

Utilization Review In STAR+PLUS Medicaid Managed Care

AN ANNUAL REPORT
REQUIRED BY

Senate Bill 348

**83rd Legislature
Regular Session, 2013**



Program Operations ♦ Medicaid and CHIP Division

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SENATE BILL 348
ANNUAL REPORT ON UTILIZATION REVIEW
IN STAR+PLUS MEDICAID MANAGED CARE

Introduction

Senate Bill (S.B.) 348, 83rd Legislature, Regular Session, 2013 directs the Health and Human Services Commission (HHSC) to “...provide a report to the standing committees of the senate and house of representatives with jurisdiction over the Medicaid program not later than December 1 of each year. The report must:

- (1) summarize the results of the utilization reviews conducted under this section during the preceding fiscal year;
- (2) provide analysis of errors committed by each reviewed managed care organization; and
- (3) extrapolate those findings and make recommendations for improving the efficiency of the program.”

EXECUTIVE SUMMARY

Utilization review is a process in which assessments, service delivery plans, and supporting documentation are reviewed to:

- (1) determine if services are appropriate and timely to meet the needs of an individual;
- (2) evaluate the conduct of the assessments; and
- (3) evaluate the quality of the services delivered.

Within the health and human services arena, registered nurses performing utilization reviews help to protect the health and safety of our most vulnerable populations. These reviews also serve as a tool to ensure public funds earmarked for health and social service programs are spent wisely and effectively.

In 2013, the 83rd Texas Legislature unanimously passed S.B. 348. The bill, codified in Title 4 Government Code §533.00281, Utilization Review for STAR+PLUS Medicaid Managed Care, directs the Health and Human Services Commission (HHSC) to establish an annual utilization review process for managed care organizations (MCOs) participating in the STAR+PLUS Medicaid managed care program. Provisions in the bill grant HHSC discretion to determine what topics the utilization review process will examine, but require 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 (upgraded) in the Home and Community Based Services (HCBS) STAR+PLUS waiver program.

The process of conducting utilization reviews was implemented by HHSC during fiscal year 2014. Over the first year, HHSC Utilization Management and Review (UMR) staff developed a work plan, processes, and protocols to guide implementation of utilization review. Staff also conducted reviews of test cases, MCOs policies and procedures, and HHSC contract and policy requirements. The reviews conducted in the first year provide insight into the need for better oversight of, and technical assistance for, the STAR+PLUS MCOs to ensure health plan members are assessed in a timely manner and service plans accurately address the members' needs.

The fiscal year 2015 findings found in this report are not statistically valid per MCO and should not be generalized to the larger population because of the focused sample size. However, the direction in legislation points to reviews of members who are upgraded to HCBS STAR+PLUS waiver program and conduct of assessments and related documents associated with service planning. So the reviews centered around a statistically valid sample of members who were newly-enrolled in the HCBS STAR+PLUS waiver program, excluding certain groups.

The review of member upgrades to the HCBS STAR+PLUS waiver revealed MCOs faced challenges with the upgrade process, from determining whether the members had needs which could only be met through the HCBS STAR+PLUS waiver, to use of accurate assessments for service planning and timeliness of the upgrades. The fiscal year 2015 findings are arranged in an A.C.T. format (appropriateness of the upgrade process; conduct of assessments and documents relating to the assessments; and timeliness).

BACKGROUND

STAR+PLUS

The State of Texas Access Reform Plus (STAR+PLUS) Medicaid managed care program integrates the delivery of acute care services, pharmacy services, and long-term services and supports (LTSS) to individuals age 65 and older; and, to individuals under age 65 who have a disability, many of whom qualify for Supplemental Security Income (SSI) or SSI-related benefits. STAR+PLUS services and supports are delivered through five managed care organizations (MCOs) who contract with HHSC.

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 HCBS STAR+PLUS waiver. Enrollment is voluntary for children and young adults under the age of 21 who receive SSI and SSI-related Medicaid benefits.

