

# OFFICE OF INSPECTOR GENERAL

## TEXAS HEALTH AND HUMAN SERVICES COMMISSION

### AUDIT OF MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS

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*Superior HealthPlan, Inc. SIU*



August 26, 2016  
IG Report No. IG-16-014



## HHSC IG

TEXAS HEALTH AND HUMAN  
SERVICES COMMISSION

INSPECTOR GENERAL

### WHY THE IG CONDUCTED THIS AUDIT

Superior is one of 22 managed care organizations (MCOs) contracted to provide Medicaid and CHIP health care services in Texas. Approximately 84 percent of Medicaid and CHIP enrollees are members of an MCO. At nearly \$27 billion a year, the Medicaid and CHIP programs constitute over 27 percent of the total Texas budget.

MCOs are required to establish a special investigative unit (SIU) to investigate fraudulent claims and other program waste and abuse by members and service providers. Effective SIUs are essential to support overall MCO cost containment efforts, and to ensure that state and federal funds spent on managed care are used appropriately.

The Texas Health and Human Services Commission is responsible for oversight of MCO contracts. The IG is responsible for approving SIU annual plans, and evaluating and sometimes investigating SIU referrals.

This is one of a series of performance audits to determine how effective selected MCO SIUs are at (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries.

### WHAT THE IG RECOMMENDS

HHSC should require Superior to implement corrective actions to strengthen Superior's SIU fraud, waste, and abuse detection and investigation activities.

View [IG-16-014](#)

For more information, contact:  
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# AUDIT OF MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS

## *Superior HealthPlan, Inc. SIU*

### WHAT THE IG FOUND

Superior HealthPlan, Inc. (Superior) maintains a contractually required annual SIU fraud, waste, and abuse plan. However, Superior needs to improve its SIU function in order to comply with the plan and to detect and investigate fraud, waste, and abuse effectively.

Superior received approximately \$4 billion in Medicaid and CHIP capitation and delivery supplemental payments in 2014, and \$4.3 billion in 2015. Superior paid approximately \$7 billion in medical claims dollars over those two years. During this two-year period, Superior's SIU recovered only \$16,094 in medical claims dollars.

Year	Medical Claims \$	# of SIU Investigations	SIU Recoveries	# of Referrals to IG
2014	\$ 3,288,845,575	239	\$ 9,014	9
2015	\$ 3,751,769,200	215	\$ 7,080	22
Total	\$ 7,040,614,775	454	\$ 16,094	31

Although Superior's annual fraud, waste, and abuse plan outlined the essential activities needed for an effective SIU, Superior's SIU investigation activities were limited in scope. Superior made a business decision not to investigate suspected cases of fraud, waste, or abuse that fell below amounts specified in company policy. In accordance with this policy, Superior closed preliminary and full-scale investigations that fell below these thresholds. As a result, Superior's SIU may not have identified and recovered some overpayments.

Superior's SIU detection activities were also limited. Although Superior performed manual reviews of post-payment claims data and utilized data analytics to perform pre-payment analysis, Superior did not adequately utilize post-payment data analytics to detect fraud, waste, and abuse. By not supplementing the manual review efforts of its SIU investigators with automated post-payment data analytics, Superior was less likely to detect potential cases of fraud, waste, and abuse.

Until Superior increases the scope and effectiveness of its SIU detection and investigation activities, HHSC does not have assurance that Superior is maintaining an effective SIU that successfully recovers losses due to fraud, waste, and abuse.

The HHSC Medicaid/CHIP Division concurred with the IG Audit Division recommendations outlined in this report, and will facilitate Superior's development of a corrective action plan designed to improve Superior's SIU function.

The IG Audit Division will continue to publish reports during its ongoing audit of Medicaid and CHIP SIUs as 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 Medicaid and Children’s Health Insurance Program (CHIP) special investigative units (SIUs). The objective of the audit is to evaluate the effectiveness of managed care organization (MCO) SIU performance in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC. The audit includes state fiscal years 2014 and 2015, which covers the period from September 2013 through August 2015, and includes a review of relevant SIU activities through the end of fieldwork in April 2016.

This audit report is one of a series of reports on MCO SIUs. The first report was an informational report that provided background, context, and a compilation of information provided by the 22 Texas Medicaid and CHIP MCOs.<sup>1</sup> This audit report is focused on SIU activities at SuperiorHealth Plan, Inc. (Superior). The IG Audit Division will continue to release audit reports for selected MCO SIUs as the audit proceeds.

## **Background**

Superior is a licensed Texas MCO contracted to provide Medicaid services through its network of providers. Superior is a subsidiary of Centene Corporation, a multi-national healthcare enterprise. Superior coordinates health services for CHIP members in Bexar, Nueces, El Paso, Lubbock, and Travis counties, and in the CHIP Rural Service Area.<sup>2</sup> Superior coordinates health services for the Medicaid State of Texas Access Reform (STAR) program for members in Bexar, Nueces, El Paso, Hidalgo, Lubbock, and Travis counties and in the Medicaid Rural Service Area (MRSA) Northeast and West regions of Texas. Superior also coordinates health services for the Medicaid State of Texas Access Reform Plus (STAR+PLUS) program for members<sup>3</sup> in Bexar, Nueces, Dallas, Hidalgo, Lubbock, and in the MRSA Central and Northwest regions of Texas. Superior also coordinates health services for the STAR Health program statewide.

