OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

AUDIT OF ACUTE CARE UTILIZATION MANAGEMENT IN MANAGED CARE ORGANIZATIONS

Community Health Choice, Inc.

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HHSC IG
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
INSPECTOR GENERAL

AUDIT OF ACUTE CARE UTILIZATION MANAGEMENT IN MANAGED CARE ORGANIZATIONS

Community Health Choice, Inc.

WHY THE IG CONDUCTED THIS AUDIT

Community Health Choice is a managed care organization (MCO) in Texas, and is contracted to provide Medicaid STAR and CHIP health care services in the Texas Gulf Coast Region. Approximately 84 percent of Medicaid and CHIP enrollees are members of an MCO, and at nearly $27 billion a year, the Medicaid and CHIP programs constitute over 27 percent of the total Texas budget.

MCOs are required to perform utilization management to ensure that members receive appropriate health care services, and that state and federal funds spent on managed care are used appropriately.

Utilization management includes review of (a) provider requests for members' current and future medical needs and (b) previously provided services, for medical necessity, appropriateness, timeliness, effectiveness, and compliance with state and federal requirements.

This is one of a series of performance audits evaluating the effectiveness of MCO acute care utilization management practices in ensuring that health care services provided are (a) medically necessary, (b) efficient, and (c) comply with state and federal requirements.

WHAT THE IG RECOMMENDS

HHSC should require Community Health Choice to strengthen its utilization management functions related to notification timeliness, data reliability, documentation, staff training, and "not a covered benefit" denials.

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WHAT THE IG FOUND

While Community Health Choice's utilization management program related to prospective utilization review meets many Uniform Managed Care Contract (UMCC), state, and federal requirements, and Community Health Choice performs analysis of utilization management data to identify areas of improvement and to monitor program effectiveness, there are opportunities for Community Health Choice to improve its utilization management function for acute care prior authorization.

Community Health Choice's policy was to make decisions, and notify both the provider of record and the member of its decisions, within three days. This policy aligned with the UMCC. However, Texas Insurance Code (TIC) requires that notice of favorable determinations be made within two days, but allows three days for adverse determinations. Based on its own policy and the UMCC, Community Health Choice had an 80 percent compliance rate for prior authorizations tested. Based on TIC requirements, Community Health Choice had a 60 percent compliance rate.

Criteria	In Compliance	Not in Compliance	Total Tested	Non-compliance Rate
UMCC / Community Health Choice Policy	32	8	40	20%
TIC	24	16	40	40%

Community Health Choice's electronic prior authorization data was not reliable for measuring timeliness due to no data input and edit checks in place to help ensure the accuracy of prior authorization request received and notification dates. In addition, Community Health Choice did not retain all necessary documentation to show that it consistently processed appeal acknowledgment letters and resolution letters timely.

Some utilization management personnel did not receive acquired brain injury training as required by TIC. Community Health Choice did not have a process in place to ensure and adequately document that personnel who are responsible for prospective medical necessity determinations completed the required training. Without processes to ensure that all utilization management personnel receive required training, members may be approved for unnecessary health care services or wrongfully denied needed services.

Finally, MCOs are required to provide the same Medicaid health care services under the managed care model that were covered under the fee-for-service model, but some Community Health Choice prior authorizations were incorrectly denied by a nurse for not being a covered benefit when they should have been reviewed for medical necessity.

The IG Audit Division will continue to publish reports during its ongoing audit of acute care utilization management in MCOs once it completes audit testing and validation for selected MCOs.

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INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Inspector General (IG) Audit Division is conducting an audit of acute care utilization management in managed care organizations (MCOs). The objective of the audit is to evaluate the effectiveness of MCO acute care utilization management practices in ensuring that health care services provided are (a) medically necessary, (b) efficient, and (c) comply with state and federal requirements. The audit scope covers state fiscal years 2014 and 2015, from September 1, 2013, through August 31, 2015.

The IG Audit Division issued an informational report in August 2016, the first in a series of reports on acute care[1] utilization management. That informational report presented a compilation of information provided by 19 Texas Medicaid and Children's Health Insurance Program (CHIP) MCOs.[2] This audit report focuses specifically on utilization management practices at Community Health Choice, Inc. for the Medicaid State of Texas Access Reform (STAR) program. The IG Audit Division will continue to release reports for selected MCOs as the series of audits proceeds.

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 referenced is the state fiscal year, which is the period from September 1 through August 31.

Background

Community Health Choice is a licensed Texas MCO contracted to provide Medicaid and CHIP services through its network of providers. Community Health Choice coordinates health services for two managed care programs, Medicaid STAR and CHIP. Community Health Choice primarily serves the Texas Gulf Coast Region and has its headquarters in Houston, Texas. Community Health Choice coordinates services for Medicaid STAR program members[3] in the Harris and Jefferson Managed Care Service Areas. See Appendix C for a map of the counties where Community Health Choice's Medicaid STAR program coverage is available.

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[1] "Acute care" is defined as preventative care, primary care, and other medical or behavioral health care delivered by a provider, or under the direction of a provider, for a condition having a relatively short duration. Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter A, § 353.2(2) (July 8, 2012; September 1, 2014).

[2] "MCOs" refers to the 19 health plans discussed throughout this report. An MCO is an organization that delivers and manages health care services under a risk-based arrangement.

[3] 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 dependent.

MCOs are responsible for administering, on behalf of the State of Texas, billions of dollars of Medicaid and CHIP health care services each year through their health plans. Table 1 shows a breakdown of Community Health Choice's average monthly member counts and gross premiums for the Medicaid STAR program in 2014 and 2015. Over the two-year period, Community Health Choice maintained an average of 220,152 members per month and was paid more than $1.3 billion in gross premiums. Gross premiums include gross capitation payments[4] and delivery supplemental payments.[5]

Table 1: Community Health Choice Medicaid STAR Member Counts and Gross Premiums for 2014 and 2015

Program	# of Members *(monthly average)*[6]	Gross Premiums *(billions)*
2014 Medicaid STAR	203,440	$ 0.63
2015 Medicaid STAR	236,864	$ 0.68
Total	--	$ 1.31

Source: HHSC 2014 Year-End 334-Day Financial Statistical Report (FSR) and HHSC 2015 Year-End 90-Day FSR

Community Health Choice's utilization management function is a component of its Medical Affairs Department, which is also responsible for care management, complaints, and appeals. Community Health Choice's Corporate Medical Advisory Committee has oversight and operating authority of utilization management activities within the Medical Affairs Department, and it reports to Community Health Choice's Corporate Quality Improvement Committee and Medical Care Management Committee. Community Health Choice's Board of Directors has final authority and accountability for the oversight of the quality of care and services provided to its members.

Community Health Choice holds the required utilization review agent license.[7] Community Health Choice is an affiliate of the Harris Health System, which assigns employees to perform utilization reviews in Community Health Choice's Houston office. As a utilization review agent, Community Health Choice must comply with all applicable Texas Department of Insurance regulations.[8]

[4] "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. These capitation payments include federal and state funds, and both medical and pharmacy payments.

[5] A "delivery supplemental payment" is a one-time payment per pregnancy to STAR, CHIP, and CHIP Perinatal MCOs for the delivery of live or still births.

[6] This is the monthly average number of program enrollees.

[7] A utilization review agent license is required for performance of medical reviews. The license is issued by the Texas Department of Insurance. Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1704 (February 20, 2013).

[8] Texas Insurance Code, Title 14, Chapter 4201, Subchapter A, § 4201.057 (April 1, 2007).

HHSC requires MCOs to carry out utilization management, which is sometimes called utilization review. Utilization management is the process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, and providers. It includes evaluating the medical necessity,[9] appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan.

