TEXAS HEALTH AND HUMAN SERVICES

# OFFICE OF INSPECTOR GENERAL

AUDIT REPORT

# MEDICAID STAR+PLUS NURSING FACILITY RISK GROUPS

*Reporting Errors Affected Risk Group Assignments*

**March 30, 2020**

**OIG Report No. AUD-20-008**

**HHS OIG**
**TEXAS HEALTH AND HUMAN SERVICES**
**OFFICE OF INSPECTOR GENERAL**

## WHY THE OIG CONDUCTED THIS AUDIT

HHSC made capitation payments of over $8.9 billion in fiscal year 2016 to MCOs for members in the State of Texas Access Reform Plus program (STAR+PLUS).

The audit objective was to determine (a) whether selected STAR+PLUS members were properly categorized in nursing facility risk groups and (b) the potential impact of reporting errors on risk group assignments and capitation payments to MCOs.

Capitation payments are fixed, per member, per month amounts based on the risk group HHSC assigns to an individual after considering their enrollment, eligibility, and authorization.

## WHAT THE OIG RECOMMENDS

MCS should:

- Recover managed care capitation overpayments for the 19 recipients who did not have eligibility.
- Coordinate with HHS Actuarial Analysis to develop and implement a strategy for adjusting inaccurate nursing facility risk group assignments.
- Coordinate with HHSC IT to improve accuracy of risk group assignments by updating nursing facility authorization rules within their authorization system to be dependent upon RUG effective dates.

In addition, HHSC should determine what area should enforce the requirement for nursing facilities to timely submit resident transaction notices.

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# MEDICAID STAR+PLUS NURSING FACILITY RISK GROUPS

*Reporting Errors Affected Risk Group Assignments*

## WHAT THE OIG FOUND

Between March 2015 and December 2016, the Health and Human Services Commission (HHSC) incorrectly paid managed care capitation payments of $1.38 million for 19 Medicaid recipients who should have been excluded from managed care because they were fee-for-service recipients who resided in a Texas State Veterans Home.

In addition, HHSC paid managed care organizations (MCOs):

- Nursing facility–level capitation payments for certain members who were not residing in a nursing facility.
- Non-nursing facility–level capitation payments for certain members who were residing in nursing facilities.

Nursing facility risk group assignments did not always accurately reflect members who were residing in a nursing facility because HHSC (a) did not enforce its requirement that nursing facilities submit resident transaction notices and (b) relies on resident transaction notices to assign risk groups. As a result:

- HHSC made capitation payments at the nursing facility rate rather than the community-based rate for five members who were receiving hospice services. By categorizing the five members in a risk group that reflects their medical utilization, the State of Texas would have saved $27,630 in monthly capitation payments.
- 259 members not residing in a nursing facility were categorized in a nursing facility risk group. Had SASO reflected the actual non-nursing facility status for these members, HHSC would have paid a non-nursing facility capitation payment for the members.
- 61 members residing in nursing facilities were categorized in a non-nursing facility risk group. Despite not receiving the nursing facility capitation payments, MCOs paid nursing facility claims for the 61 members.

The OIG Audit Division recognizes the complexity of risk group assignments, eligibility determinations, rate setting, and managed care capitation payments, including the implications of adjusting payments made to MCOs and capitation rates. Taking into consideration these complexities, the OIG Audit Division offered recommendations to HHSC, which, if implemented, will:

- Prevent managed care capitation payments from being paid for fee-for-service clients.
- Improve the accuracy of nursing facility risk group assignments and corresponding payments to MCOs in the future.

The OIG Audit Division presented audit results, issues, and recommendations to HHSC in a draft report dated March 4, 2020. HHSC agreed with the audit recommendations and indicated it would (a) recover the $1.38 million in capitation overpayments and (b) take actions to improve the accuracy of risk group assignments prospectively including enforcing TAC requirements for timely submittal of resident transaction notices.

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# INTRODUCTION

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit Division conducted an audit of Medicaid managed care risk group assignments for nursing facility risk groups. The audit focused on risk group assignments and associated Health and Human Services Commission (HHSC) capitation payments to managed care organizations (MCO) for MCO members in the State of Texas Access Reform Plus program (STAR+PLUS) and a Dual Eligible Medicare-Medicaid Plan (MMP)[1] who were categorized in a nursing facility level risk group or who received nursing facility care. Unless otherwise described, any reference to nursing facility risk groups or STAR+PLUS includes MMP members and risk groups. Specifically, the audit examined:

- Capitation payments to MCOs at the HHSC nursing facility–level capitation rate for members for whom the MCOs did not report any nursing facility medical encounters for at least 12 months in which the capitation payments were paid.

- Capitation payments to MCOs at the HHSC non-nursing facility–level capitation rate for members for whom the MCOs reported nursing facility encounters for at least 12 months in which the payments were paid.

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

## Objective and Scope

The audit objective was to determine (a) whether selected STAR+PLUS members were properly categorized in nursing facility risk groups and (b) the potential impact of reporting errors on risk group assignments and capitation payments to MCOs.

The audit scope included HHSC capitation payments to MCOs for STAR+PLUS members and MCO encounters for nursing facility services from March 2015 through December 2016. It also included HHSC System, MCO, and nursing facility activities and systems related to the assignment of STAR+PLUS members in nursing facility risk groups, and HHSC processes for making MCO capitation payments.

[1] "Dual Eligible Medicare-Medicaid Plans" are managed care plans in which a single MCO provides for service coordination and delivery of both Medicare and Medicaid services. In order to be eligible for an MMP plan, members must already be eligible for or enrolled in the Medicaid STAR+PLUS program. MCOs who participate in the Texas Dual Eligible Integrated Care Demonstration Project contract with both the Centers for Medicare and Medicaid Services and Texas HHSC.

## Background

Medicaid and CHIP Services (MCS) is responsible for the overall management and monitoring of MCOs and the MCOs' administration of health care services. For coordinating and providing these health care services, MCOs receive capitation payments from HHSC, which are monthly prospective payments.

STAR+PLUS is a Texas Medicaid program designed to meet the health care needs of individuals with disabilities and individuals age 65 or older and serves individuals with chronic and complex conditions who need long-term care in addition to acute care services. To address these needs, STAR+PLUS was developed to integrate and deliver acute care[2] and long-term services and supports[3] through the managed care model.