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<sup>1</sup> An MCO is an organization that delivers and manages health care services under a risk-based arrangement. The MCO receives a monthly premium or capitation payment for each managed care member enrolled, based on a projection of what health care for the typical individual would cost. 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. In this report, health plans, dental maintenance organizations, and behavioral health organizations are collectively referred to as MCOs.

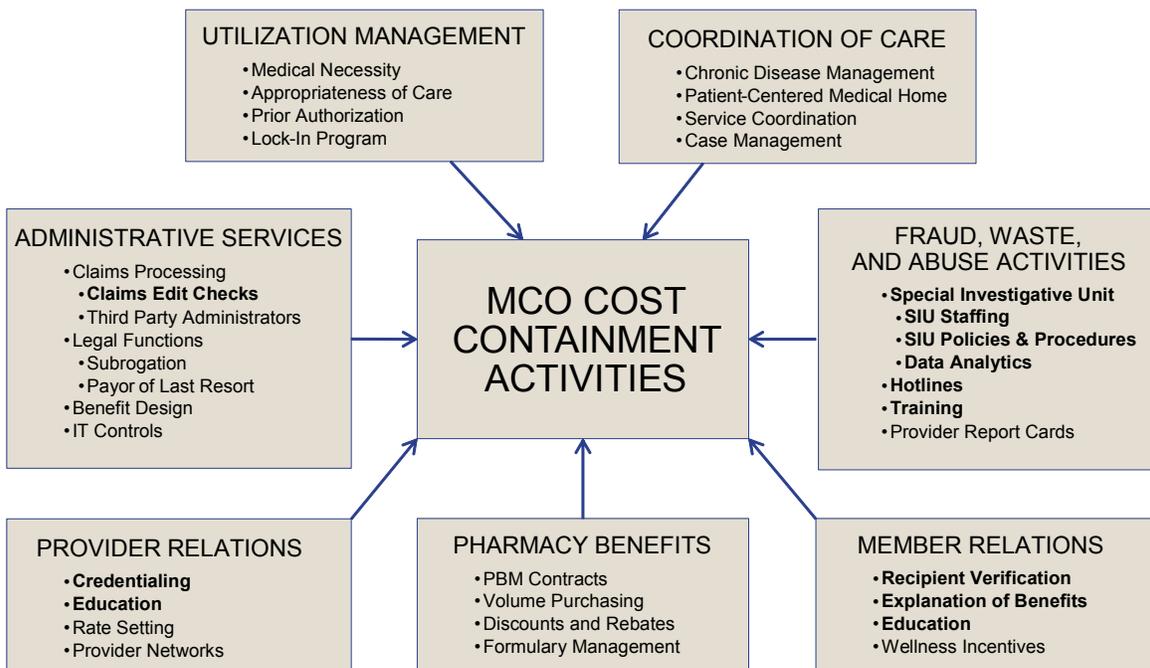
<sup>2</sup> CHIP Rural Service Area includes 170 rural counties in the state.

<sup>3</sup> 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.

Superior is one of 22 contracted MCOs responsible for administering, on behalf of the State of Texas, billions of dollars of Medicaid and CHIP health care services each year through its health plans. By contract, HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, and abuse by members and health care service providers.<sup>4</sup> An MCO may contract with an outside organization to perform all or part of the activities associated with the SIU. Superior utilizes internal staff along with staff from its parent company, Centene Management Company, to perform the SIU function.

SIUs support MCO efforts at cost containment through the prevention and detection of fraud, waste, and abuse. MCOs maintain many functions and activities outside of the SIU to control costs, and SIUs may conduct activities that relate to other business areas of the MCO besides Medicaid and CHIP. As a result, the functional and organizational structure of cost containment activities varies across MCOs. Figure 1 below provides a partial overview of the many types of activities MCOs employ to help reduce costs and impact fraud, waste, and abuse. This information is not meant to represent a complete set of activities, nor does it represent the structure of the business units at Superior or any other specific MCO.

**Figure 1: MCO Functions and Activities Related to Cost Containment**



Source: IG Audit Division

<sup>4</sup> Uniform Managed Care Contract, Special Investigative Units, Section 8.1.19.1, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015); Texas Government Code, Title 4, Subtitle 1, § 531.113 (September 1, 2003). See also Texas Administrative Code Title 1, Part 15, § 353.502 and § 370.502 (March 1, 2012).

The activities bolded in Figure 1 designate some of the areas of focus of this audit. This performance audit evaluated Superior's SIU efforts related to:

- Prevention processes, such as the organizational code of ethics, credentialing and re-credentialing, exclusion verification, and fraud, waste, and abuse training.
- Detection activities, such as complex data analysis, periodic provider audits, intake of fraud referrals, and verification that recipients received billed services.
- Investigation efforts, such as conducting preliminary investigations and SIU case management.
- Disposition of fraud, waste, and abuse investigations, including referrals to the IG, corrective action plans, and monetary recovery.
- Reporting of SIU activities to the IG, including a monthly report of ongoing investigations and annual reporting of SIU recoveries.

