

Audit Report

**Processing of  
Outlier Nursing Facility  
STAR+PLUS  
Claims and Adjustments**

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**Amerigroup Texas, Inc., and  
Amerigroup Texas Insurance  
Company**



**Inspector  
General**

**Texas Health  
and Human Services**

**August 28, 2020  
OIG Report No. AUD-20-021**

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## HHS OIG

TEXAS HEALTH AND HUMAN  
SERVICES  
OFFICE OF  
INSPECTOR GENERAL

August 28, 2020

Audit Report

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

*Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company*

## 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 \$711,445,858 to Amerigroup for its administration of the State of Texas Access Reform PLUS (STAR+PLUS) program for nursing facility residents. This audit was of STAR+PLUS nursing facility outlier claims Amerigroup paid.

The audit focused on outlier claims defined as (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 SAS notice, and (c) unprocessed RUG rate retroactive adjustments. The audit objective was to determine whether Amerigroup timely and accurately adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

## WHAT THE OIG RECOMMENDS

Amerigroup should strengthen its process for identifying and processing retroactive rate adjustments to ensure it meets requirements established by the Uniform Managed Care Contract and Uniform Managed Care Manual.

## MANAGEMENT RESPONSE

OIG presented preliminary audit results, issues, and recommendations to Amerigroup in a draft report dated July 22, 2020. Amerigroup did not agree with the audit findings in Issue 1 but indicated it will take corrective actions and agreed with the recommendation in Issue 2. Amerigroup's action plans are included in the report following each recommendation and its full response is in Appendix A.

For more information, contact:  
[OIG.AuditReports@hhsc.state.tx.us](mailto:OIG.AuditReports@hhsc.state.tx.us)

## WHAT THE OIG FOUND

Amerigroup adjudicated and paid most clean claims accurately and timely. Additionally, based on information self-reported in the Texas Health and Human Services Commission (HHSC) Defined Claims Summary Report, Amerigroup adjudicated an average of 99.8 percent of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by the Uniform Managed Care Contract.

However, Amerigroup did not always (a) process HHSC Resource Utilization Group (RUG) rate adjustments as required, or (b) process other types of adjustments. Specifically:

- Amerigroup did not (a) process RUG rate adjustments in compliance with the contract, (b) pay nursing facilities correct Medicaid-funded RUG rates for its claims, and (c) adjust related encounters as appropriate. An analysis by the Office of Inspector General (OIG) determined that Amerigroup only processed 60 of the identified RUG adjustments in the amount of \$80,536.50. As of January 16, 2020, Amerigroup had not processed the remaining 833 retroactive RUG adjustments, expected to reduce prior payments by \$758,289.81.

Amerigroup is required by contract to retroactively process RUG rate adjustments automatically no later than 30 days after receipt of an HHSC notification. Amerigroup has 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. That business rule is based on the Uniform Managed Care Manual requirement to finalize claims within 24 months of the date of service, and on information Amerigroup shared with and guidance it received from HHSC. However, that information and guidance was not always clear, and the Uniform Managed Care Contract requires an automatic retroactive adjustment without a time limitation.

- Based on the outlier claims audit results, Amerigroup did not consistently process other types of claims adjustments from SAS notices within required timelines, which resulted in delayed payments to nursing facilities. Specifically, Amerigroup did not process 12 of 30 (40 percent) adjustments tested within 30 days of the HHSC SAS notification as required. The delayed payment amount on the 12 adjustments totaled \$21,225.36.

## BACKGROUND

Nursing facilities submit claims to managed care organizations (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 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 Amerigroup Texas, Inc., and Amerigroup Texas Insurance Company (Amerigroup),<sup>1</sup> 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. Amerigroup was one of five MCOs audited to address this concern. All five MCOs are scheduled for audit in state fiscal year 2020. Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

STAR+PLUS is a Texas Medicaid managed care program for members with disabilities or who are age 65 or older. Five MCOs in Texas participate in the STAR+PLUS program: Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas, Superior HealthPlan, and United Healthcare Community Plan. The STAR+PLUS program served an average of 526,768 members per month in 2018, of whom Amerigroup served an average of 131,437, or 25 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 Amerigroup's administration of health care services through STAR+PLUS. MCS promulgates policy and rules related to the participation of nursing facilities in Medicaid, and, in the case of managed care, administers those policies and rules through provisions of the Texas Uniform Managed Care Contract (UMCC) and the Uniform Managed Care Manual (UMCM).

