Utilization Review in STAR+PLUS Managed Care

As Required by Texas Government Code,
Section 533.00281(d)

Health and Human Services

November 2017
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Executive Summary

The report on *Utilization Review in STAR+PLUS Managed Care* is submitted in compliance with Texas Government Code, Section 533.00281(d). Section 533.00281 requires the Health and Human Services Commission (HHSC) to use a utilization review process to examine how Medicaid managed care organizations (MCOs) participating in STAR+PLUS determine enrollment in the STAR+PLUS Home and Community Based Services (HCBS) program.

STAR+PLUS Medicaid managed care is for individuals 65 and older, or under 65 with a disability qualifying them for Supplemental Security Income (SSI) or related benefits. STAR+PLUS provides acute care, pharmacy, and long-term services and supports (LTSS). Some members with additional medical needs in the community are eligible for STAR+PLUS HCBS.

HHSC Managed Care LTSS Utilization Review\(^1\) staff complete utilization reviews annually to ensure MCOs are correctly assessing and enrolling members in STAR+PLUS HCBS and providing services at appropriate levels. Beginning fiscal year 2017, a statistically valid sample of the STAR+PLUS HCBS population was reviewed.

Key fiscal year 2017 findings:

- MCOs demonstrated a notable improvement in timely and accurate completion of assessments and service plans, but face challenges initiating services and following up on identified needs, including nursing services and durable medical equipment (DME).
- MCOs more accurately assessed and documented justifications for newly-enrolled HCBS members, but face challenges documenting justifications for services on members’ annual reassessment service plans.

\(^1\) Previously the Utilization Management and Review (UMR) unit, but renamed to better reflect functions. The utilization review unit under the Office of the Medical Director now has three sections: Managed Care LTSS, Managed Care Acute Care, and IDD Waivers/Community Services/Hospice.
Based on findings, HHSC recommends MCOs establish internal processes to:

- act on assessed service needs and identify HCBS members who have not received assessed services timely; and
- provide a full-circle approach to coordinated care and service coordination, from the assessment to verification of service delivery.
Section 533.00281(d) requires HHSC to conduct utilization reviews to ensure appropriated funds are spent effectively to provide needed services, and submit a report on findings annually, by December 1, to the standing committees of the Senate and House of Representatives with jurisdiction over Medicaid.

The report must:

- summarize the results of utilization reviews conducted under the section during the preceding fiscal year;
- provide analysis of errors committed by each reviewed MCO; and
- extrapolate those findings and make recommendations for improving the efficiency of the program.

Section 533.00281 grants HHSC discretion to determine which topics the utilization review process will examine, but requires HHSC to include in the process a thorough investigation of each MCO's policies and procedures for determining whether an individual or health plan member should be enrolled in STAR+PLUS HCBS.

Because findings are not statistically valid for each MCO reviewed, this report's findings are based on the sample across all MCOs.
2. Background

HHSC’s STAR+PLUS and STAR+PLUS HCBS programs are managed care programs. Such programs are designed to meet members’ health care needs by “reduc[ing] unnecessary health care utilization so that only medically necessary services are provided,” 2 while also guarding against underutilization. 3

Utilization review plays a crucial role in ensuring MCOs contracted to provide STAR+PLUS and STAR+PLUS HCBS services meet contractual obligations and provide members with the required standard of medically necessary services,4 including accurately determining whether members should be enrolled in STAR+PLUS HCBS.

Through the utilization review process, assessments, service delivery plans, and supporting documentation are reviewed to:

- determine if services are timely and meet the needs of the individual;
- evaluate the conduct of assessments; and
- evaluate the quality of services delivered.

**STAR+PLUS and STAR+PLUS HCBS**

The STAR+PLUS Medicaid managed care program integrates the delivery of acute care services, pharmacy services, and LTSS to individuals 65 and older and individuals under 65 with a disability that may qualify them for SSI or SSI-related

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3 Underutilization is when an organization shows a pattern of failing to provide its members with medically necessary health care services on a timely basis.

4 Capitated payment also serves as a built-in incentive for MCOs to control health care expenditures and maximize health outcomes.
benefits. Enrollment in STAR+PLUS is mandatory for most adults receiving SSI, as well as adults who do not receive SSI (non-SSI), but who qualify for the STAR+PLUS HCBS program. Enrollment in STAR+PLUS was voluntary for children and young adults under the age of 21 who receive SSI and SSI-related Medicaid benefits until implementation of the STAR Kids managed care program on November 1, 2016.

