



Audit Report

Administrative and Medical Expenses Reported on Financial Statistical Reports

UnitedHealthcare Community Plan of Texas, L.L.C.
and UnitedHealthcare Insurance Company, Inc.



**Inspector
General**

Texas Health
and Human Services

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Results in Brief

Why OIG Conducted This Audit

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted an audit of UnitedHealthcare Community Plan of Texas, L.L.C. and UnitedHealthcare Insurance Company, Inc.'s (UnitedHealthcare's) process for preparing and submitting expenses on its 334-day 2020 Medical financial statistical reports (Medical FSRs) and Combined Administrative and Quality Improvement Expenses financial statistical report (Combined FSR) based on an identified risk of incorrectly reported expenses on the financial statistical reports (FSRs), including unallowable expenses without sufficient documentation. When unallowable and questioned expenses are included on FSRs, the reported net income may be inaccurate. As a result, there is a risk that the Texas Health and Human Services Commission (HHSC) may rely on inaccurate information when setting capitation rates and calculating experience rebates.

UnitedHealthcare is a managed care organization (MCO) contracted to provide Medicaid and CHIP services to Texas Medicaid and CHIP members through its network of providers. During the period from September 1, 2019, through August 31, 2020, UnitedHealthcare reported \$4 billion in total gross revenue and served an average of 312,964 members per month for all programs and service areas.

Conclusion

UnitedHealthcare Community Plan of Texas, L.L.C. and UnitedHealthcare Insurance Company, Inc.'s (UnitedHealthcare's) process for preparing and submitting expenses on its 334-day 2020 Medical financial statistical reports (Medical FSRs) and Combined Administrative and Quality Improvement Expenses financial statistical report (Combined FSR) had some control weaknesses. UnitedHealthcare had a process for preparing financial statistical reports (FSRs), which included effective controls related to (a) identifying and removing unallowable general ledger accounts, (b) reconciling FSR data, and (c) assigning and communicating authority and responsibility of the FSR reporting process. UnitedHealthcare also accurately reported prescription expenses tested on the STAR Kids Medical FSR for the Harris service area. However, UnitedHealthcare (a) incorrectly reported and did not maintain readily available documentation to support affiliate outsourced service expenses on its Combined FSR and (b) incorrectly reported behavioral health claims expenses on its STAR+PLUS Medical FSR for the Travis service area. As a result of these two issues, UnitedHealthcare overstated expenses by \$8,159,962.

Key Results

UnitedHealthcare had some control weaknesses concerning (a) documentation to support that affiliate outsourced service expenses are accurately reported at fair market value and (b) its process for determining affiliate administrative rates.

UnitedHealthcare had a rationale for reporting affiliate outsourced services expenses at fair market value. However, it was not prepared to provide documentation to support its fair market value prior to submitting the Combined FSR, including:

- How it determined the cost of affiliate outsourced services.
- How it qualified to report affiliate outsourced service expenses at fair market value.
- The fair market value rate for the affiliate outsourced service expenses.

Summary of Review

The audit objective was to determine whether (a) UnitedHealthcare reported expenses on selected components of its Medical and Combined FSRs submitted to HHSC in accordance with contract requirements and laws and (b) the related internal controls over the preparation of the FSRs were designed and operating effectively.

The audit scope included UnitedHealthcare's Medical and Combined FSRs and related internal controls over the preparation of those FSRs for state fiscal year 2020, which covered the period from September 1, 2019, through August 31, 2020.

Background

FSRs are a reporting mechanism used by MCOs to provide financial information, including medical and administrative expenses, related to the Medicaid and CHIP programs in which the MCO participates. MCOs are required to submit quarterly and annual Medical FSRs for each program and every service area for which the MCO provides coverage, and a separate Combined FSR to report administrative expenses. The information reported in the Medical and Combined FSRs is also used by HHSC to calculate each MCO's experience rebate.

Management Response

UnitedHealthcare predominantly agreed with the audit recommendations and indicated work to implement corrective actions was underway.

In addition to not providing adequate support for its fair market value reporting, UnitedHealthcare did not require two of the three tested affiliates to provide unredacted customer contracts upon request from the Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit). Further, UnitedHealthcare did not report all affiliate outsourced service expenses at or below determined fair market value rates or calculate a reasonable fair market value rate for all affiliates.

As a result of the control weaknesses, OIG Audit recalculated the fair market value rate for two of the three tested affiliates and determined that UnitedHealthcare inaccurately reported an estimated \$7,939,507 of affiliate outsourced service expenses above fair market value on the Combined FSR.

Further, UnitedHealthcare inaccurately reported expenses above its contracted provider rate for 4 of 52 (7.7 percent) behavioral health claims expenses tested. As a result, UnitedHealthcare overstated behavioral health claims expenses totaling \$11,663. Based on this issue, OIG Audit performed further analysis and identified an additional 183 behavioral health claims expenses across the claims population, resulting in overstatements totaling \$208,793, that UnitedHealthcare incorrectly reported.

Recommendations

UnitedHealthcare should:

- Ensure all subcontractors and affiliates are obligated, in writing, to provide OIG prompt, reasonable, and adequate access to any support that is related to the scope of the contract between the Texas Health and Human Services Commission (HHSC) and UnitedHealthcare, as required by the Uniform Managed Care Contract.
- Prepare and maintain documentation to support qualification to report at fair market value prior to the beginning of the state fiscal year.
- Report affiliate outsourced service expenses at or below fair market value, when using the fair market value method to report expenses.
- Work with HHSC Financial Reporting and Audit Coordination (FRAC) to determine the appropriateness of utilizing the HHSC Texas Medicaid and CHIP MCO rate setting packets as a basis for determining fair market value affiliate outsourced service rates and ensure all components of its fair market value calculations are supported by reasonable rationale.
- Ensure behavioral health claims expenses it reports on its FSRs are accurate in accordance with provider contracts.

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Audit Overview

Overall Conclusion

UnitedHealthcare Community Plan of Texas, L.L.C. and UnitedHealthcare Insurance Company, Inc.'s (UnitedHealthcare's)¹ process for preparing and submitting expenses on its 334-day 2020 Medical financial statistical reports (Medical FSRs)² and Combined Administrative and Quality Improvement Expenses³ financial statistical report (Combined FSR)^{4,5} had some control weaknesses. UnitedHealthcare had a process for preparing financial statistical reports (FSRs), which included effective controls related to (a) identifying and removing unallowable general ledger accounts, (b) reconciling FSR data, and (c) assigning and communicating authority and responsibility of the FSR reporting process. UnitedHealthcare also accurately reported prescription expenses tested on the STAR Kids Medical FSR for the Harris service area (STAR Kids Medical FSR–Harris). However, UnitedHealthcare (a) incorrectly reported and did not maintain readily available documentation to support

¹ UnitedHealthcare Community Plan of Texas, L.L.C. is the UnitedHealthcare affiliate managed care organization (MCO) responsible for compliance with the Uniform Managed Care Contract. UnitedHealthcare Insurance Company, Inc. is the UnitedHealthcare affiliate MCO responsible for compliance with the STAR Kids Managed Care Contract and the STAR+PLUS Medicaid Rural Service Area (MRSA) Managed Care Contract. For the purposes of this report, UnitedHealthcare Community Plan of Texas, L.L.C. and UnitedHealthcare Insurance Company, Inc. are referenced together with the combined abbreviation, "UnitedHealthcare."

