TEXAS HEALTH AND HUMAN SERVICES COMMISSION

INSPECTOR GENERAL

AUDIT OF ACUTE CARE UTILIZATION MANAGEMENT IN MANAGED CARE ORGANIZATIONS

Amerigroup Texas, Inc. and

Amerigroup Texas Insurance Company

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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 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 focused specifically on utilization management practices at Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company[3] (Amerigroup) for the Medicaid State of Texas Access Reform (STAR) and Medicaid State of Texas Access Reform Plus (STAR+PLUS) programs. The audit scope covers state fiscal years 2014 and 2015, from September 1, 2013, through August 31, 2015. This is the last in the series of audits of utilization management in MCOs. The IG Audit Division will release a summary report based on the results and observations of the audits.

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.

Objective

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.

Background

Amerigroup is a licensed Texas MCO contracted to provide Medicaid and CHIP services through its network of providers. Amerigroup coordinates health services

[1] "Acute care" is defined as preventive 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. 1 Tex. Admin. Code § 353.2(2) (July 8, 2012; September 1, 2014).

[2] An MCO is an organization that delivers and manages health care services under a risk-based arrangement.

[3] Amerigroup Texas collectively refers to Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company. Amerigroup Texas, Inc. provides services to members located in the Bexar, Dallas, El Paso, Jefferson, Harris, Lubbock, Tarrant, and Travis service delivery areas. Amerigroup Texas Insurance Company provides services to members located in Medicaid Rural Service Areas (MRSA) Central, Northeast, and West.

for several managed care programs, including CHIP, Medicaid STAR, and STAR+PLUS. Amerigroup is a wholly owned subsidiary of Amerigroup Corporation, which is a wholly owned subsidiary of Anthem, Inc.[4] Amerigroup coordinates services for Medicaid STAR and STAR+PLUS program members[5] in most areas of the state. See Appendix C for a map of the counties where Amerigroup's Medicaid STAR and STAR+PLUS programs are available.

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 Amerigroup's average monthly member counts and gross premiums for the Medicaid STAR and STAR+PLUS programs in 2014 and 2015. Over the two-year period, Amerigroup maintained an average of 674,809 members per month and was paid more than $5.8 billion in gross premiums. Gross premiums include gross capitation payments[6] and delivery supplemental payments.[7]

Table 1: Amerigroup Medicaid STAR and STAR+PLUS Member Counts and Gross Premiums for 2014 and 2015

Program	# of Members *(monthly average)*[8]	Gross Premiums *(billions)*
STAR	545,107	$ 2.84
STAR+PLUS	129,702	$ 2.96
Totals	--	$ 5.80

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

Amerigroup's utilization management function is a component of its Healthcare Management Services department. Amerigroup's Texas regional vice president medical director is responsible for the daily oversight and operating authority of utilization management activities in Texas. That position reports to Amerigroup's Texas health plan president and chief executive officer, who has final authority and accountability for the oversight of the quality of care and services provided to Texas Medicaid members. The vice president of Healthcare Management Services

[4] In December 2014, WellPoint, Inc. changed its corporate name to Anthem, Inc.

[5] 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.

[6] "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.

[7] 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.

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

within Amerigroup Corporation has ultimate responsibility for the general operational and clinical oversight of the Amerigroup Texas utilization management program.

Amerigroup holds the required utilization review agent license.[9] As a utilization review agent, Amerigroup must comply with applicable Texas Department of Insurance regulations.[10] Amerigroup staff perform utilization management functions in the company's Texas offices in Austin, El Paso, Grand Prairie, Houston, Lubbock, and San Antonio, as well as in offices in Virginia Beach, Virginia, and Tampa, Florida.

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,[11] appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan.

Utilization review[12] may take place prospectively, concurrently, or retrospectively.[13]

- 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.

[9] A utilization review agent license is required for performance of medical reviews. The license is issued by the Texas Department of Insurance. 28 Tex. Admin. Code § 19.1704 (February 20, 2013).

[10] Tex. Ins. Code § 4201.057 (April 1, 2007).

[11] "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. 1 Tex. Admin. Code § 353.2(60) (July 8, 2012; September 1, 2014).

[12] Tex. Ins. Code § 4201.002 (September 1, 2009).

[13] 28 Tex. Admin. Code § 1703 (February 20, 2013).

