THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
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Internal Audit CONNECTED

Single Case Agreements

August 18, 2025

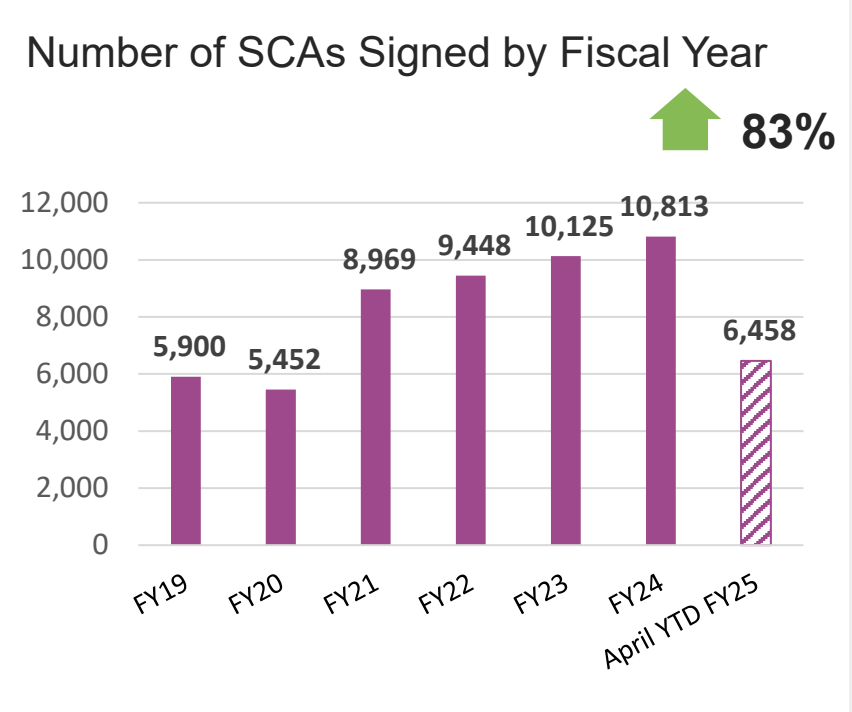
MDA25AS0021

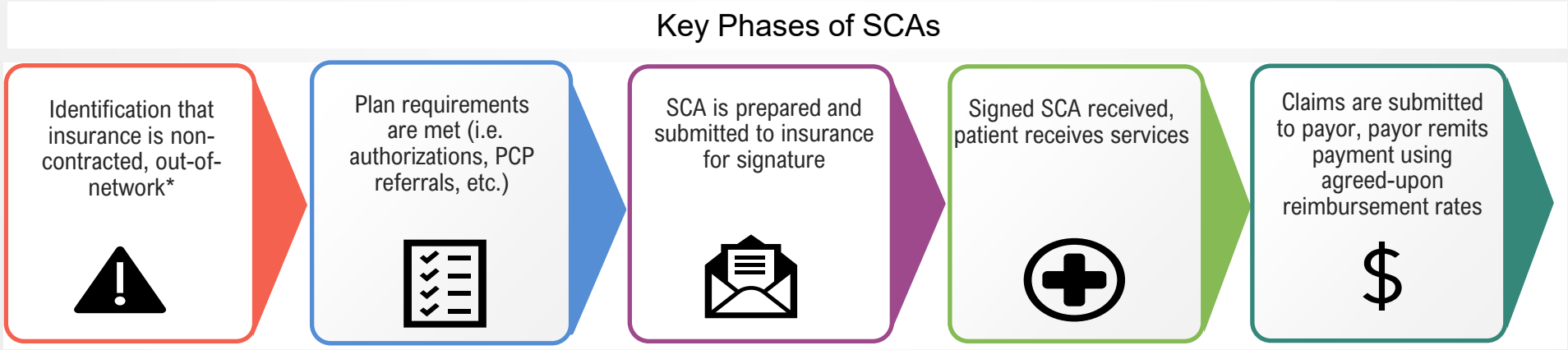
EXECUTIVE SUMMARY

As part of the Fiscal Year 2025 Work Plan, Internal Audit conducted an audit of Single Case Agreements (SCAs). The objective was to assess the controls in place over SCAs to determine whether the institution collected the contracted amount for services rendered. The audit period covered September 1, 2024, thru April 30, 2025.

