Summary of Results: Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments

Selected Texas Managed Care Organizations

May 28, 2021
OIG Report No. AUD-21-011

Inspector General

Texas Health and Human Services

HHS OIG
TEXAS HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WHY THE OIG CONDUCTED THIS SERIES OF AUDITS

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division conducted a series of audits in 2020 of State of Texas Access Reform PLUS (STAR+PLUS) nursing facility claims paid by the five Texas managed care organizations (MCOs) that participate in the STAR+PLUS program:

- Amerigroup Texas, Inc., and Amerigroup Insurance Company
- Cigna-HealthSpring Life and Health Insurance Company, Inc.
- Molina Healthcare of Texas
- Superior HealthPlan
- UnitedHealthcare Community Plan

The OIG Audit and Inspections Division conducted these audits 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. HHSC paid a total of $2.9 billion in nursing facility capitation to the five MCOs during the audit scope.

RECOMMENDATIONS AND ACTION PLANS

In the five audits, OIG recommended that MCOs (a) ensure their processes effectively identify and process all retroactive claims and RUG rate adjustments within 30 days of an HHSC SAS notice, and (b) identify and process remaining retroactive RUG rate adjustments.

The MCOs generally agreed with the recommendations highlighted in this summary and all developed corrective action plans to address the issues. As of the date of this report, four MCOs had completed their corrective action plans and the fifth was scheduled to be completed in June 2021.

For more information, contact:
OIGAuditReports@hhsc.state.tx.us

SUMMARY OF RESULTS: PROCESSING OF OUTLIER NURSING FACILITY STAR+PLUS CLAIMS AND ADJUSTMENTS

Selected Texas Managed Care Organizations

WHAT THE OIG OBSERVED

OIG Audit conducted five audits of outlier claims for MCOs that participate in STAR+PLUS Medicaid managed care to determine whether the MCOs accurately and timely adjudicated qualified nursing facility provider clean claims. The populations for the five MCO audits were outlier claims initially paid past the 90-day requirement. For these audits, 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 and (b) the date the final payment is made.

Based on self-reported information, all five MCOs audited paid between 97 percent and 99.99 percent of clean claims timely. However, the MCOs did not consistently make payment adjustments timely, which, in some cases, resulted in significant delays in payments to nursing facilities. In addition, the MCOs did not consistently process retroactive OIG nursing facility utilization review RUG rate adjustments as required. The audited MCOs did not consistently process claims adjustments within required timelines. MCOs are required to automatically process claims adjustments within 30 days of receiving a notification that an adjustment is needed. Testing indicated that, among outliers, MCOs were late adjusting claims between 40 percent and 90 percent of the time, and as a result, delays in payments from MCOs to nursing facilities ranged from more than a month to nearly two years. Significant delays in payments to nursing facilities could impact the nursing facilities' ability to operate and provide quality care to residents.

HHSC OIG retroactively adjusts the RUG rate (the amount Medicaid pays for the daily care of residents who require a certain level of nursing care) for some service levels, which can affect past payments. When it identifies a needed RUG rate adjustment, the OIG Utilization Review group notifies Texas Medicaid and Healthcare Partnership (TMHP) or the MCOs, as applicable, of the needed RUG rate adjustments to adjust the claims.

As of January 2020, the MCOs had not processed expected outstanding adjustments going back to 2015. Specifically, they had not processed $363,259.00 in adjustments that were expected to increase payments to nursing homes and $2,563,294.23 in adjustments that were expected to reduce prior payments. When combined, those expected changes resulted in a net estimated overpayment amount of $2.2 million. Table 1 shows the shows the scale of the net expected outstanding nursing facility RUG rate adjustments, which resulted in overpayments due to be returned to the state of Texas.

Table 1: Expected Outstanding Adjustments

MCO	Outstanding Net Overpayment as of January 2020
Amerigroup	$758,289.81
Cigna	231,373.99
Molina	315,023.30
Superior	313,190.95
United	582,157.21

Source: OIG Audit

TABLE OF CONTENTS

INTRODUCTION

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted a series of audits of State of Texas Access Reform PLUS (STAR+PLUS) nursing facility claims paid by the five Texas managed care organizations (MCOs) that participate in the STAR+PLUS program:

- Amerigroup Texas, Inc., and Amerigroup Insurance Company (Amerigroup), issued August 28, 2020
- Cigna-HealthSpring Life and Health Insurance Company, Inc. (Cigna), issued August 26, 2020
- Molina Healthcare of Texas (Molina), issued December 9, 2020
- Superior HealthPlan (Superior), issued November 20, 2020
- UnitedHealthcare Community Plan (United), issued August 28, 2020

