OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ACUTE CARE UTILIZATION MANAGEMENT IN MANAGED CARE ORGANIZATIONS

Informational Report

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HHSC IG
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
INSPECTOR GENERAL

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WHY IG IS CONDUCTING THIS AUDIT

At approximately $27 billion a year, the Medicaid and CHIP programs constitute over 27 percent of the total Texas budget. Approximately 84 percent of individuals enrolled in Medicaid or CHIP are members of a managed care organization (MCO).

MCOs are required to perform utilization management functions, through which MCOs review provider requests for members' current and future medical needs. MCOs also review previously provided services for medical necessity, appropriateness, timeliness, effectiveness, and compliance with state and federal requirements.

Effective utilization management is essential to ensuring that members receive applicable health care services, and that state and federal funds spent on managed care are used appropriately.

The IG Audit Division is conducting a performance audit 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.

THIS INFORMATIONAL REPORT

This informational report, which is not an audit report under generally accepted government auditing standards, contains the IG Audit Division's compilation and analysis of non-audited information submitted by MCOs and non-audited information from other sources.

View **IG-16-060**
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WHAT IG FOUND

Through utilization management, MCOs assess the medical necessity, efficiency, and appropriateness of health care services and treatment plans on a prospective, concurrent, or retrospective basis. MCOs apply either regulatory or contract criteria to determine certain utilization management policies, but refer to a variety of evidence-based criteria to develop their utilization management guidelines. MCOs also apply different organizational structures for implementing utilization management activities.

MCOs perform prospective utilization reviews before recommended health care services are provided. Prospective utilization reviews include practices such as pre-certification, pre-admission screenings, and prior authorization of certain medical services. Prior authorization is a common prospective utilization management technique used by MCOs to verify covered benefits, determine medical necessity, and assist with the monitoring and approval of health care service requests. MCOs approved over 90 percent of all prior authorization requests, including acute care services and long-term care services.

On average, nine percent of prior authorization requests are denied. Most MCOs reported that acute care prior authorizations are denied because the requested service did not meet criteria, was not a covered benefit, or lacked the clinical information required to determine medical necessity. Eight percent of those denials are appealed, and over a third of those appeals are reversed.

MCOs varied in the percentages of prior authorization requests denied and appealed, but the widest variance MCOs reported was related to reversals on appeal of denied prior authorization requests. On average, 42 percent of appealed prior authorization denials are reversed. MCO reversals of appealed prior authorization denials ranged from as low as 5 percent to more than 80 percent.

Concurrent utilization reviews evaluate ongoing health care or requests for an extension of treatment beyond previously approved health care. Retrospective utilization reviews evaluate health care services that have already been provided to a member and have not been reviewed for medical necessity. Several MCOs identified areas for improvement through review and analysis of utilization management data. MCOs monitored program effectiveness including (a) conducting an annual evaluation of the utilization management program and work plan, (b) analyzing utilization management data and statistics, (c) monitoring provider utilization through provider profile reports, and (d) surveying member and provider satisfaction.

The IG Audit Division will publish audit 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 will cover state fiscal years 2014 and 2015, which includes September 2013 through August 2015. This informational report provides background, data, IG Audit Division's initial observations of utilization management infrastructure and activities, and provides context for upcoming audit reports the IG Audit Division will issue as the audit proceeds.

The audit is in the fieldwork phase, which began in early March 2016. During audit planning, the IG Audit Division requested information from the MCOs[1] about their utilization management functions. MCOs responded to the request for information, and while the IG Audit Division has not performed audit test work to validate the information the MCOs provided, the IG Audit Division is reporting a compilation of that information in this informational report.

Background

Contracted 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. The contracts[2] require MCOs to perform utilization management functions, which MCOs use to review (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. MCOs may contract with an outside organization to perform all or part of the activities associated with utilization management.

Texas Health and Human Services (HHS) agencies administer public health programs for the State of Texas. Within HHS, the HHSC Medicaid/CHIP Division oversees Medicaid and CHIP and contracts directly with the 19 MCOs included in this report.

Medicaid and CHIP are jointly funded state-federal programs that provide medical coverage to eligible individuals. Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, people age 65 and older, and adults and

[1] MCOs refer 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.

[2] HHSC Uniform Managed Care Contract.

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, or with a disability requiring long-term health care services. CHIP provides health coverage to low-income, uninsured children in families with incomes too high to qualify for Medicaid. In federal fiscal year 2013, Texas spent $26.8 billion on Medicaid and CHIP. This represented 27 percent of the entire 2013 Texas state budget.[3]

Medicaid and CHIP program health care services include medical, dental, prescription drug, disability, behavioral health, and long-term support services. In 2013, there were approximately 4.3 million individuals enrolled in Medicaid or CHIP.[4] One hundred percent of CHIP enrollees were in managed care, and collectively, approximately 84 percent of the combined Medicaid and CHIP populations (3.6 million individuals) were enrolled in managed care.[5] Under managed care, the MCO receives a monthly premium, also called a capitation payment, for each managed care 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.

Planned Audit Reports

The IG Audit Division will publish four audit reports during its audit of acute care utilization management as it completes audit testing and validation for selected MCOs. Later this year, the IG Audit Division plans to issue a final report summarizing results from all of the site visits it conducts at selected MCOs. These audit reports will follow generally accepted government auditing standards issued by the Comptroller General of the United States.

This Informational Report

This informational report, which is not an audit report under generally accepted government auditing standards, contains the IG Audit Division's compilation and analysis of non-audited information submitted by MCOs and non-audited information from other sources.