An SCA is a patient-specific letter of agreement between the institution and the patient's non-contracted, out-of-network insurance payor/plan where the purpose is to agree upon the specific reimbursement terms for technical and professional service fees. These agreements are prepared by the Managed Care Department, through coordination with the respective payors, and are up to one year in duration.

As shown in the graph to the right, the number of SCAs has increased significantly over the last 5 years; over 10,000 SCAs are executed annually. Below depicts a summary of the key phases of an SCA (*not an exhaustive list of all processes or departments which may be involved*):



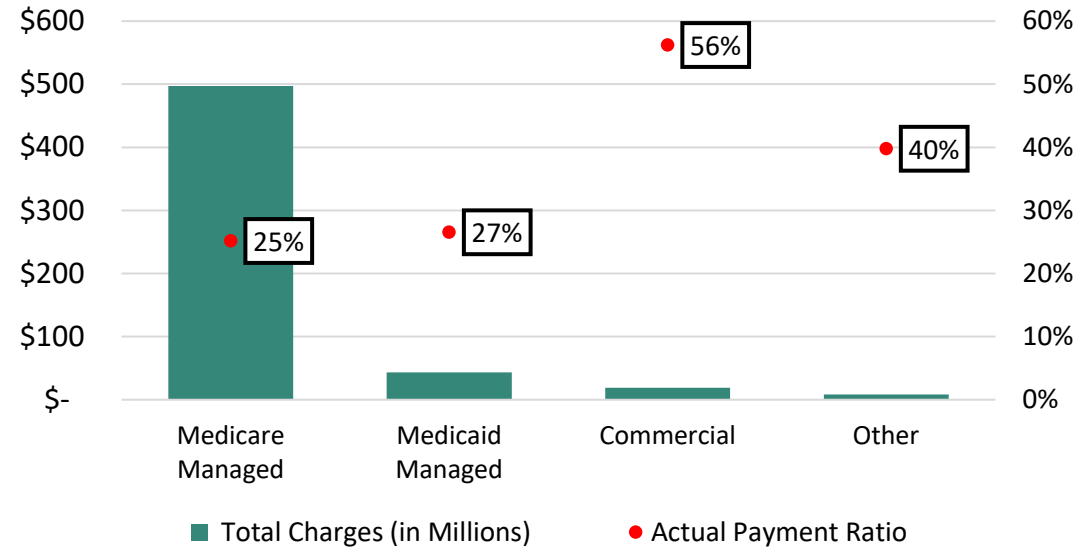


*Note: Historically, SCAs have been executed for Managed Medicare and Managed Medicaid Plans