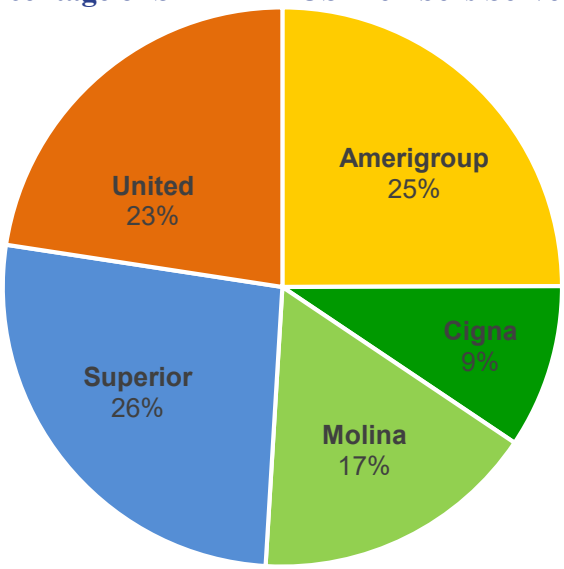
OIG Audit conducted these audits as a follow-up to complaints of nursing facility payments from MCOs being delayed by more than 90 days and of unprocessed nursing facility utilization review resource utilization group (RUG) rate retroactive adjustments. The audits determined that, while the MCOs self-reported that they processed the vast majority of all clean claims timely, errors with identifying and processing claims adjustments led to significant delays in some payments to nursing facilities. In November 2020, the Texas Medicaid and Healthcare Partnership (TMHP) streamlined the data files the MCOs use to process the needed adjustments, and the MCOs have improved their procedures for identifying and processing those adjustments. TMHP is a group of contractors under the leadership of Accenture. Accenture administers Texas Medicaid and other state health-care programs on behalf of the Texas Health and Human Services Commission.

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. The STAR+PLUS program served an average of 526,768 members per month in 2018. HHSC paid a total of $2.9 billion in nursing facility capitation to the five MCOs in 2018.

Figure 1 shows the proportion of members served by each MCO.

Figure 1: Percentage of STAR+PLUS Members Served by Each MCO in 2018



Source: HHSC Healthcare Statistics, 2018 Historical Medicaid Enrollment

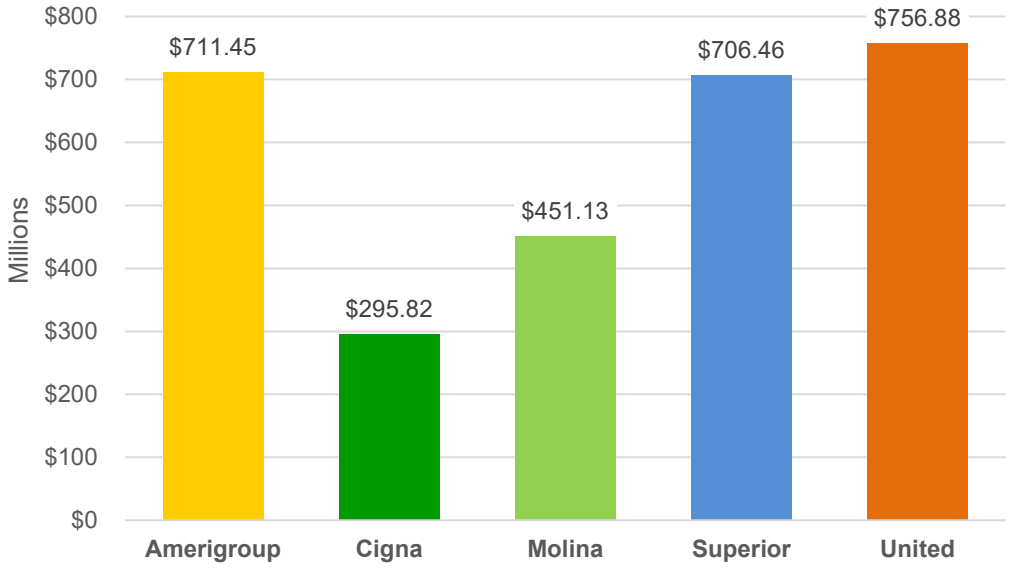
Texas Health and Human Services Commission (HHSC) Medicaid and CHIP Services (MCS) is responsible for overall management of the STAR+PLUS program and for oversight of MCOs. MCS promulgates policy and rules related to the participation of nursing facilities in Medicaid, and, in the case of managed care, 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 establishes RUG rates for nursing facility members and 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]

[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.*

Figure 2 shows the amounts HHSC paid the MCOs for administering the STAR+PLUS program for nursing facility residents in 2018.