Nursing facilities are primarily reimbursed through a managed care model. For Medicaid residents in nursing facilities who are members of an MCO, HHSC makes a monthly capitation payment to the MCO for each resident. The MCO, in turn, receives claims from the nursing facility and reimburses the nursing facility a daily rate for the resident based on the RUG level of the resident.<sup>2</sup> During 2018,

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<sup>1</sup> Amerigroup collectively refers to Amerigroup Texas, Inc. and Amerigroup Insurance Company. Amerigroup Texas, Inc. operates the STAR+PLUS Program in Bexar, El Paso, Harris, Jefferson, Lubbock, Tarrant, and Travis counties. Amerigroup Insurance Company operates the STAR+PLUS program in the Medicaid Rural Service Area West. Both contracting entities operate under the brand name Amerigroup.

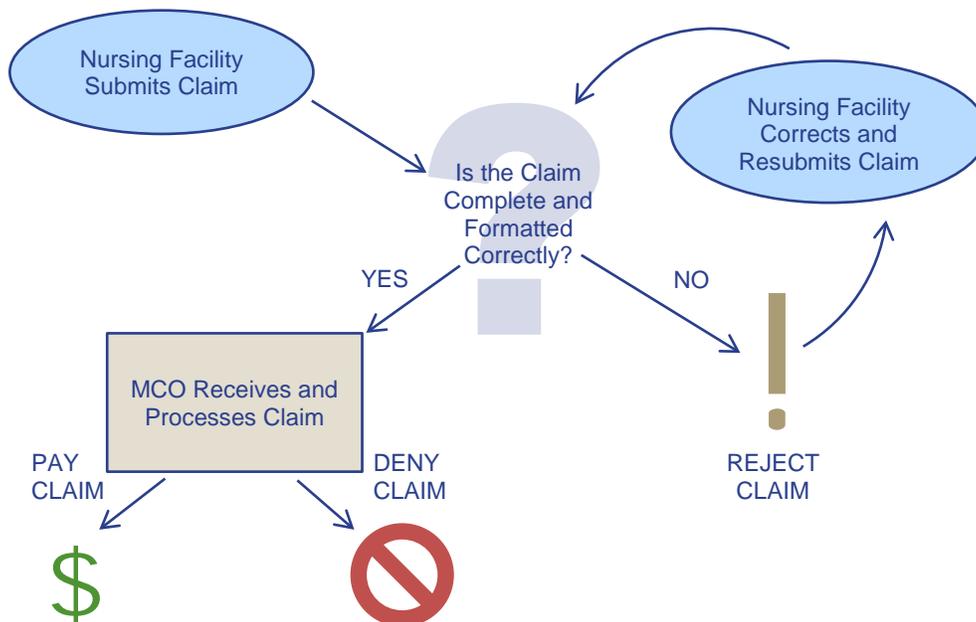
<sup>2</sup> HHSC determines the payment amount associated with a specific RUG level. RUG levels are assigned based on the level of care needed by the member.

HHSC made capitation payments of \$711,445,858.03 to Amerigroup 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 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