In 2015, STAR+PLUS expanded to include nursing facility residents enrolled in Medicaid. The goal of the expansion was to improve the quality of care for Medicaid nursing facility residents by giving them access to coordination of health care and other services provided by MCOs to their STAR+PLUS members, ensuring members' needs were addressed in the least restrictive yet most appropriate setting, and reducing unnecessary hospitalizations and potentially preventable events.

In 2016, HHSC processed over $8.9 billion in medical and pharmacy capitation payments for 6.4 million cumulative months of service[4,5] covering approximately 536,000 STAR+PLUS members.

During the audit period, HHSC contracted with five MCOs (Amerigroup Texas, Inc., Cigna-HealthSpring, Molina Healthcare of Texas, Inc., Superior HealthPlan, Inc., and UnitedHealthcare Community Plan of Texas, L.L.C.) to provide STAR+PLUS services across 13 service delivery areas. STAR+PLUS MCOs are required to adhere to the terms and conditions of the Uniform Managed Care Contract.[6]

[2] "Acute care" is preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration.

[3] STAR+PLUS long-term services and supports also include attendant care and adult day health services.

[4] HHSC prospectively pays MCOs to coordinate covered medical and pharmacy services for each month of eligibility.

[5] The 6.4 million months are the total months of service for the 536,000 STAR+PLUS members in 2016.

[6] The managed care contracts relevant to STAR+PLUS include the Uniform Managed Care Contract, the STAR+PLUS Expansion Contract, the STAR+PLUS Medicaid Rural Service Area (MRSA) Contract, and the Medicare-Medicaid Dual Demonstration (MMDD) Contract. For the purpose of this report, the Uniform Managed Care Contract is used for referencing contract requirements.

Capitation Payments, Risk Groups, and Nursing Facility Claims

Medicaid managed care contracts are risk based, and HHSC makes capitation payments to MCOs at fixed, per member, per month rates based on the members' associated risk group. HHSC is responsible for defining risk groups, establishing the associated payment rates, and assigning Medicaid enrollees to a risk group. Risk groups are defined by such criteria as age, gender, program type, and eligibility category.[7] Capitation rates vary by risk group and service delivery area. Details about STAR+PLUS nursing facility capitation rates are given in Appendix C.

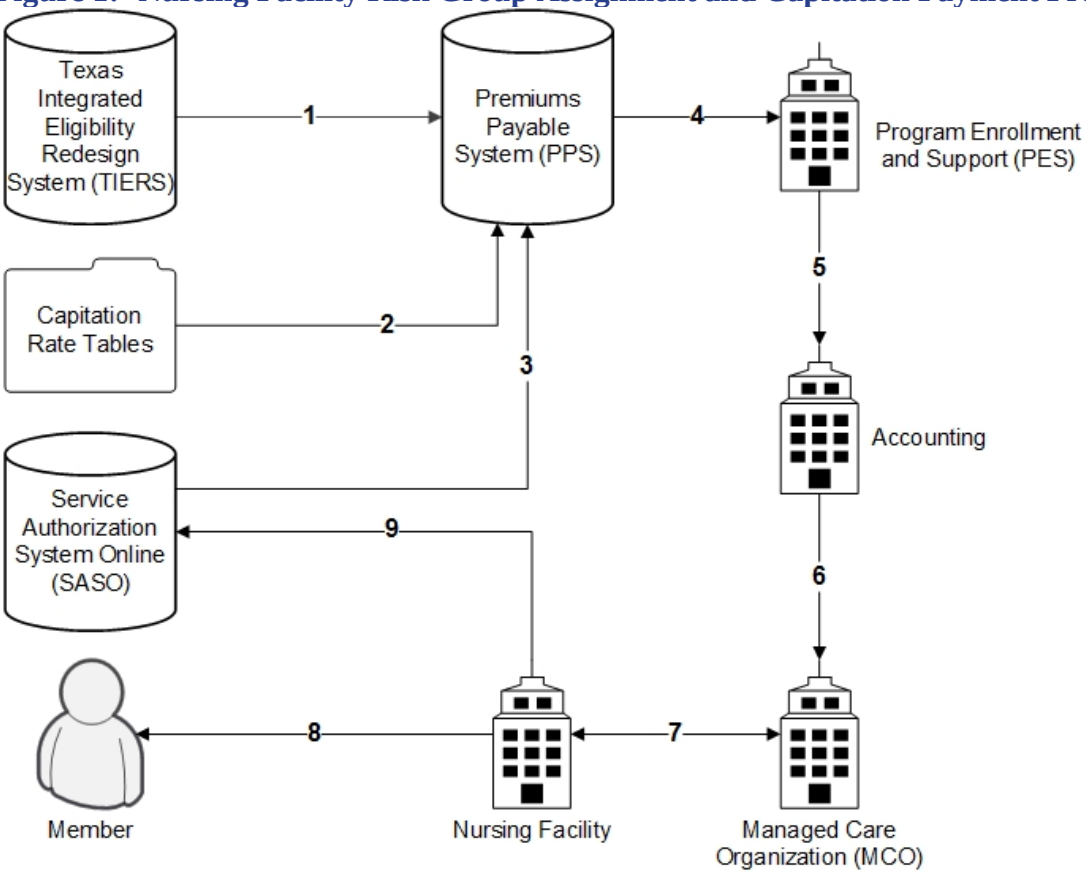
Medicaid enrollees are assigned a risk group based on their enrollment, eligibility, and authorization information. While medical utilization and expenses incurred by the MCOs are expected to vary across members within a risk group, nursing facility risk groups are defined to include only members who are authorized to reside in a nursing facility.

The member composition of each risk group affects the rate calculation for that risk group. Changing the defined member composition of a single risk group could impact the rates for all risk groups within a program. For example, if the definition of nursing facility risk groups were changed to only include those who are residing in a nursing facility, the number of members may decrease as members authorized but not residing in a nursing facility would be removed. Those members removed from the nursing facility risk groups would need to be included in a non-nursing facility community-based risk group, changing the composition and increasing the total number of members in the community-based risk groups. The number of members in a risk group and their related medical expenses are components of the capitation rate calculated for each group. Therefore, changes in either or both of those factors could affect the capitation rate.