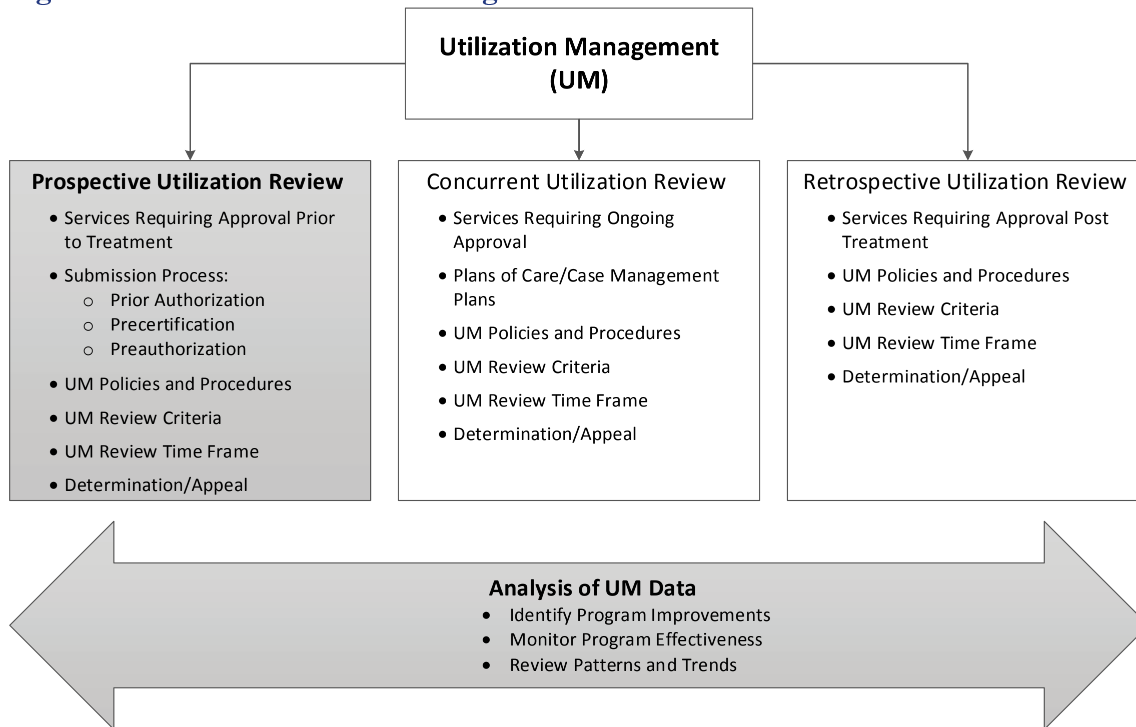
Utilization reviews may result in favorable or adverse action. Members may request an appeal of any adverse determination.[14] An MCO's utilization management function requires policies, procedures, and organizational structures to execute utilization management strategies that comply with state and 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 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-utilization 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.

[14] 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.

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,[15] and is limited to Medicaid STAR and STAR+PLUS. Additionally, the IG Audit Division reviewed Amerigroup's analysis of utilization management data, which includes prospective, concurrent, and retrospective review.

The IG Audit Division evaluated Amerigroup's utilization management processes by:

- Reviewing relevant policies, procedures, and processes, and assessing compliance with state and federal requirements.
- Evaluating prior authorization standards.
- Assessing under-utilization or inappropriate utilization of health care services by reviewing prior authorization data.

[15] "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.

- Confirming the timely administration of prior authorizations, adverse determinations, and appeals.
- Interviewing utilization management staff and reviewing examples of Amerigroup'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 2015, there were approximately 4.4 million Texans enrolled in Medicaid or CHIP.[16]

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,[17] but most are enrolled through a managed care model.[18] Under managed care, the MCO receives a capitation payment for each member enrolled, based on historical expenses by population served in Medicaid. 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 networks of providers. In federal fiscal year 2015, Texas spent $30 billion on Medicaid and CHIP, which represented 29 percent of the entire 2015 state budget.[19]

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

[16] This is the 2015 average monthly number of enrollees in Medicaid and CHIP.

[17] 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.

[18] 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.

[19] Texas Medicaid and CHIP expenditures in 2015 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.

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 Amerigroup in a draft report dated April 28, 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. Amerigroup did not provide separate comments. The HHSC Medicaid and CHIP Services Department concurred with the IG Audit Division recommendations, and will facilitate Amerigroup's development of a corrective action plan designed to improve Amerigroup's utilization management function.

AUDIT RESULTS

The UMCC requires MCOs to have a written utilization management program description.[20] 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

Amerigroup maintained a written utilization management program description that met UMCC requirements. In addition, Amerigroup 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.

Denials for "Not a Covered Benefit"

MCOs are required to provide the same Medicaid health care services under the managed care model that would be covered under the fee-for-service model. The IG Audit Division tested a sample of 30 prior authorization requests that were denied as "not a covered benefit." These denials were evaluated to determine whether the prior authorization requests would have been approved under Medicaid fee-for-service. All 30 prior authorization requests were appropriately denied,[21] as they would not have been covered under Medicaid fee-for-service.

