Utilization Review in STAR+PLUS Managed Care

As Required by

Government Code Section

533.00281

Texas Health and Human

Services Commission

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Contents

1. Executive Summary

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

The STAR+PLUS Medicaid managed care program serves adults who are eligible for supplemental security income (SSI) and those over age 65. STAR+PLUS provides acute care, pharmacy, and long-term services and supports (LTSS). Some members are eligible to receive enhanced LTSS in the community as an alternative to care in a nursing facility through the STAR+PLUS HCBS program.

HHSC staff complete URs annually to determine if MCOs are correctly assessing and enrolling members in STAR+PLUS HCBS and providing needed services. For the fiscal year 2020 HCBS review, HHSC's primary focus was on members whose assessments indicate they have the most needs as indicated by the top two resource utilization group (RUG) classifications, Extensive Services (ES) and Special Care (SC). The review also included a risk-based sample of members in each of these groups based on MCO risk, as determined by each MCO's historic rate of complaint referrals. Because of the novel coronavirus (COVID-19) public health emergency, HHSC made changes to the review process; however, COVID-19 did not impact the focus of the review.

Through the third quarter (March-May 2020) of fiscal year 2020, the HCBS reviews revealed improvement in MCO compliance with the STAR+PLUS HCBS program criteria of documenting a justification for at least one waiver service (assessment driven service planning), the completion of the contractually required assessments and service planning documents (conduct of assessment), and timeliness of assessments. MCO performance in timeliness as it relates to the follow-up call remains unchanged.

This report includes findings through the third quarter of fiscal year 2020. HHSC is finalizing the findings from the fourth quarter. HHSC anticipates the fourth quarter

findings will be finalized in Spring 2021 and will provide a supplemental report, including recommendations, upon finalizing findings.

2. Introduction

Texas Government Code Section 533.00281 requires HHSC to conduct utilization reviews (UR) in STAR+PLUS. These reviews focus on the STAR+PLUS Home and Community Based Services (HCBS) program to ensure appropriated funds are spent effectively to provide needed community-based services as an alternative to care in a nursing facility. HHSC must annually provide a report which:

- summarizes the results of UR conducted during the preceding fiscal year;
- provides analysis of errors or issues by each reviewed Medicaid managed care organization (MCO); and
- extrapolates findings and makes recommendations for improving the efficiency of the program.

This statute requires HHSC to investigate each MCO's procedures for determining whether an individual should be enrolled in STAR+PLUS HCBS, including the conduct of assessments and related records. It also grants HHSC the discretion to determine topics the UR process examines.

The review focused on contractual requirements for the conduct of assessment, assessment driven service planning[1], timeliness, and service delivery.

[1] Assessment driven service planning requires MCOs to address identified needs from required assessments, service planning documents, and other MCO documentation.

3. Background

The STAR+PLUS program integrates the delivery of acute care, pharmacy and long-term services and supports through a MCO. STAR+PLUS serves individuals who:

- are age 65 or older;
- are age 21 and older with a disability receiving supplemental security income (SSI) or SSI-related Medicaid;
- are enrolled in the Medicaid for Breast and Cervical Cancer program;
- are residing in a nursing facility and eligible for Medicaid; or
- meet the income and eligibility requirements for the STAR+PLUS HCBS program.

The STAR+PLUS HCBS program is available to individuals enrolled in STAR+PLUS or who are released from the program's interest list and meet the following criteria: income requirements; medical necessity for a nursing facility admission; have an unmet need for at least one program service; and can safely be served in the community. Individuals enrolled in a STAR+PLUS MCO, referred to as members, can request an assessment. Alternatively, an MCO may determine the member would benefit from the program and initiate the assessment process with the member's consent. Individuals in the community, not otherwise eligible for Medicaid, can request to be assessed for the program by being placed on an interest list. Individuals on the interest list are assessed on a first-come, first-served basis when an opening for the program is available. STAR+PLUS HCBS is also available to members enrolled in the Texas Dual Eligible Integrated Care Demonstration Project (Dual Demonstration).

