Audit Report

Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments

Cigna-HealthSpring Life and Health Insurance Company, Inc.

August 26, 2020
OIG Report No. AUD-20-019

Inspector General

Texas Health and Human Services

HHS OIG
TEXAS HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WHY THE OIG CONDUCTED THIS AUDIT

OIG conducted this audit as a follow-up to complaints of nursing facility payments from MCOs being delayed by more than 90 days and of unprocessed nursing facility utilization review RUG rate retroactive adjustments. During 2018, HHSC made capitation payments of $295,819,857.81 to Cigna-HealthSpring for its administration of the State of Texas Access Reform PLUS (STAR+PLUS) program for nursing facility residents. This audit was of STAR+PLUS nursing facility clean claims paid by Cigna-HealthSpring.

The audit focused on (a) clean claim payments made more than 90 days after received date, (b) retroactive adjusted claim payments made more than 30 days after the receipt of the HHSC notice, and (c) unprocessed RUG rate retroactive adjustments. The audit objective was to determine whether Cigna-HealthSpring accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

WHAT THE OIG RECOMMENDS

Cigna-HealthSpring should design and implement an effective process to automatically identify and process all retroactive rate adjustments as required by the Uniform Managed Care Contract and Uniform Managed Care Manual.

MANAGEMENT RESPONSE

OIG presented preliminary audit results, issues, and recommendations to Cigna-HealthSpring in a draft report dated August 5, 2020. Cigna-HealthSpring generally agreed with the recommendations and indicated it will take corrective actions. Cigna-HealthSpring's management responses are included in the report.

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AUDIT OF PROCESSING OF OUTLIER NURSING FACILITY STAR+PLUS CLAIMS AND ADJUSTMENTS

Cigna-HealthSpring Life and Health Insurance Company, Inc.

WHAT THE OIG FOUND

Cigna-HealthSpring adjudicated and paid most clean claims accurately and timely. Additionally, based on self-reported information, Cigna-HealthSpring adjudicated an average of over 99.8 percent of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by the Uniform Managed Care Contract.

However, Cigna-HealthSpring did not always process (a) Texas Health and Human Services Commission (HHSC) Resource Utilization Group (RUG) rate adjustments as required, or (b) other types of adjustments timely. Specifically:

- An analysis of encounter data conducted by OIG determined that Cigna-HealthSpring processed only 46 (13 percent) of the identified RUG adjustments, in the amount of $62,819.27. As of January 16, 2020, Cigna-HealthSpring had not processed the remaining 304 (87 percent) retroactive RUG adjustments, with an expected net recovery of $231,373.99, which includes adjustments expected to reduce prior payments by $289,121.84 and adjustments expected to increase prior payments by $48,747.85.

  STAR+PLUS managed care organizations (MCOs) are required by contract to retroactively process RUG rate adjustments automatically no later than 30 days after receipt of an HHSC notification. However, during fiscal year 2018, Cigna-HealthSpring did not have an automatic process in place to identify and process all retroactive RUG rate adjustments. As a result, it did not (a) process RUG rate adjustments in compliance with the contract, (b) pay nursing facilities correct Medicaid-funded RUG rates for its claims, and (c) adjust related encounters as required.

- Cigna-HealthSpring did not consistently process other types of claims adjustments from HHSC notices within required timelines, which resulted in delayed payments to nursing facilities. Specifically, Cigna-HealthSpring did not process 19 of 29 (66 percent) adjustments tested within 30 days of the HHSC notification as required. The delayed payment amount for the 19 adjustments totaled $3,773.74.

BACKGROUND

Nursing facilities submit claims to MCOs for payment. If the claim contains complete information, the MCO will pay or deny it as appropriate, and then is able to accurately report the claim. If a claim does not contain all the necessary elements, the claim is rejected and returned to the nursing facility to provide the needed information. Once a claim has been paid or denied, MCOs are required to automatically adjust payments through retroactive payment adjustments. Claim payment adjustments occur when the MCO makes a change to the claim in response to new information from HHSC or the Office of Inspector General (OIG), the nursing facility, or the MCO's quality review results.

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INTRODUCTION

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division conducted an audit of State of Texas Access Reform PLUS (STAR+PLUS) nursing facility claims paid by Cigna-HealthSpring Life and Health Insurance Company, Inc. (Cigna-HealthSpring), a Medicaid managed care organization (MCO).