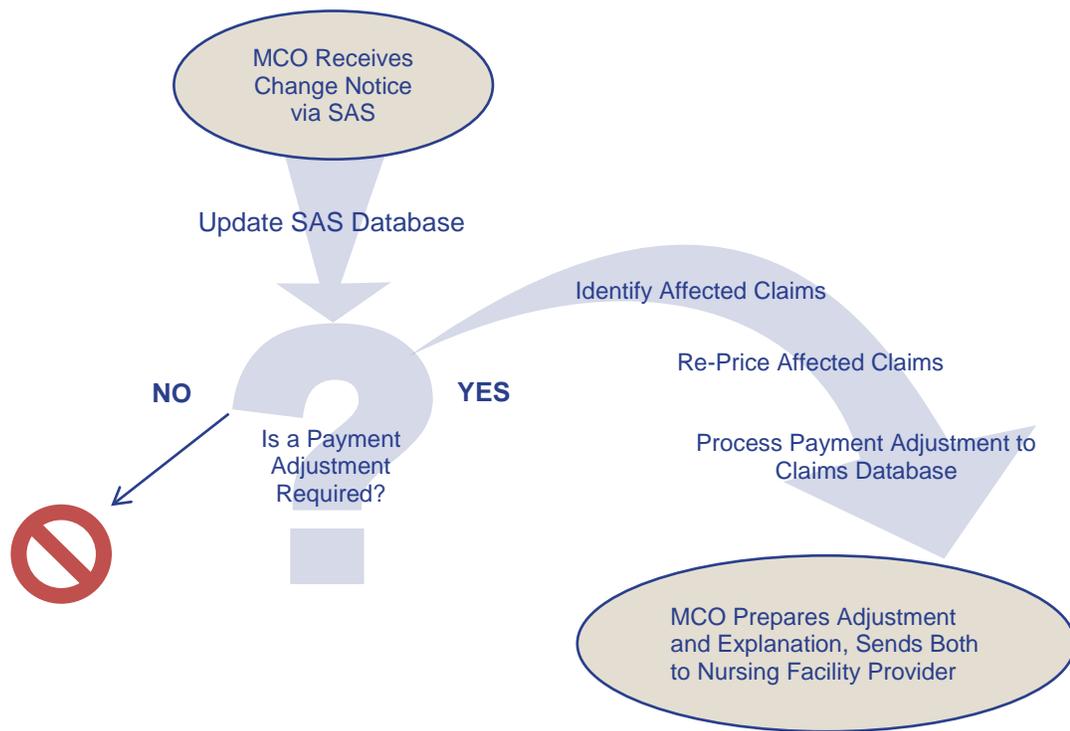
The MCO must use the Initial and Daily Service Authorization System (SAS) provider and rate data, determined by HHSC, in the adjudication of nursing facility claims. After a claim is adjudicated, new information may require it to be adjusted. MCOs can only adjust an adjudicated claim.

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

This audit focused on outlier claims defined as (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<sup>3</sup> of retroactive adjustments through April 13, 2019.

## Methodology

The audit population for this report is outlier claims initially paid past the 90-day requirement.<sup>4</sup> 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<sup>5</sup> and (b) the date the final payment is made.

The OIG Audit and Inspections Division selected from the outlier claims a statistically valid sample of 30 Amerigroup STAR+PLUS clean claims and 30 Amerigroup 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 699 clean claims and 25,382 adjusted claims identified as outliers.

To accomplish its objectives, the OIG Audit and Inspections Division requested information from HHSC and Amerigroup, 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 Amerigroup, as well as through collection and review of:

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

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<sup>3</sup> 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.

<sup>4</sup> 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."

<sup>5</sup> Received date is defined as the date 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 Amerigroup facility in Austin, Texas, on July 15 and 16, 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 Amerigroup in a draft report dated July 22, 2020. Amerigroup did not agree with the audit findings described in Issue 1, but indicated it would take corrective actions, and agreed with the recommendations in Issue 2. Amerigroup's management responses are included in the report following each recommendation. Amerigroup's full management response letter is presented in Appendix A.

## Criteria

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

- Uniform Managed Care Contract, Attachment A, v.2.24 (2017) through v. 2.25.1 (2018)
- Uniform Managed Care Contract, Attachment B-1, v.2.24 (2017) through v. 2.25 (2018)
- STAR+PLUS Expansion Contract, v.1.28 (2017) through v.1.29 (2018)
- STAR+PLUS Medicaid Rural Service Area Contract, v. 1.13 (2017) through v. 1.14 (2018)
- Uniform Managed Care Manual, Chapter 2.3, v. 2.1 (2015)

## Auditing Standards

### Generally Accepted Government Auditing Standards

The OIG Audit and Inspections Division conducted this audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the

audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the issues and conclusions based on our audit objectives. The OIG Audit and Inspections Division believes the evidence obtained provides a reasonable basis for our issues and conclusions based on our audit objectives.

