TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

AUDIT OF STAR+PLUS SERVICE COORDINATION

Amerigroup Texas, Inc. and
Amerigroup Texas Insurance Company

July 15, 2019
OIG Report No. AUD-19-021

HHSC OIG
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

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Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company

WHY THE OIG CONDUCTED THIS AUDIT

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division has completed an audit of service coordination for STAR+PLUS Level 1 members at Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company (Amerigroup), a Medicaid and CHIP managed care organization (MCO).

The audit objective was to evaluate whether Amerigroup complied with contractual requirements for performing service coordination in support of STAR+PLUS Level 1 members. The scope of the audit included relevant activities during the period from September 1, 2016, through August 31, 2018.

WHAT THE OIG RECOMMENDS

HHSC Medicaid and CHIP Services (MCS), through its contract oversight responsibility, should ensure Amerigroup:

- Provides two face-to-face visits annually for HCBS members and quarterly face-to-face visits for members residing in a nursing facility.
- Checks on HCBS members' receipt of approved services within four weeks of the ISP start date.
- Assesses members within 30 days of their entry into a nursing facility.

MCS should also clarify requirements for the intervals between the two required face-to-face service coordination visits each year for HCBS members and consider establishing a maximum length of time allowed between the required visits.

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

WHAT THE OIG FOUND

Amerigroup assigned service coordinators to all 113 STAR+PLUS Level 1 members; assessed, within 90 days of enrollment, 32 members whose STAR+PLUS enrollment date fell within the audit period; and completed individual service plans (ISPs) for all 44 members in the Home and Community-Based Services (HCBS) program.

However, 44 of 113 STAR+PLUS Level 1 members (39 percent) did not receive one or more of the required service coordination activities. Specifically:

- 29 of 113 members did not receive the number of face-to-face visits required by the contract.
- 29 of 44 members in the HCBS program did not receive contacts following up on the receipt of approved services within 4 weeks of the ISP date, as required by the contract.
- 4 of 16 members entering a nursing facility after February 28, 2017, did not receive assessments within 30 days of admission, as required by the contract.

The length of time between the two required HCBS member visits ranged from one to 15 months. Applicable contracts do not specify an expected interval between the two required annual visits, which may result in extended timeframes between service coordination visits for HCBS members.

Amerigroup served 39,829 STAR+PLUS Level 1 members during the audit scope. The OIG Audit Division selected a statistically valid random sample of 113 of those members for testing. For certain tests, the sample of 113 Level 1 members was divided into subsets based on whether the member was served through HCBS, was in a nursing facility, or transitioned between both, because of the differing specific service coordination requirements for each group.

STAR+PLUS is a Texas Medicaid managed care program for adult members who have disabilities or are age 65 or older. MCOs are required to provide service coordination to their STAR+PLUS members. A STAR+PLUS service coordinator from the MCO works with the member, the member's family, and with the member's doctors and other providers to help ensure the member receives needed medical and long-term service and supports.

The OIG Audit Division presented preliminary audit results, issues, and recommendations to MCS and to Amerigroup in a draft report dated June 12, 2019. Amerigroup, in a comment letter, indicated that it had implemented some action plans and is implementing other actions to improve service coordination.

MCS concurred with the OIG Audit Division recommendations and will require Amerigroup to submit a corrective action plan to correct the issues noted. MCS further indicated that its Results Management unit is developing an enhanced service coordination oversight module as part of the biennial onsite operational review process that will include checking for MCO compliance with the contractual requirements noted in this audit.

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INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division has completed an audit of service coordination for State of Texas Access Reform Plus (STAR+PLUS) Level 1 members performed by Amerigroup Texas, Inc., and Amerigroup Texas Insurance Company (Amerigroup[1]), a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO).

STAR+PLUS is a Texas Medicaid managed care program for adult members who have disabilities or who are age 65 or older. STAR+PLUS members receive Medicaid health care and long-term services and supports through an MCO they select from a choice of at least two available MCOs, based on where a member lives. 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 527,331 members per month in state fiscal year 2017 (September 1, 2016, through August 31, 2017), of which Amerigroup served an average of 134,642.[2]

The selected MCO assesses the STAR+PLUS member to determine the services the member needs. Based on the results of the assessment, the member is assigned a level ranging from Level 1 to Level 3. Level 1 members are those with the greatest medical need, and are generally members who are enrolled in the Home and Community-Based Services (HCBS) program or who are residents in nursing facilities. Amerigroup served 39,829 STAR+PLUS Level 1 members in state fiscal years 2017 and 2018 (September 1, 2016, through August 31, 2018).[3]

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

[1] "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."

