Inspections Report

MCO Provider Claims Appeals

FirstCare Health Plans

November 21, 2024
OIG Report No. INS-25-004

Inspector General

Texas Health and Human Services

MCO Provider Claims Appeals

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Results in Brief

Why OIG Conducted This Inspection

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 of receipt of the provider's appeal. MCOs must respond to each provider's appeal and establish a tracking mechanism to document the status and final disposition of each appeal. MCOs are also required to submit monthly Claims Summary Reports (CSRs) to the Texas Health and Human Services Commission (HHSC) with the number and timeliness of appeals adjudicated.

A provider group voiced concerns during a 2021 legislative hearing that MCOs can discourage providers from filing appeals by routinely delaying or misplacing appeals. Without proper procedures for tracking, resolving, and reporting provider claim appeals, payments to providers may be delayed.

Summary of Review

The inspection objective was to determine whether FirstCare tracks, resolves, and reports provider claims appeals as required. The inspection scope covered the period from January 1, 2023, through January 31, 2024.

For more information, contact:
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Key Results

The Texas Health and Human Services Audit and Inspections Division (OIG Inspections) reviewed Claims Summary Reports (CSRs) FirstCare Health Plans (FirstCare) submitted to the Texas Health and Human Services Commission (HHSC) for November 2023, December 2023, and January 2024. These self-reported CSRs indicated that FirstCare completed at least 98 percent of provider claims appeals timely, as required. For the sampled appeals, FirstCare met the following requirements:

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

However, FirstCare's archived detailed reports contained discrepancies that raise questions about the reliability of the CSRs submitted to HHSC.

FirstCare's Operations Department uses reports from its data warehouse to submit monthly CSRs to HHSC. FirstCare's Claims Department, which processes provider claims appeals, then reviews the CSRs for accuracy prior to submission. Once the Operations Department submits the CSRs to HHSC, it archives the detailed reports from the data warehouse used to create the CSRs.

The initiation and resolution dates in the archived detailed reports did not always match supporting documentation and the appeal decision was not always populated. However, the turnaround time categories FirstCare reported to HHSC in the CSRs for the sampled appeals were correct. Due to the discrepancies identified between the archived detailed reports and the supporting information, OIG Inspections could not validate the accuracy of FirstCare's CSR submissions beyond the sampled appeals. Without accurate, unaltered records, the integrity of the CSR submission process may be compromised.

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Inspection Overview

Overall Results

FirstCare Health Plans (FirstCare), a Texas Medicaid managed care organization (MCO), complied with tested requirements for a sample of reviewed provider claims appeals, showing that it tracks, resolves, and reports provider claims appeals as required. However, FirstCare did not always maintain accurate records in its archived detailed reports, which are used to support the Claims Summary Reports (CSR) submitted to the Texas Health and Human Services Commission (HHSC). Specifically, of the 120 provider claims appeals tested, 46 (38 percent) did not match FirstCare's archived detailed report.

This report is considered written education in accordance with Texas Administrative Code. Opportunities for improvement identified in this report are considered written education as defined in Texas Administrative Code.[1] This report does not address compliance beyond the scope and objective of this inspection.

The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Inspections) presented preliminary inspection results and an opportunity for improvement to FirstCare in a draft report dated October 31, 2024.

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

Objective

The inspection objective was to determine whether FirstCare tracks, resolves, and reports provider claims appeals as required.

Scope

The inspection scope covered the period from January 1, 2023, through January 31, 2024.

[1] 1 Tex. Admin. Code § 371.1701 (May 1, 2016).

Background

Texas Medicaid providers can dispute denied or underpaid claims through the appeal process. MCOs must process and adjudicate appealed claims within 30 days of receipt of the provider's appeal.[2] MCOs must respond to each provider's appeal and establish a tracking mechanism to document the status and final disposition of each appeal.[3] MCOs are also required to submit monthly CSRs to HHSC with the number of appeals adjudicated and timeliness of those appeals.[4] 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. Additionally, HHSC contracts with an outside firm to conduct performance audits of each MCO to review the accuracy of CSRs.

During the scope of the inspection, FirstCare received $251 million in Texas Medicaid funds and served an average of 50,069 Texas Medicaid recipients each month.

What Prompted This Inspection

A provider group voiced concerns during a 2021 legislative hearing that MCOs can discourage providers from filing appeals by routinely delaying or misplacing appeals. Without proper procedures for tracking, resolving, and reporting provider claim appeals, payments to providers may be delayed.

[2] Uniform Managed Care Manual, Chapter 2, Section VII, v. 2.13 (Sept. 12, 2022, as amended).

[3] Uniform Managed Care Contract, Attachment B-1, § 8.2.4.2, v. 2.36 (Sept. 1, 2022, as amended).