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, which are jointly funded state-federal programs that provide medical coverage to eligible individuals. In 2013, there were approximately 4.3 million individuals enrolled in Medicaid or CHIP.<sup>5</sup>

The HHSC Medicaid/CHIP Division is responsible for overall management and monitoring of the contract with Superior. The IG is responsible for approving Superior's annual fraud, waste, and abuse plan,<sup>6</sup> and evaluating and sometimes investigating any fraud referrals it receives from Superior. Superior is required by its contract to refer suspected fraud, waste, and abuse to the IG. When the IG determines it will not pursue an SIU referral, Superior is responsible for recovery of any Medicaid and CHIP overpayments associated with the referral.

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 + PLUS program, Medicaid provides health services for individuals age 65 and 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

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<sup>5</sup> This is the 2013 average monthly number of enrollees in Medicaid and CHIP.

<sup>6</sup> Texas Government Code, Subtitle I, Subchapter C, § 531.113 (September 1, 2003).

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.<sup>7</sup>

Medicaid and CHIP programs deliver health care services (including medical, dental, prescription drug, disability, behavioral health, and long-term support services) to eligible individuals. CHIP provides services to individuals in Texas through a managed care model.<sup>8</sup> Texas Medicaid provides services to some individuals through a traditional fee-for-service model,<sup>9</sup> but most are enrolled through a managed care model. For providing these services, MCOs receive capitation payments, which 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.<sup>10</sup> These payments include federal and state funds.

In 2013, 100 percent of CHIP enrollees were in managed care. Collectively, approximately 84 percent of the combined Medicaid and CHIP populations (3.6 million individuals) were enrolled in managed care.

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

The IG Audit Division presented audit results, issues, and recommendations to the HHSC Medicaid/CHIP Division and to Superior in a draft report dated August 2, 2016. Each was provided with the opportunity to study and comment on the report. HHSC Medicaid/CHIP Division management responses to the recommendations contained in the report are included

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<sup>7</sup> 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.

<sup>8</sup> 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.

<sup>9</sup> 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.

<sup>10</sup> A "risk group" is a group of MCO members that have a similar health status and are expected to have a similar Medicaid or CHIP spending pattern. HHSC applies an acuity risk adjustment to capitation rates to recognize the anticipated cost differential among multiple health plans in a service area due to the variable health status of their respective memberships. Final capitation payments are based on this acuity risk-adjusted premium for each combination of service area and risk group.

in the report following each recommendation. Superior's comments are included in Appendix C. HHSC Medicaid/CHIP Division concurred with the IG Audit Division recommendations, and will facilitate Superior's development of a corrective action plan designed to improve Superior's SIU function.

## ISSUES AND RECOMMENDATIONS

Superior maintains a fraud, waste, and abuse plan; the fundamental contractual and regulatory SIU requirement for MCOs. The plan describes ways Superior can strengthen program integrity by monitoring service providers, auditing claims, identifying overpayments, and educating members and providers. Though the fraud, waste, and abuse plan is in place, Superior needs to improve the function of its SIU in order to effectively implement the plan. During this audit, the IG Audit Division evaluated Superior’s SIU and identified issues related to the:

- Amount of fraud, waste, and abuse recoveries.
- Investigation of cases of suspected fraud, waste, and abuse.
- Use of data analytic techniques to detect fraud, waste, and abuse.

Superior received approximately \$4.0 billion in Medicaid and CHIP capitation and delivery supplemental payments<sup>11</sup> in 2014, and \$4.3 billion in 2015. The payment increase of \$316.6 million in 2015 is primarily attributable to the addition of the STAR+PLUS program in Nueces and MRSA Central and Northwest service areas. Superior maintained an average monthly membership of 919,630 Medicaid and CHIP members during 2014, and 957,573 members during 2015. Table 1 shows the breakdown of capitation and delivery supplemental payments by program and year. Capitation payments include both medical and pharmacy payments.

**Table 1: Superior Capitation and Delivery Supplemental Payments by Program**

Program	2014	2015	Total
Medicaid	\$ 3,806,597,621	\$ 4,177,372,307	\$ 7,983,969,928
CHIP	\$ 182,098,411	\$ 124,303,439	\$ 306,401,850
<b>Total</b>	<b>\$ 3,988,696,032</b>	<b>\$ 4,301,675,746</b>	<b>\$ 8,290,371,778</b>

*Source: HHSC 2014 Year-End 334-Day FSR and HHSC 2015 Year-End 90-Day FSR*

<sup>11</sup> 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.

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**Issue 1: THE SCOPE OF SIU INVESTIGATION ACTIVITIES WAS LIMITED**

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As specified by contract and regulations, SIU fraud, waste, and abuse plans define the essential activities of the SIU. Performance of these activities is critical for successful prevention, detection, investigation, and reporting of fraud, waste, and abuse.

Superior was timely in filing its annual fraud, waste, and abuse plans and maintained plan compliance with Texas Administrative Code requirements. Superior also submitted monthly reports of ongoing investigations to the IG on a timely basis. There were no errors noted in the information Superior submitted to the IG in its monthly and annual SIU reports.

Superior was not, however, effective at producing recoveries through its investigations of fraud, waste, and abuse, and made a decision not to investigate cases of fraud, waste, and abuse that fell below thresholds Superior set.