Utilization review[10] may take place prospectively, concurrently, or retrospectively.[11]

- Prospective utilization review occurs before the service is rendered. Preauthorization, also called precertification or prior authorization, is a form of prospective utilization review.
- Concurrent utilization review occurs for ongoing health care or for an extension of treatment beyond previously approved health care. It is usually conducted during a hospital confinement to determine the medical necessity for a continued stay.
- Retrospective utilization review is often used to comprehensively monitor and evaluate the appropriateness, necessity, and efficacy of past medical treatment or health care services delivered to members. It does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

Utilization reviews may result in favorable or adverse action. Members may request an appeal of any adverse determination.[12] An MCO's utilization management function requires policies, procedures, and organizational structures to execute utilization management strategies that comply with state and federal regulations. MCOs are given the latitude to determine how they will comply with minimum requirements. They use a variety of sources to develop their policies, and apply different organizational structures for implementing utilization management.

In addition to prospective, concurrent, and retrospective utilization reviews, MCOs also perform analysis of utilization post-service. This is sometimes referred to as retrospective analysis and will be referred to in this report as "analysis of utilization management data." The HHSC Uniform Managed Care Contract (UMCC) requires all MCO utilization

[9] "Medical necessity" is a determination that health care services are reasonable and necessary to (a) prevent illness or medical conditions, and (b) treat conditions that cause suffering, pain, or physical deformity; limit function; or endanger life. Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter A, § 353.2(60) (July 8, 2012; September 1, 2014).

[10] Texas Insurance Code, Title 14, Chapter 4201, Subchapter A, § 4201.002 (September 1, 2009).

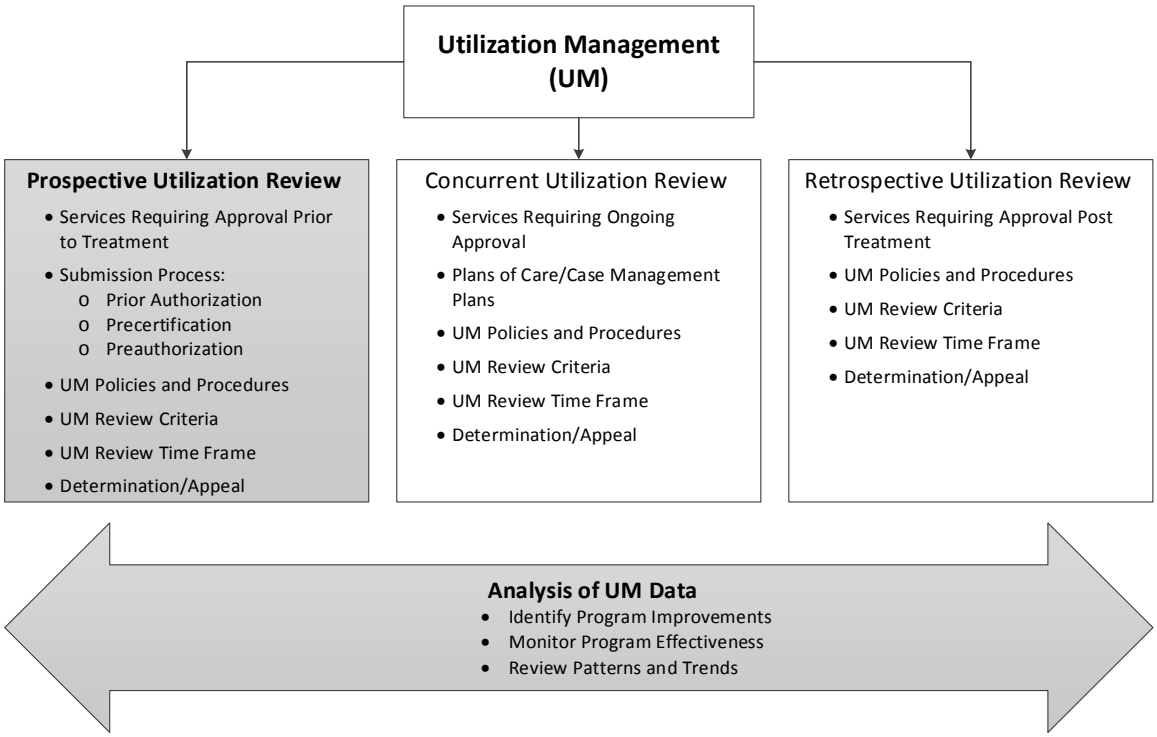
[11] Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 1703 (February 20, 2013).

[12] An adverse determination, also called a denial, is a determination by an MCO or utilization review agent that the health care services furnished, or proposed to be furnished to a patient, are not medically necessary or not appropriate.

management programs to establish policies and procedures for analysis of utilization management data, such as routinely assessing the effectiveness and efficiency of the utilization management program, detecting over- and under-utilization, and comparing utilization patterns of providers and members.

The shaded areas shown in Figure 1 highlight utilization management components and activities that were included in the audit scope. The graphic does not include all utilization management functions and activities but is used to illustrate the focus of the audit.

Figure 1: MCO Utilization Management Activities



Source: IG Audit Division

This audit focuses on acute care services, as opposed to long-term services and supports,[13] and is limited to Medicaid STAR. Additionally, the IG Audit Division reviewed Community Health Choice's analysis of utilization management data, which includes prospective, concurrent and retrospective review.

[13] "Long-term services and supports" provide assistance for persons who are age 65 and older and those with chronic disabilities, with a goal of helping such individuals be as independent as possible. Long-term services and supports may be provided in institutional long-term care settings, such as nursing facilities, or in home or community-based settings.

The IG Audit Division evaluated Community Health Choice's utilization management processes by:

- Reviewing relevant policies, procedures, and processes and assessing compliance with state and federal requirements.
- Evaluating prior authorization standards.
- Assessing underutilization or inappropriate utilization of health care services by reviewing prior authorization data.
- Confirming the timely administration of prior authorizations, adverse determinations, and appeals.
- Interviewing utilization management staff and reviewing examples of Community Health Choice's utilization monitoring, analysis, and reporting.

This audit was performed as part of the IG's responsibility to prevent, detect, and deter fraud, waste, and abuse in the Texas Health and Human Services (HHS) System. HHS agencies administer public health programs for the State of Texas, and within HHS, the HHSC Medicaid and CHIP Services Department oversees Medicaid and CHIP and contracts directly with Texas MCOs. Medicaid and CHIP are jointly funded state-federal programs that provide health care coverage to low-income individuals. In 2013, there were approximately 4.3 million Texans enrolled in Medicaid or CHIP.[14]

The Medicaid program provides health care services, including medical, dental, prescription drug, disability, behavioral health, and long-term support services, to eligible individuals. Texas Medicaid provides services to some individuals through a traditional fee-for-service model,[15] but most are enrolled through a managed care model.[16] Under managed care, the MCO receives a capitation payment for each member enrolled, based on a projection of what health care for the typical individual would cost. If members' health care costs more, the MCO may suffer losses. If members' health care costs less, the MCO may profit. This gives the MCO an incentive to control costs. MCOs deliver Medicaid services through their

[14] This is the 2013 average monthly number of enrollees in Medicaid and CHIP.

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

[16] Medicaid managed care was first introduced in pilot programs in Texas in 1993. In this model, the state 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.

networks of providers. In federal fiscal year 2013, Texas spent $26.8 billion on Medicaid and CHIP, which represented 27 percent of the entire 2013 state budget.[17]

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, people age 65 and older, and adults and children with disabilities. Through the STAR program, Medicaid provides services for pregnant women, newborns, and children. Through the STAR+PLUS program, Medicaid provides health services for individuals age 65 or older, and individuals with a disability requiring long-term health care services. Through the STAR Health program, Medicaid provides services to children and young adults currently or previously participating in the Department of Family and Protective Services conservatorship or foster care programs. CHIP provides health coverage to low-income, uninsured children in families with incomes too high to qualify for Medicaid.

