

OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

AUDIT OF ACUTE CARE UTILIZATION MANAGEMENT IN MANAGED CARE ORGANIZATIONS

Superior HealthPlan, Inc.



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HHSC IG

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

INSPECTOR GENERAL

AUDIT OF ACUTE CARE UTILIZATION MANAGEMENT IN MANAGED CARE ORGANIZATIONS

Superior HealthPlan, Inc.

WHY THE IG CONDUCTED THIS AUDIT

Superior is the largest managed care organization (MCO) in Texas, and is contracted to provide Medicaid and CHIP health care services in most areas of the state. 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 applicable health care services, and that state and federal funds spent on managed care are used appropriately.

Utilization management includes review of provider requests for members' current and future medical needs and 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 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 performance audit of Superior's utilization management function was for the period from September 1, 2013, through August 31, 2015.

WHAT THE IG RECOMMENDS

HHSC should require Superior to implement corrective actions to strengthen Superior's utilization management functions related to prior authorization timeliness, data controls, and training.

View [IG-16-061](#)

For more information, contact: IG.AuditDivision@hhsc.state.tx.us

WHAT THE IG FOUND

Superior HealthPlan's (Superior) utilization management program related to prospective utilization review met most Uniform Managed Care Contract (UMCC), state, and federal requirements tested in this audit; and Superior performed analysis of utilization management data to identify areas of improvement and to monitor program effectiveness. For the areas of prior authorization timeliness, data integrity, and training, opportunities exist for Superior to improve its utilization management function.

UMCC and Texas Insurance Code (TIC) criteria for timeliness of prior authorization notifications differ. Superior's policy is consistent with UMCC guidelines. Superior met the UMCC timeliness criteria of 3 working days 95 percent of the time for the notifications tested. For the same notifications, when applying TIC timeliness criteria of 2 working days, Superior had a 62 percent compliance rate.

Criteria	In Compliance	Not in Compliance	Total Tested	Non-Compliance Rate
Uniform Managed Care Contract / Superior Policy	35	2	37	5%
Texas Insurance Code	23	14	37	38%

In addition, Superior's electronic prior authorization data was not reliable for measuring timeliness. Superior did not have data input controls and edit checks in place to help ensure prior authorization request received dates and prior authorization determination dates were accurate. For example, approximately one percent (5,475 of 608,768) of the prior authorization determination dates in Superior's system preceded the date the initial prior authorization request was received.

Finally, some utilization management personnel did not complete acquired brain injury training as required by TIC. Superior did not have a process in place to ensure that all out-of-state contractors who made medical necessity determinations received the Texas-specific training. The purpose of the training is to prevent denial of coverage in violation of Insurance Code §1352.003 and to avoid confusion of medical benefits with mental health benefits.

The HHSC Medicaid and CHIP Services Department 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 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, which includes September 1, 2013, through August 31, 2015.

The IG Audit Division issued an informational report in August 2016 that presented a compilation of information provided by 19 Texas Medicaid and Children’s Health Insurance Program (CHIP) MCOs.¹ This audit report is one of a series of reports on acute care² utilization management, and is focused specifically on utilization management practices at Superior HealthPlan, Inc. (Superior) for the Medicaid State of Texas Access Reform (STAR) and Medicaid State of Texas Access Reform Plus (STAR+PLUS) programs. The IG Audit Division will continue to release reports for selected MCOs as the audit proceeds.

The IG Audit Division conducted the 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

Superior is a licensed Texas MCO contracted to provide Medicaid and CHIP services through its network of providers. Superior coordinates health services for several managed care programs, including the CHIP and Medicaid STAR, STAR+PLUS, and STAR Health programs. Superior is the largest Texas MCO, and it coordinates services for members³ in most areas of the state. See Appendix C for a map of Texas counties with the managed care service areas where Superior coordinates services for STAR and STAR+PLUS in Texas.

¹ “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.

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

³ MCOs refer to enrollees as “members.” An “enrollee” is an individual who is eligible for Medicaid or CHIP services and is enrolled in an MCO either as a subscriber or a dependent.

MCOs are responsible for administering, on behalf of the State of Texas, billions of dollars of Medicaid and CHIP health care services each year through their health plans. Table 1 shows a breakdown of Superior’s average monthly member counts and gross premiums for the STAR and STAR+PLUS programs for 2014 and 2015. Over the two-year period, Superior maintained an average of 843,255 members per month and was paid nearly \$8 billion in gross premiums for these two programs. Gross premiums include gross capitation payments⁴ and delivery supplemental payments.⁵

Table 1: Superior Member Counts and Gross Premiums by Program for 2014 and 2015 Combined

Program	# of Members (monthly average) ⁶	Gross Premiums (billions)
STAR	714,214	\$ 4.70
STAR+PLUS	129,041	\$ 3.35
Totals	--	\$ 8.05

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

Superior is a wholly owned subsidiary of Centene Corporation. Superior maintains a third-party management agreement with another Centene Corporation subsidiary, Centene Company of Texas, to support many operational functions, including utilization management. Centene Company of Texas holds the required utilization review agent license and its employees perform utilization review for Superior.⁷ As a utilization review agent, Superior must comply with all applicable Texas Department of Insurance regulations.⁸