EXECUTIVE SUMMARY CONTINUED

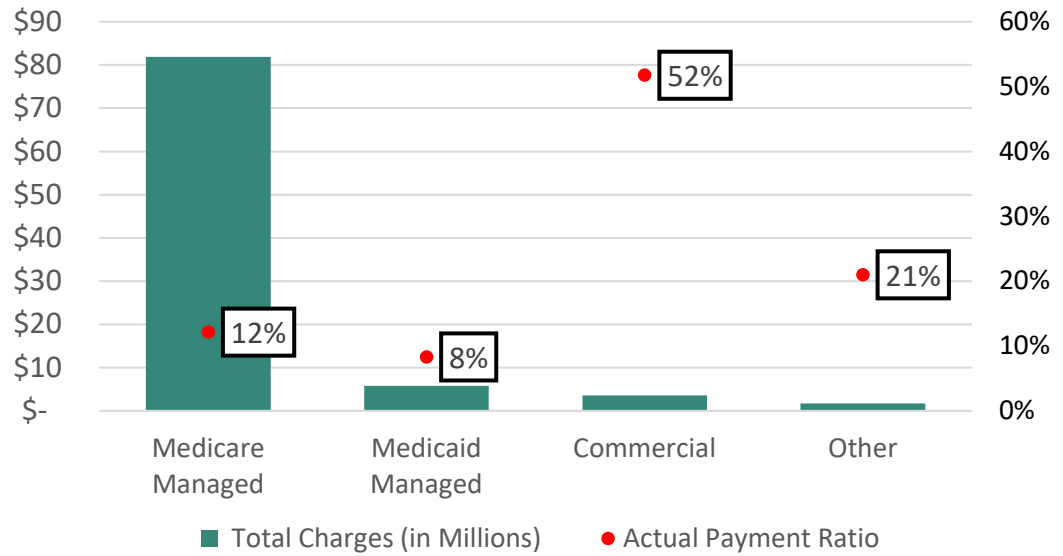
Technical Billing Total Charges vs Payment Ratio*

As of April, YTD 2025



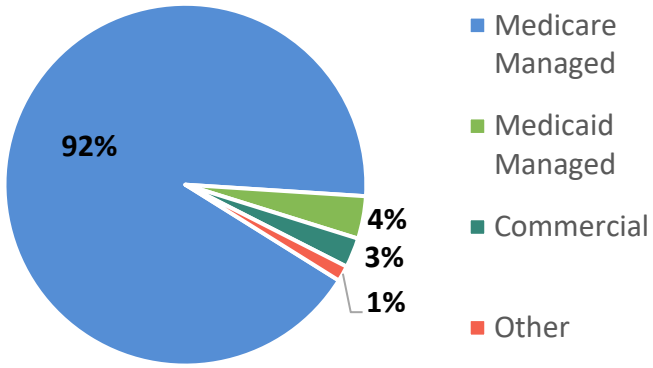
Professional Billing Total Charges vs Payment Ratio*

As of April, YTD 2025



***Payment Ratio = Total Payments Received / Total Charges**

SCAs by Financial Class



The graphs above highlight the total charges (in millions) for technical and professional billing with payment ratios calculated by financial class. Note: As these graphs are using FY25 data, the payment ratios depicted are not final due to ongoing claims and appeals.

The graphic on the left depicts the SCAs executed by financial class, showing 92% of SCAs executed and in effect are with Medicare Managed (i.e. Medicare Advantage) payor/plans.

EXECUTIVE SUMMARY (CONTINUED)

Audit Results:

Our review indicated there are limited processes which are specific and unique to SCAs. However, we found that management has:

- Implemented workflows to ensure plan requirements are met when needed (i.e., obtained authorizations, PCP referrals, etc.),
- Maintained SCAs once signed by the payor, and,
- Identified potential underpayments when they occur.

Management has also increased reimbursement rates for many payor/plans within the last year to help increase payments received from services provided under SCAs. We recommend the following to further strengthen and enhance processes around SCAs:

- Use Appropriate Reimbursement Rates Outlined in SCAs
- Strengthen Reporting and Review of SCA Activity
- Consult with Legal Services Regarding Rate Overrides
- Ensure Potential Underpayments are Consistently and Timely Addressed
- Improve Financial Clearance Processes for when SCA is not Executed

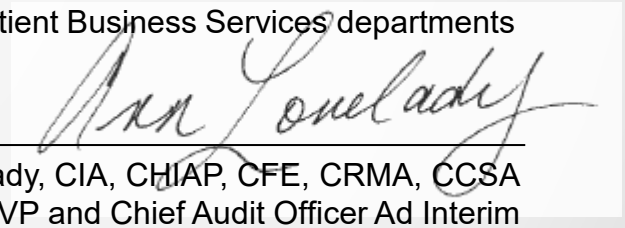
Further details are outlined in the Detailed Observations section below. Less significant issues were communicated to management separately.

