Audit Report

Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments

Superior HealthPlan, Inc.

November 20, 2020
OIG Audit Report No. AUD-21-002

Inspector General

Texas Health and Human Services

HHS OIG
TEXAS HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WHY THE OIG CONDUCTED THIS AUDIT

OIG conducted this audit as a follow-up to complaints of nursing facility payments from MCOs being delayed by more than 90 days and of unprocessed nursing facility utilization review RUG rate retroactive adjustments. During 2018, HHSC made capitation payments of $706,462,742.41 to Superior HealthPlan for its administration of the State of Texas Access Reform PLUS (STAR+PLUS) program for nursing facility residents. This audit was of STAR+PLUS nursing facility clean claims paid by Superior HealthPlan.

The audit focused on (a) clean claim payments made more than 90 days after received date, (b) retroactive adjusted claim payments made more than 30 days after the receipt of the SAS notice, and (c) unprocessed RUG rate retroactive adjustments. The audit objective was to determine whether Superior HealthPlan accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

WHAT THE OIG RECOMMENDS

Superior HealthPlan should ensure the effectiveness of its automatic process to identify and complete all retroactive RUG rate adjustments and other payment adjustments as required by the Uniform Managed Care Contract and Uniform Managed Care Manual.

MANAGEMENT RESPONSE

The OIG Audit and Inspections Division presented preliminary audit results, issues, and recommendations to Superior in a draft report dated October 30, 2020. Superior generally agreed with the recommendations and indicated it has taken corrective actions.

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AUDIT OF PROCESSING OF OUTLIER NURSING FACILITY STAR+PLUS CLAIMS AND ADJUSTMENTS

Superior HealthPlan, Inc.

WHAT THE OIG FOUND

Superior HealthPlan adjudicated and paid most clean claims accurately and timely. Additionally, based on self-reported information, Superior HealthPlan adjudicated an average of 99.99 percent of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by the Uniform Managed Care Contract.

However, Superior HealthPlan did not always (a) process HHSC Resource Utilization Group (RUG) rate adjustments as required, or (b) process other types of adjustments. Specifically:

- An analysis of encounter data by OIG determined that Superior HealthPlan processed 204 (40 percent) of the identified RUG adjustments, in the amount of $207,941.96. As of January 16, 2020, Superior HealthPlan had not processed the remaining 300 (60 percent) retroactive RUG adjustments, with an expected net recovery of $313,190.95, which includes adjustments expected to reduce prior payments by $359,466.12 and adjustments expected to increase prior payments by $46,275.17.

  STAR+PLUS managed care organizations (MCOs) are required by contract to retroactively process all RUG rate adjustments automatically no later than 30 days after receipt of an HHSC notification. However, Superior HealthPlan stated that its automatic process did not recognize SAS updates with an indicator of "new," rather than the expected indicator of "update," so certain adjustments were not identified during the audit period. As a result, Superior HealthPlan did not (a) process all RUG rate adjustments in compliance with the contract, (b) pay nursing facilities correct Medicaid-funded RUG rates for its claims, and (c) adjust related encounters as required.

- Superior HealthPlan did not consistently process other types of claims adjustments from SAS notices within required timelines, which resulted in delayed payments to nursing facilities. Specifically, Superior HealthPlan did not process 22 of 30 (73 percent) adjustments tested within 30 days of the HHSC SAS notification as required. The delayed payment amount for the 22 adjustments totaled $1,266.27.

BACKGROUND

Nursing facilities submit claims to MCOs for payment. If the claim contains complete information, the MCO will pay or deny it as appropriate, and then is able to accurately report the claim. If a claim does not contain all the necessary elements, the claim is rejected and returned to the nursing facility to provide the needed information. Once a claim has been paid or denied, MCOs are required to automatically identify and process any retroactive payment adjustments. Claim payment adjustments occur when the MCO makes a change to the claim in response to new information from HHSC or OIG, the nursing facility, or the MCO's quality review results.

TABLE OF CONTENTS

INTRODUCTION

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division conducted an audit of State of Texas Access Reform PLUS (STAR+PLUS) nursing facility claims paid by Superior HealthPlan, Inc. (Superior HealthPlan) a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO).

