OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

AUDIT OF DELIVERY SUPPLEMENTAL PAYMENTS

HHSC Management and Administration of Delivery Supplemental Payments

November 8, 2016
IG Report No. IG-16-050

This Final Audit Report is subject to appeal and may not reflect the final disposition of the matter.

HHSC IG
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
INSPECTOR GENERAL

AUDIT OF DELIVERY SUPPLEMETNAL PAYMENTS

HHSC Management and Administration of Delivery Supplemental Payments

WHY THE IG CONDUCTED THIS AUDIT

Managed care organizations (MCOs) submit delivery supplemental payment claims to the Texas Health and Human Services Commission (HHSC) to cover expenses for the delivery of a child.

Each month, HHSC Strategic Decision Support processes delivery supplemental payment claims through a series of edit checks. Claims that pass edit checks receive payments ranging from $3,100 to $3,600 per delivery; claims that fail edit checks are denied payment. In some circumstances, MCOs may resubmit or appeal denied claims.

The HHSC Medicaid and CHIP Services Department is responsible for managed care policy and oversight. On behalf of the Medicaid and CHIP Services Department, Strategic Decision Support receives, reviews, adjusts, and submits all delivery supplemental claims and administers the appeals process.

This audit evaluated the effectiveness of processes and controls intended to ensure (a) delivery supplemental payment claims and appeals were processed timely and accurately and (b) claim adjudications and appeal decisions were valid and adequately supported.

WHAT THE IG RECOMMENDS

The Medicaid and CHIP Services Department should recover $3,399,920 overpaid to MCOs and reimburse underpaid MCOs $688,858. Additionally, the delivery supplemental payment function should be moved to the Medicaid and CHIP Services Department, and additional processes and controls should be put in place to strengthen the management and administration of delivery supplemental payment activities.

View **IG-16-050**
For more information, contact:
IG.AuditDivision@hhsc.state.tx.us

WHAT THE IG FOUND

From 2013 through 2015, Strategic Decision Support processed 496,810 delivery supplemental payment claims with an overall accuracy rate of 99.84 percent. During this three-year period, MCOs received approximately $1.5 billion in delivery supplemental payments.

Year	Deliveries	Claims $	Appeals $	Total
2013	154,695	$ 496,581,402	$ 890,548	$ 497,471,950
2014	174,645	$ 501,238,774	$ 1,630,716	$ 502,869,490
2015	167,470	$ 502,780,505	$ 1,052,955	$ 503,833,460
Total	496,810	$ 1,500,600,681	$ 3,574,219	$ 1,504,174,900

Strategic Decision Support processes delivery supplemental claims in accordance with contract and Uniform Managed Care requirements. However, eligibility records used by Strategic Decision Support to process claims sometimes changed retroactively, and the IT script used to process claims contained diagnostic codes that were not related to deliveries or were no longer in use. These issues resulted in MCO overpayments totaling $2,032,118 and MCO underpayments totaling $682,559.

In addition, the administration of the appeals process requires strengthening in order to ensure appeal decisions are appropriate and consistent. Strategic Decision Support had not received guidance about whether it should enforce contract requirements that state delivery supplemental payment claims must be submitted within 210 days of the delivery, or whether it should allow for exceptions to the 210-day requirement as outlined in the Uniform Managed Care Manual. The lack of clear expectations regarding appeals criteria contributed to appeal decisions that were inconsistent with applicable requirements, resulting in MCO overpayments totaling $1,367,801 and MCO underpayments totaling $6,299.

Transferring responsibility for the delivery supplemental payment function to the Medicaid and CHIP Services Department would help ensure delivery supplemental payment claims and appeals are administered in accordance with policy and contract requirements. Strategic Decision Support provides research and analytic support to Texas Health and Human Services agency programs, but it does not possess subject matter expertise on managed care administration. Additionally, the implementation of processes and controls to guide the execution of the delivery supplemental payment function, including conducting retrospective reviews of claim adjudications and appeal decisions, would further strengthen the administration and management of delivery supplemental payment activities.

The Medicaid and CHIP Services Department and Strategic Decision Support concurred with the IG Audit Division recommendations outlined in this report, and will facilitate the development of a corrective action plan designed to address MCO overpayments and underpayments and strengthen the management of the delivery supplemental payment function.

TABLE OF CONTENTS

INTRODUCTION 1

Background *1*

ISSUES AND RECOMMENDATIONS 4

Section 1: **Claims Processing** **5**

The Impact of Retroactive Eligibility Changes Was Not Considered *6*

Edit Checks Were Based on Invalid Diagnostic Codes *7*

Recommendations 1.1-1.4 ..... *7*

Section 2: **Appeals Administration** **9**

Appeals of Edit 116 Rejections Were Approved Without Evidence of Reasonable Extenuating Circumstances *9*

Appeal Decisions Were Inconsistent With Applicable Requirements *11*

Recommendations 2.1-2.4 ..... *11*

Section 3: **Control Environment** **13**

The Organizational Placement of the Delivery Supplemental Payment Function is Not Appropriate *13*

Policies and Procedures Were Not Documented *14*

Change Controls Had Not Been Implemented *14*

Recommendations 3.1-3.3 ..... *15*

CONCLUSION 17

APPENDICES 19

A: Objective, Scope, and Methodology *19*

B: Sampling Methodology *21*

C: Table Detail *22*

D: Report Team and Report Distribution *25*

E: IG Mission and Contact Information *26*

INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Inspector General (IG) Audit Division conducted an audit of delivery supplemental payments made to managed care organizations (MCOs). [1] The audit objective was to evaluate the effectiveness of processes and controls intended to ensure (a) delivery supplemental payment claims and appeals were processed timely and accurately and (b) claim adjudications and appeal decisions were valid and adequately supported. This audit included state fiscal years 2013 through 2015, which covers the period from September 2012 through August 2015, and included a review of relevant delivery supplemental payment activities through the end of fieldwork in May 2016.

