, at (512) 936-9500.

documentation to show that \$359,912 in professional service costs tested were for STAR+PLUS.

The unallowable and questioned costs identified affect the accuracy of HealthSpring’s calculation of net income, which the Commission uses to calculate the experience rebate<sup>1</sup> amounts that HealthSpring is required to pay the Commission. For fiscal year 2015, HealthSpring paid the Commission an experience rebate of approximately \$12.5 million.

In addition, HealthSpring had weaknesses in the controls over its process for documenting the reasons for post-payment adjustments to medical claims and for ensuring that medical claims are paid within 30 days of receipt of a “clean claim”<sup>2</sup> as required. The weaknesses identified in the claims payment process could affect the continued participation of HealthSpring’s medical providers in STAR+PLUS.

Auditors communicated other, less significant issues to HealthSpring management and Commission management separately in writing.

Table 1 presents a summary of the findings in this report and the related issue ratings. (See Appendix 2 for more information about the issue rating classifications and descriptions.)

Table 1

Summary of Subchapters and Related Issue Ratings		
Subchapter	Title	Issue Rating <sup>a</sup>
1-A	HealthSpring Accurately Reported the Medical Claims and Prescription Drug Claims That It Paid in Fiscal Year 2015	Low
1-B	HealthSpring Included Unallowable Costs in the Bonuses It Reported on Its Financial Statistical Reports, and It Did Not Prepare Required Certifications and Personnel Activity Reports	High
1-C	HealthSpring Did Not Develop a Written Allocation Methodology as Required, and It Overstated Its Reported Allocated Corporate Costs on Its Financial Statistical Reports	High
1-D	HealthSpring Did Not Consistently Maintain Documentation to Show That Certain Legal and Professional Services Costs Were Applicable to STAR+PLUS and Incurred During the Reporting Period	Medium

<sup>1</sup> “Experience rebates” are a portion of a managed care organization’s net income before taxes that is returned to the State in accordance with statute and the uniform managed care contract terms.

<sup>2</sup> Title 28, Texas Administrative Code, Section 21.802 (6), defines a clean claim as follows:

- For nonelectronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy that includes required data elements and the amount paid by a health plan.
- For electronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy using the ASC X12N 837 format and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides, and trading partner agreements.

Summary of Subchapters and Related Issue Ratings		
Subchapter	Title	Issue Rating <sup>a</sup>
1-E	HealthSpring Did Not Report Accurate and Complete Information About Its Affiliate Companies	Medium
2-A	HealthSpring Did Not Consistently Document the Reasons for Post-payment Adjustments That It Made to Paid Medical Claims	High
2-B	HealthSpring Did Not Ensure That It Paid All Medical Claims Within 30 Days of Receipt of a Clean Claim as Required	Medium
<p><sup>a</sup> A subchapter is rated <b>Priority</b> if the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.</p> <p>A subchapter is rated <b>High</b> if the issues identified present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern and reduce risks to the audited entity.</p> <p>A subchapter is rated <b>Medium</b> if the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.</p> <p>A subchapter is rated <b>Low</b> if the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.</p>		

## ***Summary of Management's Response***

At the end of each chapter in this report, auditors made recommendations to address the issues identified during this audit. HealthSpring generally agreed with the recommendations in this report, and management's response is presented in Appendix 7.

## ***Audit Objective and Scope***

The objective of this audit was to determine whether selected financial processes and related controls at a Medicaid managed care organization (MCO) are designed and operating to help ensure (1) the accuracy and completeness of data that the MCO reports to the Commission and (2) compliance with applicable requirements.

The scope of this audit covered HealthSpring's contracts with the Commission for STAR+PLUS. It covered HealthSpring's financial statistical reports and its reported medical claims and pharmacy claims for fiscal year 2015. It also included the Commission's management of the MCO's subcontractor agreements and readiness review records for fiscal year 2015.

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# Detailed Results

## Chapter 1

### **HealthSpring Accurately Reported State Payments, Medical Claims, and Prescription Drug Claims on Its Financial Statistical Reports for Fiscal Year 2015; However, It Had Significant Weaknesses for Reporting Its Administrative Expenses**

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#### Unallowable Cost

The Commission's *Uniform Managed Care Manual* defines the cost principles that establish the allowability of various administrative expenses that an MCO can report on the financial statistical reports. A designation of "allowable" or "unallowable" does not generally govern whether the MCO can incur a cost or make a payment; allowability reflects only what is reportable on the financial statistical reports. To be allowable, expenses must conform to the requirements of the Commission's cost principles, which include being reasonable and allocable.

#### Questioned Cost

According to the Code of Federal Regulations, a "questioned cost" is a cost charged to MCO funds that MCO management, federal oversight entities, an independent auditor, or other audit organization authorized to conduct an audit of an MCO has questioned because of an audit or other finding. Costs may be questioned because:

- There may have been a violation of a provision of a law, regulation, contract, grant, or other agreement or document governing the use of MCO funds;
- The cost is not supported by adequate documentation; or
- The cost incurred appears unnecessary or unreasonable and does not reflect the actions a prudent person would take in the circumstances.

Sources: The Commission's *Uniform Managed Care Manual* and Title 45, Code of Federal Regulations, Section 1630.2(g).

HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) financial reporting process provided reasonable assurance that it accurately reported certain costs on its financial statistical reports to the Health and Human Services Commission (Commission). Specifically, HealthSpring accurately reported the Medicaid STAR+PLUS (STAR+PLUS) program medical claims and the prescription drug claims that it paid for fiscal year 2015, totaling \$601,313,929, as required by its contracts with the Commission.

However, the salaries, other medical expenses, bonuses, allocated corporate costs, and professional services costs that HealthSpring reported on its financial statistical reports for fiscal year 2015, totaling \$53,808,621, may be overstated. Auditors identified weaknesses in HealthSpring's controls for reporting those costs that resulted in \$3,831,812 in unallowable costs to be reported. In addition, auditors identified \$34,039,615 in questioned costs because HealthSpring did not maintain documentation to show that the reported costs were attributable to STAR+PLUS (see text box for information about unallowable and questioned costs).

HealthSpring's overstatement of the costs listed above would affect the accuracy of HealthSpring's calculation of net income. The Commission uses the reported net income to calculate the amount of "experience rebates"<sup>3</sup> that managed care organizations (MCOs), such as HealthSpring, are statutorily required to pay the Commission. As of August 2016, HealthSpring paid the Commission a total of \$12,478,448 in experience rebates for fiscal year 2015. (See Appendix 6 for more information about calculating the experience rebate that HealthSpring owed for fiscal year 2015.)

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<sup>3</sup> "Experience rebates" are a portion of an MCO's net income before taxes that is returned to the State in accordance with statute and the uniform managed care contract terms. (See Appendix 5 for more information about experience rebates.)

Table 2 summarizes the identified unallowable and questioned costs.

Table 2

Unallowable and Questioned Costs That HealthSpring Reported on Its Financial Statistical Reports for Fiscal Year 2015			
Type of Administrative Expense	Reported Costs for Fiscal Year 2015	Total Unallowable Costs Identified	Total Questioned Costs Identified
Salaries	\$ 22,848,767	\$ 0	\$ 22,848,767
Bonuses	786,457	786,457	0
Other Medical Expenses <sup>a</sup>	11,137,962	0	10,830,936 <sup>b</sup>
Allocated Corporate Costs	15,355,392	2,881,358	0
Legal and Professional Services Costs	3,680,042	163,997	359,912
<b>Totals</b>	<b>\$53,808,621</b>	<b>\$3,831,812</b>	<b>\$34,039,615</b>
<sup>a</sup> Other Medical Expenses represent salary and miscellaneous expenses related to service coordinators. A service coordinator is an employee who works with a STAR+PLUS member, the member's family, and the member's doctors and other providers to help the member get the medical and long-term care services and support they need. The coordinator must identify the member's needs and develop a plan of care. <sup>b</sup> The questioned costs for Other Medical Expenses represent only the salary costs portion of HealthSpring's reported Other Medical Expenses. See Chapter 1-B for information about Other Medical Expenses that auditors tested.			

Source: HealthSpring and the Commission.

HealthSpring also reported inaccurate and incomplete information to the Commission about its affiliate companies that provide services supporting its administration of STAR+PLUS. The Commission uses the information that HealthSpring reports as part of its monitoring efforts to ensure the transparency and reasonableness of HealthSpring's related-party transactions.

## HealthSpring Accurately Reported the Medical Claims and Prescription Drug Claims That It Paid in Fiscal Year 2015

Chapter 1-A  
Rating:

Low <sup>4</sup>

### Financial Statistical Reports

The Commission receives financial statistical reports from MCOs on a quarterly and annual basis as required by the Commission's contracts with the MCOs. Those reports are the primary statements of financial results the MCOs submit to the Commission. The Commission uses the reports to analyze the MCOs' membership, revenues, expenses, and net income by service area and program.

