Audit Report

Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments

UnitedHealthcare Community Plan

August 28, 2020
OIG Report No. AUD-20-022

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 $756,877,833.83 to UnitedHealthcare for its administration of the State of Texas Access Reform PLUS (STAR+PLUS) program for nursing facility residents. This audit was of State of STAR+PLUS nursing facility clean claims paid by UnitedHealthcare.

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 UnitedHealthcare accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

WHAT THE OIG RECOMMENDS

UnitedHealthcare should ensure the effectiveness of its automatic process to identify and complete all retroactive RUG rate adjustments and other payment 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 UnitedHealthcare on August 14, 2020. UnitedHealthcare generally agreed with the recommendations and indicated it has taken corrective actions. UnitedHealthcare's responses are included in the report.

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

UnitedHealthcare Community Plan

WHAT THE OIG FOUND

Based on self-reported information, UnitedHealthcare adjudicated almost 97 percent of clean claims within 10 days in calendar year 2018. However, UnitedHealthcare did not always (a) process HHSC Resource Utilization Group (RUG) rate adjustments as required, or (b) process other types of adjustments timely. Specifically:

- An analysis by OIG determined that UnitedHealthcare processed only 206 (21 percent) of the identified RUG adjustments, in the amount of $745,719.85. As of January 16, 2020, UnitedHealthcare had not processed the remaining 797 (79 percent) retroactive RUG adjustments, with an expected net recovery of $582,157.21, which includes adjustments expected to reduce prior payments by $683,498.17 and adjustments expected to increase prior payments by $101,340.96.

  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 a Texas Health and Human Services Commission (HHSC) notification. UnitedHealthcare implemented an automatic process to identify and process all retroactive RUG rate adjustments. United stated that after initial implementation, it experienced data challenges with SAS updates and records received from HHSC. Processes were modified and improved, but certain adjustments were not identified during the audit period. As a result, (a) UnitedHealthcare 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 UnitedHealthcare claims, and (c) related encounters were not adjusted as required.

- UnitedHealthcare did not consistently process other types of claims adjustments from SAS notices within required timelines, which resulted in delayed payments to nursing facilities. Specifically, UnitedHealthcare did not process 27 of 30 (90 percent) adjustments tested within 30 days of the HHSC SAS notification as required. The delayed payment amount on the 27 adjustments totaled $15,857.60.

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 it to the nursing facility to provide the needed information. Once a claim has been paid or denied, MCOs are required to automatically identify and process any 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 UnitedHealthcare Community Plan (UnitedHealthcare),[1] a Medicaid and Children's Health Insurance Program (CHIP) 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. United Healthcare 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 UnitedHealthcare. The STAR+PLUS program served an average of 526,768 members per month in 2018, of whom UnitedHealthcare served an average of 118,965, or 22.6 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 UnitedHealthcare'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

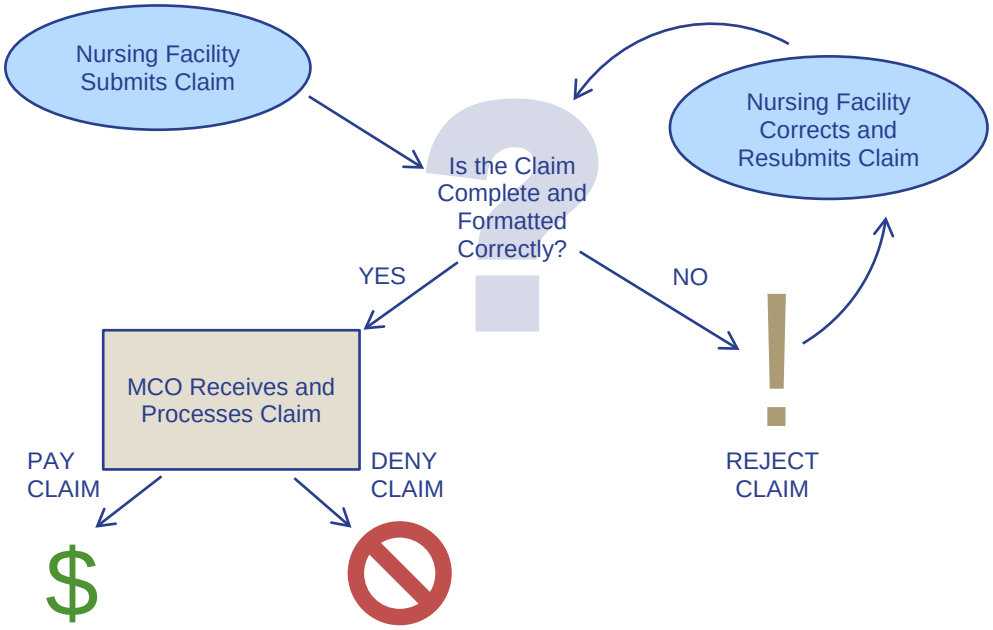
[1] UnitedHealthcare Community Plan collectively refers to UnitedHealthcare Community Health Plan of Texas, L.L.C. and UnitedHealthcare Insurance Company. UnitedHealthcare Community Health Plan of Texas, L.L.C. operates the STAR+PLUS program in Harris, Jefferson, Nueces, and Travis counties. UnitedHealthcare Insurance Company operates the STAR+PLUS program in the Medicaid Rural Services Areas Central and Northeast. Both contracting entities operate under the brand name UnitedHealthcare Community Plan.

