

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL
AUDIT REPORT

**STAR+PLUS WAIVER PROGRAM
ASSESSMENTS AND SERVICES
DELIVERED**

*Medicaid Rural Service Area West
Amerigroup Insurance Company*



February 28, 2020
OIG Report No. AUD-20-007



HHSC OIG

TEXAS HEALTH AND HUMAN
SERVICES COMMISSION
OFFICE OF
INSPECTOR GENERAL

WHY THE OIG CONDUCTED THIS AUDIT

The HHSC OIG Audit Division conducted this audit to determine whether Amerigroup properly assessed members to participate in the HCBS Waiver program. This audit focused on Amerigroup's MRSA West contract, which is designed to fill private insurance gaps in rural areas.

Specifically, the audit objectives were to determine whether Amerigroup HCBS Waiver members (a) were assessed timely, (b) were assessed at least one institutional level of care need, and (c) received planned services. The audit scope included Medicaid members in MRSA West for whom Amerigroup received fewer than 12 months of HCBS Waiver capitation payments between September 1, 2016, and August 31, 2017.

WHAT THE OIG RECOMMENDS

Amerigroup should:

- Create a process for service coordinators to (a) regularly perform utilization review and escalate cases, (b) reassess members when services are not received, and (c) document member-provided reasons for not utilizing care.
- Submit complete member assessments and individual service plans timely.
- Proactively address low staffing situations to ensure contract requirements are met.
- Implement (a) a robust managerial review of forms for completeness and accuracy, and (b) a process for service coordinators to obtain guidance on form completeness when unique situations arise.

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February 28, 2020

STAR+PLUS WAIVER PROGRAM ASSESSMENTS AND SERVICES DELIVERED

Amerigroup Insurance Company

WHAT THE OIG FOUND

Amerigroup Insurance Company (Amerigroup) did not pay any claims for certain members enrolled in the Home and Community Based Services (HCBS) Waiver program between September 2016 and August 2017. Although notes in the members' records indicated service coordinators were communicating with members as required, some members did not receive any of the planned waiver services identified on the members' individual service plans (ISPs).

The HCBS Waiver program is designed to provide a cost-effective alternative to living in a nursing facility. It is important because it helps Medicaid members who have at least one service need that meets the threshold to qualify for care provided by a nursing facility (called "an institutional level of care") to instead remain in their homes and communities.

According to the State of Texas Access Reform PLUS (STAR+PLUS) Medicaid Rural Service Area (MRSA) contract, service coordinators must (a) help members arrange care when needed, (b) perform ongoing monitoring of members' claims history, (c) compare claims history to members' ISPs, and (d) confirm all services identified on the ISP are being delivered.

The OIG Audit Division tested 216 members and determined the assessments indicated the members (a) had at least one need at the institutional level of care and (b) received medical necessity determinations for the HCBS Waiver services based on the assessments.

However, results indicated:

- Amerigroup did not pay waiver services claims in 2017 for 34 members. There was no indication in the case files and notes reviewed that the individuals refused service.

The absence of any waiver services may indicate Amerigroup service coordinators were not effectively (a) assisting members in receiving timely access to covered services or (b) monitoring members' claim history to confirm all planned services are delivered.
- Amerigroup did not submit initial assessments to Texas Medicaid and Healthcare Partnership (TMHP) timely for 5 members and did not submit ISPs to TMHP timely for 54 members, which increases the risk that some members may not receive needed services timely.
- 38 members' records were missing some required forms or information on the forms, which may impact the timeliness of service delivery.

The OIG Audit Division presented the audit results, issues, and recommendations to Amerigroup in a draft report dated February 3, 2020. Amerigroup stated that utilization management reviews performed by HHSC as well as several program changes since the period covered by the audit have remedied and will prevent similar findings in the service coordination process while improving members' health and safety.