The OIG Audit and Inspections Division conducted this audit as a follow-up to complaints of nursing facility payments from MCOs being delayed by more than 90 days and of unprocessed nursing facility utilization review resource utilization group (RUG) rate retroactive adjustments. Superior HealthPlan was one of five MCOs audited to address this concern. Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

STAR+PLUS is a Texas Medicaid managed care program for members with disabilities or who are age 65 or older. Five MCOs in Texas participate in the STAR+PLUS program: Amerigroup, Cigna HealthSpring, Molina Healthcare of Texas, Superior HealthPlan, and United Healthcare Community Plan. The STAR+PLUS program served an average of 526,768 members per month in 2018, of whom Superior HealthPlan served an average of 139,367 or 26.5 percent.

Texas Health and Human Services Commission (HHSC) Medicaid and CHIP Services (MCS) is responsible for overall management of the STAR+PLUS program and for oversight of MCOs, including Superior HealthPlan's administration of health care services through STAR+PLUS. MCS promulgates policy and rules related to the participation of nursing facilities in Medicaid, and, in the case of managed care, administers those policies and rules through provisions of the Texas Uniform Managed Care Contract (UMCC) and the Uniform Managed Care Manual (UMCM).

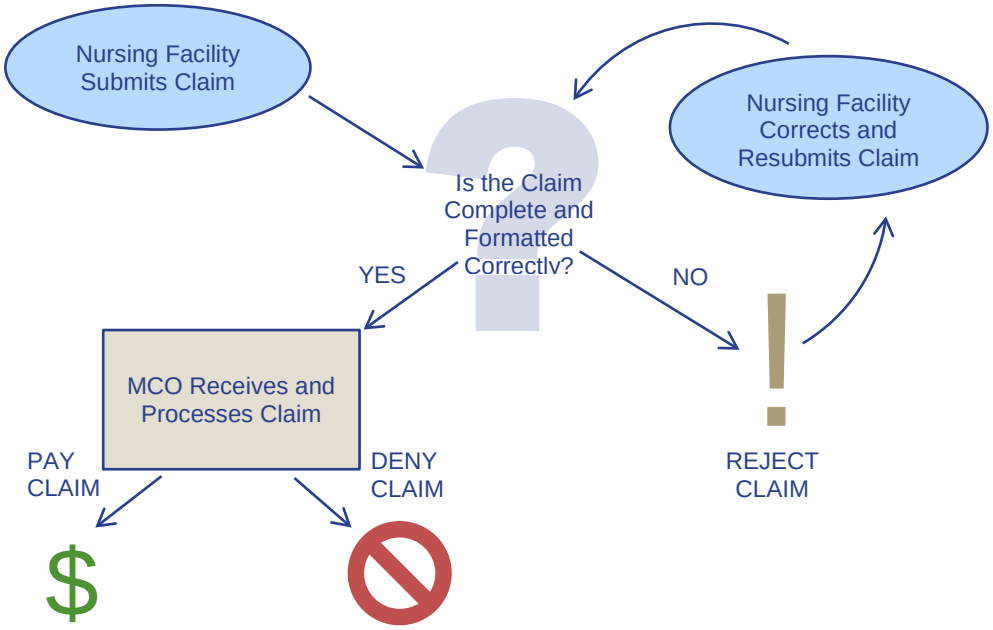
Nursing facilities are primarily reimbursed through a managed care model. For Medicaid residents in nursing facilities who are members of an MCO, HHSC makes a monthly capitation payment to the MCO for each resident. The MCO, in turn, receives claims from the nursing facility and reimburses the nursing facility a daily rate for the resident based on the RUG level of the resident.[1] During 2018, HHSC made capitation payments of $706,462,742.41 to Superior HealthPlan for its administration of the STAR+PLUS program for nursing facility residents.

[1] HHSC determines the payment amount associated with a specific RUG level. RUG levels are assigned based on the level of care needed by the member.

Claims Adjudication Process

Clean claims are defined as claims for services rendered to a member with the data necessary for the MCO to adjudicate[2] and accurately report the claim. If a claim does not contain all the elements necessary for the MCO to adjudicate it, it is rejected and returned to the nursing facility so that the nursing facility may provide the information necessary for adjudication. The claim is then processed but may be denied because of issues with member eligibility, service authorization, the provider's standing, the RUG level, or duplication of the claim. Figure 1 illustrates the claims adjudication process.

