TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

AUDIT OF STAR+PLUS SERVICE COORDINATION

HealthSpring Life and Health Insurance Co., Inc.

August 22, 2019

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

WHY THE OIG CONDUCTED THIS AUDIT

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division has conducted an audit of service coordination for State of Texas Access Reform Plus (STAR+PLUS) Level 1 members performed by HealthSpring Life and Health Insurance Co., Inc., doing business as Cigna-HealthSpring (Cigna), a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO).

The audit objective was to evaluate whether Cigna complied with contractual requirements for performing service coordination in support of STAR+PLUS Level 1 members. The audit scope included relevant activities during the period from September 1, 2017, through December 31, 2018.

WHAT THE OIG RECOMMENDS

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

- 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:
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August 22, 2019

AUDIT OF STAR+PLUS SERVICE COORDINATION

HealthSpring Life and Health Insurance Co., Inc.

WHAT THE OIG FOUND

Cigna completed individual service plans (ISPs) for all 61 members in the Home and Community-Based Services (HCBS) program.

However, 43 of 113 STAR+PLUS Level 1 members (38 percent) did not receive one or more of the required service coordination activities. Specifically:

- 28 of 113 members did not receive the number of face-to-face visits required by the contract.
- 24 of 61 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.
- 5 of 9 members entering a nursing facility during the audit period 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 13 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.

In addition, the OIG Audit Division judgmentally selected five members categorized as nursing facility residents during the audit period. Results indicated that 3 of the 5 members received 14 of 15 required service coordination visits. The other two members had not resided in a nursing facility during the audit period.

Cigna served 16,970 STAR+PLUS Level 1 members during the audit scope. The OIG Audit Division selected a 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 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 Cigna in a draft report dated July 29, 2019. Cigna, in a comment letter, indicated it has implemented system enhancements designed to more readily identify and rectify potential service coordination issues. MCS concurred with the OIG Audit Division recommendations and will require Cigna 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 conducted an audit of service coordination for State of Texas Access Reform Plus (STAR+PLUS) Level 1 members performed by HealthSpring Life and Health Insurance Co., Inc., doing business as Cigna-HealthSpring (Cigna), a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO).

STAR+PLUS is a Texas Medicaid managed care program for 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, Molina Healthcare of Texas, Superior HealthPlan, and UnitedHealthcare Community Plan. The STAR+PLUS program served an average of 526,768 members per month state fiscal year 2018 (September 1, 2017, through August 31, 2018), of which Cigna served an average of 49,746.[1]

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. Cigna served 16,970 STAR+PLUS Level 1 members during the period September 1, 2017, through December 31, 2018.[2]

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] HHS Healthcare Statistics, "Medicaid and CHIP 2018 Historical Medicaid Enrollment by SDA," https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics (accessed July 25, 2019).

[2] 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 Cigna'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 Cigna complied with contractual requirements for performing service coordination in support of STAR+PLUS Level 1 members.

The audit scope included relevant activities during fiscal year 2018 and the first four months of fiscal year 2019.

Methodology

To accomplish its objectives, the OIG Audit Division collected information through discussions and interviews with management and staff at Cigna and by reviewing documentation of service coordination activity Cigna 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 Cigna, corresponding eligibility information from OIG Data and Technology, and individual service plans (ISPs)

information from Texas Medicaid and Healthcare Partnership (TMHP). 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, 2017, through December 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 60 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 one member who transitioned from HCBS to a nursing facility, auditors tested:

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

For the 52 members in nursing facilities, auditors tested:

- Whether members received the required quarterly face-to-face visits during the audit period.
- Whether 9 members who entered a nursing facility during the audit period received an assessment within 30 days of admission.

The OIG Audit Division presented preliminary audit results, issues, and recommendations to MCS and to Cigna in a draft report dated July 29, 2019. Cigna, in a comment letter, indicated it has implemented system enhancements designed to more readily identify and rectify potential service coordination issues. MCS concurred with the OIG Audit Division recommendations and will require Cigna 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.