TABLE OF CONTENTS

INTRODUCTION	1
AUDIT RESULTS	5
ISSUE 1: NO EVIDENCE THAT SERVICES WERE PROVIDED FOR SOME HCBS WAIVER MEMBERS	5
ISSUE 2: ISPs AND ASSESSMENTS WERE NOT ALWAYS TIMELY	7
ISSUE 3: DOCUMENTATION WAS MISSING OR NOT ALWAYS COMPLETE	9
CONCLUSION	12
APPENDICES	13
<i>A: Background</i>	<i>13</i>
<i>B: Sampling Methodology</i>	<i>15</i>
<i>C: Issue 3—Incomplete Forms</i>	<i>17</i>
<i>D: Report Team and Distribution</i>	<i>18</i>
<i>E: OIG Mission, Leadership, and Contact Information</i>	<i>20</i>

INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division conducted an audit of the Home and Community-Based Services (HCBS) State of Texas Access Reform PLUS (STAR+PLUS) Waiver (HCBS Waiver) program for Medicaid managed care members served by Amerigroup Insurance Company (Amerigroup) in the Medicaid Rural Service Area (MRSA) West.¹ The HCBS Waiver is designed to provide a cost-effective alternative to living in a nursing facility. It is intended to help Medicaid members remain in their homes and communities. See Appendix A for more information about the HCBS Waiver program.

To be eligible for the HCBS Waiver program services, members must have (a) a medical necessity determination based on a submitted assessment, (b) at least one unmet need for service assessed by a managed care organization (MCO), (c) an individual service plan (ISP) developed that is at or below an established cost limit, and (d) full Medicaid coverage. Completed assessments are submitted by MCOs to Texas Medicaid and Healthcare Partnership (TMHP) for medical necessity determinations.

For the period from September 1, 2016, through August 31, 2017, Amerigroup received capitation payments for 176,672 STAR+PLUS program members, of whom 12,690 were enrolled in the HCBS Waiver. MRSA West served 2,106 of these members. The OIG Audit Division conducted the audit to determine whether Amerigroup properly assessed members to participate in the HCBS Waiver program.

Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

Objectives and Scope

The audit objectives were to determine whether Amerigroup HCBS Waiver members (a) were assessed timely, (b) were assessed at least one institutional level of care need,² and (c) received planned services.

The audit scope included Medicaid members in MRSA West for whom Amerigroup received at least one and fewer than 12 HCBS Waiver capitation

¹ Medicaid Rural Service Areas (MRSA) are used to fill gaps in private insurance coverage in rural areas. These service areas capture rural counties that do not include significant urban centers. See Appendix A.

² An “institutional level of care need” means at least one service required by the individual meets the threshold to qualify for care provided by nursing facilities.

payments during 2017;³ activities related to members' assessments, individual service planning, and service coordination; and relevant internal and information technology (IT) controls in place through the end of fieldwork in October 2018.

Methodology

The OIG Audit Division collected and analyzed documentation from HHSC and Amerigroup including assessments, individual service plans, service coordinators' case notes, paid claim data, and capitation payment data. The OIG Audit Division used this documentation and information obtained during interviews with responsible staff at HHSC and Amerigroup to meet its objectives.

The OIG Audit Division selected a statistically valid random⁴ sample of 178 HCBS Waiver members and a judgmental⁵ sample of 38 HCBS Waiver members; obtained data associated with each selected member; and reviewed, analyzed, and compared this data to Amerigroup members' file documentation. The judgmental sample was selected due to anomalies in the data indicating (a) fewer than 12 monthly STAR+PLUS HCBS Waiver capitation payments had been paid to Amerigroup and (b) Amerigroup reported no encounter data for these members during the audit scope.⁶ The statistically valid random sample was selected from the 316 HCBS Waiver members population with at least one but fewer than 12 monthly STAR+PLUS HCBS Waiver capitation payments.

This report also details the results of limited testing of IT general controls, performed to determine whether data used to form audit conclusions was reliable.

The OIG Audit Division presented the audit results, issues, and recommendations to Amerigroup in a draft report dated February 3, 2020. Amerigroup stated that utilization management reviews performed by HHSC as well as several program changes since the period covered by the audit have remedied and will prevent similar findings in the service coordination process while improving members' health and safety. The Amerigroup management responses are included in the report after each recommendation.