Background

MCOs participating in the HHSC State of Texas Access Reform (STAR), Children's Health Insurance Program (CHIP), and CHIP Perinatal programs submit and receive payments for qualified delivery supplemental payment claims to cover hospital expenses for the delivery of a child. Delivery supplemental payments are intended to make costs associated with a pregnancy equitable, in particular when a pregnant MCO member[2] transfers to a different plan toward the end of the pregnancy.

When managed care first began in Texas, the capitation rate for the pregnant women's risk group[3] was calculated to include estimated costs for all health care, including prenatal, labor, and delivery costs. Members could change from one health plan to another within their geographic area, and there were instances where members changed plans just prior to the delivery. As a result, the original plan received a number of monthly capitation payments while only being at risk for the member's prenatal treatment and other needed health services prior to delivery, and the new plan received limited capitation payments despite being at risk for the most significant portion of the cost—the delivery of the child.

---

[1] An MCO is an organization that delivers and manages health care services through a risk-based arrangement. In addition to delivery supplemental payments, MCOs receive a monthly premium or capitation payment for each managed care member enrolled, based on a projection of what health care for the typical individual would cost.

[2] MCOs refer to enrollees as "members." An "enrollee" is an individual who is eligible for Medicaid or CHIP services and is enrolled in an MCO either as a subscriber or a dependent.

[3] A "risk group" is a group of MCO members that have a similar health status and are expected to have a similar Medicaid or CHIP spending pattern. HHSC applies an acuity risk adjustment to capitation rates to recognize the anticipated cost differential among multiple health plans in a service area due to the variable health status of their respective memberships. Final capitation payments are based on this acuity risk-adjusted premium for each combination of service area and risk group.

In order to rectify this situation, capitation rates for the pregnant women's risk group were recalculated to carve out the cost of labor and delivery. Instead, the labor and delivery charges would be covered by a one-time flat rate delivery supplemental payment.

Each month, MCOs submit delivery supplemental payment claims to HHSC Strategic Decision Support via Excel files. The claims are run through an edit check process that validates claim data against eligibility databases and other information technology (IT) systems. For claims that pass the edit checks, delivery supplemental payments ranging from $3,100 to $3,600[4] per delivery are made to the MCOs; claims that fail the edit checks are denied payment and returned to the MCO. Depending on the circumstance, MCOs may resubmit or appeal denied claims.

Texas Health and Human Services (HHS) agencies administer public health programs for the State of Texas. Within HHS, the Medicaid and CHIP Services Department oversees Medicaid and CHIP programs, and is responsible for managed care policy and oversight, including receiving, reviewing, adjusting, and submitting payments for managed care services. Medicaid and CHIP programs deliver health care services (including medical, dental, prescription drug, disability, behavioral health, and long-term support services) to eligible individuals. CHIP provides services to individuals in Texas through a managed care model[5]. Texas Medicaid provides services to some individuals through a traditional fee-for-service model[6], but most are enrolled through a managed care model. Effective September 1, 2016, the Medicaid/CHIP Division became the Medicaid and CHIP Services Department as part of a larger HHS system transformation.

On behalf of the Medicaid and CHIP Services Department, Strategic Decision Support receives, reviews, adjusts, and submits all delivery supplemental payment claims and administers the appeals process. The HHSC Uniform Managed Care Manual provides guidance on processing claims and administering the appeals process. [7]

[4] Delivery supplemental payments are negotiated with the MCO, and vary by health plan and the geographic area in which the delivery occurred.

[5] Medicaid managed care was first introduced in pilot programs in Texas in 1993. In this model, HHSC contracts with MCOs who contract with Medicaid providers for the delivery of health care services to Medicaid enrollees. MCOs must provide the same services under managed care as provided under the traditional fee-for-service model.

[6] Medicaid fee-for-service was the original service delivery model for Texas Medicaid introduced in 1967. In this model, Medicaid providers are reimbursed retrospectively for a Medicaid eligible health care service or services provided to a Medicaid eligible patient.

[7] Uniform Managed Care Manual, Chapter 5.3.5.3, Version 1.4 (May 5, 2011) through Version 2.4 (July 1, 2016).

From 2013 to 2015, Strategic Decision Support processed 496,810 delivery supplemental payment claims, resulting in MCOs receiving approximately $1.5 billion in delivery supplemental payment claims and appeals dollars.[8] Table 1 shows the breakdown of delivery supplemental payments by year.

Table 1: Delivery Supplemental Payments by Year[9]

Year	Deliveries	Claims $	Appeals $	Total
2013	154,695	$ 496,581,402	$ 890,548	$ 497,471,950
2014	174,645	$ 501,238,774	$ 1,630,716	$ 502,869,490
2015	167,470	$ 502,780,505	$ 1,052,955	$ 503,833,460
Total	496,810	$ 1,500,600,681	$ 3,574,219	$ 1,504,174,900

Source: HHSC Strategic Decision Support

The IG Audit Division conducted this audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Unless otherwise described, any year that is referenced is the state fiscal year, which covers the period from September 1 through August 31.

The IG Audit Division presented audit results, issues, and recommendations to applicable HHSC management in a draft report dated August 5, 2016. HHSC management was provided the opportunity to study and comment on the report. Management responses to the recommendations contained in the report are included in the report following each recommendation. HHSC management concurred with the IG Audit Division recommendations, and will facilitate the development of a corrective action plan designed to address MCO overpayments and underpayments and strengthen the management of the delivery supplemental payment function.

[8] "Claims and appeals dollars" are the total amounts submitted to MCOs by HHSC for delivery supplemental payments. Claims and appeals dollars paid during the referenced year include claims with a delivery that may or may not have occurred within the referenced year.

[9] Table totals adjusted for rounding.