² Medical FSRs contain income statements with all reportable revenues and expenses, including administrative and quality improvement expenses, that MCOs submit to HHSC for each program and service area where the submitting MCO operates.

³ Administrative expenses directly or indirectly benefit Texas Medicaid and the Children's Health Insurance Program (CHIP), and quality improvement expenses are activities that improve health care quality.

⁴ Each managed care organization's FSRs for each state fiscal year are due to HHSC 334 days after the end of the state fiscal year and are referred to as 334-day FSRs.

⁵ Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31. For state fiscal year 2020, the period is September 1, 2019, through August 31, 2020.

affiliate outsourced service expenses⁶ on its Combined FSR and (b) incorrectly reported behavioral health claims expenses on its STAR+PLUS Medical FSR for the Travis service area (STAR+PLUS Medical FSR–Travis). As a result of these two issues, UnitedHealthcare overstated expenses by \$8,159,962.

Key Audit Results

UnitedHealthcare had some control weaknesses concerning (a) documentation to support that affiliate outsourced service expenses are accurately reported at fair market value and (b) its process for determining affiliate administrative rates.

UnitedHealthcare had a rationale for reporting affiliate outsourced service expenses at fair market value. However, it was not prepared to provide documentation to support its fair market value prior to submitting the Combined FSR, including:

- How it determined the cost of affiliate outsourced services.
- How it qualified to report affiliate outsourced service expenses at fair market value.
- The fair market value rate for the affiliate outsourced service expenses.

In addition to not providing adequate support for its fair market value reporting, UnitedHealthcare also did not require two of the three tested affiliates to provide unredacted customer contracts upon request from the Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit). Further, UnitedHealthcare did not report all affiliate outsourced service expenses at or below determined fair market value rates or calculate a reasonable fair market value rate for all affiliates.

Objective

The audit objective was to determine whether (a) UnitedHealthcare reported expenses on selected components of its Medical and Combined FSRs submitted to the Texas Health and Human Services Commission (HHSC) in accordance with contract requirements and laws and (b) the related internal controls over the preparation of the FSRs were designed and operating effectively.

Scope

The audit scope included UnitedHealthcare's Medical and Combined FSRs and related internal controls over the preparation of those FSRs for state fiscal year 2020, which covered the period from September 1, 2019, through August 31, 2020.

⁶ Affiliate outsourced service expenses are administrative and quality improvement expenses associated with services provided by related parties.

As a result of the control weaknesses, OIG Audit recalculated the fair market value rate for two of the three tested affiliates and determined that UnitedHealthcare inaccurately reported an estimated \$7,939,507 of affiliate outsourced service expenses above fair market value on the Combined FSR.

Further, UnitedHealthcare inaccurately reported expenses above its contracted provider rate⁷ for 4 of 52 (7.7 percent) behavioral health claims expenses tested. As a result, UnitedHealthcare overstated behavioral health claims expenses totaling \$11,663. Based on this issue, OIG Audit performed further analysis and identified an additional 183 behavioral health claims expenses across the claims population,⁸ resulting in overstatements totaling \$208,793, that UnitedHealthcare inaccurately reported.

Table 1 details the overall impact of UnitedHealthcare's inaccurately reported expenses totaling \$8,159,962.

What Prompted This Audit

OIG Audit conducted an audit of UnitedHealthcare's Medical and Combined FSRs based on an identified risk of incorrectly reported expenses on the FSRs, including unallowable expenses without sufficient documentation. When unallowable and questioned expenses are included on FSRs, the reported net income may be inaccurate. As a result, there is a risk that HHSC may rely on inaccurate information when setting capitation rates and calculating experience rebates.

Table 1: Summary of UnitedHealthcare's Inaccurately Reported Expenses

Finding Type	Tested Expenses	Additional Expenses Across the Population
Estimated inaccurately reported affiliate outsourced service expenses	\$ 7,939,507	—
Inaccurately reported behavioral health claims expenses	\$ 11,663	\$ 208,793
Total	\$ 7,951,169⁹	\$208,793

Source: OIG Audit

⁷ For behavioral health services, UnitedHealthcare maintains a contract with each of its providers that specifies the contracted price for each type of service.

⁸ OIG Audit identified additional expenses when results from claims expenses tested as part of this audit could be applied to similar transactions across the entire population of claims expenses.

⁹ Discrepancy between the individual amounts and the total is due to rounding.

OIG Audit used the results of testing performed to determine an estimated recalculation of the experience rebate¹⁰ owed back to the state of Texas as a result of amounts that were identified as unallowable for inclusion on the FSR. OIG Audit calculates the adjustment of the disallowed expenses applied against UnitedHealthcare's reported net income before taxes would create an additional experience rebate balance of \$4,408,351 owed to the Texas Health and Human Services Commission (HHSC). OIG Audit's calculation is an estimate as of the date of this report without consideration of potential required resubmission of UnitedHealthcare's FSRs, financial requirements applicable to the calculation of the experience rebate, or findings from additional reviews, audits, or contractual interest¹¹ that may apply. HHSC Financial Reporting and Audit Coordination (FRAC) will be responsible for the final calculation of the experience rebate and will notify UnitedHealthcare of any additional payment owed to HHSC. Table 2 provides additional details about these amounts.

Table 2: UnitedHealthcare's Experience Rebate Amounts

Category	Amount
UnitedHealthcare's adjusted income subject to an experience rebate	\$277,459,621
UnitedHealthcare's incorrectly reported expenses	+\$ 8,159,962
OIG Audit's adjusted income subject to an experience rebate	\$285,619,583
OIG Audit's Estimated Experience Rebate	+ \$ 4,408,351

Source: OIG Audit

OIG Audit offered recommendations to UnitedHealthcare, which, if implemented, will help ensure compliance with applicable requirements.

The "Detailed Audit Results" section of this report presents additional information about the audit results. In addition, other audit issues identified in this report may

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.

¹¹ Interest rate expenses may be incurred as a result of late payments or underpayment of the experience rebate.

be referred to HHSC for potential pursuit of enforcement remedies or OIG administrative enforcement measures,¹² including administrative penalties.¹³

OIG Audit communicated other, less significant issues to UnitedHealthcare in a separate written communication.

OIG Audit presented preliminary audit results, issues, and recommendations to UnitedHealthcare in a draft report dated August 2, 2022. UnitedHealthcare predominantly agreed with the audit recommendations and indicated work to implement corrective actions was underway. UnitedHealthcare's management responses are included in the report following each recommendation.

OIG Audit thanks management and staff at UnitedHealthcare for their cooperation and assistance during this audit.