Figure 1: Claims Adjudication Process



Source: OIG Audit and Inspections Division

The MCO must use the Initial and Daily Service Authorization System (SAS) provider and rate data, determined by HHSC, in the adjudication of nursing facility claims. After a claim is adjudicated, new information may require it to be adjusted. MCOs can only adjust an adjudicated claim.

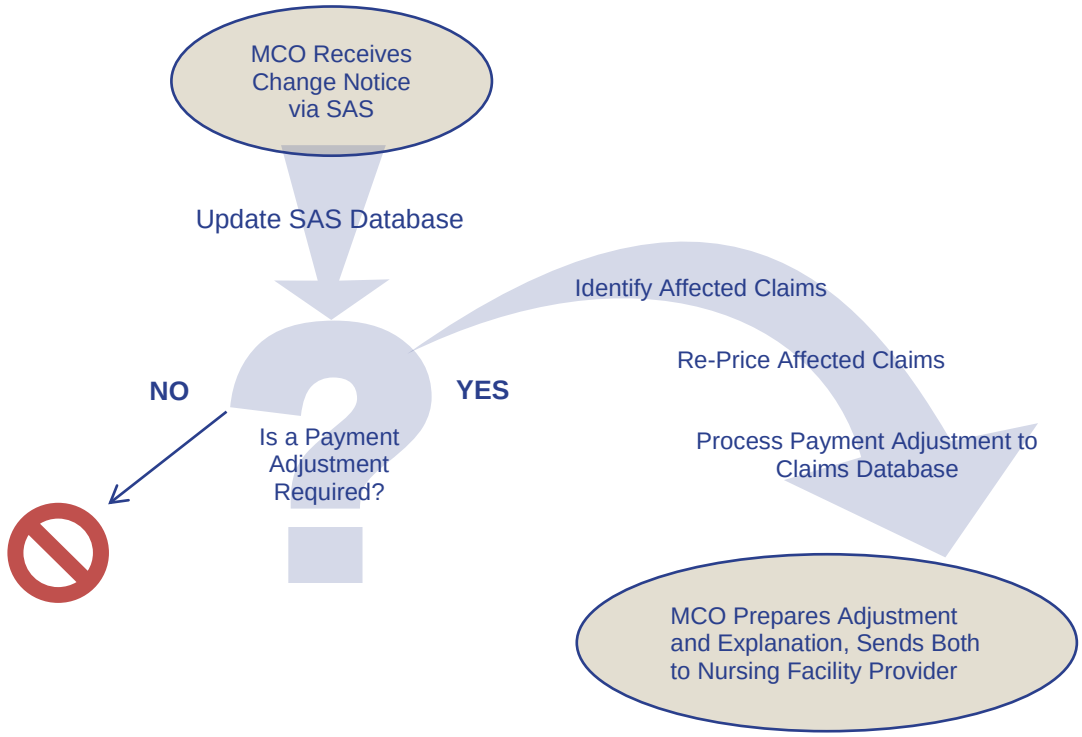
[2] Adjudicated claims are clean claims that have been either paid or denied.

Claims Adjustment Process

Claim payment adjustments occur when the MCO makes a change to the claim in response to new information from (a) HHSC, (b) the nursing facility, or (c) the MCO's quality review results.

Once a clean claim has been adjudicated, MCOs are required to automatically identify and process any HHSC retroactive payment adjustments transmitted via a SAS notice. Retroactive changes are typically made to member eligibility, the member's applied income, RUG or service level, provider contracts, provider hold, provider rate, or nursing facility service authorizations. The MCO has 30 days to review the change and process the HHSC retroactive payment adjustment. Figure 2 illustrates the payment adjustment process.

Figure 2: Payment Adjustment Process



Source: OIG Audit and Inspections Division

Objectives and Scope

The audit objective was to determine whether Superior HealthPlan accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

This audit focused on (a) clean claim payments made more than 90 days after the received date, (b) retroactive adjusted claim payments made more than 30 days after receipt of the SAS notice, and (c) unprocessed nursing facility utilization review RUG rate retroactive adjustments.

The audit scope included clean claims received during 2018, including run-out[3] of retroactive adjustments through April 13, 2019.