Superior’s utilization management functions are performed by staff in several office locations across Texas. Superior also utilizes licensed physicians as out-of-state contractors to perform utilization reviews. Superior’s utilization management function is a component of its Medical Management program, and is closely linked with Superior’s Case Management, Compliance, Pharmacy and Therapeutics, Quality Improvement, Credentialing, and Fraud and Abuse

⁴ “Capitation payments” are monthly prospective payments HHSC makes to MCOs for the provision of covered services. HHSC makes capitation payments to MCOs at fixed, per member, per month, rates based on members’ associated risk groups. These capitation payments include federal and state funds, and both medical and pharmacy payments.

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

⁶ This is the monthly average number of program enrollees.

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

⁸ Texas Insurance Code, Title 14, Chapter 4201, Subchapter A, § 4201.057 (September 1, 2009).

programs. Superior's Utilization Management Committee has daily oversight and operating authority of utilization management activities, and it reports to Superior's Quality Improvement Committee and ultimately to Superior's Board of Directors. Superior's Board of Directors has final authority and accountability for the oversight of the quality of care and services provided to its members.

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

Utilization review¹⁰ may take place prospectively, concurrently, or retrospectively.¹¹

- Prospective utilization review occurs before the service is rendered. Preauthorization, also called 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 appeal of any adverse determination.¹²

An MCO's utilization management function requires policies, procedures, and organizational structures to execute utilization management strategies that comply with state and federal regulations. MCOs are given the latitude to determine how they will comply with minimum

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

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

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

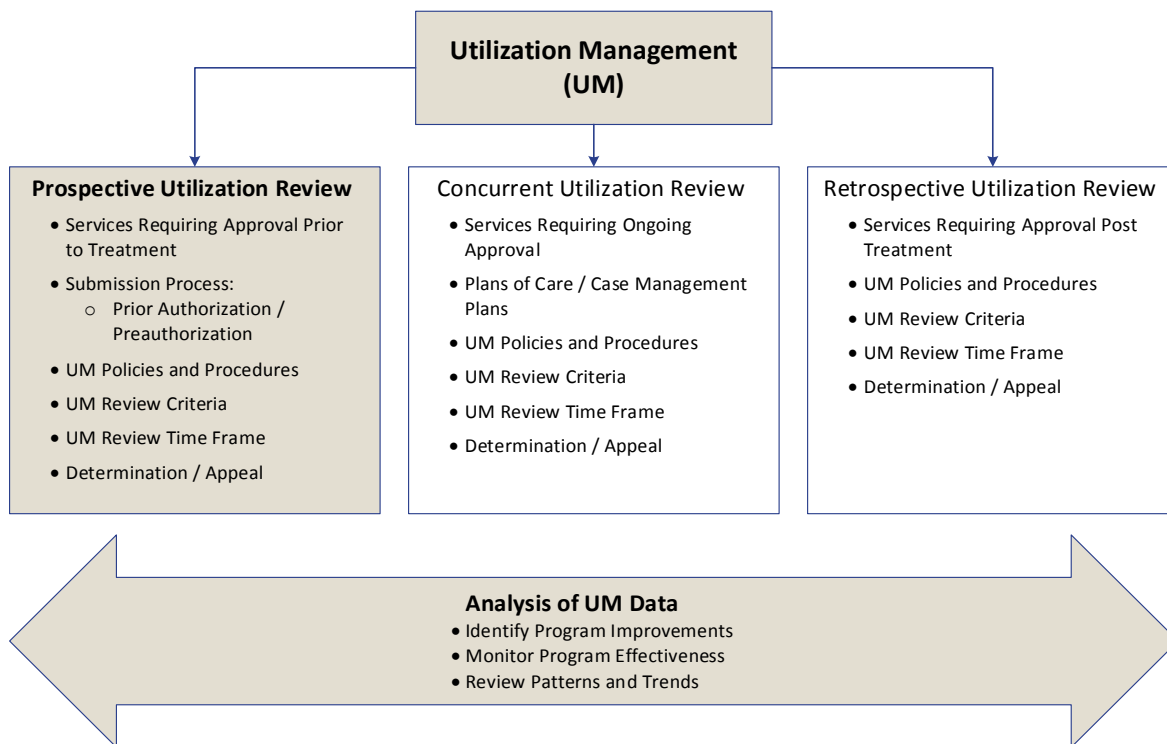
¹² An adverse determination, also called a denial, is a decision by an MCO or utilization review agent that the health care services furnished, or proposed to be furnished, to a patient are not medically necessary or not appropriate.

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

The audit focuses on acute care services, as opposed to long-term services and supports,¹³ and is limited to Medicaid STAR and Medicaid STAR+PLUS. The IG Audit Division evaluated Superior'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 Superior's utilization monitoring, analysis, and reporting.

