

# OFFICE OF INSPECTOR GENERAL

## TEXAS HEALTH AND HUMAN SERVICES COMMISSION

### AUDIT OF ACUTE CARE UTILIZATION MANAGEMENT IN MANAGED CARE ORGANIZATIONS

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*FirstCare Health Plans*



February 21, 2017  
IG Report No. IG-16-062



## HHSC IG

TEXAS HEALTH AND HUMAN  
SERVICES COMMISSION

INSPECTOR GENERAL

### WHY THE IG CONDUCTED THIS AUDIT

FirstCare is a managed care organization (MCO) in Texas, and is contracted to provide Medicaid STAR and CHIP health care services in the Lubbock Managed Care Service Area and the Medicaid Rural Service Area – West. Approximately 84 percent of Medicaid and CHIP enrollees are members of an MCO, and at nearly \$27 billion a year, the Medicaid and CHIP programs constitute over 27 percent of the total Texas budget.

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

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

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

### WHAT THE IG RECOMMENDS

HHSC should require FirstCare to strengthen its utilization management functions related to data reliability, notification timeliness, required elements for notification and appeal resolution letters, and staff training.

View [IG-16-062](#)

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# AUDIT OF ACUTE CARE UTILIZATION MANAGEMENT IN MANAGED CARE ORGANIZATIONS

*FirstCare Health Plans, Inc.*

### WHAT THE IG FOUND

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

FirstCare's policy is to make prior authorization decisions, and notify requesters of its decisions, no later than the second working day after the date of the request for utilization review. This policy is more restrictive than the UMCC requires and aligns with the Texas Insurance Code (TIC) requirement for favorable determinations. FirstCare did not consistently meet this timeliness requirement. Based on its own policy, FirstCare had a 67 percent compliance rate. Based on UMCC requirements, FirstCare had a 77 percent compliance rate. Based on TIC requirements, FirstCare had a 73 percent compliance rate.

Criteria	In Compliance	Not in Compliance	Total Tested	Non-compliance Rate
FirstCare Policy	20	10	30	33%
UMCC	23	7	30	23%
TIC	22	8	30	27%

FirstCare's electronic prior authorization data was not reliable for measuring timeliness because FirstCare did not have data input controls and edit checks in place to help ensure prior authorization dates were accurate. In addition, FirstCare did not consistently process appeal acknowledgement letters and resolution letters timely, and prior authorization adverse determination and appeal resolution letters did not consistently contain required notification elements.

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

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

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

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# INTRODUCTION

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

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

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

## **Background**

FirstCare is a licensed Texas MCO contracted to provide Medicaid and CHIP services through its network of providers. FirstCare coordinates health services for two managed care programs, Medicaid STAR and CHIP. Two Texas hospitals, Covenant Health and Hendrick Health System, own FirstCare, which has its corporate headquarters in Austin, Texas, and regional offices in Abilene, Amarillo, Lubbock, and Waco. FirstCare coordinates services for Medicaid STAR program members<sup>3</sup> in the Lubbock Managed Care Service Area and the Medicaid Rural Service Area – West. See Appendix C for a map of the counties included in

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

<sup>2</sup> “MCOs” refers to the 19 health plans discussed throughout this report. An MCO is an organization that delivers and manages health care services under a risk-based arrangement.

<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 dependent.

the managed care service areas where FirstCare’s Medicaid STAR program coverage is available.

MCOs are responsible for administering, on behalf of the State of Texas, billions of dollars of Medicaid and CHIP health care services each year through their health plans. Table 1 shows a breakdown of FirstCare’s average monthly member counts and gross premiums for the Medicaid STAR program in 2014 and 2015. Over the two-year period, FirstCare maintained an average of 91,648 members per month and was paid more than \$567 million in gross premiums. Gross premiums include gross capitation payments<sup>4</sup> and delivery supplemental payments.<sup>5</sup>

**Table 1: FirstCare Medicaid STAR Member Counts and Gross Premiums for 2014 and 2015**

Program	# of Members (monthly average) <sup>6</sup>	Gross Premiums (millions)
2014 Medicaid STAR	88,252	\$ 293
2015 Medicaid STAR	95,044	\$ 274
Total	— —	\$ 567

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

FirstCare made significant changes in key management positions during the audit period, including hiring new staff for the following positions:

- Chief Medical Officer
- Senior Vice President, Corporate Compliance and Government Programs
- Vice President, Care Management Services
- Vice President, Senior Medical Director
- Assistance Vice President, Quality Improvement
- Director, Care Management Services Operations
- Regional Medical Director

FirstCare’s utilization management function is a component of its Care Management Services program, which includes case management and disease management programs. FirstCare’s

<sup>4</sup> “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.

<sup>5</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.

<sup>6</sup> This is the monthly average number of program enrollees.

Corporate Medical Advisory Committee has oversight of the activities of the Care Management Services program, and reports to the Corporate Quality Improvement Committee.

A utilization review agent license issued by the Texas Department of Insurance is required for the performance of medical reviews.<sup>7</sup> FirstCare holds the required utilization review agent license. As a utilization review agent, FirstCare must comply with applicable Texas Department of Insurance regulations.<sup>8</sup> FirstCare staff perform utilization management functions in the company's Abilene, Austin, and Lubbock offices.

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

Utilization review<sup>10</sup> may take place prospectively, concurrently, or retrospectively.<sup>11</sup>

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

Utilization reviews may result in favorable or adverse action. Members may request an appeal of any adverse determination. An MCO's utilization management function requires policies,

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<sup>7</sup> Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1704 (February 20, 2013).

<sup>8</sup> Texas Insurance Code, Title 14, Chapter 4201, Subchapter A, § 4201.057 (April 1, 2007).

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

<sup>10</sup> Texas Insurance Code, Title 14, Chapter 4201, Subchapter A, § 4201.002 (September 1, 2009).