The IG Audit Division presented audit results, issues, and recommendations to the HHSC Medicaid and CHIP Services Department and to Community in a draft report dated February 21, 2017. Each was provided with the opportunity to study and comment on the report. The HHSC Medicaid and CHIP Services Department management responses to the recommendations contained in the report are included in the report following each recommendation. Community's comments are included in Appendix D. The HHSC Medicaid and CHIP Services Department concurred with the IG Audit Division recommendations, and will facilitate Community's development of a corrective action plan designed to improve Community's utilization management function.

[17] Texas Medicaid and CHIP expenditures in 2013 are "all funds" (which include federal and state dollars), but excludes Medicaid funding for Disproportionate Share Hospital, Upper Payment Limit, Uncompensated Care, and Delivery System Reform Incentive Payment funds. Medicaid and CHIP amounts are for the federal fiscal year, and the state budget reflects the state fiscal year which begins one month prior to the federal fiscal year.

RESULTS, ISSUES, AND RECOMMENDATIONS

The UMCC requires MCOs to have a written utilization management program description.[18] At a minimum, this program description must include:

- Procedures to evaluate the need for medically necessary covered services.
- Clinical review criteria, information sources, and processes used to review and approve the provision of covered services.
- A method for periodically reviewing and amending the utilization management clinical review criteria.
- A staff position functionally responsible for day-to-day management of the utilization management function.

Prospective Utilization Review Meets Many UMCC, State, and Federal Requirements

Community Health Choice maintained a written utilization management program description that met UMCC requirements. In addition, Community Health Choice had implemented policies and procedures related to certain prior authorization denials and appeals that complied with UMCC requirements. It also employed utilization management personnel whose qualifications and licensure complied with UMCC requirements.

Appeals

As specified by contract, MCOs are required to develop, implement, and maintain an appeals process that complies with state and federal laws and regulations.[19] An appeal is a formal process by which a member (or member's representative) requests review of an MCO action.[20]

During the prior authorization review process, providers request approval of services they propose to provide. The MCO reviews the requested service for applicability as a covered service, then checks for medical necessity and makes a determination to approve, deny, or partially approve the requested service.

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[18] Uniform Managed Care Contract, Attachment B-1, Utilization Management, Section 8.1.8, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

[19] Uniform Managed Care Contract, Attachment B-1, Medicaid Standard Member Appeal Process, Section 8.2.6.2, and Expedited Medicaid MCO Appeals, Section 8.2.6.3, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

[20] An "action" is the (a) denial or limited authorization of a requested Medicaid service, (b) reduction, suspension, or termination of a previously authorized service, (c) denial in whole or in part of payment for service, (d) failure to provide services in a timely manner, (e) failure of an MCO to act within the timeframes set forth in the contract and 42 CFR § 438.408(b), or (f) for a resident of a rural area with only one MCO, the denial of a Medicaid member's request to obtain services outside of the MCO network. Uniform Managed Care Contract, Attachment A, Definitions, Article 2, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

If the MCO makes an adverse determination for a prior authorization request, it sends an adverse determination letter (also called a denial letter)[21] to both the member (or member's representative) and the provider, detailing the:

- Principal reasons and clinical basis for the adverse determination
- Description or source of clinical guidelines used in the adverse determination
- Professional specialty of the individual making the determination
- Procedures for filing a complaint or appeal
- Member's right to a fair hearing by an independent review organization

When an appeal is received from a member, a member's representative, or a provider, the MCO must send an appeal acknowledgement letter to the appealing party within five business days acknowledging receipt of the appeal request.

The standard appeals process must then be completed within 30 calendar days after receipt of the initial oral or written request for an appeal. Appeal decisions must be made by a physician who did not review the initial prior authorization request. An appeal resolution letter is sent to the member (or member's representative) and the provider, specifying the:

- Reason and clinical basis for the determination
- Criteria used for the determination
- Professional specialty of the physician making the determination
- Procedures for filing a complaint
- Appealing party's rights and process for an independent review

The IG Audit Division tested 27 appeals of denied prior authorization requests and found that Community Health Choice's appeals process complied with applicable contract requirements and with state and federal laws and regulations. For all appeals that were tested:

- Prior authorization adverse determination letters and appeal resolution letters included required notification elements.
- A physician who did not review the initial prior authorization request reviewed the appeal.[22]

[21] Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1709 (February 20, 2013).

[22] Five appeals presented new information not included in the original request, and were reviewed by the same physician that made the initial adverse determination. The appeals were overturned and services were approved without review by a physician not involved in the initial request, in the interest of providing timely services to the member.

Qualified and Licensed Personnel

Texas Administrative Code requires MCO employees and contractors performing utilization review to be appropriately trained, qualified, and currently licensed or otherwise authorized to provide health care services from a licensing agency in the United States.[23] Audit results indicate that Community Health Choice had qualified and licensed personnel making medical necessity determinations.

To evaluate whether prior authorization request determinations were performed by qualified and licensed individuals, the IG Audit Division tested records for all 28 utilization management personnel involved in the utilization review process between September 1, 2013, and August 31, 2015. The personnel included nurses and physicians. All 28 held a current medical or nursing license with no disciplinary actions noted and met the licensing qualifications of their job description.

In addition, MCOs may conduct an inter-rater reliability assessment to help ensure the consistent application of clinical criteria and medical necessity determinations. This is not a UMCC requirement, but is a best practice. If an MCO seeks accreditation from URAC,[24] it must perform inter-rater reliability assessments. Community Health Choice had an inter-rater reliability assessment process in place.

Community Health Choice performed inter-rater reliability reviews to ensure staff were making decisions and assessments consistent with their peers, clinical criteria, and guidelines. Community Health Choice had no formal passing rate, but the chief medical officer stated the goal was a passing rate of 70 percent or greater. Rather than create a formal corrective action plan, the chief medical officer conducted post-assessment discussions with all reviewers to educate the reviewers on the correct determination and the rationale for the determination. If an individual's performance was not considered satisfactory, the reviewer's manager would spend additional time discussing the concept with the employee.

The IG Audit Division reviewed the same 28 utilization management personnel files it tested for licensure, and determined that 11 personnel were required to take the inter-rater reliability assessment.[25] Ten (91 percent) of the 11 personnel took the assessment and met the minimum score. [26]

[23] Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1706 (February 20, 2013).

[24] URAC, formerly known as the Utilization Review Accreditation Commission, is a not-for-profit organization that works to promote health care quality through the administration of evidence-based standards and measures, education, and accreditation.