## AUDIT RESULTS

Based on information self-reported in the HHSC Defined Claims Summary Report, Amerigroup adjudicated an average of 99.8 percent of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by its UMCC contract. However, Amerigroup did not always (a) process HHSC RUG rate adjustments as required, or (b) process other types of adjustments timely. As a result, Amerigroup did not process \$758,289.81 in net adjustments, which includes adjustments expected to reduce prior payments by \$911,735.02 and adjustments expected to increase prior payments by \$153,445.21. The other adjustments not timely processed resulted in payments to nursing facilities totaling \$21,225.36 being delayed between 39 and 314 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. Amerigroup did not process 833 of 893 (93 percent) of the necessary RUG rate adjustments identified by the nursing facility utilization review. Additionally, Amerigroup did not timely process 12 of 30 (40 percent) outlier claims for other types of tested SAS adjustments initiated by HHSC operations.

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#### **Issue 1: Amerigroup Did Not Process All Nursing Facility Utilization Review RUG Rate Adjustments**

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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.<sup>6</sup> However, Amerigroup did not automatically process retroactive OIG nursing facility utilization review RUG rate adjustments as required.

Specifically, 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.<sup>7</sup> 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

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<sup>6</sup> 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).

<sup>7</sup> Uniform Managed Care Manual, Chapter 2.0, Section IX, v. 2.6 (Sept. 1, 2016).

always clear.<sup>8</sup> The UMCC requires an automatic retroactive adjustment without a time limitation.

In addition, while the UMCC requires MCOs to complete all audits of provider claims within two years of the claim, it also establishes that “the two-year limitation does not apply when the officials or entities identified in Attachment A, Section 9.02(c), conclude an examination, audit, or inspection of a provider more than two years after the MCO received the claim. ... If an exception to the two-year limitation applies, then the MCO may recoup related payments from providers.”<sup>9</sup> OIG is listed as an official in the referenced attachment.

As a result of its business rule, (a) Amerigroup did not process RUG rate adjustments in compliance with the contract, (b) the nursing facilities were not paid correct Medicaid-funded RUG rates for the Amerigroup claims, and (c) related encounters were not adjusted as required. To quantify the claims that were not adjusted, an analysis of encounter data by OIG Data and Technology looked at dates of service from March 1, 2015, through February 27, 2018, with utilization review RUG rate adjustments from August 1, 2018, through December 23, 2019. The analysis determined that Amerigroup only processed 60 of the identified RUG adjustments in the amount of \$80,536.50. As of January 16, 2020, Amerigroup had not processed the remaining 833 (93 percent) retroactive RUG adjustments, with an expected net recovery of \$758,289.81, which includes adjustments expected to reduce prior payments by \$911,735.02 and adjustments expected to increase prior payments by \$153,445.21.

### **Recommendation 1**

Amerigroup should:

- Strengthen its process for identifying and processing retroactive rate adjustments.
- Identify and process remaining retroactive RUG rate adjustments included in SAS notifications highlighted in the OIG analysis.

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<sup>8</sup> In communication Amerigroup shared with HHSC, Amerigroup referenced its plans for making automatic retroactive adjustments based on the 24-month look-back period. HHSC did not comment on that specific plan element, but HHSC did approve Amerigroup’s plan as a whole. HHSC has subsequently provided guidance 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.

<sup>9</sup> Uniform Managed Care Contract, Attachment B-1, § 8.1.18.5, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018).

## **Management Response**

### Action Plan

*Amerigroup recommends 1) a prospective implementation of a retro adjustment claims process for NF modifying our existing process to include SAS data changes received >24 months in history, 2) issue recoveries or additional payments for the specific claims identified by the OIG in Issue 1.*

### Responsible Manager

*Chief of Staff / Interim Regional Vice President of Operations*

### Target Implementation Date

*Amerigroup will work with HHSC to approve a Scope of Work (SOW) document for the required change to our retro claims process. Initial estimate of completion is 6 months post SOW approval from HHSC.*

## **Auditor Comment**

In Amerigroup's full response, Amerigroup management indicated that they disagree with this finding. See Appendix A for Amerigroup's response and reasons for disagreement.