Under STAR+PLUS, nursing facilities submit a Medicaid claim to the MCO in which a Medicaid enrollee is a member, and the MCO pays the claim. Figure 1 shows how enrollment, eligibility, and authorization data is gathered through the Premiums Payable System (PPS) to (a) assign Medicaid members in a nursing facility risk group and (b) process payments to MCOs.

[7] Uniform Managed Care Contract, Attachment A, Article 2, "Population Risk Group," v. 2.24 (Sept. 1, 2017).

**Figure 1: Nursing Facility Risk Group Assignment and Capitation Payment Process**




1. Enrollment and eligibility data
2. Current and past rate tables maintained and uploaded into PPS
3. Nursing facility daily care authorization
4. PPS output files, for each MCO, that include members, risk group assignments, and associated capitation payments, including retrospective adjustments
5. Voucher to generate payments
6. Capitation payments
7. Nursing facility claims are submitted to and paid by the MCO
8. Nursing facility provides daily care
9. Nursing facility resident transaction notice

*Source: OIG Audit Division*

Nursing Facility Authorizations

The Texas Administrative Code (TAC) requires nursing facilities to submit a resident transaction notice to the TMHP Long-Term Care Portal within 72 hours of admission or discharge of a Medicaid member.[8] The resident transaction notice is processed by the Service Authorization System Online (SASO) to open and close nursing facility daily care authorizations for Medicaid nursing facility residents. PPS uses authorization information as a factor in determining whether a member is assigned to, or removed from, a nursing facility risk group. The resident transaction notice also informs HHSC of transactions and status changes for Medicaid applicants and members. A separate resident transaction notice is required for each admission or discharge from a facility, or when there is a change between payer sources.

Premiums Payable System

PPS is a group of applications that determines capitation payments for individuals enrolled in HHSC managed care programs, including STAR+PLUS. Each month, PPS uses eligibility and enrollment data received from the Texas Integrated Eligibility Redesign System (TIERS) and service authorization data from SASO to evaluate and assign managed care members into an appropriate STAR+PLUS risk group. Approved capitation rate tables are uploaded and maintained within PPS. The monthly calculation includes both the assignment of a risk group and the associated capitation rate for the prospective month and any risk group or rate adjustments related to the preceding 23 months.

Premiums Payable System Adjustments

Every month, HHSC makes capitation payment adjustments in PPS based on updated eligibility information. From March 2015 through December 2016, monthly PPS payments included 532,088 retrospective risk group adjustments, with a net capitation payment impact to STAR+PLUS of approximately $391.6 million. Table 1 shows the average number and value of retrospective capitation payment adjustments each month related to the STAR+PLUS program for March 2015 through December 2016.

**Table 1: Average STAR+PLUS Monthly Retrospective PPS Adjustments**

| Type of Adjustment | Average Number of Adjustments | Average Monthly Adjustment |
|---|---|---|
| Decreased Payments | 8,349 | ($ 9,349,882) |
| Increased Payments | 15,836 | 27,151,406 |
| Total or Net | 24,185 | $ 17,801,524 |

*Source: HHSC IT PPS Summary of Adjustments (March 2015 through December 2016)*

[8] 1 Tex. Admin. Code § 19.2615 (Sept. 3, 2008).

After PPS has finished the monthly batch process of calculating one prospective month and 23 retrospective months, summary reports and vouchers are produced for MCS Program Enrollment and Support (PES) to review. PES compares and validates selected membership counts and corresponding capitation amounts to ensure accuracy. If PES identifies errors, it notifies HHSC Information Technology (HHSC IT). Once PES validates the payment, it sends a notification to HHSC Accounting Operations to process payments to respective MCOs.

# AUDIT RESULTS

The OIG Audit Division evaluated eligibility and medical utilization information including (a) capitation payment risk group assignments, (b) managed care encounter data, (c) long-term care and acute care fee-for-service claims data, and (d) SASO authorizations. Initial analysis identified 344 STAR+PLUS members with at least 12 months of medical utilization that did not align with capitation payments made to MCOs. Audit results for these members are summarized in the following sections.

## Overpayments for Medicaid Recipients

HHSC pays daily care fee-for-service claims for Medicaid recipients residing in a Texas State Veterans Home, and those recipients should be excluded from managed care risk group assignments. Test results identified 19 fee-for-service clients incorrectly included in managed care risk group assignments. As a result, HHSC paid $1,382,143 in capitation payments to MCOs for Medicaid recipients not eligible for managed care.

## Reporting Errors Affected Risk Group Assignments

STAR+PLUS members were categorized in nursing facility risk groups when they (a) were receiving hospice services or (b) were not residing in a nursing facility. Specifically, test results identified:

- 5 members who were categorized in a nursing facility risk group although they received hospice services.

- 259 members who were categorized in a nursing facility risk group although they did not reside in a nursing facility.

In addition, 61 members were categorized in a non-nursing facility risk group even though they resided in a nursing facility.

The OIG Audit Division recognizes the complexity of risk group assignments, eligibility determinations, rate setting, and managed care capitation payments, including the implications of adjusting payments made to MCOs and capitation rates. As a result, our recommendations focus on correcting the risk group assignments prospectively.

Exceptions related to (a) managed care capitation payments for fee-for-service clients, (b) members categorized in nursing facility risk groups who did not reside in nursing facilities, and (c) members categorized in non-nursing facility risk groups who resided in nursing facilities are detailed in the sections that follow.

## MANAGED CARE CAPITATION PAYMENTS MADE FOR FEE-FOR-SERVICE CLIENTS

STAR+PLUS business rules exclude residents of Texas State Veterans Homes from being included in managed care risk group assignments.[9] According to responsible MCS management, TIERS implemented a new process in November 2016 that would close managed care eligibility for clients residing in a Texas State Veterans Home. While this process should have included retroactive eligibility adjustments, it was determined that the retroactive adjustments did not occur due to a defect. HHSC asserted that TIERS staff identified this defect and implemented a fix in January 2017.

## Issue 1: HHSC Overpaid for Certain Medicaid Recipients

HHSC paid managed care capitation payments of $1,382,143 for 19 Medicaid recipients who should have been excluded from managed care because the 19 Medicaid recipients were fee-for-service recipients who resided in a Texas State Veterans Home. Test results identified the 19 recipients had both fee-for-service claims and managed care capitation payments. MCS then determined that the recipients were residents of a Texas State Veteran's Home. While HHSC appropriately paid fee-for-service claims of $1,321,964 for daily care at the Texas State Veterans Homes, HHSC did not have effective controls in place to prevent the managed care capitation payments. Table 2 shows the fee-for-service nursing facility claims and the total nursing facility capitation payments between March 2015 and December 2016 per MCO.