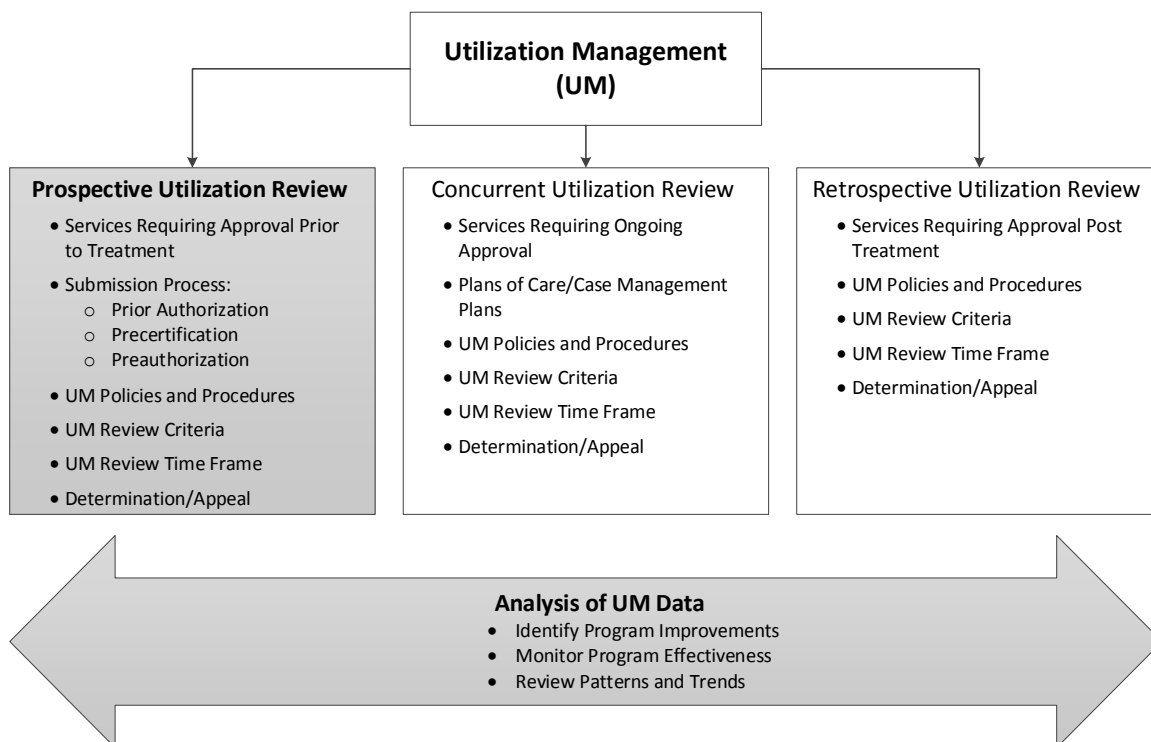
<sup>11</sup> Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, §19.1703 (February 20, 2013).

procedures, and organizational structures to execute utilization management strategies that comply with state and federal regulations. MCOs are given the latitude to determine how they will comply with minimum requirements. They use a variety of sources to develop their policies, and apply different organizational structures for implementing utilization management.

In addition to prospective, concurrent, and retrospective utilization reviews, MCOs also perform analysis of utilization post-service. This is sometimes referred to as retrospective analysis and will be referred to in this report as “analysis of utilization management data.” The HHSC Uniform Managed Care Contract (UMCC) requires all MCO utilization management programs to establish policies and procedures for analysis of utilization management data, such as routinely assessing the effectiveness and efficiency of the utilization management program, detecting over- and under-utilization, and comparing utilization patterns of providers and members.

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

**Figure 1: MCO Utilization Management Activities**



Source: IG Audit Division



This audit focuses on acute care services, as opposed to long-term services and supports,<sup>12</sup> and is limited to Medicaid STAR. Additionally, the IG Audit Division reviewed FirstCare's analysis of utilization management data, which includes prospective, concurrent, and retrospective review.

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

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

This audit was performed as part of the IG's responsibility to prevent, detect, and deter fraud, waste, and abuse in the Texas Health and Human Services (HHS) System. HHS agencies administer public health programs for the State of Texas, and within HHS, the HHSC Medicaid and CHIP Services Department oversees Medicaid and CHIP and contracts directly with Texas MCOs. Medicaid and CHIP are jointly funded state-federal programs that provide health care coverage to low-income individuals. In 2013, there were approximately 4.3 million Texans enrolled in Medicaid or CHIP.<sup>13</sup>

The Medicaid program provides health care services, including medical, dental, prescription drug, disability, behavioral health, and long-term support services, to eligible individuals. Texas Medicaid provides services to some individuals through a traditional fee-for-service model,<sup>14</sup> but most are enrolled through a managed care model.<sup>15</sup> Under managed care, the

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<sup>12</sup> "Long-term services and supports" provide assistance for persons who are age 65 and older and those with chronic disabilities, with a goal of helping such individuals be as independent as possible. Long-term services and supports may be provided in institutional long-term care settings, such as nursing facilities, or in home or community-based settings.

<sup>13</sup> This is the 2013 average monthly number of enrollees in Medicaid and CHIP.

<sup>14</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>15</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.



MCO receives a capitation payment for each member enrolled, based on a projection of what health care for the typical individual would cost. If members' health care costs more, the MCO may suffer losses. If members' health care costs less, the MCO may profit. This gives the MCO an incentive to control costs. MCOs deliver Medicaid services through their networks of providers. In federal fiscal year 2013, Texas spent \$26.8 billion on Medicaid and CHIP, which represented 27 percent of the entire 2013 state budget.<sup>16</sup>

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

The IG Audit Division presented audit results, issues, and recommendations to the HHSC Medicaid and CHIP Services Department and to FirstCare in a draft report dated January 20, 2017. Each was provided with the opportunity to study and comment on the report. The HHSC Medicaid and CHIP Services Department management responses to the recommendations contained in the report are included in the report following each recommendation. FirstCare's comments are included in Appendix D. The HHSC Medicaid and CHIP Services Department concurred with the IG Audit Division recommendations, and will facilitate FirstCare's development of a corrective action plan designed to improve FirstCare's utilization management function.

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<sup>16</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.

## RESULTS, ISSUES, AND RECOMMENDATIONS

MCOs are bound by the UMCC to have a written utilization management program description.<sup>17</sup> At a minimum, this program description must include:

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

### ***Utilization Management Policies and Processes Related to Prior Authorization Denials and Qualified Personnel Met Requirements***

FirstCare maintains a written utilization management program description that meets UMCC requirements. In addition, FirstCare has implemented policies and procedures related to certain prior authorization denials that comply with the UMCC. It also employs utilization management personnel whose qualifications and licensure comply with UMCC requirements.

#### **Denials for “Not a Covered Benefit”**

MCOs are required to provide the same Medicaid health care services under the managed care model that would be covered under the fee-for-service model. The IG Audit Division tested all 36 prior authorization requests between September 1, 2013, and August 31, 2015, that were denied as “not a covered benefit.” These denials were evaluated to determine whether the prior authorization requests would have been approved under fee-for-service Medicaid. All 36 prior authorization requests were appropriately denied, as they would not have been covered under fee-for-service Medicaid.

#### **Qualified and Licensed Personnel**

Texas Administrative Code requires MCO employees and contractors performing utilization review to be appropriately trained, qualified, and currently licensed or otherwise authorized to provide health care services from a licensing agency in the United States.<sup>18</sup> Audit results indicate that FirstCare had qualified and licensed personnel making medical necessity determinations.