Management Summary Response:

Management agrees with the observations and recommendations and has developed action plans to be implemented on or before 8/31/2026.

Appendix A outlines the methodology for this project.

The courtesy and cooperation extended by the personnel in Managed Care, Financial Clearance Center, and Patient Business Services departments is sincerely appreciated.



Ann Lovelady, CIA, CHIAP, CFE, CRMA, CCSA
AVP and Chief Audit Officer Ad Interim
August 18, 2025

Detailed Observations

1 Use Appropriate Reimbursement Rates Outlined in SCAs

Ranking: Medium

Our review revealed that the appropriate reimbursement rates outlined in Single Case Agreements (SCAs) are not used in the below scenarios:

(1) Although EPIC can calculate an expected reimbursement for each claim (*total charges x reimbursement rate = expected reimbursement*), EPIC only allows one reimbursement rate at a time to be in effect for each payor code. Therefore, we identified expected reimbursements varied while multiple rates were in effect for SCAs at the same period (i.e., when there are multiple low-volume payor/plans that do not warrant individualized codes in EPIC, they may be grouped together under one code, for example: Generic, Out of State Medicaid, etc., but have different SCA rates).

(2) Separately, we identified the increased technical reimbursement rates were not appropriately used, in an underpayment analysis performed for two payors. This resulted in the omission of $95,000 which should have been recovered.

Without using the appropriate reimbursement rates to determine and collect reimbursements, management will not be able to determine if the contracted amount for services rendered has been received. Further, there is increased risk of management making decisions based on incomplete or unreliable information, which may impact strategic planning and operating effectiveness.

Recommendation:

(1) Internal Audit recognizes the system limitations both with Epic, and on the payor's side, as well as the relatively small population impacted. Management should continue to monitor for potential technological solutions regarding this matter and consider possible alternative solutions to further mitigate this risk in the interim.

(2) Management has indicated they will re-submit previous underpayment analysis where updated rates were not used to recover omitted underpayments, if possible.

Management's Action Plan (1):

Executive Leadership Team Member: Omer Sultan
Division/Department Executive: Kabby Thompson
Owner: Fred Castellano
Implementation Date: 3/1/2026

We will continue to monitor for technology updates and solutions to provide automation.

Management's Action Plan (2):

Executive Leadership Team Member: Omer Sultan
Division/Department Executive: Miriam Flores
Owner: Artemio Mier
Implementation Date: 9/1/2025

PBS will ensure that the rate table is updated and current when running underpayment analysis for payors. The accounts that were not captured in the analysis above will be submitted to the payors.

2 Strengthen Reporting and Review of SCA Activity

Ranking: Medium

Current reporting of SCAs is limited and may not accurately capture key data required to effectively monitor and manage activity. This is demonstrated by the following:

- We identified instances where typos or mis-keys resulted in inaccurate or incomplete SCA data in Epic, which impact the data integrity used.
- As described in Observation 1, when there are multiple reimbursement rates in effect, we found that EPIC does not accurately capture the data.
- Current data involving the payors which have SCAs executed is not sufficiently disaggregated to provide meaningful insights or granular analysis.

Management has indicated they are currently working with the EHR team to enhance reporting capabilities, such as adding a field to identify when requests for SCAs are rejected. Because SCA activity is expected to significantly increase, having inaccurate and incomplete data as well as limited reporting capabilities will continue to pose challenges in effectively managing and making informed decisions about SCAs.

Recommendation:
Management should strengthen reporting capabilities related to SCA activity. This can include but not be limited to:
- Establishing review processes to ensure key data is accurately and completely captured
- Consideration of automation tools to minimize and/or support manual entry
- Coordination with the EHR team to develop and strengthen data collection and reporting capabilities.