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

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

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

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

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

¹⁶ Medicaid managed care was first introduced in pilot programs in Texas in 1993. In this model, the state contracts with MCOs who contract with Medicaid providers for the delivery of health care services to Medicaid enrollees. MCOs must provide the same services under managed care as provided under the traditional fee-for-service model.

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.¹⁷

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

The IG Audit Division presented audit results, issues, and recommendations to the HHSC Medicaid and CHIP Services Department and to Superior in a draft report dated November 10, 2016. 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. Superior's comments are included in Appendix D. The HHSC Medicaid and CHIP Services Department concurred with the IG Audit Division recommendations, and will facilitate Superior's development of a corrective action plan designed to improve Superior's utilization management function.

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

RESULTS, ISSUES, AND RECOMMENDATIONS

MCOs are bound by the UMCC to have a written utilization management program description.¹⁸ At a minimum, this program description must include:

- Procedures to evaluate the need for medically necessary covered services.
- Clinical review criteria, information sources, and processes used to review and approve requested 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.

Superior maintains a written utilization management program description that meets UMCC requirements. In addition, Superior has implemented policies and procedures related to certain prior authorization denial and appeals processes, and it employs personnel whose qualifications and licensure comply with UMCC requirements.

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

Denials for “Not a Covered Benefit”

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

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

Appeals

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

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

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

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

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

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

- Reason and clinical basis for the determination
- Criteria used for the determination

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

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

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

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

The IG Audit Division tested 63 appeals of denied prior authorization requests and found that Superior's appeals process complied with applicable contract requirements and with state and federal laws and regulations. For all appeals that were tested:

- Members (or member's representative) and providers were sent required notifications (including adverse determination, appeal acknowledgement, and appeal resolution letters) which included required language.
- A physician who did not review the initial prior authorization request reviewed the appeal.
- Appeals processing took place within required timeframes.²²

Qualified and Licensed Personnel

Texas Administrative Code requires MCO employees and contractors performing utilization review to be appropriately trained, qualified, and currently licensed or otherwise authorized to provide health care services from a licensing agency in the United States.²³ The IG Audit Division found that personnel tested were qualified and licensed to make medical necessity determinations.

To ensure prior authorization request determinations were performed by qualified and licensed personnel, the IG Audit Division tested records for 30 utilization management personnel involved in the utilization review process. The personnel included nurses, physicians, therapists, and one pharmacist. All 30 held a current license and met the licensing qualifications of their job description.

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

²² The timeframe to resolve a standard appeal is 30 calendar days after receipt of the request, and can be extended up to 14 calendar days by a member or MCO. The MCO must show a need for additional information and how the delay is in the member's interest. The timeframe for resolving an expedited appeal is three business days after receiving the request, unless the appeal relates to an ongoing emergency or denial of continued hospitalization, in which case the MCO must complete resolution of the appeal within one business day after receiving the request. Uniform Managed Care Contract, Attachment B-1, Medicaid Standard Member Appeal Process, Section 8.2.6.2, and Expedited Medicaid MCO Appeals, Section 8.2.6.3, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

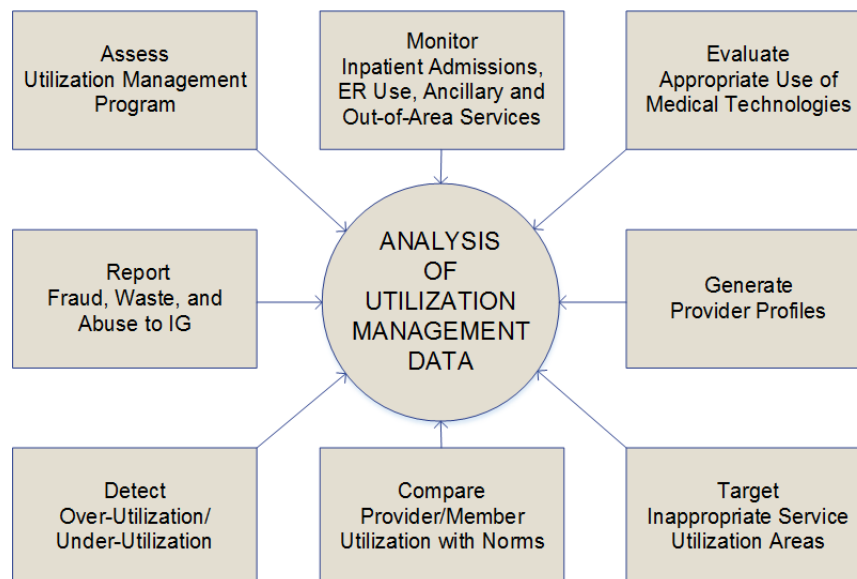
²³ Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1706 (February 20, 2013).

Committee for Quality Assurance,²⁴ it must perform inter-rater reliability assessments. The IG Audit Division noted that Superior had an inter-rater reliability assessment process in place. Superior required a passing rate of 90 percent or greater for each module tested. Personnel who did not meet the minimum score were required to take remediation training and retest. The IG Audit Division assessed the same 30 utilization management personnel files that were tested for licensure testing and determined that 23 personnel were required to take the inter-rater reliability assessment. Personnel required to take the assessment included 19 employees and 4 contracted personnel employed by other Centene facilities. All 23 personnel either met the minimum score on the initial test, retested and met the minimum score, or resigned shortly after the assessment.