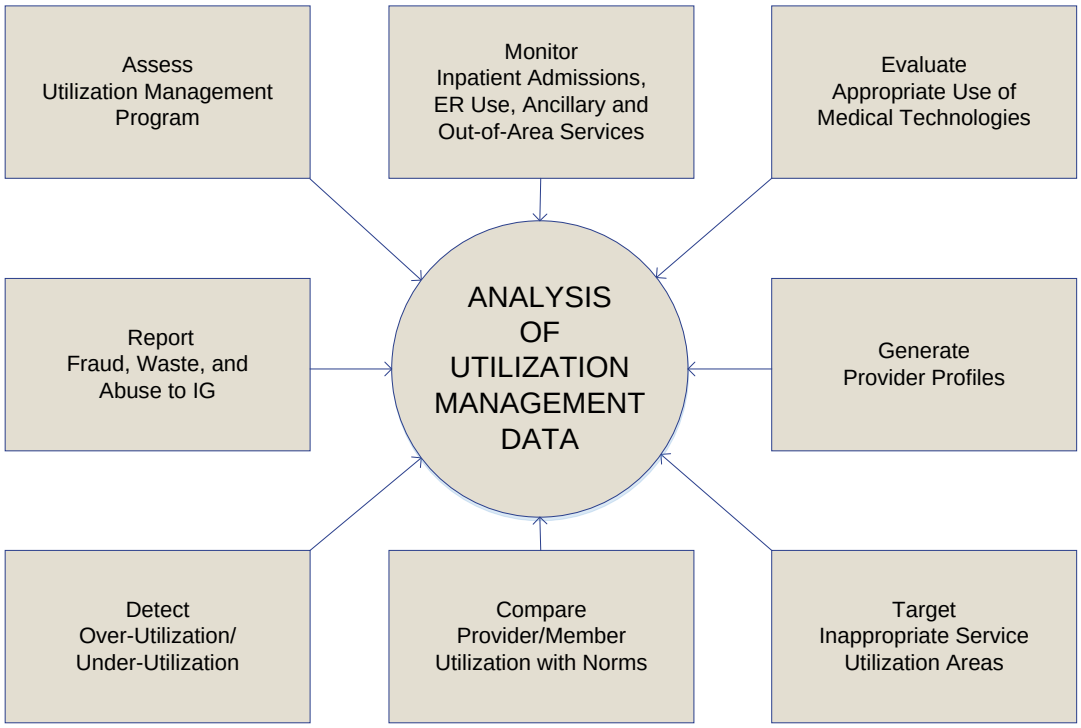
[25] The 16 personnel not required to take the inter-rater assessment tested by the IG Audit Division included personnel that (a) were hired after the assessment was administered, (b) terminated employment prior to the assessment, or (c) created the cases, conducted the assessment, and compiled the results.

[26] A contracted physician reviewer did not take the inter-rater reliability assessment.

Analysis of Utilization Management Data Was Performed

Community Health Choice identified opportunities for program improvements and monitored program effectiveness through various activities related to analysis of utilization management data. These activities included identifying trends and problems across the utilization management program and providing recommendations for improving health care management. The IG Audit Division reviewed and confirmed that Community Health Choice performed analysis of utilization management data activities, but did not evaluate the activities' effectiveness. Figure 2 provides a broad overview of the analysis activities that the UMCC requires all MCOs to perform.[27]

Figure 2: Contract Requirements for MCO Analysis of Utilization Management Data



Source: IG Audit Division

Defining Analysis of Utilization Management Data

Community Health Choice defined its requirements for analysis of utilization management data in its company documents.[28] Community Health Choice performed activities related to analysis of utilization management data regularly and conducted an annual assessment of the effectiveness and efficiency of the utilization management program. This assessment,

[27] Uniform Managed Care Contract, Attachment B-1, Utilization Management, Section 8.1.8, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

[28] Documents Community used to define its requirements for analysis of utilization management data include policies and procedures, "Utilization Management Program Description and Plan," and the "Quality Improvement Program Evaluation."

summarized as the "Quality Improvement Program Evaluation," drew on qualitative and quantitative information to identify opportunities for process improvements. Components of the annual assessment included:

- Changes to staffing, departmental processes, and structure
- Membership demographics
- Provider and member feedback about experience with utilization management
- Provider performance reviews
- Drug utilization reviews
- Summaries of utilization management data, such as completed authorizations and denials
- Summaries of top diagnoses for inpatient, outpatient, and emergency room visits
- Prior year utilization management goals and accomplishments
- Future utilization management goals.

Applying and Evaluating Medical Necessity Criteria

Community Health Choice monitored compliance with utilization review criteria and policies through analysis of its utilization management data. During prospective, concurrent, and retrospective utilization review, Community Health Choice physician and nurse reviewers evaluated the medical necessity and appropriateness of member and provider requests against various evidence-based clinical guidelines. Community Health Choice applied these guidelines in the following order of priority:

- Community Health Choice Medical Review Guidelines
- MCG[29] Guidelines
- Texas Medicaid Provider Procedure Manual
- National specialty society–developed guidelines
- Evidence-based medical literature
- Community Health Choice's medical director expertise

The Medical Care Management Committee evaluated emerging technologies and new applications of existing technologies for inclusion as medical necessity criteria. When there was a request for an emerging technology and no clinical guideline existed, the medical director could (a) review other nationally recognized support and reference tools, such as peer-reviewed medical journals or text books, (b) discuss with appropriate board certified specialists in the community, or (c) send for review by a contracted independent review company, to make a determination about covered benefits and the medical necessity and

[29] MCG guidelines were formerly known as Milliman Care Guidelines.

application of the technology. The Executive Quality and Compliance Committee and Medical Care Management Committee reviewed updates and revisions to MCG and state-specific clinical policies annually. The Board of Directors subsequently reviewed and approved the medical review guidelines, policies, and procedures reviewed and approved by Community Health Choice's reviewing committees.

Community Health Choice conducted annual inter-rater reliability assessments and reviewed this assessment data to ensure consistent application of criteria by utilization management personnel.[30] Community Health Choice also monitored the timeliness of utilization management requests to ensure they were processed within regulatory timeframes.

Utilization Management Data, Cost, and Quality of Care

Community Health Choice monitored and analyzed utilization management data to assess many areas of its business, including cost and quality of care. At least quarterly, the Medical Affairs Department and Healthcare Outcomes and Improvement Committee reviewed utilization reports to detect the under- and over-utilization of select health care services. The utilization management data reviewed contained data for select quality indicators, including:

- Total authorizations
- Hospital admissions per 1,000 members
- Hospital days per 1,000 members
- Average length of stay
- Emergency room visits per 1,000 members
- Avoidable emergency room visits
- Emergency room visits with no admit
- Readmission rates

Utilization management personnel could identify a potential quality of care issue (a) during their interactions with members, providers, or provider staff or (b) while performing trend analysis on key utilization data metrics. When an issue was identified, utilization management staff forwarded the information to the Quality and Outcomes section within the Medical Affairs Department for review, which ultimately reported to the Medical Care Management Committee.

Through analysis of utilization management data, Community Health Choice monitored the cost and quality of care delivered by primary care physicians, obstetricians, and gynecologists.

[30] Community Health Choice's policy required inter-rater reliability assessments be performed for all staff involved in utilization management decisions to test for consistency in determinations and documentation.

Community Health Choice prepared provider performance profiles[31] and held face-to-face visits to educate providers. The performance profiles provided data related to member and practice demographics, quality, utilization, and costs. Community Health Choice used the performance profiles to ensure providers achieve expected health outcomes by (a) increasing provider awareness of their performance, (b) identifying areas for process improvement, and (c) identifying provider best practices. When provider performance fell outside the normal range of its peers, Community Health Choice intervened.

Interventions might include, but were not limited to:

- Requiring the provider to receive additional education
- Monitoring the provider's utilization pattern for continued issues

Communicating utilization management data helped Community Health Choice improve provider compliance with clinical practice guidelines and performance targets, and was part of Community Health Choice's incentive strategies and improvement programs. Community Health Choice might terminate a provider from its network if recommended improvements were not implemented.

Fraud, Waste, and Abuse

Potential cases of fraud, waste, and abuse might be identified through various types of analysis, and could also be detected by members, providers, and other sources. Community Health Choice typically relied on claims-related data to identify potential cases. Some potential ways that fraud, waste, and abuse could be identified through the analysis of utilization management data included:

- Verification of services – Community Health Choice could verify that billed services were actually received by members.
- SIU analysis – Community Health Choice's post-payment review vendor analyzed claims data to identify irregular billing patterns and trends and would refer cases of potential fraud, waste, or abuse to Community Health Choice's Special Investigations Unit (SIU). Community Health Choice's SIU would investigate and determine how to resolve the potential case of fraud, waste, or abuse.