[3] 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.

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

[5] 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.

Throughout this informational report, MCOs are referenced by abbreviated names. Appendix B contains each MCO's full company name and the associated abbreviations used in this report. Unless otherwise described, any year that is referenced is the state fiscal year, which covers the period from September 1 through August 31.

DATA AND OBSERVATIONS

Section 1: MCOs VARY IN THE POLICIES AND ORGANIZATIONAL STRUCTURES APPLIED TO UTILIZATION MANAGEMENT

Utilization management assesses the medical necessity, efficiency, and appropriateness of health care services and treatment plans on a prospective, concurrent, or retrospective basis. In practice, utilization management is a process of integrating review and case management of health care services in a cooperative effort with other parties including patients, employers, and providers. Administratively, the utilization management function requires policies, procedures, and organizational structures for executing utilization management strategies that comply with state and federal regulations. HHSC does not mandate a specific approach for MCOs to develop utilization management policies or organizational structures. Instead, MCOs are given the latitude to determine how they will comply with minimum requirements provided by state and federal agencies. MCOs use a variety of sources to develop their policies, and apply different organizational structures for implementing utilization management activities.

MCOs Rely on Regulatory and Contract Sources to Determine and Define Medical Necessity, Acute Care, and Covered Services

MCOs consistently cited Texas Administrative Code (TAC) and the Uniform Managed Care Contract as their primary sources for determining and defining their policies on medical necessity, acute care, and covered services.

TAC defines medical necessity as health services that are reasonable and necessary to (a) prevent illnesses or medical conditions and (b) treat conditions that cause suffering, pain, or physical deformity; limit function; or endanger life.[6]

TAC defines acute care as, "preventive care, primary care, and other medical or behavioral health care provided by the provider or under the direction of a provider for a condition having a relatively short duration."[7] Acute care may cover services such as ambulance services,

[6] Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter A, § 353.2(60) (September 1, 2014).

[7] Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter A, § 353.2(2) (September 1, 2014).

family planning services, or physician services. The current audit of utilization management in MCOs will focus on acute care services as opposed to long-term services and supports.[8]

The Uniform Managed Care Contract provides a non-exhaustive, high-level list of covered services, and requires MCOs to ensure all Medicaid and CHIP covered services are available to their members.[9] Covered services may not be arbitrarily or inappropriately denied or reduced in amount, duration, or scope.[10]

Most MCOs Use Multiple Sources to Develop Utilization Management Guidelines

MCOs are not required to reference specific criteria to develop their utilization management care guidelines. Guidelines are evidence-based, and provide specific direction and justification for provision of health care services. Guidelines are developed through critical assessments of the latest medical and clinical research, as well as peer reviews and input from experts. Most MCOs use a combination of government, commercial, and proprietary criteria. Based on MCO survey responses, the top five criteria used to inform MCO utilization management care guidelines are MCO Internal Medical Coverage Policies, the Texas Medicaid Provider Procedures Manual, InterQual® Level of Care criteria, MCG,[11] and Federal and State Mandates. Some less frequently reported criteria include state medical association evidence-based criteria, Hayes Technology, and Aetna Clinical Policy Bulletins. MCOs reported a mixture of different criteria with no clear preference or authoritative source among the various guidelines used.

The Majority of MCOs Maintain Internal Utilization Management Functions

Fifteen of 19 MCOs perform utilization management functions using either internal staff or a combination of internal and outsourced utilization management personnel. Figure 1.1 shows the number of MCOs utilizing each type of organizational structure and total gross premiums. Nine MCOs maintain an internal utilization management function, and four MCOs outsource utilization management, while six use a combination of internal and outsourced efforts. MCOs maintaining an internal utilization management function were paid approximately $6.1 billion in gross premiums in 2015. Gross premiums paid to MCOs totaled approximately $16 billion

[8] "Long-term services and supports" provide assistance for persons who are over age 65 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.

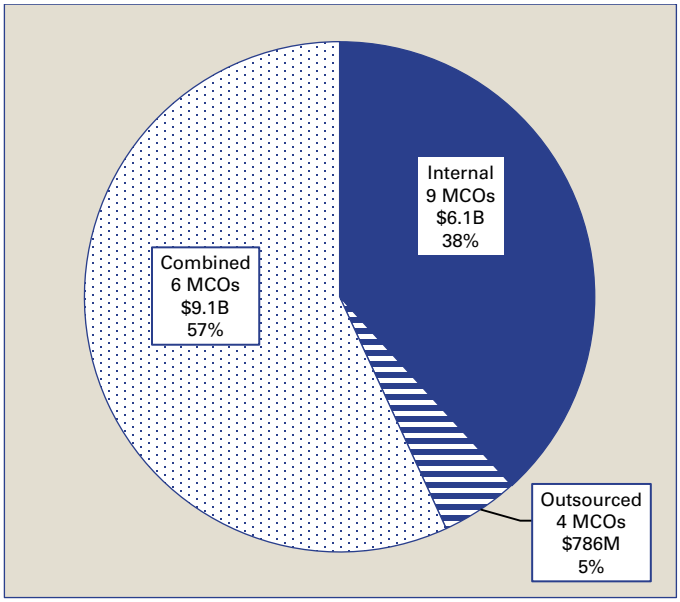
[9] MCOs refer to enrollees as "members." An "enrollee" is an individual who is eligible for Medicaid or CHIP services and is enrolled in an MCO either as a subscriber or a dependent.

[10] Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 438, § 438.210: Coverage and Authorization of Services (October 1, 2009).

