Inspections Report

Case-by-Case Services

Texas Children's Health Plan, Inc.

February 27, 2025
OIG Report No. INS-25-005

Inspector General

Texas Health and Human Services

Case-by-Case Services

Texas Children's 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 Texas Children's Health Plan, Inc. (TCHP) 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

Texas Children's Health Plan, Inc. (TCHP), 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).

The inspection analyzed 3,842 TCHP encounters of non-covered procedure codes. Of the 3,842 encounters, 3,364 (88 percent), totaling $635,183 were classified as case-by-case services using financial arrangement code 21. The inspection consisted of reviewing the 478 (12 percent) not coded with financial arrangement code 21.

None of the 478 tested encounters related to non-covered services were coded with the correct financial arrangement code to classify them as case-by-case services. TCHP confirmed with OIG Inspections that it included the non-covered services as covered medical expenses, thereby overstating the total medical expenses by $132,664 on its 2022 FSR. However, TCHP documented the reason for providing non-covered Medicaid services, as required, in all 20 patient records tested.

Recommendations

TCHP should:

- Implement controls to correctly classify non-covered services it provides as case-by-case services using financial arrangement code 21.
- Report the 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.
- Consult HHSC Financial Reporting and Audit Coordination to determine how best to correct the misreported medical expenses.

Management Response

TCHP acknowledged the recommendation and indicated all corrective actions would be implemented by April 2025.

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Inspection Overview

Overall Results

Texas Children's Health Plan, Inc. (TCHP), 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).

Inspection Terminology

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

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

The inspection analyzed 3,842 TCHP encounters of non-covered procedure codes. Of the 3,842 encounters, 3,364 (88 percent), totaling $635,183 were classified as case-by-case services using financial arrangement code 21. The inspection consisted of reviewing the 478 (12 percent) not coded with financial arrangement code 21.

None of the 478 tested encounters related to non-covered services were coded with the correct financial arrangement code to classify them as case-by-case services. TCHP confirmed with OIG Inspections that it included the non-covered services as covered medical expenses, thereby overstating the total medical expenses by $132,664 on its 2022 FSR.

From the encounters classified as case-by-case services, OIG Inspections tested 20 patient records for supporting documentation. In all 20 patient records, TCHP documented the reason for providing non-covered Medicaid services, as required.

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

[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.

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

OIG Inspections presented preliminary inspection results, observations, and recommendations to TCHP in a draft report dated February 6, 2025. TCHP acknowledged the recommendations and indicated all corrective actions would be implemented by April 2025. TCHP's management response is included in the report following the recommendations.

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

Objective

The inspection objective was to determine whether TCHP 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-

[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).

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

During the scope of the inspection, TCHP received almost $1.9 billion in Texas Medicaid funds and served an average of 514,503 Texas Medicaid recipients from two 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.

[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).

[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

TCHP 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 inspection analyzed 3,842 TCHP encounters of non-covered procedure codes. Of the 3,842 encounters, 3,364 (88 percent), totaling $635,183 were classified as case-by-case services using financial arrangement code 21. The inspection consisted of reviewing the 478 (12 percent) not coded with financial arrangement code 21.

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 TCHP in a separate written communication.

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

TCHP incorrectly included the 478 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 $132,664.

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

Of the 478 encounters:

- 370 used financial arrangement code 07 (internal fee-for-service general claims).
- 108 used financial arrangement code 08 (internal behavioral health claims).

[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.

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]

TCHP did not code the 478 tested encounters as case-by-case services, but rather misclassified them as covered benefits. TCHP misclassified reported encounter data and carried the error through to its financial reporting, resulting in $132,664 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.

Recommendation 1.a

TCHP should implement controls to correctly classify the non-covered services it provides as case-by-case services using financial code 21.

Recommendation 1.b

TCHP should report the 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.

Recommendation 1.c

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

Management Response

Action Plan

As evidenced by the 88% during the SFY22 audit period, Texas Children's Health Plan (TCHP) had controls in place to classify non-covered Medicaid services as case-by-case using the correct financial arrangement code. TCHP acknowledges the recommendations outlined by the OIG and the opportunity for improvement.

[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).

[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.

Accordingly, TCHP has taken steps to strengthen our processes for non-covered and non-payable services. These improvements include:

1. At the beginning of FY2023, TCHP introduced additional procedural controls to prevent misclassification of non-covered services. Training programs were conducted to ensure staff understands the correct application of financial arrangement codes. Additional refresher training will be provided going forward on an as-needed basis.
2. In August 2022, TCHP launched a new operating system which allows for advanced configuration and automation capabilities. This new platform requires non-covered services to be authorized under a "non-payable" authorization type, which supports proper identification and tracking. Claims for non-covered and non-payable codes will not be reimbursed without an appropriate authorization. TCHP will be developing a process for ongoing case-by-case encounters monitoring to further support ongoing compliance.
3. TCHP has enhanced its clinical oversight of case-by-case requests and the supporting documentation by our Medical Directors. Further supporting the oversight of utilization of the proper financial arrangement code, which claim payments will be contingent upon.

TCHP will consult with HHSC's Financial Reporting and Audit Coordination (FRAC) team to discuss the best approach for correcting the misreported medical expenses.

Responsible Managers

- Chief Operating Officer (Primary)
- Medical Director
- Director of Finance

Target Implementation Date

April 2025

Appendix A: Methodology, Standards, and Criteria

Detailed Methodology

To achieve its objective, OIG Inspections collected information through (a) discussions with TCHP staff and (b) a review of TCHP'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 27,947 TCHP encounters.

Of the 27,947 encounters, OIG Inspections excluded those with:

- Paid amounts between $0.00 and $0.99, which eliminated 1,731 encounters.
- Age at the time of service less than 21 years old,[12] which eliminated 20,850 encounters.

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

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

- Applicable outpatient hospital revenue codes, which eliminated 1,524 encounters.
- Financial arrangement code 21, which eliminated 3,364 encounters.

These applied parameters reduced the population to 478 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)

Appendix B: Related Reports

- Case-by-Case Services: Parkland Community Health Plan, Inc., INS-25-003, November 4, 2024
- 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 Texas Children's Health Plan:

Homepage, TCHP HealthPlan (texaschildrenshealthplan.org) (accessed September 14, 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
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- James Aldridge, CFE, Manager of Inspections
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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:

- 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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