Source: The Commission.

### Medical Claims and Pharmacy Claims Tested

The samples auditors tested were selected as follows:

- **Medical Claims.** Auditors selected a random sample of 60 paid medical claims and used professional judgment to select a risk-based sample of 17 additional medical claims to test.
- **Pharmacy Claims.** Auditors selected a random sample of eight vendor payments to HealthSpring's pharmacy benefit manager and used professional judgment to select a risk-based sample of three additional vendor payments to test.

HealthSpring's financial reporting processes and controls provided reasonable assurance that the \$601,313,929 in medical claims and prescription drug claims it paid in fiscal year 2015 were accurately calculated and reported on its financial statistical reports to the Commission (see text box for information about the required financial statistical reports).

Auditors tested samples of HealthSpring's medical claims and vendor payments to its pharmacy benefit manager<sup>5</sup> that were reported as paid during fiscal year 2015 (see text box for additional details on the medical claims and pharmacy claims tested). The tested medical claims and pharmacy claims were accurate, supported by documentation, and submitted for eligible STAR+PLUS members.

**Paid medical claims tested were accurate, supported by documentation, and submitted by eligible providers for eligible STAR+PLUS members.**

The medical claim payments tested that HealthSpring reported on its financial statistical reports for fiscal year 2015 were allowable, supported by documentation, and documented accurately in HealthSpring's claims processing system. HealthSpring reported a total of \$510,400,761 in medical claim payments for fiscal year 2015. Auditors tested a sample of 77 medical claim payments, totaling \$786,899, and verified that:

- The medical claim payment amounts matched the payment amounts shown in (1) HealthSpring's claims processing system, (2) the medical claims data that HealthSpring reported to the Commission, and (3) copies of the explanation of payment (EOP) statements that HealthSpring sent to medical providers.

<sup>4</sup> The risks related to the issues discussed in Chapter 1-A are rated as Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/function(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

<sup>5</sup> HealthSpring contracts with a pharmacy benefit manager to manage and pay pharmacy drug claims purchased through its STAR+PLUS contract. HealthSpring reimburses its pharmacy benefit manager for the pharmacy drug claims paid, and it pays a monthly management fee to the pharmacy benefit manager for the services provided. For fiscal year 2015, HealthSpring reported that it paid \$538,000 to its pharmacy benefit manager.



- Eligible providers submitted the medical claims, and those claims were for eligible STAR+PLUS members.

However, auditors identified weaknesses in HealthSpring’s controls over post-payment adjustments to medical claims and for ensuring the timeliness of medical claims payments (see Chapter 2).

**HealthSpring’s vendor payments to its pharmacy benefit manager were accurate, supported by documentation, and for pharmacy claims for eligible STAR+PLUS members.**

The pharmacy claims payments tested were accurate and supported by documentation. HealthSpring reported that it paid its pharmacy benefit manager a total of \$90,913,168 in fiscal year 2015. Auditors tested a sample of 11 payments to the pharmacy benefit manager, totaling \$18,960,236, and verified that the payment amounts matched the weekly invoices that HealthSpring received from its pharmacy benefit manager.

In addition, auditors verified that the payments for a sample of 81 pharmacy claims from HealthSpring (1) matched the payment amounts reported to the Commission and (2) were for pharmacy claims for eligible STAR+PLUS members.

Chapter 1-B

### **HealthSpring Included Unallowable Costs in the Bonuses It Reported on Its Financial Statistical Reports, and It Did Not Prepare Required Certifications and Personnel Activity Reports**

HealthSpring included unallowable costs and questioned costs on its financial statistical reports for fiscal year 2015. Auditors identified \$786,457 in bonuses that HealthSpring should not have reported on its financial statistical reports for fiscal year 2015. The amount that HealthSpring reported was for bonuses that were paid to staff employed by its affiliate companies. The Commission’s reporting requirements specify that bonuses paid to affiliates are unallowable costs.

**Chapter 1-B  
Rating:  
High<sup>6</sup>**

In addition, auditors identified \$33,679,703 in questioned salaries and other medical expenses<sup>7</sup> (see Table 3). HealthSpring did not prepare certifications

<sup>6</sup> The risks related to the issues discussed in Chapter 1-B are rated as High because they present risks or results that if not addressed could substantially affect the audited entity’s ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.

<sup>7</sup> Other medical expenses represent the salaries and other costs associated with service coordinator positions. A service coordinator is an employee who works with a STAR+PLUS member, the member’s family, and the member’s doctors and other providers to help the member get the medical and long-term care services and support needed. The coordinator must

and personnel activity reports to show that the amounts reported for salaries and other medical expenses were for staff who worked on STAR+PLUS as required by the Commission.

Table 3

Fiscal Year 2015 Salaries, Bonuses, and Other Medical Expenses <sup>a</sup>		
Total Reported Costs for Fiscal Year 2015	Total Unallowable Costs Identified	Total Questioned Costs Identified <sup>b</sup>
\$34,773,186	\$786,457	\$33,679,703
<sup>a</sup> Other Medical Expenses represent salary and miscellaneous expenses related to service coordinators. <sup>b</sup> The questioned costs include only the salary costs and the salary portion of the Other Medical Expenses HealthSpring reported.		

Source: HealthSpring and the Commission.

The unallowable costs and questioned costs that auditors identified affect the Commission’s calculation of the experience rebate amount that HealthSpring may owe the Commission for fiscal year 2015. (See Appendix 5 for more information about how the Commission calculates the experience rebate amounts that an MCO may owe it.)

**HealthSpring erroneously reported bonuses that were paid to an affiliate company’s staff on its financial statistical reports.**

HealthSpring reported bonuses totaling \$786,457 on its financial statistical reports that were paid to staff employed by HealthSpring’s affiliate companies (see Chapter 1-E for more information about HealthSpring’s affiliate companies and Appendix 4 for information on HealthSpring’s corporate structure, including its affiliate companies). While salaries for affiliate companies should be reported, the Commission’s *Uniform Managed Care Manual* states that bonuses paid or payable to an affiliate are unallowable. The bonuses paid to staff employed by HealthSpring’s affiliate companies should not be reported on HealthSpring’s financial statistical reports.

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identify the member’s needs and develop a plan of care. Auditors tested only the salary costs included in the other medical expense amount that HealthSpring reported on its financial statistical reports for fiscal year 2015.

### Reporting Requirements for Affiliate Salaries

The Commission's *Uniform Managed Care Manual* specifies the following reporting requirements for affiliate salaries:

- Where employees are expected to work solely on a single contract, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that contract for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having firsthand knowledge of the work performed by the employee.
- Where employees work on multiple activities, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation that meets the standards in Section VI(14)(h)(5) unless a substitute system has been reviewed in advance by the Commission and will be subject to audit. Documentary support will be required where employees work on more than one activity within the MCO.

HealthSpring did not perform required certifications and prepare personnel activity reports to support the salary amounts reported on its financial statistical reports.

Auditors identified \$33,679,703 in questioned costs for salaries (totaling \$22,848,767) and for other medical expenses (totaling \$10,830,936) that HealthSpring reported on its financial statistical reports for fiscal year 2015. HealthSpring's management asserted to auditors that it did not have any staff that worked on the STAR+PLUS contracts, and that the staff who worked on the STAR+PLUS contracts were employed by its affiliate company, GulfQuest, L.P. (GulfQuest). The salary amount that HealthSpring reported on its financial statistical reports were the salary costs for staff employed by its affiliate companies. While HealthSpring correctly reported actual salary costs for staff employed by its affiliate companies on its financial statistical reports, as required, it did not perform required certifications and prepare personnel activity reports to show that affiliate companies' salaries that it used to calculate the reported amounts on its financial statistical reports were for staff who worked on STAR+PLUS-related activities (see text box for reporting requirements for affiliate company salaries).

Preparing certifications and personnel activity reports is important to help ensure that HealthSpring does not include the salary amounts or allocated salary amounts for affiliate companies' staff who may work on HealthSpring's other lines of Medicaid and Medicare health care programs located outside Texas.

### Recommendations

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission how to resolve the identified questioned costs, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Comply with the Commission's requirements that it not include bonuses paid by its affiliate companies on its financial statistical reports.
- Perform periodic certifications and prepare personnel activity reports that support the amount of time its staff or its affiliate companies' staff spend working on STAR+PLUS as required.