Analysis of Utilization Management Data Was Performed

Superior identified opportunities for program improvement and monitored program effectiveness through various activities related to analysis of utilization management data. The IG Audit Division reviewed and confirmed that Superior performed analysis of utilization management data activities, but did not evaluate the activities' effectiveness. Figure 2 provides a broad overview of the analysis activities that the UMCC requires all MCOs to perform.²⁵

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



Source: IG Audit Division

²⁴ The National Committee for Quality Assurance (NCQA) 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.

²⁵ 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).

Defining Analysis of Utilization Management Data

Superior defines its requirements for analysis of utilization management data in its corporate documents.²⁶ Superior performs activities related to analysis of utilization management data daily, weekly, monthly, quarterly, and annually. The IG Audit Division verified that Superior conducts an annual assessment of the effectiveness and efficiency of its utilization management program. This assessment, summarized as the *Utilization Management Program Evaluation*, draws on qualitative and quantitative information to identify opportunities for process improvements. Components of the annual assessment include:

- Changes to staffing, departmental processes, and structure.
- Inter-rater reliability results.
- Membership demographics.
- Provider and member experience with utilization management.
- Provider performance and drug utilization reviews.
- Summaries of utilization management data, such as appeals, denials, and top diagnoses.
- Summaries of inpatient, readmission, emergency room, durable medical equipment, and therapy utilization data.
- Prior year utilization management goals and accomplishments.
- Future utilization management goals.

Applying and Evaluating Medical Necessity Criteria

The IG Audit Division verified that Superior monitors compliance with utilization review criteria and policies through analysis of utilization management data. During prospective, concurrent, and retrospective utilization review, Superior physician and nurse reviewers evaluate the medical necessity and appropriateness of member and provider requests against various evidence-based clinical guidelines. Superior applies these guidelines in the following order of priority:

1. Superior HealthPlan clinical policy
2. Centene Management Company clinical policy
3. McKesson's InterQual[®] clinical criteria
4. Texas Medicaid clinical policy
5. Superior medical director expertise

²⁶ Documents Superior uses to define its requirements for analysis of utilization management data include policies and procedures, *Centene Company of Texas, LP Utilization Management Program Description*, and the *Utilization Management Program Evaluation*.

The Centene Clinical Policy Committee evaluates 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 other nationally recognized support and reference tools, such as (a) the Agency for Healthcare Research and Quality (AHRQ), (b) UpToDate[®], (c) Hayes technology assessments, and (d) Cochrane reviews, to make a determination about covered benefits and the medical necessity and application of the technology. The Utilization Management and Quality Improvement Committees review updates and revisions to McKesson's InterQual guidelines and state-specific clinical policies annually. The Centene Clinical Policy Committee subsequently reviews, updates, and approves all Superior and Centene clinical policies.

Superior conducts annual inter-rater reliability assessments and reviews this assessment data to ensure consistent application of criteria by utilization management personnel.²⁷ Superior also monitors the regulatory timeframes of utilization management requests to ensure timely processing. A user-interface dashboard of key performance indicators allows management to quickly identify areas that may not meet required regulatory timeframes for medical necessity determinations.

Utilization Management Data, Cost, and Quality of Care

Superior monitors and analyzes utilization management data to assess many areas of its business, including cost and quality of care. At least annually, the Utilization Management Committee reviews data regarding the under- and over-utilization of select health care services. The Medical Management Department and the Quality Improvement Department review utilization management data that provides information on select quality indicators, including:

- Hospital days per 1,000 members
- Discharges per 1,000 members
- Average length of stay
- Emergency room visits per 1,000 members
- Non-emergent emergency room visits
- Emergency room visits with no office visit
- High emergency room utilizers
- Readmission rates for adults and children
- Neonatal admission rates

²⁷ Superior's inter-rater reliability policy requires inter-rater reliability assessments to be performed for all staff involved in utilization management decisions to test for consistency in determinations and documentation. A corrective action plan is developed for any individual that does not meet the minimum score set by Superior for each module tested.

- Neonatal intensive care unit admission rates
- Durable medical equipment utilization
- Therapy utilization

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

Through analysis of utilization management data, Superior monitors the cost and quality of care delivered by high-volume primary care physicians, obstetricians and gynecologists, specialists, and acute care hospitals. Superior prepares provider performance profiles²⁸ and schedules face-to-face visits to educate providers. The performance profiles provide data related to patterns of care, member panel analysis, quality, cost, and utilization. Superior uses the performance profiles to (a) increase provider awareness of their performance, (b) identify areas for process improvement, and (c) expand opportunities to work closely with providers in the development, implementation, and ongoing monitoring of performance improvement initiatives.