³ Capitation payments are made monthly. Having at least one capitation payment but fewer than 12 in a fiscal year may indicate that member may be new to the HCBS Waiver program that year.

⁴ "Random sampling" is a method by which every element in the population has an equal chance of being selected.

⁵ "Judgmental sampling" is a non-probability sampling method where the auditor selects the sample based on certain characteristics, such as dollar amount, timeframe, or type of transaction.

⁶ The judgmental sample was selected using encounter data, and the audit test work was conducted on the paid claims file obtained from Amerigroup. See Appendix B for the detailed sampling methodology.

Criteria

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

- 1 Tex. Admin. Code § 353.1153 (2016)
- STAR+PLUS MRSA Contract, v. 1.10 (2016) through v. 1.12 (2017)
- STAR+PLUS Handbook, v. 16-2 (2016) through v. 17-4 (2017)
- Texas Medicaid and Healthcare Partnership, “Medical Necessity and Level of Care Assessment–Version 3.0,” v.17 (2016) and “3.0 Medical Necessity and Level of Care Assessment (MN/LOC) Item by Item Guide,” (2016 and 2017)
- Texas Health and Human Services, Form H2060, “Needs Assessment Questionnaire and Task/Hour Guide,” (Nov. 2014)
- Texas Health and Human Services, Form H2060-A, Addendum to Form H2060 (Feb. 2016)
- Texas Health and Human Services, Form H2060-B, Needs Assessment Addendum (Mar. 2015)
- Texas Health and Human Services, Form H6516, “Community First Choice Assessment,” (Mar. 2015)
- Texas Health and Human Services, Form H1700-1, “STAR+PLUS Waiver Individual Service Plan,” (Mar. 2014)

Auditing Standards

Generally Accepted Government Auditing Standards

The OIG Audit 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 Division believes the evidence obtained provides a reasonable basis for our issues and conclusions based on our audit objectives.

ISACA

The OIG Audit Division performed work in accordance with the IT Standards, Guidelines, and Tools and Techniques for Audit and Assurance and Control Professionals published by ISACA.

AUDIT RESULTS

The OIG Audit Division tested 216 members and determined these HCBS STAR+PLUS members (a) had at least one need at the institutional level of care and (b) received medical necessity determinations for the HCBS Waiver services based on the assessments.

Of the 216 members tested, 34 members did not have any claims paid by Amerigroup under the HCBS Waiver during or soon after the audit period. Notes in the members' records indicated service coordinators were communicating with members as required; however, it appears these 34 members did not receive any of the planned waiver services identified on the members' ISPs. There was no indication in the case files and notes reviewed that the individuals refused service. An additional four members became eligible for services at the end of the scope period, Amerigroup asserted that services for these four members were received after the scope period, but the OIG Audit Division did not review documentation to confirm the assertion. Issues related to timeliness of assessments and completeness of required documents were noted.

The OIG Audit Division determined the program data was reliable for purposes of this audit.

Information about exceptions related to claims activity and assessment timeliness and completeness are included in the issues that follow.

Issue 1: No Evidence That Services Were Provided for Some HCBS Waiver Members

HCBS Waiver members are Level 1 members, which indicates the highest and most complex level of care is required. MCOs must provide these members with (a) a single identified person as service coordinator, and (b) two face-to-face service coordination contacts annually.⁷

MCOs are required to provide service coordination to their STAR+PLUS members. MCO service coordinators work with the member, the member's family, and with the member's doctors and other providers to help ensure the member receives needed medical and long-term service and supports.

⁷ STAR+PLUS MRSA Contract, Attachment B-1 § 8.1.36.1, v. 1.10 (Sept. 1, 2016) through v. 1.12 (June 1, 2017).

MCO service coordinators:

- Identify physical health, mental health, and long-term services and supports needs, and develop a service plan.
- Assist members in receiving timely access to providers and covered services.
- Coordinate covered services with non-managed care programs.

According to the STAR+PLUS MRSA contract,⁸ service coordinators must (a) help members arrange care when needed, (b) perform ongoing monitoring of members' claims history, (c) compare claims history to the members' ISPs, and (d) confirm all services identified on the ISP are delivered.