## HealthSpring Did Not Develop a Written Allocation Methodology as Required and It Overstated Its Reported Allocated Corporate Costs on Its Financial Statistical Reports

Chapter 1-C  
Rating:  
High <sup>8</sup>

HealthSpring's methodology for calculating allocated corporate costs, totaling \$15,355,392, reported on its financial statistical reports for fiscal year 2015 was not in compliance with the Commission's requirements. The Commission's *Uniform Managed Care Manual* requires an MCO to ensure that:

- It develops a written allocation methodology policy.
- Costs clearly represent specifically identified operating services provided.
- Services directly benefit the Commission or its clients/customers.

However, HealthSpring did not have a written allocation methodology policy in place for fiscal year 2015 as required. In addition, its methodology for calculating allocated corporate costs included certain costs that were not allowable by the Commission. As a result, HealthSpring included \$2,881,358 in unallowable costs in the allocated corporate cost it reported (see Table 4).

Table 4

Fiscal Year 2015 Allocated Corporate Costs		
Total Reported Costs on the Financial Statistical Reports	Total Unallowable Costs Identified	Total Questioned Costs Identified
\$15,355,392	\$2,881,358	\$0

Source: HealthSpring and the Commission.

### HealthSpring did not have a written policy for calculating the allocated corporate costs reported on its financial statistical reports to the Commission.

HealthSpring's methodology for calculating its allocated corporate costs was based on spreadsheets created to calculate the allocated corporate costs that it reported on its financial statistical reports for STAR+PLUS. However, HealthSpring did not have a written policy, as required by the Commission, to help ensure that allocated corporate costs it reported were calculated correctly and that those costs were properly reviewed and approved. Having a written policy is important because HealthSpring's corporate operations manage other Medicaid and Medicare health programs throughout the

<sup>8</sup> The risks related to the issues discussed in Chapter 1-C are rated as High because they present risks or results that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.

United States, including a separate contract with the Commission for the Medicaid-Medicare Plan.<sup>9</sup> HealthSpring uses the costs from those programs when determining the basis for allocating costs to its STAR+PLUS contracts. Without a written allocation methodology, there is an increased risk that HealthSpring may use inconsistent methods to calculate and allocate its corporate costs among STAR+PLUS and its other health care programs. Those inconsistencies could affect the accuracy of its reported net income amount, which the Commission uses to calculate HealthSpring's experience rebates.

**The allocated corporate costs that HealthSpring reported for fiscal year 2015 included unallowable costs.**

The costs that HealthSpring included in its calculation for determining the allocated corporate costs to report on its financial statistical reports for fiscal year 2015 included \$2,881,358 in unallowable costs. Specifically, the reported amount included the following unallowable costs:

- Allocated corporate costs for advertising, charitable donations, non-STAR+PLUS affiliate expenses, employee events, gifts, bonuses, and stock options, totaling \$2,736,870, were indirect costs that did not provide a direct benefit to STAR+PLUS. The Commission's *Uniform Managed Care Manual* states that the expenses identified are unallowable.
- Allocated corporate costs for severance pay, totaling \$144,488, were accrual amounts and not actual expenses that HealthSpring incurred. The Commission's *Uniform Managed Care Manual* states that severance payments, but not accruals, associated with normal turnover are allowable.

**HealthSpring did not maintain documentation to support the reasonableness and accuracy of internally generated financial reports and services that its corporate divisions provided.**

HealthSpring did not have documentation to show the following:

- Email confirmations from managers of its corporate divisions whose staff salaries were included in the allocated corporate costs reported on the financial statistical reports for fiscal year 2015. HealthSpring stated that

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<sup>9</sup> According to the Commission, on May 23, 2014, the U.S. Centers for Medicare and Medicaid Services (CMS) announced that the State of Texas would partner with CMS to test a new model for providing Medicare and Medicaid enrollees with a coordinated, person-centered care experience. Texas and CMS would contract with Medicare and Medicaid plans to coordinate the delivery of and be accountable for covered Medicare and Medicaid services for participating Medicare and Medicaid enrollees. Under the demonstration, Medicare and Medicaid Plans would cover Medicare benefits in addition to the existing set of Medicaid benefits currently offered under STAR+PLUS, allowing for an integrated set of benefits for enrollees.

the email confirmations could show when staff were assigned to work on STAR+PLUS activities.

- How HealthSpring identified all of its Medicaid and Medicare health care programs for which it set the rate of allocating its corporate costs among its Medicaid and Medicare health care programs based on those programs' number of members and applicable financial information.

The Commission's *Uniform Managed Care Manual* states that for costs to be allowable, they must be adequately documented. Without adequate documentation, HealthSpring cannot show that the salaries and other information used to create the rate it used to allocate its corporate costs to STAR+PLUS is reasonable and accurate.

### **Recommendations**

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Document its methodology for calculating allocated corporate costs for STAR+PLUS as required.
- Ensure that its methodology for calculating corporate allocation amounts align with the Commission's requirements.
- Maintain copies of emails and other documentation to support management assertions used for determining allocated corporate costs.

## HealthSpring Did Not Consistently Maintain Documentation to Show That Certain Legal and Professional Services Costs Were Applicable to STAR+PLUS and Incurred During the Reporting Period

**Chapter 1-D  
Rating:**  
Medium <sup>10</sup>

HealthSpring did not consistently maintain documentation to support the reasonableness and appropriateness of the vendor payment amounts that it used to calculate and report its legal and professional services costs, totaling \$3,680,042, on its financial statistical reports for fiscal year 2015. Auditors tested a sample of 26 vendor payments that totaled \$934,227 and identified unallowable costs and questioned costs (see Table 5).

Table 5

Fiscal Year 2015 Legal and Professional Services		
Total Reported Costs on the Financial Statistical Reports	Total Unallowable Costs Identified	Total Questioned Costs Identified
\$3,680,042	\$163,997	\$359,912

Source: HealthSpring and the Commission.

### Legal and Professional Services Costs Tested

Auditors used professional judgment to select a risk-based sample of 26 expenditures from the general ledger of one of HealthSpring's affiliate companies, GulfQuest, which manages HealthSpring's operations for STAR+PLUS. (See Chapter 1-E for more information.)

Specifically, 10 (38.5 percent) of those 26 vendor payments tested were for services provided in fiscal year 2014 but paid for in fiscal year 2015. Those 10 payment totaled \$163,997. The Commission's *Uniform Managed Care Manual* requires administrative expenses to be reported based on the date incurred rather than the date paid. It also requires prior quarters' data to be updated as needed.

In addition, 6 (23.1 percent) of the 26 vendor payments tested did not have documentation to show that the vendor payment was related to STAR+PLUS (see text box for information about the sample tested). Those 6 payments totaled \$359,912. The Commission's *Uniform Managed Care Manual* specifies that a cost is allowable only to the extent of the benefits the Commission received under the contract.

Without consistent documentation to show the appropriateness and reasonableness of the legal and professional services costs, there is an increased risk that the legal and professional services costs that HealthSpring reported on its financial statistical reports for fiscal year 2015 may be

<sup>10</sup> The risks related to the issues discussed in Chapter 1-D are rated as Medium because they present risks or results that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.

overstated. This may affect the experience rebate amount HealthSpring may owe the Commission. (See Appendix 5 for more information for how the Commission calculates the experience rebate amount an MCO may owe.)

## Recommendations

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission how to resolve the questioned costs that auditors identified, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Maintain supporting documentation to show that a vendor payment is for services related to STAR+PLUS and that the reported amounts are accurate.
- Report vendor payments based on the dates on which the costs were incurred.

Chapter 1-E

### HealthSpring Did Not Report Accurate and Complete Information About Its Affiliate Companies

Chapter 1-E  
Rating:  
Medium <sup>11</sup>

HealthSpring reported inaccurate information about its affiliate companies involved with the services provided for its STAR+PLUS contracts with the Commission. The Commission's contract requires that an MCO submit an annual affiliate report that provides organizational and financial information on affiliate companies involved with the services provided under managed care contracts.

In addition, HealthSpring did not provide the Commission with copies of its contracts with its affiliate companies that provide administrative services under its STAR+PLUS contracts with the Commission. The Commission's

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<sup>11</sup> The risks related to the issues discussed in Chapter 1-E are rated as Medium because they present risks or results that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.



contract specifies that an MCO must submit to the Commission a copy of its contract agreements with affiliate companies.<sup>12</sup>

Auditors also identified payments to affiliate companies that did not have documentation to support amounts paid or were not calculated according to contract requirements.

The Commission uses the affiliate information and copies of affiliate company contracts with MCOs to support its monitoring efforts to ensure the transparency and reasonableness of an MCO's related-party transactions.

