

Utilization Review In STAR+PLUS Medicaid Managed Care

AN ANNUAL REPORT
REQUIRED BY

Senate Bill 348

**83rd Legislature
Regular Session, 2013**



Program Operations ♦ Medicaid/CHIP Division

December 1, 2014

TABLE OF CONTENTS

Senate Bill 348.....	1
Executive Summary.....	3
Background.....	4
STAR+PLUS	4
HCBS STAR+PLUS Waiver.....	4
Fiscal Year 2014 Activities.....	5
Organizational Development.....	5
Development of UMR protocols.....	5
Quality Assurance Plan.....	6
Test Review Activities.....	6
Coordination with STAR+PLUS MCOs	6
Test Review Process	6
Post Test Review Activities	7
Test Review Outcomes	7
General Observations.....	8
Analysis of MCO Procedures	8
Conclusion	11

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

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 whereby assessments, service delivery plans, and supporting documentation are reviewed to 1) determine if services are appropriate 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 disadvantaged 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 Legislature unanimously passed of S.B. 348. The bill, codified in Title 4 Government Code §533.00281, Utilization Review for STAR+PLUS Medicaid Managed Care, directs 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 the Health and Human Services Commission (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 past 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 over the past 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 initial findings found in this report are not representative across health plans and should not be generalized to the larger population because of the small test sample size. Preliminary results indicate the majority of members are appropriately upgraded to HCBS STAR+PLUS waiver program services according to program policy. For those instances where the member was upgraded inappropriately because their only unmet need was personal assistance services (PAS), UMR staff used the test review process as an opportunity to educate MCOs on program policy and the appropriate use of Medicaid State Plan services over upgrading to waiver services.

The review of MCO policies and procedures to determine whether and individual or member should be enrolled in the MBCS STAR+PLUS waiver identified commonalities and distinct differences among MCOs related to upgrades. Through the review process, HHSC also discovered instances where MCO staff does not consistently follow written program and operational policies. As a result of these test findings, UMR staff provided technical assistance to each STAR+PLUS MCO and will continue to provide support as MMSC and the MCOs continue to implement process improvements.

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) that 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 Home and Community Based Services (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 2014 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 assigned nine new full-time equivalent (FTE) positions allocated under Rider 66 to the new Utilization Management and Review (UMR) unit within Medicaid/CHIP Division – Program Operations. As of publication of this report, all nine positions are filled. The UMR unit manager was the first to be hired in October 2013. Of the eight positions reporting to the unit manager, seven are registered nurses.

The remainder of fiscal year 2014 was devoted to development of a work plan, and processes and protocols to guide implementation of utilization review in the managed care environment. The fiscal year 2014 work plan and timeline included the following activities.

Timeline	Activity
November 2013 - March 2014	▶ Complete hiring process
December 2013 - April 2014	▶ Train staff and develop protocols
May 2014 - August 2014	▶ Begin Fiscal Year 2014 UMR activities
September 2014 - November 2014	▶ Continuation of Fiscal Year 2014 UMR activities
December 1, 2014	▶ Fiscal Year 2014 report to Legislature
September 2014 - August 2015	▶ Fiscal Year 2015 UMR activities
September 1, 2016	▶ Expiration of S.B. 348 Subsection (c)

Development of UMR protocols

In addition to the activities described above, UMR staff completed a limited random-sample test review from each STAR+PLUS MCO and conducted a detailed investigation of a complaint, as part of the development phase in fiscal year 2014. UMR staff is continuing to work on developing review processes and protocols to conduct a statistically valid sample in the near future, including:

- Sampling methodologies;
- Review tools development;
- Database development to house review outcomes for reporting;
- Internal quality assurance (QA) review function to ensure the outcomes, review tools, and policies and procedures are consistently applied;
- Communications with internal HHSC divisions to report UMR outcomes for purposes of monitoring contracts with MCOs, risk management, informing contract language and operations policy updates, and performance measure development/quality initiatives; and

- Development of an internal referral process to HHSC Health Plan Management for any health and safety issues identified during reviews.

Quality Assurance Plan

A 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 work plan for fiscal year 2015.