[20] 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).

[21] For 1 of 30, Amerigroup inappropriately denied a procedure code for one prior authorization request tested. The prior authorization had several procedure codes and all procedure codes were appropriately denied or approved, except for one.

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.[22] An appeal is a formal process by which a member (or member's representative) requests review of an MCO action.[23]

During the prior authorization review process, providers request approval of services. 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.

If the MCO makes an adverse determination for a prior authorization request, it sends an adverse determination letter (also called a denial letter)[24] 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.

[22] 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).

[23] 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 C.F.R. § 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).

[24] 28 Tex. Admin. Code § 19.1709 (February 20, 2013).

The standard appeals process must then be completed within 30 calendar days after receipt of the initial oral or written request for an appeal.[25] 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 35 appeals of denied prior authorization requests and found that Amerigroup's appeals process complied with applicable contract requirements and with state and federal laws and regulations. For all appeals 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.
- The appeals processing took place within required timeframes.[26]

[25] 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 MCO. The MCO must show a need for additional information and how the delay is in the member's interest. The timeframe for resolving an expedited appeal is three business days after receiving the request, unless the appeal relates to an ongoing emergency or denial of continued hospitalization, in which case the MCO must complete resolution of the appeal 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).

[26] Four appeal acknowledgment and resolution letters could not be shown to be timely because the original request lacked a date stamp. The IG Audit Division relied on the date stamp to determine the date the appeal was received instead of relying on the date entered into the utilization management system. These four were timely according to the receipt date in the system. However, that date could not be verified. A fifth appeal was not processed within 30 days of receipt because the appeal was misrouted. Irrespective of the processing delay, the appeal would not have been considered because it was received more than 30 days from the prior authorization denial letter.

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.[27] Audit results indicated that Amerigroup 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 a sample of 39 utilization management personnel involved in the utilization review process between September 1, 2013, and August 31, 2015. The personnel included nurses and physicians. All 39 held a current medical or nursing license with no disciplinary actions noted and met the licensing qualifications of their job description.[28]

In addition, MCOs may conduct an inter-rater reliability assessment to help ensure the consistent application of clinical criteria and medical necessity determinations. If an MCO seeks accreditation from the National Committee for Quality Assurance (NCQA),[29] it must perform inter-rater reliability assessments. Amerigroup had an inter-rater reliability assessment process in place.

Amerigroup performed inter-rater reliability reviews to ensure staff were making assessments and determinations consistent with their peers, clinical criteria, and guidelines. Amerigroup required a passing rate of 80 percent or greater for each module tested. A plan of action was prepared for personnel who did not meet the minimum score.

The IG Audit Division reviewed the same 39 utilization management personnel files it tested for licensure, and determined that 37 personnel were required to take the inter-rater reliability assessment. Two personnel were not required to take the assessment because they did not directly perform utilization reviews.

[27] 28 Tex. Admin. Code § 19.1706 (February 20, 2013).

[28] Six nurse reviewers' licenses did not meet the licensure requirements associated with their Anthem, Inc. job title. After Amerigroup was integrated into Anthem, Inc., personnel received new job titles. Some were assigned inappropriately to job titles that required a registered nurse (RN) license rather than a licensed vocational nurse (LVN) license. Amerigroup stated it corrected the inappropriate job titles effective January 11, 2016. Amerigroup made one exception for a manager that maintained an LVN license and supervised other LVN nurse reviewers.

[29] The National Committee for Quality Assurance is a private, not-for-profit organization that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

Of the 37 personnel performing utilization reviews:

- Thirty (81 percent) had taken the assessment and met the minimum score.
- Two did not achieve the minimum score on the assessment, but received a corrective action plan.
- Five did not take the inter-rate reliability assessment as required by Amerigroup's policy.

