Inspections Report

Case-by-Case Services

Community Health Choice

July 11, 2024
OIG Report No. INS-24-008

Inspector General

Texas Health and Human Services

Case-by-Case Services

Community Health Choice

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 Health Choice (Community) reported case-by-case services in accordance with applicable requirements. The inspection scope covered the period from September 1, 2021, through August 31, 2022.

For more information, contact:
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Key Results

Community Health Choice Texas, Inc. (Community), 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 did not maintain documentation to support the reason for providing case-by-case services.

Of the 6,152 tested encounters, 4,797 encounters (78 percent) were not coded with the correct financial arrangement code to classify them as case-by-case services. Community confirmed that it included the non-covered services as covered medical expenses, thereby overstating the total Medicaid medical expenses by $934,772 on its 2022 FSR.

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

Recommendations

Community 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 provided as case-by-case services.

Management Response

Community agreed with the recommendations and indicated all corrective actions would be implemented by October 2024.

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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 Health Choice Texas, Inc. (Community), 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 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 as part of a series of inspections on the reporting of case-by-case services.

Of the 6,152 encounters tested, Community did not code 4,797 (78 percent) with the correct financial arrangement code to classify them as case-by-case services.

Community confirmed with OIG Inspections that it included the non-covered services as covered medical expenses, thereby overstating the total medical expenses by $934,772 on its 2022 FSR.

Additionally, Community 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, which, if implemented, will help improve the accuracy of Community's encounter data and FSR reporting.

This report is considered written education in accordance with Texas Administrative Code.[2] Inspection findings identified in this report (a) may be referred to HHSC for potential pursuit of enforcement remedies or (b) may be subject to OIG administrative enforcement measures,[3] including administrative penalties.[4]

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[1] FSRs contain income statements with all reportable revenues and expenses, including medical, administrative, and quality improvement expenses, that MCOs submit to HHSC for each program and service area where the submitting MCO operates.

[2] 1 Tex. Admin. Code § 371.1701 (May 1, 2016).

[3] 1 Tex. Admin. Code § 371.1603 (May 20, 2020).

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

OIG Inspections presented preliminary inspection results, observations, and recommendations to Community in a draft report dated June 13, 2024. Community agreed with the recommendations and indicated all corrective actions would be implemented by October 2024. Community's management responses are included in the report following each recommendation.

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

Objective

The inspection objective was to determine whether Community 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.[5]

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

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

payments and are financially responsible for the case-by-case benefits they provide.[6]

During the scope of the inspection, Community received $1.8 billion in Texas Medicaid funds and served an average of 370,690 Texas Medicaid recipients from two counties each month.

What Prompted This Inspection

In 2019, the OIG audited provider claims reported by an MCO,[7] 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.

[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).

[7] 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 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. OIG Inspections also communicated other, less significant issues to Community in a separate written communication.

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

Community incorrectly included 4,797 of 6,152 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 $934,772.

Community did not code these encounters for non-covered services as case-by-case services using financial arrangement code 21.[8] In follow-up communication with OIG Inspections, it stated the claims were, "Paid per provider contract but misclassified in FSR and encounter reporting."

Of the 4,797 encounters:

- 4,446 used financial arrangement code 07 (internal fee-for-service general claims).
- 351 used financial arrangement code 08 (internal behavioral health 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.[9]

[8] 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.

[9] 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).

Community did not code the 4,797 tested encounters as case-by-case services, but rather misclassified them as covered benefits. Community misclassified reported encounter data and carried the error through to its financial reporting, resulting in $934,772 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[10] 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 recognized that the tested procedure codes were not covered Medicaid benefits. Its claims payer system did not deny the claims, resulting in it processing 4,797encounters as covered Medicaid benefits.

Recommendation 1.1

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

Recommendation 1.2

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

Management Response

Action Plan

Community Health Choice Texas, Inc. ("Community") acknowledges the observation and the need to accurately classify non-covered services it provides as case-by-case services in its encounter and FSR reporting. Community has identified a comprehensive list of non-payable codes and has developed a process to ensure case-by-case services are accurately classified and assigned to

[10] 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.

FAC 21 on all encounters and claims received on and after dates of service of 7/1/24, which will support more accurate reporting of such costs on future FSRs.

Responsible Managers

- Chief Financial Officer
- Chief Operating Officer

Target Implementation Date

July 2024

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

OIG Inspections randomly selected 50 records from the 6,152 encounters to test whether Community recorded the reason for providing the case-by-case service. Of the 50, 39 should have been recoded as case-by-case services with required documentation.

Community 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.[11]

Recommendation 2

Community 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 acknowledges the observation and the need to develop and implement processes and improve upon its system controls for creating and maintaining supporting documentation for claims classified as case-by-case services. Community will implement controls in our claims payment system that will flag non-covered and non-payable services. The control will result in the

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

claim being in a pend or denied status until an authorization request is received. Authorization requests for these codes will require review by a nurse or Medical Director before approving or denying the authorization. Should the service be deemed medically necessary or satisfy other criteria supporting the provision of case-by-case services, the nurse or Medical Director will be required to document the reason that the authorization is approved in compliance with the UMCC. Additional training will be provided to the Medical Affairs Department and its leadership team to ensure that the requirements are clear and followed going forward.

Responsible Managers

- Chief Medical Officer
- Chief Operating Officer

Target Implementation Date

October 2024

Appendix A: Methodology, Standards, and Criteria

Detailed Methodology

To achieve its objective, OIG Inspections collected information through (a) discussions with Community staff and (b) a review of Community'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.[12]

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 that did not indicate any case-by-case services reporting.

OIG Fraud Analytics and Data Operations staff provided data consisting of 19,891 Community encounters, which consisted of 38 procedure codes.

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

OIG Inspections applied two parameters to the 19,891 encounters:

- Excluded paid amounts between $0.00 and $0.99, which eliminated 2,171 encounters.
- Excluded age at the time of service less than 22 years old,[13] which eliminated 11,568 encounters.

These applied parameters reduced the population to 6,152 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)

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

Appendix B: Related Reports

- 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 Health Choice:

Homepage, Community Health Choice Texas, Inc., https://www.communityhealthchoice.org/ (accessed July 10, 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
- Jeffrey Fullam, CFE, Lead Inspector
- Casey Gibson, Lead Inspector
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- Lisa Wright, Chief Executive Officer and President
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- Chris Buley, Chief Legal Officer and Interim Chief Compliance Officer
- Laurie Levermann, Chief Operating Officer
- Marylou Buyse, Chief Medical Officer
- Anna Mateja, Chief Financial Officer

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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