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

The OIG Audit and Inspections Division has reviewed the work supporting the report findings and stands by its conclusions. As Managed Care Compliance and Operations communicated to Amerigroup on July 8, 2020, Attachment B of the State of Texas Uniform Managed Care Contract takes precedence over HHSC's Uniform Managed Care Manual. Attachment B states that MCOs must retroactively adjust payments to nursing facilities within 30 days of receipt of HHSC notifications, without exception. This requirement includes adjustments for claims with dates of service outside of the 24-month claim finalization timeframe in the UMCM. In addition, based on a further review of adjustment data as of August 2020, Amerigroup continues to not process certain required RUG rate adjustments.

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## Issue 2: Amerigroup Did Not Process Other Retroactive Claims Adjustments Timely

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Amerigroup did not process 12 of 30 (40 percent) adjustments tested within 30 days of the HHSC SAS notification as required, which resulted in delayed payments to nursing facilities. The UMCC requires Amerigroup to automatically process payment adjustments within 30 days of receiving a SAS notification from HHSC indicating that an adjustment is needed.<sup>10</sup> In addition, the UMCM requires that MCOs automatically adjust claims for other changes, such as service authorizations and applied income.<sup>11</sup> 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 selected a random sample of 30 adjusted claims from a total of 699 nursing facility claims that were paid more than 90 days after the claim was first submitted by the nursing facility. Amerigroup did not process 12 (40 percent) of the adjustments tested within 30 days of the HHSC SAS notification as required because when Amerigroup first adjudicated the claims, it determined that the members were not enrolled in or eligible for services in the STAR+PLUS program for the dates of service.

HHSC provided SAS notices of retroactive eligibility for the dates of service after the initial denials; however, Amerigroup did not automatically process the retroactive adjustments within 30 days of the SAS notice as required by the UMCC. Subsequently, the nursing facilities resubmitted the 12 claims and Amerigroup paid those resubmitted claims as new claims, instead of retroactive payment adjustments to prior denied claims.

These delays occurred because Amerigroup's process did not properly identify and process SAS notices. As a result, payments for those 12 claims, which totaled \$21,225.36, were delayed between 39 and 314 days.

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<sup>10</sup> 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).

<sup>11</sup> Uniform Managed Care Manual, Chapter 2.3, Section VIII.A, v. 2.1 (Mar. 1, 2015).

## **Recommendation 2**

Amerigroup should strengthen its current process to identify and process all retroactive payment adjustments within 30 days of an HHSC SAS notice.

## **Management Response**

### Action Plan

*In April 2020, Amerigroup identified explanation (EX) codes that were excluded in the automatic retroactive adjustment process. The excluded EX codes included some explanation codes that were tied to claims that denied for member eligibility. The identified EX codes were removed from the exclusion list for the retroactive adjustment process. This change ensures that all members with retroactive eligibility with denied claims, due to their eligibility at the time of claim payment, will be captured in the retroactive adjustment process.*

### Responsible Manager

*Medicaid State Operations Director*

### Implementation Date

*Amerigroup implemented the change in April 2020.*

## CONCLUSION

Based on information self-reported in the HHSC Defined Claims Summary Report, Amerigroup adjudicated an average of 99.8 percent of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by its UMCC contract.

However, Amerigroup did not process all retroactive adjustments as required by contract. Specifically, Amerigroup did not:

- Make all required RUG rate adjustments. As of January 16, 2020, Amerigroup had only processed 60 (7 percent) of the identified RUG adjustments in the amount of \$80,536.50. Amerigroup had not processed the remaining 833 (93 percent) retroactive RUG adjustments with an expected net recovery of \$758,289.81. As a result, nursing facilities were not paid correctly, and related encounters were not adjusted.
- Retroactively process 12 of 30 payment adjustments tested (40 percent) within 30 days of the HHSC SAS notification, as contractually required. The delayed payment amount totaled \$21,225.36.

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

For instances of noncompliance identified in this audit report, MCS may consider tailored contractual remedies to compel Amerigroup to meet contractual requirements related to its nursing facility claims function. In addition, audit findings in this report may be subject to OIG administrative enforcement measures, including administrative penalties.<sup>12,13</sup>

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

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<sup>12</sup> 1 Tex. Admin. Code § 371.1603 (May 1, 2016).