[2] "Medicaid and CHIP MCO Enrollment by SDA, Final (SFY 2017)," HHSC, https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics (accessed Mar. 13, 2019).

[3] HHSC Medicaid Premiums Payable System data.

MCO service coordinators:

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

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.

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 evaluate whether Amerigroup complied with contractual requirements for performing service coordination in support of STAR+PLUS Level 1 members.

The audit scope included relevant activities during 2017 and 2018.

Methodology

To accomplish its objectives, the OIG Audit Division collected information through discussions and interviews with management and staff at Amerigroup and by reviewing documentation of service coordination activity Amerigroup provided to a sample of STAR+PLUS Level 1 members, and by reviewing:

- Policies and practices associated with the provision of service coordination activities to members.
- Information systems that support service coordination activities.
- General controls around data and the information technology systems used by service coordinators

For STAR+PLUS Level 1 members selected for testing, the OIG Audit Division reviewed service coordination data obtained from Amerigroup to corresponding eligibility information from OIG Data and Technology and individual service plans (ISPs) information from Texas Medicaid and Healthcare Partnership. The data was determined to be sufficiently reliable for audit purposes.

For the purposes of the audit, Level 1 members were defined as those in HCBS or nursing facility status at some time during the audit period, September 1, 2016, through August 31, 2018. For certain tests, the sample of 113 Level 1 members was divided into subsets based on whether the member was served through HCBS, was in a nursing facility, or transitioned between both, because of the differing specific service coordination requirements for each group.

For the 32 members whose STAR+PLUS enrollment date fell within the audit period, auditors tested whether each member was assessed within 90 days of enrollment.

For the 39 members being served by HCBS, auditors tested:

- Whether ISPs had been created for members.
- If service coordinators followed up with members regarding receipt of service in the members' ISPs.
- Whether members received the two annual face-to-face visits required during the audit period.

For the 69 members in nursing facilities, auditors tested:

- Whether members received the required quarterly face-to-face visits during the audit period.
- Whether 16 members who entered a nursing facility after February 28, 2017, received an assessment within 30 days of admission.

For the five members who transitioned from nursing facilities to HCBS or HCBS to nursing facilities, auditors tested:

- Whether members received required service coordination for applicable periods of time they were either in the HCBS program or a resident in a nursing facility.

The OIG Audit Division presented preliminary audit results, issues, and recommendations to MCS and to Amerigroup in a draft report dated June 12, 2019. Amerigroup, in a comment letter, indicated that it had implemented some action plans and is implementing other actions to improve service coordination.

MCS concurred with the OIG Audit Division recommendations and will require Amerigroup to submit a corrective action plan to correct the issues noted. MCS further indicated that its Results Management unit is developing an enhanced service coordination oversight module as part of the biennial onsite operational

review process that will include checking for MCO compliance with the contractual requirements noted in this audit. The MCS management responses are included in the report following each recommendation. Amerigroup's comments are included in Appendix B.

Criteria

- Uniform Managed Care Contract, Attachment B-1 §§ 8.3.2.1, 8.3.3.2, and 8.3.6.4 v. 2.19 (2016) through v. 2.25.1 (2018)
- STAR+PLUS Dallas and Tarrant Service Areas Contract, Attachment B-1 §§ 8.1.34.1, 8.1.35.2, and 8.1.40 v. 1.24 (2016) through v. 1.29 (2018)
- STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 §§ 8.1.36.1, 8.1.37.2, and 8.1.42 v. 1.10 (2016) through v. 1.14 (2018)
- STAR+PLUS Handbook, §§1200 and 1210 (2017 through 2018)

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.

RESULTS

Amerigroup assigned service coordinators to all 113 STAR+PLUS Level 1 members; assessed, within 90 days of enrollment, 32 members whose STAR+PLUS enrollment date fell within the audit period; and completed ISPs for all 44 members in the HCBS program.