The OIG Audit and Inspections Division conducted this audit as a follow-up to complaints of nursing facility payments from MCOs being delayed by more than 90 days and of unprocessed nursing facility utilization review resource utilization group (RUG) rate retroactive adjustments. Cigna-HealthSpring was one of five MCOs audited to address this concern. All five MCOs are scheduled for audit in state fiscal year 2020. Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

STAR+PLUS is a Texas Medicaid managed care program for members with disabilities or who are age 65 or older. Five MCOs in Texas participate in the STAR+PLUS program: Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas, Superior HealthPlan, and United Healthcare Community Plan. The STAR+PLUS program served an average of 526,768 members per month in 2018, of whom Cigna-HealthSpring served an average of 49,796, or 9.5 percent.

Texas Health and Human Services Commission (HHSC) Medicaid and CHIP Services (MCS) is responsible for overall management of the STAR+PLUS program and for oversight of MCOs, including Cigna-HealthSpring's administration of health care services through STAR+PLUS. MCS promulgates policy and rules related to the participation of nursing facilities in Medicaid, and, in the case of managed care, administers those policies and rules through provisions of the Texas Uniform Managed Care Contract (UMCC) and the Uniform Managed Care Manual (UMCM).

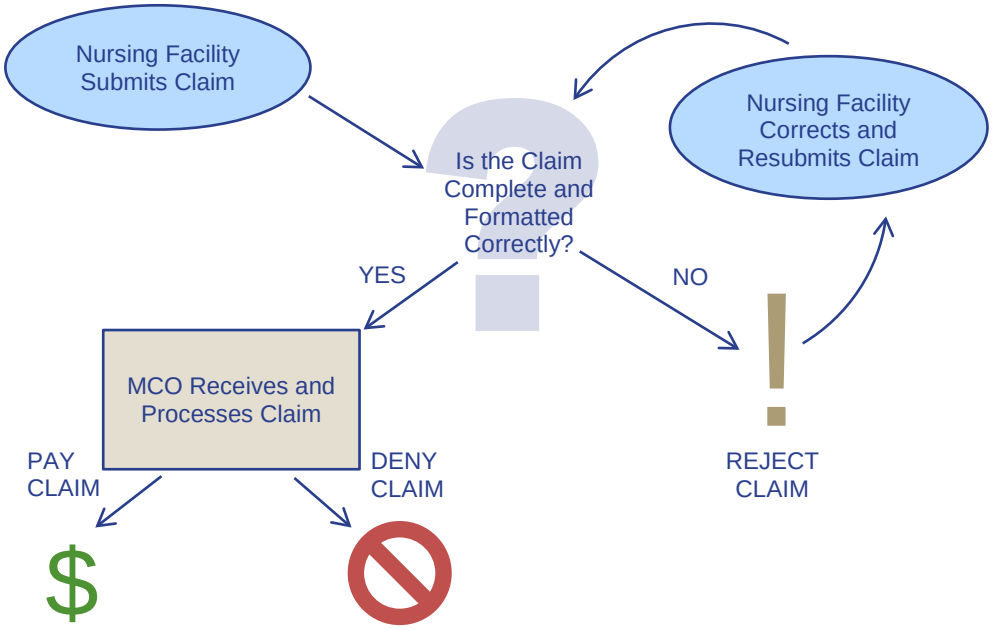
Nursing facilities are primarily reimbursed through a managed care model. For Medicaid residents in nursing facilities who are members of an MCO, HHSC makes a monthly capitation payment to the MCO for each resident. The MCO, in turn, receives claims from the nursing facility and reimburses the nursing facility a daily rate for the resident based on the RUG level of the resident.[1] During 2018, HHSC made capitation payments of $295,819,857.81 to Cigna-HealthSpring for its administration of the STAR+PLUS program for nursing facility residents.

[1] HHSC determines the payment amount associated with a specific RUG level. RUG levels are assigned based on the level of care needed by the member.

Claims Adjudication Process

Clean claims are defined as claims for services rendered to a member with the data necessary for the MCO to adjudicate[2] and accurately report the claim. If a claim does not contain all the elements necessary for the MCO to adjudicate it, it is rejected and returned to the nursing facility so that the nursing facility may provide the information necessary for adjudication. The claim is then processed but may be denied because of issues with member eligibility, service authorization, the provider's standing, the RUG level, or duplication of the claim. Figure 1 illustrates the claims adjudication process.