Figure 2: Capitation for STAR+PLUS Nursing Facility Residents in 2018

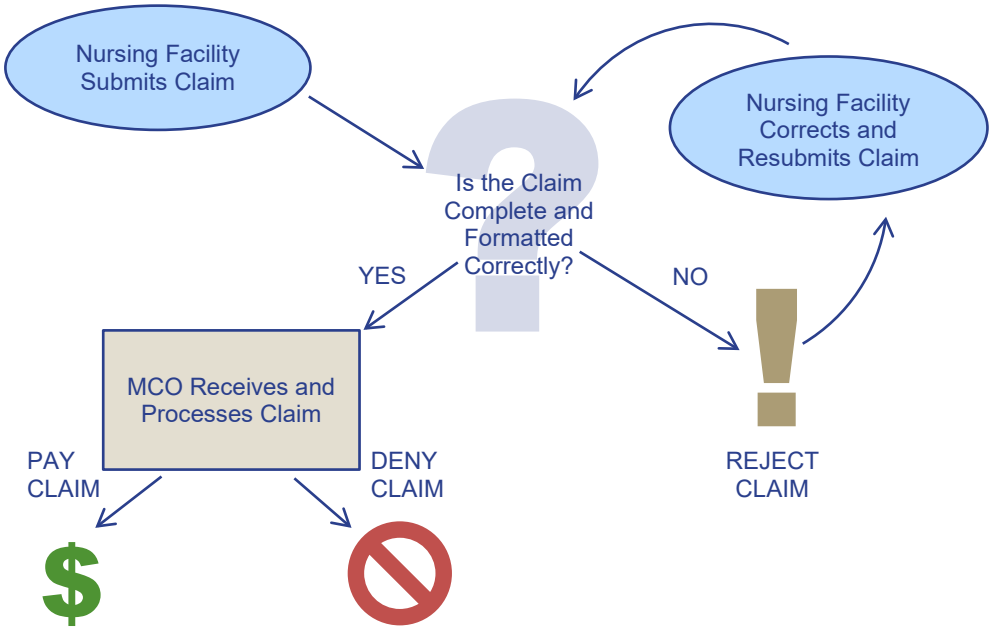


Source: HHSC 2018 Year-End, 334-Day Financial Statistical Reports

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. Figure 3 illustrates the claims adjudication process.

Figure 3: Claims Adjudication Process



Source: OIG Audit

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.

Claims Adjustment Process

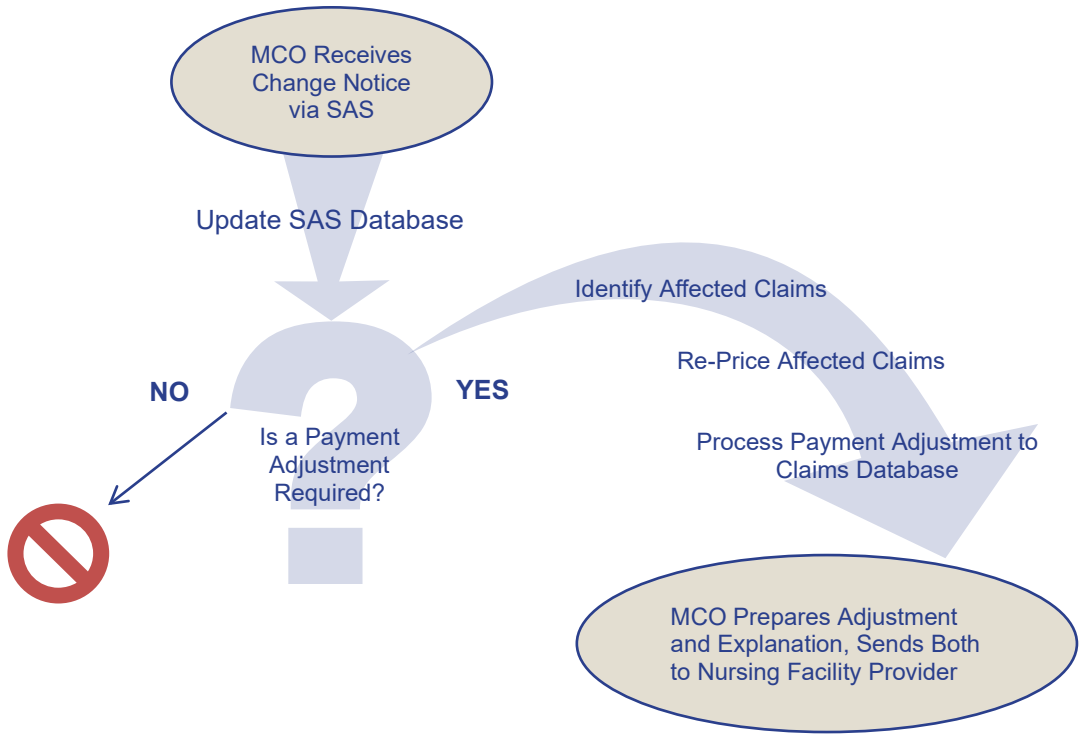
Claim adjustments occur when the MCO makes a change to the claim in response to new information from (a) HHSC, (b) the nursing facility, or (c) the MCO's quality review results.

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

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

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 4 illustrates the payment adjustment process.