HCBS STAR+PLUS Waiver

To be eligible for the HCBS STAR+PLUS waiver, an individual must be 21 years old, meet financial eligibility, have a nursing facility medical necessity level of care, and have an unmet need for at least one HCBS STAR+PLUS waiver service. HCBS STAR+PLUS waiver services include:

- Personal assistance services (including the three service delivery options):
 - Self-directed model
 - Self-directed agency model
 - Agency model
- Protective supervision
- In-home and out-of-home respite services
- Nursing services (in the home)
- Emergency response services (emergency call button)
- Home-delivered meals
- Minor home modifications
- Adaptive aids and medical equipment
- Medical supplies not available under the Texas Medicaid State Plan or STAR+PLUS waiver
- 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

FISCAL YEAR 2015 ACTIVITIES

Organizational Development

With funding provided by the 2014-15 General Appropriations Act (Article II, HHSC, Rider 66, Senate Bill 1, 83rd Legislature, Regular Session, 2013), HHSC developed a new Utilization Management and Review (UMR) unit within Medicaid and CHIP Division – Program Operations. The unit was fully-staffed for operations in fiscal year 2015.

Timeline	Activity
September 2014 - November 2014	▶ Finalize fiscal year 2014 UMR activities (on-site visits to MCOs to report test review findings)
December 1, 2014	▶ Submit fiscal year 2014 report to the legislature
September 2014 - August 2015	▶ Complete fiscal year 2015 UMR activities
December 2015	▶ Submit fiscal year 2015 report to legislature
September 2015 - August 2016	▶ Fiscal Year 2016 UMR activities
September 1, 2016	▶ Anticipate expiration of S.B. 348 Subsection (c)

Quality Assurance Plan

A UMR quality assurance (QA) workgroup, established in 2014, developed an internal quality assurance plan (QAP), with input from UMR staff and HHSC management. The QAP directs the activities of the QA team, by defining and documenting the goals, planned activities, timeframes, responsible staff, and reporting parameters. It includes a program overview and annual work plan.

QA Activities Fiscal Year 2015

UMR quality assurance (QA) workgroup implemented various QA activities as directed by the internal QAP during fiscal year 2015. The workgroup strengthened the work plan by adding and refining domains, measures, planned activities, and reporting parameters to better reflect the sample review activities. Two reliability studies were conducted at the beginning phase of the UMR sample review to ensure the validity and reliability of the UMR tool instruments and to further enhance the UMR tool instructions. Data validation activities included a detailed analysis of the data importing process.

During fiscal year 2015, UMR's QA work plan has been significantly enriched and the findings from the QA activities identify the areas for improvements, encourage the continued use of these types of studies to inform future actions, and promote continuous improvement of utilization review activities.

Fiscal Year 2015 Review Activities

In the second year of S.B. 348 implementation, UMR staff completed 272 reviews for members newly-enrolled in HCBS STAR+PLUS waiver. These reviews reinforced coordination with MCOs, provided insight for future reviews, and informed UMR operations.

Review Process

A statistically valid sample of 272 STAR+PLUS members upgraded to the HCBS STAR+PLUS waiver in January and February of fiscal year 2015 were randomly selected from the five MCOs participating in the STAR+PLUS Medicaid managed care program. The sample was drawn statewide, but excluded the recently-added Medicaid Rural Service Areas and the Medical Assistance Only population. UMR staff performed on-site visits to each of the five STAR+PLUS MCOs between March and June 2015. The review process included:

- provision of a Record Request Form to each STAR+PLUS MCO prior to the reviews being conducted, as well as during the on-site visits;
- review of case records on sample cases while on site at each STAR+PLUS MCO;
- home visits by HHSC UMR registered nurses for sample members;
- submission of referrals to HHSC Health Plan Management section when access to care issues or other contract violations were discovered; and
- compilation and reporting of results from fiscal year 2015 reviews to HHSC leadership and to the STAR+PLUS MCOs.