[11] "MCG" was previously known as the Milliman Care Guidelines.

in 2015 and were composed of gross capitation[12] and delivery supplemental[13] payments. Ten MCOs, totaling approximately $9.9 billion in gross premiums, fell into either combined or outsourced utilization management structures. Each utilization management organizational structure includes MCOs of varying sizes based on annual gross premiums.

Figure 1.1: Organizational Structure of the Utilization Management Function by Total MCO Gross Premiums for 2015



Source: IG Audit Survey 2015 and HHSC 2015 Year-End 90-day FSR

[12] "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.

[13] 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.

Section 2: MCOs UTILIZE PROSPECTIVE UTILIZATION REVIEW ACTIVITIES TO MONITOR ACUTE CARE SERVICES

There are three primary activities that contribute to effective utilization management: prospective utilization review, concurrent utilization review, and retrospective utilization review. MCOs perform prospective utilization reviews before recommended health care services are provided. Prospective utilization reviews include practices such as pre-certification, pre-admission screenings, and prior authorization of certain medical services. Prior authorization is a common prospective utilization management technique used by MCOs to verify covered benefits, determine medical necessity, and assist with the monitoring and approval of health care service requests. For instance, a prior authorization may include a determination by the MCO that a recommended health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary.

MCOs refer to the Uniform Managed Care Contract to determine Medicaid covered services and minimum requirements. The contract defines the length of time the MCO has to provide a response to prior authorization requests, and prohibits MCOs from requiring prior authorization for emergency services. Beyond contract requirements, each MCO designs its own list of services requiring prior authorization.

MCOs Approve Most Prior Authorization Requests

MCOs approved over 90 percent of all prior authorization requests. Prior authorization requests reported by the MCOs included acute care services and long-term care services. For 2014 and 2015, prior authorization requests totaled 2,425,838. This included 1,152,564 for STAR, 1,124,399 for STAR+PLUS, and 148,875 for CHIP. While MCO responses to the IG Audit Survey included prior authorization requests for acute care and prior authorizations for long-term services, the current audit of utilization management will focus only on acute care services.

The Majority of Prior Authorization Requests Are for Acute Care Services

Prior authorization requests for acute care services accounted for 58 percent[14] of prior authorization requests across all three programs. Table 2.1 shows total prior authorization and acute care prior authorization requests by program type for 2014 and 2015. MCOs reported that prior authorization requests for acute care services represented 81 percent of total prior authorization requests in the STAR program, while CHIP followed at 63 percent, and STAR+PLUS at 34 percent.

[14] This is a weighted average across all programs. All averages referenced in this report are weighted averages.

Table 2.1: Total and Acute Care Prior Authorization (PA) Requests by Program for 2014 and 2015

Program	Total # PA Requests	Total # Acute Care PA Requests	% of Total PA Requests that were for Acute Care
STAR	1,152,564	937,357	81%
STAR+PLUS	1,124,399	382,104	34%
CHIP	148,875	93,909	63%
Totals	2,425,838	1,413,370	58%

Source: IG Audit Survey 2015

Some of the variation in prior authorization percentages reflected in Table 2.1 is related to the demographic differences among the program populations served and the services covered by the specific programs. For instance, STAR provides services for pregnant women, newborns, and children, who require medical care that is considered short-term, acute care services rather than long-term services. CHIP covers children under age 19, and the STAR+PLUS program primarily consists of individuals who are age 65 or older, or have a disability, requiring more long-term health care services. Long-term services include services such as attendant care and adult day health care.

MCOs Cited "Criteria Not Met" as the Most Common Reason for Denial of Acute Care Prior Authorization Requests

Most MCOs reported that acute care prior authorizations were denied either because the requested service did not meet criteria or was not a covered benefit. As reflected in Table 2.2, lack of clinical information required to determine medical necessity was another common MCO response. Table 2.2 lists the top five reasons MCOs cited for denial of acute care prior authorizations.

Table 2.2: Most Common Reasons for MCO Denial of Acute Care Services

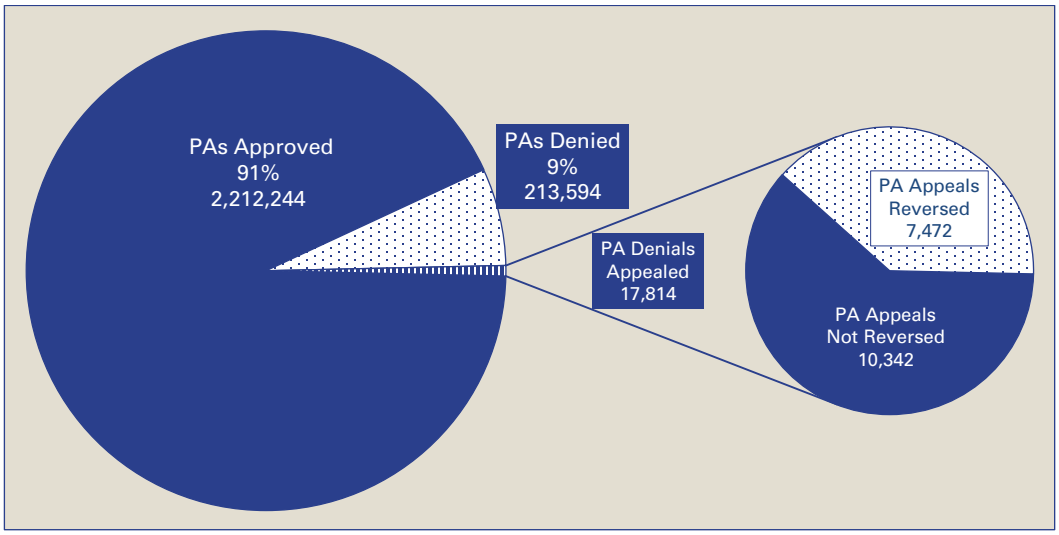
Reason	# of MCOs
1. Criteria not met.	15
2. Not a covered benefit.	14
3. Lack of clinical information to determine medical necessity.	10
4. Lack of timely precertification.	5
5. Authorization was not requested from an in-network provider.	5