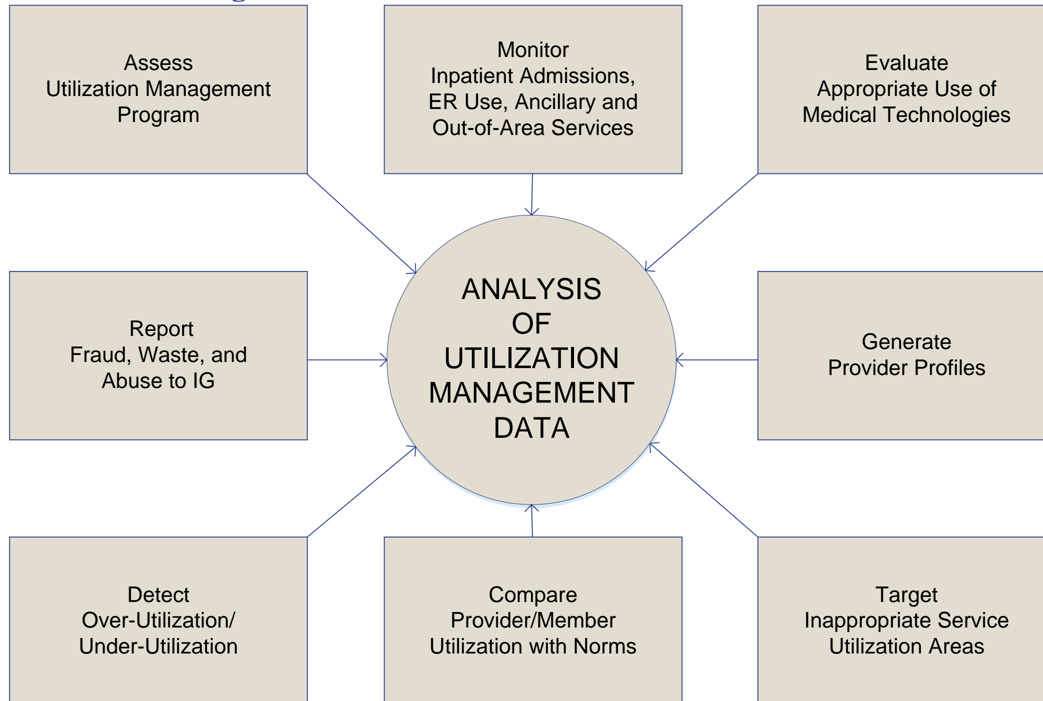
Inter-rater reliability assessments are not a requirement of the UMCC, but are a best practice and a requirement for NCQA accreditation.

Analysis of Utilization Management Data Was Performed

Amerigroup 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 Amerigroup 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.[30]

[30] 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).

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



Source: IG Audit Division

Defining Analysis of Utilization Management Data

Amerigroup defined its requirements for analysis of utilization management data in its company documents.[31] Amerigroup 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, summarized as the "Health Care Management Program Evaluation," drew on qualitative and quantitative information to identify opportunities for process improvements. Components of the annual assessment included:

- Membership demographics.
- Summaries of criteria selection, approval, and implementation.
- Summaries of utilization management data related to inpatients, outpatients, and inter-rater reliability assessment.
- Summaries of adverse determination appeals data.

[31] Documents Amerigroup used to define its requirements for analysis of utilization management data include policies and procedures, "Utilization Management (UM) Program Description," and the "Health Care Management Program Evaluation."

- Prior year utilization management accomplishments and barriers.
- Future utilization management goals.

Applying and Evaluating Medical Necessity Criteria

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

- State manuals and Centers for Medicare and Medicaid Services (CMS) guidelines.
- WellPoint Medical Policies.
- McKesson InterQual® Level of Care criteria.
- WellPoint Clinical Guidelines.
- Nationally recognized evidence based medical literature.
- Amerigroup medical director expertise.

Amerigroup's Medical Policy and Technology Assessment Committee (MPTAC) is responsible for evaluating emerging technologies and new applications of existing technologies for inclusion as medical necessity criteria. When a request for an emerging technology is received and no clinical guideline exists, the medical director has the discretion to review nationally recognized support and reference sources to make a determination about covered benefits and the medical necessity and application of the technology.

Annually, Amerigroup's Government Business Division Medical Operations Committee (MOC) reviews and approves criteria used to make medical necessity determinations. The MPTAC, Texas Medical Advisory Committee, Medical Management Committee, and Quality Management Committee review updates and revisions to McKessson InterQual® guidelines and state-specific clinical policies used by Amerigroup. The MOC subsequently reviews, adopts, and approves all Government Business Division medical policy related to clinical guidelines, disease management programs, and utilization management policies and procedures approved at the health plan level.

Utilization Management Data, Cost, and Quality of Care

Amerigroup monitored and analyzed utilization management data to assess many areas of its business, including cost and quality of care. The HealthCare Management, Quality Management, and Health Promotion Department regularly reviewed utilization reports to detect the under- and over-utilization of select health care services. The results of the reviews were reported to the Medical Advisory Committee and the Quality Management Committee. The utilization management data reviewed contained data for select quality indicators, including:

- Hospital admissions per 1,000 members
- Hospital days per 1,000 members
- Average length of stay
- Emergency room visits per 1,000 members
- Cost per emergency room visit
- Readmission rates

Utilization management personnel might identify a potential quality of care issue (a) during 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 Management Department for review. At least annually, the Quality Management Department reviewed and analyzed the quality of care data to identify trends and opportunities for improvement, and had the discretion to forward any corrective actions taken to the Medical Advisory Committee.