Figure 4: Payment Adjustment Process



Source: OIG Audit

Objectives and Scope

The objective of the audits was to determine whether the five MCOs accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

These five audits 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 scope of the audits included clean claims received during 2018, including run-out[3] of retroactive adjustments through April 13, 2019.

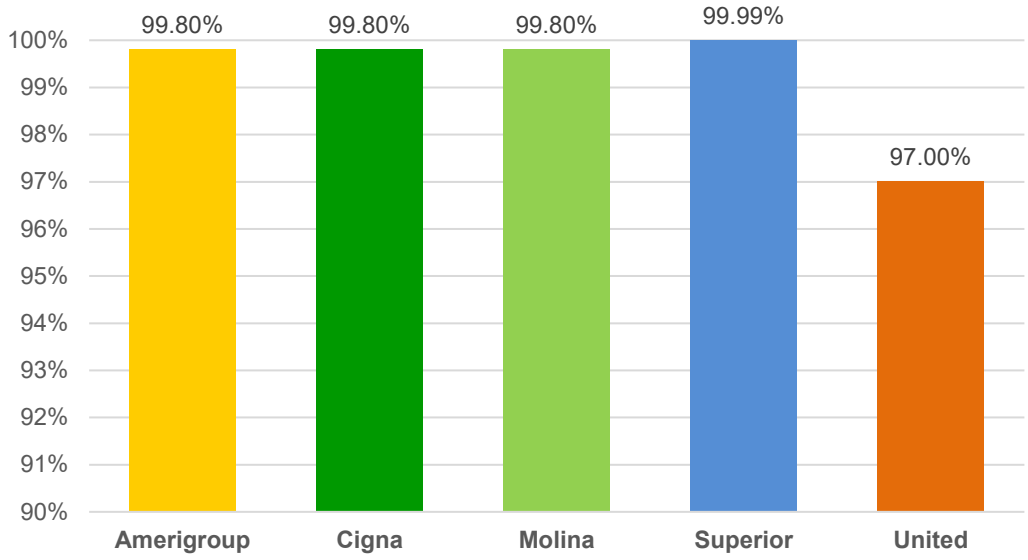
[3] After the claim has been adjudicated there is the possibility of a retroactive payment adjustment. For this audit, the runout period for a retroactive payment adjustment was cut off as of April 13, 2019.

OBSERVATIONS

The populations for the five MCO audits were outlier claims initially paid past the 90-day requirement.[4] For these audits, 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.

Based on self-reported information, the audited MCOs paid most clean claims timely. Figure 5 shows the reported average percentage of clean claims that were adjudicated within 10 days in calendar year.

Figure 5: Self-Reported Average Percentage of All MCO Clean Claims Adjudicated Timely



Source: MCO Nursing Facility Claims Summary Reports

Although the MCOs adjudicated most clean claims within required timelines, in all five audits, MCOs did not always (a) make payment adjustments timely or (b) make retroactive utilization review adjustments timely or at all. Discussion of those two observations follow. Amerigroup had a separate issue related to an internal business rule, which is described in Appendix B.

[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 on which the nursing facility provider submits the claims to the MCO or the HHSC-designated portal.

Observation 1: MCOs Did Not Process Retroactive Claims Adjustments Timely

The audited MCOs did not consistently process claims adjustments within required timelines, which in some cases resulted in delayed payments to nursing facilities. The UMCC requires MCOs to automatically process claims adjustments within 30 days of receiving a SAS notification from HHSC indicating that an adjustment is needed.[6] In addition, the UMCM requires that MCOs automatically adjust claims for other changes, such as service authorizations and applied income.[7] Processing those adjustments timely is important because those adjustments result in payment increases or decreases to nursing facilities.

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

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

OIG Audit tested a statistically valid sample of 30 adjusted claims identified as outliers. The high percentage of late adjustments in the sample was indicative of the MCO's late processing of the claims adjustments. Due to the high percentage of late adjustments, further testing was not necessary. Table 1 shows the sampled claims processed after the 30-day timeframe and the total dollar amount for those delayed claims tested.

Table 1: Sampled Adjustments Processed After 30 Days

MCO	Adjusted Claims Sampled	Total Processed Late	Percentage of Late Adjustments	Total Late Payment
Amerigroup	30	12	40%	$21,225.36
Cigna	29[8]	19	66%	3,773.74
Molina	30	13	43%	16,540.29
Superior	30	22	73%	1,266.27
United	30	27	90%	15,857.60

Source: OIG Audit

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

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

[8] Thirty claims were originally sampled for Cigna, but one was later found to be out of scope.

Although the MCOs eventually made the required adjustments, the percentage of those processed late could have a significant financial impact on nursing facilities. Table 2 projects the results of the statistically valid samples testing to the claims populations to show the potential number of adjustments presumed to have been delayed.