About 10 percent of the overall STAR+PLUS population requires the additional services available through STAR+PLUS HCBS. To be eligible for STAR+PLUS HCBS, an individual must be 21 years old, meet financial eligibility, meet medical necessity criteria to qualify for admission to a nursing facility, and have an unmet need for at least one STAR+PLUS HCBS waiver service:

- Personal assistance services (includes multiple service delivery options)
- Protective supervision
- In-home and out-of-home respite services
- Nursing services (in-home)
- Emergency response services (emergency call button)
- Home-delivered meals
- Minor home modifications
- Adaptive aids and medical equipment
- Medical supplies
- Therapies (physical, occupational, and speech)
- Dental services
- Supported employment
- Employment assistance
- Cognitive rehabilitation therapy
- Transition assistance services
- Financial management services
- Assisted living
- Adult foster care

Service coordination is a key element of the STAR+PLUS HCBS program. This specialized care management provided by MCO registered nurses (RNs) for each HCBS member provides coordinated access to an array of providers and covered services. It also leads to assessment-driven service planning to meet the unique needs of individual members.
3. Fiscal Year 2017 Utilization Review Activities

Technical Assistance and Training

In preparation for the current utilization review and to address prior findings, utilization review staff focused efforts in fiscal year 2016 on providing technical assistance and training to STAR+PLUS MCOs. Training and technical assistance provided included:

- MCO service coordinators were required to participate in eight live webinars to learn how to conduct assessments for service planning, appropriately develop and implement service plans for STAR+PLUS HCBS timely, and complete service justification forms.
- MCOs received training and technical assistance on STAR+PLUS HCBS requirements.

Review Topic Selection

In addition to investigating each MCO’s policies and procedures for determining whether an individual or health plan member should be enrolled in STAR+PLUS HCBS, HHSC exercised its discretion under Section 533.00281 to determine other review topics.

Other review topics chosen for the fiscal year 2017 utilization review include the ability of MCOs to assess, develop, and implement a plan for providing skilled nursing services and their ability to provide access to DME. Both topics were chosen based on challenges identified during the fiscal year 2015 review. Because fiscal year 2016 activities were devoted to technical assistance and training for MCOs on HCBS requirements, utilization review data in this report are compared where possible to fiscal year 2015 data.

Review Process

The utilization review process included the following activities completed for each of the five STAR+PLUS MCOs:

- On-site Visit – completed by utilization review RN staff in October 2016, to discuss review parameters and guidelines for submittal of documentation
related to the sample members and to review case notes in the MCO system to show what documentation is being requested.

- Records Request – request for documentation for all HCBS member case types per instructions and details included on the records request form.
- Desk Reviews – review of all records submitted for each sample member.
- Home Visits – completed by utilization review RN staff for all sample members to confirm the reviewed MCO documentation fully and accurately captures the member’s needs.
- Referrals – submission of internal complaints (referrals) to HHSC Managed Care Compliance and Operations section when access to care or health and safety issues were discovered.
- Reporting – compilation and reporting of results from fiscal year 2017 reviews to HHSC leadership and STAR+PLUS MCOs.

**Quality Assurance**

An internal quality assurance plan is in place to ensure accuracy and consistency of review tools and processes. As part of the plan, inter-rater reliability testing is completed to ensure consistency among reviewers and quality checks are performed to ensure data accuracy. This plan also ensures utilization review goals, activities, timeframes, responsibilities, and reporting parameters meet legislative and executive leadership direction.
4. Utilization Review Findings

Fiscal year 2017 utilization review findings are discussed below. Where comparisons are made between the fiscal years 2015 and 2017 reviews, it is important to note expanded member types in the 2017 sample were used.

Conduct of Assessments

The MCO RN service coordinator is responsible for the development and ongoing revision of an assessment-driven individual service plan (ISP) to meet the needs of each member. Accurate completion of STAR+PLUS HCBS forms guides the process and documents the planning steps.

Development of the ISP is a holistic nursing process which includes assessments, an interview with the member/authorized representative and family, and a thorough investigation of available resources.

Findings

Generally, the fiscal year 2017 utilization review revealed the same types of issues with conduct of assessments as identified by the fiscal year 2015 review. However, MCOs showed strength or improvement in several areas. The majority of MCOs completed required assessments, service justifications and ISPs more accurately for newly-enrolled HCBS members.