**HealthSpring provided the Commission inaccurate and incomplete information on its affiliate companies involved with its STAR+PLUS contracts.**

While HealthSpring submitted an affiliate report for fiscal year 2015 as required, that report included inaccurate and incomplete information on the services provided by and management fees paid to its affiliate companies. Specifically, HealthSpring's affiliate report included the following inaccurate and incomplete information:

- HealthSpring identified only one affiliate company on its affiliate report, GulfQuest. However, HealthSpring contracts with a different affiliate company, HealthSpring Management of America (HMA), for the professional services that HealthSpring described on its affiliate report. HMA has a subcontract agreement with GulfQuest to provide the actual professional services to HealthSpring. (HealthSpring's contract with HMA and HMA's subcontract with GulfQuest is discussed in more detail later in this chapter.)
- HealthSpring inaccurately reported that it paid management fees to GulfQuest that totaled \$342,000,000 in fiscal year 2015 for the professional services provided; however, auditors determined that for STAR+PLUS HealthSpring's payments totaled \$104,668,705 and those payments were paid to HMA.
- HealthSpring did not include four additional affiliate companies—Bravo Health MidAtlantic, HealthSpring USA, Newquest LLC, and Newquest of Illinois—on its affiliate report. On its financial statistical reports for fiscal year 2015, HealthSpring reported allocated corporate costs from Newquest LLC totaling \$10,878,506 and salaries and bonuses totaling \$681,531 that were related to those four companies. The Commission's contracts with HealthSpring specify that an MCO must submit a list of all

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<sup>12</sup> Under the Commission's contract with HealthSpring for STAR+PLUS, all material subcontracts should be reported. A material subcontract is any contract, subcontract, or agreement between an MCO and another entity that meets certain criteria, including whether the other entity is an affiliate of the MCO.

affiliates and a schedule of all transactions with affiliates that will be allowable for reporting purposes. Those transactions should describe the financial terms, provide a detailed description of the services to be provided, and include an estimated amount that will be incurred by the MCO for such services.

**HealthSpring did not provide the Commission a copy of its contracts with the affiliate companies that provide administrative services on its STAR+PLUS contracts.**

HealthSpring did not provide the Commission a copy of the contracts that it had with its affiliate companies for STAR+PLUS. Specifically, HealthSpring did not provide the Commission copies of the following contracts:

- **HMA.** HealthSpring's contract with HMA, effective January 1, 2012, specifies that it will provide management and administrative services to HealthSpring. For STAR+PLUS, HealthSpring will pay HMA a monthly management fee based on a percentage of HealthSpring's operating revenue for the calendar year.
- **GulfQuest.** HMA subcontracted its contracted services with HealthSpring to GulfQuest. HMA's subcontract agreement with GulfQuest, executed on July 15, 2010, assigned to GulfQuest the management and administrative services that HMA was contracted to provide to HealthSpring.

Having copies of the contracts between MCOs and their affiliate companies, including applicable subcontract agreements, helps the Commission to ensure the transparency of the financial terms for the services that affiliate companies provide to MCOs.

See Appendix 4 for more information about HealthSpring's affiliate companies.

**HealthSpring did not have documentation to support the accuracy and appropriateness of payments to HMA for service coordinator-related costs.**

HealthSpring's payments to HMA included an amount intended to reimburse GulfQuest for service coordinator-related expenses. HealthSpring's contract with HMA specified that HealthSpring would be invoiced by HMA on a monthly basis for service coordinator-related costs and that the invoice would have sufficient detail supporting the costs. However, HealthSpring did not receive invoices as required. HealthSpring asserted that it based its reimbursement to HMA on a monthly financial report that shows the amount it owes HMA. The financial report does not show any specific information related to the reimbursement amount. It only shows the total amount owed HMA for the STAR+PLUS program and other healthcare programs HMA manages for HealthSpring. For fiscal year 2015, HealthSpring asserted that it

reimbursed HMA for service coordinator-related costs that totaled \$10,669,435. (See Chapter 1-B for more information about the service coordinator-related salaries that HealthSpring reported.)

**HMA's payments to GulfQuest were calculated using a methodology that differed from the methodology required by its contract.**

HMA's payments to GulfQuest were not calculated according to the payment requirements in its contract with GulfQuest. While HMA's contract with GulfQuest stated that it would pay a certain percentage of its operating revenues to GulfQuest, HMA actually paid to GulfQuest all the management fees that it received from HealthSpring for STAR+PLUS.

### **Recommendations**

HealthSpring should:

- Report all of its affiliate companies involved in STAR+PLUS, and report accurate and complete information about those companies and costs to the Commission as required.
- Ensure that it provides the Commission copies of all of its contracts with affiliate companies, including subcontract agreements, that provide services on its STAR+PLUS contracts as required.
- Obtain and maintain documentation to support its payments to HMA for service coordinator-related expenses.
- Ensure that HMA's payments to GulfQuest are calculated and paid in accordance with contract requirements.

## **HealthSpring Did Not Consistently Document the Reasons for Post-payment Adjustments to Medical Claims and Pay Medical Claims Within the Required Timeframe**

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Because of weaknesses in HealthSpring’s controls over post-payment adjustments to medical claims, it did not consistently document the reasons for its post-payment adjustments that it made to medical claims. In addition, weaknesses in HealthSpring’s controls resulted in some medical claims tested not being paid within 30 days of receipt of a “clean claim” as required by HealthSpring’s contracts with the Commission. (See Chapter 2-B for additional information on clean claims.)

The weaknesses identified in HealthSpring’s claims payment process could affect the continued participation of HealthSpring’s medical providers in STAR+PLUS.

Chapter 2-A

### **HealthSpring Did Not Consistently Document the Reasons for Post-payment Adjustments That It Made to Paid Medical Claims**

**Chapter 2-A  
Rating:  
High<sup>13</sup>**

Auditors tested a sample of 61 post-payment adjustments to medical claims, totaling \$52,209 that HealthSpring reported to the Commission (see text box for more information about the claims tested). The post-payment adjustments tested resulted in HealthSpring reversing the original payment amount to a provider. For 27 (44 percent) of 61 medical claims tested, totaling \$32,067, HealthSpring did not record the reason it made the post-payment adjustment in its claims processing system. The Commission’s *Uniform Managed Care Claims Manual* requires an MCO’s claims system to maintain adequate audit trails and report accurate medical provider service data on paid medical claims to the Commission.

In addition, HealthSpring did not document the reason it adjusted a claim on the Explanation of Payment (EOP) for 9 (33 percent) of those 27 medical claims. An EOP notifies a medical provider about the processing status of a medical claim that HealthSpring has received. Those 9 medical claims totaled \$12,780. For the other 18 medical claims tested, the EOP included a code that indicated only that the medical claim was adjusted. The code did not provide any details about the reason the medical claim was adjusted.

#### **Post-payment Adjustments Tested**

Auditors selected a random sample of 60 post-payment adjusted medical claims and used professional judgment to select 1 additional post-payment adjusted medical claim to determine whether the post-payment adjustment matched the medical service information shown in (1) HealthSpring’s claims processing system and (2) copies of the EOP statements that HealthSpring submitted to medical providers. Auditors also determined whether HealthSpring documented its reasons for the adjustments.

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<sup>13</sup> The risks related to the issues discussed in Chapter 2-A are rated as High because they present risks or results that not addressed could substantially affect the audited entity’s ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern and reduce risks to the audited entity.

The post-payment adjustments that auditors tested were reversals of medical claim payments by HealthSpring to medical providers. In some cases a new payment may have been issued to the provider. However, due to the lack of documentation describing the reasons for post-payment adjustments, auditors were unable to always determine whether a post-payment adjustment was reasonable and whether a new payment had been paid to a medical provider. As a result, there is an increased risk that HealthSpring may have inappropriately recouped its payments to medical providers.

**Recommendation**

HealthSpring should develop, document, and implement a process to ensure that it records the reason for all post-payment adjustments to medical claims in its claims processing system and on the EOPs sent to medical providers.

Chapter 2-B

**HealthSpring Did Not Ensure That It Paid All Medical Claims Within 30 Days of Receipt of a Clean Claim as Required**

**Chapter 2-B  
Rating:  
Medium<sup>14</sup>**

Auditors tested a sample of 77 paid medical claims that totaled \$786,889 (see text box for more information about the claims tested). HealthSpring did not process 15 (20 percent) of the 77 paid medical claims tested within 30 days of receipt of a clean claim as required (see Table 6). Those 15 claims totaled \$386,779.

**Medical Claims Tested**  
Auditors selected a random sample of 60 paid medical claims and used professional judgment to select a risk-based sample of 17 additional paid medical claims to test. Auditors verified whether the payment amounts matched the payment amounts shown in (1) HealthSpring’s claims processing system, (2) the medical claims data that HealthSpring reported to the Commission, and (3) copies of the EOP statements that HealthSpring submitted to medical providers. Auditors also determined whether the medical claims were processed in a timely manner and in compliance with the Commission’s requirements.

