Utilization Review in STAR+PLUS Managed Care – Supplemental Report

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 services, 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.

The fiscal year 2019 HCBS reviews, previously reported by HHSC in December 2019[1], revealed improvement in 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 also demonstrated improvement from the fiscal year 2017 review in the area of timeliness for the follow-up and initial assessments and reassessments. However, the review indicates areas of non-compliance remain.

Key findings of the fiscal year 2019 reviews include:

- Continued improvement by all MCOs in documenting a justification for at least one HCBS service.

[1] Utilization Review in STAR+PLUS Managed Care: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/utilization-review-star-plus-medicaid-managed-care-dec-2019.pdf

- Performance above 80% in the completion of the contractually required medical and functional assessments and service planning documents/forms.
- Continued issues related to compliance with the requirement for a four-week follow up-call.

Based on the findings in 2019, HHSC recommends MCOs continue corrective action to ensure coordinated care for members. HHSC also recommends MCOs perform follow-up and document follow-up attempts for needs/services that are identified to ensure services are delivered.

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 which:

- summarizes the results of utilization reviews 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.

HHSC submitted a report to the legislature in December 2019 based on findings through quarter three of fiscal year 2019. At that time, the findings from quarter four were not final. This supplemental report includes findings from the full fiscal year 2019 review.

The 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.

In fiscal year 2017, a statistically valid sample of the STAR+PLUS HCBS population was reviewed. 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 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[2], timeliness, and service delivery.

[2] 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 who receive 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[3]: income requirements; level of care 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, or their legally authorized representative, 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 contractually required 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

[3] Chapter 353, Texas Administrative Code, Section 353.1153

include enhanced LTSS such as:

- Personal assistance services
- Respite 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
- Habilitative 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. 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 home visit or a delay in initiation was identified, the HHSC nurse makes a referral, or internal complaint, to the HHSC Managed Care Compliance and Operations unit to ensure follow up on the issue until it is resolved. If the HHSC nurse identifies a new issue at the home visit, such as a need for a new item or service, the HHSC 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 reviewed a random sample of 357 members enrolled in STAR+PLUS HCBS with an individual service plan (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 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 corrective action plans[4] (CAPs) to identify the root cause of the issues and processes to remedy them. Four of the MCOs were cited for a combination of failure to provide a covered service, failure to provide an administrative service, and/or failure to meet contractual assessment timeframes; one was only cited for failure to meet contractual assessment timeframes. HHSC 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] 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 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. The sample criteria focused on access and provision of skilled nursing services and DME. This approach 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 of 2019 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.

5. Utilization Review Findings

UR findings from fiscal year 2019 are discussed below. It is important to note the fiscal year 2019 HCBS review was conducted as a follow-up to the fiscal year 2017 HCBS review to evaluate if the interventions implemented by the MCOs corrected the previous areas of non-compliance.

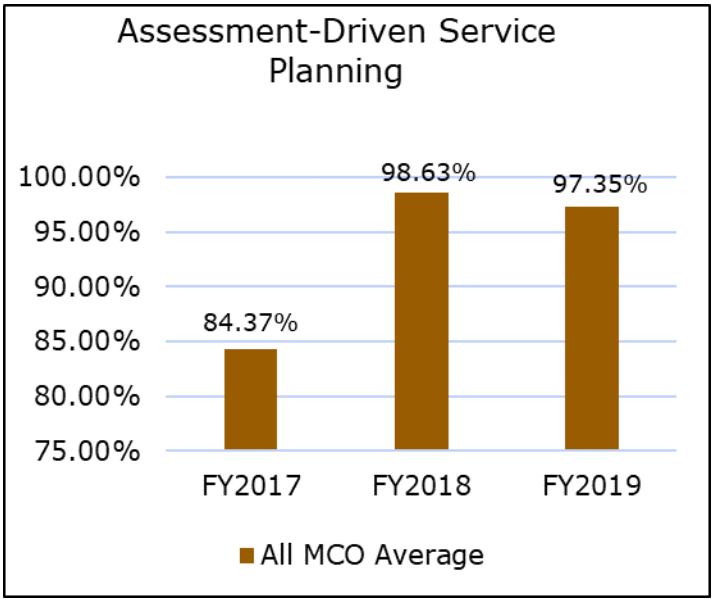
Assessment-Driven Service Planning

Assessment-driven service planning determines the appropriateness of an individual's placement in STAR+PLUS HCBS. 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 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.

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. As noted in Chart 1, findings of the 2019 review indicate that all MCOs are performing above 80 percent, with an average performance of 97.35 percent.