MCOs experienced challenges:

- assessing and documenting justifications for HCBS on members’ annual reassessment service plans;
- completing or accurately completing forms supporting the ISP, including:
  - Form 2060-A, which was accurately completed only 37 percent of the time and is used to document nursing delegation and the need and level of protective supervision; and
  - Form H1700-B, which was accurately completed only 34 percent of the time and is used to document all available third-party resources and non-waiver services, including informal support; and
• providing needed items and services identified by the MCO and member through assessments and as noted in MCO documentation, with 42.5 percent of sample members having one or more needs identified during the assessment without resolution.

**Process for Determining Enrollment in STAR+PLUS HCBS**

To assess members as eligible for enrollment in STAR+PLUS HCBS, per contract and waiver eligibility requirements, MCOs must demonstrate the individual has a minimum of one unmet need for at least one HCBS service. Form H1700-A is the primary documentation establishing medical need and rationale for all STAR+PLUS HCBS items or services requested and included on the ISP. The rationale must describe why the item or service is necessary and how it benefits the member in terms of medical treatment, rehabilitation, or the ability to compensate for functional limitations.

**Findings**

The fiscal year 2017 utilization review showed improvement in the percent of reviewed newly-enrolled cases with an adequate rationale for at least one HCBS item or service listed in the ISP, compared to the 64.3 percent rate found in fiscal year 2015.

**Table 1. Percent of Reviewed Cases with Adequate Rationale for HCBS Item or Service – Fiscal Year 2017**

<table>
<thead>
<tr>
<th>HCBS Eligibility Type</th>
<th>Adequate Rationale</th>
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<tbody>
<tr>
<td>SSI newly-enrolled</td>
<td>84.9%</td>
</tr>
<tr>
<td>Medical Assistance Only (MAO) newly-enrolled</td>
<td>97.2%</td>
</tr>
<tr>
<td>Reassessments of all types</td>
<td>64.7%</td>
</tr>
</tbody>
</table>

**Skilled Nursing Services**

All HCBS program members have a skilled nursing need as evidenced by the medical necessity determination. MCOs must meet the assessed skilled nursing needs of STAR+PLUS HCBS program members.
Findings

Generally, the fiscal year 2017 utilization review revealed the same issues with skilled nursing services as identified by the fiscal year 2015 review. However, MCOs demonstrated improvement in documenting how skilled nursing needs were addressed and utilization review nurses referred fewer internal complaints regarding skilled nursing services.

Table 2. Internal Complaints Referred

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Internal Complaints Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year 2015</td>
<td>37</td>
</tr>
<tr>
<td>Fiscal Year 2017</td>
<td>18</td>
</tr>
</tbody>
</table>

MCOs experienced challenges in previous years:

- consistently identifying and documenting skilled nursing service needs; and
- appropriately addressing skilled nursing services documented in the ISP through informal supports, third-party resources, or other sources.

Failure to provide skilled nursing services was one of the most common issues referred as internal complaints to HHSC Managed Care Compliance and Operations.

Durable Medical Equipment

MCOs must meet the assessed DME needs, including adaptive aids and medical supplies, of HCBS program members.

Findings

Generally, the fiscal year 2017 utilization review and stakeholder input revealed the same significant issues with DME services as identified by the fiscal year 2015 review.

MCOs experienced challenges:

- identifying DME needs and failing to provide services through STAR+PLUS HCBS or third-party resources; and
- documenting identified DME services provided through STAR+PLUS HCBS or third-party resources.
Failure to provide DME was one of the most common issues referred as internal complaints to HHSC Health Plan Management.

HHSC utilization review staff plan to use information collected as part of the fiscal year 2017 utilization review to clarify STAR+PLUS policy and contract language related to DME to ensure greater consistency of adherence to STAR+PLUS HCBS program requirements and member experience across health plans.

**Timeliness**

Timely development of the ISP ensures the member receives HCBS services without delay. For Medical Assistance Only (MAO)\(^5\) individuals it is a component of Medicaid eligibility.

**Findings**

The fiscal year 2017 utilization review showed overall improvement for all but one MCO in meeting the contractually required timeframes for assessing and developing an ISP compared to fiscal year 2015, when only 29.8 percent of ISPs were submitted timely.