**Table 2: Managed Care Capitation Overpayments for Fee-For-Service Recipients**

| MCO | Members | Nursing Facility Fee-For-Service Paid Claims[10] | Managed Care Capitation Overpayment |
|---|---|---|---|
| Amerigroup | 2 | $ 100,897 | $ 113,289 |
| Cigna-HealthSpring | 4 | 212,790 | 242,836 |
| Molina Healthcare | 3 | 144,074 | 205,399 |
| Superior HealthPlan | 4 | 184,223 | 254,645 |
| UnitedHealthcare | 7 | 679,980 | 565,974 |
| Members Enrolled in Multiple MCOs | (1) | | |
| Total | 19 | $1,321,964 | $1,382,143 |

*Source: PPS Monthly Capitation Payments; Long-Term Care Fee-For-Service Claims; MCO Encounters; OIG Audit Division Analysis*

[9] Texas HHSC Medicaid CHIP Division, "Medicaid Managed Care Expansion – Nursing Facility Transition to STAR+PLUS Program, STAR+PLUS Business Rules" v. 7.00 (Oct. 10, 2014).

[10] These are the fee-for-service claims that HHSC correctly paid directly to providers.

### Recommendation 1

MCS should recover the managed care capitation overpayments for the 19 Medicaid recipients who did not have Medicaid managed care eligibility because they resided in a Texas State Veterans Home, including capitation overpayments that were made outside the 24-month adjustment period.

### Management Response

Action Plan

*MCS agrees that the overpayment for the 19 Medicaid recipients residing in a Texas State Veterans Home should be recovered. These overpayments occurred as a result of a TIERS defect that allowed the managed care segment to remain open when the member entered a Texas State Veterans Home. This defect was identified in December 2016, with corrections completed by January 2017. The system properly ensures that the managed care segment is closed for Medicaid managed care members who will reside in a Texas State Veterans Home and moves these members to fee-for-service the day before the member enters the facility. No further system work is necessary to address the issue.*

*MCS staff will identify appropriate options for recovering the managed care capitation payments associated with these 19 Medicaid recipients outside the 24-month adjustment period.*

Responsible Manager

*Deputy Associate Commissioner of MCS Program Enrollment and Support*

Target Implementation Dates

*May 2020 – Identify options for recovery of the overpayments*
*December 2020 – Complete the recovery of the overpayments*

## REPORTING ERRORS AFFECTED NURSING FACILITY RISK GROUP ASSIGNMENTS

The OIG Audit Division reviewed PPS capitation payments, MCO encounters, SASO authorizations, and eligibility data for the period of March 2015 through December 2016. During this period, there were 12,965 Medicaid members for whom HHSC paid at least one month of nursing facility capitation in a month for which the MCO paid no corresponding nursing facility claim.

Of these, the OIG Audit Division tested risk group assignments and associated capitation payments for 283 members for whom HHSC made 12 or more months of

nursing facility capitation payments within the 22-month period when there were no corresponding MCO nursing facility claims payments.

In some instances, HHSC will pay for services beyond what is covered through managed care and, in those cases, HHSC pays claims directly to the service provider. These additional services do not include services already covered by the MCO contract. For example, HHSC pays for hospice care directly to a hospice provider through payment of a fee-for-service claim, in addition to a capitation payment for the same Medicaid member to the MCO. In situations like these, the capitation payment HHSC pays the MCO is lower than the standard nursing facility capitation payment to account for HHSC paying for hospice care.

For most of the 283 members, HHSC should have made capitation payments. The capitation payments, however, would have been based on lower non-nursing facility rates if the members had been assigned to the correct risk group. Where errors or discrepancies in risk group assignments existed, the OIG Audit Division worked with HHSC IT to recalculate capitation amounts to reflect the amount HHSC should have paid had the correct risk group assignments been in effect when the capitation payments were made.

## Issue 2: HHSC Made Nursing Facility Risk Group Payments to MCOs for Members in Hospice

From March 2015 through December 2016, HHSC paid $283,662 in monthly nursing facility capitation payments for five members who were receiving hospice services. Subsequent to the March 2015 nursing facility expansion of STAR+PLUS, hospice has remained part of Medicaid fee-for-service. For managed care members who are in hospice care, HHSC pays the MCOs a community-based capitation payment, and also makes fee-for-service payments for hospice claims. The five members identified were receiving hospice services, but the HHSC capitation payments to the MCOs were at the nursing facility rate rather than the community-based rate.

By categorizing the five members in a risk group that reflects their medical utilization, the State of Texas would save $27,630 in monthly capitation payments.

Table 3 shows the difference in capitation payments per MCO.

**Table 3: Impact of Incorrect Risk Group Assignment**

| MCO | Members | Total Capitation Payments | Recalculated Capitation Amounts[11] | Difference Between Actual and Recalculated Payments |
|---|---|---|---|---|
| Amerigroup | 2 | $125,280 | $115,240 | $10,040 |
| Cigna-HealthSpring | 3 | 158,382 | 140,792 | 17,590 |
| Total | 5 | $283,662 | $256,032 | $27,630 |

*Source: PPS Monthly Nursing Facility Capitation Payments; SASO Daily Care Nursing Facility Authorizations; MCO Encounters; Fee-For-Service Long Term Care Claims; Fee-For-Service Acute Care Claims; OIG Audit Division Analysis*

## Recommendation 2

MCS should coordinate with HHS Actuarial Analysis to develop and implement a strategy for adjusting inaccurate nursing facility risk group assignments of STAR+PLUS members without (a) adversely impacting the actuarial soundness of rates and (b) inappropriately compensating MCOs.