ISSUES AND RECOMMENDATIONS

During this audit, the IG Audit Division evaluated delivery supplemental payment activities and identified issues related to the:

- Impact of retroactive eligibility changes on prior claim adjudications.
- Inclusion of invalid diagnostic codes in the IT script used to process claims.
- Application of appeal criteria and requirements contained in the Uniform Managed Care Contract and Uniform Managed Care Manual.
- Organizational placement of the delivery supplemental payment function.
- Documentation of policies and procedures necessary to support the delivery supplemental payment function.
- Implementation of IT change controls necessary to protect systems used for delivery supplemental payments from inappropriate or unwarranted changes.

The sections that follow provide detailed results of the IG Audit Division's review and offer recommendations which, if implemented, will strengthen the management and administration of the delivery supplemental payment function.

Section 1: CLAIMS PROCESSING

From 2013 through 2015, Strategic Decision Support processed 496,810 delivery supplemental payment claims. Unless an edit check prevented payment during processing, claims were approved for payment without additional review by Strategic Decision Support.

Replicating the IT script used by Strategic Decision Support, the IG Audit Division reprocessed all claims from the three-year audit period. Applying eligibility information available at the time the claims were reprocessed, results of audit test work indicated that 496,003 out of 496,810 claim adjudications reviewed were correct, which translates to an overall accuracy rate of 99.84 percent.

Additionally, because neither the Medicaid and CHIP Services Department nor Strategic Decision Support performed subsequent claim verifications against an independent data source, the IG Audit Division worked with the HHSC Fraud Detection and Investigative Strategy Directorate to match 17,502 claims to records consistent with pregnancy and delivery care, including (a) MCO encounter data related to a pregnancy or delivery, (b) a TIERS[10] case record confirming the date of delivery, or (c) a Bureau of Vital Statistics birth certificate. Based on the results of its analysis, the Fraud Detection and Investigative Strategy Directorate determined that all claims tested had a relevant corresponding record.

Results of other IG Audit Division test work, however, indicated that:

- Eligibility records relied upon by Strategic Decision Support to process claims sometimes changed retroactively, therefore changing the adjudication of a previously processed claim.
- Invalid diagnostic codes were used as part of the automated edit checks within the IT script used to process claims.

As a result, 807 claims were inappropriately processed during the three-year audit period. Table 2 details the results of the inappropriately processed claims and related overpayments and underpayments[11] made to MCOs.

[10] The Texas Integrated Enrollment Redesign System (TIERS) is the automated system that supports HHSC's eligibility determinations for cash assistance, medical assistance, and food assistance.

[11] Overpayment and underpayment amounts adjusted for rounding.

Table 2: Delivery Supplemental Payment Claims Processing Results

Claims Processing Results	# of Claims	Overpayments	Underpayments
Inappropriately Processed Due To Retroactive Eligibility Changes	741	$ 1,805,939	$ 682,559
Inappropriately Processed Due To Inclusion Of Invalid Diagnostic Codes	66	$ 226,179	$ 0
Total	807	$ 2,032,118	$ 682,559

Source: HHSC Strategic Decision Support

The Impact of Retroactive Eligibility Changes Was Not Considered

Following contract[12] and Uniform Managed Care Manual requirements, Strategic Decision Support processes claims within 20 business days of receipt from MCOs. The Uniform Managed Care Manual states that "MCOs will submit the [delivery supplemental payment] reports…on the first business day of each month" and "HHSC will pay the MCOs within twenty (20) business days from the given deadline."[13] Once it receives claims each month, Strategic Decision Support runs an edit check process with the latest known eligibility information for members associated with the claims.

However, eligibility information was sometimes updated after claims had been processed for the month. For the period reviewed, 741 claims that correctly passed or failed edit checks at the time they were processed by Strategic Decision Support would have later been approved for or denied payment if retroactive eligibility changes were applied. As a result, HHSC overpaid MCOs by $1,805,939 for 541 claims that correctly passed edit checks when they were originally processed, but should have been denied payment if retroactive eligibility changes were applied. Additionally, MCOs were underpaid $682,559 by HHSC for 200 claims that correctly failed edit checks when they were originally processed, but should have been approved for payment if retroactive eligibility changes were applied.

For example, there were 299 instances where a claim that correctly passed edit checks at the time it was processed should have been denied payment because the member's Medicaid, CHIP, or CHIP Perinatal identification number was not found in the member's HHSC managed care eligibility file in the month of delivery. This type of processing error occurs when, for example, a member eligible at the time the claim was processed was later determined to not have eligibility in the month of delivery. Conducting retrospective reviews of claim adjudications would help reduce processing errors by accounting for eligibility changes that occur after claims have been processed for the month.

[12] Uniform Managed Care Contract, Attachment A - Medicaid and CHIP Managed Care Services RFP, Uniform Managed Care Contract Terms and Conditions, Section 10.09, Version 2.3 (September 1, 2012) through Version 2.16 (September 1, 2015)

[13] Uniform Managed Care Manual, Chapter 5.3.5.3, Version 1.4 (May 5, 2011) through Version 2.4 (July 1, 2016).

Edit Checks Were Based on Invalid Diagnostic Codes

The Uniform Managed Care Manual states that "HHSC will check that the procedure or diagnosis code submitted is a valid delivery related procedure/diagnosis code."[14] Through its automated edit checks, Strategic Decision Support verifies that MCOs submit properly coded and supported claims each month.

However, the IT script used to process claims included diagnostic codes (a) not related to deliveries or (b) related to deliveries, but no longer utilized because more relevant diagnostic codes were available. A claim that included one of these diagnostic codes would have been inappropriately processed as a valid claim. Consequently, 66 claims submitted with invalid diagnostic codes were inappropriately approved for payment, resulting in HHSC overpaying MCOs by $226,179.