Key Program Data

UnitedHealthcare is a managed care organization (MCO) contracted to provide Medicaid and Children's Health Insurance Program (CHIP) services to Texas Medicaid and CHIP members through its network of providers.¹⁵ The managed care contracts relevant to this audit include the Uniform Managed Care Contract, the STAR+PLUS Medicaid Rural Service Area (MRSA) Managed Care Contract, and the STAR Kids Managed Care Contract.¹⁶ For the

Experience Rebate Calculation and Payment

UnitedHealthcare reported net income of \$277,459,621 on its 2020 334-day FSRs. As a result, UnitedHealthcare calculated an experience rebate of \$47,007,219 owed to HHSC. FRAC confirmed that, as of July 28, 2022, UnitedHealthcare has remitted \$51,502,865¹⁴ in payments to HHSC towards its calculated experience rebate.

¹² 1 Tex. Admin. Code § 371.1603 (May 20, 2020).

¹³ Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

¹⁴ Payments by UnitedHealthcare include (a) \$50,025,108 towards the experience rebate owed and (b) \$1,477,757 towards interest determined by UnitedHealthcare and added to their payment.

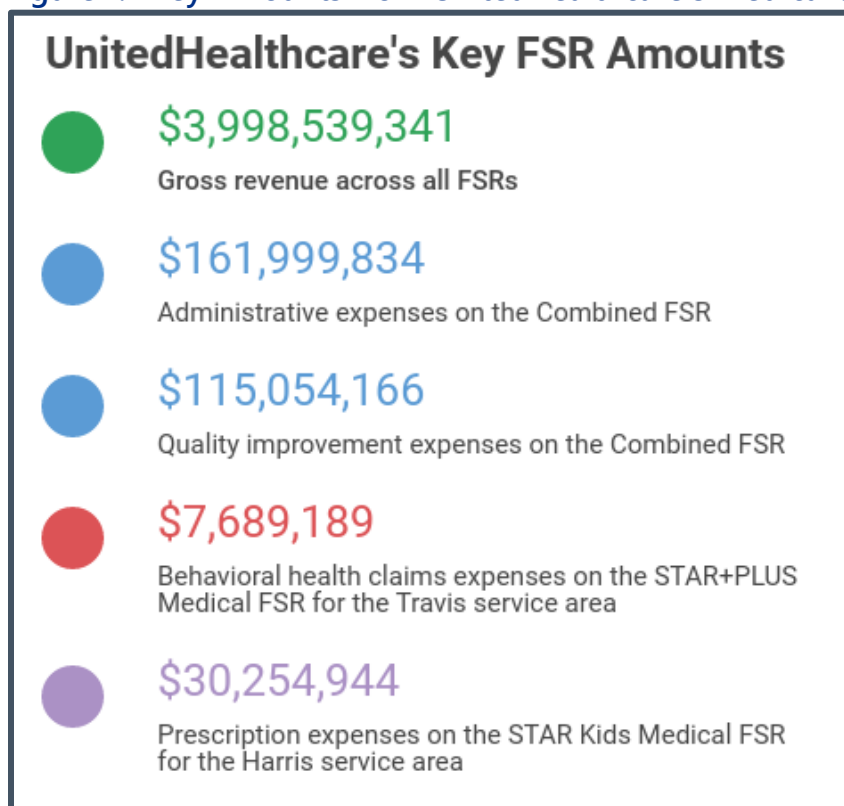
¹⁵ UnitedHealthcare provides health care services in seven service areas—Harris, Hidalgo, Jefferson, MRSA Central, MRSA Northeast, Nueces, and Travis—through the STAR program, the STAR+PLUS program, the STAR Kids program, and CHIP.

¹⁶ UnitedHealthcare Community Plan of Texas, L.L.C. is the UnitedHealthcare affiliate MCO responsible for compliance with the Uniform Managed Care Contract. UnitedHealthcare Insurance Company, Inc. is the UnitedHealthcare affiliate MCO responsible for compliance with the STAR Kids Managed Care Contract and the STAR+PLUS MRSA Managed Care Contract.

purpose of this report, the Uniform Managed Care Contract is used for referencing contract requirements. See Appendix C for a map of Texas areas where UnitedHealthcare provides services.

During the period from September 1, 2019, through August 31, 2020, UnitedHealthcare reported \$4 billion in total gross revenue¹⁷ and served an average of 312,964 members per month for all programs and service areas. Figure 1 provides key amounts that UnitedHealthcare reported on its FSRs during the period from September 1, 2019, through August 31, 2020.

Figure 1: Key Amounts from UnitedHealthcare's Medical and Combined FSRs



Source: OIG Audit, based on UnitedHealthcare's 334-day 2020 Medical and Combined FSRs

¹⁷ Gross revenue reported on the FSRs includes capitated medical premium payments, delivery supplemental payments, pharmacy premiums, and investment income.

Under the managed care model, MCOs receive a capitation payment for each member enrolled, based on historical expenses of the populations served. Capitation payments are monthly prospective payments HHSC makes to MCOs for the provision of covered services. HHSC makes capitation payments to MCOs at fixed, per member per month rates based on members' associated risk groups.

FSRs are a reporting mechanism used by MCOs to provide financial information, including medical and administrative expenses, related to the Medicaid and CHIP programs in which the MCO participates. MCOs are required to submit quarterly and annual Medical FSRs for each program and every service area for which the MCO provides coverage, and a separate Combined FSR to report administrative expenses.¹⁸ The Combined FSR consists of two sections—an Administrative section (Administrative FSR) and a Quality Improvement section (Quality Improvement FSR)—with four numbered parts each.

The information reported in the Medical and Combined FSRs is also used by HHSC to calculate each MCO's experience rebate.

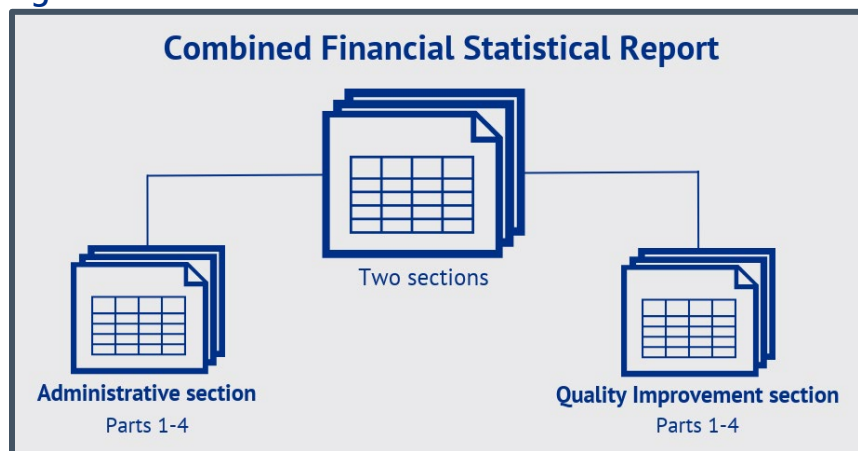
It is important to note that future capitation payments will be set using amounts reported on the 2020 FSRs prior to completion of the 2020 FSR agreed upon procedures engagements.¹⁹

¹⁸ Uniform Managed Care Contract, Attachment B-1, § 8.1.17.1, v. 2.29 (Sept. 1, 2019) through v. 2.33 (June 1, 2021).