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<sup>17</sup> Uniform Managed Care Contract, Attachment B-1, Utilization Management, Section 8.1.8, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

<sup>18</sup> Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1706 (February 20, 2013).

To evaluate whether prior authorization request determinations were performed by qualified and licensed individuals, the IG Audit Division tested records for all 21 utilization management personnel involved in the utilization review process between September 1, 2013, and August 31, 2015. The personnel included nurses and physicians. All 21 held a current medical or nursing license with no disciplinary actions noted and met the licensing qualifications of their job description.

In addition, MCOs may conduct an inter-rater reliability assessment to help ensure the consistent application of clinical criteria and medical necessity determinations. This is not a UMCC requirement, but is a best practice. If an MCO seeks accreditation from the National Committee for Quality Assurance,<sup>19</sup> it must perform inter-rater reliability assessments. FirstCare requires inter-rater reliability assessments for all involved in utilization management decisions to test for consistency in determinations and documentation. A corrective action plan is to be developed for any individual that does not meet the minimum score set by FirstCare for each module tested.

The IG Audit Division noted that FirstCare had an inter-rater reliability assessment process in place, but it did not retain employee-level supporting documentation. The documentation it did maintain included two reports. One summarized results for eight prior authorization nurse reviewers, and the other summarized results for four physician reviewers. The summary reports described the assessment methodology and the aggregate quantitative and qualitative results for each case, including the number of reviewers that incorrectly answered a case question, the reason the answer was incorrect, and a notation if additional coaching was provided. FirstCare required a passing rate of 90 percent or greater for each case tested. Per policy, personnel who did not meet the minimum score were required to take remediation training and be re-assessed.

The IG Audit Division reviewed the same 21 utilization management personnel files it tested for licensure, and determined that 12 FirstCare personnel took the inter-rater reliability assessment.<sup>20</sup> FirstCare indicated it provided remediation training to individuals who did not achieve a passing rate.

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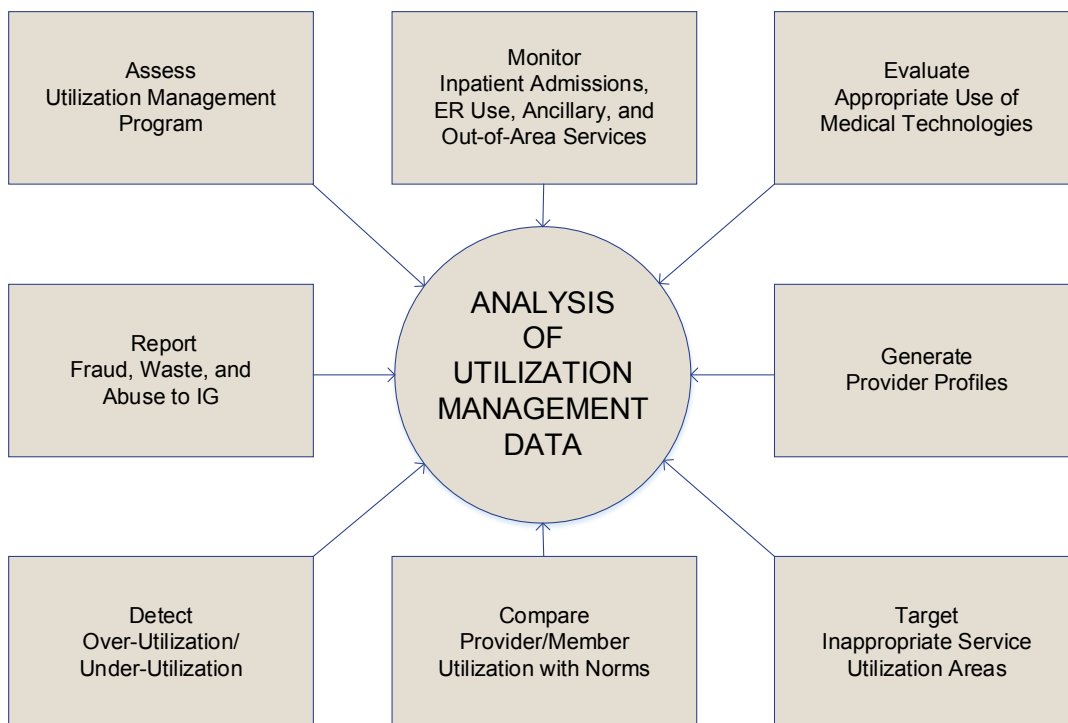
<sup>19</sup> The National Committee for Quality Assurance is a private, not-for-profit organization that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

<sup>20</sup> Nine personnel were not required to take the inter-rater assessment. These nine personnel included individuals that (a) were hired or transitioned to the department after the assessment was administered, (b) terminated employment prior to the assessment, (c) created the cases, conducted the assessment, and compiled the results, or (d) were upper management who did not perform the utilization reviews.

### ***Analysis of Utilization Management Data Was Performed***

FirstCare identified opportunities for program improvements and monitored program effectiveness through various activities related to analysis of utilization management data. These activities included identifying trends and problems across the utilization management program, and providing recommendations for improving health care management. The IG Audit Division reviewed and confirmed that FirstCare performed analysis of utilization management data activities. Figure 2 provides a broad overview of the analysis activities the UMCC requires all MCOs to perform.<sup>21</sup>

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



Source: IG Audit Division

### **Defining Analysis of Utilization Management Data**

FirstCare defined its requirements for analysis of utilization management data in its company documents<sup>22</sup> and regularly performed activities related to analysis of utilization management data. FirstCare conducted an annual assessment of the effectiveness and efficiency of its

<sup>21</sup> Uniform Managed Care Contract, Attachment B-1, Utilization Management, Section 8.1.8, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

<sup>22</sup> Documents FirstCare used to define its requirements for analysis of utilization management data included policies and procedures, "Care Management Services Program Description," and "Care Management Services Program Evaluation."

utilization management program. This assessment, summarized as the “Care Management Services Program Evaluation,” drew on qualitative and quantitative information to identify opportunities for process improvements. Components of the annual assessment included:

- Changes to governance and administration
- Changes to clinical criteria
- Changes to prospective, concurrent, and retrospective review
- Program initiatives
- Departmental goals and status
- Annual evaluation of the Complex Case Management program

#### **Applying and Evaluating Medical Necessity Criteria**

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

1. FirstCare internal guidelines
2. MCG<sup>23</sup> guidelines
3. Hayes Knowledge Center
4. Medicare guidelines
5. Texas Medicaid clinical policies
6. FirstCare’s medical director expertise

The Medical Technology Advisory Committee evaluated emerging technologies and new applications of existing technologies for inclusion as medical necessity criteria. When there is a request for an emerging technology and no clinical guideline exists, the medical director may review Hayes Knowledge Center to make a determination about covered benefits and the medical necessity and application of the technology. The chief medical officer reviewed updates and revisions to MCG guidelines and state-specific clinical policies annually. The Medical Advisory Committee subsequently reviewed and approved the clinical policies updates and revisions.