Source: IG Audit Survey 2015

Nine Percent of All Prior Authorization Requests are Denied

On average, across all programs, nine percent of prior authorization requests are denied. Eight percent, or 17,814, of those denials are appealed, and over a third of those appeals are reversed. See Figure 2.1 for a breakdown of prior authorization requests denied, appealed, and reversed.

Figure 2.1: Total Prior Authorization Request Approvals, Denials, Appeals, and Reversals for 2014 and 2015

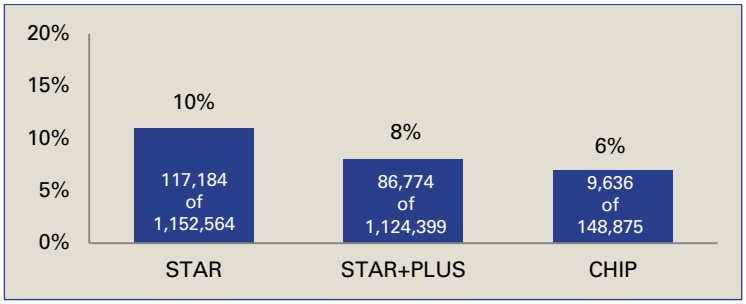


Source: IG Audit Survey 2015

Prior Authorization Request Denial, Appeal, and Reversal Percentages Vary, But Are Similar by Program Type

Percentages of denials, appeals, and reversals of prior authorization requests were similar by program type. Figure 2.2 shows a breakdown of the percentage of denials of total prior authorization requests by program. Prior authorization request denials averaged nine percent, and ranged from six percent for CHIP to ten percent for STAR.

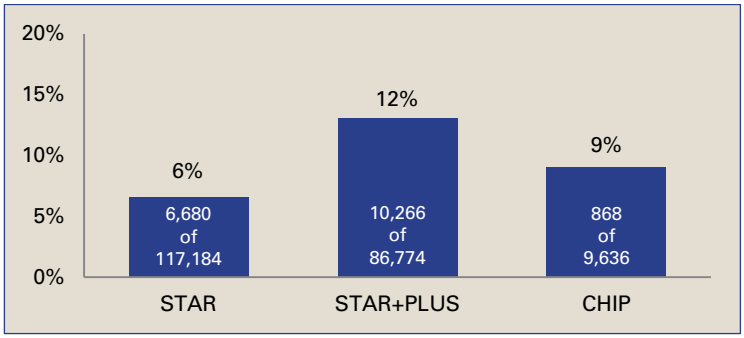
Figure 2.2: Percentage of Denials of Total Prior Authorization Requests by Program Type for 2014 and 2015



Source: IG Audit Survey 2015

Figure 2.3 shows appeals of prior authorization request denials by program. Appeals of prior authorization request denials averaged 9 percent, and ranged from 6 percent for STAR to 12 percent for STAR+PLUS.

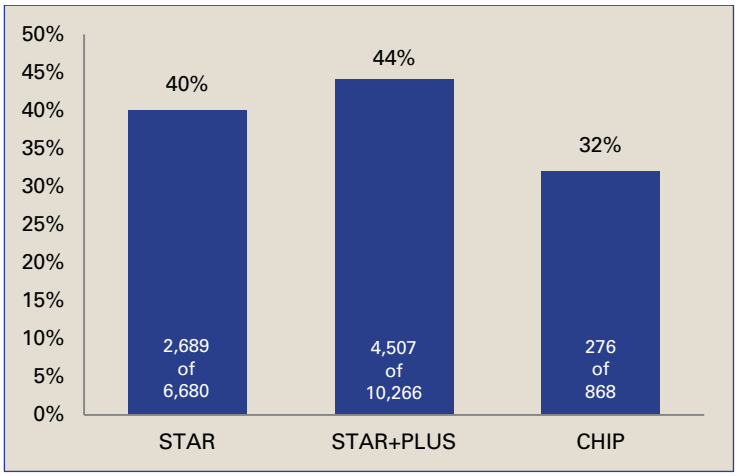
Figure 2.3: Percentage of Appeals of Total Prior Authorization Request Denials by Program Type for 2014 and 2015



Source: IG Audit Survey 2015

Figure 2.4 shows the percentage of reversals[15] of prior authorization appeals by program. Prior authorization request reversals averaged 42 percent, and ranged from 32 percent for CHIP to 44 percent for STAR+PLUS.

Figure 2.4: Percentage of Reversals of Total Prior Authorization Request Appeals by Program Type for 2014 and 2015



Source: IG Audit Survey 2015

[15] Some MCOs use the term "overturn" rather than "reversal."

Prior authorization percentages appealed, denied, and reversed were similar when grouped by program type, but varied significantly by individual MCO.

Most MCOs Report Denial of Prior Authorization Requests of Less than Five Percent

Table 2.3 shows the range of denial percentages for the MCOs. MCOs denied an average of nine percent of prior authorization requests, however, denials ranged from less than one percent by Christus Health Plan and Seton Health Plan to 16 percent by Community Health Choice.

