Inspections Report

Case-by-Case Services

Community First Health Plans

August 6, 2024

OIG Report No. INS-24-009

Inspector General

Texas Health and Human Services

Case-by-Case Services

Community First Health Plans

Results in Brief

Why OIG Conducted This Inspection

Case-by-case services are additional health-related services not covered by the state plan that an MCO may offer individual members. MCOs have the flexibility to provide case-by-case services without obtaining approval from the Texas Health and Human Services Commission (HHSC). MCOs may not include case-by-case services in the reporting of Medicaid medical expenses HHSC uses to calculate capitation payments. MCOs are financially responsible for the case-by-case services they provide.

The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Inspections) initiated this inspection series because of the potential for MCOs to misclassify encounters in their HHSC financial reports.

Summary of Review

The inspection objective was to determine whether Community First Health Plans (Community First) reported case-by-case services in accordance with applicable requirements. The inspection scope covered the period from September 1, 2021, through August 31, 2022.

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Key Results

Community First Health Plans, Inc. (Community First), a Texas Medicaid managed care organization (MCO), misclassified encounter data for non-covered services on its financial statistical reports (FSRs) submitted to the Texas Health and Human Services Commission (HHSC). Additionally, Community First did not maintain documentation to support the reason for providing case-by-case services.

Of the 1,720 tested encounters, 322 (19 percent) were not coded with the correct financial arrangement code to classify them as case-by-case services. Community First confirmed that it included the non-covered services as covered medical expenses, thereby overstating the total Medicaid medical expenses by $141,948 on its 2022 FSR.

Additionally, Community First did not have a mechanism to document the reason for providing non-covered services as case-by-case services, as required.

Recommendations

Community First should:

- Implement controls to correctly classify non-covered services it provides as case-by-case services.
- Code non-covered services as case-by-case services using financial arrangement code 21 and report the benefits as “Total Case-by Case Services” on part 5 of the FSR, “Medical Expenses by Service Type,” in the “Not Included in Total Medical Above” section.
- Consult HHSC Financial Reporting and Audit Coordination to determine how best to correct the misreported medical expenses.
- Develop and implement a process to document the reason for providing non-covered services as case-by-case services.

Management Response

Community First agreed with the recommendations and indicated all corrective actions would be implemented by January 2025.

Table of Contents

Inspection Overview 1

Overall Results 1

Objective 2

Scope 2

Background 2

What Prompted This Inspection 3

Detailed Results 4

Observation 1: Community First Did Not Accurately Report Non-Covered Services as Case-by-Case Services 4

Observation 2: Community First Did Not Maintain Required Documentation for Case-by-Case Services 7

Appendix A: Methodology, Standards, and Criteria 9

Appendix B: Related Reports 11

Appendix C: Resources for Additional Information 12

Appendix D: Report Team and Distribution 13

Appendix E: OIG Mission, Leadership, and Contact Information 15

Inspection Overview

Overall Results

Inspection Terminology

Case-by-case services are additional health-related services not covered by the state plan that an MCO may offer individual members.

Community First Health Plans, Inc. (Community First), a Texas Medicaid managed care organization (MCO), misclassified encounter data for non-covered services on its financial statistical reports[1] (FSRs) submitted to the Texas Health and Human Services Commission (HHSC). Additionally, Community First did not maintain documentation to support the reason for providing case-by-case services.

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Inspections) selected Community First as part of a series of inspections on the reporting of case-by-case services.

Of the 1,720 encounters tested, Community First did not submit 322 (19 percent) encounters with the correct financial arrangement code[2] to classify them as case-by-case services.

Community First confirmed with OIG Inspections that it included the non-covered services as medical expenses, thereby overstating the total medical expenses by $141,948 on its 2022 FSR.

Additionally, Community First did not have a mechanism to document the reason for providing non-covered services as case-by-case services, as required.

OIG Inspections offered recommendations to Community First, which, if implemented, will improve the accuracy of Community First's encounter data and FSR reporting.