[31] At least annually, performance profiles are prepared for primary care physicians, obstetricians, and gynecologists on specific quality and utilization indicators and member demographics. For non-obstetrics primary care providers with more than 100 assigned members and obstetricians or gynecologists that perform more than 40 deliveries, the profile may be accompanied by an office visit from Community Health Choice's medical director and a member of the Healthcare Analysis Team.

Issue 1: NOTIFICATIONS OF PRIOR AUTHORIZATION REQUEST DETERMINATION DID NOT CONSISTENTLY MEET TIMELINESS REQUIREMENTS

MCOs are required to evaluate prior authorization requests and issue coverage determinations within timelines established in the UMCC and Texas Insurance Code (TIC). Community Health Choice's "Prior Authorization for Health Services/Treatment" policy was based on the UMCC, which is less restrictive than TIC. The UMCC requires the same timeframes whether the MCO is issuing a favorable or adverse determination, while TIC timeline requirements differ based on whether there is a favorable or adverse determination.

UMCC

Under UMCC, the MCO must issue all coverage determinations,[32] including favorable and adverse determination notices, according to the following timeline:

- Within three business days after receipt of the request for authorization of services.[33]

TIC

TIC has separate timeliness requirements for favorable and adverse prior authorization determinations:

- Notice of a favorable determination[34] must be transmitted no later than the second working day after the date that a utilization review agent receives a request for utilization review with all information necessary to complete the review.[35]
- Notice of an adverse determination must be provided within three working days to the provider of record and the patient.[36]

To test the timeliness of prior authorization coverage determinations, the IG Audit Division selected and examined a sample of 40 prior authorization requests. The IG Audit Division reviewed source documents to evaluate the accuracy of computer generated data for each

[32] UMCC allows for the timeline for certain request determinations to be extended if an MCO receives a request for a member under age 21, and the request does not contain complete documentation or information. In such cases, the MCO will contact the provider describing the information necessary to complete the prior authorization process and will allow the provider seven calendar days to provide additional information. HHSC Uniform Managed Care Manual, Chapter 3.22, Notification Process for Incomplete Prior Authorization Requests, Version 1.0 (January 15, 2010) through Version 2.1 (April 5, 2016).

[33] Uniform Managed Care Contract, Attachment B-1, Utilization Management, Section 8.1.8, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

[34] The written notification of a favorable determination made in utilization review must be mailed or electronically transmitted as required by Insurance Code 4201.302. Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1709 (February 20, 2013).

[35] Texas Insurance Code, Title 14, Chapter 4201, § 4201.302 (April 1, 2007).

[36] Texas Insurance Code, Title 14, Chapter 4201, § 4201.304 (April 1, 2007).

sampled request. The IG Audit Division reviewed fax, phone, or web portal authorization requests to determine the prior authorization receipt date. It also reviewed coverage determination letters, and the documented date of approval or denial of requested services in QNXT, which is the utilization management information system Community Health Choice uses to process prior authorization request, appeals, and denials. To determine whether Community Health Choice processed prior authorization requests and issued coverage determinations in compliance with required timeliness guidelines, the IG Audit Division calculated the difference between (a) the date the prior authorization was received and (b) the date the corresponding coverage determination was issued.[37]

Community Health Choice's policy was to make decisions, and notify the provider of record and member of its decisions, within three days. This policy aligned with the UMCC. However, Community Health Choice's policy did not distinguish between favorable and adverse determinations. TIC requires that notice of favorable determinations be made within two days but allows three days for adverse determinations.

Table 2 shows the results of the IG Audit Division's testing of the timeliness of Community Health Choice's notifications of prior authorization determinations based on criteria from Community Health Choice's policy, the UMCC, and TIC. Based on its own policy and the UMCC, Community Health Choice had an 80 percent compliance rate. Based on TIC requirements, Community Health Choice had a 60 percent compliance rate.

Table 2: Prior Authorization Testing Results for All Criteria

Criteria	In Compliance	Not in Compliance	Total Tested	Non-compliance Rate
UMCC / Community Health Choice Policy	32	8	40	20%
TIC	24	16	40	40%

Source: IG Audit Division

Table 3 shows more detailed results of the timeliness of Community Health Choice's notifications of prior authorization determinations. Based on TIC requirements, Community Health Choice had a 58 percent compliance rate for timeliness of favorable determinations and processed all adverse determinations tested timely.

[37] In calculating a period of days, the first day is excluded and the last day is included. If the last day of any period is a Saturday, Sunday, or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday, or legal holiday. Texas Government Code, Title 3, Subtitle B, Chapter 311, Subchapter A, § 311.014 (September 1, 1985).

Table 3: Prior Authorization Testing Results under TIC Criteria

TIC Determination	In Compliance	Not in Compliance	Total Tested	Non-compliance Rate
Favorable	22	16	38	42%
Adverse[38]	2	0	2	0%
Total	24	16	40	40%

Source: IG Audit Division

Community Health Choice did not always follow its policy, UMCC, or TIC requirements, for timeliness of utilization management decisions and notifications. Failure to comply with prior authorization requirements resulted in some members not being notified of prior authorization decisions within timeliness requirements. This could impact a member's ability to receive health care services timely.

Recommendation 1

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require that Community Health Choice meets prior authorization notification timeliness requirements.

HHSC Medicaid and CHIP Services Department Management Response

The Medicaid and CHIP Services Department agrees with the recommendation. The Department will allow Community Health Choice ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that identifies the specific steps Community Health Choice will take to ensure Community Health Choice meets UMCC prior authorization notification timeliness requirements.

The Medicaid and CHIP Services Department expects Community Health Choice to take immediate corrective action under the CAP and will allow Community Health Choice 90 calendar days to implement all actions within the CAP. The Medicaid and CHIP Services Department will require Community Health Choice to submit monthly updates detailing the status of each milestone.

In addition, the Medicaid and CHIP Services Department will contact the Texas Department of Insurance to ensure both agencies agree on the appropriate contract requirements for prior authorization notification timeliness, including requirements appearing in the Texas Insurance Code. If necessary, the Medicaid and CHIP Services Department will work with the HHSC Office of Chief Counsel to amend the UMCC language to reflect the agreed prior authorization notification timeliness requirements. Medicaid and CHIP Services Department,

[38] Community Health Choice may partially approve a prior authorization request. The IG Audit Division tested those partially approved requests under the timeframe for adverse determinations.

in coordination with the HHSC Office of Chief Counsel, will contact the Texas Department of Insurance within 30 days of the final issuance of this report. Anticipated date for contract changes, if any, is March 2018.

Responsible Individuals:

- Director, Health Plan Management
- Director, Utilization Review
- Director, Policy and Program Development

Target Implementation Dates:

- June 2017 - Implementation of Community Health Choice corrective actions
- March 2018 - Revisions to UMCC (if needed)

Issue 2: ELECTRONIC PRIOR AUTHORIZATION DATA WAS NOT RELIABLE FOR MEASURING TIMELINESS

The QNXT system, used by Community Health Choice to process prior authorization requests, contained data entry errors for prior authorization determination dates. Less than one percent (302 of 55,993) of the prior authorization determination dates preceded the date the initial prior authorization request was received. Data was missing for eight percent (4,607 of 55,993) of the prior authorization determination dates. QNXT also listed 126 prior authorization determination dates that were expected to fall within the audit scope period of September 1, 2013, through August 31, 2015, but instead were listed either (a) before September 1, 2013, or (b) more than 15 calendar days after August 31, 2015.[39] There were also 345 prior authorization determination dates that occurred past the audit scope. The out-of-scope determination dates ranged from the years 2001 to 2078.

MCOs are required to maintain a management information system that enables the MCO to meet UMCC requirements, including all applicable state and federal laws, rules, and regulations.[40] The management information system must have the capacity and capability to capture and utilize various data elements required for MCO administration. QNXT did not have data input and edit checks in place to help ensure prior authorization request received dates and notification dates were accurate.

