Inspections Report

Case-by-Case Services

Parkland Community Health Plan, Inc.

November 4, 2024
OIG Report No. INS-25-003

Inspector General

Texas Health and Human Services

Case-by-Case Services

Parkland Community Health Plan, Inc.

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 Parkland Community Health Plan, Inc. (Parkland) 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:
OIGInspectionsReports@hhs.texas.gov

Key Results

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

None of the 11,411 tested encounters related to non-covered services were coded with the correct financial arrangement code to classify them as case-by-case services. Parkland confirmed with OIG Inspections that it included the non-covered services as covered medical expenses, thereby overstating the total medical expenses by $450,329 on its 2022 FSR.

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

Recommendations

Parkland 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

Parkland acknowledged the recommendations and indicated all corrective actions would be implemented by March 2025.

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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.

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

None of the 11,411 tested encounters related to non-covered services were coded with the correct financial arrangement code to classify them as case-by-case services. Parkland confirmed with OIG Inspections that it included the non-covered services as covered medical expenses, thereby overstating the total medical expenses by $450,329 on its 2022 FSR.

Additionally, Parkland 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 Parkland, which, if implemented, will help improve the accuracy of Parkland'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] 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 Parkland in a draft report dated October 16, 2024. Parkland acknowledged the recommendations and indicated all corrective actions would be implemented by March 2025. Parkland's management responses are included in the report following each recommendation.

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

Objective

The inspection objective was to determine whether Parkland 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, Parkland received $896 million in Texas Medicaid funds and served an average of 221,163 Texas Medicaid recipients 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.

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[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

Parkland may provide Medicaid members with additional benefits that are outside the scope of services in 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 Parkland in a separate written communication.

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

Parkland incorrectly included the 11,411 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 $450,329.

Parkland did not code these encounters for non-covered services as case-by-case services using financial arrangement code 21.[8] In written communications, Parkland 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 11,411 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]

Parkland did not code the 11,411 tested encounters as case-by-case services, but rather misclassified them as covered benefits. Parkland misclassified reported encounter data and carried the error through to its financial reporting, resulting in $450,329 in overstated medical expenses in the FSRs. FSRs are one of the sources

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[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).

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.

Parkland recognized that the tested procedure codes were not covered Medicaid benefits. Its claims payer system did not deny the claims, resulting in it processing 11,411 encounters as covered Medicaid benefits.

Recommendation 1.1

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

Recommendation 1.2

Parkland 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

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

Management Response

Action Plan

Parkland Community Health Plan ("Parkland") has reviewed Observation 1 and acknowledges the recommendations outlined by the OIG. We recognize the importance of establishing effective controls to accurately classify non-covered services as case-by-case services and to apply the appropriate financial arrangement code (FAC 21). Accurate reporting is critical to ensuring that case-by-case services are correctly reflected in financial statistical reports (FSRs) without overstating total Medicaid medical expenses.

In alignment with the recommendations, Parkland has initiated efforts to address the inspection findings and is implementing solutions to reduce the risk of non-

[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.

compliance. Specifically, we are conducting a comprehensive review of our claims-to-encounter processes to ensure that non-covered services are appropriately categorized and correctly coded with FAC 21.

To further support compliance, we are developing ongoing monitoring procedures to audit claims and encounters involving case-by-case services. Additionally, we have begun reviewing previously submitted claims to reconcile data reported to HHSC.

Responsible Managers

- Finance Director
- Claims Director
- Vice President, Health Plan Operations

Target Implementation Date

March 1, 2025

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

For the 11,411 tested encounters, Parkland did not maintain documentation to support the reason for providing case-by-case services.

Parkland 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

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

Management Response

Action Plan

Parkland has reviewed Observation 2 and acknowledges the recommendation provided by the OIG. We are committed to enhance and implement system controls to ensure compliance. Parkland will leverage its prior authorization and appeals processes to ensure appropriate documentation is obtained and maintained to support the reason for providing non-covered services as case-by-case services.

We will also review the configuration of its claims payment system to ensure proper controls are in place to accurately identify and deny non-covered services. If payment is requested for non-covered services, an appeal must include appropriate clinical documentation to assess medical necessity. Authorization details and supporting documentation will be recorded in our clinical management system. If a non-covered service is determined to be medically necessary upon review, the associated claim will be reconsidered for payment as an authorized case-by-case service.

[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).

Responsible Managers

- Medical Director
- Claims Director
- Vice President, Health Plan Operations

Target Implementation Date

March 1, 2025

Appendix A: Methodology, Standards, and Criteria

Detailed Methodology

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

- Encounter data for selected procedure codes from September 1, 2021, through August 31, 2022.
- Policies and procedures that address the objective.
- 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 80,333 Parkland encounters.

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

Of the 80,333 encounters, OIG Inspections excluded those with:

- Paid amounts between $0.00 and $0.99, which eliminated 37,037 encounters.
- Age at the time of service less than 21 years old,[13] which eliminated 29,009 encounters.
- Applicable outpatient hospital revenue codes, which eliminated 2,678 encounters.

Inspections selected the 20 most frequently occurring procedure codes, which reduced the population to 11,411 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

- Case-by-Case Services: Superior HealthPlans, Inc., and Superior HealthPlan Network, INS-25-001, October 23, 2024
- 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 Parkland Community Health Plan, Inc.:

Homepage, Parkland Community Health Plan
https://parklandhealthplan.com (accessed August 17, 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

Report Distribution

Texas Health and Human Services Commission

- Cecile Erwin Young, Executive Commissioner
- Kate Hendrix, Chief of Staff
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- Nicole Guerrero, Chief Audit Executive
- Emily Zalkovsky, Chief Medicaid and CHIP Services Officer, Medicaid and CHIP Services
- Camisha D. Banks, Deputy Executive Commissioner for Managed Care
- Michael Lopez, Deputy Executive Commissioner for Operations, Medicaid and CHIP Services

Parkland Community Health Plan

- Victoria Mora, Chief Executive Officer
- Misty Jones, Vice President, Health Plan Operations
- Amanda Hudgens, Senior Director Compliance-Ethics
- Amrita Waingankar, Medical Director
- Gordon Davis, Finance Director
- Guadalupe Garcia, Claims Director

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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To Contact OIG

- Email: oig.generalinquiries@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