Methodology

The audit population for this report is outlier claims initially paid past the 90-day requirement.[4] For this audit, outlier claims are considered nursing facility claims for the same member and service dates with more than 90 days between (a) the date the claim was first received[5] and (b) the date the final payment is made.

The OIG Audit and Inspections Division selected statistically valid samples of 30 Superior HealthPlan STAR+PLUS clean claims and 30 Superior HealthPlan STAR+PLUS adjusted claims to test the timeliness, accuracy, and causes of any delays in adjudicated claims or processing of payment adjustments. The samples were chosen from a total of 113,243 clean claims and 21,689 adjusted claims identified as outliers.

To accomplish its objectives, the OIG Audit and Inspections Division requested information from HHSC and Superior HealthPlan, including paid claim data, denied claim data, encounter data, and SAS file documentation.

[3] After the claim has been adjudicated there is the possibility of a retroactive payment adjustment. For this audit, the runout period for a retroactive payment adjustment was cut off as of April 13, 2019.

[4] Uniform Managed Care Manual, Chapter 2.3 Section X.2, v. 2.1 (Mar. 1, 2015) states, "Within 90 days of the Received Date, adjudicate 99 percent of all Clean Claims by Program and by Service Area."

[5] Received date is defined as the date on which the nursing facility provider submits the claims to the MCO or the HHSC-designated portal.

The OIG Audit and Inspections Division obtained additional information through discussion and interviews with responsible staff at HHSC and Superior HealthPlan, as well as through collection and review of:

- Documentation supporting compliance with contractual requirements
- Information systems that support claims and adjustment processing
- Claims data and related encounter data
- Policies and business practices associated with the processing of claims and retroactive adjustments

The OIG Audit and Inspections Division conducted on-site fieldwork at the Superior HealthPlan facility in Austin, Texas, on November 18 and 19, 2019. While on site, the OIG Audit and Inspections Division reviewed documentation for selected STAR+PLUS nursing facility claims to evaluate whether the documents would provide adequate support for compliance with contract provisions. Auditors also discussed general controls around data and the information technology system application controls used by claims staff.

The OIG Audit and Inspections Division presented preliminary audit results, issues, and recommendations to Superior in a draft report dated October 30, 2020. Superior generally agreed with the recommendations and indicated it has taken corrective actions. Superior's responses to the recommendations are included in the report following each recommendation, and its complete response is given in Appendix A.

Criteria

The OIG Audit and Inspections Division used the following criteria to evaluate the information provided:

- Uniform Managed Care Contract, Attachment A, v.2.24 (2017) through v. 2.25.1 (2018)
- Uniform Managed Care Contract, Attachment B-1, v.2.24 (2017) through v. 2.25 (2018)
- STAR+PLUS Expansion Contract, v.1.28 (2017) through v.1.29 (2018)
- STAR+PLUS Medicaid Rural Service Area Contract, v. 1.13 (2017) through v. 1.14 (2018)
- Uniform Managed Care Manual, Chapter 2.3, v. 2.1 (2015)

Auditing Standards

Generally Accepted Government Auditing Standards

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

AUDIT RESULTS

Based on self-reported information, Superior HealthPlan adjudicated an average of 99.99 percent of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by its UMCC contract. However, Superior HealthPlan did not always (a) process all HHSC RUG rate adjustments as required, or (b) process other types of adjustments timely. Specifically, as of January 31, 2020, Superior HealthPlan had not processed $313,190.95 in net RUG rate adjustments, and for 22 of 30 other types of adjustments tested (73 percent), Superior HealthPlan did not process other types of adjustments totaling $1,266.27 timely, which caused delays in payments to nursing facilities that ranged from 31 to 661 days.

RETROACTIVE CLAIM ADJUSTMENTS

MCOs are required to automatically identify and process all HHSC retroactive payment adjustments. The MCO has 30 days to review the change and process the HHSC retroactive payment adjustment. Superior HealthPlan did not process 300 of 504 (60 percent) of the necessary RUG rate adjustments identified by the nursing facility utilization review. Additionally, Superior HealthPlan did not timely process 22 of 30 (73 percent) other type of SAS adjustments initiated by HHSC operations.

