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Food for Thought
STAR+PLUS Medicaid Managed Care Program

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The Texas Association of Health Plans (TAHP) is the statewide trade association representing private health insurers, health maintenance organizations, and other related health care entities operating in Texas.

- Health Plans - Employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid
- 28 Health Plan Members, including the 20 Medicaid Health Plans
- 2 Dental Medicaid Managed Care Organizations
- TAHP advocates for public and private health care solutions that improve the affordability, access and accountability of health care for many Texans

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The Role of Medicaid Managed Care

- **Improving Quality and Provider Oversight**
  - State uses contracting, licensure and regulation
  - Health plans use care management and contracting/credentialing – increased focus on outcomes
- **Goal of Managed Care: To better manage care to improve access, quality, and outcomes while ensuring appropriate utilization and containing costs**
  - Full-risk, capitated model
    - Medicaid managed care organizations (MCOs) at full-risk for costs and outcomes
    - Encourages appropriate utilization and coordination of services
    - Promotes quality improvement
  - Integrated managed care model
    - Builds on the managed care model by integrating acute care and long-term care services and supports (LTSS)
    - STAR+PLUS Program (and STAR Kids beginning Fall 2016)

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Why MCOs

Designed and tested to best address critical program challenges:

- Unique members
- Program eligibility barriers & opportunities
- Complex service delivery
- Integration of federal, state & local

Proven model & enhanced resources

- Cost effectiveness, budget certainty, aligned incentives
- Enhanced management resources & expertise
- Value-added benefits, new community resources, economic impact

MCO & State Incentives Aligned

- Costs & quality
- Fraud and aberrant billing or utilization trends
- Timely access to appropriate level of care
- Integration of physical and behavioral health
- Pharmacy carve in=MCOs assume financial risk for pharmacy outcomes and costs
- Proven success with member transition from nursing home to community

Federal and State Oversight—CMS, HHSC, TDI

- Contracts: Outcome measures & performance standards
- 30-plus report deliverables, 3 types of audits: claims, financial reporting and operational audits, plus ad hoc audits
- EQRO – External Quality Reporting
- Fines, liquidated damages, corrective action plans
- Accountability criteria non-existent in FFS

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Why MCOs

Financial

- MCO premium at risk "highest in the nation"
- Claims analytics, trending and management of aberrant utilization and billing patterns
- Fraud programs
- Third-party recovery
- Integration of pharmacy, physical and behavioral health data

Access to Care and Network Adequacy

- Provider credentialing
- Network and access criteria
- Outreach and education
- Member and provider satisfaction surveys
- "The right care, the right place, the right time"

Clinical and Quality Improvement Resources

- Evidence-based standards and criteria
- Service coordination, education and outreach
- Case management & Disease management
- Defined quality, performance deliverables, targets, monitoring

Value-added Benefits and New Community Resources

- "Value added" enhanced benefits for Medicaid members
- Community resources targeted to local community need
- Positive economic impact