¹⁹ The agreed upon procedures engagements are attestation engagements performed on each MCO's 334-day FSRs by independent, external accounting firms contracted by HHSC to gain confidence on reported FSR data.

Figure 2 outlines the structure of UnitedHealthcare's Combined FSR.

Figure 2: Structure of UnitedHealthcare's Combined FSR



Source: OIG Audit

Auditing Standards

Generally Accepted Government Auditing Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Detailed Audit Results

OIG Audit reviewed the allowability of affiliate outsourced service expenses reported on the Combined FSR. For each expense tested, UnitedHealthcare provided documentation intended to support that the affiliate outsourced service expenses qualified to be reported at fair market value.

Additionally, OIG Audit reviewed the allowability of behavioral health claims expenses on UnitedHealthcare's STAR+PLUS Medical FSR for the Travis service area^{20,21} and prescription expenses on UnitedHealthcare's STAR Kids Medical FSR for the Harris service area.^{22,23} For each expense tested, UnitedHealthcare provided documentation intended to support that the expenses were allowable, existed, and were paid. All 32 prescription expenses tested were allowable and fully supported.

For the purposes of this report, a designation of "allowable" or "unallowable" reflects what is reportable on the FSRs. To be allowable, expenses must conform to the requirements of Uniform Managed Care Manual cost principles, which include being reasonable and allocable. Costs that are not allowable may still be incurred and paid by the MCO but may not be reported on the FSR.²⁴

Overall, UnitedHealthcare's system of internal controls operated as intended; however, UnitedHealthcare had some internal control weaknesses that resulted in certain incorrectly reported expenses on its Medical and Combined FSRs. The

²⁰ The STAR+PLUS Medical FSR–Travis contains a summary income statement with all reportable revenues and expenses for the STAR+PLUS program operated by UnitedHealthcare in the Travis service area.

²¹ On the STAR+PLUS Medical FSR–Travis, OIG Audit only tested behavioral health claims expenses. During the period from September 1, 2019, through August 31, 2020, UnitedHealthcare served an average of 14,604 Texas Medicaid members per month enrolled in STAR+PLUS in the Travis service area.

²² The STAR Kids Medical FSR–Harris contains a summary income statement with all reportable revenues and expenses for the STAR Kids program operated by UnitedHealthcare in the Harris service area.

²³ On the STAR Kids Medical FSR–Harris, OIG Audit only tested prescription expenses. During the period from September 1, 2019, through August 31, 2020, UnitedHealthcare served an average of 9,666 Texas Medicaid members per month enrolled in STAR Kids in the Harris service area.

²⁴ Uniform Managed Care Manual, Chapter 6.1, § I(A), v. 2.7 (May 29, 2019) through v. 2.9 (June 14, 2021).

following sections of this report provide additional detail about the instances of noncompliance identified by OIG Audit.

Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31. For state fiscal year 2020, the period is September 1, 2019, through August 31, 2020.

Chapter 1: UnitedHealthcare Did Not Meet All Contract Requirements When Reporting Affiliate Outsourced Service Expenses at Fair Market Value on the Combined FSR

On the Combined FSR, MCOs are required to report affiliate outsourced service expenses at cost, unless they qualify for reporting at fair market value. For an MCO to qualify for reporting affiliate outsourced service expenses at fair market value, all of the following conditions must be present:

- The MCO must represent less than 40 percent of the affiliate's total administrative service revenue.²⁵
- The affiliate must provide administrative services to at least four other customers.
- The MCO must demonstrate that administrative services are provided predominately through a fee model rather than a cost model.^{26,27}

Once these conditions are met, the MCO must then demonstrate that the expenses were reported at fair market value.²⁸

UnitedHealthcare Corporate and Affiliate Structure

UnitedHealth Group, Inc. (UnitedHealth Group) is the ultimate parent company of UnitedHealthcare Community Plan of Texas, L.L.C., UnitedHealthcare Insurance Company, Inc., MARCH Vision Care Group, Inc. (MARCH Vision), OptumRx, Inc. (OptumRx), and United Behavioral Health, Inc. (United Behavioral Health). As indicated by the dotted lines in Figure 3, UnitedHealthcare Community Plan of Texas, L.L.C. and UnitedHealthcare Insurance Company, Inc. contract with MARCH

²⁵ Administrative service revenue is the revenue an organization generates for providing administrative services to other organizations.

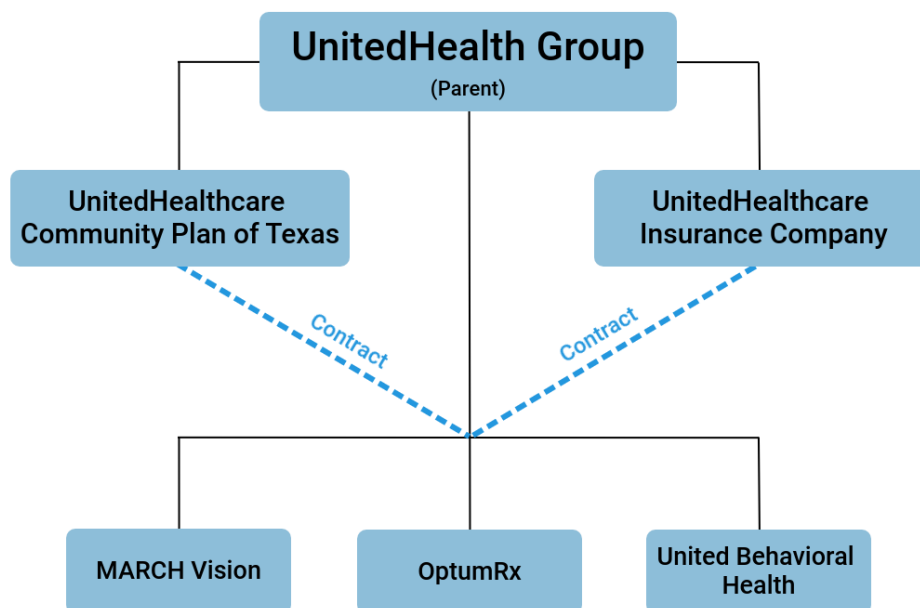
²⁶ Uniform Managed Care Manual, Chapter 6.1, § I(D)(5), v. 2.7 (May 29, 2019) through v. 2.9 (June 14, 2021).

²⁷ Under a fee model, expenses are charged based on a set rate for the service. Under a cost model, expenses are charged based on costs incurred to perform the service.

²⁸ Uniform Managed Care Manual, Chapter 6.1, § I(E)(3)–(4), v. 2.7 (May 29, 2019) through v. 2.9 (June 14, 2021).