Figure 1: Claims Adjudication Process



Source: OIG Audit and Inspections Division

The MCO must use the Initial and Daily Service Authorization System (SAS) provider and rate data, determined by HHSC, in the adjudication of nursing facility claims. After a claim is adjudicated, new information may require it to be adjusted. MCOs can only adjust an adjudicated claim.

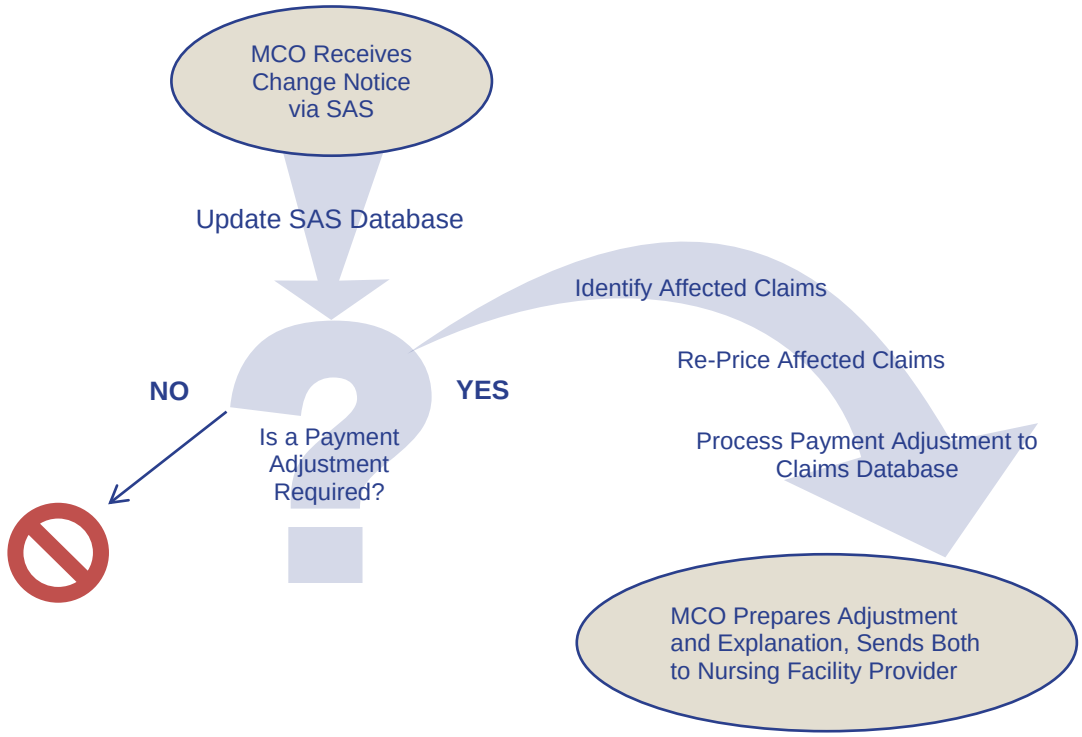
[2] Adjudicated claims are clean claims that have been either paid or denied.

Claims Adjustment Process

Claim payment adjustments occur when the MCO makes a change to the claim in response to new information from (a) HHSC, (b) the nursing facility, or (c) the MCO's quality review results.

Once a clean claim has been adjudicated, MCOs are required to automatically identify and process any HHSC retroactive payment adjustments transmitted via a SAS notice. Retroactive changes are typically made to member eligibility, the member's applied income, RUG or service level, provider contracts, provider hold, provider rate, or nursing facility service authorizations. The MCO has 30 days to review the change and process the HHSC retroactive payment adjustment. Figure 2 illustrates the payment adjustment process.

Figure 2: Payment Adjustment Process



Source: OIG Audit and Inspections Division

Objectives and Scope

The audit objective was to determine whether Cigna-HealthSpring accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

This audit focused on (a) clean claim payments made more than 90 days after the received date, (b) retroactive adjusted claim payments made more than 30 days after receipt of the SAS notice, and (c) unprocessed nursing facility utilization review RUG rate retroactive adjustments.

The audit scope included clean claims received during 2018, including run-out[3] of retroactive adjustments through April 13, 2019.