Criteria

- Uniform Managed Care Contract, Attachment B-1 §§ 8.3.2.1, 8.3.2.2, 8.3.2.3, 8.3.3.2 and 8.3.6.4 v. 2.24 (2017) through v. 2.26 (2018)

- STAR+PLUS Dallas and Tarrant Service Areas Contract, Attachment B-1 §§ 8.1.34.1, 8.1.34.2, 8.1.34.3, 8.1.35.2, and 8.1.40 v. 1.28 (2017) through v. 1.30 (2018)

- STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 §§ 8.1.36.1, 8.1.36.2, 8.1.36.3, 8.1.37.2, and 8.1.42 v. 1.13 (2017) through v. 1.15 (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

Cigna completed ISPs for all 61 members in the HCBS program. However, 43 of the sample of 113 STAR+PLUS Level 1 members (38 percent) did not receive one or more of the required service coordination activities. Details about these exceptions are given in Appendix A. Specifically:

- 28 of 113 members did not receive the required number of face-to-face visits required by the contract.
- 24 of 61 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.
- 5 of 9 members entering a nursing facility during the audit period 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.[3] The number of visits required for the members in the sample varied based on their time in the HCBS program or a nursing facility. For example, a member enrolled in HCBS for 10 months would not require face-to-face visits since the contract does not specify a maximum length of time between visits, only that they receive 2 within 12 months.

[3] Uniform Managed Care Contract, Attachment B-1 § 8.3.2.1, v. 2.24 (Sept. 1, 2017) through v. 2.26 (Sept. 1, 2018); STAR+PLUS Dallas and Tarrant Service Areas Contract, Attachment B-1 §§ 8.1.34.1, v.1.28 (Sept. 1, 2017) through v.1.30 (Sept. 1, 2018); and STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 § 8.1.36.1, v. 1.13 (Sept. 1, 2017) through v. 1.15 (Sept. 1, 2018).

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

Cigna 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, 28 (25 percent) did not receive one or more of the service coordination visits Cigna should have provided.

Taking into consideration the number of months each member was enrolled in the program, there should have been 265 service coordination visits provided to the 113 sampled members. The 28 members who did not receive all visits should have received 76 visits, but received 44 visits. Overall, 32 (12 percent) of the 265 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	17	34	16	18
Nursing Facility	10	40	27	13
Transition to Nursing Facility	1	2	1	1
Nursing Facility Subtotal	11	42	28	14
Total	28	76	44	32

Source: OIG Audit Division Analysis of Information Provided by Cigna

HCBS Members

Of the 61 members in the sample who were in HCBS status at some point during the audit period, 17 (28 percent) received fewer than the required number of face-to-face service coordination contacts.

There should have been 94 service coordination visits provided to these 61 members. The 17 members who did not receive all visits should have received 34 visits, but received 16 visits. Overall, 18 (19 percent) of the 94 required visits were not provided.

For the 17 members who received fewer than the required number of face-to-face service coordination visits:

- 16 members did not receive one required visit
- One member did not receive 2 required visits

The length of time between the two required annual HCBS member visits each year varied widely. The length of time between visits, for the purposes of this audit, are called intervals. For the 61 members, 44 intervals occurred during the audit period. The 44 intervals between visits ranged from one to 13 months. The interval between visits ranged from one to four months in ten instances. The interval between visits ranged from 10 to 13 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."[4] 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 53 members in the sample who were in a nursing facility at some point during the audit period, 11 (21 percent) received fewer than the required number of face-to-face service coordination contacts.

There should have been 171 service coordination visits provided to these 53 members. The 11 members who did not receive all visits should have received 42 visits, but received 28 visits. Overall, 14 (8 percent) of the 171 required visits were not provided.

For the 11 members who received fewer than the required number of quarterly face-to-face service coordination visits:

- Eight members did not receive one required visit
- Three member did not receive two required visits

By not providing evidence to show that service coordinators made the required number of face-to-face contacts with members, Cigna did not demonstrate that it met its contractual obligation. Further, Cigna did not establish with evidence that it was aware of all members' current conditions or had ensured that members were receiving the appropriate services.

[4] Uniform Managed Care Contract, Attachment B-1 § 8.3.2.1, v. 2.24 (Sept. 1, 2017) through v. 2.26 (Sept. 1, 2018); STAR+PLUS Dallas and Tarrant Service Areas Contract, Attachment B-1 §§ 8.1.34.1, v.1.28 (Sept. 1, 2017) through v.1.30 (Sept. 1, 2018); and STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 § 8.1.36.1, v. 1.13 (Sept. 1, 2017) through v. 1.15 (Sept. 1, 2018).