## Management Response

Action Plan

*MCS agrees with the recommendation to develop a strategy that addresses incorrect assignment of nursing facility risk groups identified in the audit, such as individuals that receive hospice services without moving into the community-based risk group. MCS and Actuarial Analysis communicate regularly, particularly around identified payment issues that may impact capitation rates. To better identify and resolve issues, the two groups will formalize the established communication process by scheduling regular meetings to discuss overall STAR +PLUS nursing facility program health and any potential prospective rate change analysis needs to adjust nursing facility risk group assumptions. Additionally, MCS and Actuarial Analysis will use the meetings to consider ways to identify, monitor, and correct risk group assignments prospectively within the parameters of rate setting practices.*

Responsible Managers

- *Deputy Associate Commissioner of MCS Program Enrollment and Support*
- *HHS Chief Actuary*

[11] The OIG Audit Division recalculated the capitation payments for the months in which there was a paid hospice claim. All other months were kept at the original nursing facility capitation payment amount.

Target Implementation Date

*May 2020*

## Issue 3: HHSC Made Nursing Facility Risk Group Payments to MCOs for Members Not Residing in a Nursing Facility

The OIG Audit Division evaluated activities and processes associated with the assignment of a nursing facility risk group for 259 members. Results indicated that weaknesses exist in the nursing facility risk group assignment process in the following areas:

- Nursing facilities do not always submit resident transaction notices within required timeframes.

- SASO does not verify open authorizations against other supporting data such as Resource Utilization Group (RUG) level or Minimum Data Set (MDS) assessment results, missing an opportunity to identify erroneous authorization data being submitted to PPS for monthly risk group categorizations and capitation payment calculations.

Nursing facility risk groups are designed to include only members who are authorized to reside in a nursing facility and TAC requires nursing facilities to inform HHSC when a resident is admitted to or discharged from a nursing facility, or when certain eligibility changes occur.[12] Nursing facilities are required to submit this notice within 72 hours of the change and HHSC relies on this information to help ensure members are assigned to the correct managed care risk group.

Between March 2015 and December 2016, HHSC paid $26.6 million in monthly nursing facility capitation payments for 259 members who were not in a nursing facility during the month for which the capitation payment was made. Although MCOs did not pay nursing facility claims for those 259 members, MCOs received nursing facility capitation payments for those members. Additionally, 117 of those 259 members had no paid claims[13] during months for which nursing facility capitation payments were made for the members.

The 259 members were categorized in nursing facility risk groups based on the member having authorizations in SASO, which had not been updated by nursing facilities and remained open even though the member no longer resided in a nursing facility. Had SASO reflected the accurate non-nursing facility status for

[12] 1 Tex. Admin. Code § 19.2615 (Sept. 3, 2008).

[13] This analysis is based on submitted MCO encounter data.

these members, HHSC would have paid a non-nursing facility capitation payment for the members. The breakdown of those members and associated payments is summarized in Table 4.

**Table 4: Nursing Facility Capitation Payments for Members Not Residing in Nursing Facilities**

| Member Circumstance | Number of Members Affected | Capitation Payment Made |
|---|---|---|
| Received no Medicaid services over the entire 22-month period[14] | 38 | $ 3,359,800 |
| Received no Medicaid services during months in which HHSC paid a nursing facility capitation amount to their MCO | 22 | 1,484,431 |
| Not in a nursing facility but received other medical services through their MCO | 142 | 17,628,777 |
| Not in a nursing facility and did not receive any services through their MCO but received paid services through Medicaid fee for service | 57 | 4,137,927 |
| Total | 259 | $26,610,935 |

*Source: PPS Monthly Nursing Facility Capitation Payments; SASO Daily Care Nursing Facility Authorizations; MCO Encounters; Fee-For-Service Long Term Care Claims; Fee For Service Acute Care Claims; OIG Audit Division Analysis*

When an authorization for daily care at a nursing facility is not updated by the nursing facility and remains erroneously open in SASO, information sent to and processed by PPS results in the member being inaccurately assigned to a nursing facility risk group. As of July 2017, SASO maintained indefinitely open nursing facility authorizations for 205 of the 283 members described in Issues 1 through 3. An indefinitely open nursing facility authorization has an end date of December 31, 9999, in the SASO system.

In order for a nursing facility fee-for-service claim to be paid, several criteria must be met. First, there must be an open authorization for nursing facility daily care (authorizations are created by a nursing facility submitting a resident transaction notice indicating the Medicaid recipient is at the facility). There must also be a RUG level assigned to the member, as determined by an MDS assessment, that corresponds to the service date on the claim[15] (nursing facilities are required to

[14] For some of the 38 members, however, nursing facility capitation payments were not made to MCOs in every one of the 22 months. For the other months, non-nursing facility capitation payments may have been made to MCOs.

[15] Under both the managed care and fee-for-service models, nursing facilities are reimbursed a daily rate, based on an assigned RUG level, for each resident. The RUG level is based on the resource intensity of the resident as measured by items reported on MDS assessments.

complete a new MDS assessment at least every 92 days).[16,17] Both open authorizations and RUG levels are maintained in SASO. However, HHSC is not applying the fee-for-service criteria when assigning STAR+PLUS members to nursing facility risk groups.

The OIG Audit Division recognizes the complexity of risk group assignments, eligibility determinations, rate setting, and managed care capitation payments, including the implications of adjusting (a) payments made to MCOs and (b) capitation rates.

## Recommendation 3a

MCS should coordinate with HHS Actuarial Analysis to develop and implement a strategy for adjusting inaccurate nursing facility risk group assignments of STAR+PLUS members without (a) adversely impacting the actuarial soundness of rates and (b) inappropriately compensating MCOs.

This coordination should include quantifying the anticipated financial impact of adjusting inaccurate nursing facility risk group assignment of members who are not residing in a nursing facility to an appropriate risk group, and adjusting rates going forward as appropriate.

## Management Response

Action Plan

*MCS and Actuarial Analysis agree with the recommendation to develop and implement a strategy for adjusting STAR+PLUS nursing facility risk group assignments to more accurately reflect members residing in a nursing facility. As noted in the response to Recommendation 2, MCS and Actuarial Analysis will use the meetings noted in the Action Plan under Recommendation 2 to consider ways to identify, monitor, and correct risk group assignments prospectively within the parameters of rate setting practices and actuarial soundness. Recommendations generated from these meetings will be assessed and prioritized for implementation on an ongoing basis. Changes to risk group assignments must be included in the capitation rate development process and align with the start of the prospective rating period to be actuarially sound.*

*It is important to note that HHSC's actuaries and HHSC's consulting actuaries studied this issue and determined that HHSC neither overcompensated nor undercompensated the STAR+PLUS MCOs as a result of incorrect risk group*

[16] Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Chapter 2, v. 1.12 (Oct. 1, 2014) and v. 1.13 (Oct. 1, 2015).