Through analysis of utilization management data, Amerigroup monitored the cost and quality of care delivered by providers. Amerigroup prepared provider performance profiles[32] with data related to member episode volume, utilization, and costs. Amerigroup used the performance profiles to (a) increase providers' awareness of their performance relative to their peers' and (b) show providers opportunities they might be missing in caring for their patients.

Amerigroup might intervene if a provider's performance fell outside the normal range. Interventions might include, but were not limited to:

- Educating providers
- Monitoring provider's utilization pattern for continued issues
- Initiating peer review
- Developing an action plan
- Performing ongoing reviews of medical records

[32] At least annually, performance profiles are prepared on an individual provider, provider group or both.

Communicating utilization management data helped Amerigroup improve provider compliance with clinical practice guidelines and performance targets, and was used to monitor and support Amerigroup's quality improvement initiatives. Amerigroup might terminate a provider from its network if recommended improvements were not implemented.

Fraud, Waste, and Abuse

Amerigroup stated that 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. Amerigroup 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:

- Prepayment data mining – Amerigroup performed prepayment data mining to identify potential overpayments post-adjudication but prior to check run, including evaluating claims to identify mutually exclusive codes.
- Post-payment data mining – Amerigroup, in conjunction with its vendors, performed post-payment data mining to identify overpayments. This analysis did not require medical records to be reviewed. The overpayment identification and recovery details were shared with the Amerigroup Medicaid Special Investigations Unit (SIU) monthly for provider-level review.
- Complex audit – Amerigroup, in conjunction with its vendors, performed complex audits. Complex audits included a review of medical records and other supporting documentation to support a claim. Claims identified for complex review were those with a high probability of a billing error or incorrect application of coding rules. Complex audits included diagnosis related grouping validation and hospital bill audits, which could identify undocumented or unsupported charges, duplicate billings, or unbundling.
- SIU analysis – Amerigroup's SIU analyzed claims data and compared member and provider utilization rates to its peers to identify outliers. The Cost Containment Unit provided a monthly report summarizing all overpayments identified, by provider, and Amerigroup's SIU reviewed the data for potential leads. Amerigroup's SIU investigated the potential leads and determined how to resolve the potential cases of fraud, waste, or abuse.

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). Amerigroup's "Health Care Management Services Denial – TX" policy was based on the UMCC, which is less restrictive than TIC. Amerigroup's policy is more restrictive than both the UMCC and TIC, because the date received is counted as the first day and the policy does not distinguish between favorable and adverse determinations. 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.

<u>UMCC</u>

Under UMCC, the MCO must issue all coverage determinations,[33] including favorable and adverse determination notices, within three business days after receipt of the request for authorization of services.[34]

<u>TIC</u>

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

- Notice of a favorable determination[35] 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.[36]
- Notice of an adverse determination must be provided within three working days to the provider of record and the patient.[37]

[33] The UMCC requires the timeline for certain request determinations to be extended if an MCO receives an incomplete prior authorization request for a member under age 21. In such cases, the MCO must 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).

[34] 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).

[35] The written notification of a favorable determination made in utilization review must be mailed or electronically transmitted. Tex. Ins. Code § 4201.302; 28 Tex. Admin. Code § 19.1709 (February 20, 2013).

[36] Tex. Ins. Code § 4201.302 (April 1, 2007).

[37] Tex. Ins. Code § 4201.304 (April 1, 2007).

To test the timeliness of prior authorization coverage determinations, the IG Audit Division tested a sample of 83 prior authorization requests.[38] The IG Audit Division reviewed source documents to evaluate the accuracy of computer generated data for each sampled request. The IG Audit Division reviewed fax, phone, and web portal authorization requests to determine prior authorization receipt dates. It also reviewed coverage determination letters and the documented date of approval or denial of requested services in FACETS, which is the utilization management information system Amerigroup uses to process prior authorization request, appeals, and denials. To determine whether Amerigroup 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.[39]

Amerigroup's policy requires a decision and notification within three business days of the receipt of the request and counts the day received as day one. The UMCC and TIC, per the Texas Government Code, do not count the day received (first day) in calculating the period of days.