Based on the paid claim file it provided, Amerigroup did not pay any waiver services claims in 2017 for 34 of the 216 HCBS Waiver members tested (15.7 percent).⁹ The absence of any waiver services paid claims in 2017 for 34 HCBS Waiver members may indicate Amerigroup service coordinators were not effectively (a) assisting members in receiving timely access to covered services or (b) monitoring members' claim history to confirm all planned services are delivered.

The waiver services on ISPs address unique, complex needs and help members stay in their homes instead of moving into institutions. When members in this population do not receive planned services, their medical condition may deteriorate and result in institutionalization.

Recommendation 1

Amerigroup should:

- Create a process for service coordinators to (a) regularly perform utilization review and escalate cases when members are not utilizing services as planned.
- If applicable, reassess members who have not received planned services to determine whether the members should remain in the HCBS Waiver risk group.
- Document member-provided reasons for not utilizing care.

⁸ STAR+PLUS MRSA Contract, Attachment B-1 § 8.1.37.2, v. 1.10 (Sept. 1, 2016) through v. 1.12 (June 1, 2017).

⁹ Seventeen of the 41 HCBS Waiver members were judgmentally selected for testing based on encounter data indicating no services were provided. The remaining 24 members without services were identified among the 178 members included in the statistically valid random sample.

Management Response

Action Plan

- *Members who qualify medically for the waiver program (SPW), are monitored for the first 120 days of their Individual Service Plan (ISP) to ensure services identified on their ISP are in place or in progress, and to further assess their need/desire for additional waiver specific items or services.*
- *Members who do not utilize a waiver service in the first 120 days of their ISP year, because they chose not to, are moved to a non-wavier status based on regulatory guidance as long as they remain financially qualified to receive Medicaid benefits.*
- *All attempts to arrange or initiate services are documented in the clinical documentation system.*

Responsible Manager

Regional Vice President Government Business Division – Special Programs Texas

Implementation Date

Process implemented in state fiscal year 2018

Issue 2: ISPs and Assessments Were Not Always Timely

Amerigroup did not complete and submit initial assessments or ISPs to TMHP in a timely manner, as follows:

Initial Assessments Not Timely Submitted

Assessments must be completed and submitted to TMHP within 45 days of receiving notification that an assessment is needed.¹⁰ For 5 of 216 sample members tested (2.3 percent), Amerigroup submitted assessments more than 45 days after the member's release from HHSC interest list or after member notified Amerigroup of a significant change in medical condition. The late assessment submissions ranged from 2 to 72 days late.

¹⁰ STAR+PLUS MRSA Contract, Attachment B-1 § 8.1.38.1, v. 1.10 (Sept. 1, 2016) through v. 1.12 (June 1, 2017).

ISPs Not Timely Submitted

ISPs must be completed and submitted to TMHP within 45 days of notification an assessment is authorized.¹¹ ISP must reflect services needed to address needs identified in the assessment.

For 54 of 216 sample members tested (25 percent), Amerigroup did not submit completed ISP forms to TMHP within 45 days of the notification that an assessment is authorized. The late ISP submissions ranged from 7 to 210 days late. The OIG Audit Division did not conduct work to determine the effect on members' medical condition based on late documentation submission, however, there is a risk that delays in the submission of these forms could result in members not receiving needed services timely.

Recommendation 2

Amerigroup should:

- Submit complete member assessments and ISPs within 45 days of notification of authorization.
- Monitor staffing levels and proactively address low staffing situations to ensure contract requirements are met.

Management Response

Action Plan

- *The goal of the SC process, for members new to Amerigroup or newly upgraded to the waiver program, is to submit their ISP within 45 days of the upgrade trigger date or program enrollment date for members coming off of the interest list. Both of these situations rely on several processes to come together: successful member contact, in-person assessment, obtaining primary physician signature approving waiver program application, and successfully submitting the assessment and ISP to TMHP or Texas Medicaid & Healthcare Partnership, HHSC's State Medicaid Contractor. The primary difficulties are reaching the member and obtaining physician signature. Significant improvements have been made in the last three years to streamline the physician order process and reduce the time to reach the member. This includes identifying the member's primary physician and beginning outreach to obtain their signature at the same time the*

¹¹ STAR+PLUS Handbook § 3316, v. 16-2 (June 1, 2016) through 17-4 (May 23, 2017).

assessment is scheduled. This process is continually reviewed and updated to ensure timeliness of ISP submission.