daily rate for the resident based on the RUG level of the resident.[2] During 2018, HHSC made capitation payments of $756,877,833.83 to UnitedHealthcare for its administration of the STAR+PLUS program for nursing facility residents.

Claims Adjudication Process

Clean claims are defined as claims for services rendered to a member with the data necessary for the MCO to adjudicate[3] 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] 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.

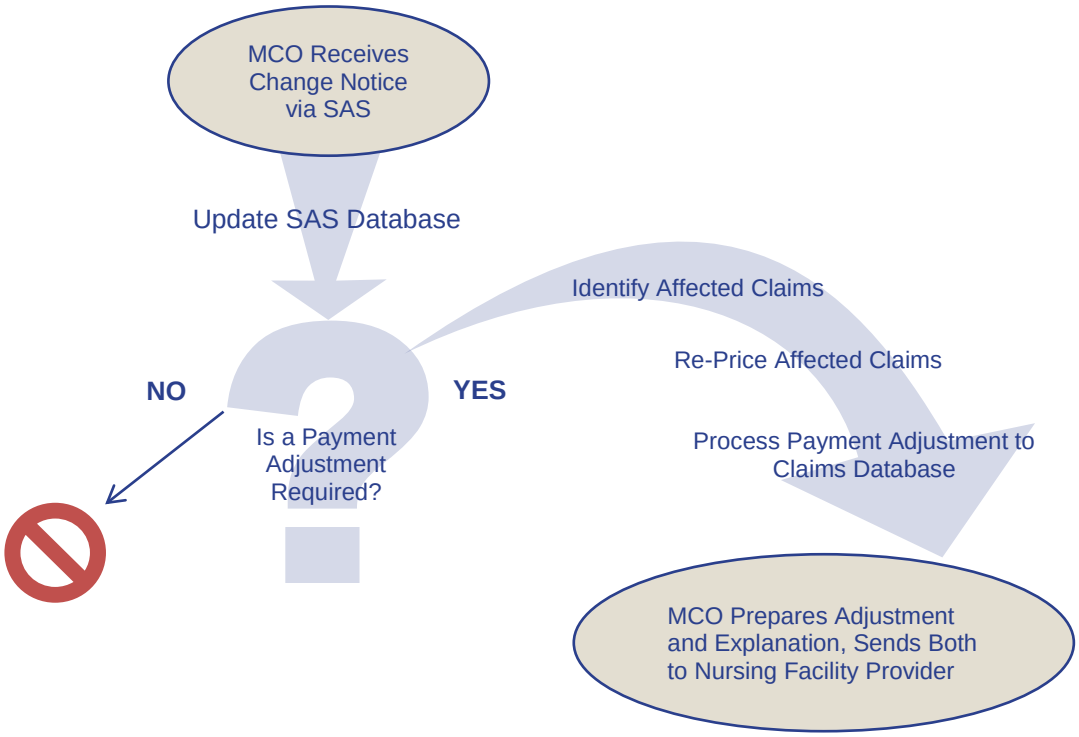
[3] Adjudicated claims are clean claims that have been either paid or denied.

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 UnitedHealthcare 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[4] of retroactive adjustments through April 13, 2019.

Methodology

The audit population for this report is outlier claims initially paid past the 90-day requirement.[5] 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[6] and (b) the date the final payment is made.