For example, there were 23 instances where a claim submitted with a diagnostic code used for a likely miscarriage of a pregnancy less than 20 weeks gestation passed edit checks during processing. While this is a valid diagnostic code, it is not approved for delivery supplemental payments and should not have been included in the list of allowable codes within the IT script used to process claims. Strategic Decision Support should periodically review the IT script to ensure only valid diagnostic codes that appropriately support the approval of delivery supplemental payments are used when automated edit checks are run each month.

Recommendations 1.1-1.4

1.1 The Medicaid and CHIP Services Department should recover $2,032,118 from MCOs for (a) 541 claims that were appropriately paid during the month of processing, but would have been denied payment if subsequent eligibility changes were applied and (b) 66 claims that were inappropriately paid due to the inclusion of invalid diagnostic codes in the IT script used to process claims.

1.2 The Medicaid and CHIP Services Department should pay MCOs $682,559 for 200 claims that were appropriately denied payment during the month of processing, but would have been paid if subsequent eligibility changes were applied.

1.3 Strategic Decision Support should update claims processing procedures to (a) periodically perform retrospective reviews to identify whether claim adjudications were impacted by retroactive eligibility changes and (b) eliminate invalid diagnostic codes from the IT script used to process claims.

1.4 The Medicaid and CHIP Services Department should periodically, and on a sample basis, verify that claims are supported by (a) MCO encounter data related to a pregnancy or delivery, (b) a TIERS case record confirming the date of delivery, or (c) a Bureau of Vital Statistics birth certificate.

[14] Uniform Managed Care Manual, Chapter 5.3.5.3, Version 1.4 (May 5, 2011) through Version 2.4 (July 1, 2016).

HHSC Medicaid and CHIP Services Department Management Response 1.1-1.2

- *Medicaid and CHIP Services Department Finance will combine the amounts to be recovered under recommendation 1.1 with amounts to be paid under recommendation 1.2.*
- *Medicaid and CHIP Services Department Finance will prepare demand letters for each of the MCOs for which an amount is due.*
- *Medicaid and CHIP Services Department Finance will prepare a Request for Disbursement to each MCO for which an amount is owed.*

Responsible Individual: Director of Financial Reporting and Audit Coordination, Medicaid and CHIP Services Department

Target Implementation Date: November 2016

HHSC Strategic Decision Support Management Response 1.3

- *Strategic Decision Support will update the current processing procedures to include periodic retrospective programmatic reviews to identify claims requiring an adjustment due to subsequent eligibility changes.*
- *Strategic Decision Support has already updated the current processing procedures to eliminate invalid diagnostic codes from the IT script used to process claims.*

Responsible Individual: Director, Strategic Decision Support

Target Implementation Date: November 2016

HHSC Medicaid and CHIP Services Department Management Response 1.4

Medicaid and CHIP Services Department Health Plan Management will develop a sampling methodology to periodically verify that claims are supported by (a) MCO encounter data related to a pregnancy or delivery, (b) a TIERS case record confirming the date of delivery, (c) a Bureau of Vital Statistics birth certificate, or (d) other support documentation as required by the Contract.

Responsible Individual: Director of Health Plan Management, Medicaid and CHIP Services Department

Target Implementation Date: November 2016

Section 2: APPEALS ADMINISTRATION

In accordance with contract and Uniform Managed Care Manual requirements, delivery supplemental payment claims that fail edit checks, are submitted without required data elements, or are submitted more than 210 days after the date of delivery are denied payment by Strategic Decision Support. However, if the MCO considers the denied claim payable, the Uniform Managed Care Manual outlines the process for MCOs to resubmit or appeal the claim. Strategic Decision Support administers the appeals process for all delivery supplemental payment claims.

For the three-year audit period, the IG Audit Division conducted a retrospective analysis of 1,100 appeals of delivery supplemental payment claims to evaluate the administration of the appeals process and assess the clarity of the criteria used to execute the appeals process.

During its review, the IG Audit Division identified issues related to (a) incorrect appeal decisions for claims rejected by Edit 116, which rejects claims for not being submitted within contractually required timeframes, and (b) appeal decisions that were inconsistent with contract and Uniform Managed Care Manual requirements. The results of audit test work indicated that 422 appeals were incorrectly approved or denied during the three-year audit period. Table 3 shows the results of incorrect appeal decisions, and the related overpayments and underpayments[15] made to MCOs.

Table 3: Delivery Supplemental Payment Claims Appeal Results

Appeal Results	# of Appeals	Overpayments	Underpayments
Incorrect Edit 116 Rejection Appeal Decisions	408	$ 1,327,423	$ 0
Appeal Decisions Inconsistent With Applicable Requirements	14	$ 40,378	$ 6,298
Total	422	$ 1,367,801	$ 6,298

Source: HHSC Strategic Decision Support

Appeals of Edit 116 Rejections Were Approved Without Evidence of Reasonable Extenuating Circumstances

MCOs are required by contract to submit claims within 210 days after the date of delivery. Contract requirements state that "[the] MCO will not be entitled to Delivery Supplemental Payments for deliveries that are not reported to HHSC within 210 days after the date of delivery, or within thirty (30) days from the date of discharge from the Hospital for the stay

[15] Overpayment and underpayment amounts adjusted for rounding.

related to the delivery, whichever is later."[16] Claims denied payment for not meeting the 210-day requirement are rejected by Edit 116.

The Uniform Managed Care Manual allows MCOs to appeal claims rejected by Edit 116 if the MCO believes there were extenuating circumstances that prevented the claim from being submitted within the 210-day deadline. The Uniform Managed Care Manual states that "[of] those [claims] that were rejected, claims that an MCO considers payable should be appealed or resubmitted based on the specific circumstances."[17] Additionally, for appeals filed after a claim has been rejected by Edit 116, the Uniform Managed Care Manual states that "extenuating circumstances" for not meeting the 210-day requirement "can be considered but must be explained/documented and submitted to HHSC."[18]

However, Strategic Decision Support was not provided guidance on whether it should enforce the contract, which does not include exceptions to the 210-day requirement, or allow exceptions to the requirement as outlined in the Uniform Managed Care Manual. Furthermore, the Uniform Managed Care Manual does not define what constitutes an "extenuating circumstance" supporting an exception to the requirement, leaving the determination to the independent judgment of Strategic Decision Support.