Table 2.3: MCO Denial of Prior Authorization Requests in 2014 and 2015

Percentage of PA Requests Denied	# of MCOs
0% to 5%	9
6% to 10%	7
11% to 15%	2
16% to 20%	1

Source: IG Audit Survey 2015

MCOs Report Appeals of Prior Authorization Denials Ranging from 3 to 30 Percent

When a prior authorization request is denied, an average of eight percent of those denials are appealed. Table 2.4 shows the range of appeal percentages for MCO denials of prior authorization requests. MCO appeals ranged from less than 3 percent for Amerigroup Texas and Driscoll Children's Health Plan, to more than 30 percent for UnitedHealthcare and Parkland Community Health Plan.

Table 2.4: MCO Appeals of Denied Prior Authorization Requests in 2014 and 2015

Percentage of Denied PA Requests Appealed	# of MCOs
0% to 5%	8
6% to 10%	3
11% to 20%	3
21% to 30%	2
31% to 100%	3[16]

Source: IG Audit Survey 2015

[16] Christus Health Plan reported 100 percent. However, this included only one denial which was both appealed and reversed.

Reversals on Appeal of Prior Authorization Denials Varied Widely by MCO with Reports as High as 81 Percent

The widest variance MCOs reported was related to reversals on appeal of denied prior authorization requests. On average, 42 percent of appealed prior authorization denials were reversed. As listed in Table 2.2, common reasons for prior authorization denials include "criteria not met" and a "lack of clinical information required to determine medical necessity." Some reversals may result from the provider submitting sufficient additional information to the MCO during the appeal process. Also, some reversals are not complete reversals and may maintain a partial denial of services. MCO reversals of appealed prior authorization denials ranged from as low as five percent by Superior HealthPlan to more than 80 percent by Parkland Health Plan. Table 2.5 shows the range of reversals on appeal of denied prior authorization requests.

Table 2.5: MCO Reversals on Appeal of Prior Authorization Denials in 2014 and 2015

Reversal % of Appealed PA Requests	# of MCOs
0% to 20%	2
21% to 40%	8
41% to 60%	3
61% to 80%	4
81% to 100%	2[17]

Source: IG Audit Survey 2015

[17] Christus Health Plan reported 100 percent. However, this included only one denial which was both appealed and reversed.

Section 3: MCOs PERFORM UTILIZATION MANAGEMENT ANALYSIS ACTIVITIES TO EVALUATE ACUTE CARE SERVICES

Texas Administrative Code requires MCOs to perform concurrent and retrospective utilization review to determine whether health care services are, or were, medically necessary, efficient, and appropriate.[18] Concurrent utilization review is a form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care. Concurrent utilization review is usually conducted during a hospital confinement to determine the medical necessity for continued hospitalization. Retrospective utilization review is used to evaluate health care services that have already been provided to a member and have not been reviewed for medical necessity. Retrospective utilization review does not include a review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.[19]

In addition to prospective, concurrent, and retrospective utilization review, most MCOs reported performing analysis on utilization management data to identify opportunities for improvement to the overall program. Most MCOs indicated that the utilization management function interfaced with other MCO business areas to perform analysis of utilization management data. The business areas most often referenced as providing this data analysis were the Quality Improvement Committee, Quality Improvement Department, Quality Management, Provider Advisory Committee, Medical Management Committee, and Special Investigative Unit.

MCOs Identify Program Improvements through Analysis of Utilization Management Data

Several MCOs identified areas for improvement through review and analysis of utilization management data. For example, two MCOs implemented or enhanced their peer-to-peer review[20] process, which allows a provider to discuss a case with the MCO medical director. One MCO eliminated the need for prior authorization for several services, because the MCO determined that almost all of the prior authorization requests in those service categories were medically necessary, leaving no return-on-investment for requiring prior authorization for these services. Removing the prior authorization requirement reduced an administrative burden for providers, and eliminated a barrier to timely provision of services.

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

[19] Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1703(29) (February 20, 2013).

[20] "Peer-to-peer review" gives a treating provider the opportunity to discuss a patient's plan of treatment with a physician during utilization review. This peer-to-peer review process occurs prior to MCO issuance of a denial or adverse determination regarding a request for health care services.

One MCO is working to streamline the prior authorization process for services that have straightforward criteria and are commonly requested through the use of online "auto-authorization"[21]. This improvement is designed to speed up the time-to-determination, enabling providers to get a quick answer to move ahead with member treatment plans.

One MCO noted that analysis of utilization management data prompted the provision of system-wide education for providers on various topics, implementation of claims edits to close payment loopholes, and the discovery of system configuration issues.

MCOs Monitor Program Effectiveness through Analysis of Utilization Management Data

MCOs reported using utilization management data to monitor program effectiveness including (a) conducting an annual evaluation of the utilization management program and work plan, (b) analyzing utilization management data and statistics, (c) monitoring provider utilization through provider profile reports, and (d) surveying member and provider satisfaction.

MCOs used the annual evaluation process to further assess the effectiveness of their respective utilization management program and work plan. The results of an annual evaluation are sometimes submitted for review and approval by MCO internal committees. An annual evaluation may entail (a) review of utilization management goals, objectives, and activities; (b) comparison of clinical and service outcomes against program objectives; (c) review of demonstrated improvements in quality of access, care, and service; and (d) potential recommendations for the upcoming year.

