Inspections Report

Case-by-Case Services

Superior HealthPlan, Inc., and
Superior HealthPlan Network

Inspector General

Texas Health and Human Services

October 23, 2024
OIG Report No. INS-25-001

Case-by-Case Services

Superior HealthPlan, Inc., and Superior HealthPlan Network

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 Superior HealthPlan Inc. and Superior HealthPlan Network (Superior) 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

Superior HealthPlan Inc. and Superior HealthPlan Network (Superior), 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).

Of the 6,604 encounters tested, Superior did not code 1,517 (23 percent) with the correct financial arrangement code to classify them as case-by-case services. Superior confirmed with OIG Inspections that it included the non-covered services as covered medical expenses, thereby overstating the total medical expenses by $65,588 on its 2022 FSR.

From the encounters classified as case-by-case services, OIG Inspections tested 32 patient records for supporting documentation. Superior had documentation to support the reason for providing non-covered Medicaid services, as required.

Recommendations

Superior 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.

Management Response

Superior agreed with the recommendations and indicated all corrective actions had been 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.

Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior), 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).

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

Of the 6,604 encounters tested, Superior did not code 1,517 (23 percent) with the correct financial arrangement code to classify them as case-by-case services.

Superior confirmed with OIG Inspections that it included the non-covered services as covered medical expenses, thereby overstating the total medical expenses by $65,588 on its 2022 FSR.

From the encounters classified as case-by-case services, OIG Inspections tested 32 patient records for supporting documentation. Superior had documentation to support the reason for providing non-covered Medicaid services, as required.

OIG Inspections offered recommendations to Superior, which, if implemented, will help improve the accuracy of its encounter data and FSR reporting.

This report is considered written education in accordance with Texas Administrative Code.[2] The inspection finding 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] This

[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).

report does not address compliance beyond the scope and objective of this inspection.

OIG Inspections presented preliminary inspection results, observations, and recommendations to Superior in a draft report dated October 2, 2024. Superior agreed with the recommendations and indicated all corrective actions had been implemented by October 2024. Superior's management response is included in the report following the recommendation.

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

Objective

The inspection objective was to determine whether Superior 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

[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).

reporting of Medicaid medical expenses HHSC uses to calculate capitation payments and MCOs are financially responsible for the case-by-case benefits they provide.[6]

During the scope of the inspection, Superior received almost $9.6 billion in Texas Medicaid funds and served an average of nearly 1.3 million Texas Medicaid recipients from 11 service areas 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

Superior 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 section provides additional detail about the finding of noncompliance observed by OIG Inspections. OIG Inspections also communicated other, less significant issues to Superior in a separate written communication.

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

Superior incorrectly included 1,517 of 6,604 tested encounters (23 percent) 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 $65,588.

Superior did not code these encounters for non-covered services as case-by-case services using financial arrangement code 21.[8] In written communications, Superior confirmed the claims were paid in error due to incorrect claims payer system configuration and manual processing errors for the procedure codes associated with these encounters.

All 1,517 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.[9]

Superior did not code the 1,517 tested encounters as case-by-case services, but rather misclassified them as covered benefits. Superior misclassified reported

[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).

encounter data and carried the error through to its financial reporting, resulting in $65,588 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.

Superior recognized that the tested procedure codes were not covered Medicaid benefits. Manual errors and an incorrectly configured claims payer system resulted in Superior erroneously processing 1,517 encounters as covered Medicaid benefits.

Recommendation 1.a

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

Recommendation 1.b

Superior 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.c

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

Management Response

Action Plan

During the SFY 22 audit period, Superior had controls in place to classify non-covered Medicaid services as case-by-case using the correct financial arrangement code, as evidenced by the 77% of non-covered service claims submitted to HHSC as encounters using the accurate and appropriate case-by-case financial arrangement code.

[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.

Subsequent to SFY22, Superior identified opportunities for improvement to increase compliance. These additional controls include:

1. Updating configuration for a subset of procedure codes billed by a few contracted provider groups previously coded incorrectly. These provider groups accounted for the majority percentage of encounters not appropriately submitted as case-by-case encounters during SFY22.
2. Additional training of claims analysts to address the manual processing errors that caused the failure to categorize certain non-covered procedure codes as case-by-case services. Periodic reporting will be extracted on an ongoing basis to verify all non-covered codes are accurately submitted in encounters as case-by-case services, and to also validate that covered codes are not submitted in error as case-by-case encounters.
3. Updating the claims system configuration to remediate certain non-covered codes that resulted in erroneous reimbursement.

Superior has initiated communication with HHSC's Financial Reporting and Audit Coordination (FRAC) on this topic and requested recommended next steps for FSR reporting for the impacted period.

Responsible Managers

- Chief Financial Officer
- Vice President, Configuration and Claims Support Services

Implementation Date

October 2024

Appendix A: Methodology, Standards, and Criteria

Detailed Methodology

To achieve its objective, OIG Inspections collected information through (a) discussions with Superior staff and (b) a review of Superior'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.[11]

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.

OIG Fraud Analytics and Data Operations staff provided data consisting of 55,896 Superior encounters.

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

Of the 55,896 encounters, OIG Inspections excluded those with:

- Paid amounts between $0.00 and $0.99, which eliminated 20,516 encounters.
- Age at the time of service less than 21 years old,[12] which eliminated 25,824 encounters.

Inspections selected the 20 most frequently occurring procedure codes, which reduced the population to 6,604 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)

[12] 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 First Health Plans, INS-24-009, August 6, 2024
- 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 Superior HealthPlan:

Homepage, Superior HealthPlan
https://www.superiorhealthplan.com (accessed August 7, 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
- Mo Brantley, Senior Audit Operations Analyst

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- Sara Robins, Vice President, Compliance
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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:

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- 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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