When provider performance falls outside the normal range of its peers, Superior intervenes. Interventions may include:

- Provider education
- Sharing of best practices and documentation tools
- Assistance with analyzing barriers to care
- Development of corrective action plans
- Ongoing review of medical records

Communicating utilization management data helps Superior improve provider compliance with clinical practice guidelines and performance targets and is part of Superior's incentive strategies and improvement programs. Superior may terminate a provider from its network if the provider does not implement recommended improvements.

²⁸ Quarterly performance profiles are prepared for physicians and providers on specific quality indicators, such as patterns of care, quality measures, cost and utilization summary measures, utilization rates per 1,000 members, and episode detail analysis. Annual performance profiles are prepared for hospitals, obstetricians and gynecologists, and high-volume specialists.

Fraud, Waste, and Abuse

Superior also monitors and analyzes utilization management data to identify potential cases of fraud, waste, or abuse. This is typically performed using claims-related data.

Potential cases of fraud, waste, and abuse may be identified through various types of analysis, as well as by members, providers, and other sources. Some potential ways that fraud, waste, and abuse may be identified through the analysis of utilization management data include:

- Verification of services – Superior may randomly verify that billed services were received by a member.
- Prepayment edits – Superior uses predictive modeling to identify aberrant claims and then uses clinicians to review the identified claims prior to payment. This process aims to identify incorrect billing practices prior to payment, such as unbundling, upcoding, inappropriate use of modifiers, billing spikes, and billing by deceased providers.
- Prepayment audits – Superior uses code editing software to review claims data. The software assists in the identification of unbundling, mutually exclusive codes, frequency by day, and age or gender discrepancies.
- Post-payment audits – Superior audits paid claims, including adjudicated, rejected, and appealed claims. Fraud and abuse software helps identify irregularities and potential cases are reported to the SIU for further investigation. Some edits Superior uses to identify areas of potential risk on a post-payment basis include:
 - Diagnosis or procedures incompatible with age or gender.
 - Mutually exclusive codes billed together.
 - Ambulance upcoding.
 - Add-on codes included without primary current procedural terminology codes being billed.
 - Non-emergency procedures that are billed on a Sunday or a holiday.
- SIU analysis – Superior’s SIU analyzes claims data and compares a provider’s utilization rates to its peers to identify outliers. Suspicious or unusual activity may also indicate a potential quality of care issue, which would be referred to the Quality Improvement Department for review. Superior’s SIU investigates and determines how to resolve the potential case of fraud, waste, or abuse.

For further information about Superior’s SIU, see the IG Audit Division audit report IG-16-014 issued on August 26, 2016.

Issue 1: PRIOR AUTHORIZATION REQUEST DETERMINATIONS DID NOT CONSISTENTLY MEET TIMELINESS REQUIREMENTS

MCOs are required to evaluate prior authorization requests and issue coverage determinations within timelines established in the UMCC and Texas Insurance Code (TIC). The UMCC and TIC have different timelines for issuing prior authorization coverage determinations.

Superior's prior authorization policy²⁹ is consistent with UMCC timelines, which require the same timeframes whether the MCO is issuing a favorable or adverse determination. TIC timeliness requirements differ based on whether there is a favorable or adverse determination.

UMCC

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

- Within three business days after receipt of the request for authorization of services.^{30,31}

Texas Insurance Code

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

- Notice of a favorable determination³² 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.³³
- Notice of an adverse determination must be provided within three working days to the provider of record and to the patient.³⁴

²⁹ *Timeliness of UM Decisions and Notifications Policy.*

³⁰ If an MCO receives a request for a member under age 21, and the request does not contain complete documentation or information, the MCO will contact the provider describing the information necessary to complete the prior authorization process and will allow the provider 7 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).

³¹ 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).

³² 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).

³³ Texas Insurance Code, Title 14, Chapter 4201, § 4201.302 (April 1, 2007).

³⁴ 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 examined a sample of 37 prior authorization requests. The IG Audit Division reviewed source documents to verify computer generated data associated with each sampled request. The IG Audit Division reviewed phone, fax, or web portal authorization requests to verify the prior authorization receipt date and reviewed coverage determination letters and the documented approval or denial of requested services in the TruCare system to verify the determination date. To determine whether Superior 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 request was received and (b) the date the corresponding coverage determination was issued.³⁵

Table 2 shows the results of the IG Audit Division's testing of the timeliness of Superior's prior authorization determinations based on criteria from the UMCC, Superior's policy, and TIC. Superior was compliant with the UMCC timeliness criteria of 3 working days for 95 percent of the notifications tested. For the same notifications, when applying TIC timeliness criteria, Superior had a 62 percent compliance rate.

Table 2: Prior Authorization Testing Results for All Criteria

Criteria	In Compliance	Not in Compliance	Total Tested	Non-Compliance Rate
UMCC / Superior Policy	35	2	37	5%
TIC	23	14	37	38%

Source: IG Audit Division

Table 3 shows more detailed results of the timeliness of Superior's prior authorization determinations based on criteria from TIC. Based on TIC requirements, Superior had a 39 percent non-compliance rate for timeliness of favorable determinations, and a 25 percent non-compliance rate for timeliness of adverse determinations.