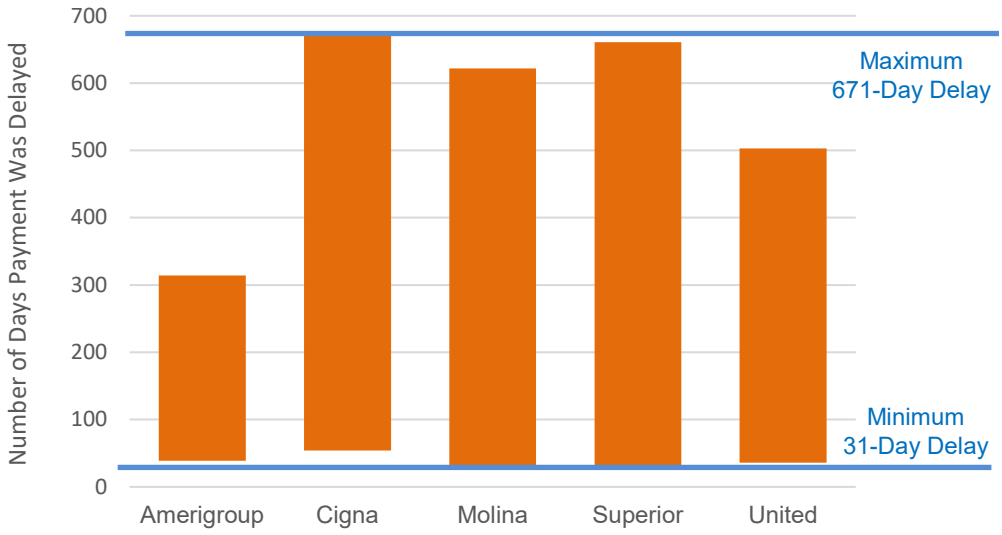
Table 2: Presumable Implications of Adjustments Processed After 30 Days

MCO	Adjusted Claims Population	Percentage of Late Adjustments	Potential Total Late Claims Adjustments[9]
Amerigroup	25,382	40%	6,336
Cigna	722	66%	353
Molina	59,441	43%	16,567
Superior	21,689	73%	12,367
United	52,820	90%	40,220

Source: OIG Audit

Figure 6 shows the range of payment delays for the sampled overdue adjustments for each MCO, including the shortest delays of about a month to the longest delays of nearly two years. Significant delays in payments to nursing facilities could impact the nursing facilities' ability to operate and provide quality care to residents.

Figure 6: Range of Payment Delays for Tested Overdue Adjustments



Source: OIG Audit

[9] Potential total late claim adjustments shown are the lower limit at a 90 percent confidence level.

According to the MCOs, claims adjustment delays occurred because:

- Automatic processes to identify and process all adjustments resulting from SAS notices were not in place.
- An auto-adjustment process required a manual request to run the files.
- Processes did not recognize SAS updates with an indicator of "new," rather than the expected indicator of "update."
- SAS updates and records received from HHSC presented data challenges.

OIG Recommendations and Management Responses

OIG Audit recommended that the MCOs ensure their processes effectively identify and process all retroactive claims adjustments within 30 days of an HHSC SAS notice. All five MCOs indicated that, before the reports were issued, they had already strengthened their processes to ensure adjustments are processed within 30 days.

HHSC Managed Care Compliance and Operations entered into corrective action plans (CAPs) with all five MCOs as a result of the audits. Corrective actions the MCOs outlined in their CAPs for this issue include:

- Identifying explanation codes that were excluded from the automatic retroactive adjustment process.
- Creating a weekly report to capture other updates from SAS file identifying impacted claims that need to be updated.
- Automating the claims adjustment process so it is not dependent on a manual process.
- Dedicating programming and staff resources to respond to inconsistencies in file formats and data files.
- Deploying enhancements for SAS data load improvements and claims reconsideration processes.

Observation 2: MCOs Did Not Process All Nursing Facility Utilization Review RUG Rate Adjustments

The audited MCOs did not consistently process retroactive RUG rate adjustments within required timelines, as a result the nursing facilities were not paid correct Medicaid-funded RUG rates for certain MCO claims.

Retroactive RUG rate adjustments to a claim may be needed due to:

- OIG nursing facility utilization review results
- Nursing facility rate enhancements