Chart 1. Percent Meeting Standard



Conducting Assessments

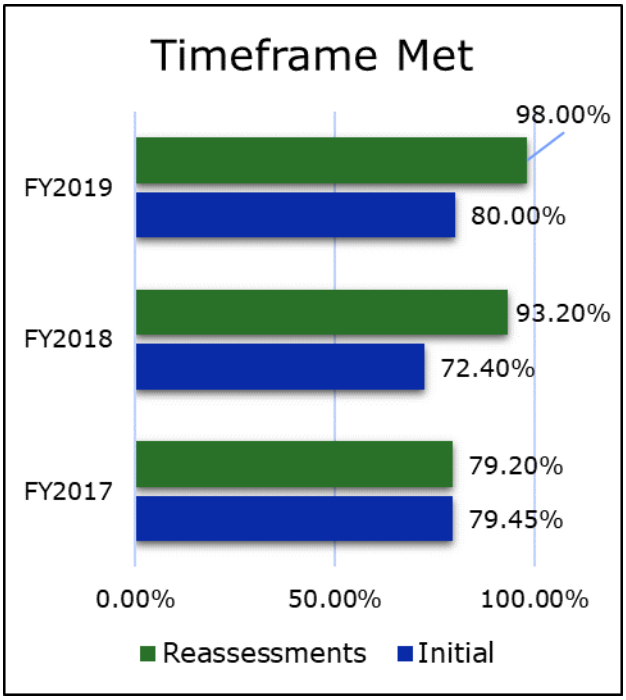
The MCO service coordinator is responsible for the development, maintenance, and revision of an assessment-driven ISP to meet the needs of each member. Development of the ISP is a holistic nursing process which includes standardized assessments, an interview with the member/authorized representative and member's 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 fiscal year 2017 review, HHSC reviewed multiple forms as part of one performance measure. Based on the 2017 findings, HHSC removed some of the forms that were reviewed in 2017, resulting in a revised performance measure for fiscal year 2019. The 2019 HCBS review revealed compliance by all MCOs in the completion of the contractually required assessments and service planning documents and forms, with an average performance of 96.90 percent for all five plans.

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. MCOs must have all reassessment activities completed no earlier than 90 days and no later than 30 days before the previous ISP expires. Chart 2 shows MCO performance in completion of both initial assessments and reassessments. Assessment activities may be delayed for justifiable reasons including difficulty obtaining a physician signature (required for initial eligibility for the program), the availability of a member or their representative, or a request from the member for a later assessment date.

Chart 1. Percent Timely



For 2019 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 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 facility or alternative community-based services. If the

MCO documented issues obtaining the physician's signature and the efforts to obtain the signature, HHSC did not consider this a failure to meet contractual timeframes. In fiscal year 2018, MCO compliance with timeliness of completing both assessments and reassessments was 82.80 percent. Table 1 shows the fiscal year 2019 performance for all MCOs.

Table 1. Assessment Timeliness

Assessment Type	Number of Members Reviewed	Timeframe Met	Timeframe not Met
Initial	55	80.00%	20.00%
Reassessment	300	98.00%	2.00%
Total	355	89.00%	11.00%

MCOs are also required to meet timeliness standards with respect to service coordination follow-up after the initiation of HCBS services. The service coordinator must contact the member no later 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 MCO's service coordination documentation.

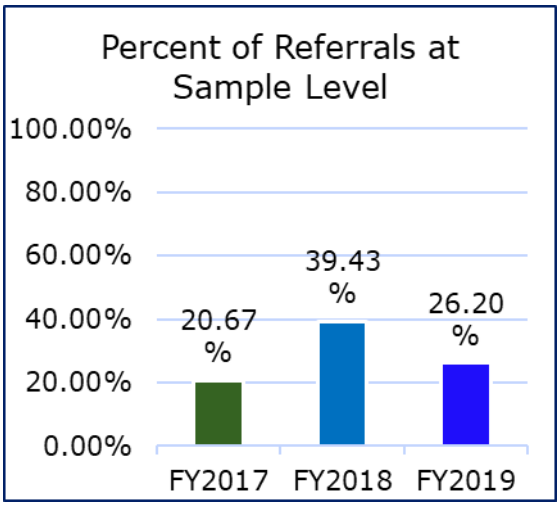
MCOs' approach to this requirement vary considerably. One MCO has a dedicated team conducting the four-week follow-up and another MCO has service coordinators following up one week after the ISP start date and then again four weeks after the ISP start date. MCOs use reports for tracking when the calls need to take place. Within MCOs, the quality of documentation varies from service coordinator to service coordinator. For fiscal year 2019, the requirement to conduct and document a four-week follow-up call continues to be an area of concern with only two of the five MCOs performing above 80 percent. The two most common issues with this requirement are that the documentation provided does not show that a call was made, and the call does not document that all services are in place. The state overall average for this performance measure was just over 50 percent.