This report is considered written education in accordance with Texas Administrative Code.[3] Inspection findings identified in this report (a) may be referred to HHSC for

[1] FSRs contain income statements with all reportable revenues and expenses, including administrative and quality improvement expenses, that MCOs submit to HHSC for each program and service area where the submitting MCO operates.
[2] MCOs include the financial arrangement code in their encounter data, which indicates how they reimbursed the claim.
[3] 1 Tex. Admin. Code § 371.1701 (May 1, 2016).

potential pursuit of enforcement remedies or (b) may be subject to OIG administrative enforcement measures,[4] including administrative penalties.[5]

OIG Inspections presented preliminary inspection results, observations, and recommendations to Community First in a draft report dated July 22, 2024. Community First agreed with the recommendations and indicated all corrective actions would be implemented by January 2025. Community First's management responses are included in the report following each recommendation.

OIG Inspections thanks management and staff at Community First for their cooperation and assistance during this inspection.

Objective

The inspection objective was to determine whether Community First reported case-by-case services in accordance with applicable requirements.

Scope

The inspection scope covered the period from September 1, 2021, through August 31, 2022.

Background

The MCOs' contracts with HHSC specify the scope of benefits that are covered under Medicaid. MCOs receive a fixed monthly capitation payment for each member to provide covered benefits. There may be situations in which MCOs opt to provide additional benefits outside the scope of services included in their contracts.

Case-by-case services are additional health-related services not covered by the state plan that an MCO may offer individual members. Case-by-case services allow MCOs to exercise their judgment in providing quality and appropriate care to their members. Some of the factors that MCOs may consider when approving case-by-case services are medical necessity, cost-effectiveness, and the potential for improving the member's health.[6]

[4] 1 Tex. Admin. Code § 371.1603 (May 20, 2020).

[5] Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

[6] Uniform Managed Care Contract, Attachment B 1, § 8.1.2.2, v. 2.34 (Sept. 1, 2021) and v. 2.35 (Mar. 1, 2022).

MCOs have the flexibility to provide case-by-case services without obtaining approval from HHSC. However, MCOs may not include case-by-case services in the reporting of Medicaid medical expenses HHSC uses to calculate capitation payments and are financially responsible for the case-by-case benefits they provide.[7]

During the scope of the inspection, Community First received $668 million in Texas Medicaid funds and served an average of 143,843 Texas Medicaid recipients each month.

What Prompted This Inspection

In 2019, the OIG audited provider claims reported by an MCO,[8] which found encounters coded with incorrect financial arrangement codes. As a result, the MCO misclassified the encounters in HHSC financial reports. Appendix B includes the link to the audit report.

OIG Inspections initiated this inspection series because of the potential for MCOs to misclassify encounters in their HHSC financial reports.

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[7] Uniform Managed Care Contract, Attachment B 1, § 8.1.2.2, v. 2.34 (Sept. 1, 2021) and v. 2.35 (Mar. 1, 2022).

[8] Texas HHS Office of Inspector General, *UnitedHealthcare Encounter Data: Records of Provider Services Delivered Under a Sub-Capitated Agreement Were Coded Incorrectly*, OIG Report No. AUD-19-011 (Feb. 26, 2019).

Detailed Results

Community First may provide benefits to individual Medicaid members beyond the scope of its contract with HHSC. The MCO must maintain documentation supporting the reason for providing the non-covered services and report the corresponding encounters as case-by-case services on the FSRs.

The following report sections provide additional detail about the findings of noncompliance observed by OIG Inspections.

Observation 1: Community First Did Not Accurately Report Non-Covered Services as Case-by-Case Services

Community First incorrectly included 322 of 1,720 tested encounters as part of its total Medicaid medical expenses in its FSRs. These encounters for non-covered services were not coded as case-by-case services. The misreported expenses totaled $141,948.

Community First did not code these encounters for non-covered services as case-by-case services using financial arrangement code 21.[9] In written communications, Community First confirmed the claims were paid in error due to the reimbursement terms in its provider contract, incorrect claims payer system configuration for the procedure codes associated with these encounters, and manual processing errors.

All 322 encounters used financial arrangement code 07 (internal fee-for-service general claims).

MCOs must enter the expenses paid for non-covered services as "Total Case-by-Case Services" on part 5 of the FSR, "Medical Expenses by Service Type," in the "Not Included in Total Medical Above" section.[10]

Community First did not code the 322 tested encounters as case-by-case services, but rather misclassified them as covered benefits. Community First misclassified reported encounter data and carried the error through to its financial reporting,

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[9] Texas Medicaid and Healthcare Partnership, Publication 837P, Texas Medicaid: HIPAA Transaction Standard Companion Guide-MCO, v. 17 (Sept. 2021, as amended) requires code 21 to identify a case-by-case service encounter.

