Inspections Report

MCO Provider Claims Appeals

Community First Health Plans

March 14, 2025
OIG Report No. INS-25-006

Inspector General

Texas Health and Human Services

Texas Health and Human Services Office of Inspector General Audit and Inspections Division

MCO PROVIDER CLAIMS APPEALS

Community First Health Plans

March 14, 2025

Dear Theresa Scepanski:

The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Inspections) conducted an inspection to determine whether Community First Health Plans, Inc. (Community First) resolves and reports provider claims appeals as required.

Background

These self-reported CSRs indicated that Community First completed at least 98 percent of provider claims appeals timely, as required.

OIG Inspections reviewed (a) archived detailed reports to compare to Claims Summary Reports (CSRs) Community First submitted to the Texas Health and Human Services Commission (HHSC) and (b) a risk-based sample of 90 State of Texas Access Reform (STAR) program claims appeals reported in the CSRs from April 2024 through June 2024. The archived detailed reports matched what was reported in the CSRs. Community First complied with tested requirements for the sample of reviewed provider claims appeals, showing that it resolves and reports provider claims appeals as required. As a result, OIG Inspections identified no issues or opportunities for improvement in this inspection.

The attachment to this letter contains additional details on this inspection.

Sincerely,

Anton Dutchover

Anton Dutchover, CPA
Deputy Inspector General of Audit and Inspections

Attachment

cc: Cecile Erwin Young, HHS Executive Commissioner
Raymond Charles Winter, HHS Inspector General

Attachment

Section 1: Summary of Inspection Results

Texas Medicaid providers can dispute denied or underpaid claims through the appeal process. Managed care organizations (MCOs) must process and adjudicate appealed claims within 30 days from receipt of the provider's appeal.[1] MCOs must respond to each provider's appeal and establish a tracking mechanism to document the status and final disposition of each appeal.[2] MCOs are also required to submit monthly Claims Summary Reports (CSRs) to the Texas Health and Human Services Commission (HHSC) with the number of appeals adjudicated and timeliness of those appeals.[3] Each month, HHSC reviews the CSRs to monitor the timeliness with which MCOs processed appealed claims. If an MCO fails to resolve at least 98 percent of provider appeals within 30 days, it faces contractual remedies, such as liquidated damages and, if necessary, corrective action plans. HHSC is in the process of renewing a contract with an outside firm to conduct performance audits of each MCO to review the accuracy of CSRs.

The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Inspections) reviewed Community First Health Plans, Inc.'s (Community First's) archived detailed reports used to support the CSRs Community First submitted to HHSC for April 2024, May 2024, and June 2024. The archived detailed reports matched what was reported in the CSRs, indicating Community First completed at least 98 percent of provider claims appeals timely, as required.

OIG Inspections selected a risk-based, non-statistical sample of 90 State of Texas Access Reform (STAR) program claims appeals from April through June 2024, then traced to supporting documents to determine the accuracy of the information in the archived detailed reports.

[1] Uniform Managed Care Manual, Chapter 2, Section VII, v. 2.14 (March 1, 2023, as amended).

[2] Uniform Managed Care Contract, Attachment B-1, § 8.2.4.2, v. 2.39 (March 1, 2024, as amended).

[3] Uniform Managed Care Contract, Attachment B-1, § 8.1.20.2 (a), v. 2.39 (March 1, 2024, as amended) and Uniform Managed Care Manual, Chapter 5.24.1, v. 2.4 (Sept. 1, 2022, as amended).

For the sampled claims appeals, the supporting evidence matched the archived detailed reports, and Community First met the following requirements:

- Notifying providers of the appeals results.
- Providing reasons when denying appeals.
- Resolving all tested appeals within 30 days.

Community First complied with tested requirements for the sample of reviewed provider claims appeals, showing that it resolves and reports provider claims appeals as required. OIG Inspections did not identify any issues or opportunities for improvement.

Section 2: Objective, Scope, Methodology, Standards, and Criteria

Objective and Scope

The inspection objective was to determine whether Community First resolves and reports provider claims appeals as required.

The inspection scope covered the period from April 1, 2024, through June 30, 2024.

Methodology

To select an MCO for inspection, OIG Inspections considered MCOs with one or more months below the 98 percent standard for timeliness on their CSRs during the period of July 2023 through June 2024. While Community First missed the standard in an earlier month of the selected period, it showed compliance with the 98 percent requirement for April, May, and June 2024. OIG Inspections selected it to verify the accuracy of its reporting.

To achieve its inspection objective, OIG Inspections collected information through (a) discussions with Community First staff and (b) a review of:

- CSRs and archived detailed reports for April 2024 through June 2024.
- Appealed claims' audit logs and supporting documentation.
- Explanation of payments.

The inspection team:

1. Reviewed archived detailed reports that support the CSR submissions.
2. Tested a risk-based sample of 90 STAR program claims appeals from April 2024 through June 2024 for compliance with applicable requirements.
3. For the sampled claim appeals, verified that the claim appeal initiation date, resolution date, claim appeal decision, and number of days to resolve the appeal matched the archived detailed reports.

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

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 §§ 8.1.20.2 (a) and 8.2.4.2 (2024, as amended)
- Uniform Managed Care Manual, Chapter 2, Section VII, v. 2.14 (2023, as amended)
- Uniform Managed Care Manual, Chapter 5.24.1, v. 2.4 (2022, as amended)

Section 3: Related Reports

- MCO Provider Claims Appeals: FirstCare Health Plans, INS-25-004, November 21, 2024

Section 4: 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
- Marco Diaz, CFE, Lead Inspector
- Gabriella Berger, Inspector
- Mo Brantley, Senior Audit Operations Analyst

Report Distribution

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- Emily Zalkovsky, Chief Medicaid and CHIP Services Officer, Medicaid and CHIP Services
- Camisha D. Banks, Deputy Executive Commissioner for Managed Care, Medicaid and CHIP Services
- Michael Lopez, Deputy Executive Commissioner for Operations, Medicaid and CHIP Services

Community First Health Plans

- Theresa Scepanski, President and Chief Executive Officer
- Kethra Barnes, Executive Director, Compliance and Risk Management
- Sarah Herron, Director of Audit Services, Compliance and Risk Management

Section 5: 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
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To Contact OIG

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