***In 2014 and 2015, 454 Investigations Opened With \$16,094 Medical Claims Dollars Recovered***

Though Superior is maintaining an SIU function, its SIU investigations produced limited recoveries in 2014 and 2015. During the two-year period under review, Superior:

- Opened a total of 454 fraud, waste, or abuse investigations.<sup>12</sup>
- Recovered \$16,094 in Medicaid or CHIP overpayments that occurred due to health care provider fraud, waste, or abuse.
- Referred 31 cases to the IG and no cases to the Office of Attorney General's Medicaid Fraud Control Unit.

During the two-year audit period, Superior's SIU opened 454 investigations of suspected fraud, waste, or abuse. From September 2015 through March 2016, Superior opened and investigated another 86 cases.

During the same period, Superior's health care providers submitted approximately 46.5 million Medicaid and CHIP medical claims and were paid approximately \$7.0 billion medical

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<sup>12</sup> SIU investigations include both preliminary and full-scale investigations. A preliminary investigation may be closed without becoming a full-scale investigation.

claims dollars.<sup>13</sup> Table 2 shows the number and amount of medical claims by year along with the numbers of SIU investigations, referrals to the IG, and amounts recovered.

**Table 2: Superior Medicaid and CHIP Medical Claims and SIU Performance Results**

Year	Medical Claims	Medical Claims \$	# of SIU Investigations <sup>14</sup>	SIU Recoveries <sup>15</sup>	Referrals to IG
2014	23,461,480	\$ 3,288,845,575	239	\$ 9,014	9
2015	23,082,479	\$ 3,751,769,200	215	\$ 7,080	22
Total	46,543,959	\$ 7,040,614,775	454	\$ 16,094	31

Source: Superior Correspondence; HHSC 2014 Year-End 334-Day FSR and HHSC 2015 Year-End 90-Day FSR

### ***Not All Cases of Suspected Fraud, Waste, and Abuse Were Investigated***

In June 2015, Superior made a business decision to implement Centene's corporate Fraud, Waste, and Abuse Plan relating to claims paid. Centene's Review/Investigation Process Threshold policy states that if "the provider/member meets any of the following conditions, an educational letter may be sent in place of completing a full investigation: The provider has not submitted claims in the prior nine (9) months [or if] paid charges over the past twelve (12) months are less than \$20,000 for the provider and \$1,500 for the member." In accordance with this policy, Superior closed preliminary and full-scale investigations that fell below the thresholds.

There is no dollar threshold below which a suspected case of fraud, waste, or abuse does not require investigation. Texas Administrative Code states that "the MCO is responsible for investigating possible acts of waste, abuse, or fraud for all services, including those that the MCO subcontracts to outside entities."<sup>16</sup> The decision by Superior to close cases without completing the investigation process is not in compliance with regulatory requirements.

<sup>13</sup> "Medical claims dollars" are the total amounts submitted to MCOs by health care providers as payment requests for medical services performed. MCOs pay these medical claims as expenses for delivering covered health care services to members. Medical claims dollars include claims with a date of service that falls within the referenced year, and may or may not have been paid during the referenced year. Medical claims dollars for 2014 and 2015 include both medical and pharmacy amounts, but do not include MCO administrative costs. The informational report previously published for this audit did not include pharmacy amounts in medical claims dollars.

<sup>14</sup> This includes the number of investigations opened during the referenced year, regardless of whether they resulted in recoveries during the current or future years.

<sup>15</sup> This includes the amounts recovered during the referenced year. Investigations may have been opened during the current or prior years.

<sup>16</sup> Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(b) (March 1, 2012).

The IG Audit Division reviewed a sample of 50 cases opened during the audit period. Fifteen of the 50 cases reviewed were closed without further investigation based on the threshold requirements. After implementation of the threshold requirements in June 2015, Superior's SIU would open a case as a preliminary investigation, but prior to completing the preliminary investigation process, Superior would apply the threshold requirement and close the case if it fell below the dollar limit.

Superior's management stated that it focused its efforts to minimize losses due to fraud, waste, and abuse on prepayment review of claims. Prepayment claims review is discussed in Issue 2 of this report. Performance of prepayment claims review, however, does not remove the requirement to fully investigate all cases of suspected fraud, waste, or abuse.

Although Superior has investigated and recovered some overpayments, it may not identify and is not investigating all potential fraud, waste, and abuse cases. As a result, Superior's SIU may not identify and recover some overpayments, and may not enforce necessary corrective actions for providers.

#### **Recommendation 1.1 - 1.3**

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Superior to put corrective actions in place to strengthen its fraud, waste, and abuse activities, including requiring:

- 1.1 Investigation of all suspected cases of fraud, waste, and abuse, including those under the \$20,000 and \$1,500 thresholds Superior established.
- 1.2 Corrective action plans to be established when providers have been involved in fraud, waste, or abuse.
- 1.3 Appropriate resolution, including collection of recoveries, for cases that are returned to the SIU by the IG.

The HHSC Medicaid/CHIP Division should consider tailored contractual remedies to compel Superior to perform SIU activities effectively.