Vision, OptumRx, and United Behavioral Health to provide vision, pharmacy, and behavioral health administrative services for Medicaid and CHIP in the service areas where UnitedHealthcare operates. Figure 3 shows the contract and ownership structures among UnitedHealth Group's subsidiary entities.

Figure 3: Contract and Ownership Structures Among UnitedHealth Group's Subsidiaries



Source: OIG Audit

UnitedHealthcare's Cost Reporting Process

UnitedHealthcare initially asserted that, for the three affiliates tested,²⁹ affiliate outsourced service expenses were reported at cost on the Combined FSR. UnitedHealthcare provided profit and loss statements for the affiliates, which showed the affiliates reporting at a monetary loss. UnitedHealthcare further asserted that, since the affiliates were not making a profit, UnitedHealthcare was reporting the affiliate outsourced service expenses for these affiliates at cost on the Combined FSR. Because the profit and loss statements UnitedHealthcare

²⁹ As part of the audit, OIG Audit reviewed three affiliates: (a) OptumRx, a pharmacy benefits manager, (b) MARCH Vision, a vision administrative services contractor, and (c) United Behavioral Health, a behavioral health administrative services contractor.

provided to OIG Audit did not include transactional level details nor source documentation, these statements were insufficient (a) to support affiliate outsourced service expenses reported at cost and (b) for audit testing.³⁰

UnitedHealthcare's Fair Market Value Reporting Process

UnitedHealthcare subsequently asserted that it reported the affiliate outsourced service expenses at fair market value on the Combined FSR. To qualify for an exception to cost-based reporting, UnitedHealthcare sufficiently demonstrated that (a) less than 40 percent of each affiliate's total administrative service revenue was represented by UnitedHealthcare and (b) administrative services were provided predominantly through a fee model. However, to demonstrate that the affiliates provided administrative services to at least four other customers, UnitedHealthcare provided four heavily redacted customer contracts for each affiliate.

OIG Audit requested that UnitedHealthcare and its affiliates provide unredacted customer contracts for OIG Audit to use as comparable sources for determining a fair market value rate.³¹ Because UnitedHealthcare had not provided any other support demonstrating that affiliate outsourced service expenses were reported at fair market value, the rates within the redacted contracts were the only evidence available to determine fair market value.

Subsequently, MARCH Vision provided its four contracts unredacted, and OIG Audit was able to determine that UnitedHealthcare qualified to report affiliate outsourced service expenses for MARCH Vision at fair market value. OIG Audit's review of the contracted rates indicated UnitedHealthcare was accurately reporting MARCH Vision expenses at fair market value.

Additionally, OptumRx and United Behavioral Health both asserted they would not provide the unredacted customer contracts because the contracts contained confidentiality clauses that prevented them from doing so. UnitedHealthcare asserted that they could not require OptumRx or United Behavioral Health to provide the unredacted customer contracts to OIG Audit. Since the redacted

³⁰ 2 C.F.R. § 200.403(g) (Dec. 26, 2013, through Nov. 12, 2020).

³¹ Uniform Managed Care Contract, Attachment A, § 4.08(f) and 9.02(a), v. 2.29 (Sept. 1, 2019) through v. 2.33 (June 1, 2021).

contracts obscured entire sections of the contracts, including customer names and portions of the fee schedules, OIG Audit could not determine if the redacted contracts were comparable sources to calculate a fair market value rate.

As an alternative to providing unredacted contracts for OptumRx and United Behavioral Health, UnitedHealthcare supported the affiliate outsourced service expenses for both affiliates qualified to be reported at fair market value by providing OIG Audit with, for each affiliate, (a) a list of four customers and (b) associated screenshots from customer websites. Additionally, UnitedHealthcare asserted that it determined the affiliate outsourced service fair market value rates for both OptumRx and United Behavioral Health using HHSC's Texas Medicaid and CHIP MCO rate setting packets (rate setting packets).³²

Based on the redacted OptumRx and United Behavioral Health customer contracts, the customer lists, and the screenshots, OIG Audit determined that UnitedHealthcare qualified to report the affiliate outsourced service expenses for both OptumRx and United Behavioral Health at fair market value for 2020. However, because UnitedHealthcare changed its methodology during the course of the audit, UnitedHealthcare could not have been prepared to support fair market value qualification for all affiliate outsourced service expenses prior to the beginning of 2020 as required by the Uniform Managed Care Manual.³³

Overstated Pharmacy Affiliate Expenses

For OptumRx, UnitedHealthcare asserted that it used the rate setting packets' per member per month rate of \$1.80 for pharmacy administrative expenses as the comparable pharmacy fair market value affiliate outsourced service rate. OIG Audit calculated a reported effective affiliate outsourced service rate using UnitedHealthcare's reported administrative expense amounts and number of members served for OptumRx, resulting in a rate of \$3.04 per member per month. Based on UnitedHealthcare's determined fair market value rate of \$1.80 and its reported effective rate of \$3.04, OIG Audit calculated that

³² The rate setting packets detail the development of medical and prescription drug premium rates for the Medicaid and CHIP programs and service areas where each MCO operates. The premium rates are developed using historical data.

³³ Uniform Managed Care Manual, Chapter 6.1, § I(E)(3), v. 2.7 (May 29, 2019) through v. 2.9 (June 14, 2021).

UnitedHealthcare reported pharmacy affiliate outsourced service expenses for OptumRx above fair market value by \$1.24 per member per month. As a result, UnitedHealthcare inaccurately reported an estimated \$4,639,954 of pharmacy affiliate outsourced service expenses above fair market value on the Combined FSR. Table 3 provides additional details about these amounts.

Table 3: UnitedHealthcare’s Estimated Pharmacy Affiliate Outsourced Service Expenses Adjustments for OptumRx

Category	Per Member Per Month Rate	Pharmacy Affiliate Outsourced Service Expenses Amounts for OptumRx
UnitedHealthcare’s reported expenses	\$3.04	\$11,399,979
OIG Audit’s adjusted amount	\$1.80	\$ 6,760,025
OIG Audit’s calculated affiliate expenses reported above fair market value	\$1.24	\$ 4,639,954

Source: OIG Audit

Overstated Behavioral Health Expenses

For United Behavioral Health, UnitedHealthcare used a combination of rates from the rate setting packets and internal data to calculate behavioral health fair market value affiliate outsourced service rates; however, OIG Audit determined that certain components of UnitedHealthcare’s calculation were incorrectly included. For example, UnitedHealthcare calculated the fair market value rates using the risk margin,³⁴ premium,³⁵ and total cost³⁶ rates from the rate setting packets. Because the premium and total cost rates in the rate setting packets are calculated using the risk margin rate, UnitedHealthcare’s use of the risk margin rate again in its fair market value calculations had the effect of improperly duplicating the risk margin within UnitedHealthcare’s calculated rates.

³⁴ The risk margin rates are provisions for the risk assumed by MCOs while operating in Medicaid and CHIP programs.

³⁵ The premium rates are monthly capitation payments made by HHSC to the MCOs for each member enrolled in the MCOs’ Medicaid and CHIP health plans.