Methodology

The audit population for this report is outlier claims initially paid past the 90-day requirement.[4] For this audit, outlier claims are considered nursing facility claims for the same member and service dates with more than 90 days between (a) the date the claim was first received[5] and (b) the date the final payment is made.

The OIG Audit and Inspections Division selected statistically valid samples of 30 Cigna-HealthSpring STAR+PLUS clean claims and 29 Cigna-HealthSpring STAR+PLUS adjusted claims to test the timeliness, accuracy, and causes of any delays in adjudicated claims or processing of payment adjustments. The samples were chosen from a total of 25,382 clean claims and 722 adjusted claims identified as outliers. In addition, subsequent to on-site work, OIG analyzed encounters associated with RUG-level adjustments provided to Cigna-HealthSpring, which totaled 350 claims.

To accomplish its objectives, the OIG Audit and Inspections Division requested information from HHSC and Cigna-HealthSpring, including paid claim data, denied claim data, encounter data, and SAS file documentation.

[3] After the claim has been adjudicated there is the possibility of a retroactive payment adjustment. For this audit, the runout period for a retroactive payment adjustment was cut off as of April 13, 2019.

[4] Uniform Managed Care Manual, Chapter 2.3 Section X.2, v. 2.1 (Mar. 1, 2015) states, "Within 90 days of the Received Date, adjudicate 99 percent of all Clean Claims by Program and by Service Area."

[5] Received date is defined as the date the nursing facility provider submits the claims to the MCO or the HHSC-designated portal.

The OIG Audit and Inspections Division obtained additional information through discussion and interviews with responsible staff at HHSC and Cigna-HealthSpring, as well as through collection and review of:

- Documentation supporting compliance with contractual requirements
- Information systems that support claims and adjustment processing
- Claims data and related encounter data
- Policies and business practices associated with the processing of claims and retroactive adjustments

The OIG Audit and Inspections Division conducted on-site fieldwork at the Cigna-HealthSpring facility in Bedford, Texas, on November 4 through November 8, 2019. While on site, the OIG Audit and Inspections Division reviewed documentation for selected STAR+PLUS nursing facility claims to evaluate whether the documents would provide adequate support for compliance with contract provisions. Auditors also discussed general controls around data and the information technology system application controls used by claims staff.

The OIG Audit and Inspections Division presented preliminary audit results, issues, and recommendations to Cigna-HealthSpring in a draft report dated August 5, 2020. Cigna-HeathSpring generally agreed with the recommendations and indicated it will take corrective actions. Cigna-HeathSpring's management responses are included in the report following each recommendation.

Criteria

The OIG Audit and Inspections Division used the following criteria to evaluate the information provided:

- Uniform Managed Care Contract, Attachment A, v.2.24 (2017) through v. 2.25.1 (2018)

- Uniform Managed Care Contract, Attachment B-1, v.2.24 (2017) through v. 2.25 (2018)

- STAR+PLUS Expansion Contract, v.1.28 (2017) through v.1.29 (2018)

- STAR+PLUS Medicaid Rural Service Area Contract, v. 1.13 (2017) through v. 1.14 (2018)

- Uniform Managed Care Manual, Chapter 2.3, v. 2.1 (2015)

Auditing Standards

Generally Accepted Government Auditing Standards

The OIG Audit and Inspections Division conducted this audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the issues and conclusions based on our audit objectives. The OIG Audit and Inspections Division believes the evidence obtained provides a reasonable basis for our issues and conclusions based on our audit objectives.

AUDIT RESULTS

Based on self-reported information, Cigna-HealthSpring adjudicated an average of over 99.8 percent of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by its UMCC contract. However, Cigna-HealthSpring did not always (a) process HHSC RUG rate adjustments as required, or (b) process other types of adjustments timely. Specifically, Cigna-HealthSpring did not process $231,373.99 in net RUG rate adjustments, and for 19 (66 percent) of 29 other types of adjustments tested, Cigna-HealthSpring did not process the adjustments totaling $3,773.74 timely, which caused delays in payments to nursing facilities that ranged from 54 to 671 days.

RETROACTIVE CLAIM ADJUSTMENTS

MCOs are required to automatically adjust payments through retroactive payment adjustments. The MCO has 30 days to review the change and process the HHSC retroactive payment adjustment. Cigna-HealthSpring did not process 304 of 350 (87 percent) of the necessary RUG rate adjustments identified by the nursing facility utilization review. Additionally, Cigna-HealthSpring did not timely process 19 of 29 (66 percent) other types of tested SAS adjustments initiated by HHSC operations.