The OIG Audit and Inspections Division selected statistically valid samples of 30 UnitedHealthcare STAR+PLUS clean claims and 30 UnitedHealthcare 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 1,552 clean claims and 52,820 adjusted claims identified as outliers.

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

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

- Documentation supporting compliance with contractual requirements
- Information systems that support claims and adjustment processing

[4] 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.

[5] 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."

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

- 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 UnitedHealthcare facility in Sugarland, Texas, on December 9 and 10, 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 UnitedHealthcare in a draft report dated August 14, 2020. UnitedHealthcare generally agreed with the recommendations and indicated it has taken corrective actions. UnitedHealthcare'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 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, UnitedHealthcare adjudicated almost 97 percent of clean claims within 10 days in calendar year 2018. However, UnitedHealthcare did not always (a) process HHSC RUG rate adjustments as required, or (b) process other types of adjustments timely. Specifically, UnitedHealthcare did not process $582,157.21 in net RUG rate adjustments, and for 27 (90 percent) of 30 other types of adjustments tested, UnitedHealthcare did not process the adjustments totaling $15,857.60 timely, which caused delays in payments to nursing facilities that ranged from 36 to503 days.

RETROACTIVE CLAIM ADJUSTMENTS

MCOs are required to automatically identify and process any HHSC retroactive payment adjustments. The MCO has 30 days to review the change and process the HHSC retroactive payment adjustment. UnitedHealthcare did not process 797 of 1,003 (79 percent) of the necessary RUG rate adjustments identified by the nursing facility utilization review. Additionally, UnitedHealthcare did not timely process 27 of 30 (90 percent) other types of tested SAS adjustments initiated by HHSC operations.

Issue 1: UnitedHealthcare 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.[7] However, UnitedHealthcare did not automatically process retroactive OIG nursing facility utilization review RUG rate adjustments as required.

UnitedHealthcare implemented an automatic process to identify and process all retroactive RUG rate adjustments. United Healthcare stated that after initial implementation, it experienced data challenges with SAS updates and records received from HHSC. Processes were modified and improved, but certain adjustments were not identified during the audit period. As a result, (a) UnitedHealthcare did not process all RUG rate adjustments in compliance with the contract, (b) nursing facilities were not paid correct Medicaid-funded RUG rates for certain UnitedHealthcare claims, and (c) related encounters were not adjusted as required. To quantify the claims that were not adjusted, an analysis 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,

[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).

2018, through December 23, 2019. The analysis determined that UnitedHealthcare only processed 206 (21 percent) of the identified RUG adjustments in the amount of $745,719.85. As of January 16, 2020, UnitedHealthcare had not processed the remaining 797 (79 percent) retroactive RUG adjustments, with an expected net recovery of $582,157.21, which includes adjustments expected to reduce prior payments by $683,498.17 and adjustments expected to increase prior payments by $101,340.96.

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

Recommendation 1

UnitedHealthcare should:

- Ensure the effectiveness of its 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

UnitedHealthcare (UHC) understands the importance of timely and accurate payments to all of our providers and continually looks for opportunities to improve speed and accuracy of our claims adjudication.

As contractually required, UHC has always had an automated process in place to identify and process payment adjustments due to SAS data changes. Upon initial implementation most MCOs experienced challenges with SAS data updates and overlapping records from HHSC.

UHC has been working diligently with HHSC since implementation on multiple enhancements including changes in SAS data loading process, claim identification, and claim reconsideration processes resulting in improved automation and improved completeness/timeliness. We are looking forward to HHSC's implementation of SAS data changes effective 9/1/2020 to improve SAS data quality.

Action Plan

- *Ensure the effectiveness of its automatic process to identify and complete all retroactive RUG rate adjustments within 30 days of the HHSC SAS notice.*
  - *Enhancements have been completed and deployed for SAS data load improvements and claims reconsideration processes.*

- *Identify and process remaining retroactive RUG rate adjustments included in SAS notifications highlighted in the OIG analysis.*
  - *Regarding the recommendation to process the remaining RUG rate adjustments, UHC conducted a random audit of overpayments outlined. Through this audit, we identified that over 90% of the reported overpayments have already been processed in previous adjustments. Of the remaining 10%, these include providers on hold due to Change of Ownership (CHOW) in which we cannot process adjustments until released by the state. As per normal process, UHC reviews CHOWs regularly and will reprocess as soon as the providers are released from hold.*

Responsible Manager

Director of Operations

Implementation Date

Completed

Issue 2: UnitedHealthcare Did Not Process Other Retroactive Claims Adjustments Timely

UnitedHealthcare did not consistently process other types of claims adjustments within required timelines, which resulted in delayed payments to nursing facilities. The UMCC requires UnitedHealthcare to automatically process payment adjustments within 30 days of receiving a SAS notification from HHSC indicating that an adjustment is needed.[8] In addition, the UMCM requires that MCOs automatically adjust claims for other changes, such as service authorizations and applied income.[9] Processing those adjustments timely is important because those adjustments result in payment increases or decreases to nursing facilities.