<sup>13</sup> Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

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## Appendix A: Amerigroup's Management Response

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August 19, 2020

Joel A. Brophy, CIA CFE CRMA CICA  
Audit Director  
Texas Health and Human Services Commission (HHSC)  
Office of Inspector General, Audit Division  
P.O. Box 85200  
Austin, Texas 78708-5200

*Re: Management Responses for the OIG Audit "Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments – Amerigroup Texas, Inc. & Amerigroup Texas Insurance Company."*

Dear Mr. Brophy:

Amerigroup adjudicated and paid nursing facility (NF) clean claims accurately and timely. Based on HHSC's defined Claims Summary Report (CSR), Amerigroup adjudicated an average of 99.8 percent of NF clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by the Uniform Managed Care Contract.

The OIG sampling included 26,104 outlier claims. Outlier claims are defined as 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 SAS notice, and (c) unprocessed nursing facility utilization review RUG rate retroactive adjustments. Of the outlier sampling, 833 claims were included in Issue 1 and 12 in Issue 2 representing 0.16% and 0.005% respectively of the total paid NF custodial claims for the audit time period by Amerigroup.

Amerigroup respectfully disagrees with OIG's audit findings on Issue 1. The primary dispute in the audit that resulted in Issue 1 aligned with Amerigroup's business rule to apply a 24 month lookback period for all SAS data changes and the corresponding claims adjustments. Amerigroup's business rules were developed based on the requirement in the HHSC Uniform Managed Care Manual (UMCM) Chapter 2.3, Nursing Facility Claims Manual, which states, "The MCO is required to finalize all claims, including Appealed Claims, within 24 months from the date of service." In addition, UMCM Chapter 8.6, State Mandate Requirements for STAR+PLUS Nursing Facility Provider, states "The MCO will issue a final disposition of all pending and appealed claims no later than 24 months after the date of service."

Amerigroup conducted a legal and regulatory review of our ability to extend the retrospective review period of these nursing facility claims beyond the 24 month period. No exceptions were found to HHSC's contract language that requires an MCO to complete all audits of a provider claim no later than two years after receipt of a clean claim, except for cases involving Fraud, Waste, or Abuse that were not discovered within the two-year period following receipt of the claim, or when HHSC determines that an

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audit of a provider may be required more than two years after the MCO received the claim, or when HHSC has recovered a capitation from an MCO based on a Member's ineligibility.

Since Amerigroup has not received any such direction from HHSC to override the state contract prohibition of a 2-year lookback period, and as there is no known Fraud, Waste, or Abuse involving these claims, Amerigroup does not believe it was allowed to recoup these claims payments from the providers, without causing a breach of contract.

Amerigroup was placed on an escalated NF Corrective Action Plan (CAP) by HHSC on July 8, 2015 that was later accepted on February 4, 2016 and closed on June 27, 2018. During the remediation activities related to the CAP, all of Amerigroup's governing business rules for SAS data management, new day claims, retro adjustments and other NF functions were reviewed in detail by HHSC and TMHP consultants. The 24 month lookback period was part of the business rules that HHSC and TMHP reviewed and approved. As explicitly shown in the confidential and proprietary supporting documentation provided to both OIG and HHSC, HHSC approved Amerigroup's complete business rules governing the NF claims process.

Amerigroup does not dispute its obligation to adhere to Fraud, Waste and Abuse exceptions in the managed care contract. There is a clear delineation of new day and retro adjustment claim processing for custodial NF's verses an audit conducted by an authority or official.

The following statement is included in the audit report as the reason Amerigroup should have adjusted claims past the two-year period. "If an exception to the two-year limitation applies, then the MCO may recoup related payments from providers. OIG is listed as an official in the referenced attachment." Amerigroup agrees with this when Amerigroup is notified that the recoupment is 1) in cases of Fraud, Waste or Abuse that the MCO did not discover within the two-year period following receipt of a claim; (2) the RAC or the officials and entities identified in Section 2.3.1 conclude an examination, audit, or inspection of a Provider more than two years after the MCO received the claim; or (3) if HHSC has recovered a payment from the MCO based on the Member's Program ineligibility.

Amerigroup was not notified that any of these three existed. Amerigroup was sent a SAS update notice, which follows the standard claims requirement.