Service coordination, a key element of the STAR+PLUS program, is provided by a registered nurse for members in the STAR+PLUS HCBS program. The MCO service coordinator is responsible for assessing a member's needs, developing a service plan to address those needs, coordinating timely access to covered services for members, and coordinating services provided by third party resources. For members in the STAR+PLUS HCBS program, covered services include enhanced LTSS such as:

- Personal assistance services
- Protective supervision
- Respite services in or out-of-home
- Nursing services (in-home)
- Emergency response services
- 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

UR is crucial to ensure MCOs meet contractual obligations and provide members with the required standard of medically necessary services, including accurately determining whether members should be enrolled in STAR+PLUS HCBS. UR of STAR+PLUS HCBS is performed by registered nurses who have the same Resource Utilization Group (RUG) certification and person-centered planning training required for STAR+PLUS HCBS MCO service coordinators. UR includes a desk review of a member's assessments, service planning documentation, and MCO records, including case notes. It also includes a home visit with the member to ensure identified needs are addressed.

If the MCO identified a need for a service during the assessment process and the need was not addressed by the MCO at the time of the HHSC UR home visit or a delay in initiation was identified, the HHSC UR nurse makes a referral, or internal complaint, to the HHSC Managed Care Compliance and Oversight unit to ensure follow up on the issue until it is resolved. If the HHSC UR nurse identifies a new issue at the home visit, such as a need for a new item or service, the HHSC UR nurse follows up in writing to notify the MCO service coordinator of the need for the member to be assessed and to address the newly identified issue.

HHSC began conducting reviews of the STAR+PLUS HCBS program in fiscal year 2014. Over time, the reviews have changed in size and scope based on review findings and identified issues.

Following the fiscal year 2017 review and subsequent report, HHSC took contractual actions against some MCOs; liquidated damages were assessed against all five[2] MCOs and four MCOs were placed on corrective action plans[3] (CAPs) to identify the root cause of the issues and processes to remedy them. These four MCOs were cited for a combination of failing to meet timeliness requirements related to assessments and individual service plan (ISP) timeframes, failure to provide a covered service, and/or failure to provide an administrative service. HHSC UR reviewed and approved the MCOs' interventions and corrective actions related to each area of non-compliance. MCOs under CAPs began to address identified issues in fiscal year 2018 and remain on CAPs until the MCO demonstrates, based on the findings from subsequent annual reviews, the remediation of issue(s).

[2] Five MCOs currently participate in STAR+PLUS: Amerigroup, Cigna, Molina, Superior, and United.

[3] Corrective action plan means the detailed written plan that may be required by HHSC to correct or resolve a deficiency or event causing the assessment of a remedy or damage against MCO.

4. Fiscal Year 2020 HCBS Utilization Review Activities

In fiscal year 2020, HHSC conducted a review of the STAR+PLUS HCBS program using the following sample criteria:

- A statistically valid random sample of members from the population of the top two RUG classifications [Extensive Services (ES) and Special Care (SC)], combined, from each MCO.
- An additional sample from the remaining ES/SC members from each MCO, with sample sizes based on MCO risk, as determined by each MCO's historic rate of complaint referrals.

The review consisted of 814 members[4] with an ISP start date of October 2019 or November 2019. This was more than double the number of reviews conducted (355) in fiscal year 2019. Desk reviews and home visits for fiscal year 2020 took place between March 2020 and September 2020 and were conducted by 17 nurses. On March 16, 2020, HHSC implemented COVID-19 precautions and suspended all face-to-face home visits and began performing telephone interviews with members.

Throughout the review period, HHSC meets with the MCOs on a quarterly basis to communicate the results of the reviews and provide technical assistance to facilitate improvement. Following these meetings, MCOs have a deadline of two weeks to submit additional documentation to rebut identified issues. HHSC staff review all documentation submitted within the allotted timeframe. Based on the review of the documentation, HHSC may adjust the findings and/or make recommendations for policy changes. As of this report date, HHSC is working with the MCOs to finalize the findings from the fourth quarter (June-August 2020).

[4] One member had to be removed from the sample due to a nursing facility placement. The MCO did not have any other members who met the sample criteria available resulting in the sample size being adjusted to 813.

5. Utilization Review Findings

UR findings from fiscal year 2020 are discussed below. The findings are based on reviews through the third quarter of fiscal year 2020 and are preliminary until the fourth quarter findings are finalized.

Assessment Driven Service Planning

Eligibility for STAR+PLUS HCBS requires an individual be financially eligible, meet the level of care requirements for admission into a nursing facility, and have a documented need for at least one HCBS service.

For purposes of assessing compliance with contractual requirements, HHSC reviewed the presence of a rationale to justify the need for at least one HCBS service for the member. HHSC UR nurses reviewed MCO assessment and service planning documentation as well as case notes to identify whether a member's assessment documented an unmet need that could only be addressed by STAR+PLUS HCBS.