The QA team also completed an internal study to help establish the reliability of the 2014 test review tool. The purpose of the study was to test the reliability of the utilization review tool. Staff used the study results to modify and enhance the tool and processes. The QAP includes activities to encourage the continued use of these types of studies to inform future actions and to promote continuous improvement of utilization review activities.

Test Review Activities

In the first year of implementation, UMR staff completed sample test reviews of each STAR+PLUS MCO. The initial reviews served as a testing ground for coordination with MCOs, the review tool, and UMR internal processes.

Coordination with STAR+PLUS MCOs

UMR staff performed on-site visits to each of the five STAR+PLUS MCOs between March and April 2014 to:

- Meet key STAR+PLUS MCO staff, and discuss the utilization review initiative related to S.B. 348;
- Review and obtain copies of MCO policies and procedures for upgrading health plan members to the HCBS STAR+PLUS waiver program, and related assessments; and
- Review a variety of case examples in the MCO systems to familiarize UMR staff with how HCBS STAR+PLUS waiver program documentation can be requested and viewed to expedite upcoming reviews.

Test Review Process

Fifteen health plan members (not a statistically valid sample), who upgraded to HCBS STAR+PLUS waiver in fiscal year 2014, were selected for the test review. Three case reviews were conducted for each of the five MCOs participating in the STAR+PLUS Medicaid managed care program. The test review consisted of 15 desk reviews, 13 home visits followed by a follow-up site visit to each MCO. Two health plan members were excluded from the home visit due to their health status. The test review process included:

- Thorough review of MCO procedures for determining when a member should be upgraded to the HCBS STAR+PLUS waiver program;

- Review of the medical necessity/level of care (MN/LOC) and functional assessment documents for members in the test sample to determine inconsistencies in the assessments;
- Review of the individual service plans (ISP) and related documentation for members in the test sample to:
 - Determine if ISPs reflect assessed needs;
 - Identify unmet needs of the members;
 - Perform a home visit with each member in the test review sample; and
- Testing of UMR internal processes (e.g., transmission of documents from the MCOs; group testing of the review tool, including inter-rater reliability; database testing).

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

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

Post Test Review Activities

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

- Documenting member home visits;
- Providing feedback and follow-up with MCO service coordinators;
- Three referrals to HHSC Health Plan Management on health and safety issues identified, which required MCO action;
- Developing narratives and flowcharts of MCO policies and procedures for upgrades individually and collectively; and
- Follow-up site visits to each of the five STAR+PLUS MCOs to:
 - Present the UMR test review outcomes;
 - Provide technical assistance on the process and required documentation for “upgrades;”
 - Present and obtain additional information and clarification on MCO policies and procedures for “upgrades;” and
- Discuss HHSC plans for fiscal year 2015 utilization review activities.

Test Review Outcomes

The test reviews conducted in fiscal year 2014 informed and improved the UMR internal processes and protocols for future sample reviews. Of the 15 cases reviewed, the utilization review process identified areas where MCOs have opportunities for improvement related to the HCBS STAR+PLUS waiver program. These areas include:

- Meeting the 45-calendar day timeframe for the upgrade process;
- Responding to the needs identified by the member and/or the needs identified by MCO assessments of the member;
- Following all program requirements established by HHSC; and
- Conducting assessments and completing forms related to the assessments.

A follow-up visit was conducted with each STAR+PLUS MCO after reviews were concluded. These follow-up visits provided an opportunity for UMR staff to discuss with each MCO the actions necessary to make improvements to their processes and to provide other technical assistance. As a result, MCOs have begun implementing process improvements to improve service delivery and performance in the identified areas.

HHSC will develop a statistically valid sampling methodology that will be used in the utilization review process beginning in fiscal year 2015.

General Observations

The reviews and resulting referrals to HHSC Health Plan Management also highlight the importance of a coordinated process to address and facilitate follow-up action on contract compliance and process issues resulting from performing utilization reviews. Other general issues identified during the 2014 test reviews, which are being addressed internally by HHSC, include:

- Gaps in the STAR+PLUS contract requirements and HCBS-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; and
 - Skilled nursing needs of members are appropriately assessed and met; and
- A necessary edit to the HHSC administrative claims contractor's portal for the initial MN/LOC assessment process to prevent approvals of outdated assessments if the submittal date is greater than 120 calendar days from the date of the assessment.