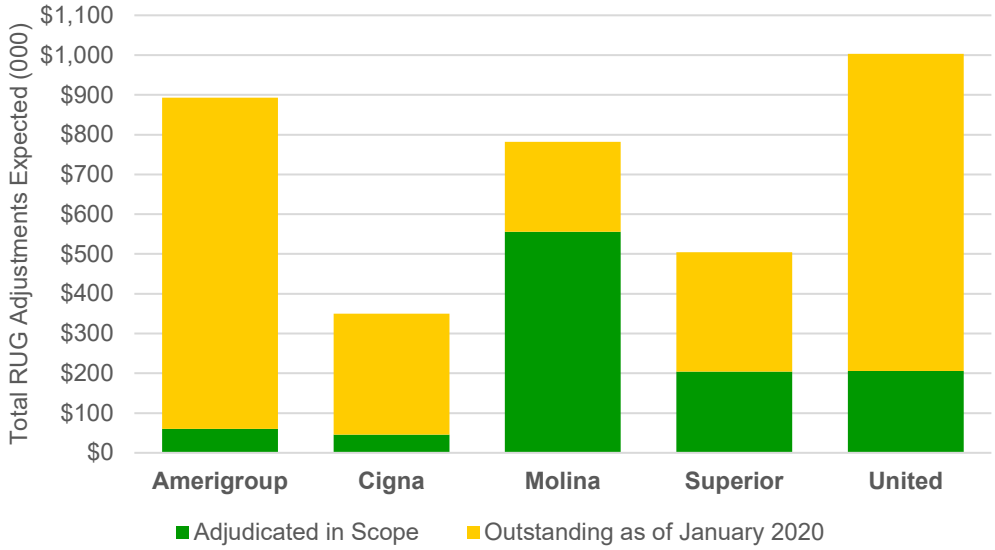
When it identifies a needed RUG rate adjustment, the OIG Utilization Review group notifies TMHP or the MCOs, as applicable, of the needed RUG rate adjustments to adjust the claims. For the MCO overpayments, OIG sends a notification letter to the MCOs to submit payment to the OIG, and MCOs are required to remit any overpayment to OIG. 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.[10]

To quantify the nursing facility utilization review adjustments that were not made, OIG analyzed encounter data with dates of service from March 1, 2015, through February 27, 2018, with utilization review RUG rate adjustments from August 1, 2018, through December 23, 2019.

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

Figure 7 shows, of the expected RUG adjustments identified in the OIG analysis, the proportion completed during the audit scope and those that were still outstanding as of January 2020.

Figure 7: Identified RUG Adjustments



Source: OIG Audit

As of January 2020, the MCOs had not processed expected outstanding adjustments. Specifically, they had not processed $363,259.00 in adjustments expected to increase payments to nursing facilities and $2,563,294.23 in adjustments that were expected to reduce prior payments, and therefore, would result in overpayments that were due back to HHSC. When combined, those changes resulted in a net estimated overpayment amount of $2.2 million. These findings are detailed in Appendix B.

The MCOs identified different causes for not processing these adjustments, including:

- All MCOs had inadequate automatic processes to identify the adjustments
- All MCO systems had difficulties with the SAS update format
- One MCO had an internal business rule not to adjust claims after they were removed from the MCO's active database
- One MCO did not have an automatic process to identify the adjustments

Furthermore, some of the MCOs said they received SAS data from HHSC with overlapping effective and termination dates, which provided challenges in loading and applying data in their claims adjudication system. They also asserted that the prevalence and volume of retroactive SAS data as the root cause for delayed adjustments, noting that, in addition to retroactive RUG assignments, HHSC allows

retroactivity in nursing facility provider rate enhancement level designations, liability insurance add-ons, and member share of cost deductions.

OIG Recommendations and Management Responses

OIG Audit recommended that the five MCOs:

- Ensure the effectiveness of their automatic processes to identify and complete all retroactive RUG rate adjustments within 30 days of the HHS SAS notice.

- Identify and process remaining retroactive RUG rate adjustments included in SAS notifications highlighted in the OIG analysis.

Some MCOs noted their difficulty with the updates was in part due to the confusing nature of the update files they received from TMHP. The MCOs all indicated that they would improve their processes to automatically identify claims adjustments and finalize the outstanding claims.

In October 2020, TMHP changed the location of some files the MCOs use to distribute and submit SAS record changes. TMHP streamlined files and deleted older files to help ensure that the MCOs going forward are utilizing the correct data files. In an effort to prevent the processing of outdated provider files, documents were moved to allow data files to be purged after the 90-day data retention policy.

Corrective actions the MCOs outlined in their CAPs for this issue include:

- Deploying enhancements for SAS data load improvements and claims reconsideration processes.

- Issuing recoveries or additional payments for the specific claims identified by the OIG.

- Performing a prospective implementation of a retroactive adjustment claims process for nursing facilities, modifying our existing process to include SAS data changes received more than 24 months in the past.

- Implementing an automated procedure to process retroactive RUG rate adjustments, when possible.

- Creating a weekly report to capture RUG rate updates from the SAS file identifying impacted claims that need to be updated.

- Updating the weekly adjustment process so that it is not dependent on a manual process.

CONCLUSION

This series of five MCO audits was conducted in response to nursing home complaints that the MCOs processing their STAR+PLUS claims were not processing all claims timely. The audits found that, while MCOs were paying most nursing facility claims timely, there were significant delays in payments in some cases.