³⁵ In calculating a period of days, the first day is excluded and the last day is included. If the last day of any period is a Saturday, Sunday, or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday, or legal holiday. Texas Government Code, Title 3, Subtitle B, Chapter 311, Subchapter A, § 311.014 (September 1, 1985).

Table 3: Prior Authorization Testing Results under TIC Criteria

Determination	In Compliance	Not in Compliance	Total Tested	Non-Compliance Rate
Favorable	20	13	33	39%
Adverse	3	1	4	25%
Total	23	14	37	38%

Source: IG Audit Division

Utilizing the UMCC timeliness criteria, Superior met its policy for timeliness in 95 percent of notifications evaluated. However, Superior did not comply with the more stringent TIC timeliness requirements, resulting in some members not receiving medically necessary healthcare services within TIC timeliness requirements.

Recommendation 1

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should ensure that Superior meets timeliness requirements.

HHSC Medicaid and CHIP Services Department Management Response

The Medicaid and CHIP Services Department is in agreement with the recommendation and will contact Texas Department of Insurance to ensure that both agencies are in agreement with the contract requirements for timeliness. Upon agreement, and if necessary, HPM will work with HHSC legal to amend the UMCC language to reflect the requirement.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: September 2017

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

The TruCare system, the utilization management information system Superior uses to process prior authorization requests, denials, and appeals, contained numerous data entry errors for prior authorization request received dates and prior authorization determination dates.

For example, approximately one percent (5,475 of 608,768) of the prior authorization determination dates in the TruCare system preceded the date the initial prior authorization request was received. In addition, the TruCare system included 1,514 prior authorization request received dates that should have fallen within the audit scope period, but instead were listed (a) after August 31, 2015, or (b) more than 15 calendar days prior to September 1, 2013. Prior authorization request received dates ranged from the years 2000 to 2021 for prior authorization requests with determination dates in 2014 and 2015.

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.³⁶ The management information system must have the capacity and capability to accurately capture and utilize various data elements required for MCO administration. The TruCare system, however, did not have data input controls and edit checks in place to help ensure prior authorization request received dates and prior authorization determination dates were accurate.

The absence of reliable dates hinders Superior 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 Superior to put corrective actions in place to strengthen the reliability of prior authorization data. These corrective actions should include implementation of input controls and edit checks for prior authorization request received date and prior authorization determination date in the TruCare system, which will increase the reliability of those dates and help Superior to comply with UMCC requirements related to information management.

³⁶ Uniform Managed Care Contract, Attachment B-1, Utilization Management, Section 8.1.18, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015).

HHSC Medicaid and CHIP Services Department Management Response

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

- Input controls and edit checks for prior authorization request received date and prior authorization determination date in the TruCare system.

The Medicaid and CHIP Services Department 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.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: March 2017

Issue 3: REQUIRED TRAINING WAS NOT COMPLETED BY ALL SUPERIOR CONTRACTOR STAFF

Superior's out-of-state contractors did not complete the acquired brain injury training as required by TIC.³⁷ An MCO must provide adequate training to personnel responsible for precertification, certification, and recertification of services or treatment relating to acquired brain injury. The purpose of the training is to prevent denial of coverage in violation of TIC³⁸ and to avoid confusing medical benefits with mental health benefits.³⁹

The IG Audit Division tested a sample of 26 employee and 4 contractor files for utilization management personnel involved in the prospective utilization review process during 2014 and 2015 and determined that 23 personnel were required to take the training. Two of the 23 individuals (8.7 percent) tested were not provided training and their files contained no evidence that they received acquired brain injury training. These two individuals were contractors who operated outside of Texas and were employed by other Centene facilities. Superior did not have a process in place to ensure that out-of-state contractors who made medical necessity determinations received the required Texas-specific training. Allowing Superior personnel to make medical necessity determinations without the acquired brain injury training could result in an inappropriate determination, such as the approval of unnecessary health care services or the wrongful denial of health care services.

Recommendation 3

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require Superior to implement a process to ensure that all personnel, including out-of-state contractors, receive required Texas Medicaid trainings, including training in acquired brain injury.

³⁷ Texas Insurance Code, Title 8, Subtitle E, Chapter 1352, § 1352.004 (September 1, 2007).

³⁸ 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).

³⁹ Texas Administrative Code, Title 28, Part 1, Chapter 19, Subchapter R, § 19.1706 (February 20, 2013).

HHSC Medicaid and CHIP Services Department Management Response

The Medicaid and CHIP Services Department is in agreement with the recommendation and will allow Superior 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, including out-of-state contractors, receive required Texas Medicaid trainings, including training in acquired brain injury.