**Table 3. Timely Submission of ISP**

<table>
<thead>
<tr>
<th>HCBS Eligibility Type</th>
<th>Timely submission of ISP</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI newly-enrolled</td>
<td>81.1%</td>
</tr>
<tr>
<td>MAO newly-enrolled</td>
<td>77.8%</td>
</tr>
<tr>
<td>Reassessments of all types</td>
<td>79.2%</td>
</tr>
</tbody>
</table>

MCOs experienced challenges meeting a contract requirement added in March 2016 requiring MCO service coordinators to contact HCBS members no later than four weeks after the ISP start date to determine if ISP services are in place. This requirement was not met for 71.5 percent of the sampled members. HHSC utilization review staff addressed non-compliance with each MCO when presenting the fiscal year 2017 findings. MCOs were informed this standard will be measured in

\(^5\) MAO means a person that does not receive SSI benefits but qualifies financially and functionally for Medicaid assistance. For this population, their functional eligibility has been determined with medical necessity for HCBS.
fiscal year 2018 and will be subject to contract actions, such as actual or liquidated damages.

**Referrals**

HHSC utilization review staff make internal complaints or referrals to HHSC Health Plan Management for resolution of issues related to health and safety and access to care when these issues are identified as part of the review process and home visits to members.

**Findings**

In fiscal year 2017, referrals were made for about 20 percent of HCBS members (74 out of a total 358 members sampled), compared to fiscal year 2015 when referrals were made for about 37 percent of HCBS members (100 out of a total 272 members sampled). Some members had multiple issues on referrals. Some referrals may result in contract actions, such as actual or liquidated damages.

**Table 4. Number of Members Referred**

<table>
<thead>
<tr>
<th>Referral Type</th>
<th>Number of Members referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>58</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>13</td>
</tr>
<tr>
<td>Access to Care &amp; Health and Safety</td>
<td>3</td>
</tr>
</tbody>
</table>

MCOs experienced challenges with commonly referred issues:

- **Lack of Assessment-driven Service Plan** – MCOs identified a need for one or more waiver items or services not authorized by the member’s service plan.
- **Lack of Follow-up** – MCOs identified and authorized a waiver item or service, but failed to ensure the item or service was delivered to the member.
- **Lack of Dual-eligible Coordination** – MCOs identified a need that could be provided by Medicare, but failed to coordinate the authorization process, as outlined in the Uniform Managed Care Contract.
- **Failure to Provide Skilled Nursing and DME Services** - MCOs either identified a need for skilled nursing services or DME and failed to provide them, or failed to identify the need in assessments. This was the most common referral.
5. Recommendations

HHSC recommends the following to improve the efficiency of the program:

- Develop methods for HHSC oversight of MCOs policies and procedures to ensure MCOs:
  - provide a full-circle approach to coordinated care and service coordination, from the assessment, development of the service plan, to verification of service delivery; and
  - establish internal processes to act on assessed service needs and identify HCBS members who have not received assessed services timely.
- Continue to identify areas for HHSC to clarify contract and policy language to ensure greater adherence to STAR+PLUS HCBS program requirements and consistency of member experience across health plans.
- Continue to identify and implement improvements to the utilization review process to include automation and data-driven reviews.
6. Conclusion

Fiscal Year 2017 utilization reviews showed MCO improvement in some assessed areas, but MCOs faced continued challenges in many of the same areas where issues were identified in the fiscal year 2015 review. Additional technical assistance and training has been offered to the MCOs, and enhancements to contract and policy language continues.

HHSC utilization review staff will continue offering consultations, technical assistance, and training to MCOs, which have proven receptive to participating in these opportunities to:

- improve internal processes and procedures to meet HCBS requirements;
- develop internal quality assurance activities to ensure service coordinators and internal HCBS activities meet contract requirements;
- respond to members’ needs and changes in health status timely and adequately;
- appropriately assess and deliver DME and skilled nursing services;
- evaluate and follow up on service plans; and
- coordinate access to an array of providers and third-party covered services.
## List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>HHSC</td>
<td>Health and Human Services Commission</td>
</tr>
<tr>
<td>HCBS</td>
<td>Home and Community Based Services</td>
</tr>
<tr>
<td>ISP</td>
<td>Individual Service Plan</td>
</tr>
<tr>
<td>LTSS</td>
<td>Long-term Services and Supports</td>
</tr>
<tr>
<td>MAO</td>
<td>Medical Assistance Only</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SSI</td>
<td>Social Security Income</td>
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