³⁶ The total cost rates are costs the MCOs are projected to encounter when operating in Medicaid and CHIP program service areas.

Additionally, for part of the year, UnitedHealthcare used pharmacy-related rates from the rate setting packets in its fair market value calculation. Behavioral health data is not used in setting pharmacy rates in the rate setting packets; therefore, UnitedHealthcare should not use pharmacy rates to calculate behavioral health fair market values. Since behavioral health data is used in setting medical rates in the rate setting packets, OIG Audit did not remove medical rates from its calculation.

After removing the risk margin and pharmacy rate components from UnitedHealthcare's fair market value calculation that were incorrectly included, OIG Audit recalculated the fair market value using the rate setting packets and UnitedHealthcare's internal data. As a result, UnitedHealthcare inaccurately reported an estimated \$3,299,552 of behavioral health affiliate outsourced service expenses above fair market value on the Combined FSR. Table 4 provides additional details about these amounts.

Table 4: UnitedHealthcare's Estimated Behavioral Health Affiliate Outsourced Service Expenses Adjustments for United Behavioral Health

Category	Behavioral Health Affiliate Outsourced Service Expenses Amounts for United Behavioral Health
UnitedHealthcare's reported expenses	\$15,280,752
OIG Audit's adjusted amount	\$11,981,200
OIG Audit's calculated affiliate expenses reported above fair market value	\$ 3,299,552

Source: OIG Audit

Table 5 provides additional detail about the amount of UnitedHealthcare's estimated inaccurately reported affiliate outsourced service expenses, totaling an estimated \$7,939,507.³⁷

Table 5: UnitedHealthcare's Estimated Inaccurately Reported Outsourced Service Expenses Per Affiliate and Program

Program	UnitedHealthcare's Overstated Expenses for OptumRx	UnitedHealthcare's Overstated Expenses for United Behavioral Health
STAR	\$ 2,178,499	\$ 48,264
STAR+PLUS	1,880,405	2,881,436
STAR Kids	435,211	358,048
CHIP	145,839	11,804
Total	\$4,639,954	\$3,299,552

Source: OIG Audit

Prior to using the rate setting packets to determine fair market value affiliate outsourced service rates, UnitedHealthcare did not obtain any assurance from HHSC that this was an appropriate use of the packets. OIG Audit used the rate setting packets in the fair market value recalculations based on UnitedHealthcare's assertions of their use; however, OIG Audit does not attest to the appropriateness of utilizing the rate setting packets in determining fair market value. HHSC maintains full discretion to determine the appropriateness of using the rate setting packets to determine fair market value on all current and future FSRs.

Recommendation 1a

UnitedHealthcare should ensure all subcontractors and affiliates are obligated, in writing, to provide OIG prompt, reasonable, and adequate access to any support that is related to the scope of the contract between HHSC and UnitedHealthcare, as required by the Uniform Managed Care Contract.

Management Response

Action Plan

UnitedHealthcare does include obligations in its agreements that require its subcontractors to provide information related to the contract between HHSC

³⁷ Discrepancy between the individual amounts and the total is due to rounding.

and UnitedHealthcare upon request, and that do satisfy the requirements contained in the Uniform Managed Care Contract. During the course of this audit, the OIG inquired about audit support information from UnitedHealthcare's subcontractors and affiliates that pertained to agreements that are unrelated to the agreement between HHSC and UnitedHealthcare for Medicaid services. Those agreements were with third party customers of the subcontractors and affiliates. Such agreements are not subject to the contractual disclosure obligations that would apply to a contract that is related to the Medicaid agreement between HHSC and UnitedHealthcare.

Responsible Manager

Chief Financial Officer

Target Implementation Date

Implemented

Auditor Comment

OIG Audit appreciates the feedback provided by UnitedHealthcare in its management response and respects UnitedHealthcare's position on the reported issue. OIG Audit stands by this recommendation. UnitedHealthcare and its subcontractors must provide prompt, reasonable, and adequate access to any records that are related to the scope of the Uniform Managed Care Contract, which includes qualifying for an exception to cost-based reporting. Because UnitedHealthcare asserted that it based its fair market value on its affiliates' contracts with other customers, OIG Audit requested information to support that assertion. The Uniform Managed Care Manual requires MCOs to provide supporting documentation for fair market value to HHSC and auditors. When MCOs report costs at fair market value, support may include names of specific unaffiliated entities that are sold to, prices to each, time frame, and the comparability of the services being sold and price.

Recommendation 1b

UnitedHealthcare should prepare and maintain documentation to support qualification to report at fair market value prior to the beginning of the state fiscal year.

Management Response

Action Plan

MCO will work with affiliates to gather support prior to the beginning of the State fiscal year.

Responsible Manager

Chief Financial Officer

Target Implementation Date

Work is already underway to gather support for subsequent years, beginning with State fiscal year 2020 in preparation for the agreed upon procedures audit.

Recommendation 1c

UnitedHealthcare should report affiliate outsourced service expenses at or below fair market value, when using the fair market value method to report expenses.

Management Response

Action Plan

MCO will review current and future FSR reporting to ensure that what is being reported on the FSR's is either at actual cost or at or below fair market value reporting.

Responsible Manager

Chief Financial Officer

Target Implementation Date

Work is already underway to ensure filings are compliant.

Recommendation 1d

UnitedHealthcare should (a) work with FRAC to determine the appropriateness of utilizing the HHSC Texas Medicaid and CHIP MCO rate setting packets as a basis for determining fair market value affiliate outsourced service rates and (b) ensure

all components of its fair market value calculations are supported by reasonable rationale.

Management Response

Action Plan

The MCO will work with FRAC to determine the appropriateness of utilizing the HHSC Texas Medicaid and CHIP MCO rate setting packets as a basis for determining fair market value affiliate outsourced service rates.

Responsible Manager

Chief Financial Officer

Target Implementation Date

MCO will reach out to FRAC to discuss this issue in August 2022.

Chapter 2: UnitedHealthcare Incorrectly Reported Behavioral Health Claims Expenses on the STAR+PLUS Medical FSR–Travis

On its STAR+PLUS Medical FSR–Travis, UnitedHealthcare inaccurately reported some behavioral health claims expenses. To be reported on the FSRs, expenses must be necessary, reasonable, and consistent with the MCO’s policies and procedures.³⁸ Specifically, UnitedHealthcare inaccurately reported expenses above its contracted provider rate for 4 of 52 (7.7 percent) behavioral health claims expenses tested. As a result, UnitedHealthcare overstated Medicaid behavioral health claims expenses totaling \$11,663.³⁹

OIG Audit performed further analysis and identified an additional 183 behavioral health claims expenses across the claims population⁴⁰ that UnitedHealthcare inaccurately reported above the contracted provider rates, resulting in overstatements totaling \$208,793. UnitedHealthcare asserted that the overstatements occurred because the contract rates were not accurately programmed into its claims processing system.

Table 6 details the number and amount of UnitedHealthcare’s inaccurately reported behavioral health claims expenses.