Table 2 shows the results of the IG Audit Division's testing of the timeliness of Amerigroup's notifications of prior authorization determinations based on criteria from Amerigroup's policy, the UMCC, and TIC. Amerigroup had an 89 percent compliance rate based on its own policy. Based on UMCC requirements, Amerigroup's compliance rate was 96 percent. Based on TIC requirements, Amerigroup had a 92 percent compliance rate.

Table 2: Prior Authorization Testing Results for All Criteria

Criteria	In Compliance	Not in Compliance	Total Tested	Non-compliance Rate
Amerigroup Policy	74	9	83	11%
UMCC	80	3	83	4%
TIC	76	7	83	8%

Source: IG Audit Division

Table 3 shows more detailed results of the timeliness of Amerigroup's notifications of prior authorization determinations. Based on TIC requirements, Amerigroup

[38] A sample of 93 prior authorizations was selected for testing. However, ten prior authorizations were not included in the results because the sample items were (a) not a true prior authorization, (b) not within scope, or (c) were subject to the process for incomplete prior authorization requests for members under age 21, which has different timeliness requirements.

[39] 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. 3 Tex. Gov. Code § 311.014 (September 1, 1985).

had a 90 percent compliance rate for timeliness of favorable determinations and processed all adverse determinations tested timely.

Table 3: Prior Authorization Testing Results under TIC Criteria

TIC Determination	In Compliance	Not in Compliance	Total Tested	Non-compliance Rate
Favorable	60	7	67	10%
Adverse[40]	16	0	16	0%
Total	76	7	83	8%

Source: IG Audit Division

Amerigroup 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 Amerigroup meet prior authorization notification timeliness requirements.

HHSC Medicaid and CHIP Services Department Management Response

Action Plan

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

The Medicaid and CHIP Services Department expects Amerigroup to take immediate corrective action under the CAP and will allow Amerigroup 90 calendar days to implement all actions within the CAP. The Medicaid and CHIP Services Department will require Amerigroup 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

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

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, 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 Manager

Director, Health Plan Management

Director, Utilization Review

Director, Policy and Program Development

Target Implementation Date

September 2017 – Implementation of Amerigroup's corrective actions

March 2018 – Revisions to UMCC (if needed)

Issue 2: Electronic Prior Authorization Data Was Not Reliable for Measuring Timeliness

The FACETS system, used by Amerigroup to process prior authorization requests, contained data entry errors for (a) prior authorization received dates and (b) prior authorization determination dates. The IG Audit Division determined that the data extract for prior authorizations it initially received was incomplete because the initial prior authorization data extract did not contain prior authorization determination dates. As a result, Amerigroup provided a second data extract of prior authorizations.

FACETS listed 1,841 of 85,071 (2.2 percent) prior authorization request received 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.[41] The out-of-scope prior authorization received dates included years ranging from 1814 to 2016.

In the second prior authorization data extract, 1,455 of 408,215 (less than one percent) of the prior authorization determination dates preceded the date the initial prior authorization request was received. FACETS also listed 42,234 of 408,215 (10.3 percent) prior authorization request received dates that were expected to fall within the audit scope period, but instead were listed either (a) before September 1, 2013, or (b) more than 15 calendar days after August 31, 2015. The out-of-scope prior authorization received dates and prior authorization determination dates included years ranging from 1813 to 2016, and 2005 to 2016, respectively, suggesting that errors were made when staff entered dates into the system.

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.[42] The management information system must have the capacity and capability to capture and utilize various data elements required for MCO administration. FACETS did not have data input and edit checks in place to help ensure prior authorization request received dates and prior authorization determination dates were accurate.

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

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[41] 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).

[42] 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).

Recommendation 2

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

HHSC Medicaid and CHIP Services Department Management Response

Action Plan

The Medicaid and CHIP Services Department agrees with the recommendation. The Department will allow Amerigroup 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 FACETS 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 Amerigroup to take immediate corrective action under the CAP and will allow Amerigroup 90 calendar days to implement all actions within the CAP. The Medicaid and CHIP Services Department will require Amerigroup to submit monthly updates detailing the status of each milestone.

Responsible Manager

Director, Health Plan Management

Director, Utilization Review

Target Implementation Date

September 2017

Issue 3: Amerigroup 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.[43] The purpose of the training is to prevent denial of coverage in violation of TIC[44] and to avoid confusing medical benefits with mental health benefits.[45]

The IG Audit Division tested a sample of personnel files for 36 employees[46] and 3 contractors involved in the prospective utilization review process who were employed during state fiscal years 2014 or 2015, and determined that 37 personnel were required to take the training.[47] Of those 37 personnel, 11 (30 percent) had received acquired brain injury training. Amerigroup was unable to provide evidence that the remaining 26 personnel (70 percent) received required training. [48]

Based on the results from testing records from calendar years 2014 and 2015, Amerigroup did not have a process in place to ensure that all personnel who are responsible for prospective medical necessity determinations received the required training. Allowing Amerigroup 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 3

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require Amerigroup to implement a process to ensure that all personnel involved in prospective utilization review receive acquired brain injury training, and any other required Texas Medicaid trainings.