The Medicaid and CHIP Services Department 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.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: March 2017

CONCLUSION

The IG Audit Division's audit of Superior's acute care utilization management included an evaluation of policies and practices associated with prior authorizations and appeals; an assessment of the qualifications of Superior personnel; and review of Superior'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 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 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 covering the period from September 1, 2013, through August 31, 2015, the IG Audit Division determined that:

- Superior's utilization management program related to prospective utilization review meets many UMCC, state, and federal requirements.
- Superior performs analysis of utilization management data to identify improvements and monitor program effectiveness.
- Superior's processes follow the UMCC timeliness criteria for Medicaid prior authorization determinations, which is different than TIC requirements.
- Superior's electronic prior authorization data was not reliable for measuring timeliness, and some utilization management personnel did not receive required training.

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

- Reduce the time allowed for notification of Superior's approval or denial of a prior authorization request 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.
- Increase utilization management personnel knowledge of issues related to acquired brain injury to help ensure appropriate determinations of medical necessity.

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

Appendix A: OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

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

- Assessing the utilization management practices applied to prior authorization requests 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, had acquired brain injury training, and were currently licensed.
- Reviewing 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 Superior and by:

- Reviewing contract requirements related to state and federal laws and regulations.
- Assessing policies and procedures associated with prior authorization requests and appeals.
- Observing the prior authorization and appeals process.
- Analyzing and testing prior authorization and appeal records.
- Testing “not a covered benefit” denials.
- Examining job descriptions, medical license numbers, and inter-rater reliability assessments of utilization management personnel.
- Interviewing staff and reviewing utilization management data dashboards, reports, and other monitoring activities.

The IG Audit Division issued an engagement letter to Superior on March 17, 2016, and conducted site visits on March 28, 2016, through March 30, 2016; April 5, 2016, through April 8, 2016; and June 2, 2016, at Superior’s facility in Austin, Texas. While on-site, the IG Audit Division interviewed relevant personnel, observed a demonstration of Superior’s utilization management system, tested prior authorization and appeal records, reviewed job

descriptions and licensure information, and reviewed documentation related to analysis of utilization management data.

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 utilization management policies and procedures
- Superior 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 regarding prior authorizations and appeals by (a) reviewing query parameters, (b) walking through the prior authorization and appeal data entry process, (c) interviewing Superior employees knowledgeable about the data, and (d) reviewing source documents.

The IG Audit Division determined that appeals 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 date field. There were no data entry system input controls in place, as confirmed by analyzing population date fields and considering employee testimony. As a result, the IG Audit Division adjusted audit procedures and tested prior authorization processing time by selecting a sample and using source documentation rather than relying on IT system data.

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

Appendix B: SAMPLING METHODOLOGY

Prior Authorizations

The IG Audit Division selected a random⁴⁰ sample of 35 prior authorizations stratified⁴¹ by years (2014 and 2015) and Medicaid programs (STAR and STAR+PLUS). It also judgmentally⁴² selected five prior authorizations to obtain audit coverage for urgent and expedited authorization requests. Three of the 40 sampled prior authorizations were not tested.⁴³ For the 37 prior authorizations, testing was performed to determine:

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

Prior Authorizations Denied as “Not a Covered Benefit”

The IG Audit Division tested 30 of 2,989 prior authorizations from 2014 and 2015 to determine if the denial was appropriate. These prior authorization requests were denied for not being a covered benefit. Code of Federal Regulations⁴⁴ requires MCOs to provide health care services that are furnished in an amount, duration, and scope that is not less than the amount, duration, and scope for the same service furnished to beneficiaries under fee-for-service Medicaid.

Appeals

The IG Audit Division tested a sample of 63 appeals that comprised 58 random and 5 judgmentally selected appeals. The random sample was stratified by years (2014 and 2015) and Medicaid programs (STAR and STAR+PLUS). The judgmental sample was selected to obtain audit coverage of appeals that were not provided by Superior in the original data request.

⁴⁰ Random sampling is a method by which every element in the population has an equal chance of being selected.

⁴¹ Stratified sampling is a method by which the population is divided into subpopulations, each of which is a group of sampling units that have similar characteristics.

⁴² 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.

⁴³ Two of the prior authorizations were for long-term services and supports, which were out of audit scope, and one was an appeal that was added to TruCare as a prior authorization, but subsequently voided.

⁴⁴ Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 438, § 438.210 (October 1, 2009).

Testing was performed to determine:

- Accuracy of appeals 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 and Licensed Personnel

The IG Audit Division judgmentally selected a sample of 30 utilization management personnel performing prospective reviews. The sample consisted of 26 Superior employees and 4 contractors that were employed or under contract in 2015. Testing was performed to determine whether Superior employees and contractors were:

- Qualified for their positions
- Currently licensed
- Trained in acquired brain injury treatment⁴⁵
- Assessed on inter-rater reliability

⁴⁵ Superior's utilization management staff may be required to take multiple trainings, but the IG Audit Division specifically tested for training in the treatment of acquired brain injury.

Appendix D: SUPERIOR COMMENTS

Office of Inspector General · Texas Health and Human Services Commission
Audit of Acute Care Utilization Management in Managed Care Organizations
Superior HealthPlan Comments
November 18, 2016



Superior disputes the IG's application of Texas Insurance Code (TIC) timeliness criteria to the Medicaid prior authorization sample.