The absence of reliable dates hinders Community Health Choice and HHSC efforts to effectively monitor (a) timely processing of prior authorization requests and (b) compliance with related state and UMCC requirements.

Recommendation 2

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require Community Health Choice to implement data input controls or edit checks into the QNXT system, or establish other control mechanisms that will improve the reliability of prior authorization request received and notification of determination dates maintained in the system.

[39] The cutoff date of 15 calendar days after August 31, 2015, was used to account for incomplete prior authorization requests. HHSC Uniform Managed Care Manual, Chapter 3.22, Notification Process for Incomplete Prior Authorization Requests, Version 1.0 (January 15, 2010) through Version 2.1 (April 5, 2016).

[40] Uniform Managed Care Contract, Attachment B-1, Utilization Management, Section 8.1.18, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

HHSC Medicaid and CHIP Services Department Management Response

The Medicaid and CHIP Services Department agrees with the recommendation. The Department will allow Community Health Choice ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of data input controls or edit checks into the QNXT system, or the establishment of other control mechanisms that will comparably improve the reliability of prior authorization request received dates and notification of determination dates maintained in the system.

The Medicaid and CHIP Services Department expects Community Health Choice to take immediate corrective action under the CAP and will allow Community Health Choice 90 calendar days to implement all actions within the CAP. The Medicaid and CHIP Services Department will require Community Health Choice to submit monthly updates detailing the status of each milestone.

Responsible Individuals:

- Director, Health Plan Management
- Director, Utilization Review

Target Implementation Date: June 2017

ISSUE 3: TIMELINESS OF SOME APPEAL LETTERS COULD NOT BE DETERMINED DUE TO LACK OF DOCUMENTATION

Community Health Choice did not retain all necessary documentation to show that it consistently processed appeal acknowledgment letters and resolution letters timely. When an appeal is received from a member, a member's representative, or a provider, the MCO must send an appeal acknowledgement letter to the appealing party within five business days acknowledging receipt of the appeal request. The standard appeal process must be completed within 30 calendar days after receipt of the initial oral or written request for an appeal. [41]

To test the timeliness of appeals processing, the IG Audit Division selected and examined a sample of 27 appeals. To determine whether the appeal acknowledgment letter was sent timely, the IG Audit Division calculated the difference between the appeal request receipt date and the date of the acknowledgment letter. To evaluate the accuracy of the date the appeal was received, the IG Audit Division identified the appeal receipt date by reviewing the date stamp on a written appeal request, the fax date of when the request was received, or the date in QNXT for oral appeal requests. To determine whether appeals were completed within 30 calendar days, the IG Audit Division calculated the difference between the appeal request receipt date and date of the appeal resolution letter. To evaluate the accuracy of the recorded date the appeal was received, the IG Audit Division identified the appeal receipt date by reviewing the date stamp on a written appeal request, the fax date of when the request was received, or the date in QNXT for oral appeal requests.

Of the appeals tested that had complete documentation, all were sent timely. However, the IG Audit Division could not determine:

- When two appeal requests were received because the appeal requests were not retained.
- If or when one acknowledgment letter was sent to the appealing party because the letter was not retained.
- The date of one appeal resolution letter because it was not retained.

[41] The timeframe to resolve a standard appeal is 30 calendar days after receipt of the request, and can be extended up to 14 calendar days by a member (or member's representative), or by the MCO if it shows that there is a need for additional information about how the delay is in the member's interest. The timeframe for resolving an expedited appeal is three business days after receiving the request - except for an ongoing emergency, or denial of continued hospitalization, which requires processing within one business day after receiving the request. Uniform Managed Care Contract, Attachment B-1, Medicaid Standard Member Appeal Process, Section 8.2.6.2, and Expedited Medicaid MCO Appeals, Section 8.2.6.3, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

Community Health Choice did not have a process in place to ensure all source documents were retained for all appeals requests and notifications. Not properly maintaining appeal documents impacts Community Health Choice's ability to demonstrate appeal notifications were sent timely.

Recommendation 3

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require that Community Health Choice's appeal process complies with UMCC requirements regarding documentation.

HHSC Medicaid and CHIP Services Department Management Response

The Medicaid and CHIP Services Department agrees with the recommendation. The Department will allow Community Health Choice ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that identifies the specific steps Community Health Choice will take to ensure Community Health Choice meets UMCC requirements regarding appeals process documentation.

The Medicaid and CHIP Services Department expects Community Health Choice to take immediate corrective action under the CAP and will allow Community Health Choice 90 calendar days to implement all actions within the CAP. The Medicaid and CHIP Services Department will require Community Health Choice to submit monthly updates detailing the status of each milestone.

Responsible Individuals:

- Director, Health Plan Management
- Director, Utilization Review

Target Implementation Date: June 2017

Issue 4: COMMUNITY HEALTH CHOICE PERSONNEL DID NOT RECEIVE REQUIRED TRAINING

TIC requires MCOs to provide adequate training to personnel responsible for precertification, certification, and recertification of services or treatment relating to acquired brain injury.[42] The purpose of the training is to prevent denial of coverage in violation of TIC[43] and to avoid confusing medical benefits with mental health benefits.[44]

The IG Audit Division tested the population of personnel files for the 27 employees and 1 contractor involved in the prospective utilization review process who were employed during state fiscal years 2014 or 2015, and determined that 26 personnel were required to take the training.[45] According to Community Health Choice's management, training related to the requirements for acquired brain injury treatment were incorporated into an employee's general training, whether it was received during onboarding or during yearly refresher training. Of the 26 personnel required to take the training, Community Health Choice asserted that 6 personnel received training during onboarding and provided the onboarding date, but did not provide documentation to substantiate the statement. Community Health Choice was unable to provide evidence that the remaining 20 personnel completed training during either onboarding or through their yearly refresher training.

Community Health Choice did not have a process in place to ensure and adequately document that personnel who are responsible for prospective medical necessity determinations received the required training. Allowing Community Health Choice personnel to perform medical necessity determinations without acquired brain injury training could result in an inappropriate determination, such as the approval of unnecessary health care services or the wrongful denial of health care services.

Recommendation 4

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require Community Health Choice to implement a process to ensure

[42] Texas Insurance Code, Title 8, Subtitle E, Chapter 1352, § 1352.004 (September 1, 2007).

[43] A health benefit plan must include coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, and remediation required for and related to treatment of an acquired brain injury. Texas Insurance Code, Title 8, Subtitle E, Chapter 1352, § 1352.003 (September 1, 2013).

[44] Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1706 (February 20, 2013).

[45] Two personnel were not required to take the acquired brain injury treatment related training: 1 who had been employed for only 17 days, and another who was responsible for the acquired brain injury treatment policies and reading materials.

and adequately document that all personnel involved in prospective utilization review receive required Texas Medicaid trainings, including training in acquired brain injury.

HHSC Medicaid and CHIP Services Department Management Response

The Medicaid and CHIP Services Department agrees with the recommendation. The Department will allow Community Health Choice ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that identifies the specific steps Community Health Choice will take to ensure all personnel involved in prospective utilization review receive required Texas Medicaid trainings, including training in acquired brain injury, and that training documentation is maintained.

The Medicaid and CHIP Services Department expects Community Health Choice to take immediate corrective action under the CAP and will allow Community Health Choice 90 calendar days to implement all actions within the CAP. The Medicaid and CHIP Services Department will require Community Health Choice to submit monthly updates detailing the status of each milestone.