FirstCare performed limited monitoring related to timeliness of utilization management requests to evaluate processing timeliness. The quality of FirstCare’s monitoring improved over the audit period as it implemented new processes and reporting improvements to help ensure compliance with regulatory timeframes.

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<sup>23</sup> MCG guidelines were formerly known as Milliman Care Guidelines.

**Utilization Management Data, Cost, and Quality of Care**

FirstCare monitored and analyzed utilization management data to assess many areas of its business, including cost and quality of care. The Medical Management Department and the Utilization Management Oversight Committee regularly<sup>24</sup> reviewed utilization reports to detect the under- and over-utilization of select health care services. The utilization management data reviewed contained data for select quality indicators, including:

- Hospital days per 1,000 members
- Average length of stay
- Emergency room visits per 1,000 members
- Readmission rates for adults and children
- Maternity admission rates per 1,000 members
- Neonatal Intensive Care Unit admission rates
- Therapy utilization
- Per member per month spending by major service category

When utilization management personnel identified a potential quality of care issue during interactions with members, providers, or provider staff, they forwarded the information to the Quality Improvement Department for review. Medical Management Department staff may also identify a quality of care issue while analyzing trends of key utilization data metrics.

Through the Medical Management Department's monitoring and analysis of utilization management data, FirstCare monitored trends in the utilization of services and costs. FirstCare compared the trends to major MCG categories of inpatient, outpatient, emergency, professional services, and pharmacy. FirstCare also identified providers with unusual or high utilization patterns; however, it did not have a formal process to generate individual provider profiles that summarized a provider's performance on select quality indicators. FirstCare does perform provider interventions when a provider's utilization results indicate suspected fraud, waste, or abuse.

**Fraud, Waste, and Abuse**

Potential cases of fraud, waste, or abuse may be identified through various types of analysis, as well as by members, providers, and other sources.

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<sup>24</sup> The Medical Management Department reviews utilization management reports monthly. The Utilization Management Oversight Committee reviews the reports every two months.

Some potential ways that fraud, waste, and abuse may be identified through the analysis of utilization management data include:

- Post-payment claim audits – Two post-payment review vendors identify trends and outliers for FirstCare. Outliers are sent to and reviewed by the FirstCare recovery analyst, who approves or denies recovery of the claim.
- SIU analysis – FirstCare’s Special Investigations Unit<sup>25</sup> reviews providers identified as having irregular billing patterns. FirstCare’s recovery analyst and the post-payment review vendors may make referrals to the Special Investigative Unit.

When provider performance fell outside the normal trends, FirstCare intervened.

Interventions included:

- Provider education
- Development of corrective action plans
- Ongoing review of medical records

FirstCare may terminate a provider from its network if the provider does not implement recommended improvements.

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<sup>25</sup> FirstCare’s Special Investigations Unit was formed after it hired the senior vice president of corporate compliance and governmental programs in December 2014.



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## **ISSUE 1: NOTIFICATIONS OF PRIOR AUTHORIZATION REQUEST DETERMINATION DID NOT CONSISTENTLY MEET TIMELINESS REQUIREMENTS**

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MCOs are required to evaluate prior authorization requests and issue coverage determinations within timelines established in the UMCC and Texas Insurance Code (TIC). FirstCare’s “Timeliness of UM Decisions” policy is based on the TIC timeliness requirement for a favorable determination, which is more restrictive than the UMCC requirement. The UMCC requires the same timeframes whether the MCO is issuing a favorable or adverse determination, while TIC timeline requirements differ based on whether there is a favorable or adverse determination.

### **UMCC**

Under UMCC, the MCO must issue all coverage determinations,<sup>26</sup> including favorable and adverse determination notices, according to the following timeline:

- Within three business days after receipt of the request for authorization of services.<sup>27</sup>

### **Texas Insurance Code**

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

- Notice of a favorable determination<sup>28</sup> must be transmitted no later than the second working day after the date that a utilization review agent receives a request for utilization review with all information necessary to complete the review.<sup>29</sup>
- Notice of an adverse determination must be provided within three working days to the provider of record and the patient.<sup>30</sup>

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<sup>26</sup> UMCC allows for the timeline for certain request determinations to be extended if an MCO receives a request for a member under age 21, and the request does not contain complete documentation or information. In such cases, the MCO will contact the provider describing the information necessary to complete the prior authorization process and will allow the provider seven calendar days to provide additional information. HHSC Uniform Managed Care Manual, Chapter 3.22, Notification Process for Incomplete Prior Authorization Requests, Version 1.0 (January 15, 2010) through Version 2.1 (April 5, 2016).

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

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

<sup>29</sup> Texas Insurance Code, Title 14, Chapter 4201, § 4201.302 (April 1, 2007).

<sup>30</sup> Texas Insurance Code, Title 14, Chapter 4201, § 4201.304 (April 1, 2007).

To test the timeliness of prior authorization coverage determinations, the IG Audit Division selected and examined a sample of 30 prior authorization requests. The IG Audit Division reviewed source documents to evaluate the accuracy of computer generated data for each sampled request. The IG Audit Division reviewed fax, phone, or web portal authorization requests to determine the prior authorization receipt date. It also reviewed coverage determination letters, and the documented date of approval or denial of requested services in HealthRules, which is the utilization management information system FirstCare uses to process prior authorization request, appeals, and denials. To determine whether FirstCare processed prior authorization requests and issued coverage determinations in compliance with required timeliness guidelines, the IG Audit Division calculated the difference between (a) the date the prior authorization was received and (b) the date the corresponding coverage determination was issued.<sup>31</sup>

FirstCare's policy is to make decisions, and notify requestors of its decisions, not later than the second working day after the date of the request for utilization review (when the agent receives all information necessary to complete the review). This policy is more restrictive than the UMCC requires and aligns with TIC requirements for favorable determinations. However, a difference with TIC requirements is that FirstCare's policy does not distinguish between favorable and adverse determinations. TIC requires that notice of favorable determinations be made within two days but allows three days for adverse determinations.

Table 2 shows the results of the IG Audit Division's testing of the timeliness of FirstCare's prior authorization determinations based on criteria from FirstCare's policy, UMCC, and TIC. Based on its own policy, FirstCare had a 67 percent compliance rate. Based on UMCC requirements, FirstCare had a 77 percent compliance rate. Based on TIC requirements, FirstCare had a 73 percent compliance rate.