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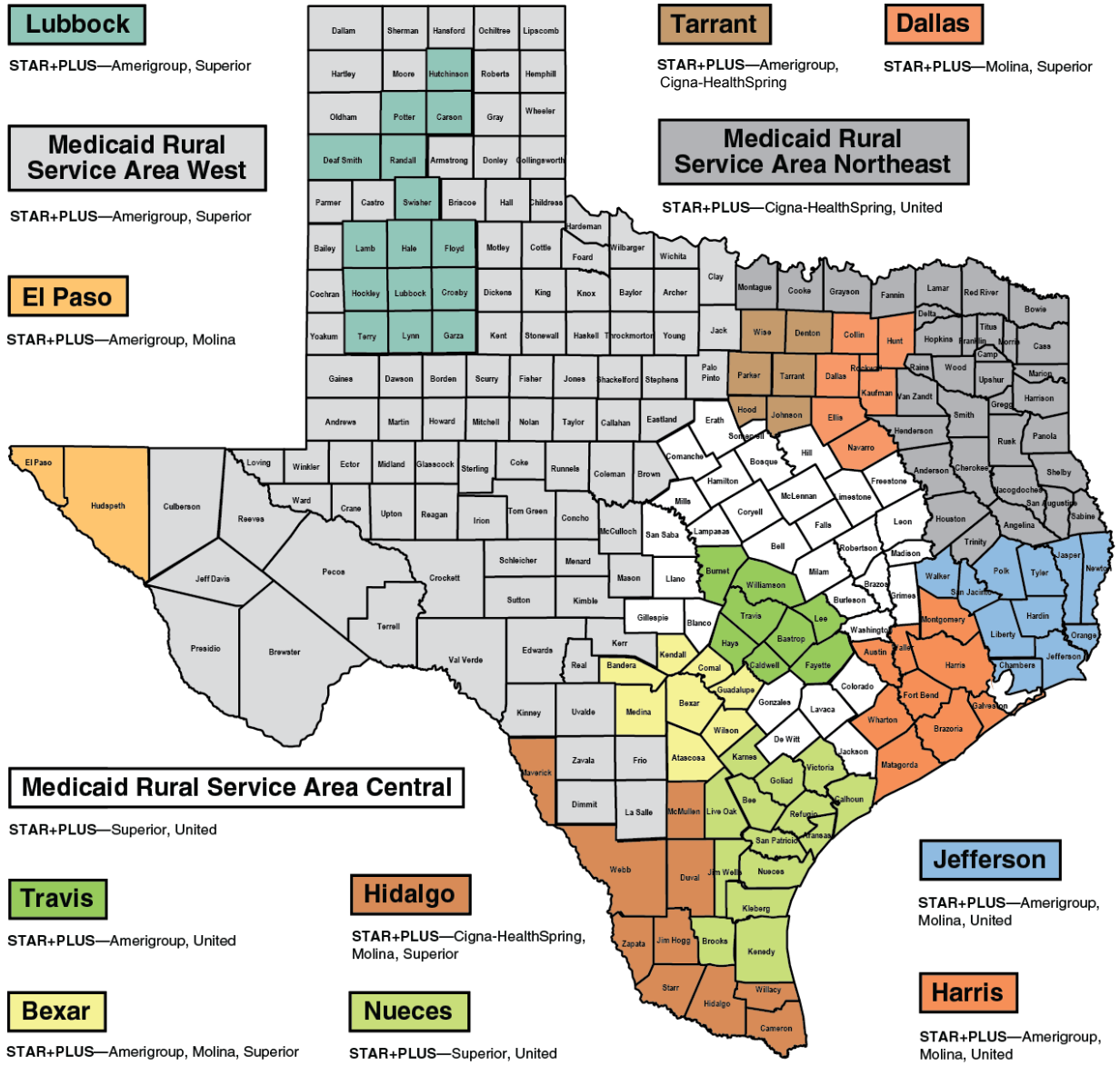
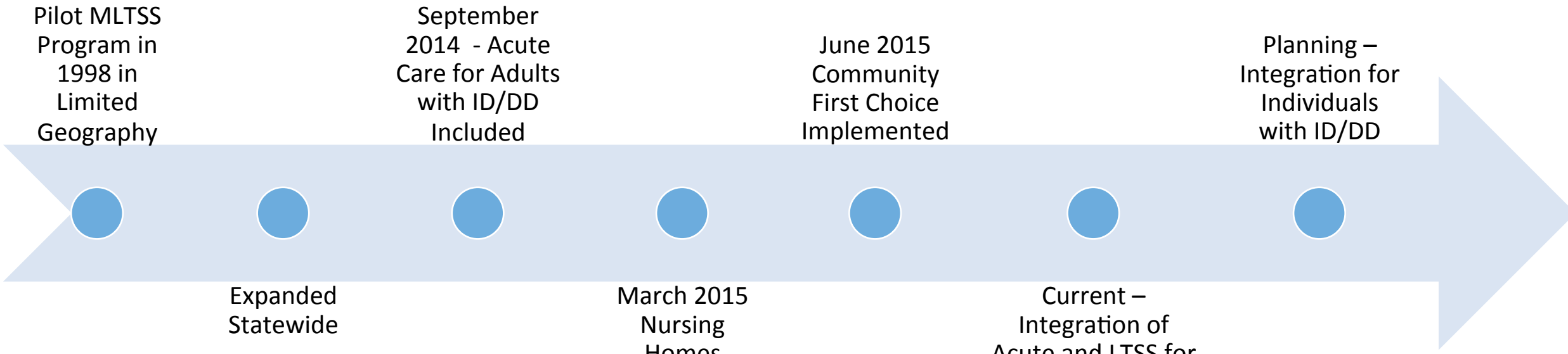
STAR+PLUS