- *Staffing and productivity are monitored closely and resources are adjusted as necessary to fill gaps when we have open positions.*

Responsible Manager

Regional Vice President Government Business Division – Special Programs Texas

Implementation Date

Process implemented in state fiscal year 2018

Issue 3: Documentation Was Missing or Not Always Complete

Out of the 316 Amerigroup HCBS Waiver members' files reviewed, 38 members' files had 86 forms that were missing or the information on the form was incomplete.¹² Not all HCBS Waiver members required the same forms; auditors determined a form was missing or information on the form was missing based on program handbook guidance. See Appendix A for details. According to Amerigroup, when service coordinators encounter unique situations that the form instructions do not address, some fields may remain blank (e.g., ISP is submitted to TMHP before the individual plan is approved, so the services start date is missing on the form).

Service coordinator training did not specifically address which forms to complete or which fields on the forms are required. However, incomplete or missing documentation may affect the members' STAR+PLUS HCBS Waiver eligibility or increase the document processing time which may impact the timeliness of service delivery.

Table 1 summarizes the number of exceptions found per form; additional details are in Appendix C.

¹² STAR+PLUS Handbook § 3316, v. 16-2 (June 1, 2016) through 17-4 (May 23, 2017).

Table 1. Missing and Incomplete HCBS Waiver Documentation Per Form

Form	Program Forms Missing	Program Forms Incomplete	Service Coordinator Signed for Member	Total
MN/LOC	5	1	—	6
H2060 Series	24	2	—	26
H6516	4	15	2	21
H1700-1	4	—	—	4
H1700-2	9	6	5	20
H1700-A	7	2	—	9
Total	53	26	7	86

Source: OIG Audit Division

Recommendation 3

Amerigroup should:

- Implement robust managerial review of forms for completeness and accuracy.
- Create a process and train service coordinators to obtain guidance when unique situations arise in the field which the standard instructions do not address.

Management Response

Action Plan

- *Managers perform quarterly quality reviews for each Service Coordinator on their team. SC’s who score below a 90 percent for a single quarter are re-educated and coached to improve timeliness, accuracy, and form completeness. SC’s who score below 90 percent for two quarters are place on corrective action plans. Because there is no way to review every assessment and form, we rely on annual and ad hoc refresher trainings to ensure the SC’s hear the most updated information.*

Amerigroup does not intend to implement additional processes at this time, however, we continually look for ways to improve the quality of work and performance of our Service Coordinators. Our current plan which re-educates service coordinators who receive a score less than 90 percent on their quality reviews is effective in keeping service coordinators at a satisfactory level of performance.

- *Service Coordinators are instructed to reach out to peers and/or leads/managers when difficult situations present themselves. Monthly one-*

on-one's with their manager affords them opportunities to discuss non-urgent scenarios and obtain additional guidance as needed. Our goal is to ensure all team members have access to resources and subject matter experts at all times.

Responsible Manager

Regional Vice President Government Business Division – Special Programs Texas

Implementation Date

Quarterly Quality Reviews have been in place since SFY 2015 and manager 1:1's and unique scenario discussions were in place prior to 2015.

CONCLUSION

The OIG Audit Division evaluated Amerigroup HCBS Waiver documentation for the members in MRSA West during 2017 to determine whether Amerigroup HCBS Waiver members (a) were timely assessed, (b) were assessed at least one institutional level of care need, and (c) received the services planned timely.

The OIG Audit Division also evaluated IT general application controls to determine whether controls existed and were sufficient to protect the reliability of system data utilized for audit testing.