However, 44 of 113 STAR+PLUS Level 1 members (39 percent) did not receive one or more of the required service coordination activities. Details about these exceptions are given in Appendix A. Specifically:

- 29 of 113 members did not receive the number of face-to-face visits required by the contract.
- 29 of 44 members in the HCBS program did not receive contacts following up on the receipt of approved services within 4 weeks of the ISP date, as required by the contract.
- 4 of 16 members entering a nursing facility after February 28, 2017, did not receive assessments within 30 days of admission, as required by the contract.

Issues related to face-to-face visits, follow-up contacts for HCBS members, and initial assessments for nursing facility residents are discussed in the sections that follow.

FACE-TO-FACE VISITS

MCOs are required to provide a minimum of two face-to-face service coordination visits annually to STAR+PLUS Level 1 members in the HCBS program, and quarterly face-to-face visits to members residing in a nursing facility. Nursing facility face-to-face visits may include nursing facility care planning meetings or interdisciplinary team meetings. MCOs are required to maintain, and make available upon request, documentation verifying the occurrence of required face-to-face service coordination visits.[4]

[4] Uniform Managed Care Contract, Attachment B-1 § 8.3.2.1 v. 2.19 (Sept. 1, 2016) through v. 2.25.1 (July 1, 2018), STAR+PLUS Dallas and Tarrant Service Areas Contract, Attachment B-1 § 8.1.34.1 v. 1.24 (Sept. 1, 2016) through v. 1.29 (Mar. 1, 2018), and STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 § 8.1.36.1, v. 1.10 (Sept. 1, 2016) through v. 1.14 (Mar. 1, 2018).

Issue 1: Service Coordinators Did Not Provide All Required Face-to-Face Visits

Amerigroup service coordinators did not provide all required face-to-face visits to STAR+PLUS Level 1 members. Of 113 sampled STAR+PLUS Level 1 members, 29 (26 percent) did not receive one or more of the service coordination visits Amerigroup should have provided.

There should have been 440 service coordination visits provided to the 113 sampled members. The 29 members who did not receive all visits should have received 118 visits, but received 73 visits. Overall, 45 (10 percent) of the 440 required visits were not provided. Members in HCBS and nursing facilities require different numbers of visits, and so are presented separately here. Table 1 summarizes the exceptions in Issue 1.

Table 1: Summary of Missing Face-To-Face Visits

Member Status	Number of Members	Number of Required Visits	Number of Visits Received	Missing Visits
HCBS	19	71	45	26
Transition to HCBS	3	9	6	3
HCBS Subtotal	22	80	51	29
Nursing Facility	7	38	22	16
Total	29	118	73	45

Source: OIG Audit Division

HCBS Members

Of the 39 members in the sample who were HCBS program-only members, 19 (49 percent) received fewer than the required number of face-to-face service coordination contacts. Of the 5 members in the sample who transitioned between HCBS and nursing facilities, 3 (60 percent) received fewer than the required number of face-to-face visits while in HCBS status.

There should have been 131 service coordination visits provided to these 44 members. The 22 members who did not receive all visits should have received 80 visits, but received 51 visits. Overall, 29 (22 percent) of the 131 required visits were not provided.

For the 22 members who received fewer than the required number of face-to-face service coordination visits:

- 15 members did not receive one required visit
- 7 members did not receive 2 required visits

The incidence of missed visits declined from 26 percent in 2017 to 18 percent in 2018. Table 2 shows HCBS members and missed visits by fiscal year.

Table 2: HCBS Members and Missed Visits by Fiscal Year

Audit Results	2017	2018
Members in Sample[5]	40	34
Members With Missing Visits[6]	18	11
Required Visits for Members in Sample	69	62
Missing Visits	18	11
Percent of Required Visits Missed	26	18

Source: OIG Audit Division

The length of time between the two required HCBS member visits each year varied widely. For the 44 members, there were 63 instances where 2 visits were required in a year. The length of time between visits, for the purposes of this audit, are called intervals. The 63 intervals between visits ranged from one to 15 months. The interval between visits ranged from one to 4 months in 28 instances. The interval between visits ranged from 12 to 15 months in 11 instances.

Applicable contracts do not specify an expected interval between the two required visits each year. The contracts say only that HCBS members "must receive a minimum of two face-to-face service coordination contacts annually."[7] The lack of clarity regarding expectations for the interval between the two required visits each year may result in extended timeframes between service coordination visits for HCBS members.