To determine whether appeals of Edit 116 rejections were appropriately decided, the IG Audit Division evaluated the reasonableness[19] of the extenuating circumstance documented in the appeal form for all appeals processed during the three-year audit period. Based on the results of its review, the IG Audit Division determined that 408 appeals had been approved despite the MCOs failing to provide evidence of an extenuating circumstance reasonably supporting an exception to the 210-day requirement. As a result, HHSC overpaid MCOs by $1,327,423.

For example, one appeal was incorrectly approved because the MCO stated the provider did not submit required insurance claims to the MCO in a timely manner. However, supporting documentation submitted with the appeal showed that the MCO received all required insurance claims from the provider in January 2013, well before the MCO submitted the claim to HHSC in October 2013. The creation of a standardized definition for an extenuating

[16] Uniform Managed Care Contract, Attachment A - Medicaid and CHIP Managed Care Services RFP, Uniform Managed Care Contract Terms and Conditions, Section 10.09, Version 2.3 (September 1, 2012) through Version 2.16 (September 1, 2015).

[17] Uniform Managed Care Manual, Chapter 5.3.5.3, Version 1.4 (May 5, 2011) through Version 2.4 (July 1, 2016).

[18] Uniform Managed Care Manual, Chapter 5.3.5.3, Version 1.4 (May 5, 2011) through Version 2.4 (July 1, 2016).

[19] The "reasonableness" of the extenuating circumstance was independently determined by the IG Audit Division. For example, the date on the explanation of benefits provided by the member's primary insurance was used to assess the length of time between when the provider submitted all necessary insurance claims to the MCO to when the MCO submitted the delivery supplemental payment claim to HHSC.

circumstance supporting an exception to the 210-day requirement would help ensure appeals of Edit 116 rejections are decided consistently and accurately.

Appeal Decisions Were Inconsistent With Applicable Requirements

To determine whether prior appeal decisions were appropriate, the IG Audit Division tested a sample of appeals by replicating the review process used by Strategic Decision Support. Based on the results of its analysis, the IG Audit Division determined that 12 appeals were incorrectly approved and 2 appeals were incorrectly denied because Strategic Decision Support applied criteria inconsistent with contract and Uniform Managed Care Manual requirements. As a result, HHSC overpaid MCOs by $40,378 for the 12 incorrectly approved appeals and underpaid MCOs by $6,298 for the 2 incorrectly denied appeals.

For example, one appeal was incorrectly denied because the member gave birth in an ambulance rather than in a hospital, even though delivery in a hospital is not a requirement for delivery supplemental payments. Strategic Decision Support will need to strengthen its review process to ensure appeal decisions are consistent with contract and Uniform Managed Care Manual requirements.

Recommendations 2.1-2.4

2.1 The Medicaid and CHIP Services Department should recover $1,327,423 from MCOs for 408 appeals submitted without evidence of reasonable extenuating circumstances. Additionally, the Medicaid and CHIP Services Department should recover $40,378 from MCOs for 12 incorrectly approved appeals.

2.2 The Medicaid and CHIP Services Department should pay MCOs $6,298 for 2 incorrectly denied appeals.

2.3 The Medicaid and CHIP Services Department should determine whether to (a) enforce the contract provision requiring delivery supplemental payment claims be submitted within 210 days of the delivery or (b) allow exceptions to the 210-day requirement as indicated in the Uniform Managed Care Manual. If extenuating circumstances will be allowed, the Medicaid and CHIP Services Department should also (a) define the criteria warranting an exception to the 210-day requirement and (b) communicate the criteria to MCOs and Strategic Decision Support to ensure related appeal decisions are consistent and appropriate.

2.4 The Medicaid and CHIP Services Department should coordinate with Strategic Decision Support to strengthen the administration of the appeals process so appeal decisions are consistent with contract and Uniform Managed Care Manual requirements.

HHSC Medicaid and CHIP Services Department Management Response 2.1-2.2

- *Medicaid and CHIP Services Department Finance will combine the amounts to be recovered under recommendation 2.1 with amounts to be paid under recommendation 2.2.*
- *Medicaid and CHIP Services Department Finance will prepare demand letters for each of the MCOs for which an amount is due.*
- *Medicaid and CHIP Services Department Finance will prepare a Request for Disbursement to each MCO for which an amount is due.*

Responsible Individual: Director of Financial Reporting and Audit Coordination, Medicaid and CHIP Services Department

Target Implementation Date: November 2016

HHSC Medicaid and CHIP Services Department Management Response 2.3

- *Medicaid and CHIP Services Department Health Plan Management will review contract provisions regarding requirement of delivery supplemental payment claims to be submitted within 210 days of the delivery and the exceptions to the 210-day requirement indicated in the Uniform Managed Care Manual.*
- *Medicaid and CHIP Services Department Health Plan Management will develop criteria to determine when the contract provisions shall be enforced versus when the exceptions will be granted as denoted in the Uniform Managed Care Manual.*

Responsible Individual: Director of Health Plan Management, Medicaid and CHIP Services Department

Target Implementation Date: November 2016

HHSC Medicaid and CHIP Services Department Management Response 2.4

The Medicaid and CHIP Services Department will coordinate with Strategic Decision Support and will modify the appeal process to be consistent with the criteria developed by Health Plan Management.

Responsible Individual: Director of Financial Reporting and Audit Coordination, Medicaid and CHIP Services Department

Target Implementation Date: March 2017

Section 3: CONTROL ENVIRONMENT

During fieldwork, the IG Audit Division evaluated the control environment supporting the delivery supplemental payment function and found that HHSC delivery supplemental payment activities could be strengthened by (a) transferring the organizational placement of the delivery supplemental payment function to the Medicaid and CHIP Services Department, (b) documenting policies and procedures, and (c) implementing change controls for the IT system used to process claims.