Preliminary findings of the 2020 HCBS review revealed improvement by all MCOs in meeting the STAR+PLUS HCBS program eligibility criteria of documenting a justification for at least one waiver service, as required by contract. In the fiscal year 2019 review, the statewide MCO average for this measure was 97.35 percent. Preliminary findings of the 2020 review, indicate statewide performance by all MCOs at near 100 percent compliance.

Conducting Assessments

The MCO service coordinator is responsible for the development, maintenance, and revision of an assessment-driven ISP to meet the needs of each member. Development of the ISP is a holistic nursing process which includes assessments, an interview with the member/authorized representative and informal supports, and a thorough investigation of available resources. Accurate completion of STAR+PLUS HCBS forms guides the process and documents the planning steps. HHSC evaluates the MCO's conduct of assessment through a desk review of the MCO's service coordination documentation.

In the 2019 review, the statewide MCO average for this measure was 96.90 percent. Preliminary findings of the 2020 HCBS review revealed improvement in the

completion of the contractually required assessments and service planning documents and forms with compliance near 100 percent.

Timeliness

HHSC sets forth specific timeframes for the completion of assessment activities in STAR+PLUS contracts to ensure timely access to necessary services. Individuals released from an interest list or requesting assessment for the HCBS program must have all assessment activities completed within 45 days of request. Members must have all reassessment activities completed no earlier than 90 days and no later than 30 days before their previous ISP expires. Assessment activities may be delayed for reasons including difficulty obtaining a physician signature (required for initial eligibility for the program), a preference of a member, or their representative's availability.

For 2020 reviews, HHSC not only looked at timeliness, but also whether the MCO documented a legitimate reason for a delayed assessment and service plan development. If the documentation provided explained why a timeframe was not met, HHSC UR considered the documentation as meeting the standard of timeliness. For example, for an initial assessment, a physician must sign a form agreeing the member requires nursing services. If the MCO documented issues obtaining the physician's signature and the efforts to obtain the signature, HHSC UR did not count as a failure to meet contractual timeframes. In fiscal year 2019, the MCO performance in timeliness of assessments and reassessments was 89.00 percent. Preliminary findings for fiscal year 2020 show a slight improvement in performance with compliance at 91.08 percent.

MCOs are also required to meet timeliness standards with respect to service coordination and follow-up after the initiation of HCBS services. The service coordinator must contact the member no less than four weeks following the start of the service plan to determine whether the services identified in the ISP are in place. HHSC verifies compliance with these contractual requirements through a desk review of the MCOs service coordination documentation.

MCOs' approach to this requirement vary considerably. One MCO has a dedicated team conducting the four-week follow-up and another MCO has service coordinators following up one week after the ISP start date and then again four weeks after the ISP start date. MCOs use reports for tracking when the calls need to take place. Within MCOs, the quality of documentation varies from service coordinator to

service coordinator. For fiscal year 2020, the requirement for a four-week follow-up call continues to be an area of concern. In fiscal year 2019, the state overall average performance for this measure was just over 50 percent. Preliminary findings for fiscal year 2020 show the compliance remains at just above 50 percent.