Additional Judgmental Sample

The OIG Audit Division judgmentally[5] selected five Cigna STAR+PLUS Level 1 members categorized as nursing facility residents from September 1, 2016, through February 2, 2019. The five members were selected because of the absence of encounter data supporting services delivered to these members during the audit period.

The OIG Audit Division asked Cigna to submit evidence of service coordination activity for the five members during the audit period of September 1, 2017, through December 31, 2018. Cigna submitted evidence indicating three of the five members were in a nursing facility, and the other two were not in a nursing facility during the audit period.

Table 2 details the number of face-to-face visits the three members confirmed to be residing in a nursing facility should have received during the audit period, the number of visits provided, and the number of missed visits.

Table 2: Summary of Face-to-Face Visits for Three Judgmentally Selected Members

Sample ID	Number of Visits Required	Number of Visits Completed	Number of Visits Missed
114	5	5	0
115	5	5	0
118	5	4	1
Total	15	14	1

Source: OIG Audit Division Analysis of Information Provided by Cigna

For the two members not residing in a nursing facility, members 116 and 117, Cigna did not conduct required face-to-face visits because the members resided in the community during the audit period. Cigna became aware that the members had moved back into the community, in March 2015 for member 116 and December 2013 for member 117. The information provided by Cigna indicated that, on multiple occasions, the members were advised to update their status and location with HHSC.

Cigna asserted that both members' level of care was revised to Level 3 based on their non-nursing facility status. Level 3 members require two telephone contacts annually. Cigna provided documentation that member 116 received three contacts during the audit period. For member 117, Cigna did not provide documentation of two telephone contacts during the audit period.

[5] "Judgmental sampling" is a non-probability sampling method where the auditor selects the sample based on certain characteristics, such as dollar amount, timeframe, or type of transaction.

The Texas Administrative Code requires nursing facilities to submit a resident transaction notice to TMHP, within 72 hours of discharge of a Medicaid member. The notice is processed to close the nursing facility authorization for the dismissed member, who subsequently is removed from a nursing facility risk group.[6] The respective nursing facilities that members 116 and 117 previously resided in did not submit required resident transaction notices to HHSC when the members were discharged from the facility.

Recommendation 1.1

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

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

Management Response

Action Plan

Medicaid and CHIP Services Department (MCS) agrees with the recommendation. Managed Care Compliance and Operations (MCCO) will require Cigna to submit a corrective action plan (CAP) to document how Cigna 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 to close CAP and implement oversight module

[6] 40 Tex. Admin. Code § 19.2615 (Sept. 3, 2008).

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.[7]

[7] Uniform Managed Care Contract, Attachment B-1 § 8.3.3.2, v. 2.24 (Sept. 1, 2017) through v. 2.26 (Sept. 1, 2018); STAR+PLUS Dallas and Tarrant Service Areas Contract, Attachment B-1 §§ 8.1.35.2, v.1.28 (Sept. 1, 2017) through v.1.30 (Sept. 1, 2018); and STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 § 8.1.37.2, v. 1.13 (Sept. 1, 2017) through v. 1.15 (Sept. 1, 2018).

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

Cigna 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 61 members in the sample who participated in the HCBS program had 70 ISPs with beginning dates during the audit period. For 24 of the 70 ISPs (34 percent), associated with 24 of the 61 members, Cigna service coordinators did not contact the member within 4 weeks of the ISP start date.

Compliance with this requirement improved over the course of the audit period. Of the 24 ISPs without timely follow up, 21 had start dates during the first 6 months of the audit period (September 1, 2017, through February 28, 2018). Only 3 of the 24 instances occurred during the last 10 months of the 16-month audit period.

By not providing evidence to show that service coordinators verified the timely receipt of approved services, Cigna did not demonstrate that it met all of its contractual obligations. In addition, Cigna did not establish with evidence that it was aware of all members who may not have received 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 Cigna 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 Cigna to submit a CAP to document how Cigna will ensure Cigna 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 to close CAP and implement oversight module

INITIAL ASSESSMENTS FOR NURSING FACILITY RESIDENTS

MCOs are required to assess a STAR+PLUS Level 1 member within 30 days of the member's entry into a nursing facility.[8]

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

Cigna service coordinators did not always conduct assessments of STAR+PLUS Level 1 members within 30 days of a member's entry into a nursing facility. Of the 9 members who entered nursing facilities during the audit period, 5 (56 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, Cigna did not meet its contractual obligations. Also, Cigna 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 Cigna's service coordinators assess members within 30 days of a member's entry into a nursing facility.