Management's Action Plan:

Executive Leadership Team Member: Omer Sultan
Division/Department Executive: Kabby Thompson
Owner: Fred Castellano
Implementation Date: 4/1/2026

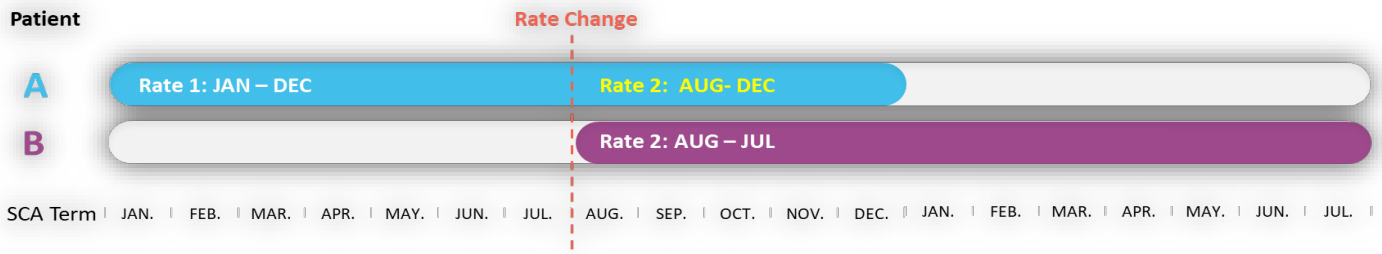
Managed Care is working with IT to restore and enhance SCA reporting. The planned implementation is dependent upon IT resources.

3 Consult with Legal Services Regarding Rate Overrides

Ranking: Medium

According to Managed Care, when reimbursement rates change the new rates should override and supersede all previously executed and currently in effect rates, regardless of the time frame any previous SCA was signed (depicted below). However, we confirmed there is no language within SCAs which allow for reimbursement rates to be overridden or superseded. Therefore, although the reimbursement rates for certain payor/plan's SCAs were increased in 2024, Patient Business Services (PBS) utilized the older, lower rates when determining and following-up on underpaid patient accounts. Additionally, if language is not added to SCAs, the institution would have no recourse should a payor refuse to reimburse at the higher rates.

Example: Patient A and Patient B



Patient A: *SCA executed with Rate 1 for January 1 - December 31 The rate for that payor changes August 1*
Patient B: *SCA executed with Rate 2 for August 1 through July 31*

According to Managed Care, as of August 1, Rate 2 should override and supersede Rate 1 for the remainder of Patient A's SCA term (August 1, through December 31).

Recommendation:
Managed Care should consult with Legal Services to revise SCA language to allow for rate changes that will supersede previously agreed-upon rates. This practice should also be communicated to PBS.

Management's Action Plan:
Executive Leadership Team Member: Omer Sultan
Division/Department Executive: Kabby Thompson
Owner: Fred Castellano
Implementation Date: 1/1/2026

Managed Care will initiate a review of the SCA language with legal. The language should specify which rates supersede in the case of a rate change during the term of the SCA. The intent is for the rates listed in the SCA to supersede, but it needs supporting language.

4 Ensure Potential Underpayments are Consistently and Timely Addressed

Ranking: Medium

As of May 9th, 2025, there was approximately $100K in account balances that are related to SCA activity in a PBS workqueue. In 2022, PBS developed a monthly robotic process automation (RPA) that identifies potentially underpaid technical billing accounts for certain financial classes and loads them into a workqueue for review, verification, and follow-up on true underpayments. In 2022 and 2023, PBS submitted underpayment files for multiple years to UHC Medicare Advantage and Humana Medicare Advantage recovering over $5M. Management intended to establish a team consistently focused on payment accuracy, but due to resource constraints, addressing workqueue items occur only as resources permit. As a result, approximately 17% of the 8,600 accounts have remained in the workqueue for over a year. Without addressing these workqueue items timely and consistently, revenues may be lost as claims may expire due to filing deadlines.

Recommendation:
Management should ensure potential underpayments for underpaid technical billing accounts identified are consistently and timely addressed. This could include working with EHR team to determine if there are alternative solutions to the current workqueue process.