Nursing Facility Members

Of the 69 members in the sample who were nursing facility-only members, 7 (10 percent) received fewer than the required number of face-to-face service coordination contacts. All five of the members in the sample who transitioned between HCBS and nursing facilities received the required number of visits while in a nursing facility.

There should have been 309 service coordination visits provided to these 74 members. The 7 members who did not receive all visits should have received 38

[5] Of the 44 members in the sample, 8 should have received face-to-face visits in 2017 only, 2 should have received face-to-face visits in 2018 only, and 32 should have received face-to-face visits in both years. The remaining two members in the sample did not require face-to-face visits.

[6] Service coordinator visits were missed in both years for some members.

[7] Uniform Managed Care Contract, Attachment B-1 § 8.3.2.1 v. 2.19 (Sept. 1, 2016) through v. 2.25.1 (July 1, 2018), STAR+PLUS Dallas and Tarrant Service Areas Contract, Attachment B-1 § 8.1.34.1 v. 1.24 (Sept. 1, 2016) through v. 1.29 (Mar. 1, 2018), and STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 § 8.1.36.1, v. 1.10 (Sept. 1, 2016) through v. 1.14 (Mar. 1, 2018).

visits, but received 22 visits. Overall, 16 (5 percent) of the 309 required visits were not provided.

For the seven members who received fewer than the required number of quarterly face-to-face service coordination visits:

- Three members did not receive one required visit
- One member did not receive two required visits
- One member did not receive three required visits
- Two members did not receive four required visits

The incidence of missed visits declined from 8 percent in 2017 to 2 percent in 2018. Table 3 shows nursing facility members and missed visits by fiscal year.

Table 3. Nursing Facility Members and Missed Visits by Fiscal Year

Audit Results	2017	2018
Members in Sample[8]	51	52
Members With Missing Visits[9]	7	1
Required Visits for Members in Sample	158	151
Missing Visits	13	3
Percent of Required Visits Missed	8	2

Source: OIG Audit Division

By not ensuring service coordinators make the required number of face-to-face contacts with members, Amerigroup did not meet its contractual obligations. Further, Amerigroup may not have been aware of members' current conditions or ensure that members were receiving the appropriate services.

Recommendation 1.1

MCS, through its contract oversight responsibility, including the use of tailored contractual remedies as appropriate, should ensure Amerigroup provides:

- Two face-to-face visits annually for HCBS members
- Quarterly face-to-face visits for members in a nursing facility

[8] Of the 73 members in the sample, 16 should have received face-to-face visits in 2017 only, 15 should have received face-to-face visits in 2018 only, and 39 should have received face-to-face visits in both years. The remaining three members in the sample did not require face-to-face visits.

[9] Service coordinator visits were missed in both years for one member.

Management Response

Action Plan

Medicaid and CHIP Services Department (MCS) agrees with the recommendation. Managed Care Compliance and Operations (MCCO) will require Amerigroup to submit a corrective action plan (CAP) to document how Amerigroup will ensure members receive the contractually required number of visits for HCBS members and members in nursing facilities. Results Management (RM) is currently developing and will implement an enhanced service coordination oversight module as part of the biennial onsite Operational Review process. Compliance with contract requirements for service coordination visits will be included as part of this enhanced oversight module.

Responsible Manager

Director, Managed Care Compliance and Operations
Director, Results Management

Target Implementation Date

March 2020

Recommendation 1.2

MCS should clarify requirements for the interval between the two required face-to-face service coordination visits each year for HCBS members and consider establishing a maximum length of time that may elapse between the required visits.

Management Response

Action Plan

MCS will use its service coordination workgroup to develop the appropriate maximum length of time that may elapse between required visits and consider application across managed care programs for consistency. MCS will implement a contract change with the new maximum length of time effective 9/1/2020 in line with the annual managed care contract cycle.

Responsible Manager

Director, Policy and Program Development

Target Implementation Date

September 2020

FOLLOW-UP CONTACTS FOR HCBS MEMBERS

An MCO must complete an initial ISP, which is a written detail of the supports, activities, and resources required, for a STAR+PLUS Level 1 member once the member becomes a participant in the HCBS program. A service coordinator, or a member of the MCO's service coordination team, must contact a STAR+PLUS Level 1 member in the HCBS program no later than four weeks after the member's ISP start date to determine whether the services identified in the ISP are in place. After the initial ISP is established, the MCO must complete a new ISP for the member on an annual basis.[10]

Issue 2: Service Coordinators Did Not Always Follow Up Within Required Timeframes to Check on Members' Receipt of Approved Services

Amerigroup did not provide evidence to show that service coordinators contacted all HCBS members within four weeks of the ISP start date to determine whether the members were receiving the services identified in their ISPs.