The Organizational Placement of the Delivery Supplemental Payment Function is Not Appropriate

Responsibility for managing and administering delivery supplemental payment claims and appeals is inappropriately placed within Strategic Decision Support. The function was previously transferred to Strategic Decision Support during a prior HHS System transformation when staff knowledgeable about the efforts required to process claims and appeals switched program areas. Strategic Decision Support provides research, analytic support, and data reporting for the Medicaid and CHIP Services Department and other HHS agency programs, but does not possess subject matter expertise on managed care administration.

The responsibility for processing delivery supplemental payment claims and appeals should be placed within the Medicaid and CHIP Services Department, which oversees all managed care services. The Medicaid and CHIP Services Department should have direct responsibility for the key activities required to manage the delivery supplemental payment function, including:

- Overseeing and approving delivery supplemental payments to MCOs.
- Administering the appeals process, including reviewing the criteria used to support appeal decisions.
- Interpreting and implementing contract and Uniform Managed Care Manual requirements used to guide delivery supplemental payment activities.
- Overseeing the maintenance of the IT system used to process claims.
- Providing assurance that prior claim adjudications and appeal decisions were appropriate through retrospective reviews.

According to Strategic Decision Support management, the overall effort required to manage and process delivery supplemental payments is approximately one-half of a full-time equivalent. The inappropriate organizational placement of the delivery supplemental payment function was reported previously in the 2008 HHSC Internal Audit report *Audit of Medicaid/CHIP Division Managed Care Contract Monitoring Processes*.

Policies and Procedures Were Not Documented

The Medicaid and CHIP Services Department and Strategic Decision Support had not developed written policies and procedures to guide the execution of the delivery supplemental payment function. Although the Uniform Managed Care Manual provides general instructions for processing claims and appeals, detailed policies and procedures are necessary to provide guidance on:

- Processing claims and appeals within expected timeframes and in accordance with contract and Uniform Managed Care Manual requirements.
- Conducting retrospective reviews to determine whether prior claim adjudications and appeal decisions were appropriate.
- Seeking input on managed care policy clarification.

For example, detailed procedures are needed to strengthen the administration of the appeals process. Strategic Decision Support did not notify MCOs when a submitted appeal was received by HHSC, establish a timeline for the appeals process, or provide a mechanism for MCOs to check the status of the appeal. Additionally, some appeals were not processed until several months after they had been received by Strategic Decision Support. The lack of defined expectations between the MCO and Strategic Decision Support led to instances where MCOs submitted multiple appeals for the same claim, which resulted in additional time and effort to process, identify, and resolve the appeals. Detailed policies and procedures would help improve transparency and efficiency in the administration of the appeals process.

Change Controls Had Not Been Implemented

Strategic Decision Support had not developed and implemented IT change controls in accordance with the HHSC Change Management Standard. The standard, which "establishes a set of rules and administrative guidelines used to manage changes in a rational and predictable manner,"[20] helps ensure that:

- A change management log is maintained for all changes to an IT system.
- Scheduled changes are reviewed by responsible business and program areas to determine if the change is necessary and appropriate.
- Scheduled changes are reviewed by applicable IT staff and data owners to determine that the change has been adequately planned and tested, does not suffer from inadequate backup planning, and will not negatively impact key business processes.

Establishing change controls or a formal change management process would help ensure the IT system used to process claims is protected from unauthorized changes, updated in accordance with state guidance, and tested sufficiently before changes are implemented.

[20] HHSC IT Handbook, Section 1.6, Change Management, Version 1.0 (April 21, 2005).

Recommendations 3.1-3.3

3.1 HHSC should transfer responsibility for managing and administering delivery supplemental payment claims and appeals to the Medicaid and CHIP Services Department.

3.2 The Medicaid and CHIP Services Department should establish detailed written policies and procedures for delivery supplemental payment activities to include (a) processing delivery supplemental payment claims in accordance with contract and Uniform Managed Care Manual requirements, (b) administering the appeals process, and (c) applying change controls to the IT system used to process claims.

3.3 Strategic Decision Support should coordinate with HHSC IT to transfer custody and maintenance of the IT system used to process claims to HHSC IT.

HHSC Management Response 3.1

- *Medicaid and CHIP Services Department management and Strategic Decision Support will meet to determine and document a plan to transfer management and administration of delivery supplemental claims and appeals to the Medicaid and CHIP Services Department.*
- *Strategic Decision Support will transfer all documentation for delivery supplemental payment claims and appeals processing to the Medicaid and CHIP Services Department.*
- *Strategic Decision Support will train designated Medicaid and CHIP Services Department staff on delivery supplemental payment claims and appeals processing.*
- *The Medicaid and CHIP Services Department will advise the MCOs on the change of contact person for delivery supplemental payment claims and appeals processing.*

Responsible Individuals: Chief Operating Officer; Deputy Executive Commissioner, Medical Social Services

Target Implementation Date: March 2017

HHSC Medicaid and CHIP Services Department Management Response 3.2

The Medicaid and CHIP Services Department will establish policies and procedures for delivery supplemental payment activities.

Responsible Individuals: Director of Health Plan Management, Medicaid and CHIP Services Department; Director of Financial Reporting and Audit Coordination, Medicaid and CHIP Services Department

Target Implementation Date: March 2017

HHSC Strategic Decision Support Management Response 3.3

- *Strategic Decision Support will transfer physical custody of the system to HHSC IT.*
- *Strategic Decision Support will transfer all documentation for the system to HHSC IT.*
- *Strategic Decision Support will provide training on the system to designated HHSC IT staff.*

Responsible Individuals: Director, Strategic Decision Support; Director, HHSC IT - Applications

Target Implementation Date: March 2017

CONCLUSION

The IG Audit Division completed an audit of delivery supplemental payments. The audit included an evaluation of delivery supplemental payment claims and appeals, associated policies and procedures, and supporting IT systems. The IG Audit Division evaluated delivery supplemental payment claims and appeals submitted by MCOs between September 1, 2012 and August 31, 2015. Audit work was conducted in Austin, Texas.