**Table 2: Prior Authorization Testing Results for All Criteria**

Criteria	In Compliance	Not in Compliance	Total Tested	Non-compliance Rate
FirstCare Policy	20	10	30	33%
UMCC	23	7	30	23%
TIC	22	8	30	27%

Source: IG Audit Division

Table 3 shows more detailed results of the timeliness of FirstCare's prior authorization determinations based on criteria from TIC. Based on TIC requirements, FirstCare had a

<sup>31</sup> In calculating a period of days, the first day is excluded and the last day is included. If the last day of any period is a Saturday, Sunday, or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday, or legal holiday. Texas Government Code, Title 3, Subtitle B, Chapter 311, Subchapter A, § 311.014 (September 1, 1985).

69 percent compliance rate for timeliness of favorable determinations and processed all adverse determinations tested timely.

**Table 3: Prior Authorization Testing Results under TIC Criteria**

TIC Determination	In Compliance	Not in Compliance	Total Tested	Non-compliance Rate
Favorable	18	8	26	31%
Adverse <sup>32</sup>	4	0	4	0%
Total	22	8	30	27%

Source: IG Audit Division

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

#### **Recommendation 1**

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

#### **HHSC Medicaid and CHIP Services Department Management Response**

The Medicaid and CHIP Services Department is in agreement with the recommendation and will allow FirstCare ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of policies and procedures to ensure that FirstCare meets prior authorization notification timeliness requirements.

The Medicaid and CHIP Services Department expects immediate actions to begin and would allow 90 calendar days for all actions within the CAP to be fully implemented. The Medicaid and CHIP Services Department will require FirstCare to submit monthly updates detailing the status of each milestone.

<sup>32</sup> FirstCare may partially approve a prior authorization request. The IG Audit Division tested those partially approved requests under the timeframe for adverse determinations.

Prior to approving actions within the CAP, the Medicaid and CHIP Services Department will request the IG Investigations Division perform a joint review of the CAP since the audit findings and related recommendations relate to the identification and prevention of fraud, waste, and abuse.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: June 2017

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

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The HealthRules system, used by FirstCare to process prior authorization requests, contained data entry errors for prior authorization request received dates and notification of determination dates. Approximately one percent (698 of 74,102) of the prior authorization notification dates preceded the date the initial prior authorization request was received. Data was missing for 1,848 prior authorization request received dates and 11,375 notification dates. Additionally, 74 percent of prior authorizations did not indicate whether the request was subject to a standard, expedited,<sup>33</sup> or extended<sup>34</sup> timeline. Without the applicable timeliness standard being apparent, those requests could not be tested for timeliness. HealthRules also listed 43 prior authorization request received dates that were expected to fall within the audit scope period of September 1, 2013, through August 31, 2015, but instead were listed either (a) after August 31, 2015, or (b) more than 15 calendar days prior to September 1, 2013. There were also 838 prior authorization notification dates that occurred past the audit scope. The out-of-scope request received dates and notification dates ranged from the years 2002 to 2201.

MCOs are required to maintain a management information system that enables the MCO to meet UMCC requirements, including all applicable state and federal laws, rules, and regulations.<sup>35</sup> The management information system must have the capacity and capability to capture and utilize various data elements required for MCO administration. HealthRules did not have data input and edit checks in place to help ensure prior authorization request received dates and notification dates were accurate.

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

### Recommendation 2

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require FirstCare to implement data input controls and edit checks into the HealthRules system, or establish other control mechanisms that will improve the reliability

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<sup>33</sup> A patient who is hospitalized at the time of the adverse determination may be entitled to expedited notification. Texas Insurance Code, Title 14, Chapter 4201, § 4201.304 (April 1, 2007).

<sup>34</sup> HHSC Uniform Managed Care Manual, Chapter 3.22, Notification Process for Incomplete Prior Authorization Requests, Version 1.0 (January 15, 2010) through Version 2.1 (April 5, 2016).

<sup>35</sup> Uniform Managed Care Contract, Attachment B-1, Utilization Management, Section 8.1.18, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

of prior authorization request received and notification of determination dates maintained in the system.

**HHSC Medicaid and CHIP Services Department Management Response**

The Medicaid and CHIP Services Department is in agreement with the recommendation and will allow FirstCare ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of policies and procedures to strengthen the reliability of prior authorization data, including implementation of input controls and edit checks for prior authorization request received and notification of determination dates in the HealthRules system.

The Medicaid and CHIP Services Department expects immediate actions to begin and would allow 90 calendar days for all actions within the CAP to be fully implemented. The Medicaid and CHIP Services Department will require FirstCare to submit monthly updates detailing the status of each milestone.

Prior to approving actions within the CAP, the Medicaid and CHIP Services Department will request the IG Investigations Division perform a joint review of the CAP since the audit findings and related recommendations relate to the identification and prevention of fraud, waste, and abuse.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: June 2017

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### **ISSUE 3: APPEALS PROCESS DID NOT COMPLY WITH UMCC, STATE, AND FEDERAL REQUIREMENTS**

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FirstCare's prior authorization adverse determination and appeal resolution letters did not always contain all required notification elements. Additionally, FirstCare did not consistently process appeal acknowledgement letters and resolution letters timely. However, for the appeals tested, FirstCare complied with the requirement that a physician not involved in a prior authorization adverse determination review the appeal request.

The contract requires that MCOs develop, implement, and maintain an appeals process that complies with state and federal laws and regulations.<sup>36</sup> An appeal is a formal process by which a member (or member's representative) requests review of an MCO action.<sup>37</sup> The MCO reviews the requested service for applicability as a covered service, then checks for medical necessity and makes a determination to approve, deny, or partially approve or deny the requested service.

#### **Required Notification Elements**

If an adverse determination is made, regulations<sup>38</sup> require the MCO to send an adverse determination letter (also called a denial letter) to both the member (or member's representative) and provider, detailing the:

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

Fourteen of the 38 prior authorization denial letters tested (37 percent) did not contain all required elements. None of the 14 letters indicated the professional specialty of the individual

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<sup>36</sup> Uniform Managed Care Contract, Attachment B-1, Medicaid Standard Member Appeal Process, Section 8.2.6.2, and Expedited Medicaid MCO Appeals, Section 8.2.6.3, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

<sup>37</sup> An "action" is (a) the denial or limited authorization of a requested Medicaid service, (b) the reduction, suspension, or termination of a previously authorized service, (c) the denial in whole or in part of payment for services, (d) failure to provide services in a timely manner, (e) failure of an MCO to act within the timeframes set forth in the contract, or (f) for a resident of a rural area with only one MCO, the denial of a Medicaid member request to obtain services outside of the MCO network. Uniform Managed Care Contract, Attachment A, Definitions, Article 2, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

<sup>38</sup> Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1709 (February 20, 2013).



making the determination, and 2 of the 14 letters did not specify the clinical guidelines used in the adverse determination. The IG Audit Division noted improvement of the denial letter process for those denial letters dated January 2015 or later.