Table 6: UnitedHealthcare’s Inaccurately Reported Behavioral Health Claims Expenses

Finding Type	Tested Claims Expenses		Additional Expenses Across the Population	
	Number	Amount	Number	Amount
Inaccurately Reported Expenses	4	\$11,663	183	\$208,793

Source: OIG Audit

³⁸ 2 C.F.R. § 200.403(a) and (c) (Dec. 26, 2013, through Nov. 12, 2020).

³⁹ UnitedHealthcare paid the four claims to two providers for one procedure code and one revenue code.

⁴⁰ To perform the additional analysis, OIG Audit reviewed all behavioral health claims expenses reported on the STAR+PLUS Medical FSR–Travis for the two providers and their procedure and revenue codes that were overstated.

Recommendation 2

UnitedHealthcare should ensure behavioral health claims expenses it reports on its FSRs are accurate in accordance with provider contracts.

Management Response

Action Plan

The MCO will review current processes and procedures to ensure any provider overpayments, that are not subsequently recouped, are excluded from FSR filings.

Responsible Manager

Chief Financial Officer

Target Implementation Date

August 2022

Appendix A: Objective, Scope, and Criteria

Objective and Scope

The audit objective was to determine whether (a) UnitedHealthcare reported expenses on selected components of its Medical and Combined FSRs submitted to HHSC in accordance with contract requirements and laws and (b) the related internal controls over the preparation of the FSRs were designed and operating effectively.

The audit scope included UnitedHealthcare's Medical and Combined FSRs and related internal controls over the preparation of those FSRs for state fiscal year 2020, which covered the period from September 1, 2019, through August 31, 2020.

Criteria

OIG Audit used the following criteria to evaluate the information provided:

- 2 C.F.R. § 200.403 (2013 through 2020)
- Uniform Managed Care Contract, Attachment A, §§ 4.08 and 9.02, v. 2.29 (2019) through v. 2.33 (2021)
- Uniform Managed Care Contract, Attachment B-1, § 8.1.17.1, v. 2.29 (2019) through v. 2.33 (2021)
- Uniform Managed Care Manual, Chapter 6.1, v. 2.7 (2019) through v. 2.9 (2021)

Appendix B: Methodology and Data Reliability

OIG Audit issued an engagement letter to UnitedHealthcare on March 30, 2022, providing information about the upcoming audit, and conducted fieldwork from March 30, 2022, through June 29, 2022.

OIG Audit reviewed UnitedHealthcare's Administrative FSR, Part 1, and the Quality Improvement FSR, Part 1. Both parts consisted of direct expenses reported for Texas Medicaid and CHIP. Additionally, OIG Audit reviewed UnitedHealthcare's (a) STAR+PLUS Medical FSR–Travis, Part 1, and (b) STAR Kids Medical FSR–Harris, Part 1. On all of the FSRs OIG Audit reviewed, each part is divided into line items, which indicate the type of revenues or expenses stated. OIG Audit tested the following expenses on UnitedHealthcare's FSRs:

The Combined FSR consists of two sections—an Administrative section (Administrative FSR) and a Quality Improvement section (Quality Improvement FSR).

- Administrative FSR, Part 1:
 - Line 20 – Outsourced Services (Capitated Arrangements)
 - Line 22 – PBM Administrative Fees – Fees based on transaction volume
- Quality Improvement FSR, Part 1:
 - Line 17 – Outsourced Services
- STAR+PLUS Medical FSR–Travis, Part 1:
 - Line 21 – Other Medical Expenses
- STAR Kids Medical FSR–Harris, Part 1:
 - Line 21 – Prescription Expenses (excluding PBM Administrative)

OIG Audit reviewed UnitedHealthcare's system of internal controls, including components of internal control,⁴¹ within the context of the audit objectives by:

- Interviewing UnitedHealthcare management and staff with oversight responsibilities for maintenance, submission, review, and approval of FSR-related activities.
- Reviewing relevant documentation, such as policies, procedures, and documented approvals.
- Performing selected tests of relevant documentation.

Sampling Methodology and Data Reliability

Auditors selected nonstatistical samples related to expenses reported on the Combined FSR, STAR+PLUS Medical FSR–Travis, and STAR Kids Medical FSR–Harris. The sample items were not representative of the populations; therefore, it would not be appropriate to project the test results to the populations.

To assess the reliability of data related to the Combined FSR, STAR+PLUS Medical FSR–Travis, and STAR Kids Medical FSR–Harris, auditors (a) analyzed the data for reasonableness and completeness, (b) compared the data against published FSR data, and (c) interviewed staff who were knowledgeable about the data. OIG Audit determined that the data was sufficiently reliable for the purpose of this audit.

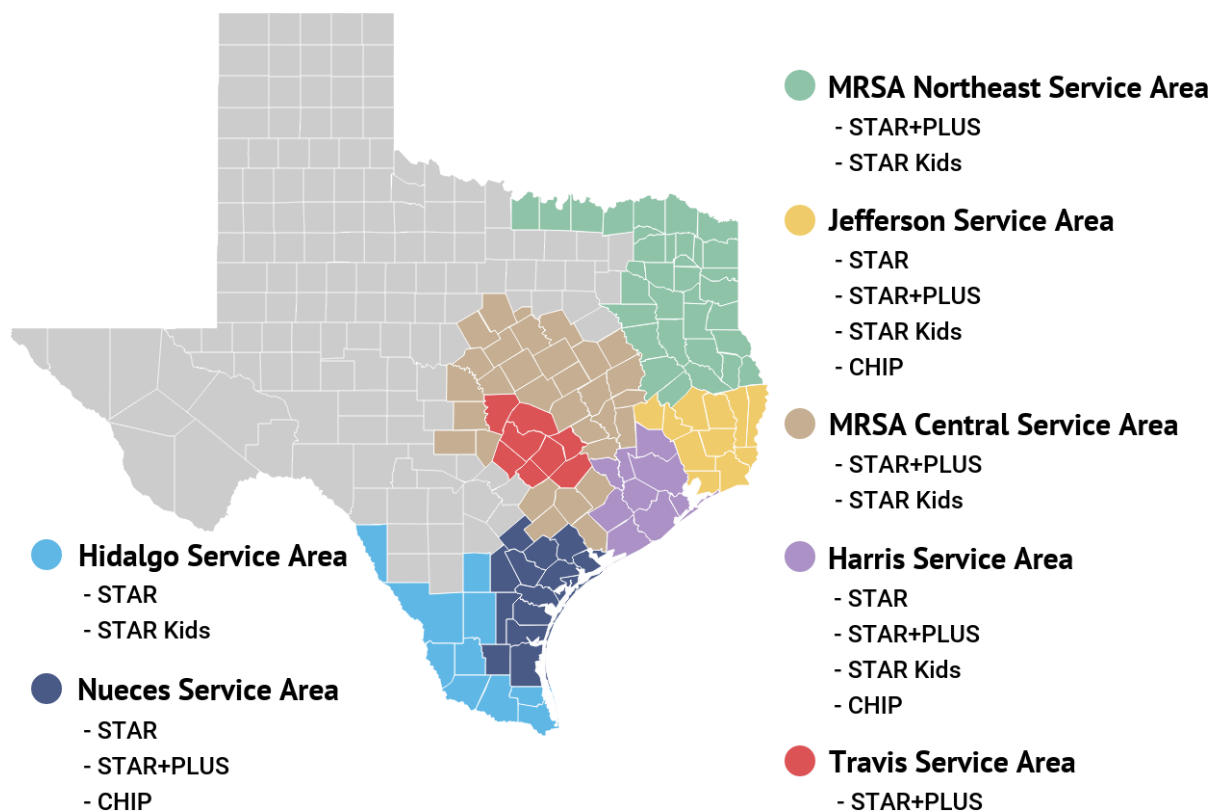
⁴¹ For more information on the components of internal control, see the United States Government Accountability Office's *Standards for Internal Control in the Federal Government*, (Sept. 2014), <https://www.gao.gov/assets/gao-14-704g.pdf> (accessed Apr. 16, 2021).