Management's Action Plan:

Executive Leadership Team Member: Omer Sultan
Division/Department Executive: Miriam Flores
Owner: Artemio Mier
Implementation Date: 8/31/2026

Management intends to establish a team consistently focused on payment accuracy and has created the foundation for a payment accuracy team. While the resources are limited at this time, we hope to increase the number of resources dedicated to payment accuracy in FY 2026. The team continues to address underpayments from the Medicare Advantage Plans utilizing the RPA process. The RPA spreadsheet process may include items in the workqueue. For efficiency and to minimize rework, the team utilizes the spreadsheets with the payors and does not remove those accounts from the workqueue. Currently, the payment accuracy work is on an overtime basis with multiple teams sharing resources. PBS has collaborated with the IT team to develop an RPA (Robotic Process Automation) solution that enhances the quality and accuracy of data used in the underpayment analysis. To fully leverage the results generated by this process, we now require the appropriate resources to effectively analyze the information and take timely, accurate action.

While we allow time for resources to become available, PBS management will continue to assign this work on an overtime basis.

5 Improve Financial Clearance Processes when SCA is not Executed

Ranking: Medium

Our review revealed some instances where non-contracted, out-of-network (OON) patients received services at the institution without an executed SCA. We understand that based on the circumstance, non-contracted, OON may not always warrant an SCA. Most of the instances we reviewed involved non-emergent/urgent patients cleared by the Financial Clearance Center whose OON coverage had erroneously not been terminated in Epic and been identified as self-pay. According to management, the system requires that insurance coverage be loaded to verify eligibility/benefits and request an SCA. However, the patient is technically self-pay until all the SCA is finalized. There is a manual workaround for these cases and there is the possibility that the patients may not have been financially counseled on their potential financial obligations. When services are provided to patients with OON coverage without a properly executed SCA, reduced or lost revenues may occur, due to lower reimbursement rates.

Recommendation:
When an SCA is warranted, Management should improve processes to terminate coverage, identify patients as self pay, and financially counsel the patient if services are planned to be provided without an executed SCA.

Management's Action Plan:

Executive Leadership Team Member: Omer Sultan
Division/Department Executive: Miriam Flores
Owner: Angela Bailey
Implementation Date: 1/1/2026

*Management will partner with IT to identify a technical solution to support a dual workflow that permits coverage options of **pending SCA with insurance coverage loaded while patient is in self-pay status**. This will ensure that subsequent processes to efficiently and accurately manage this patient population are in place. Additionally, management will:*

- *Review and update workflow to ensure capturing of all patient scenarios*
- *Update current state SOPs, as applicable*
- *Retrain staff on updated workflow/SOPS*
- *Review templates used to document coverage and self-pay status in EPIC*
- *Modify any scripting, where needed*

Appendix A

Objective, Scope, and Methodology:

The objective was to assess the controls in place over SCAs to determine whether the institution collected the contracted amount for services rendered. The audit period covered September 1, 2024, thru April 30, 2025

Our procedures included, but were not limited to, the following:

- Reviewed relevant policies and procedures
- Interviewed key personnel who identify, execute, and collect on Single Case Agreements (SCAs)
- Inspected relevant source documentation i.e., referrals, authorizations, signed SCAs, EPIC coverages, etc.
- Recalculated the expected reimbursement amounts
- Analyzed the robotic process automation (RPA) information
- Assessed workqueues for inactivity, trends, commonalities, etc., and
- Evaluated charges and payments for selected patients in comparison to SCA effective dates

Our internal audit was conducted in accordance with the *Global Internal Audit Standards*. The internal audit function at MD Anderson Cancer Center is independent per the *Generally Accepted Government Auditing Standards* (GAGAS) requirements for internal auditors.

Team: Ann Lovelady, Randy Ray, Rahcel Bourns, Tammie Wells, Anthony Buancore, Sacha Nouedoui

Number of Priority Findings to be monitored by UT System: (*None)*
A Priority Finding is defined as "*an issue identified by an internal audit that, if not addressed timely, could directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole."*