The 44 members in the sample who participated in the HCBS program had 62 ISPs with beginning dates during the audit period. For 38 of the 62 ISPs (61 percent), associated with 29 of the 44 members, Amerigroup service coordinators did not contact the member within 4 weeks of the ISP start date. For 21 members, there was no evidence of a timely follow-up contact in 2017. For 17 members, there was no evidence of a timely follow-up contact in 2018. For 9 of the 29 members, there was no evidence of a timely follow-up contact in either year. Details about these exceptions are given in Table 4.

[10] Uniform Managed Care Contract, Attachment B-1 § 8.3.3.2 v. 2.19 (Sept. 1, 2016) through v. 2.25.1 (July 1, 2018), STAR+PLUS Dallas and Tarrant Service Areas Contract, Attachment B-1 § 8.1.35.2 v. 1.24 (Sept. 1, 2016) through v. 1.29 (Mar. 1, 2018), and STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 § 8.1.37.2, v. 1.10 (Sept. 1, 2016) through v. 1.14 (Mar. 1, 2018).

Table 4: HCBS Members Without Evidence of a Timely Follow-Up Contact

Sample ID	2017	2018
3		✓
6	✓	
10	✓	
12	✓	
13	✓	
20		✓
39	✓	✓
41		✓
46		✓
47	✓	✓
49		✓
50	✓	
52	✓	✓
55	✓	✓
60	✓	
65		✓
66	✓	
67	✓	
69	✓	
71	✓	✓
72	✓	
77	✓	✓
82	✓	✓
83	✓	
103		✓
106	✓	✓
107	✓	✓
110	✓	
113		✓
Total	21	17

Source: OIG Audit Division

By not ensuring service coordinators verified the members' timely receipt of approved services, Amerigroup did not meet its contractual obligations. In addition, Amerigroup may not have been aware of members who did not receive approved services within four weeks of the ISP start date and may have been experiencing delays in obtaining services.

Recommendation 2

MCS, through its contract oversight responsibility, including the use of tailored contractual remedies as appropriate, should ensure Amerigroup checks on members' receipt of approved services within four weeks of the ISP start date.

Management Response

Action Plan

MCS agrees with the recommendation. MCCO will require Amerigroup to submit a CAP to document how Amerigroup will ensure Amerigroup verifies members' receipt of approved services within four weeks of the ISP start date. RM is currently developing and will implement an enhanced service coordination oversight module as part of the biennial onsite Operational Review process. Compliance with contract requirements for service coordination verification of members' receipt of approved services within four weeks of the ISP start date will be included as part of this enhanced oversight module.

Responsible Manager

Director, Managed Care Compliance and Operations
Director, Results Management

Target Implementation Date

March 2020

Initial Assessments for Nursing Facility Residents

Effective March 1, 2017, MCOs are required to assess a STAR+PLUS Level 1 member within 30 days of the member's entry into a nursing facility.[11] No such requirement was in place for the first six months of the audit period.

Issue 3: Service Coordinators Did Not Always Assess Members in Nursing Facilities Within 30 Days of Admission

Amerigroup service coordinators did not always conduct assessments of STAR+PLUS Level 1 members within 30 days of a member's entry into a nursing

[11] Uniform Managed Care Contract, Attachment B-1 § 8.3.6.4 v. 2.19 (Sept. 1, 2016) through v. 2.25.1 (July 1, 2018), STAR+PLUS Dallas and Tarrant Service Areas Contract, Attachment B-1 § 8.1.40 v. 1.24 (Sept. 1, 2016) through v. 1.29 (Mar. 1, 2018), and STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 § 8.1.42, v. 1.10 (Sept. 1, 2016) through v. 1.14 (Mar. 1, 2018), and STAR+PLUS Handbook, § 1210, rev. 17-1(Mar. 1, 2017) through rev. 18-1 (Mar. 1, 2018).

facility. Of the 16 members who entered nursing facilities during the audit period, 4 (25 percent) did not receive a timely assessment.