In reviewing each health plan member's case file, UMR staff used the A.C.T. framework to determine:

- A=Appropriateness of upgrade process
- C=Conduct of assessments and records relating to those assessments
- T=Timeliness

Post Review Activities

The UMR team conducted post-review activities, which included:

- documenting member home visits;
- providing feedback and follow-up to MCO service coordinators;
- internal referrals to HHSC Health Plan Management;
- external referrals to Department of Family and Protective Services - Adult Protective Services, Department of Aging and Disability Services - Consumer Rights and Services; and Office of the Inspector General;
- determining trends related to service coordination;
- follow-up presentations to each of the five STAR+PLUS MCOs to present the UMR fiscal year 2015 review outcomes; and
- discussing HHSC UMR plans for fiscal year 2016 utilization review activities.

Review Outcomes

The reviews conducted in fiscal year 2015 informed and improved the UMR internal processes and protocols for future sample reviews. Of the 272 cases reviewed, the utilization review process identified areas where MCOs have opportunities for improvement related to the HCBS STAR+PLUS waiver program. Areas of needed improvement are:

- Appropriateness of the upgrade process
 - service coordinator exploration, documentation, and utilization of third-party resources and value added services;
 - service coordinator development and documentation of individualized rationales/justifications for items and services on the individual service plan (ISP);
 - ensure items and services listed on the ISP meet the member's unmet need(s); and
 - ensure applicable services are initiated on the effective date of the ISP.
- Conduct of Assessments
 - Service coordinators must assess for all available resources, and document on the required forms, when developing the ISP.
 - Service coordinators should ensure indications on the Community Medical Necessity and Level of Care (MN/LOC) Assessment Instrument of the need for speech therapy, occupational therapy, physical therapy, and dental are addressed on the ISP, or in service coordinator documentation.
 - All HCBS STAR+PLUS waiver members have a skilled nursing need as evidenced by medical necessity determination. MCO service coordinators must assess for, and address, skilled nursing needs for each HCBS STAR+PLUS member.
 - Items and services requested by the member, or identified as a need in MCO documentation, must be addressed by the MCO.
 - MN/LOC submittal, processing and approval should be monitored by the MCO to ensure no delay of upgrade or service for the member.
- Timeliness
 - The upgrade process, including identifying the need for upgrade, MN/LOC assessment, service plan development, and ISP posting, must meet the 45-day timeframe outlined in the Uniform Managed Care Contract (UMCC).

HHSC is developing a risk-based review methodology for fiscal year 2016, which incorporates the above-referenced outcomes, and technical assistance for each STAR+PLUS MCO.

General Observations

Comprehensive, timely and complete assessments and associated required forms completion are essential in the development of an ISP uniquely relevant to each member. The fiscal year 2015 findings revealed a widespread lack of documentation on a majority of the HCBS STAR+PLUS waiver required forms and assessments. This lack of documentation has resulted in individual service plans that do not accurately address or reflect the needs of the member.

The fiscal year 2015 reviews and resulting referrals to HHSC Health Plan Management for access to care issues, and other contract compliance issues, validate the need for an HHSC-coordinated process to address and facilitate follow-up action on contract compliance and MCO process issues. Other general issues identified during the fiscal year 2015 reviews, which are being addressed internally by HHSC, and with MCOs, include:

- Enhancements to the UMCC requirements and HCBS STAR+PLUS waiver-related policy.
- Service coordination improvement recommendations to further ensure:
 - timely and adequate response to member's needs and change in health status; seamless care coordination and continuity of care;
 - skilled nursing needs of members are appropriately assessed and met;
 - evaluation and follow-up on service plans;
 - coordinated access to an array of providers and third-party covered services; and
 - technical assistance and training.

Analysis of MCO Upgrade Process

UMR staff also identified areas where HHSC is providing clearer contract and policy language, which in turn will ensure for greater consistency across health plans. The enrollment process, while governed by mandatory contract requirements, allows for creative and proprietary flexibility in MCO operations. However, the member experience should be consistent and intact across all MCOs.