Analysis of MCO Procedures

During fiscal year 2014, per direction of S.B. 348, UMR staff requested from each MCO, internal policies and procedures for determining whether an individual or member should be enrolled in the HCBS STAR+PLUS waiver program. UMR staff completed a thorough investigation of each MCO's policies and procedures. Each MCO reviewed the summary in person at the follow-up site visit. UMR obtained verbal confirmation from each MCO on the accuracy of UMR's policy and procedure investigation summary. The analysis revealed commonalities and differences in MCOs' policies and procedures in the following categories:

- Identification and referral for potential upgrade;
- Assessment;
- Care planning;
- Implementation; and
- Evaluation.

UMR staff also identified areas where HHSC could provide 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. Some of the differences identified are the absence of MCO internal operational policies to support or provide guidance to MCO staff on existing contract or policy requirements.

All STAR+PLUS MCOs have external sources (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 test reviews revealed opportunities for staff training related to appropriate completion of, and relationship between, assessment forms and service planning documents.

Specifically, the reviews identified a disconnect between the intent of how one of the required assessments (the MN/LOC, which establishes medical necessity for HCBS) relates to the need for HCBS and the development of the service plan. Other areas for improvement include:

- Ensuring approval of medical necessity only when the MN/LOC assessment provides evidence the member has a need for skilled nursing. The medical necessity helps to inform individual service plan development. Of the cases reviewed, though a limited number, the connection between the skilled nursing need and the development of the individual service plan was not apparent through MCO documentation of the skilled nursing need being met through the HCBS STAR+PLUS waiver program, informal supports, third-party resources, or other action; and
- Developing service planning documents and the individual service plan based on the assessments, the interview with the member, and a thorough investigation of available resources. The identified needs for certain services in the HCBS waiver service array should have a rationale for those services which are individualized for that particular member's needs.

The link between medical necessity and the individual service plan development is a basic principle of the HCBS STAR+PLUS waiver.

In general, STAR+PLUS MCOs have policies and procedures usually replicating language from the HHSC Uniform Managed Care Contract and the STAR+PLUS handbook. MCOs can improve their HCBS STAR+PLUS waiver assessment and service plan development by continuing to support RN service coordinators to holistically engage in the established nursing process (assessment, nursing diagnosis, outcome identification, planning, implementation, and evaluation). This process includes the identification of supports and services, assisting the member to live successfully in the community, and ultimately ensuring Medicaid funds are used in the best interest of the member.

CONCLUSION

Based on direction from S.B. 348, HHSC was able to quickly establish the new UMR unit within Medicaid/CHIP – Program Operations. Over a short period of time, protocols, review tools, a database, quality assurance plan, and other internal policies and procedures were created, tested, and employed. Ongoing referral processes to HHSC Health Plan Management and internal communications with multiple internal HHSC divisions have been successful. Seven registered nurses with a combined 114 years of nursing experience, and a program specialist with 16 years of experience, currently work under the UMR unit manager with 31 years of managerial, contract management, casework, and social work experience. The nurses not only provide clinical expertise to the UMR process, they also have other skill sets to complement the 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 2014 site visits, each of the MCOs were receptive to the technical assistance provided. They expressed willingness to continually improve internal processes and procedures to meet HCBS requirements, and other opportunities for improvement. The activities of 2014 helped establish rapport with the STAR+PLUS MCOs in the spirit of collaboration on behalf of members receiving services under the HCBS waiver.

HHSC will use the lessons learned during 2014 as UMR staff move forward with fiscal year 2015 activities, which include use of a statistically valid sample of STAR+PLUS members upgraded to the HCBS STAR+PLUS waiver. This will not be a sample stratified by each STAR+PLUS MCO due to the number of members which would be in a stratified review sample (approximately 1,910 cases).

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. The continued development and testing of the UMR protocols in fiscal year 2015 will inform future review processes, leading to a more risk-based review plan.