By not ensuring service coordinators assessed members within 30 days of the members' admission to a nursing facility, Amerigroup did not meet its contractual obligations. Also, Amerigroup may not have been timely aware of a member's current condition and may not have known to take appropriate action to ensure the member received appropriate care.

Recommendation 3

MCS, through its contract oversight responsibility, including the use of tailored contractual remedies as appropriate, should ensure that Amerigroup's service coordinators assess members within 30 days of a member's entry into a nursing facility.

Management Response

Action Plan

MCS agrees with the recommendation. MCCO will require Amerigroup to submit a CAP to document how Amerigroup will ensure service coordinators assess members within 30 days of entry into a nursing facility. RM is currently developing and will implement an enhanced service coordination oversight module as part of the biennial onsite Operational Review process. Compliance with contract requirements for service coordinator assessment of members within 30 days of a member's entry into a nursing facility will be included as part of this enhanced oversight module.

Responsible Manager

Director, Managed Care Compliance and Operations
Director, Results Management

Target Implementation Date

March 2020

CONCLUSION

Amerigroup assigned service coordinators to all 113 STAR+PLUS Level 1 members; assessed, within 90 days of enrollment, 32 members whose STAR+PLUS enrollment date fell within the audit period; and completed ISPs for all 44 members in the HCBS program.

However, 44 of 113 STAR+PLUS Level 1 members (39 percent) did not receive one or more of the required service coordination activities. Specifically:

- 29 of 113 members did not receive the number of face-to-face visits required by the contract.
- 29 of 44 members in the HCBS program did not receive contacts following up on the receipt of approved services within 4 weeks of the ISP start date, as required by the contract.
- 4 of 16 members entering a nursing facility after February 28, 2017, did not receive assessments within 30 days of admission, as required by the contract.

The OIG Audit Division offered recommendations to MCS which, if implemented, will result in Amerigroup complying with its contractual requirements to:

- Provide two face-to-face visits annually for HCBS members and quarterly face-to-face visits for members residing in a nursing facility.
- Check on HCBS members' receipt of approved services within four weeks of the ISP start date.
- Assess members within 30 days of a member's entry into a nursing facility.

In addition, the OIG Audit Division offered a recommendation to MCS which, if implemented, will clarify requirements for the interval between the two required face-to-face service coordination visits each year for HCBS members.

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

Appendix A: Audit Exceptions Detail

The table below provides details about the members who did not receive one or more of the required service coordination activities for the following issues discussed in the report.

Issue 1: Service Coordinators Did Not Provide All Required Face-to-Face Visits

Issue 2: Service Coordinators Did Not Always Follow Up Within Required Timeframes to Check on Members' Receipt of Approved Services

Issue 3: Service Coordinators Did Not Always Assess Members in Nursing Facilities Within 30 Days of Admission

Sample ID	Issue 1	Issue 2	Issue 3
2	✓		
3		✓	✓
6	✓	✓	
9	✓		
10		✓	
12	✓	✓	
13	✓	✓	
20		✓	
23			✓
30	✓		
33	✓		
39	✓	✓	
40	✓		
41	✓	✓	
42	✓		
46		✓	
47		✓	
49	✓	✓	
50		✓	
52	✓	✓	
55	✓	✓	
59	✓		
60	✓	✓	
61			✓
63	✓		

Sample ID	Issue 1	Issue 2	Issue 3
65	✓	✓	
66	✓	✓	
67	✓	✓	
69	✓	✓	
71	✓	✓	
72	✓	✓	
77		✓	
78	✓		
82	✓	✓	
83		✓	
90			✓
98	✓		
102	✓		
103		✓	
106	✓	✓	
107		✓	
109	✓		
110		✓	
113		✓	
Total Members: 44	29	29	4

Source: OIG Audit Division

Appendix B: Amerigroup Comment Letter

Amerigroup
An Anthem Company

June 25, 2019

Steve Sizemore, CIA, CISA, CGAP
Audit Director
Texas Health and Human Services Commission
Office of Inspector General
Mail Code 1326
P.O. Box 85200
Austin, Texas 78708-5200

Dear Mr. Sizemore:

Amerigroup welcomes the opportunity to respond to the Office of the Inspector General audit of STAR+Plus Service Coordination for the state fiscal years 2017 and 2018. We appreciate the professionalism and cooperation of the Office of Inspector General's audit team and thank them for working with us during the audit.