[10] Uniform Managed Care Manual, Chapter 5.3.1.90, v. 2.0.1 (Aug. 1, 2021) and Chapter 5.3.1.100, v. 2.0 (Nov. 28, 2022).

resulting in $141,948 in overstated medical expenses in the FSRs. FSRs are one of the sources of information HHSC uses to determine the capitation rate it pays each MCO. In addition, HHSC uses the FSR to calculate the potential experience rebate[11] the MCO may owe. Inaccurate data on the FSRs affects those calculations and may lead to the state overpaying an MCO for Medicaid services.

Community First recognized that the tested procedure codes were not covered Medicaid benefits. Community First acknowledged that its claims payer system did not deny the claims, resulting in it processing 322 encounters as covered Medicaid benefits.

Recommendation 1.1

Community First should implement controls to correctly classify non-covered services it provides as case-by-case services.

Recommendation 1.2

Community First should code non-covered services as case-by-case services using financial arrangement code 21 and report the benefits as "Total Case-by Case Services" on part 5 of the FSR, "Medical Expenses by Service Type," in the "Not Included in Total Medical Above" section.

Recommendation 1.3

Community First should consult with HHSC Financial Reporting and Audit Coordination to determine how best to correct the misreported medical expenses.

Management Response

Action Plan

Community First has reviewed Observation 1 and acknowledges each of the recommendations as written. Community First understands the importance of implementing the necessary controls to correctly classify non-covered services as case-by-case services and ensure proper use of financial arrangement code (FAC) 21 to correctly classify encounters as case-by-case. We further understand the importance of accurately reporting case-by-case services to ensure such services do not overstate total Medicaid medical expenses on the FSR.

[11] An "experience rebate" is the portion of the MCO's net income before taxes that is shared with the state based on profit-sharing provisions in HHSC's contracts with the MCO.

To comply with these recommendations, Community First has begun to flow out the inspection results and test various outcomes that help to significantly reduce and ultimately eliminate the possibility of non-compliance. Specifically, Community First will conduct a comprehensive assessment of its claims to encounters lifecycle to ensure non-payable codes are appropriately categorized as case-by-case services and ensure respective encounters are correctly coded with FAC 21.

Community First will develop and implement ongoing monitoring processes to audit claims and encounters for case-by-case services. We have begun reviewing impacted claims to reconcile reports already submitted to HHSC. Lastly, Community First will consult with HHSC Financial Reporting and Audit Coordination to determine how best correct misreported medical expenses.

Responsible Managers

- Chief Financial Officer
- Executive Director, Information Systems

Target Implementation Date

January 31, 2025

Observation 2: Community First Did Not Maintain Required Documentation for Case-by-Case Services

OIG Inspections randomly selected 50 records from the 1,720 encounters to test whether Community First documented the reason for providing the case-by-case service. Of the 50, 24 should have been recorded as case-by-case services with required documentation.

Community First did not have a mechanism to document the reason for providing non-covered services as case-by-case services, as required. HHSC requires MCOs to maintain documentation of each authorized case-by-case service provided to each member. The documentation must include the reason for providing the benefit.[12]

Recommendation 2

Community First should develop and implement a process to document the reason for providing non-covered services as case-by-case services.

Management Response

Action Plan

Community First has reviewed Observation 2 and acknowledges the recommendation as written. To comply with this recommendation, Community First will leverage its prior authorization and appeal processes to ensure appropriate documentation is obtained to support the reason for providing non-covered services as case-by-case services.

Community First will review configuration within our claims payment system to ensure proper controls are in place to accurately identify and deny non-covered services without an approved authorization on file. If payment is requested for non-covered services, an appeal must be received with appropriate clinical documentation to assess for medical necessity. Authorization details and supporting documentation will be captured in our clinical management system. If a non-covered service(s) is deemed medically necessary after receipt of supporting documentation, the associated claim will be reconsidered for payment as an authorized case-by-case service.

[12] Uniform Managed Care Contract, Attachment B 1, § 8.1.2.2, v. 2.34 (Sept. 1, 2021) and v. 2.35 (Mar. 1, 2022).

Community First will develop and implement cross-functional operating procedures to ensure approved authorizations and supporting documentation is on file for non-covered services deemed payable as case-by-case. Community First will also develop and implement ongoing monitoring processes to evaluate the effectiveness of controls put in place to prevent improper payment of non-covered services when there is no approved authorization with supporting documentation on file.