Issue 1: Cigna-HealthSpring Did Not Process All Nursing Facility Utilization Review RUG Rate Adjustments

The UMCC requires the MCO to retroactively adjust payments automatically no later than 30 days after receipt of an HHSC SAS notification of a change to RUG rates.[6] However, Cigna-HealthSpring did not automatically process retroactive nursing facility utilization review RUG rate adjustments as required.

Cigna-HealthSpring did not have an automatic process in place to identify and process all retroactive RUG rate adjustments. As a result, (a) Cigna-HealthSpring did not process all RUG rate adjustments in compliance with the contract, (b) the nursing facilities were not paid correct Medicaid-funded RUG rates for certain Cigna-HealthSpring claims, and (c) related encounters were not adjusted as required. To quantify the claims that were not adjusted, an analysis of encounter data by OIG Data and Technology looked at dates of service March 1, 2015, through February 27, 2018, with utilization review RUG rate adjustments from August 1, 2018, through December 23, 2019. The analysis determined that Cigna-HealthSpring only processed 46 (13 percent) of the identified RUG adjustments in

[6] Uniform Managed Care Contract, Attachment B-1, §§ 8.1.18.5, 8.3.9.4, and 8.3.9.5, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018).

the amount of $62,819.27. As of January 16, 2020, Cigna-HealthSpring had not processed the remaining 304 (87 percent) retroactive RUG adjustments, with an expected net recovery of $231,373.99, which includes adjustments expected to reduce prior payments by $280,121.84 and adjustments expected to increase prior payments by $48,747.85.

A further review of data as of August 2020 indicated that Cigna-HealthSpring was making progress toward processing its outstanding RUG adjustments.

Recommendation 1

Cigna-HealthSpring should:

- Design and implement an effective automatic process to identify and complete all retroactive RUG rate adjustments within 30 days of the HHSC SAS notice.
- Identify and process remaining retroactive RUG rate adjustments included in SAS notifications highlighted in the OIG analysis.

Management Response

Action Plan

Prior to this Audit, Cigna recognized the need to automate processes for retroactive RUG rate adjustments. By May of 2018, Cigna had implemented an automated system that increased our automatic adjudication rates for retroactive RUG rate adjustments to 84%. Using this new automated process, Cigna now completes impacted claims within the required 30 day timeframe. In July 2019, Cigna implemented a weekly report that captures Service Authorization System (SAS) updates for Applied Income (AI) and HHSC Resource Utilization Group (RUG) changes. Affected claims are submitted as a project or go through our auto adjudication process ensuring timely reprocessing of those claims. Of the 308 adjustments identified for retroactive RUG adjustments, 178 of the encounters rejected internally and those encounters will be resubmitted. Cigna completed a system conversion in October/November 2019 to our existing outbound encounter submission process and post production issues have had some impact on the submission of older encounters. We have identified the issue and will soon be able to resubmit the older encounters for processing. The 308 claims were reviewed to ensure they were paid appropriately. All claims identified as requiring adjustments were reprocessed with the exception of 9. The 9 claims were not reprocessed due to the RUG rate not impacting them. This type of claim should pay at a set rate minus the applied income.

Responsible Manager

Claims Director

Target Implementation Date

Automation of claim adjudication for Nursing Facility claims went into production in May of 2018. In July 2019, a report was created that is run each week allowing us to capture SAS updates and reprocess any impacted claims within the 30 day timeframe. These claims are submitted as a project or go through our auto adjudication process. Claims that were identified as requiring reprocessing due to a rate change have been reprocessed. Required encounter resubmissions identified in this audit will be complete by October 1, 2020.

Auditor Comment

The OIG Audit and Inspections Division appreciates the feedback provided by Cigna-HealthSpring in its management response letter, and respects Cigna-HealthSpring's position on reported issues. The OIG Audit and Inspections Division offers the following comments regarding Cigna-HealthSpring's management response for Issue 1.

OIG Audit and Inspections Division has reviewed the work supporting the report findings and stands by its conclusion that the nine claims highlighted in Cigna-HealthSpring's response should be reprocessed.