[8] Uniform Managed Care Contract, Attachment B-1 § 8.3.6.4 v. 2.24 (Sept. 1, 2017) through v. 2.26 (Sept. 1, 2018); STAR+PLUS Dallas and Tarrant Service Areas Contract, Attachment B-1 § 8.1.40 v. 1.28 (Sept. 1, 2017) through v. 1.30 (Sept. 1, 2018); STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 § 8.1.42, v. 1.13 (Sept. 1, 2017) through v. 1.15 (Sept. 1, 2018); and STAR+PLUS Handbook, § 1210, revisions 17-5 (Sept. 1, 2017) through 18-3 (Oct. 1, 2018).

Management Response

Action Plan

MCS agrees with the recommendation. MCCO will require Cigna to submit a CAP to document how Cigna 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 to close CAP and implement oversight module

CONCLUSION

Cigna completed ISPs for all 61 members in the HCBS program. However, 43 of 113 STAR+PLUS Level 1 members (38 percent) did not receive one or more of the required service coordination activities. Specifically:

- 28 of 113 members did not receive the required number of face-to-face visits required by the contract.
- 24 of 61 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.
- 5 of 9 members entering a nursing facility during the audit period 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 Cigna 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 Cigna 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
4	✓		
5	✓	✓	
8	✓	✓	
10	✓		
13		✓	
15	✓		
18	✓		
23		✓	
31	✓		
32	✓		
33	✓	✓	
34	✓		
35		✓	
40	✓	✓	
41	✓		
42	✓	✓	
44	✓	✓	
50		✓	
52		✓	
54	✓		✓
55	✓		
56		✓	
58		✓	
59	✓		
60	✓		

Sample ID	Issue 1	Issue 2	Issue 3
62		✓	
64	✓	✓	
65	✓		✓
73	✓	✓	
75	✓	✓	
77	✓	✓	
78	✓		
80			✓
82			✓
84		✓	
85		✓	
91		✓	
92	✓		✓
102	✓	✓	
104	✓		
110		✓	
111	✓		
113		✓	
Total Members: 43	28	24	5

Source: OIG Audit Division Analysis of Information Provided by Cigna

Appendix B: Cigna Comment Letter

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August 19, 2019

Via Electronic Mail and Overnight Delivery

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Re: Management Response to Audit of STAR+PLUS Service Coordination

Dear Mr. Sizemore,

On behalf of Cigna-HealthSpring, I am submitting this management response to the recommendations set forth in the draft audit report issued on July 29, 2019 by the Office of Inspector General ("OIG"), Texas Health and Human Services Commission ("HHSC").

We appreciate the OIG's express recognition that our performance increased over the course of the audit period, as this confirms the effectiveness of our proactive operational initiatives and our ongoing commitment to compliance. As you may know, the Q3 SFY2019 HHSC Utilization Review report of Cigna-HealthSpring's Home and Community Based Services ("HCBS") program, published in July 2019, resulted in a similar acknowledgement of our accomplishments in achieving a perfect (100%) score in initial assessments, which exceeds the overall score for all Texas Medicaid managed care organizations by over thirty percent (30%), and a performance score for four-week follow up visits that exceeds the overall managed care score by over thirty-five percent (35%). Against that backdrop, our responses to the OIG's recommendations are as follows.

Recommendation 1.1 – MCS, through its contractual oversight responsibility, including the use of tailored contractual remedies as appropriate, should ensure Cigna provides: i.) two face-to-face visits annually for HCBS members, ii.) quarterly face-to-face visits for members in a nursing facility.

Steve Sizemore
August 12, 2019
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Cigna-HealthSpring takes all findings of noncompliance seriously, and it has reviewed the records of the members in the test population. Cigna-HealthSpring determined that several of the members did not receive face-to-face visits during the period being tested because they were not enrolled for Level 1 benefits at the time.