As of September 2020, there were approximately 1,211 nursing facilities in Texas, with an average capacity of 114 beds.[11] OIG Audit tested statistically valid sample of 30 adjusted claims identified as outliers for each MCO. That testing identified high error rates, indicating that the five MCOs did not process adjustments within required timeframes. Specifically, within our samples, payments associated with adjustments that were not processed timely resulted in delayed payments to nursing facilities ranging between 31 days and 671 days. Significant delays in payments to nursing facilities could impact the nursing facilities' ability to operate and provide quality care to residents.

In addition, MCOs did not consistently process retroactive OIG nursing facility utilization review RUG rate adjustments as required. Table 3 shows the remaining RUG rate net adjustments (overpayments) to be processed by the MCOs as of January 2020, as a percentage of the total paid nursing facility claims in 2020. While the expected outstanding net adjustments were for periods prior to 2020, this percentage illustrates the low percentage of outstanding adjustments compared to annual nursing facility claims paid.

Table 3: Expected Outstanding Nursing Facility RUG Rate Adjustments

MCO	Total Nursing Facility Paid Claims in 2020	Expected Outstanding Net Adjustment as of January 2020	Percentage of Total Nursing Facility Claims in 2020
Amerigroup	$ 489,506,315.89	$758,289.81	0.15%
Cigna	135,267,244.13	231,373.99	0.17%
Molina	392,521,927.17	315,023.30	0.08%
Superior	409,122,037.27	313,190.95	0.08%
United	403,242,874.28	582,157.21	0.14%

Source: HHSC Q4 2020 Financial Statistical Reports and OIG Audit

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. As a result of the MCOs not processing these adjustments timely, the nursing

[11] Texas Health and Human Services Commission, "HHSC List of Nursing Facility Providers with an Active License as of 9/15/2020," https://web.archive.org/web/20200916064353if_/https:/apps.hhs.texas.gov/providers/directories/NF.xlsx (accessed May 14, 2021).

facilities were not paid the correct amount based on the RUG rate for certain claims.

All five of the MCOs stated in their management responses to their audits that they have made improvements to their processes, which should help shorten the length of time they need within their operations to properly adjudicate RUG rate adjustments.

As of the date of this report, the CAPs had the following status:

- Amerigroup—CAP estimated completion date June 15, 2021
- Cigna—CAP closed April 12, 2021
- Molina—CAP closed April 20, 2021
- Superior—CAP closed May 15, 2021
- United—CAP closed April 5, 2021

Appendix A: Audit Methodology and Criteria

Methodology

The population for the five MCO audits was outlier claims initially paid past the 90-day requirement.[12] For the five audits, 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[13] and (b) the date the final payment is made.

OIG Audit selected statistically valid samples of 30 STAR+PLUS clean claims and 30 STAR+PLUS adjusted claims paid after the 90-day requirement to test the timeliness, accuracy, and causes of any delays in adjudicated claims or processing of payment adjustments. Table 4 shows the populations and samples for each MCO.

Table 4: Audit Populations and Samples by MCO

MCO	Clean Claims Population[14]	Clean Claims Sampled	Adjusted Claims Population[15]	Adjusted Claims Sampled
Amerigroup	699	30	25,382	30
Cigna	25,382	30	722	29
Molina	1,839	30	59,441	30
Superior	113,243	30	21,689	30
United	1,552	30	52,820	30

Source: OIG Audit

To accomplish its objectives, OIG Audit requested information from HHSC and the MCOs, including paid claim data, denied claim data, encounter data, and SAS file documentation.

[12] 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."

[13] Received date is defined as the date on which the Nursing Facility Provider submits the claims to the MCO or the HHSC-Designated Portal.

[14] The population of outlier clean claims initially paid at least 90 days after the claim received date.

[15] The population of outlier adjusted claims processed at least 90 days after the claim received date.

OIG Audit obtained additional information through discussion and interviews with responsible staff at HHSC and the MCOs, 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

Criteria

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

Appendix B: Audit Detailed Findings

Findings Related to Other Adjustments

The five MCOs did not process adjustments tested within 30 days of the HHSC SAS notification as required, which resulted in delayed payments to nursing facilities. A summary of each MCO's cause for the issue, as well as the number of late claims, total late, payment, and length of delay follows:

Amerigroup:

- Process did not properly identify and process SAS notices.
- Payments for 12 of 30 adjustments (40 percent), totaling $21,225.36, were delayed between 39 and 314 days.

Cigna:

- Did not have an automatic process in place to identify and process all payment adjustments resulting from SAS notices.
- Payments for 19 of 29 (66 percent) adjustments, totaling $3,773.74, were delayed between 54 and 671 days.

Molina:

- Its auto-adjustment process required a manual request to run the files. Due to the inconsistency of running the manual request, certain adjustments were not identified during the period.
- Payments for 13 of the 30 adjustments (43 percent), totaling $16,540.29, were delayed between 31 and 622 days.