Issue 1: Superior HealthPlan Did Not Process All Nursing Facility Utilization Review RUG Rate Adjustments

The UMCC requires the MCO to retroactively adjust payments automatically no later than 30 days after receipt of an HHSC SAS notification of a change to RUG rates.[6] However, Superior HealthPlan did not automatically process all retroactive OIG nursing facility utilization review RUG rate adjustments as required.

Superior HealthPlan stated that in August 2016, it discovered that its system did not recognize SAS updates with an indicator of "new," rather than the expected indicator of "update." Superior HealthPlan further stated that systematic updates were requested and implemented over several years to address all the modifications required to accurately identify retroactive SAS updates. The most recent modifications needed were identified in early 2019.

A secondary, more manual, process was added to address the issue, but certain adjustments were not identified during the audit period. As a result, (a) Superior HealthPlan did not process all RUG rate adjustments in compliance with the

[6] Uniform Managed Care Contract, Attachment B-1, §§ 8.1.18.5, 8.3.9.4, and 8.3.9.5, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018).

contract, (b) the nursing facilities were not paid correct Medicaid-funded RUG rates for certain Superior HealthPlan claims, and (c) related encounters were not adjusted as required. An analysis by OIG determined that Superior HealthPlan processed 204 (40 percent) of the identified RUG adjustments in the amount of $207,941.96. As of January 16, 2020, Superior HealthPlan had not processed the remaining $313,190.95, which includes adjustments expected to reduce prior payments by $359,466.12 and adjustments expected to increase prior payments by $46,275.17.

A further review of data as of August 2020 indicated that Superior HealthPlan was making progress toward processing its outstanding RUG adjustments.

Recommendation 1

Superior HealthPlan should:

- Ensure the effectiveness of its automatic process to identify and complete all retroactive RUG rate adjustments within 30 days of the HHSC SAS notice.
- Identify and process all remaining retroactive RUG rate adjustments included in SAS notifications highlighted in the OIG analysis.

Management Response

Action Plan

The HHSC daily SAS data file interface process has presented ongoing challenges to all of the managed care organizations, as well as the providers, all of whom have expressed frustration and discontent with the process. Superior has responded to those opportunities for improvement by dedicating programming and staff resources to respond to flaws and inconsistencies in file formats and data files, frequently being forced to adopt interim manual process and reviews to fulfill timely and accurate payment obligations to its nursing facility providers.

Superior strives to achieve 100% compliance in the timely processing of all retroactive RUG rate adjustments within 30 days of the HHSC SAS notice. On a current basis, Superior continues to monitor, track and reconcile the daily HHSC SAS file notices to claims to identify any aberrances in the SAS data files for immediate remediation.

Superior confirms that all retroactive RUG rate adjustments included in SAS notifications highlighted in the OIG analysis have been identified and applicable claim adjustments finalized.

Responsible Manager

Vice President of Configuration and Claims Support

Implementation

Complete

Issue 2: Superior HealthPlan Did Not Process Other Retroactive Claims Adjustments Timely

Superior HealthPlan did not consistently process other types of claims adjustments within required timelines, which resulted in delayed payments to nursing facilities. The UMCC requires Superior HealthPlan to automatically process payment adjustments within 30 days of receiving a SAS notification from HHSC indicating that an adjustment is needed.[7] In addition, the UMCM requires that MCOs automatically adjust claims for other changes, such as service authorizations and applied income.[8] Processing those adjustments timely is important because those adjustments result in payment increases or decreases to nursing facilities.

Retroactive adjustments to a claim may be needed due to changes in:

- Member eligibility
- Provider status change
- Nursing facility service authorization
- RUG level
- Service level
- Amount of applied income

OIG selected a random sample of 30 adjusted claims from a total of 113,243 nursing facility claims that were paid more than 90 days after the claim was first submitted by the nursing facility. For those 30 claims, Superior HealthPlan adjudicated the clean claims and later received retroactive adjustments from HHSC via SAS notification. Superior HealthPlan eventually identified these retroactive changes and processed the associated payment adjustments. However, Superior HealthPlan did not process adjustments for 22 of the 30 claims (73 percent) tested within 30 days of the HHSC SAS notification as required.