Responsible Managers

- Chief Medical Officer
- Executive Director, Information Systems

Target Implementation Date

January 31, 2025

Appendix A: Methodology, Standards, and Criteria

Detailed Methodology

To achieve its objective, OIG Inspections collected information through (a) discussions with Community First staff and (b) a review of Community First's:

- Encounter data for selected procedure codes from September 1, 2021, through August 31, 2022.
- Policies and procedures that address the objective.
- Selected patient records.
- Fourth quarter 2022 FSRs for the State of Texas Access Reform (STAR) program.[13]

To select an MCO for inspection, OIG Inspections considered the following criteria:

- MCOs' responses to an OIG Inspections questionnaire.
- Number of encounters for procedure codes that are not covered Medicaid benefits.
- Dollar amounts paid to providers for procedure codes that are not covered Medicaid benefits.
- Fourth quarter 2022 STAR FSRs with no reported dollar amounts for case-by-case services.

OIG Fraud Analytics and Data Operations staff provided data consisting of 9,967 Community First encounters, which consisted of 40 procedure codes.

[13] The inspection focused on the STAR program, which provides care for 75 percent of Texas Medicaid beneficiaries.

OIG Inspections applied three parameters to the 9,967 encounters:

- Excluded encounters containing financial arrangement codes 11[14] and 21, which eliminated 2,649 encounters.
- Excluded paid amounts between $0.00 and $0.99, which eliminated seven encounters.
- Excluded age at the time of service less than 22 years old,[15] which eliminated 5,591 encounters.

These applied parameters reduced the population to 1,720 encounters.

Standards

OIG Inspections conducts inspections of Texas HHS programs, systems, and functions. Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of fraud, waste, or abuse. Inspection reports present factual data accurately, fairly, and objectively, and present findings, conclusions, and recommendations in a persuasive manner to strengthen program effectiveness and efficiency. OIG Inspections conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

Criteria

OIG Inspections used the following criteria to evaluate the information provided:

- Uniform Managed Care Contract, Attachment B 1, § 8.1.2.2, v. 2.34 (2021) and v. 2.35 (2022)
- Uniform Managed Care Manual, Chapter 5.3.1.90, v. 2.0.1 (2021) and Chapter 5.3.1.100, v. 2.0 (2022)

[14] Financial arrangement code 11 (value-added services) is like financial arrangement code 21 as these services are not included in the rate setting process.

[15] The age parameter served to exclude encounters for Texas Health Steps services, which are not considered case-by-case services.

Appendix B: Related Reports

- Case-by-Case Services: Community Health Choice, INS-24-008, July 11, 2024
- UnitedHealthcare Encounter Data: Records of Provider Services Delivered Under a Sub-Capitated Agreement Were Coded Incorrectly, AUD-19-011, February 26, 2019

Appendix C: Resources for Additional Information

The following resources provide additional information about the topics covered in this report.

For more information on Community First Health Plans:

Homepage Community First Health Plans, Inc., https://communityfirsthealthplans.com/ (accessed July 12, 2024)

Appendix D: Report Team and Distribution

Report Team

OIG staff members who contributed to this inspection report include:

- Anton Dutchover, CPA, Deputy Inspector General of Audit and Inspections
- Bruce Andrews, CPA, CISA, Director of Inspections
- James Aldridge, CFE, Manager of Inspections
- Casey Gibson, Lead Inspector
- Jeffrey Fullam, CFE, Lead Inspector
- Mo Brantley, Senior Audit Operations Analyst

Report Distribution

Texas Health and Human Services Commission

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- Camisha D. Banks, Deputy Executive Commissioner for Managed Care
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Community First Health Plans

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- Dr. Jessica Yao, Chief Medical Officer
- Kethra Barnes, Executive Director of Compliance and Risk Management
- Kevin Nyaribo, Executive Director of Information Systems
- Sarah Herron, Director of Audit 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:

- Raymond Charles Winter, Inspector General
- Susan Biles, Principal Deputy Inspector General
- Kacy J. VerColen, Chief of Audit and Inspections
- Eugenia Krieg, Chief of Staff, Chief of Policy and Performance
- Erik Cary, Chief Counsel
- Diane Salisbury, Chief of Data Reviews
- Matt Chaplin, Chief of Operations
- Steve Johnson, Chief of Investigations and Utilization Reviews

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