#### **HHSC Medicaid/CHIP Division Management Response**

*The Medicaid/CHIP Division is in agreement with the recommendation and will allow Superior ten (10) days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of the following:*

- *Investigate all suspected cases of fraud, waste, and abuse, including those under the \$20,000 and \$1,500 thresholds that Superior established.*
- *Establish corrective actions plans when providers have been involved in fraud, waste, or abuse.*
- *Conduct appropriate resolution, including collection of recoveries, for cases that are returned to the SIU by IG.*

*The Medicaid/CHIP Division expects immediate actions to begin and would allow 90 days for all actions within the CAP to be fully implemented. Monthly updates detailing the status of each milestone will be expected from Superior. Additionally, Medicaid/CHIP Division leadership will consider tailored contractual remedies to compel Superior to effectively perform SIU activities.*

*Prior to approving actions within the CAP, the Medicaid/CHIP Division will request the IG Investigations Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.*

*Responsible Individual: Director, Health Plan Management*

*Target Implementation Date: December 2016*

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**Issue 2: SIU ACTIVITIES NECESSARY TO DETECT FRAUD, WASTE, AND ABUSE WERE NOT PERFORMED**

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SIU fraud, waste, and abuse plans define the activities of the SIU that are critical for the successful prevention, detection, investigation, and reporting of fraud, waste, and abuse.

The IG Audit Division evaluated Superior's prevention processes and found no issues with provider credentialing, re-credentialing, or trainings related to ethics and fraud, waste, and abuse. In the samples tested, Superior completed the credentialing process prior to the addition of each provider to the Superior network, and completed the re-credentialing process every three years. The IG Audit Division found no exceptions in the samples tested regarding the provision of fraud, waste, and abuse training to employees and subcontractors, and found no issues with the training materials and support that Superior delivers to the 74,996 providers in its network.

The IG Audit Division also evaluated Superior's fraud, waste, and abuse detection activities and found no issues related to referrals from employees, providers, and clients; recipient verification of services; provider exclusion verification; or the use of a fraud hotline.

Superior did not, however, effectively detect fraud, waste, or abuse cases through the use of post-payment data analytics.

***Prepayment Data Analytics Were Applied, But Post-Payment Data Analytic Techniques Were Not Adequately Utilized to Detect Fraud, Waste, or Abuse***

Superior's SIU reported prepayment activities for detection of fraud, waste, and abuse. During the audit period, Superior engaged two third-party claims administrators, Verisk and Lexis-Nexis, to provide routine prepayment edit checks of claims and to detect potential issues related to duplicate payments, incorrect coding, and rate errors. Automated systems applied prepayment data analytics across Superior's claims data. These prepayment reviews are standard business practice, and may effectively prevent inappropriate payment of claims, and identify abnormal claims for further research by the SIU. Prepayment efforts can provide significant cost avoidance by preventing payment on abnormal medical claims, rather than paying medical claims that must later be identified, investigated, and recovered.

Superior's SIU did not:

- Adequately utilize standardized queries for quarterly reporting, including post-payment data analytics that are effective for detecting potential fraud, waste, and abuse.
- Implement automatic triggers or establish application parameters that would identify and report suspected fraud and other abnormal claims to the SIU for further research.

Texas Administrative Code requires SIUs to detect and identify “Medicaid program violations and possible waste, abuse, and fraud overpayments through data matching, analysis, trending, and statistical activities...monitoring of service patterns for providers, subcontractors, and recipients...[and] use of edits or other evaluation techniques.”<sup>17</sup>

Superior’s SIU performed manual reviews of post-payment claims data to detect potential fraud, waste, and abuse. Superior reported that its SIU maintained 3.6 full-time equivalent staff throughout 2014 and 2015, while Superior processed 46.5 million claims resulting in over \$7.0 billion in medical claims dollars. By not supplementing the manual review efforts of its SIU investigators with automated post-payment data analytics, Superior is unlikely to detect potential or actual fraud, waste, and abuse that warrant investigative activity. Post-payment claims analysis also enables more complex data analysis over larger periods of time than is available at a prepayment level. Both post-payment claims analysis and prepayment analysis are critical components of an effective SIU function.

#### **Recommendations 2.1 - 2.2**

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Superior to put corrective actions in place to strengthen its fraud, waste, and abuse activities, including:

- 2.1 Enhancing post-payment data analytic techniques to identify unusual trends and anomalies in provider claims, and applying post-payment data analytics to effectively detect fraud, waste, and abuse.
- 2.2 Ensuring adequate personnel resources are assigned to the SIU for analysis of claims and to detect and investigate potential fraud, waste, and abuse.

The HHSC Medicaid/CHIP Division should consider tailored contractual remedies to compel Superior to perform SIU activities effectively.

#### **HHSC Medicaid/CHIP Division Management Response**

*The Medicaid/CHIP Division is in agreement with the recommendation and will allow Superior ten (10) days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of the following:*

- *Enhance post-payment data analytic techniques to identify unusual trends and anomalies in provider claims, and apply post-payment data analytics to effectively detect fraud, waste, and abuse.*
- *Ensure adequate personnel resources are assigned to the SIU for analysis of claims and to detect and investigate potential fraud, waste, and abuse.*

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<sup>17</sup> Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(c)(1) (March 1, 2012).

