Inspections Report

Delivery Supplemental Payments

Medicaid CHIP Services—
Financial Reporting and Audit Coordination

August 31, 2021
OIG Report No. INS-21-009

Inspector General

Texas Health and Human Services

TABLE OF CONTENTS

INTRODUCTION

The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Inspections) conducted an inspection of delivery supplemental payments processed by Medicaid and CHIP Services (MCS)—Financial Reporting and Audit Coordination (FRAC).

The Texas Health and Human Services Commission (HHSC) contracts with managed care organizations (MCOs) to facilitate the delivery of healthcare services for which the MCOs receive a capitation rate on a per member per month basis. MCOs participating in State of Texas Access Reform (STAR), Children's Health Insurance Program (CHIP), and CHIP perinatal programs submit and receive payments for qualified delivery supplemental payment claims to cover hospital expenses for the delivery of a child. Delivery supplemental payments are intended to make costs associated with a pregnancy equitable, in particular when a pregnant MCO member transfers to a different plan toward the end of pregnancy.

In 2016, HHS OIG audited delivery supplemental payments to evaluate the effectiveness of processes and controls intended to ensure delivery supplemental payment claims and appeals were processed timely and accurately. The 2016 OIG audit report identified issues with claims processing, appeals administration, and the control environment related to delivery supplemental payments.[1] The audit recommended transferring the delivery supplemental payment process from HHSC Strategic Decision Support to MCS—FRAC to help ensure delivery supplemental payment claims and appeals are administered in accordance with policy and contract requirements. HHSC Strategic Decision Support agreed to transferring the process to MCS FRAC and implemented the change in the 2017 fiscal year. The remainder of this inspection report will refer to FRAC as the owner of the process.

In addition, the audit contained the following recommendations relevant to the inspection objectives:

- MCS should periodically verify that claims are supported by data.
- Delivery supplemental payment claims procedures should be updated to perform periodic retrospective reviews to identify whether retroactive eligibility changes affected claim adjudications.
- MCS should establish detailed written policies and procedures for processing delivery supplemental payment claims in accordance with the

[1] "Audit of Delivery Supplemental Payments," OIG Report No. IG-16-050 (Nov. 8, 2016).

Uniformed Managed Care Contract and Uniform Managed Care Manual requirements.

The audit found claims whose payment amounts would have been different if changes in eligibility status after the delivery had been applied retroactively. Eligibility can change from the time of the original delivery supplemental payment claim submission. If FRAC were to do reviews in which prior claims submitted were reviewed with updated coverage, they would be able to identify changes in eligibility which may result in overpayments and underpayments made by HHSC to MCOs if applied retroactively.

Objectives and Scope

The inspection objectives were to determine whether FRAC:

- Periodically verifies that claims are valid and adequately supported.
- Conducts retrospective reviews of delivery supplemental payment claims to reprocess claims as necessary and adjust identified overpayments and underpayments due to eligibility changes including those identified in the 2016 audit.
- Implemented policies and procedures to ensure delivery supplemental payment claims are processed timely and accurately.

The inspection scope covered current processes and claims in the period from January 1, 2021, through March 31, 2021. The inspection scope additionally covered actions taken since the 2016 audit to address the inspection objectives.

Background

More than 50 percent of all Texas births are covered by Medicaid.[2] MCOs must submit a monthly report to HHSC identifying delivery supplemental payment claims for payment. MCOs that administer STAR and CHIP programs receive a one-time delivery supplemental payment from HHSC for each eligible birth by a member within 20 business days after receipt of a complete and accurate report from the MCO.[3] The payment amount is a function of the average delivery cost in

[2] Texas Medicaid and CHIP Reference Guide, 13th ed., Texas Health and Human Services Commission (2020).

[3] Uniform Managed Care Contract, Attachment A, § 10.09(c), v. 2.31 (Sept. 1, 2020) through v. 2.32 (Mar. 1, 2021).

the service area for STAR MCOs. CHIP Perinatal MCOs receive a lump-sum payment of $3,100 for each birth.[4]

Methodology

OIG Inspections reviewed policies and procedures implemented by FRAC that address the inspection objectives as well as the recommendations identified in the 2016 audit of delivery supplemental payments.

The inspection team reviewed a sample of 970 delivery supplemental payment claims that were ultimately paid from a population of 34,530 delivery supplemental payment claims received from January 1, 2021, to March 30, 2021. The 970 claims were tested against Texas Integrated Eligibility Redesign System (TIERS) case data to identify potential discrepancies between case and claim data.[5] Additionally, the team performed a data analysis of all 34,530 claims and their diagnosis codes to identify diagnosis codes that would invalidate a delivery supplemental payment claim. Details about the methodology are given in Appendix A.