As a secondary dispute to Issue 1, Amerigroup disagrees with 85 (10%) of the 833 missed RUG adjustments. Of the 85, Amerigroup appropriately adjusted 36 for the recovery or payment amounts expected by the OIG, 48 were adjusted by Amerigroup with variances in the final payment amounts expected by the OIG, and 1 was for Medicare coinsurance (REV0101) and is out of scope to the audit.

OIG is recommending that Amerigroup, "Strengthen its process for identifying and processing retroactive rate adjustments." Based on the OIG's recommendations, Amerigroup will be modifying our existing NF claims processes to adhere to the new interpretation of the contract requirements. Amerigroup will also consult with HHSC about an amendment to State Contract to make the contract language clear that the 24 month lookback period does not apply in these circumstances.

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## Issue 1: Amerigroup Did Not Process All Nursing Facility Utilization Review RUG Rate Adjustments

Recommendation 1:

Amerigroup should:

- Strengthen its process for identifying and processing retroactive rate adjustments.
- Identify and process remaining retroactive RUG rate adjustments included in SAS notifications highlighted in the OIG analysis.

### Action Plan

Amerigroup recommends 1) a prospective implementation of a retro adjustment claims process for NF modifying our existing process to include SAS data changes received >24 months in history, 2) issue recoveries or additional payments for the specific claims identified by the OIG in Issue 1.

### Responsible Manager

Greg Thompson

### Target Implementation Date

Amerigroup will work with HHSC to approve a Scope of Work (SOW) document for the required change to our retro claims process. Initial estimate of completion is 6 months post SOW approval from HHSC.

## Issue 2: Amerigroup Did Not Process Other Retroactive Claims Adjustments Timely

Recommendation 2: Amerigroup should strengthen its current process to identify and process all retroactive payment adjustments within 30 days of an HHSC SAS notice.

### Action Plan

In April 2020, Amerigroup identified explanation (EX) codes that were excluded in the automatic retroactive adjustment process. The excluded EX codes included some explanation codes that were tied to claims that denied for member eligibility. The identified EX codes were removed from the exclusion list for the retroactive adjustment process. This change ensures that all members with retroactive eligibility with denied claims, due to their eligibility at the time of claim payment, will be captured in the retroactive adjustment process.

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2505 N Hwy 360, Suite 300  
Grand Prairie, TX 75050  
512.382.4989

[www.amerigroup.com](http://www.amerigroup.com)

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Responsible Manager

Jessica McFarlin

Target Implementation Date

Amerigroup implemented the change in April 2020.

Sincerely,

A handwritten signature in black ink that reads "Patrick Sturdivant". The signature is fluid and cursive, with a large initial "P" and "S".

Patrick Sturdivant  
President, Amerigroup Texas

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## Appendix B: Report Team and Distribution

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### 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, Assistant Deputy Inspector General of Audit and Inspections
- Joel A. Brophy, CIA, CFE, CRMA, CICA, Audit Director
- Bruce Andrews, CPA, CISA, Audit Manager
- Kanette Blomberg, CPA, 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
- Anton Dutchover, CPA, Quality Assurance Reviewer
- Patrick Weir, Program 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, Jr., 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

- Camisha Banks, Interim Director, Managed Care Compliance and Operations, Medicaid and CHIP Services
- Katherine Scheib, Deputy Associate Commissioner, Medicaid and CHIP Services

#### Amerigroup

- Patrick Sturdivant, President
- Greg Thompson, Chief of Staff and Interim Regional Vice President of Operations
- Jessica McFarlin, Director II, Medicaid State Operations
- Katherine Stevenson, Director II, Compliance and Regulatory
- Stephen Ford, Managing Associate General Counsel

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## Appendix C: OIG Mission, Leadership, and Contact Information

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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

### To Obtain Copies of OIG Reports

- OIG website: [ReportTexasFraud.com](http://ReportTexasFraud.com)

### To Report Fraud, Waste, and Abuse in Texas HHS Programs

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

### To Contact OIG

- Email: [OIGCommunications@hhsc.state.tx.us](mailto:OIGCommunications@hhsc.state.tx.us)
- Mail: Texas Health and Human Services  
Office of Inspector General  
P.O. Box 85200  
Austin, Texas 78708-5200
- Phone: 512-491-2000