Referrals

Upon identification of an issue related to access to care or member health and safety, an HHSC 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.

In fiscal year 2017, referrals were made for 74 of the 358 members sampled. In fiscal year 2018, HHSC conducted a targeted review of members in the highest resource utilization groups (RUGs). This population has complex care needs and higher needs than members in the lower RUGs, which contributed to an increase in referrals for that year. In fiscal year 2019, referrals were made for 93 of the 355 members reviewed. Chart 3 shows the percent of referrals at the sample level for fiscal years 2017-2019.

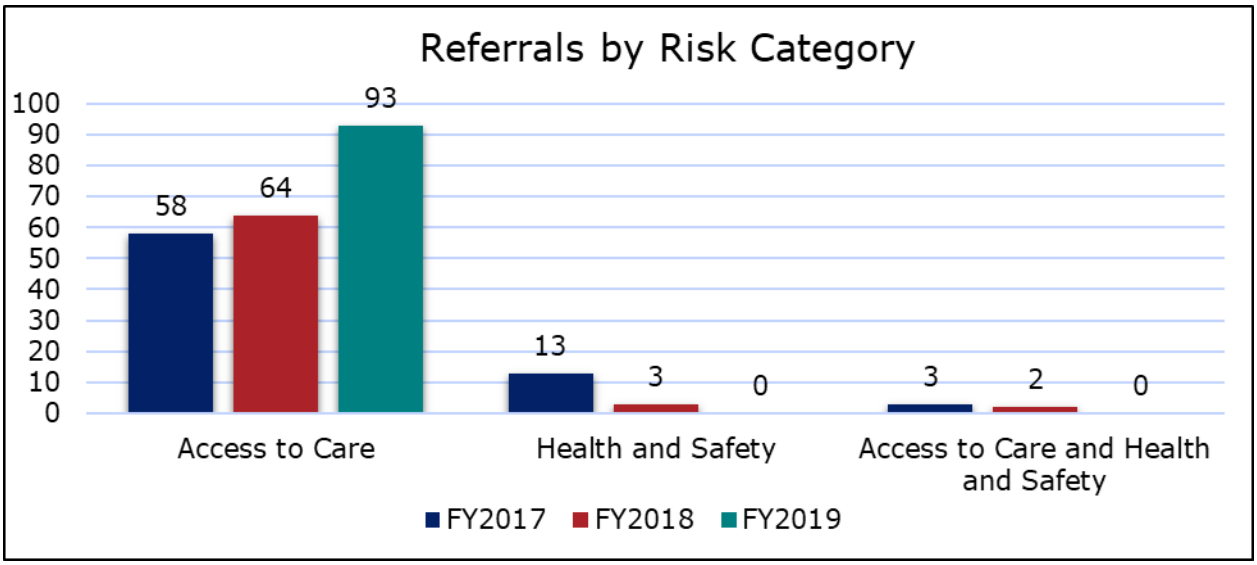
Chart 2. Percent of Referrals



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 would not make a referral to MCCO.

Chart 3. Number of Referral by Type and Year



Beginning with fiscal year 2018 reviews, HHSC implemented an internal process improvement which included quality assurance (QA) reviews of all sample member cases. Analysis is performed to assess the accuracy of the MCO performance. This involves examining and reviewing UR outcomes to determine compliance with program regulations, internal policies and procedures, state and federal statutes, identifying inaccuracies, and correcting such inaccuracies. As a result of the QA process, an increase in access to care issues were identified in fiscal year 2019, as shown in Chart 4. The increase in access to care referrals, as well as the decrease in health and safety referrals, are attributed to the internal process improvements implemented by HHSC. HHSC has worked with the MCOs to resolve the complaint to member satisfaction; however, the resolution will not prevent HHSC from enforcing contract actions related to referrals.

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.

HHSC reviewed and approved the corrective action plans in late fall of 2018. Due to implementation date and timeframe of review, some interventions were not implemented, and the impact of these interventions was not evident in the 2019 HCBS review.

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. HHSC will utilize appropriate contractual remedies for each MCO to address their specific incidences of non-compliance.