Eligibility Issues

According to the Draft Audit Report, the scope of this audit was the provision of service coordination to Level 1 members. The confusion arises because some members had been ineligible for Level 1 care during the actual dates being tested, but subsequent eligibility determinations implemented the Level 1 services with retroactive effective dates, making it seem as though the members should have been receiving a higher level of services. When a retroactive eligibility determination is effectuated, the HHSC eligibility records do not retain the enrollment and level of care data that had been approved for that member during the actual test period dates. Cigna-HealthSpring confirmed the lower enrollment levels of care for certain members through its archive of daily enrollment files, and it produced those files to the OIG during its audit field work.

This concern affects all Medicaid health plans. The Texas Association of Health Plans ("TAHP") has notified HHSC of its concerns regarding nursing facility reconciliation of data affecting ineligibility periods, disenrollments, reinstatements, and retroactive eligibility determinations. TAHP provided detailed information from five different Medicaid plans about the fiscal effects of inaccurate nursing facility eligibility data. The health plans found that the data discrepancies created difficulties in assigning appropriate benefits, adjudicating claims, reconciling premium revenues, and developing quality programs.

If a health plan is expected to provide face-to-face care coordination services within a limited time period but it does not learn about that member's Level 1 enrollment or admission to an inpatient or residential facility until after the deadline has elapsed, timely compliance is an impossibility. These circumstances are beyond the control of the health plan.

Cigna-HealthSpring respectfully submits that such members may be outliers within the audit testing population. Although the audit findings are technically true, the circumstances surrounding such cases illustrate a more complex situation.

For example, one of the members in the test population was transferred from nursing care to a hospital admission, and then was discharged from the hospital to a different nursing facility. Neither of the nursing facilities nor the hospital notified Cigna-HealthSpring of these transfers. The Service Coordinator traveled to the original nursing facility twice in an effort to complete the quarterly visit, but was informed by facility staff that the member was not in residence. The Service Coordinator was ultimately able to visit the member, but due to the timing of the hospital discharge, the Service Coordinator's visit did not occur before the end of the quarter, so the untimely visit resulted in an audit finding.

Cigna-HealthSpring has also identified an instance in which a member transferred from HCBS to a hospital and later to a hospice admission before all HCBS face-to-face visits had been completed within the audit period.

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Cigna-HealthSpring makes every effort to maintain current records on all members, and to arrange the appropriate services for those members who change levels of care or whose eligibility is later reinstated on a retroactive basis. HHSC has acknowledged that these transitional patients can create confusion and difficulty in determining contract performance. Corrective action requires the collaboration of CMS, Cigna-HealthSpring, HHSC, and health facility providers.

Documentation

Cigna-HealthSpring acknowledges, however, that its documentation does not clearly evidence the timely performance of eighteen biannual HCBS visits, fourteen quarterly nursing facility visits in the standard test population, and one quarterly nursing facility visit in the judgmentally-selected nursing facility population. Cigna-HealthSpring notes that in some instances, the visits were performed but they occurred shortly after the test period, thereby resulting in audit findings. In other instances, Cigna-HealthSpring was unable to produce sufficient documentation of the services, particularly during the early months of the audit period. The members' files and attached documents had to be manually reviewed in a search for the correct visit documentation and these limitations in the reporting data may have also affected the information that was available to the auditors during this engagement.

Cigna-HealthSpring has since developed a system enhancement that now pulls more detailed HCBS reports. Cigna-HealthSpring has also continued to monitor those individuals and has determined that they received required services during the following ISP year.

With respect to the nursing facility quarterly visits, the original iteration of the Service Coordinator system application did not capture in-facility Inter-Disciplinary Care Team ("IDCT") meetings between the team and the member as one of the quarterly face-to-face visits. It is likely that if these IDCT meetings had been tracked and reported appropriately, some of the audit findings from the standard test population would not have been issued. Cigna-HealthSpring has implemented system enhancements to capture these visits more accurately.

To the extent any face-to-face visits may not have occurred, the recent system enhancements are designed to more readily identify any lapses. Moreover, Cigna-HealthSpring has modified its internal processes to require more frequent automated reporting so that delays can be identified more quickly and rectified within the contractual deadlines.

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.