MCOs also analyze utilization management data and statistics to identify patterns, service variances, and areas of concern in health plan performance. MCOs differ in the utilization management data they analyze, but some examples include: emergency room utilization, inpatient acute care utilization, frequency of selected procedures, claims reports, member complaints and appeals, HEDIS[22] findings, and key clinical indicators for high risk conditions and populations.

MCOs reported monitoring provider utilization practices through provider profiling, and varied in the frequency of conducting provider profiling. For example, an MCO may utilize provider profiling to (a) identify provider utilization patterns that vary significantly from peer network provider groups, (b) identify trends that can be addressed through provider outreach, and (c) provide information to network providers about their specific practice patterns.

[21] "Auto-authorization" is an online tool that providers can use to request services, find answers to criteria questions, and obtain approval authorizations immediately.

[22] "HEDIS" (Healthcare Effectiveness Data and Information Set) measures are performance measures used by health plans to measure performance on various dimensions of care and service.

Finally, MCOs review survey results from member and provider satisfaction surveys to discover areas that are working well, and to identify opportunities for improvement. Member surveys may include, but are not limited to, questions related to practitioners, utilization, quality of care, quality of service, quality of member services, requests to change practitioners, requests to change sites, cultural competency, and availability and accessibility of healthcare services. Provider surveys may include, but are not limited to, questions related to provider satisfaction with MCO utilization management policies and procedures, claims processing, and MCO responses to inquiries, complaints, and appeals.

CONCLUSION

The IG Audit Division completed a review of MCO responses to the IG Request for Information and Audit Survey. Based on self-reported information from 19 MCOs regarding their approach to utilization management, the IG Audit Division found that MCOs:

- Consistently apply either regulatory or contract criteria to determine certain utilization management policies, but refer to a variety of evidence-based criteria to develop their utilization management guidelines.
- Are fairly evenly divided as to whether their utilization management function is internal, outsourced, or a combined internal and outsourced effort.
- Approved over 90 percent of all prior authorization requests.
- Varied in their prior authorization request appeal, denial, and reversal percentages.
- Varied the most in reversal percentages of prior authorization request appeals that ranged from less than five percent to as high as 81 percent.
- Identified and implemented program improvements through analysis of utilization management data.

The IG Audit Division plans to further examine information related to the areas listed above during audit fieldwork at selected MCOs. During audit planning, the IG Audit Division assessed risk areas related to utilization management policies and activities to determine which risks should be further evaluated and tested during audit fieldwork. In March 2016, the IG Audit Division issued an Engagement Memo detailing the audit scope and objective; and indicating the start of audit fieldwork at selected MCOs. Fieldwork will include:

- Reviewing MCO policies, procedures, and processes governing utilization management practices and compliance with state and federal requirements.
- Evaluating prior authorization standards written, developed, and implemented.
- Assessing for underutilization or inappropriate utilization of health care services by reviewing prior authorization data.
- Ensuring the timeliness of the prior authorization process, including denials and appeals, and the timeliness of health care service administration.
- Evaluating utilization monitoring, analysis, and reporting.

Appendix A: OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the audit is to evaluate the effectiveness of MCO acute care utilization management practices at selected managed care organizations in ensuring that health care services provided are (a) medically necessary, (b) efficient, and (c) comply with state and federal requirements.

Scope

The scope of this summary of utilization management information is MCO self-reported data. This informational report, as well as the ongoing performance audit of acute care utilization management in Texas Medicaid and CHIP MCOs, covers the period from September 1, 2013 through August 31, 2015.

Methodology

The IG Audit Division distributed a Request for Information and IG Audit Survey to 19 MCO health plans serving Medicaid and CHIP enrollees in Texas. The IG Audit Division collected documentary evidence about each MCO including:

- Utilization management organizational charts.
- Policies and practices associated with utilization management and related health service activities.
- Data related to utilization management in 2014 and 2015.

The IG Audit Division supplemented the information received in response to the Request for Information and IG Audit Survey with documentation MCOs previously submitted to the IG and to the HHSC Medicaid/CHIP Division. The IG Audit Division also conducted discussions and interviews with responsible management at the HHSC Medicaid/CHIP Division.

The IG Audit Division analyzed the reported information to help identify:

- Each MCO's utilization management organizational structure and key activities related to prospective, concurrent, and retrospective utilization reviews.
- Each MCO's outcomes related to prospective utilization review and analysis of utilization management data.
- Areas of strength and potential risks.
- Areas of consistency and variation across the MCOs.
- Activities IG may evaluate further during the fieldwork phase of the audit.

The IG Audit Division used the following criteria to evaluate the information provided:

- MCO Utilization Management Policies and Procedures
- Uniform Managed Care Manual
- Uniform Managed Care Contract
- Texas Administrative Code
- Texas Insurance Code
- Texas Government Code

IG is conducting the ongoing performance audit in accordance with generally accepted government auditing standards (GAGAS) issued by the Comptroller General of the United States. This informational report was not produced in accordance with GAGAS, as it is not an audit report, but rather a summary of information provided by MCOs and compiled by the IG Audit Division. The information reported by the MCOs has not been validated, but is sufficient for satisfying the objective of this informational report to provide background, data, and IG Audit Division initial observations on MCO utilization management activities in Texas. Once the IG Audit Division has collected further information and performed audit testing, evidence gathering, and other audit procedures required for data validation and compliance with GAGAS, the IG Audit Division will communicate detailed findings in subsequent audit reports.