For a written or oral appeal to be acted upon, it must be filed within 30 calendar days after the date of issuance of written notification of an adverse determination. The appeal must be reviewed by a physician who has not previously reviewed the case.<sup>39</sup> The IG Audit Division tested all 38 appeals from 2014 and 2015 to determine (a) accuracy of appeal data, (b) timeliness of appeals processing and compliance with applicable contract requirements and regulations, and (c) compliance of notification letters with applicable contract requirements and regulations.

Of the 38 total appeals, 2 were not tested to determine whether a separate physician reviewed the appeal because the appeal requests were submitted to FirstCare more than 30 calendar days after the date of the prior authorization adverse determination notice, and were not considered by FirstCare. The remaining 36 appeals were reviewed by a physician who had not reviewed the corresponding initial prior authorization request.

Five of the 33 appeal resolution letters tested<sup>40</sup> (15 percent) did not contain all required elements. Three appeal resolution letters did not notify the member (or member's representative) and the provider of the right to a fair hearing; one appeal resolution letter omitted the specialty of the physician who made the determination; and the IG Audit Division could not determine if one appeal resolution letter contained all the notification elements because the resolution letter was not retained by FirstCare.

### **Timeliness of Notifications**

To determine whether the appeal acknowledgment letter was sent timely, the IG Audit Division calculated the difference between the appeal request receipt date and the date of acknowledgement letter. To evaluate the accuracy of the date the appeal was received, the IG Audit Division identified the appeal receipt date by reviewing the date stamp on a written appeal request, the fax date of when the request was received, or the date in HealthRules for oral appeal requests. Eight of the 38 appeal acknowledgment letters tested (21 percent) were not determined to have been sent to the appealing party within 5 working days from receipt of the appeal, specifically:

- The IG Audit Division could not determine if or when two acknowledgement letters were sent to the appealing party because the letters were not retained.

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<sup>39</sup> Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1711 (February 20, 2013).

<sup>40</sup> Of the 38 appeals that occurred in the audit period, 5 resulted in the adverse determination being reversed. Those five letters were not subject to this test.

- The IG Audit Division could not determine when two appeal requests were received because they lacked a date stamp indicating when FirstCare received the appeal.
- Four acknowledgment letters were not sent timely.

To determine whether appeals were completed within 30 calendar days,<sup>41</sup> the IG Audit Division calculated the difference between the appeal request receipt date and date of the appeal resolution letter. To evaluate the accuracy of the date the appeal was received, the IG Audit Division identified the appeal receipt date by reviewing the date stamp on a written appeal request, the fax date of when the request was received, or the date in HealthRules for oral appeal requests. Six of the 38 appeal requests tested (16 percent) were not determined to have been completed within 30 calendar days after receipt of the initial written or oral appeal request, specifically:

- Three appeals were not processed timely.
- The IG Audit Division could not determine when two appeals were received because they lacked a date stamp indicating date of receipt.
- The IG Audit Division could not determine when one appeal resolution letter was sent to the appealing party because it was not retained.

According to FirstCare, due to manual processes and lack of staffing, some appeal acknowledgement and resolution letters were not issued timely and some adverse determination letters and appeal resolution letters did not contain all required notification elements, which may lead to members not being aware of their appeal rights and not receiving appropriate medical care.

### **Recommendation 3**

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require that FirstCare's appeals process complies with UMCC and state and federal requirements.

### **HHSC Medicaid and CHIP Services Department Management Response**

The Medicaid and CHIP Services Department is in agreement with the recommendation and will allow FirstCare ten (10) business days from receipt of the final audit report to submit a

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

corrective action plan (CAP) that includes implementation of policies and procedures to ensure that FirstCare's appeals process complies with UMCC and state and federal requirements.

The Medicaid and CHIP Services Department expects immediate actions to begin and would allow 90 calendar days for all actions within the CAP to be fully implemented. The Medicaid and CHIP Services Department will require FirstCare to submit monthly updates detailing the status of each milestone.

Prior to approving actions within the CAP, the Medicaid and CHIP Services Department will request the IG Investigations Division perform a joint review of the CAP since the audit findings and related recommendations relate to the identification and prevention of fraud, waste, and abuse.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: June 2017

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## ISSUE 4: REQUIRED TRAINING WAS NOT COMPLETED BY ALL FIRSTCARE STAFF

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TIC requires MCOs to provide adequate training to personnel responsible for precertification, certification, and recertification of services or treatment relating to acquired brain injury.<sup>42</sup> The purpose of the training is to prevent denial of coverage in violation of TIC<sup>43</sup> and to avoid confusing medical benefits with mental health benefits.<sup>44</sup> Though not required by TIC, FirstCare's policy was to administer the acquired brain injury training annually, but its process did not ensure all required personnel completed training.

The IG Audit Division reviewed the human resources files for all 21 utilization management personnel involved in the prospective utilization review process who were employed during state fiscal years 2014 or 2015 for evidence that individuals completed the annual training. Seven of the 21 individuals were not employed by FirstCare when the acquired brain injury training was administered during calendar year 2014. The personnel file for 1 of the 14 individuals (7 percent) FirstCare scheduled to take the acquired brain injury training in 2014 contained no evidence that the individual completed any acquired brain injury training. The individual left FirstCare's employment prior to the subsequent annual training.

In the subsequent calendar year, FirstCare changed its method of administering the training from a group presentation to an emailed presentation it sent to staff employed on December 31, 2015. The personnel files for 6 of the 11 individuals (55 percent) FirstCare required to take the acquired brain injury training during calendar year 2015 contained no evidence that individuals reviewed the training presentation emailed to them that year. There was nothing documented to indicate that FirstCare followed up to ensure the training was completed. TAC requires the MCO to maintain documentation demonstrating that staff performing utilization review are appropriately trained.

These records indicate that FirstCare did not have a process in place to ensure that all personnel who were responsible for prospective medical necessity determinations completed acquired brain injury training each year. Allowing FirstCare personnel to perform medical necessity determinations without acquired brain injury training could result in an inappropriate

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<sup>42</sup> Texas Insurance Code, Title 8, Subtitle E, Chapter 1352, § 1352.004 (September 1, 2007).

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

<sup>44</sup> Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1706 (February 20, 2013).

determination, such as the approval of unnecessary health care services or the wrongful denial of health care services.

**Recommendation 4**

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

**HHSC Medicaid and CHIP Services Department Management Response**

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

The Medicaid and CHIP Services Department expects immediate actions to begin and would allow 90 calendar days for all actions within the CAP to be fully implemented. The Medicaid and CHIP Services Department will require FirstCare to submit monthly updates detailing the status of each milestone.