The Medicaid and CHIP Services Department and Strategic Decision Support share accountability for ensuring valid delivery supplemental payment claims and appeals are processed timely and appropriately, and that payments made to MCOs are accurate and supported.

Based on the results of its audit of delivery supplemental payments, the IG Audit Division concludes that:

- Using January 2016 eligibility information, 496,003 out of 496,810 claim adjudications reviewed were correct, an accuracy rate of 99.84 percent.
- Paid claims were consistent with actual deliveries.
- Retrospective reviews to confirm claim adjudications and appeal decisions were appropriate were not conducted.
- Appeals were not always processed in accordance with contract and Uniform Managed Care Manual requirements.
- Claim and appeal overpayments totaled $3,399,920, while underpayments totaled $688,858.16. [21]
- The organizational placement of the delivery supplemental payment function should be moved to the Medicaid and CHIP Services Department.
- Formal policies and procedures to guide the execution of the delivery supplemental payment function had not been established, and IT change controls and processes required strengthening.

The IG Audit Division offered recommendations to the Medicaid and CHIP Services Department and Strategic Decision Support which, if implemented, will:

- Further improve the accuracy of claims processing through the correction of coding errors and implementation of retrospective reviews to account for eligibility changes.
- Strengthen the administration of the appeals process by aligning and clarifying contract and Uniform Managed Care Manual requirements.

[21] Overpayment and underpayment amounts adjusted for rounding.

- Provide the appropriate organizational placement and responsibility for management and administration of claims and appeals.
- Establish strong business processes and controls over delivery supplemental payments, which total approximately $500 million annually.

The IG Audit Division thanks management and staff at the Medicaid and CHIP Services Department, Strategic Decision Support, HHSC Financial Services, and the Fraud Detection and Investigative Strategy Directorate for their cooperation and assistance during this audit.

Appendix A: OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the audit was to evaluate the effectiveness of processes and controls intended to ensure (a) delivery supplemental payment claims and appeals were processed timely and accurately and (b) claim adjudications and appeal decisions were valid and adequately supported.

Scope

Delivery supplemental payment claims and appeals processed September 1, 2012 through August 31, 2015, to include:

- Policies and procedures relevant to the processing of claims and appeals.
- IT systems relevant to the processing of claims and appeals.
- Monitoring and oversight of MCOs submitting claims and appeals.

Methodology

To accomplish its objectives, the IG Audit Division collected information by:

- Interviewing key staff at the Medicaid and CHIP Services Department, Strategic Decision Support, and Financial Services.
- Reviewing Medicaid and CHIP Services Department and Strategic Decision Support policies, procedures, processes, and controls necessary to perform delivery supplemental payment activities.
- Reviewing contract and Uniform Managed Care Manual requirements for delivery supplemental payments.
- Developing and executing an IT script to perform parallel processing of claims.
- Evaluating claim adjudications and appeal decisions made from September 1, 2012 through August 31, 2015.

Professional judgment was exercised in planning, executing, and reporting the results of this audit. The IG Audit Division used the following criteria to evaluate the information provided:

- Code of Federal Regulations
- COSO Internal Control - Integrated Framework (2013)
- HHSC IT Handbook
- Texas Administration Code
- Texas Government Code

- Uniform Managed Care Contract Terms and Conditions
- Uniform Managed Care Manual

The IG Audit Division reviewed the IT system used to process claims and the data contained in the claims database maintained by Strategic Decision Support. The audit work performed on the control environment for the database identified issues with maintenance, access, and change management processes that could lead to data reliability issues. The IG Audit Division made recommendations to mitigate these risks.

The IG Audit Division tested the integrity of the data contained within the claims database by auditing all claims for the three-year audit period. The audit procedures included reprocessing claims in accordance with the criteria that existed at the time the original claim was submitted investigating results that differed from the claims database. No discrepancies were identified with the database claims records. As a result of the work performed, the IG Audit Division determined the data in the claims database was sufficiently reliable for the purposes of this audit.

The IG Audit Division conducted the audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that auditors plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the issues and conclusions based on audit objectives. The IG Audit Division believes that the evidence obtained provides a reasonable basis for the issues and conclusions based on audit objectives.

Appendix B: SAMPLING METHODOLOGY

The IG Audit Division examined delivery supplemental payment activities for the period from September 2012 through August 2015. After an initial assessment of risk across delivery supplemental payment activities and performance outcomes, the IG Audit Division performed testing from the population of delivery supplemental payment claim and appeal files.

Delivery Supplemental Payment Claims

The IG Audit Division conducted sample testing in order to assess whether the administration of the claims process was efficient and accurate, and whether inappropriate claim adjudications resulted in MCO overpayments or underpayments. The IG Audit Division tested 100 percent of claims filed during the three-year audit period. Using January 2016 eligibility information, the IG Audit Division reprocessed claims by applying the criteria in place at the time the claims were originally processed.

The IG Audit Division evaluated whether (a) prior claim adjudications made by Strategic Decision Support were appropriate and (b) claims were processed in accordance with contract and Uniform Managed Care Manual requirements.

Delivery Supplemental Payment Appeals

The IG Audit Division conducted sample testing in order to assess whether the administration of the appeals process was efficient and accurate, and whether inappropriate appeals determinations resulted in MCO overpayments or underpayments. The IG Audit Division selected a simple random sample[22] using a random number generator. The sample size of appeals included 174 appeals from the total population of 998 appeals processed in November 2012, June 2014, and August 2015. The value of the appeals selected for the random sample totaled $519,664.19. Two MCOs filed 1,022 appeals for claims rejected by Edit 116 during the audited three-year period, and the IG Audit Division tested 100 percent of those appeals due to the high percent of identified errors.