- **Primary health care delivery model for individuals age 65 or older and individuals with disabilities in Medicaid**
- **First STAR+PLUS pilot initiated in 1998**
- **Statewide as of Sept. 1, 2014**
- **Acute care for adults with IDD carved-in Sept. 1, 2014**
- **Nursing homes carved-in March 1, 2015**
- **Community First Choice implemented June 1, 2015**
- **Future integration of acute care and LTSS for individuals with IDD through STAR+PLUS/STAR KIDS**
- **Key Features:**
  - Integrates acute care and long-term care to promote quality and access to care in the least restrictive, most appropriate setting
  - Service coordinators
  - Value-added benefits



Long Term Supports and Services

STAR+PLUS – Primary health care delivery model for individuals age 65 or older and individuals with disabilities in Medicaid



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What Integrated Care Looks Like

Acute Care

(non-exhaustive list)

- Emergency & Non-emergency Ambulance Services
- Behavioral Health Services
- Outpatient Mental Health Services
- Psychiatry Services
- Substance Use Disorder Treatment Services
- Chiropractic Services
- Durable Medical Equipment
- Hospital Services (Inpatient and Outpatient)
- Laboratory
- Podiatry
- Primary Care Services
- Specialty Physician Services
- Radiology
- Therapies (Physical, Occupational, Speech)
- Prescription Drugs

SERVICE COORDINATION

Service Coordination = Specialized care management service that is performed by a Service Coordinator, and includes (but not limited to):

- Identification of needs
- Development of a Plan of Care
- Assistance to ensure timely and coordinated access to an array of providers and covered services
- Coordination of covered services with services outside the benefit plan

Service Coordination is an integral service and the main feature of the STAR+PLUS program.

Long-Term Care Services & Supports

(non-exhaustive list)

- Nursing Facility Services
- Personal Assistance Services (PAS)
- Community First Choice (CFC)
- Day Activity & Health Services (DAHS)
- STAR+PLUS HCBS Waiver (CBA waiver in Traditional Medicaid):
  - Assisted Living
  - Adaptive Aids
  - Minor Home Modifications
  - Personal Assistance Services
  - Respite Care
  - Emergency Response
  - Transition Assistance Services
  - Home Delivered Meals
  - Nursing Services
  - Medical Supplies
  - Adult Foster Care
  - Dental
  - Therapies
  - Financial Management Services
  - Cognitive Rehabilitation Therapy
  - Supported Employment & Employment Assistance

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Managed Care Quality Initiatives

- **External Quality Review Organization (EQRO)**
  - Contracted by HHSC to provide an external independent review of quality outcomes, timeliness of services, and access to services provided by MCOs
- **MCO Performance Indicator Dashboards**
  - Includes MCO performance on PPEs, access to care, member satisfaction with care, population-specific preventive health, care for certain chronic conditions
  - Specific LTSS and NF measures added to MCO dashboards for CY 2015
- **MCO Report Cards**
  - Allow members to easily compare the MCOs on specific quality measures
- **Member Surveys**
  - Conducted by state's EQRO using validated and nationally accepted survey instruments

Other Managed Care Quality Initiatives

- **Performance Improvement Projects (PIPs)**
  - Topics recommended by EQRO and based on MCO performance
- **Dual Demonstration**
  - Six county pilot program
  - Integrates Medicare acute care and Medicaid LTSS to better coordinate services
  - Shared savings between federal government and state
- **HB 1, HHSC Rider 67**
  - HHSC will evaluate how Texas Medicaid providers and MCOs use existing pay for quality measures to improve health care delivery and impact of these initiatives on quality of care and improved outcomes

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Integration of Care Produced Savings and Quality: Produced Early Results

REDUCING THE HIGHEST COST DRIVERS IN MEDICAID

28% Reduction in independent hospitalization

40% Reduction in emergency room visits

KEEPING PEOPLE IN THEIR COMMUNITIES

70% Increase in the use of community based services

38% Increase in the use of adult day care services

Source: Institute for Child Health Policy. The Impact of Care Coordination on the Provision of Health Care Services to Disabled and Chronically Ill Medicaid Enrollees. November 2003.