The tested Amerigroup members enrolled in the HCBS Waiver program in MRSA West during 2017 had an institutional level of care need documented. However, test results indicated:

- Amerigroup did not pay waiver services claims in 2017 for 34 members
- Members did not have assessments or ISPs completed or submitted timely to TMHP
- Members' records were missing forms or information on the forms

The absence of any waiver services paid claims in 2017 for 34 HCBS Waiver members indicates that Amerigroup might not have been (a) assisting members in receiving timely access to providers and covered services or (b) monitoring members' claim history to compare to the ISP and confirm all services identified were being delivered.

The OIG Audit Division offered recommendations to Amerigroup, which if implemented, will:

- Increase service coordinator contact with HCBS Waiver members and improve coordination of planned services delivery.
- Improve timely completion and submission of assessments and ISPs to TMHP.
- Reduce instances of missing or incomplete documentation.

The OIG Audit Division thanks management and staff at Amerigroup for their cooperation and assistance during this audit.

Appendix A: Background

Background

The HCBS Waiver, a Medicaid program, is a cost-effective alternative to nursing facility care for Medicaid or Dual Eligible Medicaid-Medicare members who qualify and choose to live in the community. Services offered in the HCBS Waiver program may include:

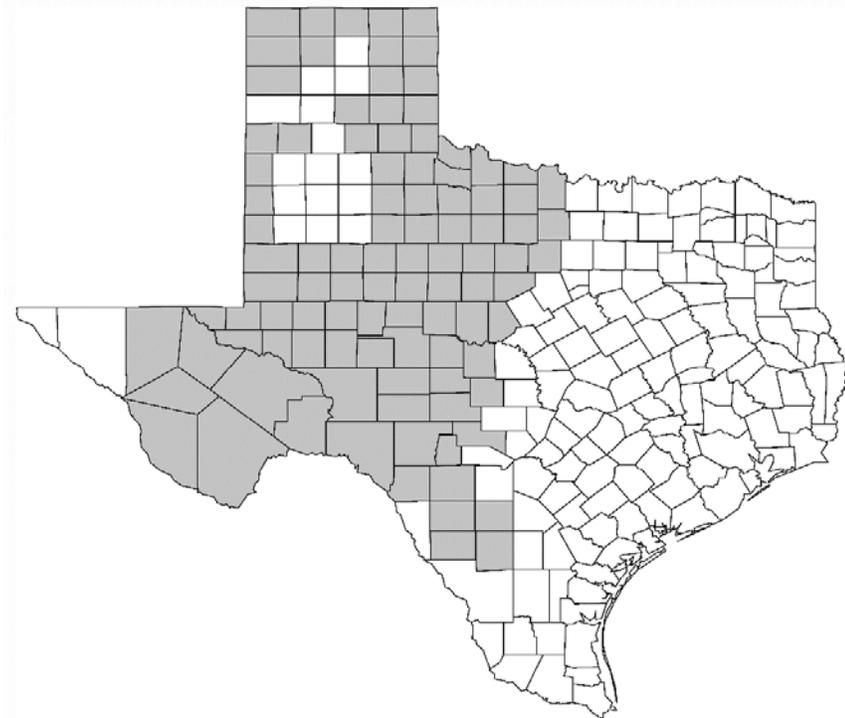
- Nursing services
- Personal attendant services
- Physical, occupational, and speech therapy
- Adaptive aids
- Medical supplies
- Minor home modifications
- Emergency response services
- Assisted living
- Adult foster care
- Home-delivered meals
- Dental services
- Transition assistance services
- Respite care

To be eligible for the HCBS Waiver, a member must be at least 21 years of age, meet income and resource requirements for Medicaid nursing facility care, and receive determination from HHSC that they meet the medical necessity criteria to be in a nursing facility.

Amerigroup is a licensed Texas MCO contracted to facilitate the provision of HCBS STAR+PLUS services through its network of providers. During the scope of the audit, Amerigroup had 25 registered nurses who covered the MRSA West with an average workload of 35–38 member visits per month.

Figure 1 shows a map of the 99-county MRSA West, which is the scope of this audit.

Figure 1. Medicaid Rural Service Area West



Source: Texas Association of Counties

The following forms were reviewed:

Medical Necessity and Level of Care Assessment (MNLOC), documents the assessment or reassessment of a member's medical necessity for HCBS Waiver Services.