Prior to approving actions within the CAP, the Medicaid and CHIP Services Department will request the IG Investigations Division perform a joint review of the CAP since the audit findings and related recommendations relate to the identification and prevention of fraud, waste, and abuse.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: June 2017

## CONCLUSION

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

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

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

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

- Had utilization management policies and processes related to prior authorization denials that met requirements.
- Employed qualified personnel who met licensure and inter-rater reliability assessment requirements.
- Performed analysis of utilization management data to identify improvements and monitor program effectiveness.
- Followed a more restrictive criteria for timeliness of prior authorization notifications than UMCC requires.
- Did not consistently process prior authorizations timely.
- Relied on electronic prior authorization data that was not accurate.
- Did not ensure that prior authorization adverse determination and appeal resolution letters contained all required notification elements.
- Did not consistently process appeal acknowledgement letters and resolution letters timely.
- Ensured that a physician not involved in the prior authorization adverse determination reviewed the appeal requests for all the appeals tested.
- Did not ensure all utilization management personnel received required training.

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

- Reduce the number of untimely notifications of FirstCare's decisions regarding prior authorization requests for health care services.
- Improve the accuracy of prior authorization data and provide a more reliable basis for analyzing and making recommendations regarding utilization management.
- Improve FirstCare's compliance with the requirement that appeal resolution letters contain all necessary notification elements.
- Reduce the number of untimely notifications of FirstCare's approval or denial of appeals.
- Increase utilization management personnel knowledge of issues related to acquired brain injury to help ensure appropriate determinations of medical necessity.

The IG Audit Division thanks the management and staff of the HHSC Medicaid and CHIP Services Department and at FirstCare 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 this audit was to evaluate the effectiveness of FirstCare's acute care utilization management practices in ensuring that health care services provided were (a) medically necessary, (b) efficient, and (c) comply with state and federal requirements.

### ***Scope***

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

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

### ***Methodology***

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

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

The IG Audit Division issued an engagement letter to FirstCare on March 17, 2016, and conducted site visits in April and May 2016 at FirstCare's facility in Austin, Texas. While on-site, the IG Audit Division interviewed relevant personnel, observed a demonstration of FirstCare's utilization management system, tested prior authorization and appeal records, reviewed job descriptions and medical licensure information, and reviewed documentation related to retrospective analysis.

Professional judgment was exercised in planning, executing, and reporting the results of this audit. The IG Audit Division used the following criteria to evaluate the information provided:

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

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

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

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

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## Appendix B: SAMPLING METHODOLOGY

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### ***Prior Authorizations***

The IG Audit Division selected a random<sup>45</sup> sample of 30 Medicaid STAR program prior authorizations from 2014 and 2015 and tested to determine:

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

### ***Prior Authorizations Denied as “Not a Covered Benefit”***

The IG Audit Division tested all 36 prior authorizations from 2014 and 2015 that were denied for not being a covered benefit to determine if the denial was appropriate. Code of Federal Regulations<sup>46</sup> requires MCOs to provide health care services that are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same service furnished to beneficiaries under fee-for-service Medicaid.

### ***Appeals***

The IG Audit Division tested all 38 appeals from 2014 and 2015 to determine:

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

### ***Qualified Personnel***

The IG Audit Division tested all 21 FirstCare utilization management staff involved in prospective reviews to determine whether they were:

- Qualified for their positions
- Currently licensed
- Trained in acquired brain injury treatment<sup>47</sup>
- Assessed on inter-rater reliability

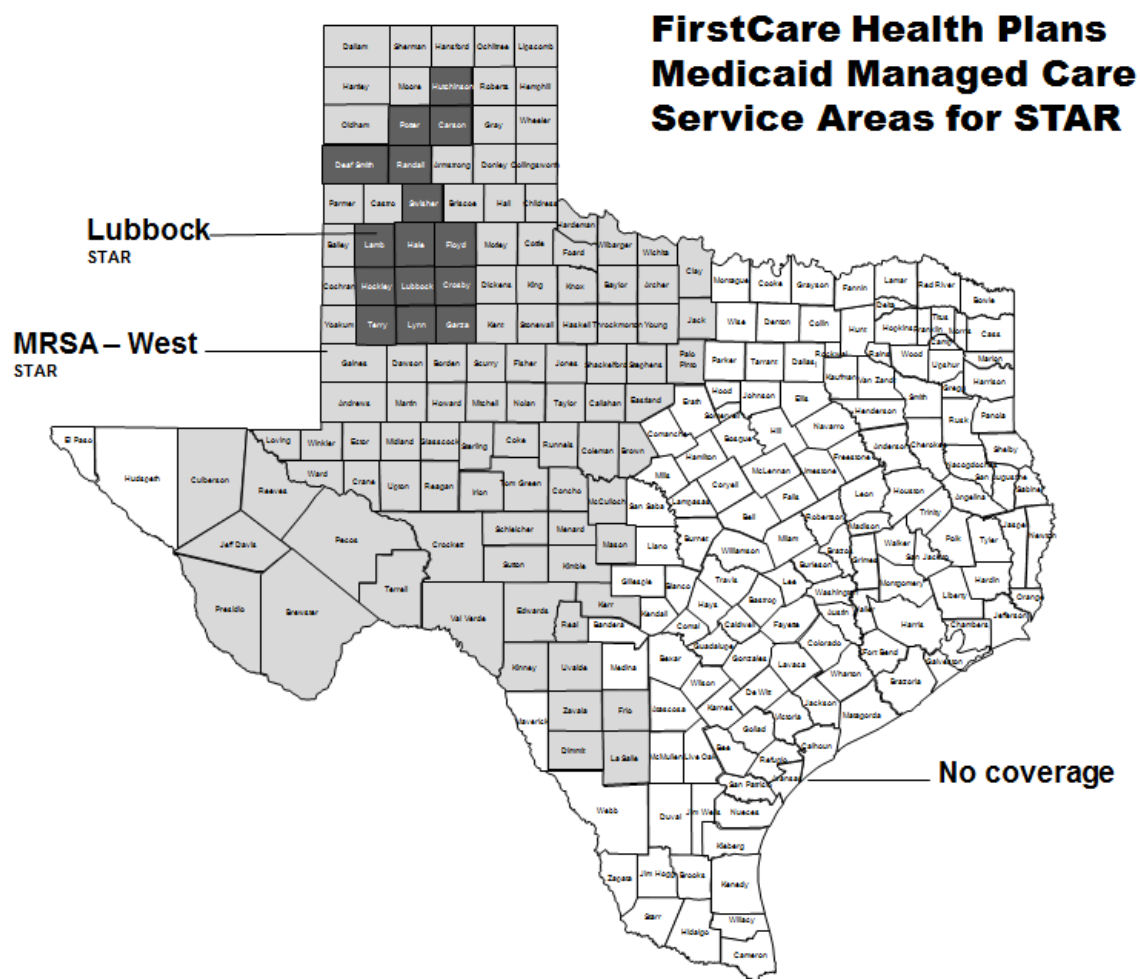
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<sup>45</sup> Random sampling is a method by which every element in the population has an equal chance of being selected.