Appendix C: HHSC Service Areas Covered by UnitedHealthcare

UnitedHealthcare provides health care services to Texas Medicaid and CHIP members in the Harris, Hidalgo, Jefferson, Medicaid Rural Service Area (MRSA) Central, MRSA Northeast, Nueces, and Travis service areas through the STAR program, the STAR+PLUS program, the STAR Kids program, and CHIP.

Figure C.1 illustrates the Texas managed care service areas and associated programs covered by UnitedHealthcare.

Figure C.1: Texas Managed Care Service Areas and Programs Covered by UnitedHealthcare



Source: OIG Audit

Table C.1 identifies the Texas counties included in the service areas covered by UnitedHealthcare.

Table C.1: UnitedHealthcare Service Area Counties⁴²

Service Area	Texas Counties
Harris	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, and Wharton
Hidalgo	Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, and Zapata
Jefferson	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, and Walker
MRSA Central	Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, Shelby, Somervell, and Washington
MRSA Northeast	Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, San Saba, Smith, Titus, Trinity, Upshur, Van Zandt, and Wood
Nueces	Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, and Victoria
Travis	Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson

Source: OIG Audit compiled from information contained in "MCO Service Area Information," HHS, <https://www.txvendordrug.com/about/manuals/pharmacy-provider-procedure-manual/p-19-documents/managed-care-resource-documents> (accessed July 7, 2022)

⁴² The counties included in each service area are current as of January 1, 2022.

Appendix D: Summary of Recommendations

Table D.1: Summary of Recommendations to UnitedHealthcare

No.	Recommendation
1a	UnitedHealthcare should ensure all subcontractors and affiliates are obligated, in writing, to provide OIG prompt, reasonable, and adequate access to any support that is related to the scope of the contract between HHSC and UnitedHealthcare, as required by the Uniform Managed Care Contract.
1b	UnitedHealthcare should prepare and maintain documentation to support qualification to report at fair market value prior to the beginning of the state fiscal year.
1c	UnitedHealthcare should report affiliate outsourced service expenses at or below fair market value, when using the fair market value method to report expenses.
1d	UnitedHealthcare should (a) work with FRAC to determine the appropriateness of utilizing the HHSC Texas Medicaid and CHIP MCO rate setting packets as a basis for determining fair market value affiliate outsourced service rates and (b) ensure all components of its fair market value calculations are supported by reasonable rationale.
2	UnitedHealthcare should ensure behavioral health claims expenses it reports on its FSRs are accurate in accordance with provider contracts.

Source: OIG Audit

Appendix E: Related Reports

- Administrative Expenses Reported by Molina Healthcare of Texas, Inc. on Its Financial Statistical Report, [AUD-22-021](#), August 16, 2022
- Driscoll Health Plan: A Texas Medicaid and CHIP Managed Care Organization, [AUD-21-010](#), May 27, 2021
- Reporting and Compliance of Affiliate Third-Party Administrator Services: MCNA Insurance Company, [AUD-21-007](#), February 25, 2021
- Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Molina Healthcare of Texas, [AUD-21-004](#), December 9, 2020
- Audit of Medicaid and CHIP MCO Special Investigative Units: Molina Healthcare of Texas, [AUD-20-011](#), May 22, 2020
- Audit of Texas Medicaid and CHIP Pharmacy Benefit Services Delivered by Molina and Its PBM, Caremark, [AUD-19-023](#), July 19, 2019

Appendix F: Resources for Additional Information

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

For more information on Medicaid and CHIP Financial Statistical Reports:

"Medicaid & CHIP Financial Statistical Report," HHSC,
<https://www.hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management/medicaid-chip-financial-statistical-reports> (accessed July 8, 2022)

For more information on UnitedHealthcare Community Plan of Texas, L.L.C.:

"Texas health plans," UnitedHealthcare Community Plan,
<https://www.uhccommunityplan.com/tx> (accessed July 7, 2022)

For more information on UnitedHealthcare Insurance Company, Inc.:

Homepage, UnitedHealthcare, <https://www.uhc.com/about-us> (accessed July 18, 2022)

For more information on UnitedHealth Group, Inc:

Homepage, UnitedHealth Group, <https://www.unitedhealthgroup.com/> (accessed July 18, 2022)

For more information on OptumRx, Inc.:

Homepage, OptumRx, <https://www.optumrx.com/public/landing> (accessed July 7, 2022)

For more information on MARCH Vision Care, Inc.:

Homepage, MARCH Vision Care, <https://www.marchvisioncare.com/> (accessed July 7, 2022)

For more information on United Behavioral Health, Inc. (also referred to as Optum Behavioral Health):

"Behavioral Health," Optum,
<https://www.optum.com/business/solutions/behavioral-health.html?V=optum.com/mentalhealth> (accessed July 7, 2022)

Appendix G: Report Team and Distribution

Report Team

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- Anton Dutchover, CPA, Audit Director
- Amy Adler, CPA, CFE, Audit Director
- Patrick Smith, CIA, CRMA, Senior Managing Auditor
- Errol Baugh, Senior Auditor
- Abram Valdes, CPA, Senior Auditor
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- Stacie Evans, Associate Auditor
- Jim Hicks, CISA, Quality Assurance Reviewer
- Erin Powell, Quality Assurance Reviewer
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- Camisha Banks, Deputy Associate Commissioner of Managed Care Compliance and Operations

UnitedHealthcare

- Don Langer, Chief Executive Officer
- Jeffrey Rayl, Chief Financial Officer
- Deborah Deska, Compliance Officer

Appendix H: 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
- Audrey O'Neill, Principal Deputy Inspector General, Chief of Audit and Inspections
- Susan Biles, Chief of Staff, Chief of Policy and Performance
- Erik Cary, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Steve Johnson, Chief of Investigations and Reviews

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- Phone: 1-800-436-6184

To Contact OIG

- Email: OIGCommunications@hhs.texas.gov
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