Appendix B: MCO NAMES AND ABBREVIATIONS

Abbreviations		MCO Name
Aetna	AE	Aetna Better Health of Texas, Inc.
Amerigroup	AM	Amerigroup Texas, Inc.
Blue Cross	BCBS	Blue Cross and Blue Shield of Texas
Christus	CHHP	Christus Health Plan
Cigna	CIH	Cigna-Healthspring
Community First	CF	Community First Health Plans
Community Health	CHC	Community Health Choice
Cook	CCHP	Cook Children's Health Plan
Driscoll	DCHP	Driscoll Children's Health Plan
El Paso	EPFHP	El Paso First Health Plans, Inc.
FirstCare	FCHP	FirstCare Health Plans
Molina	MHT	Molina Healthcare of Texas, Inc.
Parkland	PHP	Parkland Community Health Plan, Inc.
Scott and White	SWHP	Scott and White Health Plan
Sendero	SEN	Sendero Health Plans, Inc.
Seton	SET	Seton Health Plan, Inc.
Superior	SUP	Superior HealthPlan, Inc.
Texas Children's	TCHP	Texas Children's Health Plan, Inc.
UnitedHealthcare	UHC	UnitedHealthcare Community Plan of Texas, L.L.C.

Appendix C: FIGURE AND TABLE DETAIL

Figure 1.1 Detail

Organizational Structure of the Utilization Management Function by Total MCO Gross Premiums for 2015

MCO Name	# of Medicaid and CHIP enrollees *(monthly average[23])*	Organizational Structure	Gross Premiums *(Millions)*
Sendero	14,333	Internal	$ 40.7
El Paso	75,288	Internal	$ 178.9
Aetna	83,135	Internal	$ 226.8
Community First	127,620	Internal	$ 320.3
Driscoll	140,550	Internal	$ 426.0
Cigna	48,938	Internal	$ 713.7
Community Health	263,305	Internal	$ 744.7
Molina	239,566	Internal	$ 1,575.9
UnitedHealthcare	238,940	Internal	$ 1,886.7
Christus	7,627	Combined	$ 19.5
FirstCare	99,445	Combined	$ 274.0
Cook	121,223	Combined	$ 323.6
Texas Children's	391,404	Combined	$ 944.1
Amerigroup	771,516	Combined	$ 3,231.6
Superior	957,573	Combined	$ 4,301.7
Seton	25,555	Outsourced	$ 51.8
Blue Cross	29,475	Outsourced	$ 81.4
Scott and White	41,547	Outsourced	$ 118.9
Parkland	210,422	Outsourced	$ 534.0
Total	3,887,462		$ 15,994.3

[23] This is the average monthly number of MCO members in Medicaid and CHIP managed care for these 19 MCOs in 2015.

Table 2.1 Detail by MCO

Total and Acute Care Prior Authorization Requests for 2014 and 2015

MCO Name	Total # PA Requests	Total # Acute Care PA Requests	% of PA Requests that were for Acute Care
Aetna	27,971	27,971	100%
Amerigroup	643,081	215,152	33%
Blue Cross	29,178	3,343	11%
Christus	874	382	44%
Cigna	115,270	54,256	47%
Community First	50,032	43,916	88%
Community Health	87,955	83,850	95%
Cook	11,440	11,440	100%
Driscoll	124,971	124,971	100%
El Paso	67,457	67,457	100%
FirstCare	30,460	9,368	31%
Molina	162,368	50,507	31%
Parkland	60,662	60,662	100%
Scott and White	31,006	31,006	100%
Sendero	9,618	9,618	100%
Seton	25,671	5,240	20%
Superior	570,374	364,873	64%
Texas Children's	96,522	96,522	100%
UnitedHealthcare	280,928	152,836	54%
Total	2,425,838	1,413,370	58%

Table 2.1 Detail by MCO and Program

Total and Acute Care Prior Authorization Requests for 2014 and 2015

MCO Name	Total PA Requests STAR	Total Acute Care PA Requests STAR	Total PA Requests STAR+ PLUS	Total Acute Care PA Requests STAR+ PLUS	Total PA Requests CHIP	Total Acute Care PA Requests CHIP
Aetna	25,170	25,170	-	-	2,801	2,801
Amerigroup	245,469	120,401	367,571	86,778	30,041	7,973
Blue Cross	25,098	3,114	-	-	4,080	229
Christus	787	369	-	-	87	13
Cigna	-	-	115,270	54,256	-	-
Community First	44,474	38,635	-	-	5,558	5,281
Community Health	82,305	82,305	-	-	5,650	1,545
Cook	9,291	9,291	-	-	2,149	2,149
Driscoll	118,667	118,667	-	-	6,304	6,304
El Paso	59,601	59,601	-	-	7,856	7,856
FirstCare	29,379	9,117	-	-	1,081	251
Molina	45,765	17,720	100,448	30,468	16,155	2,319
Parkland	51,430	51,430	-	-	9,232	9,232
Scott and White	31,006	31,006	-	-	-	-
Sendero	7,934	7,934	-	-	1,684	1,684
Seton	14,974	4,211	-	-	10,697	1,029
Superior	217,095	217,095	324,901	119,400	28,378	28,378
Texas Children's	82,438	82,438	-	-	14,084	14,084
UnitedHealthcare	61,681	58,853	216,209	91,202	3,038	2,781
Total	1,152,564	937,357	1,124,399	382,104	148,875	93,909