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[43] Tex. Ins. Code § 1352.004 (September 1, 2007).

[44] 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. Tex. Ins. Code § 1352.003 (September 1, 2013).

[45] 28 Tex. Admin. Code § 19.1706 (February 20, 2013).

[46] The 36 employees sampled included a program director, a chief medical director, 12 Amerigroup physician reviewers, 3 contracted physician reviewers, 10 Amerigroup nurse reviewers, and 12 National Customer Care nurse reviewers. National Customer Care is a call center with physical locations in Florida, Tennessee, and Virginia. The call center provides utilization management review for health plans under Anthem.

[47] The two personnel not required to take the acquired brain injury treatment training were upper management who did not directly perform utilization reviews.

[48] The 26 personnel that did not receive acquired brain injury training included 11 employee physicians, 3 contractor physicians, and 12 National Customer Care nurse reviewers.

HHSC Medicaid and CHIP Services Department Management Response

Action Plan

The Medicaid and CHIP Services Department agrees with the recommendation. The Department will allow Amerigroup ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that identifies the specific steps Amerigroup 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 Amerigroup to take immediate corrective action under the CAP and will allow Amerigroup 90 calendar days to implement all actions within the CAP. The Medicaid and CHIP Services Department will require Amerigroup to submit monthly updates detailing the status of each milestone.

Responsible Manager

Director, Health Plan Management

Director, Utilization Review

Target Implementation Date

September 2017

CONCLUSION

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

Based on the results of this audit, the IG Audit Division determined that Amerigroup:

- Had a utilization management program description, and policies and processes related to prior authorizations and appeals that met requirements.
- Ensured that "not a covered benefit" prior authorizations were appropriately denied.
- Processed appeals within required timeframes.
- Included all the required notification elements on prior authorization adverse determination and appeal resolution letters.
- Ensured that a physician not involved in the prior authorization adverse determination reviewed the appeal requests for all the appeals tested.
- 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 a more restrictive criteria for timeliness of prior authorization notifications than UMCC and TIC requires.
- Did not always process prior authorizations timely.
- Did not ensure the reliability of prior authorization data in its processing system.
- Did not ensure all required utilization management personnel received required training.

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

- Improve the accuracy of Amerigroup's prior authorization data and provide a more reliable basis for analyzing and making recommendations regarding utilization management.
- Reduce the number of untimely notifications of Amerigroup's approval or denial of a prior authorization request for health care services.
- Increase utilization management personnel knowledge of issues related to acquired brain injury to help ensure appropriate determinations of medical necessity.

The IG Audit Division thanks management and staff at HHSC Medicaid and CHIP Services Department and at Amerigroup 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 Amerigroup'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 Amerigroup'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 Amerigroup 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 Amerigroup on March 17, 2016, and conducted site visits in May 2016 and September 2016 at Amerigroup's facility in Grand Prairie, Texas. While on-site, the IG Audit Division interviewed relevant personnel, observed a demonstration of Amerigroup'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:

- Amerigroup utilization management policies and procedures
- Amerigroup 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) observing a demonstration of the prior authorization and appeal data entry process, (b) interviewing Amerigroup employees knowledgeable about the data, and (c) reviewing source documents.

The IG Audit Division determined that appeal data was sufficiently reliable for the purposes of this audit. However, the population of prior authorization data was not sufficiently reliable to test and analyze because of errors in the prior authorization received date and prior authorization determination date fields. 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.

Auditing Standard

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[49] sample of 82 prior authorizations stratified[50] by years (2014 and 2015) and Medicaid programs (STAR and STAR+PLUS), and also judgmentally[51] selected 11 prior authorizations for testing.[52] The sample was derived from two data extracts of the prior authorization population, because the original population was incomplete. 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 30 prior authorizations denied for not being a covered benefit from 2014 and 2015 to determine if the denial was appropriate. The Code of Federal Regulations[53] 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 a sample of 35 appeals that comprised 30 random and 5 judgmentally selected appeals. The random sample was stratified by years (2014 and 2015) and Medicaid programs (STAR and STAR+PLUS).

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

[50] 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.

[51] 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.

[52] A sample of 93 prior authorizations was selected for testing. However, 10 prior authorizations were not included in the results because the sample items were (a) not a true prior authorization, (b) not within scope, or (c) were subject to the process for incomplete prior authorization requests for members under age 21, which has different timeliness requirements.