Needs Assessment Questionnaire and Task/Hour Guide (Form H2060, H2060-A and H2060-B), document members' needs for personal attendant services to include eligibility, functional needs, and amount of personal attendant services.

Community First Care Assessment (Form H6516), documents the individual's strengths, preferences, support needs, desired outcomes, living arrangements, and priorities.

ISP forms (Forms H1700-1, H1700-2, and H1700-A), document services identified for HCBS Waiver program members. MCO service coordinators complete ISP forms each time (a) an applicant or member's eligibility is assessed for the program, (b) a change is requested or necessary in the member's service plan, or (c) a member is assessed.

Appendix B: Sampling Methodology

The OIG Audit Division initiated its examination of the HCBS Waiver program by obtaining and analyzing 2017 data from the Premium Payment System (PPS) for Amerigroup STAR+PLUS members. PPS contains a record of monthly capitation payments made to the MCOs for each enrolled member corresponding to the program rate for each applicable risk group. PPS contained capitation payment information for a total of 176,672 unique (unduplicated) Amerigroup STAR+PLUS members across Texas for 2017. Of those members, 12,690 were in the waiver risk groups (Medicaid and Dual Eligible Medicaid-Medicare).

Of the 12,690 members in the HCBS waiver, 2,106 were enrolled in the MRSA West as evidenced by the PPS payments. Of the 2,106 members enrolled in MRSA West, 316 members were enrolled after September 2016 and were considered as the population of potentially new members who are required to have an initial assessment.

From the 2,106 Waiver members in MRSA West area, auditors selected for testing a judgmental sample of 38 members (a) for whom Amerigroup did not report any encounter data and (b) who had fewer than 12 months of HCBS Waiver capitation payments (which could indicate an initial assessment completed during the year audited). Auditors obtained the paid claim file from Amerigroup and reviewed it to determine whether these 38 members had paid claims during the audit period. Fourteen of the 38 members did not have any paid claim information contained in the file provided by Amerigroup.

OIG Data and Technology Division selected a statistically valid random sample, from encounter data, of 316 potentially new members in the HCBS Waiver MRSA West during 2017. The random sample size was 178 members.

OIG obtained paid claim data from Amerigroup for the 178 members in the sample and reviewed it to determine whether these 178 members had paid claims during the audit period. Data for dental claims were obtained from the OIG Data and Technology Division. The 2,106 Amerigroup HCBS Waiver members' Medicaid IDs were matched to the paid claims based on the PCN (Patient Control Number)¹³ and the audit period. PCNs with no match in the paid claims were identified as members in the HCBS waiver who did not receive Medicaid managed care services. A distinction was made between the HCBS waiver members who did not receive any Medicaid services and those who did not receive waiver specific services (listed in Appendix A). Twenty-seven members from the 178 tested as part of the random sample did not have any paid claim information in the file provided by Amerigroup.

¹³ "Patient control number (PCN)" is the nine-digit number used to uniquely identify a Medicaid member. It is also known as the member's Medicaid number.

For purposes of discussion in this report, the judgmental and the statistical sample were combined.

Appendix C: Issue 3—Incomplete Forms

The table below provides details about Amerigroup HCBS Waiver members’ forms that were incomplete as presented under “Program Forms Incomplete” in Issue 3, Table 1.

Error	MNLOC	H2060-A	H2060-B	H6516	H1700-2	H1700-A
Missing Service Coordinator Name	1	—	—	—	—	—
Missing Dates	—	1	—	—	—	—
Missing Member Signature	—	—	—	15	6	—
Missing Service Coordinator Signature	—	—	1	—	—	2

Source: OIG Audit Division

Appendix D: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Audrey O’Neill, CIA, CFE, CGAP, Deputy IG for Audit
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- Franco Hardy, Regulatory Oversight Manager
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Appendix E: OIG Mission, Leadership, and Contact Information

The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG’s mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Juliet Charron, Chief of Strategy
- Quinton Arnold, Chief of Inspections and Investigations
- Steve Johnson, Chief of Medicaid Program Integrity

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