*The Medicaid/CHIP Division expects immediate actions to begin and would allow 90 days for all actions within the CAP to be fully implemented. Monthly updates detailing the status of each milestone will be expected from Superior. Additionally, Medicaid/CHIP Division leadership will consider tailored contractual remedies to compel Superior to effectively perform SIU activities.*

*Prior to approving actions within the CAP, the Medicaid/CHIP Division will request the IG Investigations Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.*

*Responsible Individual: Director, Health Plan Management*

*Target Implementation Date: December 2016*

## CONCLUSION

The IG Audit Division completed an audit of Superior Health Plan's SIU performance. The audit included an evaluation of policies and practices associated with preventing, detecting, investigating, and reporting fraud, waste, and abuse. The IG Audit Division conducted a site visit from April 4, 2016 through April 8, 2016 at Superior's facility in Austin, Texas.

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

- State and federal funds spent on managed care are used appropriately.
- Suspected fraud is detected, investigated, and when substantiated, reported to the IG or the Office of Attorney General's Medicaid Fraud Control Unit.
- Funds lost to fraud, waste, and abuse are recovered and reported to HHSC.
- Capitation rates established for Medicaid accurately reflect the cost of providing health care services to eligible beneficiaries.

Based on the results of its audit of Superior's SIU, the IG Audit Division concludes that:

- Superior's SIU investigations resulted in limited recoveries, due to the limited scope of Superior SIU activities.
- Superior's SIU did not investigate all cases, specifically those under Superior's self-imposed thresholds of \$20,000 for provider overpayments and \$1,500 for overpayments related to individual members.
- Superior's SIU did not adequately perform key fraud, waste, and abuse detection activities, including post-payment data analytics.

The IG Audit Division offered recommendations to the HHSC Medicaid/CHIP Division which, if implemented, will:

- Increase the scope of Superior SIU investigations, providing greater opportunity to investigate, refer, and recover fraud, waste, and abuse.
- Improve detection capabilities, increase identification of potential fraud, waste, and abuse, and increase recoveries.

The IG Audit Division thanks management and staff at the HHSC Medicaid/CHIP Division and at Superior for their cooperation and assistance during this audit.

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## Appendix A: OBJECTIVE, SCOPE, AND METHODOLOGY

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### ***Objective***

The objective of the audit was to evaluate the effectiveness of Superior's SIU performance in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC.

### ***Scope***

The scope of the performance audit of the Superior SIU included the period of September 2013 through August 2015 as well as review of relevant SIU activities through April 2016. The scope of this audit included review of:

- Contractor and subcontractor processes and activities that support SIU fraud, waste, and abuse plans.
- Policies and practices supporting the prevention, detection, investigation and recovery activities of the SIU.
- Policies and practices supporting the reporting of SIU activities and results to HHSC.
- Data and information technology systems that support SIU processes and reporting.

### ***Methodology***

To accomplish its objective, the IG Audit Division collected information for this audit through discussions and interviews with responsible management at Superior, and through request and review of the following information from Superior:

- A description of the SIU function and organizational structure.
- A list of SIU employees, including their names, titles, and a description of their qualifications.
- Policies and practices associated with prevention and detection of fraud, waste, and abuse.
- Data related to SIU performance, including investigations, recoveries, and referrals in 2014 and 2015.
- A description and flowchart of the SIU investigation process.
- Data and information systems that support the SIU activities and data processing necessary to produce reports for submission to HHSC.
- A list and a description of each automated process or control in place to detect fraud, waste, and abuse.

The IG Audit Division issued an engagement letter to Superior providing information about the upcoming SIU audit, and conducted fieldwork at Superior's facility in Austin, Texas from April 4, 2016 through April 8, 2016. While on-site, the IG Audit Division interviewed responsible SIU personnel, evaluated policies and practices relevant to the SIU function, and reviewed relevant SIU activities, including those related to prevention, detection, investigation, disposition, and reporting.

While at Superior's facility, the IG Audit Division reviewed and copied documentation and records related to the SIU function. No original records were removed from Superior's premises. Upon request, Superior sent additional documents that were requested during the audit, but were not available during the on-site review, to the IG Audit Division offices for review.

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:

- Superior Fraud, Waste, and Abuse Compliance Plan
- Superior SIU Policies and Procedures
- Uniform Managed Care Manual
- Uniform Managed Care Contract Terms and Conditions
- Texas Administrative Code
- Texas Government Code
- Code of Federal Regulations

The IG Audit Division reviewed the SIU data and reports produced by the claims management system at Superior. The IG Audit Division determined the data was sufficiently reliable for the purposes of the audit. In order to make this determination, the IG Audit Division:

- Interviewed MCO officials knowledgeable about the data.
- Validated that the queries and parameters used to produce SIU reports were appropriately modified.
- Reviewed the access management process for appropriateness.
- Reconciled potential fraud, waste, and abuse claims reports to source documents.

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

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## Appendix B: SAMPLING METHODOLOGY

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The IG Audit Division examined SIU activities for the period from September 2013 through August 2015. After an initial assessment of risk across SIU activities and contractor performance outcomes, the IG Audit Division performed testing from the population of Superior employees, subcontractors, and providers.

### ***Superior Employee and Subcontractor Training***

The IG Audit Division conducted sample testing in order to assess whether Superior employees had attended annual ethics and fraud, waste, and abuse trainings required by Texas Administrative Code. The IG Audit Division selected a simple random sample<sup>18</sup> using a random number generator. The sample size included 50 employees from the total population of 2,663 Superior staff who were employed at any time during the two-year audit period. Superior utilized 9 subcontractors during the audit period, and the IG Audit Division selected 100 percent of subcontractors to review whether fraud, waste, and abuse training was provided.