Superior is committed to compliance with all contractual and regulatory requirements for all of its health care Programs, and relies on HHSC to define the order of precedence in the event of a conflict. The three party Contract between CMS, HHSC and Superior for the Medicare-Medicaid Plan (MMP) contains an Order of Precedence clause to address any conflict among documents and regulations in the operations of that Program. The order of priority for applicability of requirements specifies the MMP Contract terms and conditions supercede all other requirements, including any state or federal requirements released to Medicare-Medicaid health Plans. The HHSC Managed Care Contract does not include Order of Precedence Rules to address the conflict in prior authorization timeliness performance standards between the HHSC Uniform Managed Care Contract (UMCC) and the TIC requirements.

Superior believes the IG's application of the 2 working day TIC timeliness criteria for Medicaid prior authorizations in the Audit Report is unmerited, and those measurements should be removed from the Report. The IG acknowledges that there is a discrepancy between the 3 business day timeliness criteria for coverage determinations in the UMCC and the TIC criteria for timeliness of prior authorization (approval) notifications. The IG further confirms that Superior's Medicaid timeliness policy is consistent with the requirements in HHSC's Medicaid Managed Care Contract, and acknowledges Superior's compliance with the HHSC contract requirements. Finally, the Texas Department of Insurance (TDI) defers oversight of utilization management procedures for all Medicaid products to HHSC, and does not include any Medicaid lines of business in the HMO Triennial review process.

Superior does not agree with the IG's statement that Superior's electronic prior authorization data was not reliable for measuring timeliness.

The IG's testing disclosed ninety-five (95%) of the prior authorization sampling were processed timely, as evidence of Superior's ability to monitor timeliness of processing prior authorization requests. Superior provided explanation to the IG that the approximate one (1%) percent discrepancy between received and determination dates in the electronic data was the result of several issues, but primarily caused by procedural error when entering the extension of an existing authorization, in which staff failed to update the request received date. Staff education for appropriate protocol has been completed, and system program editing is underway to eliminate the issue systematically.

Superior acknowledges several utilization review personnel did not complete the Texas acquired brain injury training curriculum in its entirety in SFY2015.

Consistent with many organizations, Superior's training programs and associated recordkeeping have transitioned to online systems over the last several years. However, several years ago Superior's programs and procedures for the delivery and tracking of staff training were predominantly manual systems, allowing room for error in training assignment and documentation of completion. In contrast, Superior's current online training system facilitates the assurance that all applicable staff complete all mandatory and elective training courses, including the Texas-specific acquired brain injury training. Superior has no evidence that there was any incidence of denial of coverage or confusion of medical with mental health benefits as result of the several utilization review personnel who did not fully complete the acquired brain injury training curriculum during SFY2015.

SuperiorHealthPlan.com

Audit Note

As indicated in Superior's comments, prior authorization data was not sufficiently reliable to test timeliness due to errors with the prior authorization dates. There were no data entry system input controls in place. Due to lack of data entry controls and the issues discussed in the report, the prior authorization data was not reliable to test timeliness on the entire population. As a result we adjusted audit procedures by selecting a sample from the TruCare system and using source documents.

Appendix E: REPORT TEAM AND REPORT DISTRIBUTION

Report Team

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

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Marcus Garrett, CIA, CGAP, CRMA, Audit Manager
- Anton Dutchover, CPA, Audit Project Manager
- Melissa Towb, CPA, Senior Auditor
- Marcos Castro, Auditor
- Summer Grubb, Auditor
- Jennifer Carlisle, RN, Medical Auditor
- Tenecia Jackson, RN, Medical Auditor
- Lorraine Chavana, Quality Assurance Reviewer
- Collette Antoine, MBA, MPH, Senior Audit Operations Analyst
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Report Distribution

Health and Human Services Commission

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- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Kara Crawford, Chief of Staff
- Gary Jessee, Deputy Executive Commissioner for Medical and Social Services
- Jami Snyder, Associate Commissioner, Medicaid and CHIP Services Department
- Tony Owens, Deputy Director, Health Plan Monitoring and Contract Services, Medicaid and CHIP Services Department
- Grace Windbigler, Director, Health Plan Management, Medicaid and CHIP Services Department
- Karin Hill, Director, Internal Audit

Managed Care Organizations

Superior HealthPlan, Inc.

- Tom Wise, President and Chief Executive Officer
- Cheryl Cizler, Vice President, Shared Services Compliance
- Holly Munin, Plan Chief Performance Officer
- Timothy J. Springer, Senior Vice President, Compliance

Appendix F: IG MISSION AND CONTACT INFORMATION

Inspector General Mission

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

- Stuart W. Bowen, Jr. Inspector General
- Sylvia Hernandez Kauffman Principal Deputy IG
- Christine Maldonado Chief of Staff and Deputy IG for Operations
- Olga Rodriguez Senior Advisor and
Director of Policy and Publications
- James Crowley Deputy IG for Investigations
- David Griffith Deputy IG for Audit
- Quinton Arnold Deputy IG for Inspections
- Anita D'Souza Chief Counsel

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