

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	2
2. Introduction	3
3. Background	4
4. Fiscal Year 2019 HCBS Utilization Review Activities	7
5. Utilization Review Findings	8
Appropriateness of Placement in STAR+PLUS HCBS	8
Conducting Assessments	8
Timeliness	9
Referrals	9
Summary of 2017 CAP Follow-Up	10
6. Conclusion	11
List of Acronyms	12

1. Executive Summary

The *Utilization Review in STAR+PLUS Managed Care* report is submitted in compliance with Texas Government Code, Section 533.00281(d). Per Section 533.00281, the Health and Human Services Commission (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 utilization reviews annually to determine if MCOs are correctly assessing and enrolling members in STAR+PLUS HCBS and providing needed services. Based on findings of non-compliance in fiscal year 2017, MCOs were placed on corrective action plans (CAPs). Fiscal year 2019 reviews by HHSC focused on confirming the MCO's interventions to correct areas of non-compliance.

Through quarter three of fiscal year 2019, the HCBS reviews revealed improvement in the compliance with the STAR+PLUS HCBS program criteria of documenting a justification for at least one waiver service and in the completion of the contractually required assessments and service planning documents. MCOs have also shown improvement from the fiscal year 2017 review in the area of timeliness as it relates to the follow-up. However, the preliminary results of the review indicate areas of non-compliance remain.

This report includes findings through quarter three of fiscal year 2019 as HHSC is finalizing the findings from quarter four. MCOs are allotted a period of time in which they can respond to the findings and provide additional information. HHSC anticipates the quarter four findings will be finalized in January 2020 and will provide follow-up, including recommendations, when these findings are finalized.

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 submit an annual report to the standing committees of the Texas Senate and House of Representatives with authority over the Medicaid program which:

- summarizes the results of utilization reviews conducted during the preceding fiscal year;
- provides analysis of errors or issues by each reviewed 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 2018 HCBS review included a sample of STAR+PLUS HCBS members, both initial and reassessments in the highest resource utilization groups (RUG) with an individual service plan (ISP) start date of November 1, 2017. The issues identified in the 2018 review were similar to the 2017 review findings since corrective action plans had not yet been fully implemented. The fiscal year 2019 HCBS review was conducted as a follow-up to the fiscal year 2017 HCBS review and to measure if the interventions implemented by MCOs to address findings corrected the areas of non-compliance. Performance standards and measures focused the review on contractual requirements for the conduct of assessment, assessment driven service planning, timeliness, and service delivery.¹

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 managed care organization. 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 service 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

Utilization review 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. Utilization review 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 Medicaid 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.

In fiscal year 2017, HHSC UR reviewed a random sample of 357 members enrolled in STAR+PLUS HCBS with an ISP starting on August 1, 2016. The 2017 review found MCOs experienced challenges related to:

- Assessment-driven service planning – MCOs assessed and documented a need for a service/item but failed to place it on the ISP or address the need with any other follow-up.
- Follow-up – MCOs identified a need for a service/item and placed it on the ISP for authorization but failed to follow-up and initiate services.
- Coordination for dual-eligible members – MCOs assessed and documented a need for a service/item that could be available through Medicare and failed to coordinate and/or document attempts with Medicare contractors to provide services to the member, as outlined in HHSC contracts with MCOs.

Following the 2017 review and subsequent report, HHSC took contractual actions against all STAR+PLUS MCOs; liquidated damages were assessed for all five MCOs and four MCOs were placed on CAPs to identify the root cause of the issues and processes to remedy them.² Four of the MCOs were cited for a combination of, failure to provide a covered service, failure to provide an

² 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.

administrative service, and/or failure to meet contractual assessment timeframes; one was cited only for timeliness of the completion of assessment or reassessment activities. 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, to the satisfaction of HHSC, the remediation of issue(s).

4. Fiscal Year 2019 HCBS Utilization Review Activities

In fiscal year 2019, HHSC conducted a review of the STAR+PLUS HCBS program using the same sample criteria that was used in fiscal year 2017. This allowed HHSC to follow-up on the CAPs that resulted from the 2017 review to identify if the interventions implemented by the MCO corrected the non-compliance, which HHSC was not able to do during the 2018 review due to the timing of the CAP approvals. The review consisted of initial assessments and reassessments using a statistically valid random sample at the program level of 355 members with an ISP start date of December 1, 2018.

Desk reviews and home visits for 2019 took place between March and June and were conducted by 36 nurses. HHSC had several new nurses join the review team during this time. HHSC requires significant training before a nurse may conduct a review independently; after agreement from the member, new nurses were paired with experienced nurses to complete their training.

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 and any documentation submitted within the allotted timeframe is reviewed by HHSC staff. 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 meeting with the MCOs to discuss findings from quarter four.

5. Utilization Review Findings

Utilization review findings from fiscal year 2019 are discussed below. It is important to note the state fiscal year 2019 HCBS review was conducted as a follow-up to the state fiscal year 2017 HCBS review to evaluate if the interventions implemented corrected the previous areas of non-compliance. The findings are based on reviews through the third quarter of fiscal year 2019 and are preliminary until the quarter four findings are finalized.

Appropriateness of Placement in STAR+PLUS HCBS

Eligibility for STAR+PLUS HCBS requires an individual must 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 2019 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 2017 review, all but two MCOs were performing above 80 percent. Preliminary findings of the 2019 review, indicate an improvement in performance by these two MCOs and performance near 100 percent.

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.

Preliminary findings of the 2019 HCBS review revealed improvement in the completion of the contractually required assessments and service planning documents and forms.

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 such as difficulty obtaining a physician signature (required for initial eligibility for the program) or a preference of a member or their representative's availability, or a request for a later assessment date.

For 2019 reviews, HHSC UR 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.

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 2019, the requirement for a four-week follow-up call continues to be an area of concern; however, MCOs did show some improvement from the fiscal year 2017 review.

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 Medicaid Managed Care Compliance and Oversight unit at HHSC 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 2017, referrals were made for 74 of the 358 members sampled. Through quarter three of fiscal year 2019, 43 referrals related to access to care or health and safety were made for the 186 members reviewed. These referrals were immediately addressed through the complaints process. In addition, when appropriate, HHSC will apply appropriate contractual remedies.

Summary of 2017 CAP Follow-Up

The fiscal year 2017 UR review process resulted in contract remedies to 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 have yet to be implemented and the impact of some interventions was not evident in the 2019 HCBS review due to implementation date and timeframe of review.

The MCOs have addressed some areas of non-compliance within the CAPS; 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. HHSC will utilize appropriate contractual remedies for the incidences of non-compliance.

Preliminary findings of the 2019 review show improvement; however, MCOs continue to demonstrate challenges with compliance on performance measures related to the timeliness of initial assessments and the four-week follow-up call to ensure services are initiated timely. The low performance in these areas may have contributed to the access to care referrals. HHSC will review the MCOs policies and procedures related to these areas and provide technical assistance to the MCOs to help address these issues.

6. Conclusion

Through quarter three of fiscal year 2019, UR reviews have shown improvement from the 2017 findings, especially in the areas related to appropriateness of placement and conducting assessments. However, we continue to see issues with the MCO ensuring authorized services were provided timely according to contract requirements. HHSC continues to take appropriate contractual remedies in instances of non-compliance.

HHSC staff will provide a supplemental report after the quarter four findings are finalized and will make recommendations based on those final findings. The final report will also include recommendations for additional contractual remedies.

List of Acronyms

Acronym	Full Name
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
SSI	Supplemental Security Income
STAR	State of Texas Access Reform
UR	Utilization Review