Table 6

Medical Claims Tested That HealthSpring Processed Late		
Number of Days Past Due	Number of Claims	Amount
1-10 Days	6	\$148,478
11-30 Days	6	237,471
More than 30 Days	3	830
<b>Totals</b>	<b>15</b>	<b>\$386,779</b>

Source: HealthSpring.

<sup>14</sup> The risks related to the issues discussed in Chapter 2-B are rated as Medium because they present risks or results that if not addressed could moderately affect the audited entity’s ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.

### Clean Claims

Title 28, Texas Administrative Code, Section 21.802(6), defines a **clean claim** as follows:

- For nonelectronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy that includes required data elements and the amount paid by a health plan.
- For electronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy using the ASC X12N 837 format and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides, and trading partner agreements.

The Commission's *Uniform Managed Care Manual* requires that, once an MCO receives a "clean claim" (see text box for explanation of a clean claim), it is required to pay the total amount of the claim, or part of the claim, in accordance with the contract within the 30-day claim payment period. HealthSpring reported to auditors that the 15 medical claims tested were not processed within 30 days of receipt of the clean claims as a result of a staffing shortage it experienced during fiscal year 2015. However, HealthSpring paid the interest penalties on 13 (86.7 percent) of the 15 medical claims tested that were not processed within 30 days of receipt of a clean claim. HealthSpring did not pay interest for two medical claims that it processed within 3 days after the 30-day requirement.

### Recommendations

HealthSpring should:

- Ensure that all medical claims are paid within the Commission's required timeframe.
- Pay interest penalties on all medical claims that are not processed within the Commission's required time frame.

# Appendices

Appendix 1

## **Objective, Scope, and Methodology**

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### **Objective**

The objective of this audit was to determine whether selected financial processes and related controls at a Medicaid managed care organization (MCO) are designed and operating to help ensure (1) the accuracy and completeness of data that the MCO reports to the Commission and (2) compliance with applicable requirements.

### **Scope**

The scope of this audit covered HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) contracts with the Health and Human Services Commission (Commission) for the Medicaid STAR+PLUS managed care program (STAR+PLUS). It covered HealthSpring's financial statistical reports and its reported medical claims and pharmacy claims for fiscal year 2015. It also included the Commission's management of the MCO's subcontractor agreements and readiness review records for fiscal year 2015.

### **Methodology**

The audit methodology included selecting an MCO based on the State Auditor's Office's risk assessment of MCOs that included obtaining information and data from the Commission concerning the risks associated with MCOs.

Additionally, the audit methodology included collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating results of the tests, and interviewing management and staff at HealthSpring and the Commission.

### **Data Reliability and Completeness**

Auditors assessed the reliability of data used in the audit and determined the following:

- For medical claims and pharmacy claims data managed by HealthSpring's claims processing system, auditors reconciled claims data to claim payment totals reported on HealthSpring's financial statistical reports and to medical claims and pharmacy claims data reported to the Commission. Auditors also assessed HealthSpring's reconciliation of medical claims payment data among its claims processing system,

accounting system, and direct deposit system. Auditors determined that the data was sufficiently reliable for the purposes of this audit.

- Auditors relied on HealthSpring's external auditors' prior work on general and application controls for HealthSpring's (1) claims processing system, (2) financial accounting system, and (3) third-party vendor systems and determined that data from those three information systems was sufficiently reliable for the purposes of this audit.

#### **Sampling Methodology**

For the samples discussed below, auditors applied a nonstatistical sampling methodology primarily through random selection. In some cases, auditors used professional judgment to select sample items for testing. The sample items were not generally representative of the population; therefore, it would not be appropriate to project the test results to the population. Auditors selected the following samples:

- To test the validity, accuracy, and completeness of medical claims data and medical claims payments, auditors selected a nonstatistical, random sample of 60 medical claims and used professional judgment to select a risk-based sample of 17 additional medical claims processed during fiscal year 2015.
- To test the validity, accuracy, and completeness of pharmacy claims payments, auditors selected a nonstatistical, random sample of eight vendor payments paid to HealthSpring's pharmacy benefit manager by date and used professional judgment to select a risk-based sample of three additional vendor payments paid to HealthSpring's pharmacy benefit manager that were processed during fiscal year 2015.
- To test the validity, accuracy, and allowability of salary and bonuses reported on HealthSpring's administrative financial statistical reports for fiscal year 2015, auditors selected a nonstatistical, random sample of 90 full-time staff (excluding service coordinator positions) employed during fiscal year 2015.
- To test the validity, accuracy, and allowability of other medical expenses that HealthSpring reported on the financial statistical reports for fiscal year 2015, auditors selected a nonstatistical, random sample of 90 full-time service coordinators employed during fiscal year 2015.
- To test the validity, accuracy, and allowability of professional services that HealthSpring reported on the financial statistical reports for fiscal year 2015, auditors used professional judgment to select a risk-based sample of 26 expenditures processed during fiscal year 2015.



- To test the accuracy and allowability of allocated corporate costs that HealthSpring reported on the financial statistical reports for fiscal year 2015, auditors used professional judgment to select a risk-based sample of (1) the corporate costs for 8 health insurance markets managed by HealthSpring from September 2014 through December 2014, (2) the corporate costs for 10 health insurance markets managed by HealthSpring from January 2015 through August 2015, and (3) the allocated corporate costs related to 12 full-time employees during fiscal year 2015.
- To test the validity, accuracy, and completeness of post-payment adjustments to medical claims data, auditors selected a nonstatistical, random sample of 60 adjusted medical claims that were processed during fiscal year 2015 and used professional judgment to select a risk-based sample of 5 additional adjusted medical claims processed during fiscal year 2015.
- To test the validity and completeness of medical claims data in HealthSpring's claims processing system, auditors used professional judgment to select a risk-based sample of 60 medical claims processed during fiscal year 2015.

Information collected and reviewed included the following:

- The Commission's STAR+PLUS contracts with HealthSpring.
- The Commission's STAR+PLUS member eligibility records for HealthSpring.
- The Commission's and HealthSpring's medical claims and pharmacy claims data.
- HealthSpring's policies and procedures.
- HealthSpring's financial statistical reports for fiscal year 2015.
- HealthSpring's payroll and human resources records.
- HealthSpring's supporting documentation for calculating reported allocated corporate costs for fiscal year 2015.
- External audit reports and consultant reports on HealthSpring's claims processing system, financial accounting system, and select third-party vendor systems.
- The general ledger of GulfQuest, an affiliate company of HealthSpring, of STAR+PLUS administrative expenses for fiscal year 2015.

- HealthSpring’s subcontractor agreements with its pharmacy benefit manager and affiliate companies.
- The Commission’s MCO contract monitoring policies, procedures, and manuals.
- The Commission’s readiness review records of HealthSpring.

Procedures and tests conducted included the following:

- Interviewed employees at HealthSpring and the Commission.
- Reconciled revenue payments reported on HealthSpring’s financial statistical reports for fiscal year 2015.
- Reviewed and recalculated HealthSpring’s reported allocated corporate costs on the financial statistical reports for fiscal year 2015.
- Tested to determine whether reported salaries and bonuses were accurate and supported by documentation.
- Tested to determine whether reported legal and professional costs on the financial statistical reports for fiscal year 2015 were incurred in fiscal year 2015 and applicable to STAR+PLUS.
- Tested medical claims and pharmacy claims to determine whether they were accurate, valid, supported by documentation, and submitted for eligible STAR+PLUS members.
- Reviewed the Commission’s records of HealthSpring’s readiness reviews and subcontractor agreements.

Criteria used included the following:

- Title 45, Code of Federal Regulations, Section 1630.2.
- Texas Government Code, Chapters 321, 531, 533, and 536.
- Title 1, Texas Administrative Code, Chapters 353 and 370.
- Title 28, Texas Administrative Code, Chapter 21.
- The General Appropriations Act (83rd Legislature).
- The Commission’s Uniform Managed Care Contract for STAR+PLUS.
- The Commission’s *Uniform Managed Care Manual*.

## Project Information

Audit fieldwork was conducted from July 2016 and December 2016. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The following members of the State Auditor's staff performed the audit:

- Willie J. Hicks, MBA, CGAP (Project Manager)
- Anca Pinchas, CPA, CIDA, CISA (Assistant Project Manager)
- Mary Anderson
- Salem Chuah, CPA
- Rachel Lynne Goldman, CPA
- Joseph A. Kozak, CPA, CISA
- Sarah Rajiah
- Fred Ramirez, CISA
- Michelle Rodriguez
- Dennis Ray Bushnell, CPA (Quality Control Reviewer)
- John Young, MPAff (Audit Manager)

## Issue Rating Classifications and Descriptions

Auditors used professional judgement and rated the audit findings identified in this report. Those issue ratings are summarized in the report chapters/sub-chapters. The issue ratings were determined based on the degree of risk or effect of the findings in relation to the audit objective(s).