Issue 2: Cigna-HealthSpring Did Not Process Other Retroactive Claims Adjustments Timely

Cigna-HealthSpring did not consistently process other types of claims adjustments within required timelines, which resulted in delayed payments to nursing facilities. The UMCC requires Cigna-HealthSpring to automatically process payment adjustments within 30 days of receiving a SAS notification from HHSC indicating that an adjustment is needed.[7] In addition, the UMCM requires that MCOs automatically adjust claims for other changes, such as service authorizations and applied income.[8] Processing those adjustments timely is important because those adjustments result in payment increases or decreases to nursing facilities.

[7] Uniform Managed Care Contract, Attachment B-1, §§ 8.1.18.5, 8.3.9.4, and 8.3.9.5, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018).

[8] Uniform Managed Care Manual, Chapter 2.3, Section VIII.A, v. 2.1 (Mar. 1, 2015).

Retroactive adjustments to a claim may be needed due to changes in:

- Member eligibility
- Provider status change
- Nursing facility service authorization
- RUG level
- Amount of applied income

OIG selected a random sample of 29 adjusted claims from a total of 722 nursing facility claims that were paid more than 90 days after the claim was first submitted by the nursing facility. For those 29 claims, Cigna-HealthSpring adjudicated the clean claims and later received retroactive adjustments from HHSC via a SAS notification. Cigna-HealthSpring eventually identified these retroactive changes and processed the associated payment adjustments. However, Cigna-HealthSpring did not process 19 (66 percent) of the 29 adjustments tested within 30 days of the HHSC SAS notification as required.

Specifically, of the 19 claims tested that Cigna-HealthSpring did not adjust as required:

- 15 claims required adjustment due to retroactive changes to the applied income of the member.

- Three claims required adjustment due to retroactive changes to the designated service level of the member.

- One claim required adjustment due to a retroactive change to the RUG rate.

These delays occurred because Cigna-HealthSpring did not have an automatic process in place to identify and process all payment adjustments resulting from SAS notices. As a result, payments for those 19 claims, which totaled $3,773.74, were delayed between 54 and 671 days.

Recommendation 2

Cigna-HealthSpring should implement an effective automatic process to identify and process all retroactive payment adjustments within 30 days of an HHSC SAS notice.

Management Response

Action Plan

To ensure Cigna captures SAS updates and reprocess affected claims within the 30 day timeframe, we have created a report that monitors AI and RUG changes. This is a weekly report and is reviewed to ensure any impacted claims are submitted as a project or go through our auto adjudication process completing reprocessing within our required timeframe.

Responsible Manager

Claims Director

Target Implementation Date

This monitoring report was implemented in June of 2019. The report is run weekly capturing AI and RUG changes. Impacted claims are submitted as a project or go through our auto adjudication process ensuring they are reprocessed within the required 30 day timeframe.

CONCLUSION

Cigna-HealthSpring adjudicated and paid most clean claims accurately and timely. Additionally, based on self-reported information, Cigna-HealthSpring adjudicated an average of over 99.8 percent of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by the UMCC.

However, Cigna-HealthSpring did not process all retroactive adjustments as required by contract. Specifically, Cigna-HealthSpring did not:

- Make required RUG rate adjustments. As of January 16, 2020, Cigna-HealthSpring had processed 46 (13 percent) of the identified RUG adjustments in the amount of $62,819.27. Cigna-HealthSpring had not processed the remaining 304 (87 percent) retroactive RUG adjustments with an expected net recovery of $231,373.99. As a result, nursing facilities were not paid correctly, and related encounters were not adjusted.

- Retroactively process 19 of 29 payment adjustments tested (66 percent) within 30 days of the HHSC SAS notification, as contractually required. The delayed payment amount for those 19 claims totaled $3,773.74.

The OIG Audit and Inspections Division offered recommendations to Cigna-HealthSpring, which, if implemented, will result in Cigna-HealthSpring complying with its contractual requirements to automatically identify and process all retroactive adjustments within 30 days of the HHSC SAS notification.

For instances of noncompliance identified in this audit report, MCS may consider tailored contractual remedies to compel Cigna-HealthSpring to meet contractual requirements related to its nursing facility claims function. In addition, audit findings in this report may be subject to OIG administrative enforcement measures, including administrative penalties.[9,10]

The OIG Audit and Inspections Division thanks management and staff at Cigna-HealthSpring for their cooperation and assistance during this audit.

[9] 1 Tex. Admin. Code § 371.1603 (May 1, 2016).

[10] Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

Appendix A: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

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