Responsible Individuals:

- Director, Health Plan Management
- Director, Utilization Review

Target Implementation Date: June 2017

Issue 5: SOME PRIOR AUTHORIZATION REQUESTS WERE INCORRECTLY DENIED FOR NOT BEING A COVERED BENEFIT

The IG Audit Division tested a sample of 32 prior authorization requests that were administratively denied as "not a covered benefit." Community Health Choice allowed utilization management nurses to make administrative determinations for services that are not a covered benefit, members who are not Medicaid eligible, and requests without clinical information received verbally or electronically. "Not a covered benefit" denials were evaluated to determine whether the prior authorization requests would have been approved under fee-for-service Medicaid. MCOs are required to provide the same Medicaid health care services under the managed care model that were covered under the fee-for-service model.[46]

Two of 32 prior authorizations tested (6.3 percent) were incorrectly denied by a nurse for not being a covered benefit when the prior authorization requests should have been reviewed for medical necessity. Incorrectly denying prior authorization requests can prevent a member from receiving eligible health care services.

Recommendation 5

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require Community Health Choice to implement a process to ensure eligible health care services are not incorrectly denied as not a covered benefit.

HHSC Medicaid and CHIP Services Department Management Response

The Medicaid and CHIP Services Department agrees with the recommendation. The Department will allow Community Health Choice ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of a process to ensure eligible health care services are not incorrectly denied as not a covered benefit.

The Medicaid and CHIP Services Department expects Community Health Choice to take immediate corrective action under the CAP and will allow Community Health Choice 90 calendar days to implement all actions within the CAP. The Medicaid and CHIP Services Department will require Community Health Choice to submit monthly updates detailing the status of each milestone.

[46] Code of Federal Regulations Title 42, Chapter IV, Subchapter C, Part 438 § 438.210 (October 1, 2009).

Responsible Individuals:

- Director, Health Plan Management
- Director, Utilization Review

Target Implementation Date: June 2017

CONCLUSION

The IG Audit Division's audit of Community Health Choice's acute care utilization management included an evaluation of policies and practices associated with prior authorizations and appeals, an assessment of the qualifications of Community Health Choice personnel, and a review of Community Health Choice's documentation of monitoring, analysis, and reporting efforts related to utilization management. The IG Audit Division conducted site visits in June 2016 at Community Health Choice's facility in Houston, Texas.

HHSC and Community Health Choice share accountability for ensuring that state and federal dollars are used to deliver cost-effective health care services to eligible Medicaid enrollees. An effective utilization management function is essential to ensure that:

- State and federal funds spent on managed care are used appropriately.
- Members are provided health care services that are medically necessary, appropriate, and timely.
- Members and providers receive information in a timely manner and have an avenue to appeal MCO actions.

Based on the results of this audit, the IG Audit Division determined that Community Health Choice:

- Had utilization management policies and processes related to prior authorizations and appeals that met requirements.
- Employed qualified personnel who met licensure and inter-rater reliability assessment requirements.
- Performed analysis of utilization management data to identify improvements and monitor program effectiveness.
- Followed the UMCC timeliness criteria for prior authorization determination notifications, which is different than TIC requirements.
- Did not consistently process prior authorizations timely.
- Relied on electronic prior authorization data that was not accurate.
- Did not retain documentation that it consistently processed appeal acknowledgement letters and resolution letters timely.
- Did not ensure all utilization management personnel received required training.
- Denied some prior authorization requests as "not a covered benefit" incorrectly.

The IG Audit Division offered recommendations to HHSC Medicaid and CHIP Services Department which, if implemented, will:

- Reduce the number of untimely notifications of Community Health Choice's decisions regarding prior authorization requests for health care services.
- Improve the accuracy of prior authorization data and provide a more reliable basis for analyzing and making recommendations regarding utilization management.
- Improve Community Health Choice's ability to document that appeals are acknowledged and resolved timely.
- Increase utilization management personnel knowledge of issues related to acquired brain injury to help ensure appropriate determinations of medical necessity.
- Reduce the incidence of incorrect denials of prior authorization requests.

The IG Audit Division thanks management and staff of HHSC Medicaid and CHIP Services Department and at Community Health Choice for their cooperation and assistance during this audit.

Appendix A: OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of this audit was to evaluate the effectiveness of Community Health Choice's acute care utilization management practices in ensuring that health care services provided were (a) medically necessary, (b) efficient, and (c) comply with state and federal requirements.

Scope

The performance audit of Community Health Choice's utilization management function was for the period from September 1, 2013, through August 31, 2015. The IG Audit Division focused on:

- Assessing utilization management practices applied to prior authorizations, denials, and appeals.
- Reviewing policies, procedures, and the utilization management program description to ensure compliance with state, federal, and contract requirements.
- Evaluating whether personnel making medical necessity determinations were qualified and currently licensed.
- Gaining an understanding of activities related to utilization monitoring, analysis, and reporting.

Methodology

To accomplish its objectives, the IG Audit Division collected information for this audit through discussions and interviews with responsible staff at Community Health Choice and by:

- Reviewing contract requirements related to state and federal laws and regulations.
- Assessing policies and procedures associated with prior authorizations and appeals.
- Observing the prior authorization and appeals process.
- Analyzing and testing prior authorization and appeal records.
- Examining job descriptions, professional license numbers, and inter-rater reliability assessments of utilization management personnel.
- Interviewing staff and reviewing retrospective analysis dashboards, reports, and other monitoring activities.

The IG Audit Division issued an engagement letter to Community Health Choice on March 17, 2016, and conducted site visits in June 2016 at Community Health Choice's facility in Houston, Texas. While on-site, the IG Audit Division interviewed relevant personnel,

observed a demonstration of Community Health Choice's utilization management system, tested prior authorization and appeal records, reviewed job descriptions and professional licensure information, and reviewed documentation related to retrospective analysis.

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:

- Community Health Choice utilization management policies and procedures
- Community Health Choice utilization management job descriptions
- Uniform Managed Care Contract Terms and Conditions
- Uniform Managed Care Manual
- Texas Medicaid Provider Procedure Manual
- Texas Administrative Code
- Texas Insurance Code
- Code of Federal Regulations

The IG Audit Division analyzed information and documentation to determine whether data was sufficiently reliable for the purposes of this audit. In order to make this determination, it assessed the reliability of information technology system data on prior authorizations and appeals by (a) reviewing query parameters, (b) observing a demonstration of the prior authorization and appeal data entry process, (c) interviewing Community Health Choice employees knowledgeable about the data, and (d) reviewing source documents.

The IG Audit Division determined that appeal data was sufficiently reliable for the purposes of this audit. However, the population of electronic prior authorization data was not sufficiently reliable to test and analyze because of errors in the prior authorization determination date field. There were no data entry system input controls in place, as confirmed by analyzing population date fields and considering employee testimony. As a result, the IG Audit Division adjusted audit procedures and tested prior authorization processing time by selecting a sample and using source documentation rather than relying on information technology system data.

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 its audit objectives.

Appendix B: SAMPLING METHODOLOGY

Prior Authorizations

The IG Audit Division selected a random[47] sample of 30 Medicaid STAR program prior authorizations stratified[48] by years 2014 and 2015, and judgmentally[49] selected 11 prior authorizations to obtain audit coverage for emergency and extended[50] authorization requests. One of the 41 sampled prior authorizations was an appeal and was not tested. For the 40 prior authorizations, testing was performed to determine:

- Accuracy of the prior authorization data, by tracing to source documents
- Timeliness of prior authorization processing
- Compliance of adverse determination letters with laws and regulations

Prior Authorizations Denied as "Not a Covered Benefit"

The IG Audit Division tested 32 of 320 prior authorizations denied for not being a covered benefit from 2014 and 2015 to determine if the denial was appropriate. Code of Federal Regulations[51] requires MCOs to provide health care services that are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same service furnished to beneficiaries under fee-for-service Medicaid.