[17] 40 Tex. Admin. Code § 19.801 (June 1, 2006, and Aug. 31, 2015).

*assignments. HHSC and its consulting actuaries estimated the capitation rates based on the location of members and compared them to the capitation rates based on open nursing facility authorization. In aggregate, the MCOs would have received similar payments under either scenario for the period under review.*

*More generally, actuarial soundness principles require that the rate calculation, eligibility classification, and premium payment are all aligned. Current development of the nursing facility managed care rates takes into consideration that each month a portion of STAR+PLUS members have open nursing facility authorizations assigned to the nursing facility risk group, but do not have claims. The capitation rates are based on the actual cost of the population assigned to each risk group and therefore take into consideration that a portion of the nursing facility membership does not in fact incur nursing facility expenditures. In effect, this reduces the overall average nursing facility risk group capitation rates paid for all nursing facility members, including those residing in a nursing facility.*

*As HHSC considers changing the risk group criteria, the capitation rates must be adjusted to align with the changing eligibility classification to be actuarially sound. Assumptions will be reasonable and appropriate as defined in actuarial standards, but will require interpretations of how any new eligibility definitions will operate. The net impact of categorizing these members based on location instead of authorization will increase the average cost of the remaining nursing facility risk group, but should not have a material impact on the aggregate payments in the STAR+PLUS program across all risk groups.*

Responsible Managers

- *Deputy Associate Commissioner of MCS Program Enrollment and Support*
- *HHS Chief Actuary*

Target Implementation Date

*May 2020*

## Recommendation 3b

MCS, in coordination with HHSC IT, should update nursing facility authorization rules within SASO to be dependent upon RUG effective dates.

## Management Response

Action Plan

*MCS agrees with this recommendation. The recommended nursing facility service authorization system changes are currently in process. When current systems*

*changes are complete, SAS will only send nursing facility segments with an active RUG to PPS for payment. Additional SAS system changes include 1st day of the month payment assignment to help prevent incorrect risk group assignment and capture additional waiver suspension codes to prevent systematic appearance of overlapping segments which, in the past, could trigger PPS to make an incorrect payment.*

*These changes will be applied prospectively since recouping premiums from the managed care organizations based on revised eligibility criteria without adjusting the capitation rates using the same revised eligibility criteria would violate the actuarial soundness requirements. The updates align with the implementation of updated FY 2021 nursing facility capitation rates effective September 1, 2020.*

Responsible Manager

*Deputy Associate Commissioner of MCS Program Enrollment and Support*

Target Implementation Date

*September 1, 2020*

## Recommendation 3c

HHSC should determine where authority to enforce TAC requirements for nursing facilities resides or should reside, and direct or coordinate with the responsible area to enforce the TAC requirement for nursing facilities to timely submit resident transaction notices.

## Management Response

Action Plan

*While there is significant indication that most nursing facility transaction notices are submitted accurately, MCS agrees that the accurate and timely submission of resident transaction notices is key to nursing facility risk group assignment accuracy. MCS will explore potential mechanisms to ensure the enforcement of these TAC requirements within the appropriate HHSC area, and coordinate to ensure implementation of the approved approach.*

Responsible Manager

*Deputy Associate Commissioner of MCS Policy and Program*

Target Implementation Dates

- *September 2020 – Define potential enforcement mechanisms and responsible entities*
- *January 2021 – Implement agreed upon enforcement mechanism*

### *MEMBERS IN NURSING FACILITIES WERE ASSIGNED TO NON-NURSING FACILITY RISK GROUPS*

The OIG Audit Division reviewed PPS capitation payments, MCO encounters, SASO authorizations, and eligibility data for the period of March 2015 through December 2016. During this period, there were 10,712 Medicaid members for whom an MCO paid a nursing facility claim for at least one month in which HHSC did not make a corresponding nursing facility capitation payment.

Of these, the OIG Audit Division analyzed encounter data associated with members for whom MCOs made nursing facility claims payments, and for whom HHSC did not make a corresponding nursing facility capitation payment to the applicable MCO.

## Issue 4: HHSC Made Non-Nursing Facility Risk Group Payments to MCOs for Members Residing in Nursing Facilities

The OIG Audit Division identified 61 members who were categorized in non-nursing facility risk groups, but for whom MCO-paid encounters indicated the MCOs had paid nursing facility claims for 12 or more of the months within the 22-month period included in this audit. Between March 2015 and December 2016, HHSC paid $1.6 million in monthly non-nursing facility capitation payments for 61 members who were in a nursing facility during the month for which the capitation payment was made.

Despite not receiving the nursing facility capitation payments, MCOs paid nursing facility claims for the 61 members. During the months where a non-nursing facility capitation payment was made for these members, MCOs paid approximately $2.8 million in nursing facility claims.

Table 5 shows actual capitation payment amounts paid for the 61 members.

**Table 5: Capitation Payments**

| MCO | Members | Capitation Payment Made |
|---|---|---|
| Amerigroup | 24 | $ 474,277 |
| Cigna-HealthSpring | 3 | 81,277 |
| Molina Healthcare | 16 | 452,723 |
| Superior HealthPlan | 12 | 356,779 |
| UnitedHealthcare | 9 | 200,161 |
| Members Enrolled in Multiple MCOs | (3) | |
| Total | 61 | $1,565,217 |

*Source: PPS Monthly Capitation Payments; SASO Daily Care Nursing Facility Authorizations; MCO Encounters; OIG Audit Division Analysis*

Until the status of the 61 members is addressed and a root cause analysis is performed to determine whether additional members were affected or further actions are needed, risk group miscategorizations will continue.

The OIG Audit Division recognizes the complexity of risk group assignments, eligibility determinations, rate setting, and managed care capitation payments, including the implications of adjusting (a) payments made to MCOs and (b) capitation rates.

## Recommendation 4a

MCS should coordinate with HHS Actuarial Analysis to develop and implement a strategy for adjusting inaccurate nursing facility risk group assignments of STAR+PLUS members without (a) adversely impacting the actuarial soundness of rates and (b) inappropriately compensating MCOs.