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. Inspections typically result in observations and may result in recommendations 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.

[4] Texas Medicaid and CHIP Reference Guide, 13th ed., Texas Health and Human Services Commission (2020).

[5] Texas Integrated Eligibility Redesign System (TIERS) is an application utilized by HHSC to determine eligibility for state benefits such as Medicaid.

INSPECTION RESULTS

FRAC is responsible for overseeing delivery supplemental payment claims and making payments to MCOs. FRAC has created and implemented policies and procedures to ensure delivery supplemental payment claims are processed timely and accurately in accordance with contractual requirements. Testing of the sample population of 970 claims found that all claims reviewed were valid and adequately supported by TIERS case information.

The inspection verified that the overpayments and underpayments identified in the 2016 audit have been paid or collected except for $1,641,123.68 in overpayments made to one MCO. As of July 2021, these overpayments were still outstanding pending an appeal with a decision expected by August 31, 2021.

FRAC has taken action to help eliminate acceptance of claims based on insufficient or invalid diagnosis codes by revising the list of eligible diagnosis codes and increasing the number of codes required to validate a delivery. However, 27 payments, out of the 34,530 reviewed, were not appropriate based on gestation period diagnosis codes.

While retrospective reviews of delivery supplemental payments were initially planned in response to the 2016 audit, FRAC suspended those retrospective reviews of delivery supplemental payment claims in calendar year 2018 due to technical issues with the delivery supplemental payment application.

Observation 1: FRAC Is Not Performing Retrospective Reviews of Delivery Supplemental Payment Claims

In response to the 2016 audit recommendation, FRAC asserted it designed a feature in its delivery supplemental payment application to do retrospective reviews of eligibility; however, FRAC determined that the retrospective review feature did not work as intended. As a result, FRAC has not performed any subsequent retrospective reviews.

Medicaid eligibility and MCO membership can change frequently. These changes take time to process and can occur during the processing of a delivery supplemental payment. Retrospective reviews help ensure delivery supplemental payments are made appropriately to MCOs with eligible Medicaid members.

As of 2021, FRAC asserted it was developing a new delivery supplemental payment processing application that will be deployed within the HHS Enterprise Portal in 2022. FRAC intends for the new application to include a feature to conduct retrospective reviews.

Recommendation 1

FRAC should create and implement procedures to conduct retrospective reviews.

Observation 2: Not All Pertinent Diagnosis Codes Are Included in the Automated Diagnosis Code Check When Validating Delivery Supplemental Payment Claims

The Uniform Managed Care Contract defines an eligible delivery supplemental payment claim as delivery of the birth of a live born infant, regardless of the pregnancy duration, or a stillbirth of 20 weeks or more of gestation.[6]

In 2018, FRAC verified a sample of 381 out of 37,715 delivery supplemental payment claims processed from September through November 2017 and found that 96.2 percent of the sampled accepted claims had a match to a child's date of birth in TIERS. The remaining 3.8 percent of claims without a child match contained diagnosis codes to indicate a miscarriage or stillbirth. The manual review validated claims by identifying a child with a matching date of birth or an eligible diagnosis code.

The inspection team conducted a review of the diagnosis codes associated with 34,530 delivery supplemental payment claims received from January 1, 2021, through March 30, 2021, and found that all but 27 were appropriately paid. The 27 identified claims contained diagnoses codes to indicate a stillbirth had occurred with less than 20 weeks of gestation, which do not meet the UMCC's criteria for a delivery supplemental payment. The 27 claims resulted in overpayments of $103,847.07.

The procedures for validating delivery supplemental payments consist of verifying whether claims contain eligible diagnosis codes for delivery supplemental payments. However, the current coding of the delivery supplemental payment validation process does not include an additional check for stillbirth diagnosis codes to ensure ineligible or eligible gestation periods are identified. This could result in overpayments to MCOs for ineligible delivery supplemental payment claims.

[6] Uniform Managed Care Contract, Attachment A, § 10.09(b), v. 2.31 (Sept. 1, 2020) through v. 2.32 (Mar. 1, 2021).

Recommendation 2.1

FRAC should improve procedures to ensure all pertinent diagnosis codes are identified when validating delivery supplemental payment claims.

Recommendation 2.2

FRAC should collect overpayments in the amount of $103,847.07, if appropriate, issued to MCOs for the 27 identified claims during the inspection. Additionally, FRAC should identify and collect overpayments made for claims containing stillbirth and less than 20 weeks gestation diagnosis codes in periods outside of the scope of the inspection.