In determining the ratings of audit findings, auditors considered factors such as financial impact; potential failure to meet program/function objectives; noncompliance with state statute(s), rules, regulations, and other requirements or criteria; and the inadequacy of the design and/or operating effectiveness of internal controls. In addition, evidence of potential fraud, waste, or abuse; significant control environment issues; and little to no corrective action for issues previously identified could increase the ratings for audit findings. Auditors also identified and considered other factors when appropriate.

Table 7 provides a description of the issue ratings presented in this report.

Table 7

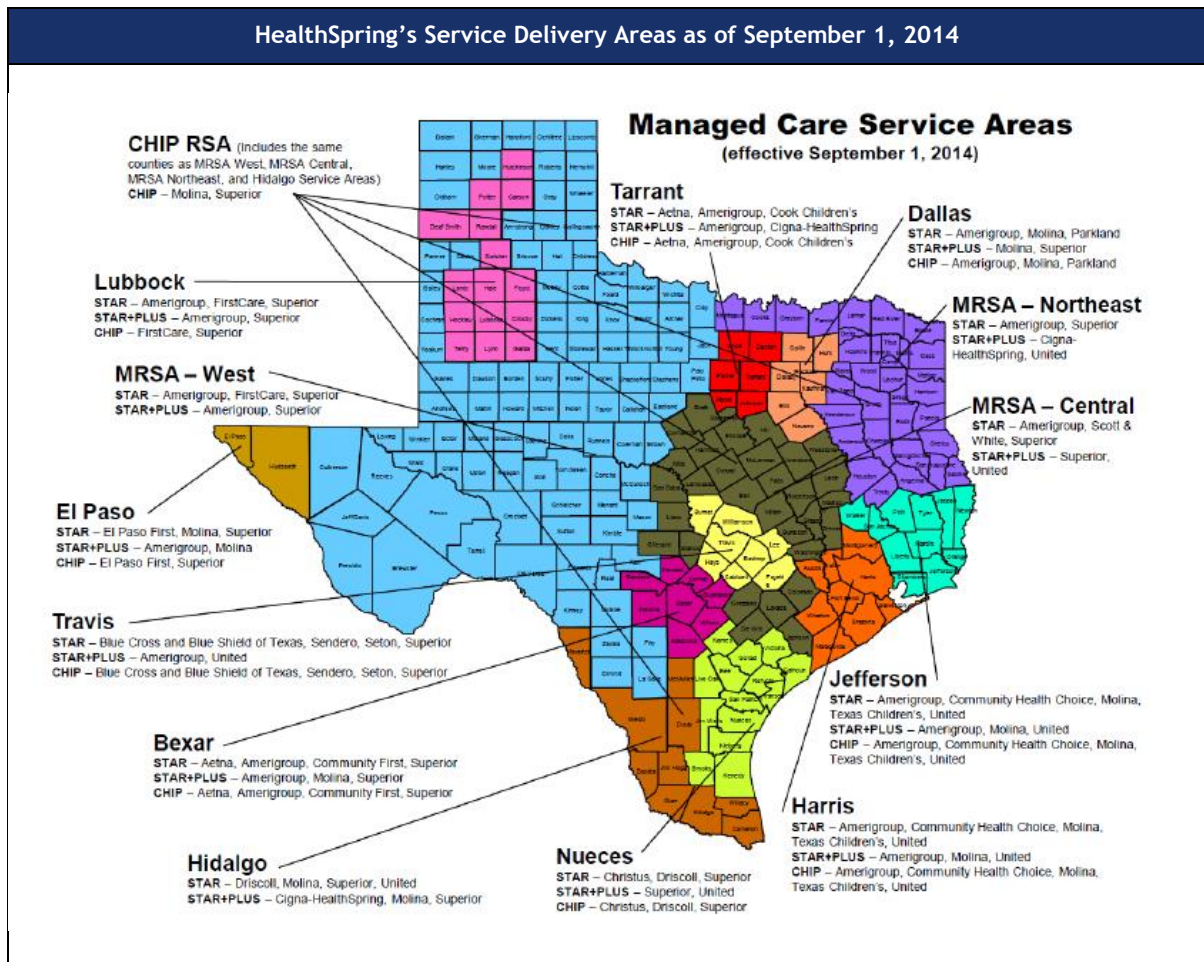
Summary of Issue Ratings	
Issue Rating	Description of Rating
Low	The audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited <u>or</u> the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.
Medium	Issues identified present risks or effects that if not addressed could <u>moderately affect</u> the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.
High	Issues identified present risks or effects that if not addressed could <u>substantially affect</u> the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.
Priority	Issues identified present risks or effects that if not addressed could <u>critically affect</u> the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern(s) and reduce risks to the audited entity.

# HealthSpring Life and Health Insurance Company, Inc. Service Delivery Areas

HealthSpring Life and Health Insurance Company, Inc. (HealthSpring) provides Medicaid STAR+PLUS managed care program services to three service delivery areas in Texas through its contracts with the Health and Human Services Commission. Those three service delivery areas are: (1) Tarrant (effective February 1, 2011); (2) Hidalgo (effective March 1, 2012); and (3) Northeast Medicaid Rural Service Areas (effective September 1, 2014).

Figure 1 is a regional map that shows the location of all the managed care service delivery areas, including HealthSpring's service delivery areas as of September 1, 2014.

Figure 1

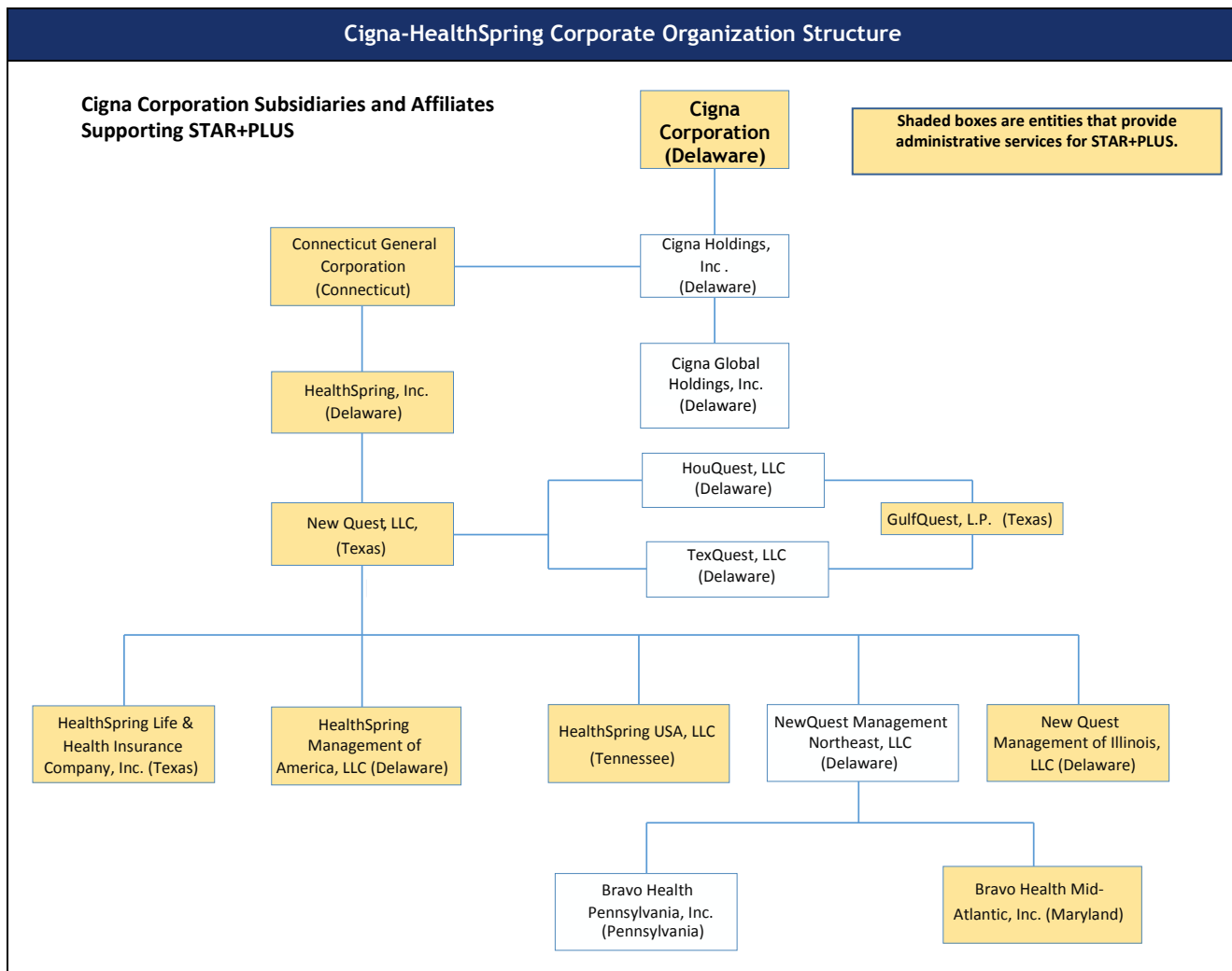


Source: *Texas Medicaid and CHIP in Perspective*, Health and Human Services Commission, February 2015.