All STAR+PLUS MCOs have external sources (e.g., member/member representative, provider agency, other agencies) to notify them of the need to assess for an upgrade to HCBS STAR+PLUS waiver. MCOs also utilize internal sources such as report data, claims data, diagnosis triggers, screening tools, or internal departmental referrals. Reports and claims data capture "sentinel diagnoses," which identify potential upgrades. Medical loss ratios determined in part by episode risk groups (ERGs) and age plus gender risk scores help in identifying potential upgrades. In fact, there are numerous factors and reports used by MCOs which provide indicators for the need for an upgrade to the HCBS STAR+PLUS waiver.

All MCOs are utilizing the assessments and forms required by contract. However, the reviews revealed opportunities for service coordination staff training related to appropriate completion of, and relationship between, assessment forms and service planning documents.

Specifically, the review data indicates a lack of MCO service coordinator understanding of the purpose of one of the required assessments (MN/LOC), and the identification of the member's skilled nursing needs, which is also an eligibility component for the HCBS STAR+PLUS waiver program. UMR found, in the 272 sample cases reviewed, the connection between skilled nursing needs identified on the MN/LOC and by the MCO registered nurse assessors' own documentation was broken. Skilled nursing needs were not appropriately addressed in the development of the ISP through the HCBS STAR+PLUS waiver program, or via informal supports, third-party resources, or other sources.

The link between medical necessity and the ISP development is a basic principle of the HCBS STAR+PLUS waiver program. A holistic nursing process for development of an ISP should include the assessments, an interview with the member/member's representative, and a thorough investigation of available resources. The identified needs for certain services in the HCBS STAR+PLUS waiver service array should include a rationale for those services, which are individualized for each member's particular needs, while ultimately ensuring Medicaid funds are used in the best interest of the member.

In general, STAR+PLUS MCOs have policies and procedures usually replicating language from the HHSC UMCC and the STAR+PLUS handbook. MCOs can improve their HCBS STAR+PLUS waiver assessment and service plan development by providing clear and consistent guidance to MCO staff on contract and HCBS STAR+PLUS waiver program policy requirements.

CONCLUSION

Based on direction from S.B. 348, HHSC was able to quickly establish the new UMR unit within Medicaid and CHIP – Program Operations. Over a short period of time, protocols, review tools, quality assurance plan, and internal tracking systems have been developed. Additionally, UMR successfully employed referral processes to HHSC Health Plan Management resulting in members receiving needed and previously-identified services. Additionally, UMR established internal communications with multiple internal HHSC divisions. The UMR registered nurses not only provide clinical expertise to the UMR process, but also offer additional skill sets to complement the ongoing development process for the unit activities, while permitting a peer-to-peer discourse with MCO service coordinators to ensure best outcomes for health plan members. The addition of utilization management and review activities has added valuable input to existing managed care contract management functions at HHSC.

During the fiscal year 2015 findings presentations, each of the MCOs were receptive to the findings and technical assistance requirement planned by UMR in fiscal year 2016. The STAR+PLUS MCOs expressed willingness to continually improve internal processes and procedures to meet HCBS requirements, and other opportunities for improvement.

HHSC will use the findings from fiscal year 2015 reviews to plan and provide intensive technical assistance to each of the STAR+PLUS MCOs. Additionally, HHSC is planning a series of webinars, targeted to MCO service coordinators, to provide training modules on HCBS STAR+PLUS waiver responsibilities encompassing assessments, service planning, ongoing monitoring of member needs, and related topics. Later in fiscal year 2016, UMR plans to conduct follow up reviews based on the technical assistance provided to each STAR+PLUS MCO. The continued expansion of the UMR review protocols in fiscal year 2016 will include sampling anyone receiving HCBS STAR+PLUS waiver services without exception.

HHSC UMR staff is committed to fulfilling the intent of S.B. 348, and also will continue to provide consultation as necessary on various types of issues, including medically-complex high-needs individuals, complaints, and issues related to individuals transitioning from services for children to adult benefit packages.