Table 2.2 Detail

Most Common Reasons for MCO Denial of Acute Care Services

Reason	Criteria not met.	Not a covered benefit.	Lack of clinical information to determine medical necessity.	Lack of timely precertification.	Authorization was not requested from an in-network provider.	In-network provider available and willing to care for member.	Denied termination or reduction of care.	Incomplete prior authorization request.	Medical review decision.	Other
Aetna	X		X			X		X		Services denied due to lack of need.
Amerigroup	X	X		X						Other insurance carrier is primary.
Blue Cross	X	X								Agreed to observation.
Christus	X									
Cigna		X	X		X	X				
Community First			X		X					
Community Health	X	X	X		X			X		
Cook	X	X		X		X				
Driscoll	X	X	X	X						
El Paso	X		X						X	Effectiveness and compliance monitored.
FirstCare	X	X								
Molina	X	X					X			Denied benefits limits exceeded.
Parkland	X		X			X		X		Services denied due to lack of need.
Scott and White	X	X		X		X	X			
Sendero	X	X	X		X					
Seton	X	X	X				X			Agreed to observation.
Superior		X		X	X					
Texas Children's	X	X								
UnitedHealthcare		X	X						X	Denied benefits limits exceeded.
Total	15	14	10	5	5	5	3	3	2	

Figure 2.1 Detail

Total Prior Authorization Request Approvals, Denials, Appeals, and Reversals for 2014 and 2015

	TOTALS
Total # PA Requests	2,425,838
Total # Approvals of PA Requests	2,212,244
Approved % of PA Requests	91%
Total # Denials of PA Requests	213,594
Denied % of PA Requests	9%
Total # Appeals of Denied PA Requests	17,814
Appealed % of Denied PA Requests	8%
Total # Reversals of Appealed PA Requests	7,472
Reversal % of Appealed PA Requests	42%

Figure 2.2, 2.3, and 2.4 Detail

Percentage of Total Prior Authorization Request Denials, Appeals, and Reversals by Program Type for 2014 and 2015

	STAR	STAR + PLUS	CHIP
Total # PA Requests	1,152,564	1,124,399	148,875
Total # Denials of PA Requests	117,184	86,774	9,636
Denied % of PA Requests	10%	8%	6%
Total # Appeals of Denied PA Requests	6,680	10,266	868
Appealed % of Denied PA Requests	6%	12%	9%
Total # Reversals of Appealed PA Requests	2,689	4,507	276
Reversal % of Appealed PA Requests	40%	44%	32%

Table 2.3 Detail

MCO Denial of Prior Authorization Requests in 2014 and 2015

MCO Name	Total # PA Requests	Total # Denials of PA Requests	Denied % of PA Requests
Christus	874	1	0.1%
Seton	25,671	209	0.8%
Texas Children's	96,522	1,591	1.7%
Parkland	60,662	1,495	2.5%
Aetna	27,971	952	3.4%
Sendero	9,618	329	3.4%
Scott and White	31,006	1,291	4.2%
El Paso	67,457	3,253	4.8%
Community First	50,032	2,432	4.9%
Cigna	115,270	6,993	6.1%
Superior	570,374	35,422	6.2%
Cook	11,440	785	6.9%
FirstCare	30,460	2,870	9.4%
Driscoll	124,971	11,790	9.4%
UnitedHealthcare	280,928	28,173	10.0%
Blue Cross	29,178	2,993	10.3%
Molina	162,368	17,817	11.0%
Amerigroup	643,081	81,016	12.6%
Community Health	87,955	14,162	16.1%

Table 2.4 Detail

MCO Appeals of Denied Prior Authorization Requests in 2014 and 2015

MCO Name	Total # Denials of PA Requests	Total # Appeals of Denied PA Requests	Appealed % of Denied PA Requests
Amerigroup	81,016	1,828	2.3%
Driscoll	11,790	295	2.5%
Superior	35,442	1,238	3.5%
Scott and White	1,291	47	3.6%
Cigna	6,993	261	3.7%
Cook	785	32	4.1%
Community Health	14,162	600	4.2%
FirstCare	2,870	124	4.3%
Texas Children's	1,591	99	6.2%
Blue Cross	2,993	201	6.7%
El Paso	3,253	323	9.9%
Community First	2,432	288	11.8%
Molina	17,817	2,599	14.6%
Aetna	952	189	19.9%
Seton	209	49	23.4%
Sendero	329	78	23.7%
UnitedHealthcare	28,173	9,012	32.0%
Parkland	1,495	550	36.8%
Christus	1	1	100.0%

Table 2.5 Detail

MCO Reversals on Appeal of Prior Authorization Denials in 2014 and 2015

MCO Name	Total # Appeals of Denied PA Requests	Total # Reversals of Appealed PA Requests	Reversal % of Appealed PA Requests
Superior	1,238	58	4.7%
Seton	49	10	20.4%
Amerigroup	1,828	429	23.5%
Community First	288	84	29.2%
Community Health	600	189	31.5%
Scott and White	47	15	31.9%
Cigna	261	93	35.6%
FirstCare	124	45	36.3%
Molina	2,599	998	38.4%
Driscoll	295	119	40.3%
Blue Cross	201	98	48.8%
UnitedHealthcare	9,012	4428	49.1%
El Paso	323	169	52.3%
Texas Children's	99	66	66.7%
Sendero	78	57	73.1%
Aetna	189	143	75.7%
Cook	32	24	78.1%
Parkland	550	445	80.9%
Christus	1	1	100.0%

Appendix D: REPORT TEAM AND REPORT DISTRIBUTION

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

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- Jennifer Carlisle, RN, Medical Auditor
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Appendix E: IG MISSION AND CONTACT INFORMATION

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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:

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- Sylvia Hernandez Kauffman — Principal Deputy IG
- Christine Maldonado — Chief of Staff and Deputy IG for Operations
- Frank Bryan — Counselor to the IG
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