[8] 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).

[9] 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 30 adjusted claims from a total of 1,552 nursing facility claims that were paid more than 90 days after the claim was first submitted by the nursing facility. For those 30 claims, UnitedHealthcare adjudicated the clean claims and later received retroactive adjustments from HHSC via a SAS notification. UnitedHealthcare eventually identified these retroactive changes and processed the associated payment adjustments. However, UnitedHealthcare did not process 27 (90 percent) of the 30 adjustments tested within 30 days of the HHSC SAS notification as required.

Specifically, of the 27 claims tested that UnitedHealthcare did not adjust as required:

- 12 claims required adjustment due to capture system update
- 6 claims required adjustment due to a retroactive change to the RUG rate
- 3 claims required adjustment due to capture fee schedule update
- 2 claims required adjustment due to changes in member eligibility
- 2 claims required adjustment due to steady state cleanup project
- 1 claim required adjustment due to retroactive changes to the applied income of the member
- 1 claim required adjustment due to nursing facility service authorization

UnitedHealthcare stated that these delays occurred because it experienced data challenges with SAS updates and records received from HHSC. While processes were modified and improved, certain adjustments were not identified timely. As a result, payments for those 27 claims, which totaled $15,857.60, were delayed between 36 and 503 days.

Recommendation 2

UnitedHealthcare should ensure its automatic process effectively identifies and processes all retroactive payments within 30 days of an HHSC SAS notice.

Management Response

As noted in the first response, the HHSC data challenges impeded UHC's ability to load data timely which resulted in delayed claims turnaround time. Manual processes were implemented as an interim solution, but some claims exceeded the 30-day turnaround time requirement. Gaps were identified and consistently addressed. A major enhancement to the claim adjustment process was implemented in 2018, which has significantly helped to close gaps and prevent missed adjustments in the future. In addition, HHSC recognized the challenges of overlapping SAS data records to MCOs and will be deploying changes to the SAS data effective September 1, 2020.

Action Plan

- *Enhancements have been completed and deployed for SAS data load improvements and claims reconsideration processes. Since deployment of our enhancements, we have experienced multiple quarters of compliance with timeliness metrics.*

- *We are looking forward to HHSC's implementation of SAS data changes effective 9/1/2020 to further improve SAS data quality and timeliness.*

Responsible Manager

Director of Operations

Implementation Date

Completed

CONCLUSION

UnitedHealthcare adjudicated and paid most clean claims accurately and timely. Based on self-reported information, UnitedHealthcare adjudicated almost 97 percent of clean claims within 10 days during calendar year 2018. However, UnitedHealthcare did not process all retroactive adjustments as required by contract. Specifically, UnitedHealthcare did not:

- Make required RUG rate adjustments. As of January 16, 2020, UnitedHealthcare had processed 206 (21 percent) of the identified RUG adjustments in the amount of $745,719.85. UnitedHealthcare had not processed the remaining 797 (79 percent) retroactive RUG adjustments with an expected net recovery of $582,157.21. As a result, nursing facilities were not paid correctly, and related encounters were not adjusted.

- Retroactively process 27 of 30 payment adjustments tested (90 percent) within 30 days of the HHSC SAS notification, as contractually required. The delayed payment amount for those 27 claims totaled $15,857.60.

The OIG Audit and Inspections Division offered recommendations to UnitedHealthcare, which, if implemented, will result in UnitedHealthcare 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 UnitedHealthcare to meet contractual requirements related to its nursing facility claims processing function. In addition, audit findings in this report may be subject to OIG administrative enforcement measures, including administrative penalties.[10,11]

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

[10] 1 Tex. Admin. Code § 371.1603 (May 1, 2016).

[11] 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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Appendix B: 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:

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- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Juliet Charron, Chief of Strategy
- Steve Johnson, Chief of Inspections and Reviews

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