[4] Uniform Managed Care Contract, Attachment B-1, § 8.1.20.2 (a), v. 2.36 (Sept. 1, 2022, as amended) and Uniform Managed Care Manual, Chapter 5.24.1, v. 2.4 (Sept. 1, 2022, as amended).

Detailed Results

OIG Inspections reviewed CSRs FirstCare submitted to HHSC for November 2023, December 2023, and January 2024. These self-reported CSRs indicated that FirstCare completed at least 98 percent of provider claims appeals timely, as required. For the sampled appeals, FirstCare met the following requirements:

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

However, FirstCare's archived detailed reports contained discrepancies that raise questions about the reliability of the CSRs submitted to HHSC. The following section of this report provides additional detail about an opportunity for improvement that does not represent an instance of noncompliance with criteria.

Opportunity for Improvement

FirstCare's Operations Department uses reports from its data warehouse to prepare monthly CSRs for submission to HHSC. FirstCare's Claims Department, which processes provider claims appeals, reviews the CSRs for accuracy prior to submission. Once the Operations Department submits the CSRs to HHSC, it archives the detailed reports from the data warehouse used to create the CSRs. The archived detailed reports include the following:

- The **denial code** identifies the reason the appeal was denied.
- The **turnaround time category** column classifies appeals as being completed within 30 days, between 31 and 90 days, and greater than 90 days.
- The **turnaround time** column identifies the actual number of days to complete an appeal between when an appeal is initiated and when it is resolved.

The turnaround time category and the actual time to complete an appeal did not always match. Also, denied appeals did not always contain a denial code. Table 1 details the discrepancies in FirstCare's archived detailed reports.

Table 1: FirstCare's Appeals Archive Details

	November 2023	December 2023	January 2024
Total Appeals	1,435	1,418	1,659
Mismatches Between Turnaround Time Category and Actual Days to Complete	81 (6%)	84 (6%)	96 (6%)
Number of Denied Appeals	379	470	473
Denied Appeals Without a Denial Code	27 (7%)	66 (14%)	23 (5%)

Source: OIG Inspections

OIG Inspections selected (a) a sample of 120 appeals for which the turnaround time did not match the turnaround category and (b) a sample of denied appeals with no denial code, then traced to supporting documents to determine the accuracy of the information in the archived detailed reports. Of the 120 provider claims appeals tested, 46[5] (38 percent) showed at least one discrepancy between the archived detailed report and the supporting information. Specifically:

- 16 (13 percent) of 120 initiation dates did not match.
- 8 (7 percent) of 120 resolution dates did not match.
- 24 (20 percent) of 120 decisions did not match.[6]

Despite the discrepancies in FirstCare's archived reports, supporting evidence showed the turnaround time categories FirstCare reported to HHSC in the CSRs for the sampled appeals were correct.

FirstCare asserted that a user revised the archived detailed reports after the CSRs were submitted. FirstCare was unable to explain why or how the archived detailed reports were modified.

Due to the discrepancies identified between the archived detailed reports and the supporting information, OIG Inspections could not validate the

[5] Two samples contained more than one mismatch.

[6] Appeal decisions are not reported in the CSRs.

accuracy of FirstCare's CSR submissions beyond the sampled appeals. Without accurate, unaltered records, the integrity of the CSR submission process may be compromised.

FirstCare should strengthen processes and controls to prevent unauthorized alterations to the archived detailed reports that support the CSR submissions.

Appendix A: Methodology, Standards, and Criteria

Detailed Methodology

To select an MCO for inspection, OIG Inspections considered MCOs with the highest number of months below the 98 percent standard for timeliness within the scope period on their CSRs.

To achieve its inspection objective, OIG Inspections collected information through (a) discussions with HHSC Managed Care Contract Oversight staff and FirstCare staff and (b) a review of:

- CSRs submitted to HHSC and archived detailed reports for November 2023 through January 2024.
- Appealed claims' audit logs.
- Explanation of payments.

The inspections team tested a risked-based sample of 120 State of Texas Access Reform (STAR) program claims appeals that contained a discrepancy from November 2023 through January 2024, for compliance with applicable requirements.

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 (2022, as amended)
- Uniform Managed Care Manual, Chapter 2, Section VII, v. 2.13 (2022, as amended)
- Uniform Managed Care Manual, Chapter 5.24.1, v. 2.4 (2022, as amended)

Appendix B: Resources for Additional Information

The following resources provide additional information about the topics covered in this report.

For more information on FirstCare Health Plans:

FirstCare Health Plans, https://www.firstcare.com/en/Home (accessed September 25, 2024)

Appendix C: 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
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FirstCare Health Plans

- Jeffrey Ingrum, President and Chief Executive Officer
- Amy Cornett, Vice President of Compliance
- Michael Baumann, Director of Corporate Ethics and Compliance

Appendix D: 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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