This coordination should include quantifying the anticipated financial impact of adjusting inaccurate non-nursing facility risk group assignment of members who are residing in a nursing facility to an appropriate risk group, and adjusting rates going forward as appropriate.

## Management Response

Action Plan

*MCS and Actuarial Analysis agree with the recommendation to develop and implement a strategy for adjusting nursing facility risk group assignments of STAR+PLUS members to more accurately reflect members residing in a nursing facility.*

*MCS and Actuarial Analysis will use the meetings defined in the Management Response to Recommendation 2 to consider ways to identify, monitor, and correct risk group assignments prospectively within the parameters of rate setting practices. Recommendations generated from these meetings will be assessed and prioritized for implementation on an ongoing basis. Changes to risk group assignments must be included in the capitation rate development process and align with the start of the prospective rating period to be actuarially sound.*

*As is stated in the Management Response to Recommendation 3a, HHSC's actuaries and HHSC's consulting actuaries determined that HHSC neither overcompensated nor undercompensated the STAR+PLUS MCOs due to incorrect risk group assignments. HHSC and its consulting actuaries estimated the capitation rates based on the location of members and compared them to the capitation rates based on open nursing facility authorization. The conclusion was that the MCOs would have received similar payments in aggregate under either scenario for the period under review.*

Responsible Managers

- *Deputy Associate Commissioner of MCS Program Enrollment and Support*
- *HHS Chief Actuary*

Target Implementation Date

*May 2020*

## Recommendation 4b

MCS, in coordination with HHSC IT and other applicable business areas, should perform root cause analysis and take appropriate action to improve prevention and detection of inaccurate non-nursing facility risk group assignments.

## Management Response

Action Plan

*Within the MCS and Actuarial Analysis ongoing meetings noted in prior Management Responses, staff will ensure that resolution proposals or mitigation strategies associated with inaccurate non-nursing facility risk group assignments are informed by root cause analyses. MCS will include staff from HHSC IT or other areas as appropriate in the risk group discussions.*

Responsible Manager

*Deputy Associate Commissioner of MCS Program Enrollment and Support*

Target Implementation Date

*May 2020*

# CONCLUSION

The OIG Audit Division completed an audit of selected STAR+PLUS managed care members assigned to nursing facility risk groups. The audit focused on members with a discrepancy between utilization and nursing facility risk group categorization for at least 12 months during the 22-month period from March 2015 through December 2016. Based on the results of its audit, the OIG Audit Division concluded that HHSC paid $1.38 million in capitation overpayments to MCOs for Medicaid recipients not eligible for managed care.

Weaknesses exist in the nursing facility risk group assignment process:

- Nursing facilities did not always submit resident transaction notices as required, and HHSC did not enforce that requirement.
- SASO daily care nursing facility authorizations did not always correctly reflect the status of STAR+PLUS members.

Reporting errors and data inaccuracies affected risk group assignments and resulted in:

- 5 members who were categorized in a nursing facility risk group although they received hospice services.
- 259 members who were categorized in a nursing facility risk group although they did not reside in a nursing facility.
- 61 members who were categorized in a non-nursing facility risk group although they resided in nursing facilities.

The OIG Audit Division recognizes the complexity of risk group assignments, eligibility determinations, rate setting, and managed care capitation payments, including the implications of adjusting payments made to MCOs and capitation rates. Taking into consideration these complexities, the OIG Audit Division offered recommendations to MCS, which, if implemented, will:

- Prevent managed care capitation from being paid for fee-for-service clients.
- Improve the accuracy of nursing facility risk group assignments and corresponding payments to MCOs in the future.

The OIG Audit Division presented preliminary audit results, issues, and recommendations to HHSC in a draft report dated March 5, 2020. HHSC provided management responses indicating it agreed with the recommendations and would

(a) take steps to recover the $1.38 million in capitation overpayments and (b) take actions to improve the accuracy of risk group assignments prospectively including enforcing TAC requirements for timely submittal of resident transaction notices. HHSC's management responses are included in the report following the recommendations.

The OIG Audit Division thanks management and staff at MCS, Regulatory Services, HHSC IT, and Financial Services for their cooperation and assistance during this audit.

# Appendix A: Objective, Scope, Audit Approach, Criteria, and Auditing Standards

## Objective

The objective of this audit was to determine whether (a) selected STAR+PLUS members were properly categorized in nursing facility risk groups and (b) the potential impact of reporting errors on the risk group assignments and capitation payments to MCOs.

## Scope

The audit scope included HHSC capitation payments to MCOs for STAR+PLUS members, and MCO encounters for nursing facility services, from March 2015 through December 2016. It also included HHS System, MCO, and nursing facility activities and systems related to the assignment of STAR+PLUS members in nursing facility risk groups, and HHSC processes for making MCO capitation payments.

## Audit Approach

To accomplish its objectives, the OIG Audit Division collected information for this audit through discussions and interviews with responsible staff at MCS, HHSC Actuarial Analysis, HHSC Accounting Operations, HHSC IT, and TMHP, and through request and review of the following information:

- PPS STAR+PLUS risk group assignments and capitation payment data
- MCO encounter data
- Long-term care fee-for-service claims data
- Acute care fee-for-service claims data
- SASO authorizations
- MDS data
- Vital Statistics Unit death records
- TIERS eligibility data
- Actuarial Analysis rate setting methodology

The OIG Audit Division issued an engagement letter on July 7, 2017, to MCS providing information about the upcoming audit, and conducted fieldwork in Austin, Texas, from July 2017 through February 2018. The OIG Audit Division interviewed responsible personnel, evaluated program policy, and analyzed relevant data related to the risk group assignment process. In addition, the OIG Audit Division worked with an independent actuary to consider the impact of retroactive adjustments to risk group assignments on capitation rates and to review actuarial analysis assertions.

The OIG Audit Division analyzed information and documentation it collected to determine whether selected STAR+PLUS members were properly categorized in nursing facility risk groups and related capitation payments were appropriate. Where errors or discrepancies in risk group assignments existed, the OIG Audit Division worked with HHSC IT to recalculate capitation amounts to reflect what HHSC would have paid had the correct risk group assignments been in effect at the time capitation payments were made.