[7] Uniform Managed Care Contract, Attachment B-1, §§ 8.1.18.5, 8.3.9.4, and 8.3.9.5, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018).

[8] Uniform Managed Care Manual, Chapter 2.3, Section VIII.A, v. 2.1 (Mar. 1, 2015).

Specifically, of the 22 claims that Superior HealthPlan did not adjust as required:

- 1 claim required adjustment due to an insurance add-on.
- 1 claim required adjustment due to nursing facility authorization.
- 8 claims required adjustment due to retroactive changes to the applied income of the member.
- 12 claims required adjustment due to retroactive changes to the RUG (service level) of the member.

Superior HealthPlan stated that these delays occurred because its automatic process did not recognize SAS updates with an indicator of "new," rather than the expected indicator of "update," so certain adjustments were not identified during the audit period. As a result, payments for those 22 claims, which totaled $1,266.27, were delayed between 31 and 661 days.

Recommendation 2

Superior HealthPlan should ensure its automatic process effectively identifies and processes all retroactive payment adjustments within 30 days of an HHSC SAS notice.

Management Response

Action Plan

The HHSC daily SAS data file interface process has presented ongoing challenges to all of the managed care organizations, as well as the providers, all of whom have expressed frustration and discontent with the process. Superior has responded to those opportunities for improvement by dedicating programming and staff resources to respond to flaws and inconsistencies in file formats and data files, frequently being forced to adopt interim manual process and reviews to fulfill timely and accurate payment obligations to its nursing facility providers.

Superior strives to achieve 100% compliance in the timely processing of all retroactive RUG rate adjustments within 30 days of the HHSC SAS notice. On a current basis, Superior continues to monitor, track and reconcile the daily HHSC SAS file notices to claims to identify any aberrances in the SAS data files for immediate remediation.

Responsible Manager

Vice President of Configuration and Claims Support

Implementation

Complete

CONCLUSION

Superior HealthPlan adjudicated and paid most clean claims accurately and timely. Additionally, based on self-reported information, Superior HealthPlan adjudicated an average of 99.99 percent of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by the UMCC. However, Superior HealthPlan did not process all retroactive adjustments as required by contract. Specifically, Superior HealthPlan did not:

- Make all required RUG rate adjustments. As of January 16, 2020, Superior HealthPlan had processed 204 (40 percent) of the identified RUG adjustments in the amount of $207,941.96. Superior HealthPlan had not processed the remaining 300 (60 percent) retroactive RUG adjustments with an expected net recovery of $313,190.95. As a result, nursing facilities were not paid correctly, and related encounters were not adjusted.

- Retroactively process 22 of 30 payment adjustments tested (73 percent) within 30 days of the HHSC SAS notification, as contractually required. The delayed payment amount for those 22 claims totaled $1,266.27.

The OIG Audit and Inspections Division offered recommendations to Superior HealthPlan, which, if implemented, will result in Superior HealthPlan complying with its contractual requirements to automatically identify and process all retroactive adjustments within 30 days of the HHSC SAS notification.

For instances of noncompliance identified in this audit report, MCS may consider tailored contractual remedies to compel Superior HealthPlan to meet contractual requirements related to its nursing facility claims function. In addition, audit findings in this report may be subject to OIG administrative enforcement measures, including administrative penalties.[9,10]

The OIG Audit and Inspections Division thanks management and staff at Superior HealthPlan for their cooperation and assistance during this audit.

[9] 1 Tex. Admin. Code § 371.1603 (May 1, 2016).

[10] Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

Appendix A: Superior's Management Responses

HHS OIG AUDIT OF PROCESSING OF OUTLIER NURSING FACILITY STAR+PLUS CLAIMS AND ADJUSTMENTS
Superior HealthPlan, Inc. and Superior HealthPlan Network
Management Response and Action Plan - November 13, 2020

WHAT THE OIG RECOMMENDS
Superior HealthPlan should ensure the effectiveness of its automatic process to identify and complete all retroactive RUG rate adjustments and other payment adjustments as required by the Uniform Managed Care Contract and Uniform Managed Care Manual.