This audit follows a previous UMR audit during SFY 2017 which identified similar issues. As such, the corrective action plans (CAPs) implemented following that audit obviously could not impact SFY 2017. We did, however, implement CAPs in order to impact SFY 2018. As a result, the auditors were able to identify areas in which the testing results showed improvement from SFY 2017 to SFY 2018. We expect to continue implementing and enhancing our CAPs to show even more improvement for SFY 2019.

Responses to specific recommendations

Recommendation 1.1

- Two face-to-face visits annually for HCBS members
- Quarterly face-to-face visits for members in a nursing facility

Amerigroup Comments:
Amerigroup utilizes multiple strategies to identify members who enter a nursing facility as early as possible. Amerigroup continues to request that nursing facilities provide timely notification when a member enters their facility. Most nursing facilities will not allow our service coordination team to review their daily census to identify our members. Because the facilities do not send us notice consistently, we also utilize both SAS authorizations and billed claims to identify new admissions. Depending on how quickly the nursing facility bills or when TMHP sends the authorization, identification of our NF members could be delayed. Any support from MCS to push nursing facilities to provide Amerigroup with those notifications will improve our ability begin quarterly face-to-face visits timely.

In addition, Amerigroup is reviewing staffing ratios and performing quality checks and audits to assure that face-to-face visits requirements are met.

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Recommendation 2

- MCS, through its contract oversight responsibility, including the use of tailored contractual remedies as appropriate, should ensure Amerigroup checks on members' receipt of approved services within four weeks of the ISP start date.

Amerigroup Comments:
As a result of the 2018 UMR audit, Amerigroup developed a dedicated 4-week follow up call team late in calendar year 2018. In addition, Amerigroup is reviewing staffing ratios and performing quality checks and audits to assure that members are in receipt of approved services within four weeks of the ISP start date.

Recommendation 3

- MCS, through its contract oversight responsibility, including the use of tailored contractual remedies as appropriate, should ensure that Amerigroup's service coordinators assess members within 30 days of a member's entry into a nursing facility.

Amerigroup Comments:
Amerigroup continues to request that nursing facilities provide timely notification when a member enters their facility. As noted above, relying on claims/authorization data delays our ability to identify and respond quickly when a member moves into a nursing facility. Support from MCS to encourage nursing facilities to provide Amerigroup with those notifications will enhance Amerigroup's ability to access members within 30 days of a member's entry into a nursing facility. In addition, Amerigroup's Nursing Facility Quality Improvement Program (NFQIP) has been designed to support early awareness of new admissions. Notification of admission is a component of the quality measure to help incentivize facilities to have members assessed within 30 days of admission.

Respectfully Submitted,

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Appendix C: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Anton Dutchover, CPA, Audit Manager
- Bruce Andrews, CPA, CISA, Audit Project Manager
- Yania Munro, CFE, CGAP, Audit Project Manager
- Megan Pedersen, Staff Auditor
- Marcos Castro, CIGA, Staff Auditor
- Mo Brantley, Senior Audit Operations Analyst

Report Distribution

Health and Human Services

- Dr. Courtney N. Phillips, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Victoria Ford, Chief Policy Officer
- Karen Ray, Chief Counsel
- Nicole Guerrero, Director of Internal Audit
- Stephanie Muth, State Medicaid Director, Medicaid and CHIP Services
- Dee Budgewater, Deputy Associate Commissioner of Policy and Program, Medicaid and CHIP Services
- Grace Windbigler, Director, Managed Care Compliance and Operations, Medicaid and CHIP Services
- Juliet Charron, Director, Results Management
- Michelle Erwin, Director, Policy and Program Development

Amerigroup

- Patrick Sturdivant, President and Chief Executive Officer
- Scott Scaff, Director, GBD Special Programs
- Bobbie Jo Jonas, Director, Regulatory Services

Appendix D: OIG Mission 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
- Olga Rodriguez, Chief of Strategy and Audit
- Quinton Arnold, Chief of Inspections and Investigations
- Steve Johnson, Interim Deputy IG for Medicaid Program Integrity
- Tony Owens, Deputy IG for Third Party Recoveries
- David Griffith, Deputy IG for Audit
- Alan Scantlen, Deputy IG for Data and Technology
- Lizet Hinojosa, Deputy IG for Benefits Program Integrity
- Judy Hoffman-Knobloch, Assistant Deputy IG for Medical Services

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

To Contact OIG

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
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