## Criteria

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

- 1 Tex. Admin. Code § 19.2615 (2008)
- 40 Tex. Admin. Code § 19.801 (2006 and 2015)
- Uniform Managed Care Contract, Attachments A and B-1, v. 2.13 (2015) through v. 2.20 (2016)
- Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Chapter 2, v. 1.12 (2014) and v. 1.13 (2015)
- Texas HHSC Medicaid CHIP Division, "Medicaid Managed Care Expansion – Nursing Facility Transition to STAR+PLUS Program, STAR+PLUS Business Rules" v. 7.00 (2014)

## Auditing Standards

Generally Accepted Government Auditing Standards

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

ISACA

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

## Appendix B: Testing Methodology

The OIG Audit Division examined the STAR+PLUS nursing facility risk group assignment process for the period of March 2015 through December 2016. After an initial assessment of the entire nursing facility population, as defined by monthly capitation payments and paid nursing facility encounters, the OIG Audit Division performed testing of the monthly risk group placement for members for whom capitation payments did not appear consistent with the level of services provided.

### Members With 12 Months or More of Nursing Facility Risk Group Payments

The OIG Audit Division analysis of nursing facility capitation payments and claims paid by MCOs for the period March 2015 through December 2016 identified 283 Medicaid members with at least 12 months of nursing facility capitation payments, but no corresponding nursing facility claims paid by MCOs.

The OIG Audit Division tested the risk group categorization for the identified 283 members against MCO encounter data, long-term and acute care fee-for-service claims data, SASO authorizations, MDS effective dates, Vital Statistics Unit death records, and TIERS eligibility data. The OIG Data and Technology Division, HHSC IT, and HHSC Vital Statistics Unit supplied all data sets used in this audit.

Capitation payments were recalculated with the help of HHSC IT in a test environment and production data was not altered. HHSC IT created a mock output file from SASO, which simulated closed nursing facility authorizations for the identified members. The mock file was loaded into a PPS test environment by HHSC IT, and the risk group assignments and corresponding payment values were automatically adjusted.

### Members Without 12 Months or More of Nursing Facility Risk Group Payments

The OIG Audit Division analysis of nursing facility capitation payments and claims paid by MCOs for the period March 2015 through December 2016 identified 61 Medicaid managed care members with at least 12 months of nursing facility claims paid by an MCO, but no corresponding nursing facility capitation payments.

Capitation payments were recalculated with the help of HHSC IT in a test environment, and production data was not altered. HHSC IT created a mock output file from SASO, which simulated open nursing facility authorizations for the identified members. The mock file was loaded into a PPS test environment by HHSC IT, and the risk group assignments and corresponding payment values were automatically adjusted.

## Appendix C: STAR+PLUS Nursing Facility Capitation Rates

Capitation rates for each managed care risk group are developed in coordination with an actuarial consultant contracted by HHSC Actuarial Analysis. Rates are reviewed and finalized by HHSC Actuarial Analysis in conjunction with other HHSC divisions including, but not limited to MCS, Legal Services, and Financial Services. Approved rates are incorporated into the managed care contracts and submitted to the Centers for Medicare and Medicaid Services for approval.

There are three nursing facility risk groups in STAR+PLUS. Nursing facility risk groups are the risk groups in STAR+PLUS with the highest projected medical utilization costs, and consequently the highest capitation rates. Residents of nursing facilities regularly require the skills of licensed nurses, and nursing facilities provide for the complete medical, social, and psychological needs of each resident. Nursing facility care includes room and board, social services, over-the-counter drugs, medical supplies and equipment, and personal needs items.

While there is only a single monthly nursing facility capitation rate applicable to each risk group in a service delivery area for each MCO, rates differ by area and over time to account for variations in medical expenses and acuity.

Capitation rates for nursing facility risk groups reflect the high medical expenses expected with a stay in a nursing facility and ranged from $4,114 to $9,556 a month in 2016. Table A1 shows the average capitation rate for each STAR+PLUS risk group in 2016.

**Table A1: Average STAR+PLUS Capitation Rates in 2016**

| STAR+ PLUS Risk Groups | Average Capitation Rate |
|---|---|
| **Non-Nursing Facility Risk Groups** | |
| Medicare Other Community Clients | $ 352 |
| MMP Dual Eligible Community | $ 546 |
| Individuals with Intellectual Disabilities (21 and Over) | $ 875 |
| Non-Medicare Other Community Clients | $1,282 |
| Medicare Community-Based Alternatives Clients | $1,654 |
| MMP Dual Eligible STAR+PLUS Waiver | $1,976 |
| Individuals with Intellectual Disabilities (Under 21) | $1,990 |
| Non-Medicare Community-Based Alternatives Clients | $4,102 |
| **Nursing Facility Risk Groups** | |
| MMP Dual Eligible Nursing Facility | $4,875 |
| Dual Eligible Nursing Facility | $4,914 |
| Non-Medicare Nursing Facility | $8,222 |

*Source: PPS Nursing Facility Rates*

## Appendix D: Report Team and Distribution

### Report Team

OIG staff members who contributed to this audit report include:

- Audrey O'Neill, CIA, CFE, CGAP, Deputy IG for Audit
- David Griffith, CPA, CIA, CGFM, Deputy IG for Audit (Retired)
- Kacy VerColen, CPA, Interim Assistant Deputy IG for Audit
- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Greg Herbert, CFE, CIA, CGAP, CGFM, Audit Manager
- Sarah Warfel, CPA, CISA, Audit Project Manager
- JoNell Abrams, CIGA, Staff Auditor
- Wende Young, CIGA, CICA, Staff Auditor
- Emery Hizon, CIGA, Staff Auditor
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### Report Distribution

Health and Human Services

- Phil Wilson, Acting Executive Commissioner
- Victoria Ford, Acting Chief Operating Officer and Chief Policy and Regulatory Officer
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- Michelle Alletto, Chief Program and Services Officer
- Nicole Guerrero, Director of Internal Audit
- Trey Woods, Chief Financial Officer
- Rachel Butler, Chief Actuary
- Stephanie Muth, State Medicaid Director, Medicaid and CHIP Services
- Fabian Aguirre, Interim Deputy Associate Commissioner, Program Enrollment and Support

- Emily Zalkovsky, Deputy Associate Commissioner, Policy and Program Development, Medicaid and CHIP Services
- Shannon Kelley, Interim Director, Health Plan Management, Medicaid and CHIP Services

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

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

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