The IG Audit Division evaluated whether Superior employees received required annual ethics and fraud, waste, and abuse trainings by comparing whether the employees in the sample had signed a fraud, waste, and abuse training sign-in sheet to indicate attendance. For subcontractors, the IG Audit Division evaluated documentation submitted by Superior relevant to subcontractor fraud, waste, and abuse training.

### ***Superior Provider Credentialing***

The IG Audit Division conducted sample testing to assess whether the provider credentialing process was conducted on a timely basis. The IG Audit Division selected a simple random sample using a random number generator. The sample size included 50 providers from the total population of 74,966 unique CHIP, STAR, STAR+PLUS, and STAR Health providers enrolled with Superior during the two-year audit period.

The IG Audit Division assessed whether the provider credentialing process was conducted on a timely basis by reviewing sampled providers' credentialing files to verify that the credentialing process was completed prior to their addition to the Superior network, and that re-credentialing was completed at least once every three years thereafter.

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<sup>18</sup> Random sampling is a method by which every element in the population has an equal chance of being selected.

The IG Audit Division requested schedules of the total population for the audit period and selected a judgmental sample<sup>19</sup> of 20 percent of the population with a minimum sample size of 25 and a maximum of 50. Where the total population was 30 or less, the IG Audit Division tested 100 percent of the population. Samples reflected a 50:50 ratio between 2014 and 2015. This methodology provided sufficient and appropriate evidence to make determinations regarding the test objectives.

### ***Superior SIU Investigations***

The IG Audit Division conducted sample testing to assess whether SIU investigations were conducted on a timely basis in accordance with statutory requirements and the fraud, waste, and abuse plan.

The IG Audit Division selected a judgmental sample of 50 cases, eight of which contained overpayments during the audit period. This methodology provided sufficient and appropriate evidence to make determinations regarding test objectives.

The IG Audit Division assessed whether investigations were conducted on a timely basis by determining whether investigations met the time frames required by Texas Administrative Code. The IG Audit Division also assessed whether appropriate records were requested and reviewed, and where applicable, whether overpayments were recovered.

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<sup>19</sup> 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.

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## Appendix C: SUPERIOR HEALTHPLAN, INC. COMMENTS

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August 19, 2016

Steve Sizemore, CIA, CISA, CGAP  
Audit Director  
Texas Health and Human Services Commission  
Office of Inspector General  
Mail Code 1326  
P.O. Box 85200  
Austin, Texas 78708-5200

Dear Mr. Sizemore:

Thank you for the opportunity to review the Superior SIU Draft Report and provide comment responses. Based on our review, Superior respectfully requests that the following comments be included in the audit report.

- ***Issue #1 The Scope of SIU Investigation Activities Was Limited***  
**In 2014 and 2015, 454 Investigations Opened With \$16,094 Medical Claims Dollars Recovered (page 6)**

**Superior Comment:**

Auditors reports the SIU's savings as \$16,094 but this does not take into account our Prepayment Savings. As a MCO we are required to provide the best health services at the most affordable cost. In order to control costs, MCO's have innovative methods and one of the innovative methods of controlling costs in the SIU includes prepayment review of medical records prior to payment. Superior's judgment is that this audit did not cover the Special Investigations Unit scope in its entirety because the scope of the audit was limited to the review of only post-payment reviews. The scope of the audit was not a holistic review of all the innovative opportunities Superior takes to address FWA.

Our Prepayment savings for the audit period were:

2014: \$40,200,768.23

2015: \$766,872.71 (This savings amount does not include Payment Integrity Savings, which were not available at the time of this response)

As indicated by the prepayment savings, Superiors SIU through front end editing and prepayment investigations saved over \$40 million dollars, which this number is much higher but at the time of this response we could only report the prepayment investigations numbers for 2015. We strongly believe that to be effective especially in stopping waste and abuse, the front end edits and prepayment are critical. We have found that when money is saved on the front end of a claim we save dollar for dollar. When we recoup overpayments on the backend of a claim we recoup approximately .25 cents on the dollar.

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**Recommendation 1.1 - 1.3**

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Superior to put corrective actions in place to strengthen its fraud, waste, and abuse activities, including requiring:

- 1.1 Investigation of all suspected cases of fraud, waste, and abuse, including those under the \$20,000 and \$1,500 thresholds Superior established.
- 1.2 Corrective action plans to be established when providers have been involved in fraud, waste, or abuse.
- 1.3 Appropriate resolution, including collection of recoveries, for cases that are returned to the SIU by IG.

**Superior Comment:**

- 1.1 Superior's SIU, prior to these audit findings had removed the \$20,000 threshold on paid claims to Provider and the \$1,500 threshold for paid claims for members. This is no longer in practice and Superior's SIU investigates any and all cases of Fraud, Waste or Abuse.
- 1.2 Superior's SIU has instituted Corrective Action Plans for providers that are not removed from the network due to their findings. The policy and procedure (CC.Comp.16) provided during the audit review outlines our Corrective Action Plans:  
*Corrective Action Plans (CAP).* Health plan staff, often with the Chief Medical Director, will develop with the provider a CAP to resolve the billing or service issues. Corrective measures vary but typically must be completed within six weeks of agreement. Quality Improvement and Provider Relation staff will monitor progress and compliance, usually up to 180 days after CAP completion. The Compliance Officer will oversee CAP implementation and completion using Compliance360.