## Cigna-HealthSpring Corporate Organization Structure

HealthSpring Life and Health Insurance Company, Inc. (HealthSpring) is a company within the Cigna Corporation. Figure 2 shows Cigna Corporation’s organization chart, which includes HealthSpring and other affiliate companies that provided services during fiscal year 2015 for HealthSpring’s Medicaid STAR+PLUS managed care program (STAR+PLUS) contract with the Health and Human Services Commission.

Figure 2



Source: HealthSpring.

## Calculating Experience Rebates

Texas Government Code, Section 533.014, requires the Health and Human Services Commission (Commission) to adopt rules that ensure that managed care organizations (MCOs) share profits they earn through the Medicaid managed care program. Title 1, Texas Administrative Code, Section 353.3, states that each MCO participating in Medicaid managed care must pay to the State an experience rebate calculated according to the graduated rebate method described in the MCO's contract with the Commission. The Commission has incorporated profit-sharing provisions into its contracts with MCOs that require MCOs to share certain percentages of their net income before taxes with the Commission. The General Appropriations Act (83rd Legislature), Rider 13, page II-91, requires that experience rebates the Commission receives from MCOs be spent on funding services for Medicaid.

According to the Commission's contracts with MCOs, an MCO must pay an experience rebate to the Commission if the MCO's net income before taxes exceeds a certain percentage, as defined by the Commission, of the total revenue the MCO receives each fiscal period. The experience rebate is calculated in accordance with a tiered rebate method that the Commission defines (see Table 8). The tiers are based on the consolidated net income before taxes for all of the MCO's Medicaid program and Children's Health Insurance Program service areas that are included in the scope of the contract, as reported on the MCO's financial statistical reports (which the Commission reviews and confirms through annual agreed-upon procedures engagements performed by its contracted audit firms).

Table 8

Tiers for Experience Rebates		
Pre-tax Income as a Percent of Revenues	MCO's Share	Commission's Share
Less than or equal to 3 percent	100 percent	0 percent
More than 3 percent and less than or equal to 5 percent	80 percent	20 percent
More than 5 percent and less than or equal to 7 percent	60 percent	40 percent
More than 7 percent and less than or equal to 9 percent	40 percent	60 percent
More than 9 percent and less than or equal to 12 percent	20 percent	80 percent
More than 12 percent	0 percent	100 percent

Source: Texas Health and Human Services Commission Uniform Managed Care Terms and Conditions.

## Calculating the Experience Rebate HealthSpring Owed for Fiscal Year 2015

Based on HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) unaudited financial statistical reports for fiscal year 2015, the Health and Human Services Commission (Commission) calculated the experience rebate amount that HealthSpring owed the Commission for that fiscal period. Table 9 shows the Commission's calculation of the pre-tax net income that is subject to the tiered rebate methodology described in Appendix 5.

Table 9

Commission's Calculation of HealthSpring's Income Subject to Experience Rebate for Fiscal Year 2015	
Unaudited Pre-Tax Net Income	\$52,709,294
Admin Cap impact: Expenses reduced <sup>a</sup>	\$7,363,317
Cap-adjusted Pre-tax Net Income	\$60,072,611
Pre-implementation Costs <sup>b</sup>	(\$3,397,931)
Adjusted Income Subject to Experience Rebate	\$56,674,680
<p><sup>a</sup> The admin cap is a calculated maximum amount of administrative expense dollars that can be deducted from revenues for the purposes of determining income subject to the experience rebate. While administrative expenses may be limited by the admin cap to determine experience rebates, all valid allowable expenses will continue to be reported on the financial statistical reports. The admin cap does not affect financial statistical reporting, but it may affect any associated experience rebate calculation. For fiscal year 2015, the \$7,363,317 amount was the difference between HealthSpring's admin cap of \$40,899,830 and its reported administrative expenses of \$48,263,147.</p> <p><sup>b</sup> The pre-implementation costs in this table are related to the Commission's contract with HealthSpring for the Northeast Medicaid Rural Service Area that was effective September 1, 2014. An MCO incurs pre-implementation costs on or after the effective date of its contract but prior to the operational start date of the contract. Pre-implementation costs must be reported for each month in which the expenses were incurred and must be reported separately in financial statistical reports.</p>	

Source: The Commission.



Table 10 shows the Commission’s calculation of the total experience rebate that HealthSpring owed the State for fiscal year 2015 as of November 2016.

Table 10

The Commission’s Calculation of HealthSpring’s Experience Rebate for Fiscal Year 2015					
Tiers - Percent of Revenue	Upper Revenue Limit	Net Income	HealthSpring’s Share	The State’s Share	State’s Share Percentage
Less than or equal to 3 percent	\$21,522,528	\$21,522,528	\$21,522,528	\$ 0	0 percent
More than 3 percent and less than or equal to 5 percent	\$35,870,880	14,348,352	11,478,681	2,869,670	20 percent
More than 5 percent and less than or equal to 7 percent	\$50,219,231	14,348,352	8,609,011	5,739,341	40 percent
More than 7 percent and less than or equal to 9 percent	\$64,567,583	6,455,449	2,582,180	3,873,270	60 percent
More than 9 percent and less than or equal to 12 percent	\$86,090,111	0	0	0	80 percent
More than 12 percent	No Limit	0	0	0	100 percent
<b>Totals</b>		<b>\$56,674,681</b>	<b>\$44,192,400</b>	<b>\$12,482,281</b>	

Source: The Commission.

## HealthSpring's Management Responses



**Jay Hurt**  
President/Chief Executive Officer  
2900 North Loop West, Suite 1300  
Houston, TX 77092  
Tel: 832-553-3311  
Fax: 832-553-3412

February 9, 2017

**Via Electronic Mail and Overnight Delivery**

Willie J. Hicks, MBA, CGAP  
Project Manager  
State Auditor's Office  
1501 N. Congress Avenue  
Austin, Texas 78701

RE: Management Responses to Recommendations in Draft Audit Report

Dear Mr. Hicks,

On behalf of HealthSpring Life and Health Insurance Company, Inc. ("HealthSpring"), I am writing to respond to the recommendations set forth in the draft audit report issued on January 26, 2017 by the State Auditor's Office.

We are pleased with the recognition that HealthSpring's financial reporting processes adequately demonstrate accurate reporting of fiscal year 2015 medical claim and prescription drug claim payments. We also appreciate the opportunity to respond in accordance with Texas Government Code § 321.014(g) to certain findings and recommendations relating to other reported costs.

**Chapter 1 – Financial Statistical Reports for Fiscal Year 2015**

**Chapter 1-A – Accurate Reporting of Medical and Prescription Drug Claims Paid**

**Recommendations**

None.

**HealthSpring Management Response**

HealthSpring is in agreement with the findings.

## **Chapter 1-B – Reporting of Bonus Costs and Personnel Certifications**

### **Recommendations**

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission how to resolve the identified questioned costs, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Comply with the Commission’s requirements that it not include bonuses paid by its affiliate companies on its financial statistical reports.
- Perform periodic certifications and prepare personnel activity reports that support the amount of time its staff or its affiliate companies’ staff spend working on STAR+PLUS as required.

### **HealthSpring Management Response**

HealthSpring acknowledges the rationale for questioning the bonus payments. However, HealthSpring maintains that the payments are more appropriately classified as questioned costs than disallowed costs, and that such payments should be resolved during discussions with the Commission.

HealthSpring employs all of its administrative personnel through an affiliate organization, and this relationship was known to the Commission at the time the contract was awarded. Consequently, bonuses for affiliated employees are not excessive or duplicative of normal allowable employee bonuses. Rather, the affiliated employee bonuses are in lieu of any other allowable bonus costs. HealthSpring proposes to discuss the bonus payments further with the Commission and to make any adjustments that may be required after final resolution.