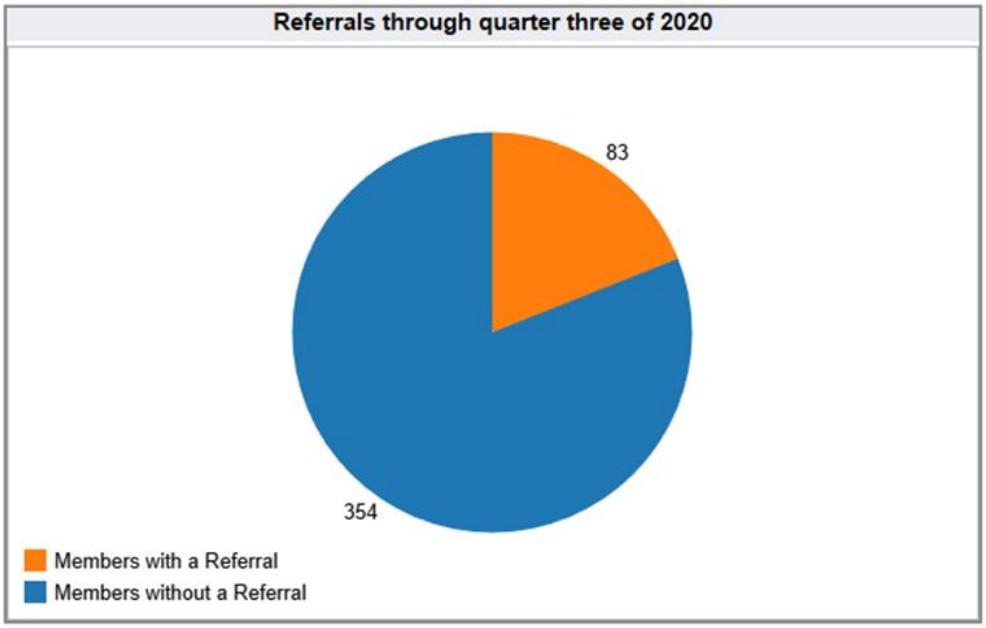
Referrals

Upon identification of an issue related to access to care or member health and safety, an HHSC UR nurse makes an internal complaint, or referral, to the HHSC Managed Care Compliance and Operations unit for resolution of identified issues. This process ensures an issue is logged as a complaint, tracked, and resolved to the member's satisfaction. There are two categories of referrals: access to care and health and safety.

An access to care referral could be generated if the MCO did not assist a member in finding a provider, such as a dentist who could perform sedation dentistry, or if there was a delay in service initiation outside the HHSC required time frames. A referral for a health and safety issue could be generated if delay or failure to provide an item or service posed a health and safety risk for a member. For example, if a member had a documented need for a nursing service and their health and safety was at risk as a result of not receiving nursing services, a health and safety referral would be made. A referral would not be made if the delivery of an item or service was outside of the MCO's control and the documentation reflected it. For example, if the MCO identified a potential need for physical therapy, but the member's physician did not agree and would not sign orders for physical therapy, HHSC UR would not make a referral to the contract compliance unit.

In fiscal year 2019 referrals were processed for lack of documentation of coordination and/or access to care issues, which resulted in referrals being made for 93 of the 355 members sampled. In fiscal year 2020, UR only processed referrals for access to care issues. Figure 1 shows the number of members who had at least one referral generated as a result of the 2020 review, through the third quarter.

Chart 1



Summary of 2017 CAP Follow-Up

The fiscal year 2017 UR review process resulted in contract remedies for four of the five STAR+PLUS MCOs. Contract remedies, including liquidated damages, were based on review outcomes.

CAP approvals were completed in late fall of 2018. Therefore, some interventions had not been implemented and the impact of these interventions was not evident in the 2019 HCBS review due to implementation date and timeframe of review.

Preliminary findings for the fiscal year 2020 review indicate the MCOs have implemented some interventions based on the fiscal year 2017 CAPs; however, it is likely HHSC will recommend CAPs for all four MCOs remain open. The MCOs have addressed some areas of non-compliance within the CAP; but MCOs should continue to address issues of non-compliance with access to care referrals related to follow-up, assessment driven service planning, and coordination for dual eligible members.

Preliminary findings of the 2020 review show improvement; however, MCOs have low performance on MCO-specific performance measures related to the timeliness of the four-week follow-up call to ensure services are initiated timely. The low performance in this area could contribute to access to care referrals.

6. Conclusion

Through the third quarter (March-May 2020) of fiscal year 2020, UR reviews have shown improvement from the 2019 findings, especially in the areas related to assessment driven service planning and conducting assessments. HHSC staff will provide a supplemental report after the fourth quarter findings are finalized and will make recommendations based on those final findings.

HHSC continues to refine procedures related to UR of MCOs delivering HCBS services and identify innovative ways to ensure members receive needed services in a timely manner. This includes:

- Continuing efforts to identify ways to use data and automated processes to better inform the use of UR resources.
- Reviewing similar elements during the next review to continue monitoring improvement.
- Increasing frequency of reporting to MCOs to allow for timely resolution of compliance issues.
- Additional reviews of MCO policies related to areas of non-compliance and recommendations for changes that could positively impact performance.

List of Acronyms

Acronym	Full Name
CAP	Corrective Action Plan
ES	Extensive Services
HHSC	Health and Human Services Commission
HCBS	Home and Community Based Services
ISP	Individual Service Plan
LTSS	Long-term Services and Supports
MCO	Managed Care Organization
RUG	Resource Utilization Group
SC	Special Care
SSI	Supplemental Security Income
STAR	State of Texas Access Reform
UR	Utilization Review