• **Issue #2 SIU Activities Necessary To Detect Fraud, Waste, and Abuse Were Not Performed Recommendations 2.1 - 2.2**

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Superior to put corrective actions in place to strengthen its fraud, waste, and abuse activities, including:

- 2.1 Enhancing post-payment data analytic techniques to identify unusual trends and anomalies in provider claims, and applying post-payment data analytics to effectively detect fraud, waste, and abuse.
- 2.2 Ensuring adequate personnel resources are assigned to the SIU for analysis of claims and to detect and investigate potential fraud, waste, and abuse.

**Superior Comment:**

- 2.1 Superior SIU uses post-payment data analytic techniques to identify unusual trends and anomalies in provider claims, and applying post-payment data analytics to effectively detect fraud, waste, and abuse. Superior SIU was contracted with LexisNexis and their

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product EDIWatch Intelligent Investigator. Intelligent Investigator is an automated tool that supports querying data from a multitude of sources, enabling faster, better, and more efficient investigations. The LexisNexis solution is a sophisticated post-pay, improper payment identification and detection tool that leverages cross-claims rules and analytics to uncover and prioritize cases for optimal investigative efficiency and recoveries. Intelligent Investigator effortlessly walks users of all levels through potentially fraudulent cases in order to uncover actionable findings. An advanced drill-down feature enables investigators and analysts to trace leads by provider, member/ patient, transaction and other related data with ease. Results are delivered through a powerful web-based portal that provides dashboard summaries of domain specific information through graphs, bar and pie charts. Special screens have been built in to assist investigators in identifying fraudulent providers or claims based on partial information from tips or leads. Users also have access to work flow tools that can be customized by department, role or individual user. Tools such as news feeds, task lists and worker production data can all be constructed as part of the individual dashboard. The easy-to-navigate system also supports usage by non-investigative departments such as provider relations, medical directors, finance and audit, among others.

Although Superior SIU did have the post payment data analytics tool in place, in February of 2014 a new Director of SIU was hired and he immediately noted that the system was antiquated. Superiors SIU then went through the process of finding and purchasing a new software system named HealthCare FraudShield. This new system is on a state of the art platform that combines the SIU's case management system along with their Post Payment data analytics. The system runs over 1500 algorithms, compared to under 50 ran by Intelligent Investigator. The system named PostShield also is updated quarterly to look for and detect new trends in the industry. The implementation process is coming to an end and the SIU expects the software to be operational by the end of August 2016.

- 2.2 Superiors SIU agrees with the recommendation. Due to the number of cases, to keep down case loads, and to improve on timeliness and investigation quality, we are currently in the process of hiring an additional investigator by the end of September 2016.

We appreciate the opportunity to provide comment responses to the Draft Report.

Please feel free to contact me with any additional questions.

Respectfully,

KaKehai Gage  
Superior HealthPlan, Compliance Manager

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## Appendix D: REPORT TEAM AND REPORT DISTRIBUTION

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### ***Report Team***

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

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Hilary Evbayiro, CPA, Audit Manager
- Jeff Jones, CPA, CIGA, Audit Project Manager
- Netza Gonzalez, MBA, MSM, CISA, CFE, IT Audit Project Manager
- Babatunde Sobanjo, PhD, Auditor
- Jude Ugwu, MBA, CFE, CRMA, Auditor
- JoNell Abrams, Auditor
- Angelica Villafuerte, Auditor
- Sarah Warfel, IT Auditor
- Lorraine Chavana, Quality Assurance Reviewer
- Scott Miller, Senior Audit Operations Analyst

### ***Report Distribution***

#### **Health and Human Services Commission**

- Charles Smith, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Kara Crawford, Chief of Staff
- Heather Griffith Peterson, Chief Operating Officer
- Gary Jessee, Deputy Executive Commissioner for Medical and Social Services
- Jami Snyder, Associate Commissioner, Medicaid/CHIP Services
- Tony Owens, Deputy Director, Medicaid/CHIP Division Contract and Performance Management
- Grace Windbigler, Director, Health Plan Management
- Karin Hill, Director of Internal Audit

#### **Superior HealthPlan, Inc.**

- Thomas Wise, President and Chief Executive Officer
- Holly Munin, Chief Performance Officer

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## Appendix E: THE IG MISSION AND CONTACT INFORMATION

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### ***Inspector General Mission***

The mission of the IG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of the IG's mission and statutory responsibility includes:

- Stuart W. Bowen, Jr.                      Inspector General
- Sylvia Hernandez Kauffman            Principal Deputy IG
- Christine Maldonado                    Chief of Staff and Deputy IG for Operations
- Frank Bryan                              Counselor to the IG
- Quinton Arnold                         Senior Advisor and  
Deputy IG for Inspections and Evaluations
- David Griffith                            Deputy IG for Audit
- James Crowley                         Deputy IG for Investigations
- Cynthia Reyna                         Chief Counsel

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

### ***To Contact the Inspector General***

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