HealthSpring also agrees to discuss the remaining questioned costs with the Commission. HealthSpring acknowledges that it was unable to produce the requisite employee certifications. Instead of using an employee certification process, HealthSpring used an alternate allocation method to achieve the same goal. HealthSpring’s process reflected an after-the-fact distribution of the actual activity of each employee and accounted for the total activity for which each employee is compensated, as the Uniform Managed Care Manual requires. HealthSpring maintains that its methodology resulted in a fair, accurate representation of the amount of time each employee spent on STAR+PLUS contracts and that the questioned costs are allowable.

In recognition of the Commission’s expectation that the sponsor fulfill the aims of the Uniform Managed Care Manual through employee certifications, HealthSpring is augmenting its process for accounting for employee activity and costs on a per-contract basis by implementing a semi-

Willie J. Hicks  
February 9, 2017  
Page 3

annual attestation process that will define clearly the percentage of time that each employee dedicates to a particular contract. The bi-annual employee certifications will be populated into automated compensation allocation reports, which will be reviewed and verified by managers.

*Responsible Persons:*

Human Resources Director  
Medicaid Finance Director Unit Managers

*Implementation Date:*

July 31, 2017

## **Chapter 1-C – Allocation Methodology and Costs**

### **Recommendations**

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Document its methodology for calculating allocated corporate costs for STAR+PLUS as required.
- Ensure that its methodology for calculating corporate allocation amounts align with the Commission's requirements.
- Maintain copies of emails and other documentation to support management assertions used for determining allocated corporate costs.

### **HealthSpring Management Response**

HealthSpring agrees with the findings and recommendations and offers the following responses.

The unallowable costs identified by the auditors were expenses incurred during the limited period of September through December 2014. While the corporate allocations were correctly reported for the remainder of the year, HealthSpring acknowledges this isolated error.

HealthSpring will adopt formal written standards describing its methodology for calculating allocated corporate costs in accordance with the Commission's requirements. The standards also will require adequate documentation and improve internal controls to ensure proper verification of corporate cost computation and allocation prior to reporting.

*Responsible Persons:*

Willie J. Hicks  
February 9, 2017  
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Financial Analysis Manager  
Medicaid Finance Director

*Implementation Date:*

June 1, 2017

#### **Chapter 1-D – Documentation of Legal and Professional Services Costs**

##### **Recommendations**

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission on how to resolve the questioned costs that auditors identified, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Maintain supporting documentation to show that a vendor payment is for services related to STAR+PLUS and that the reported amounts are accurate.
- Report vendor payments based on the dates on which the costs were incurred.

##### **HealthSpring Management Response -1**

HealthSpring generally agrees with the findings and recommendations and offers the following responses.

HealthSpring will consult with the Commission to ensure that it is reconciling properly the requirement to avoid reporting accrual cost amounts, in accordance with the Chapter 1-C findings, while still appropriately report administrative expenses based on the date incurred rather than the date paid as described in Chapter 1-D. Upon clarification, HealthSpring will adjust any costs determined by the Commission to be unallowable and adopt written standards necessary to prevent recurrence of this concern.

*Responsible Person:*

Medicaid Finance Director

*Implementation Date:*

March 31, 2017

### **HealthSpring Management Response – 2**

HealthSpring anticipates discussions with the Commission will resolve successfully concerns with the questioned costs. Although the invoices at issue do not expressly reference the STAR+PLUS program, they were all mailed to the Bedford office, which is a center of operations that supports the STAR+PLUS program. HealthSpring is confident that the documentation is sufficient to resolve these questioned costs favorably.

Additionally, HealthSpring is working with vendors to enhance its automated documentation capabilities. HealthSpring anticipates that the revised documents will identify adequately the programs for which legal and professional services were rendered.

*Responsible Person:*

Medicaid Finance Director

*Implementation Date:*

June 1, 2017

### **Chapter 1-E – Affiliated Company Reporting**

#### **Recommendations**

HealthSpring should:

- Report all its affiliated companies involved in its STAR+PLUS program and report accurate and complete information about those companies and costs to the Commission as required.
- Ensure that it provides the Commission copies of all its contracts with affiliate companies, including subcontract agreements, that provide services on its STAR+PLUS contract as required.
- Ensure that its contracts with affiliate companies clearly define all services that will be paid.
- Obtain and maintain documentation to support its payments to HMA for service coordinator-related expenses.

#### **HealthSpring Management Response**

HealthSpring generally agrees with the findings and recommendations and offers the following responses.

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HealthSpring traditionally has not reported affiliated companies that do not retain funds originating from STAR+PLUS contracts, either because they do not receive such funds or because they are solely pass-through entities. These companies include HealthSpring Management of America, LLC, and NewQuest, LLC. Additionally, HealthSpring has not reported affiliations with Bravo Health Mid-Atlantic, Inc., HealthSpring USA, LLC, and NewQuest Management of Illinois, LLC, because it has no affiliate agreements or financial relationships with any of these entities.

HealthSpring provided a copy of the Amended and Restated Management Agreement with HealthSpring Management of America, LLC in each of its responses to STAR+PLUS Requests for Proposal.

HealthSpring agrees to report all requested information relating to HealthSpring Management of America, LLC, beginning with the Affiliate Report due on August 31, 2017. HealthSpring also will provide a copy of the downstream management agreement between HealthSpring Management of America, LLC and GulfQuest, LP on a going forward basis beginning with that report. HealthSpring will break out the management fees attributable to STAR+PLUS contracts in disclosures going forward.

HealthSpring further agrees to submit an informational copy of its expense sharing agreement with its immediate parent organization, NewQuest, LLC, in which the parties agreed to the allocation of actual costs throughout the Cigna-HealthSpring organization. HealthSpring will also report a disclaimer to indicate that it pays no administrative fees to NewQuest, LLC under this agreement.

Finally, HealthSpring is amending the downstream management agreement between HealthSpring Management of America, LLC and GulfQuest, LP to clarify the payment of downstream management fees arising from the STAR+PLUS contracts. Once the amendment is finalized, HealthSpring will provide a copy to the Commission.

*Responsible Persons:*

Managing Counsel  
Senior Compliance Specialist

*Implementation Date:*

August 31, 2017

**Chapter 2 – Medical Claim Payments and Adjustments**

**Chapter 2-A – Documentation of Payment Adjustments**

**Recommendations**

HealthSpring should develop, document, and implement a process to ensure that it records the reason for all post payment adjustments to medical claims in its claims processing system and on the EOPs sent to medical providers.

#### **HealthSpring Management Response**

HealthSpring agrees with the recommendation. HealthSpring has completed a root cause analysis and determined that its post-payment memoranda were not consistently entered into the claims processing system. HealthSpring is revising its procedures to prevent a recurrence. Additionally, HealthSpring will train staff members on the revised procedures and will employ strategies to monitor their compliance with the new processes.

*Responsible Persons:*

Service Operation Director

*Implementation Date:*

March 1, 2017

#### **Chapter 2-B – Timely Medical Claim Payment**

##### **Recommendations**

HealthSpring should:

- Ensure that all medical claims are paid within the Commission’s required timeframe.
- Pay interest penalties on all medical claims that are not processed within the Commission’s required timeframe.

#### **HealthSpring Management Response**

HealthSpring is generally in agreement with the recommendations. Because the audit tested claims from fiscal year 2015, the findings do not reflect more recent changes to HealthSpring’s controls, which enhanced the timely payment of medical claims. HealthSpring currently pays medical claims within the Commission’s timeliness guidelines and interest does not normally accrue.

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HealthSpring recognizes the importance of developing and maintaining a robust program to ensure appropriate payment, allocation, and reporting of costs. To that end, HealthSpring strives



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continually to strengthen its processes and procedures. We welcome the opportunity to collaborate with you and the Commission, as we fulfill our internal commitment to those guiding principles.

Very truly yours,



Jay Hurt

cc: Charles Smith  
Executive Commissioner  
Texas Health and Human Services Commission

Gary Jessee  
Deputy Executive Commissioner, Medical and Social Services Division  
Texas Health and Human Services Commission

Stuart Bowen  
Inspector General  
Texas Health and Human Services Commission

Karin Hill  
Director of Internal Audit  
Texas Health and Human Services Commission

Richard Appel  
Medicare and Medicaid Compliance Director  
Cigna-HealthSpring

## **Related State Auditor's Office Work**

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Related State Auditor's Office Work		
Number	Product Name	Release Date
17-007	An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission	October 2016

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The Honorable Dennis Bonnen, House Ways and Means Committee

### **Office of the Governor**

The Honorable Greg Abbott, Governor

### **HealthSpring Life and Health Insurance Company, Inc.**

Mr. Jay Hurt, Division President/Chief Executive Officer

### **Health and Human Services Commission**

Mr. Charles Smith, Executive Commissioner



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