[53] 42 C.F.R §438.210 (October 1, 2009).

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

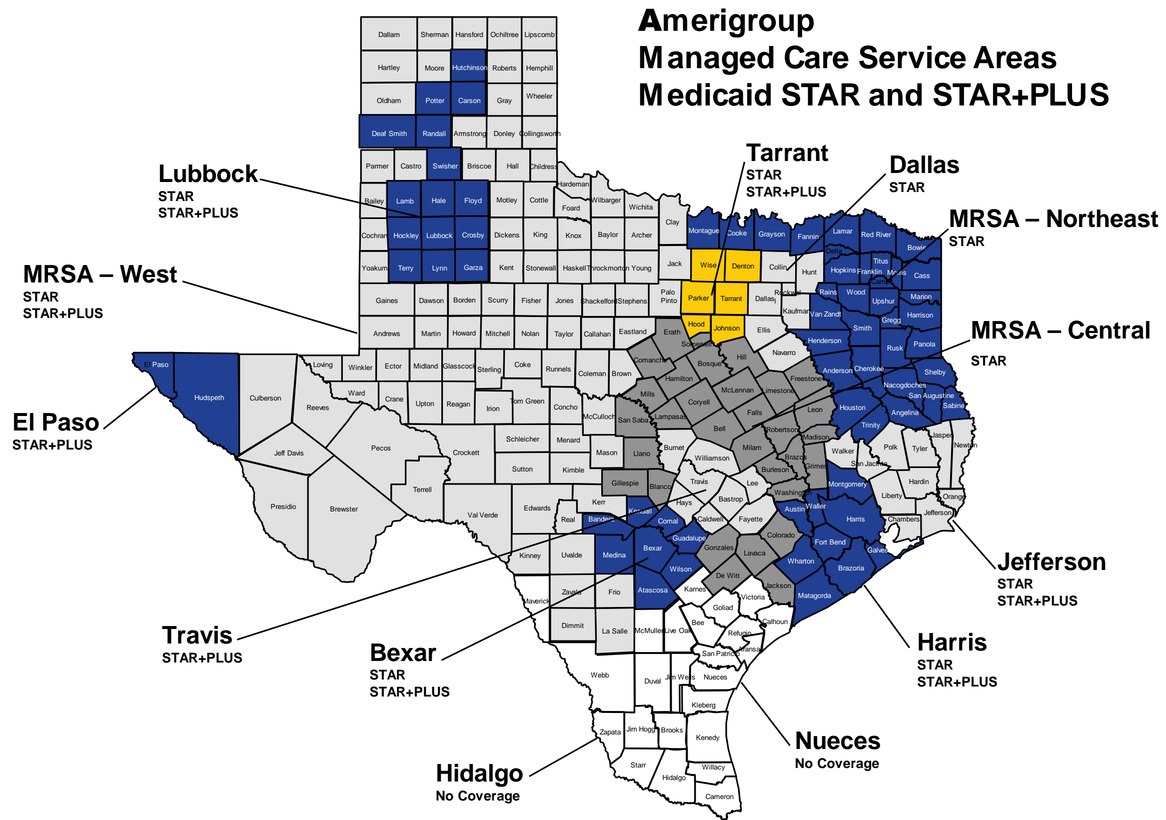
Qualified Personnel

The IG Audit Division tested a sample of 39 Amerigroup utilization management staff involved in prospective reviews to determine whether they were:

- Qualified for their positions
- Currently licensed
- Trained in acquired brain injury treatment[54]
- Assessed on inter-rater reliability

[54] Amerigroup's utilization management staff are specifically required to be trained in the treatment of acquired brain injury.

Appendix C: Amerigroup Texas, Inc. Service Areas



Appendix D: Report Team and 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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- Karin Hill, Director of Internal Audit

Amerigroup Texas, Inc.

- Tisch Scott, President
- Brandon Charles, Regional Vice President, Medical Director
- Laura Finnell, Texas Health Plan Compliance Officer

Appendix E: IG Mission and Contact Information

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:

- Sylvia Hernandez Kauffman, Principal Deputy Inspector General
- Christine Maldonado, Chief of Staff and Deputy IG for Operations
- Olga Rodriguez, Senior Advisor and Director of Policy and Publications
- Roland Luna, Deputy IG for Investigations
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections
- Alan Scantlen, Deputy IG for Data and Technology
- Deborah Weems, Deputy IG for Medical Services
- Anita D'Souza, Chief Counsel

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- Mail: Texas Health and Human Services Commission
  Inspector General
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