Appeals

The IG Audit Division tested 27 of 250 appeals from 2014 and 2015. The sample was composed of random and judgmentally selected appeals. Testing was performed to determine:

- Accuracy of appeal data, by tracing to source documents
- Timeliness of appeals processing and compliance with laws and regulations
- Compliance of notification letters with laws and regulations

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

[48] Stratified sampling is a method by which the population is divided into subpopulations, each of which is a group of sampling units that have similar characteristics.

[49] Judgmental sampling is a non-probability sampling method where the auditor selects the sample based on certain characteristics, such as dollar amount, timeframe, or type of transaction.

[50] HHSC Uniform Managed Care Manual, Chapter 3.22, Notification Process for Incomplete Prior Authorization Requests, Version 1.0 (January 15, 2010) through Version 2.1 (April 5, 2016).

[51] Code of Federal Regulations Title 42, Chapter IV, Subchapter C, Part 438 § 438.210 (October 1, 2009).

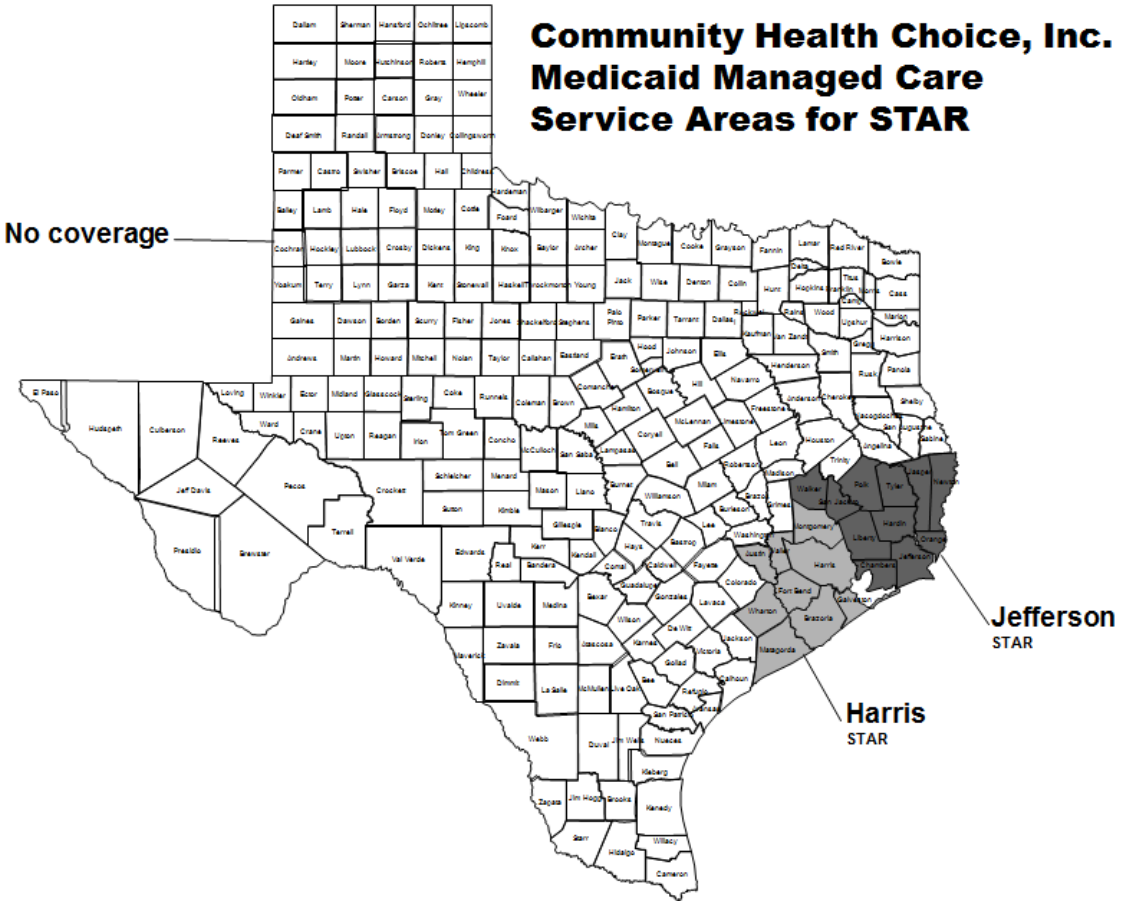
Qualified and Licensed Personnel

The IG Audit Division tested all 28 Community Health Choice utilization management staff involved in prospective reviews to determine whether they were:

- Qualified for their positions
- Currently licensed
- Trained in acquired brain injury treatment[52]
- Assessed on inter-rater reliability

[52] Community Health Choice's utilization management staff are specifically required to be trained in the treatment of acquired brain injury.

Appendix C: COMMUNITY HEALTH CHOICE, INC. SERVICE AREAS



Appendix D: COMMUNITY HEALTH CHOICE COMMENTS

COMMUNITY HEALTH CHOICE

February 24, 2017

Steven Sizemore, CIA, CISA, CGAP
Performance Audit Director
Inspector General- Texas Health and Human Services Commission
11501 Burnett Road
Bldg. 902
Austin, TX 78758

Dear Mr. Sizemore:

Re: Audit of Acute Care Utilization Management in Managed Care Organizations - Community Health Choice.

Please accept this submission in response to the recently concluded Inspector General's (IG), audit of Community Health Choice Inc.'s (Community), utilization management (UM) practices. The audit sought to evaluate the effectiveness of Community's acute care UM practices in ensuring that health care services provided are medically necessary, efficient, and comply with state and federal requirements.

Community's management thanks the IG's team for the opportunity to demonstrate the plan's improvements since CY2014 on issues of concern. We remain committed to ensuring that Community meets regulatory and contractual standards in serving our membership in the State Health programs in which we participate and we will continue to improve and invest in infrastructure to support same.

I am available to respond to any questions or concerns you may have regarding the above and may be reached directly at (713) 295-6779.

Sincerely,

Nike Otuyelu
VP, Compliance & Risk Management

CC:
Ken Janda, CEO/President
Marcus Garrett, Audit Manager, IG-HHSC
Anton Dutchover, Audit Project Manager, IG-HHSC

6 South Loop West, Suite 900 Houston, TX 77054 tel 713.295.2200 toll free 888.760.2600 fax 713.295.2293

Appendix E: 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
- Marcus Garrett, CIA, CGAP, CRMA, Audit Manager
- Anton Dutchover, CPA, Audit Project Manager
- Melissa Towb, CPA, Senior Auditor
- Marcos Castro, Auditor
- Summer Grubb, Auditor
- Jennifer Carlisle, RN, Medical Auditor
- Tenecia Jackson, RN, Medical Auditor
- Lorraine Chavana, Quality Assurance Reviewer
- Mo Brantley, Senior Audit Operations Analyst

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- Grace Windbigler, Director, Health Plan Management, Medicaid and CHIP Services Department
- Cathy Horton, Director, Utilization Review, Medicaid and CHIP Services Department
- Michelle Erwin, Director, Policy and Program Development, Medicaid and CHIP Services Department
- Karin Hill, Director of Internal Audit

Managed Care Organizations

Community Health Choice, Inc.

- Kenneth W. Janda, President and Chief Executive Officer
- Nike Otuyelu, Corporate Compliance and Risk Management
- Fred Buckwold, Chief Medical Officer
- Karen Love, Chief Operating Officer
- Leroy Mayers, Internal Audit Manager

Appendix F: 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 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 Rodriguez — Senior Advisor and Deputy IG for Inspections and Evaluations
- Roland Luna — Deputy IG for Investigations
- David Griffith — Deputy IG for Audit
- Quinton Arnold — Deputy IG for Inspections
- Debbie Weems — Deputy IG for Medical Services
- Alan Scantlen — Deputy IG for Data and Technology
- Anita D'Souza — Chief Counsel

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  Inspector General
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