<sup>46</sup> Code of Federal Regulations Title 42, Chapter IV, Subchapter C, Part 438 §438.210 (October 1, 2009).

<sup>47</sup> FirstCare’s utilization management staff are specifically required to be trained in the treatment of acquired brain injury.

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## Appendix D: FIRSTCARE COMMENTS

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January 25, 2017

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:

FirstCare has received and reviewed the recommendations in the report from the Office of Inspector General, Texas Health and Human Services Commission entitled, "*Audit of Acute Care Utilization Management in Managed Care Organizations*" for FirstCare Health Plans. We appreciate the collaborative and careful review, and agree with the recommendations.

FirstCare Health Plans appreciates the opportunity to highlight our Utilization Management (UM) program and work with the Office of the Inspector General at HHSC to improve our services and assure compliance with state and federal requirements. We are committed to providing timely, appropriate, and high-quality utilization management services to our members and providers.

The audit recommendations from years 2013 to 2015 reflect past practices. Since the time frame audited, in order to meet regulatory requirements and provide high-quality services, Firstcare has invested significant resources to improve UM operations. Our leadership, and organizational and process infrastructure for utilization management has been reassembled and deepened during 2015 and 2016 and will continue into 2017. UM program improvements include daily monitoring of authorization timeliness, retrospective internal UM audits, continuous improvement activities, and routine oversight of staff, processes and progress by multiple levels of management. In 2017, additional enhancements will include ongoing utilization trend reporting and review of compliance with HHSC utilization management requirements by a care management oversight committee. The goal of these changes is to ensure that we have transparent and sustainable utilization management services.

Overall, we appreciate the opportunity to share the improvements with you. Pages 3 and 4 contain descriptions of how we have improved our utilization management services, with respect to Recommendations 1 through 4 from the Inspector General.

We at FirstCare Health Plans appreciate the opportunity to comment on the Inspector General's recommendations. We understand our responsibility for fiscal stewardship when managing care. We place high importance on compliance because we understand that the purpose of the regulations is to ensure that members receive high-quality health care services in a timely manner. We hope that you agree that our numerous and ongoing improvements demonstrate our commitment to compliance with state and federal requirements.

If you have any questions or would like to discuss this further, you can contact me at 512-257-6226.  
Thank you.



Sincerely,

A handwritten signature in blue ink that reads "Sonya Henderson". The signature is fluid and cursive, with the first name "Sonya" being more prominent.

Sonya Henderson  
Senior Vice President and Chief Compliance Officer

Enclosure: Management representation letter





### **Recommendation 1**

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

***FirstCare Comments:*** FirstCare has implemented the following actions to meet prior authorization notification timeliness requirements:

#### ***2015-2016 Activities***

- Implemented close daily management oversight of open authorization requests, including daily operations meeting and management review of daily report of open authorizations;
- Established routine retrospective audits of authorizations to verify consistency with timeliness of decision-making and timeliness of notifications.
- Implemented continuous process improvement activities, based on results from monitoring and audits.
- Converted from manual to automated approval letters to shorten time-to-notification on approvals.
- Added weekend and holiday coverage for UM Clinical reviewers and Medical Directors.

#### ***2017 Activities***

- In planning phase for creating data warehouse of authorizations to use for expanded operational monitoring reports and for ongoing trend reports. Project start 04/2017.
- Planning for Quarterly timeliness trend reporting to the care management oversight committee beginning 10/2017 or earlier as soon as the authorization data warehouse is completed.

### **Recommendation 2**

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

***FirstCare Comments:*** FirstCare has implemented the following actions to improve the accuracy and reliability of prior authorization data:

#### ***2016 Activities***

- Reviewed fields in our utilization management software and added formatting and mandatory field requirements, where the system allows.
- Established double-check of data and dates on all denials during management review of each denial letter before mailing.
- Established retrospective audits of denials that compare accuracy of entered data to the data on the primary source documents.
- Implemented continuous process improvements, based on audit results.

#### ***2017 Activities***

- We are in the planning stage for creating a data warehouse of authorization data that is queried daily using error detection rules to identify incomplete and illogical data for correction. Project start 04/2017. Developing quarterly current state reporting of authorization data accuracy to be reviewed by the care management oversight committee, beginning 10/2017 or earlier as authorization data warehouse is completed.





### **Recommendation 3**

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require that FirstCare's appeals process complies with UMCC and state and federal requirements.

**FirstCare Comments:** First Care has mechanisms in place to ensure that the appeals process complies with UMCC, state, and federal requirements:

#### **2016**

- Added a full-time position for Quality Improvement Manager responsible for:
  - reviewing each appeal determination letter to verify that the letter contains every required element;
  - meeting with appeals staff weekly to review and ensure timeliness is met for completing and sending acknowledgement and resolution letters.
- Integrated a procedural double-check to ensure that each appeal decision is made by a different reviewer than the reviewer for the original decision.

#### **2017**

- We are in the planning stage for creating a data warehouse of appeals data that will be used for timeliness trend reporting. Project start 04/2017.

### **Recommendation 4**

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

**FirstCare Comment:** FirstCare has taken the following steps to assure that all utilization management personnel receive HHSC required training and that training records are retrievable:

#### **2016**

- Conducted annual required training for all UM employees.
- Established an annual clinical compliance workplan containing scheduled annual training for all utilization management personnel. Effective 02/2016
- Established a standardized core orientation training outline for newly hired utilization management staff that includes Texas Medicaid-required training, including acquired brain injury. Effective 08/2016
- Established and maintain a secure centralized repository of compliance-related training records. Effective 07/2016

#### **2017**

- Conducts annual required training during calendar quarter 1 of each year.
- Reviews progress with required training at quarterly clinical oversight committee. Effective March, 2017.

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## Appendix E: REPORT TEAM AND REPORT DISTRIBUTION

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### ***Report Team***

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**Managed Care Organizations****FirstCare Health Plans**

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- Barbara Berger, Vice President, Care Management Services, Quality Improvement
- Sonya Henderson, Senior Vice President, Corporate Compliance and Government Programs

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## Appendix F: 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 IG's mission and statutory responsibility includes:

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

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### ***To Report Fraud, Waste, and Abuse in Texas HHS Programs***

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

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

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