The 2019 review shows improvement; however, some MCOs have low performance on MCO-specific performance measures related to the timeliness of initial assessments and the four-week follow-up call to ensure services are initiated timely. Performance below the 80 percent benchmark 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. Recommendations

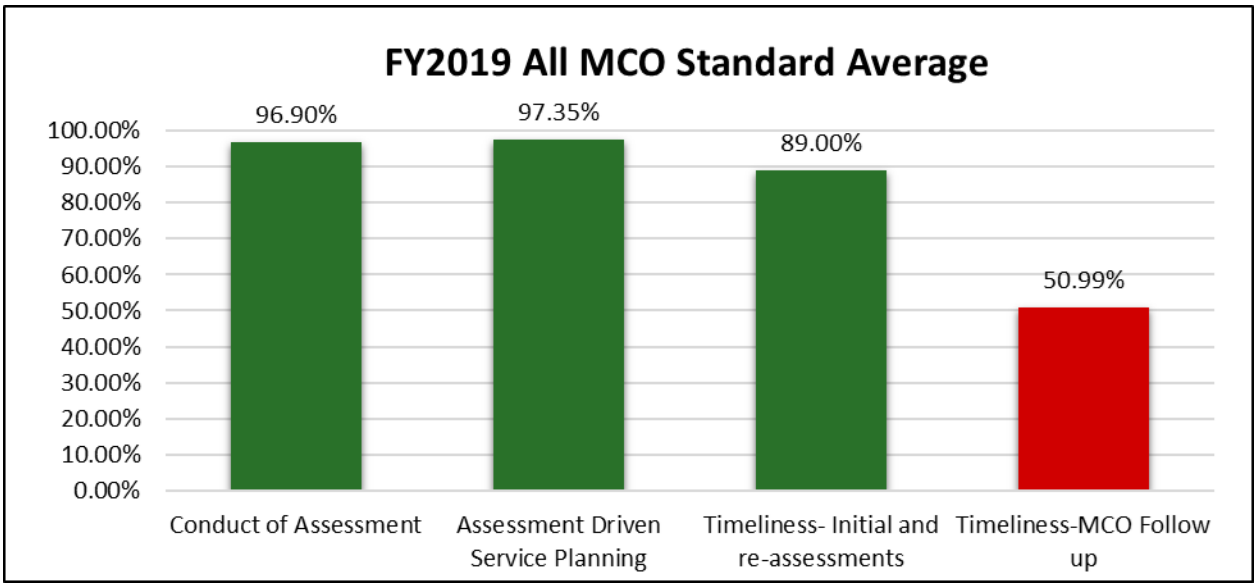
HHSC recommends the following to continue improving efficiency in the program:

- HHSC will provide technical assistance and education to MCOs who have open CAPs, which includes educating MCOs in program policies, services and processes to facilitate the creation and implementation of training and new processes that will allow for improvement in areas of non-compliance.
- MCOs should review the findings of all performance measures, perform a root cause analysis and implement interventions to correct any identified issues.
- HHSC will develop strategies to allow for expanding the scope of future reviews.
- HHSC will review agency policies and guidance to ensure clear guidance for MCOs to operationalize in the delivery of services.
- HHSC will develop tools and training protocols for staff conducting utilization reviews to enhance interrater reliability and improve knowledge base.

7. Conclusion

Fiscal year 2019 UR reviews showed improvement from the 2017 findings. As illustrated by the Chart 5, MCO performance in the areas of conducting assessments, assessment-driven service planning and timeliness of assessments is well above the 80 percent benchmark. However, there are continued issues with the MCO follow-up to ensure that items/services authorized are provided timely according to contract requirements.

Chart 4. 2019 All MCO Results



As noted in the recommendations. HHSC provides technical assistance and education to the MCOs, and reviews agency policies and guidance to ensure clear guidance for MCOs to operationalize in the delivery of services. The combined efforts of HHSC and the MCOs should result in improved performance in the next fiscal year review. HHSC continues to refine procedures and protocols related to reviews of MCOs delivering HCBS services. Increased frequency of reports and the information contained within the reports has been well-received by MCOs and allows for meaningful, continuous conversations about issues with the program in general and issues specific to an MCO. HHSC meets with the MCOs on a quarterly basis to review findings and provide technical assistance, including clarifying contract and policy language as needed, to facilitate improvement. HHSC has also implemented a rebuttal process that allows MCOs the opportunity to present

information after each meeting to ensure the review findings are accurate. Additionally, HHSC continues to provide clarification to the MCOs on identified issues to ensure improvement in the delivery of services to members.

List of Acronyms

Acronym	Full Name
CAP	Corrective Action Plan
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
QA	Quality Assurance
RUG	Resource Utilization Group
SSI	Supplemental Security Income
STAR	State of Texas Access Reform
UR	Utilization Review