CONCLUSION

Since the 2016 audit of delivery supplemental payments, FRAC has created and implemented user manuals, guides, and policies and procedures to ensure delivery supplemental payment claims are processed timely and accurately in accordance with contractual requirements. FRAC asserted that in 2017 it transitioned from a manual process to a web-based application for greater efficiency and accuracy. FRAC continues to improve and update the delivery supplemental payment application and has taken action to help eliminate acceptance of claims based on insufficient or invalid diagnosis codes by revising the list of eligible diagnosis codes and increasing the number of codes required to validate a delivery; however, not all pertinent diagnosis codes are included. Additionally, FRAC has not implemented all the recommendations from the 2016 audit. Specifically, FRAC does not perform retrospective reviews of delivery supplemental payment claims.

OIG Inspections offered recommendations to FRAC, which, if implemented, will improve the validation of paid delivery supplemental payments and assist in identifying ineligible delivery supplemental payment claims submitted by MCOs.

OIG Inspections thanks the management and staff of FRAC for their cooperation and assistance during this inspection.

Appendix A: Detailed Methodology

OIG Inspections examined delivery supplemental payment claims for January 1, 2021, to March 31, 2021. OIG Inspections identified 34,530 delivery supplemental payment claims, that were ultimately paid, during this quarter.

Validating Delivery Supplemental Payment Claim Information in TIERS

The inspection team reviewed a sample of 970 delivery supplemental payment claims from a population of 34,530 delivery supplemental payment claims received from January 1, 2021, to March 31, 2021 that were ultimately paid. The sample was generated using a random number generator in Excel for each of the months in the scope period. The team selected 300 random STAR member claims for each of the three months and all 70 CHIP member claims for the quarter. The final sample of 970 claims was tested to identify potential discrepancies between claims and case data in TIERS. The TIERS case data for the claims was reviewed to identify whether:

- The member had continued Medicaid or CHIP coverage for the month of delivery.
- A child was present in TIERS with a date of birth matching the date of delivery.
- The client had an eligible diagnosis code to validate a reason a child may be missing from the TIERS case information, such as stillbirth or miscarriage.

Identifying Invalid Diagnosis Codes in Paid Delivery Supplemental Payment Claims

The inspection team requested all information for delivery supplemental payment claims received by FRAC from MCOs in the period of January 1, 2021, to March 31, 2021. The team performed a data analysis of all 34,530 claims that were ultimately paid and their diagnosis codes to identify diagnosis codes that would invalidate a delivery supplemental payment claim.

The inspection team reviewed each claim to identify if a diagnosis code indicating a stillbirth was present. The codes identified for this diagnosis were:

- Z37.1—Single stillbirth
- Z37.4—Twins, both stillborn
- Z37.7—Other multiple births, all stillborn

The inspection further reviewed claims containing the above diagnosis codes to identify the gestation period using the following diagnosis codes:

- Z3A.01–Z3A.09—Weeks of gestation period, weeks 1–9
- Z3A.1—Weeks of gestation period, weeks 10–19

Appendix B: Report Team and Distribution

Report Team

OIG staff members who contributed to this inspection report include:

- Kacy J. VerColen, CPA, Deputy Inspector General of Audit and Inspections
- Bruce Andrews, CPA, CISA, Director of Inspections
- James Aldridge, Manager of Inspections
- Marco Diaz, Team Lead for Inspections
- Benjamin Munoz, Inspector
- Mo Brantley, CFE, Senior Audit Operations Analyst

Report Distribution

Health and Human Services

- Cecile Erwin Young, Executive Commissioner
- Kate Hendrix, Chief of Staff
- Maurice McCreary, Jr., Chief Operating Officer
- Victoria Ford, Chief Policy and Regulatory Officer
- Karen Ray, Chief Counsel
- Michelle Alletto, Chief Program and Services Officer
- Nicole Guerrero, Director of Internal Audit
- Stephanie Stephens, Deputy Executive Commissioner, Medicaid and CHIP Services
- Emily Zalkovsky, Deputy State Medicaid Director, Medicaid and CHIP Services
- Shannon Kelley, Associate Commissioner for Managed Care, Medicaid and CHIP Services
- Jason Mendl, Director, Financial Reporting and Audit Coordination
- Sri Kommana, Director, Financial Statistical Report (FSR) Reporting

Appendix C: 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
- Juliet Charron, Chief of Strategy
- Steve Johnson, Chief of Investigations and Reviews
- Audrey O'Neill, Chief of Audit and Inspections

To Obtain Copies of OIG Reports

- OIG website: ReportTexasFraud.com

To Report Fraud, Waste, and Abuse in Texas HHS Programs

- Online: https://oig.hhs.texas.gov/report-fraud-waste-or-abuse
- Phone: 1-800-436-6184

To Contact OIG

- Email: OIGCommunications@hhs.texas.gov
- Mail: Texas Health and Human Services
  Office of Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
- Phone: 512-491-2000