Superior:

- Its automatic process did not recognize SAS updates with an indicator of "new," rather than the expected indicator of "update," so certain adjustments were not identified during the audit period.
- Payments for 22 of the 30 adjustments (73 percent), totaling $1,266.27, were delayed between 31 and 661 days.

United:

- Experienced data challenges with SAS updates and records received from HHSC. While processes were modified and improved, certain adjustments were not identified timely.
- Payments for 27 of the 30 adjustments (90 percent), totaling $15,857.60, were delayed between 36 and 503 days.

Findings Related to OIG Utilization Review RUG Rate Adjustments

The five MCOs had not processed all identified retroactive RUG rate adjustments during the audit scope, and as of January 16, 2020, all five had RUG rate adjustments still yet to be processed. A summary of each MCO's unprocessed RUG rate adjustments follows:

Amerigroup:[16]

- Originally processed 60 (7 percent) of the 893 identified RUG adjustments in the amount of $80,536.50.
- Had not processed the remaining 833 (93 percent) retroactive RUG adjustments as of January 2020.
- Expected net recovery of $758,289.81, including:
  - Adjustments expected to reduce prior payments by $911,735.02
  - Adjustments expected to increase prior payments by $153,445.21

Cigna:

- Originally processed 46 (13 percent) of the 350 identified RUG adjustments in the amount of $62,819.27.
- Had not processed the remaining 304 (87 percent) retroactive RUG adjustments as of January 2020.
- Expected net recovery of $231,373.99, including:
  - Adjustments expected to reduce prior payments by $280,121.84
  - Adjustments expected to increase prior payments by $48,747.85

Molina:

- Originally processed 556 (71.1 percent) of the 782 identified RUG adjustments in the amount of $586,162.37.
- Had not processed the remaining 226 (28.9 percent) retroactive RUG adjustments as of January 2020.
- Expected net recovery of $315,023.30, including:
  - Adjustments expected to reduce prior payments by $328,473.08
  - Adjustments expected to increase prior payments by $13,449.78

[16] Amerigroup established a business rule to not process retroactive RUG rate adjustments to a claim after the claim has been removed from the 24-month active claim database. This business rule is based on the UMCM requirement to finalize claims within 24 months of the date of service. In addition, Amerigroup asserted that it based its decision on information it shared with and guidance it received from HHSC; however, that information and guidance was not always clear. HHSC has subsequently provided guidance to Amerigroup clarifying the requirement that Amerigroup must make retroactive payment adjustments even if the related claims had dates of service outside of the 24-month claim finalization timeframe in the UMCM.

Superior:

- Originally processed 204 (40 percent) of the 504 identified RUG adjustments in the amount of $207,941.96.
- Had not processed the remaining 300 (60 percent) retroactive RUG adjustments as of January 2020.
- Expected net recovery of $313,190.95, including:
  - Adjustments expected to reduce prior payments by $359,466.12
  - Adjustments expected to increase prior payments by $46,275.17

United:

- Originally processed 206 (21 percent) of the 1,003 identified RUG adjustments in the amount of $745,719.85.
- Had not processed the remaining 797 (79 percent) retroactive RUG adjustments as of January 2020.
- Expected net recovery of $582,157.21, including:
  - Adjustments expected to reduce prior payments by $683,498.17
  - Adjustments expected to increase prior payments by $101,340.96

Appendix C: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Audrey O'Neill, CIA, CFE, CGAP, Chief of Audit and Inspections
- Kacy VerColen, CPA, Deputy Inspector General of Audit and Inspections
- Joel A. Brophy, CIA, CFE, CRMA, CICA, Audit Director
- Bruce Andrews, CPA, CISA, Audit Manager
- Kenneth Johnson, CPA, CIA, CISA, Audit Project Manager
- Viviana Iftimie, CFE, Assistant Audit Project Manager
- Nathaniel Alimole, CPA, Senior Auditor
- Louis Holley, CFE, Staff Auditor
- Toni Gamble, Quality Assurance Reviewer
- Patrick Weir, Data Operations Project Manager
- Tyler Dixon, Investigative Data Analyst
- Fei Hua, Senior Statistical Analyst
- Mo Brantley, Senior Audit Operations Analyst

Report Distribution

Health and Human Services

- Cecile Erwin Young, Executive Commissioner
- Maurice McCreary, Chief Operating Officer
- Victoria Ford, Chief Policy and Regulatory Officer
- Karen Ray, Chief Counsel
- Michelle Alletto, Chief Program and Services Officer
- Nicole Guerrero, Director of Internal Audit
- Stephanie Stephens, State Medicaid Director, Medicaid and CHIP Services
- Shannon Kelley, Associate Commissioner for Managed Care

Appendix D: 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
- Steve Johnson, Chief of Investigations and Reviews

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- Online: https://oig.hhsc.texas.gov/report-fraud
- Phone: 1-800-436-6184

To Contact OIG

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- Mail: Texas Health and Human Services
  Office of Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
- Phone: 512-491-2000