Superior HealthPlan Management Response
Superior confirms that an effective automated process is in place to identify and complete the nursing facility claim adjustments required for the significant volume of SAS retroactive RUG rate adjustments and other payment updates received from HHSC on a daily basis. Superior completed more than 317,000 adjustments of previously processed nursing facility claims in 2018, predominantly in response to the daily Service Authorization System (SAS) retroactive updates received from HHSC. During that year, the volume of retroactive SAS adjustments received from HHSC prompted obligatory adjustment of a significant percentage (65%) of clean claims previously finalized. We believe the complexity and inefficiency of the SAS data interface files and process prompting the excessive volume of retroactive nursing facility claim adjustments is the major contributing factor to complaints and discontent with nursing facility claims processing, not untimeliness or delays in processing.

In support of Superior's position, and contrary to the report of noncompliance and untimely processing, Superior HealthPlan (Superior's) compliance with timely processing is in excess of 99.99% for nursing facility claims adjudicated within 10 calendar days. More specifically, of the approximate 491,000 nursing facility clean claims processed in 2018, less than 60 claims were adjudicated in more than 10 calendar days.

Superior acknowledges that the OIG's claim audit sample was not random, but chosen from a universe of all claim adjustments finalized more than 90 days after receipt of a SAS adjustment record. The OIG's claim audit universe of untimely finalized claims accounts for less than one percent (0.16%) of the total 317,000 claims Superior adjusted in 2018. In addition, the OIG has communicated that materiality of calculated payment errors was not considered in the OIG's determination of non-compliance for this audit. For example, the payment variance for two of the claims included in the OIG's non-compliant findings was less than $0.50. Further, the total variance reported for untimely payments in the OIG's audit report ($1,266.27) accounts for 0.01% of the total adjusted claim payments Superior finalized during 2018. Superior recommends that materiality be incorporated into any similar future audits for the determination of non-compliance.

OIG Recommendation 1 and 2
• Ensure the effectiveness of its automatic process to identify and complete all retroactive RUG rate adjustments within 30 days of the HHSC SAS notice. (Recommendation 1)
• Superior HealthPlan should ensure its automatic process effectively identifies and processes all retroactive payment adjustments within 30 days of an HHSC SAS notice. (Recommendation 2)

Superior HealthPlan - Action Plan Response
The HHSC daily SAS data file interface process has presented ongoing challenges to all of the managed care organizations, as well as the providers, all of whom have expressed frustration and discontent with the process. Superior has responded to those opportunities for improvement by dedicating programming and staff resources to respond to flaws and inconsistencies in file formats and data files, frequently being forced to adopt interim manual process and reviews to fulfill timely and accurate payment obligations to its nursing facility providers.

Superior strives to achieve 100% compliance in the timely processing of all retroactive RUG rate adjustments within 30 days of the HHSC SAS notice. On a current basis, Superior continues to monitor, track and reconcile the daily HHSC SAS file notices to claims to identify any aberrances in the SAS data files for immediate remediation.

HHS OIG AUDIT OF PROCESSING OF OUTLIER NURSING FACILITY STAR+PLUS CLAIMS AND ADJUSTMENTS
Superior HealthPlan, Inc. and Superior HealthPlan Network
Management Response and Action Plan - November 13, 2020

Responsible Manager: VP, Configuration and Claims Support

Target Implementation Date: Complete

OIG Recommendation 1

• ***Identify and process remaining retroactive RUG rate adjustments included in SAS notifications highlighted in the OIG analysis.***

Superior HealthPlan - Action Plan Response
Superior confirms that all retroactive RUG rate adjustments included in SAS notifications highlighted in the OIG analysis have been identified and applicable claim adjustments finalized.

Responsible Manager: VP, Configuration and Claims Support

Target Implementation Date: Complete

Appendix B: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Audrey O'Neill, CIA, CFE, CGAP, Chief of Audit and Inspections
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- Bruce Andrews, CPA, CISA, Audit Manager
- Kenneth Johnson, CPA, CIA, CISA, Audit Project Manager
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- Nathaniel Alimole, CPA, Senior Auditor
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- Toni Gamble, CGAP, Quality Assurance Reviewer
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- Louis Ayala, Compliance Manager
- Christina Lennon, Compliance Specialist
- Carlos Galvan, Compliance and Reporting Specialist

Appendix C: OIG Mission, Leadership, and Contact Information

The mission of OIG 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 OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Juliet Charron, Chief of Strategy
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