The IG Audit Division evaluated whether (a) prior appeal determinations made by Strategic Decision Support were appropriate, (b) appeals were processed in accordance with contract and Uniform Managed Care Manual requirements, and (c) duplicate appeal files were processed and subsequently inappropriately paid.

[22] Random sampling is a method by which every element in the population has an equal chance of being selected.

Appendix C: TABLE DETAIL

Table 2.1 Detail

Table 2: Delivery Supplemental Payment Claims Processing Results

MCO Name	# Inappropriately Approved Claims	Total Overpayment
Aetna	27	$ 95,947.98
Amerigroup	94	$ 353,168.66
Blue Cross	9	$ 28,637.45
Christus	5	$ 16,019.10
Community First	20	$ 64,665.44
Community Health	63	$ 216,226.06
Cook	11	$ 39,456.40
Driscoll	20	$ 65,415.49
El Paso	9	$ 29,958.24
Evercare	22	$ 75,534.41
FirstCare	39	$ 125,327.21
Molina	32	$ 106,975.21
Parkland	43	$ 149,910.94
Scott and White	8	$ 24,282.16
Sendero	4	$ 12,989.96
Seton	2	$ 6,494.98
Superior	122	$ 390,357.48
Texas Children's	73	$ 250,908.44
UnitedHealthcare	4	$ 12,400.00
Totals	607	$ 2,032,118.98

Source: HHSC Strategic Decision Support

Table 2.2 Detail

Table 2: Delivery Supplemental Payment Claims Processing Results

MCO Name	# Inappropriately Denied Claims	Total Underpayment
Aetna	11	$ 38,349.25
Amerigroup	8	$ 27,601.87
Blue Cross	1	$ 3,100.00
Christus	0	0
Community First	13	$ 42,299.08
Community Health	77	$ 268,678.50
Cook	1	$ 3,635.64
Driscoll	10	$ 32,758.90
El Paso	0	$ 0
Evercare	19	65,975.43
FirstCare	1	$ 3,100.00
Molina	25	$ 85,775.90
Parkland	9	$ 30,959.91
Scott and White	4	$ 12,141.08
Sendero	5	$ 16,237.45
Seton	1	$ 3,247.49
Superior	6	$ 19,076.54
Texas Children's	7	$ 23,422.14
UnitedHealthcare	2	$ 6,200.00
Totals	200	$ 682,559.18

Source: HHSC Strategic Decision Support

Table 3.1 Detail

Table 3: Delivery Supplemental Payment Claims Appeal Results

MCO Name	# Inappropriately Approved Appeals	Total Overpayment
Amerigroup	12	$ 41,269.09
FirstCare	9	$ 29,020.87
Molina	1	$ 3,394.58
Parkland	2	$ 7,074.26
Seton	1	$ 3,247.49
Superior	391	$ 1,269,842.74
Texas Children's	3	$ 10,432.98
UnitedHealthcare	1	$ 3,519.20
Totals	420	$ 1,367,801.21

Source: HHSC Strategic Decision Support

Table 3.2 Detail

Table 3: Delivery Supplemental Payment Claims Appeal Results

MCO Name	# Inappropriately Denied Appeals	Total Underpayment
Community	1	$ 3,266.59
FirstCare	1	$ 3,032.39
Totals	2	$ 6,298.98

Source: HHSC Strategic Decision Support

Appendix D: REPORT TEAM AND REPORT DISTRIBUTION

Report Team

The IG staff members who contributed to this audit report include:

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Angel Flores, CGAP, MSPM, Audit Project Manager
- Wende Young, CIGA, CICA, Auditor
- Fabrice Talawa, CISA, Senior IT Auditor
- Netza Gonzalez, MBA, CISA, CFE, IT Audit Project Manager
- Christal Ford, RN, Medical Auditor
- Karla Lief, RN, Medical Auditor
- Maria Johnson, CFE, Quality Assurance Reviewer
- Nicole Cook, Senior Audit Operations Analyst

Report Distribution

Health and Human Services Commission

- Charles Smith, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Kara Crawford, Chief of Staff
- Heather Griffith Peterson, Chief Operating Officer
- Gary Jessee, Deputy Executive Commissioner for Medical and Social Services
- Stephanie Muth, Deputy Executive Commissioner of Transformation
- David Kostroun, Deputy Executive Commissioner for Policy and Performance
- Heather Hall, Director, Strategic Decision Support
- Bowden Hight, Deputy Executive Commissioner for IT
- Leatha Marr, Director, HHSC-IT Applications
- Jami Snyder, Associate Commissioner, Medicaid and CHIP Services Department
- Grace Windbigler, Director of Health Plan Management, Medicaid and CHIP Services Department
- Rich Stebbins, Director of Financial Reporting and Audit Coordination, Medicaid and CHIP Services Department
- Karin Hill, Director of Internal Audit

Appendix E: IG MISSION AND CONTACT INFORMATION

Inspector General Mission

The mission of the IG 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 the IG's mission and statutory responsibility includes:

- Stuart W. Bowen, Jr. — Inspector General
- Sylvia Hernandez Kauffman — Principal Deputy IG
- Christine Maldonado — Chief of Staff and Deputy IG for Operations
- Olga Rodriquez — Senior Advisor and Director of Policy and Publications
- James Crowley — Deputy IG for Investigations
- David Griffith — Deputy IG for Audit
- Quinton Arnold — Deputy IG for Inspections and Evaluations
- Anita D'Souza — Chief Counsel

To Obtain Copies of IG Reports

- IG website: https://oig.hhsc.texas.gov

To Report Fraud, Waste, and Abuse in Texas HHS Programs

- Online: https://oig.hhsc.texas.gov/report-fraud
- Phone: 1-800-436-6184

To Contact the Inspector General

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
  Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
- Phone: 512-491-2000