We agree with the OIG's observation that some of the findings may result from vague contractual provisions, and we will collaborate with HHSC Medicaid and CHIP Services ("MCS") to develop and adhere to more precise performance criteria.

The OIG Draft Audit Report notes that the contract does not specify a maximum length of time between visits within a twelve-month period. Cigna-HealthSpring further observes that the contract does not specify whether the year is determined by calendar year, state fiscal year, or rolling annual calculations based on the date of the ISP. There may have been inconsistencies in the application of this requirement among different Service Coordinators. Cigna-HealthSpring appreciates the OIG's willingness to consider the inconsistency and raise it as a matter for further

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discussion with MCS.

Recommendation 2 – MCS, through its contract oversight responsibility, including the use of tailored remedies as appropriate, should ensure Cigna checks on members' receipt of approved services within four weeks of the ISP start date.

Cigna-HealthSpring agrees that it did not produce adequate evidence to show that Service Coordinators contacted all HCBS members in the test population within four weeks of the ISP start date to confirm the receipt of services. As part of its system improvements, Cigna-HealthSpring developed a note type for Four-Week ISP Follow Up contacts, so that these efforts are more readily identifiable within the automated system without the need for manual research to demonstrate the provision of such services.

To the extent certain ISP follow-up contacts occurred after the applicable deadlines, the automated note type will assist managers in identifying lapses or delays more quickly so they can be addressed and rectified within the contractual deadlines.

Cigna-HealthSpring notes that one of the members was admitted to the hospital, thus changing the level of care, during the test period. The member began receiving a higher level of services beyond those approved in the ISP.

Recommendation 3 – MCS, through its contract oversight responsibility, including the use of tailored contractual remedies as appropriate, should ensure that Cigna's service coordinators assess members within 30 days of a member's entry into a nursing facility.

Cigna-HealthSpring agrees that it did not produce adequate evidence to show that Service Coordinators assessed all nursing facility residents within thirty days of admission to the facility. As part of its system improvements, Cigna-HealthSpring developed a specific electronic file for IDCT Assessments that are captured and reported as such without the need for manual research. These efforts are now more readily identifiable within the automated system.

To the extent certain Admission Assessments were performed after the applicable deadlines, the more frequent reporting will assist managers in identifying lapses or delays more quickly so they can be addressed and rectified within the contractual deadlines.

Cigna-HealthSpring notes that one of the nursing facility residents in the test population was not eligible for nursing facility care during the thirty-day post-admission period of record. Rather, the member received a retroactive re-enrollment determination. Although the member was retroactively approved for services, the individual was not actually residing in the facility during the first thirty days of the enrollment period and Cigna-HealthSpring was not on notice that the member was eligible for the services.

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In conclusion, Cigna-HealthSpring has invested considerable resources toward ensuring that STAR+PLUS members are being served consistently with HHSC requirements. While some of our earlier data challenges have affected the results of this audit, we have continued to develop our systems, and those efforts have resulted in material improvements. We are committed to continuing full and transparent dialogue regarding its continued compliance and service to our members. We welcome the opportunity to collaborate with HHSC as we fulfill our internal commitment to those guiding principles.

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Despite the rebuttals set forth in this response, we are grateful to the OIG for its professionalism, impartiality, and willingness to maintain open communication with our representatives throughout the audit process. We thank you for your time and consideration of these responses and your continued partnership.

Very truly yours,

M. Daniel Chambers, Pharm.D

Appendix C: Report Team and Distribution

Report Team

The OIG staff members who contributed to this audit report include:

- David Griffith, CPA, CIA, CGFM, Deputy IG for Audit
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- Anton Dutchover, CPA, Audit Manager
- Bruce Andrews, CPA, CISA, Audit Project Manager
- JoNell Abrams, CIGA, Staff Auditor
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Report Distribution

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- Dosetta Cavaness, Vice President Service Coordination, Cigna
- Heidi Arndt, Compliance Director, Cigna
- John Marshall, Government Compliance

Appendix D: OIG Mission, Leadership, and Contact Information

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

- Sylvia Hernandez Kauffman, Inspector General
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Olga Rodriguez, Chief of Strategy and Audit
- Quinton Arnold, Chief of Inspections and Investigations
- Steve Johnson, Interim Chief of Medicaid Program Integrity

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