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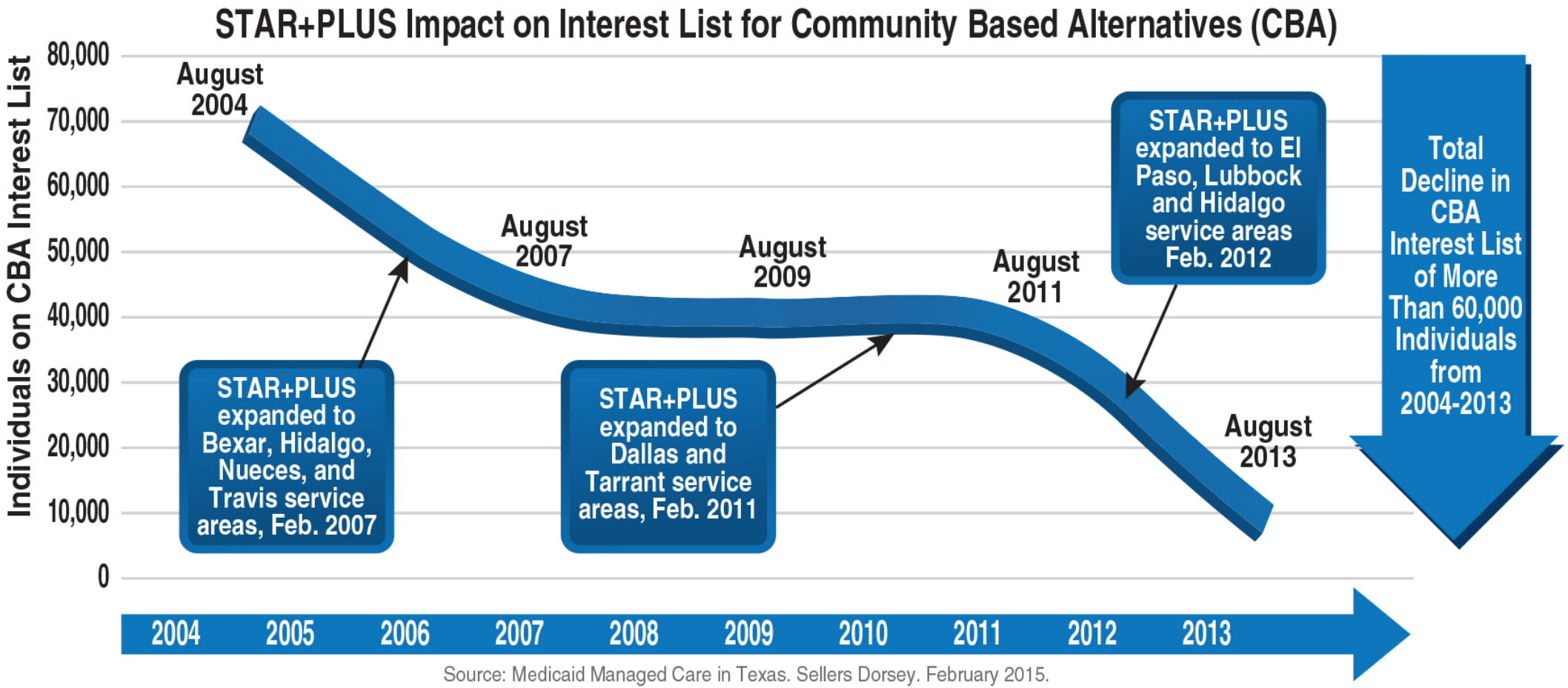
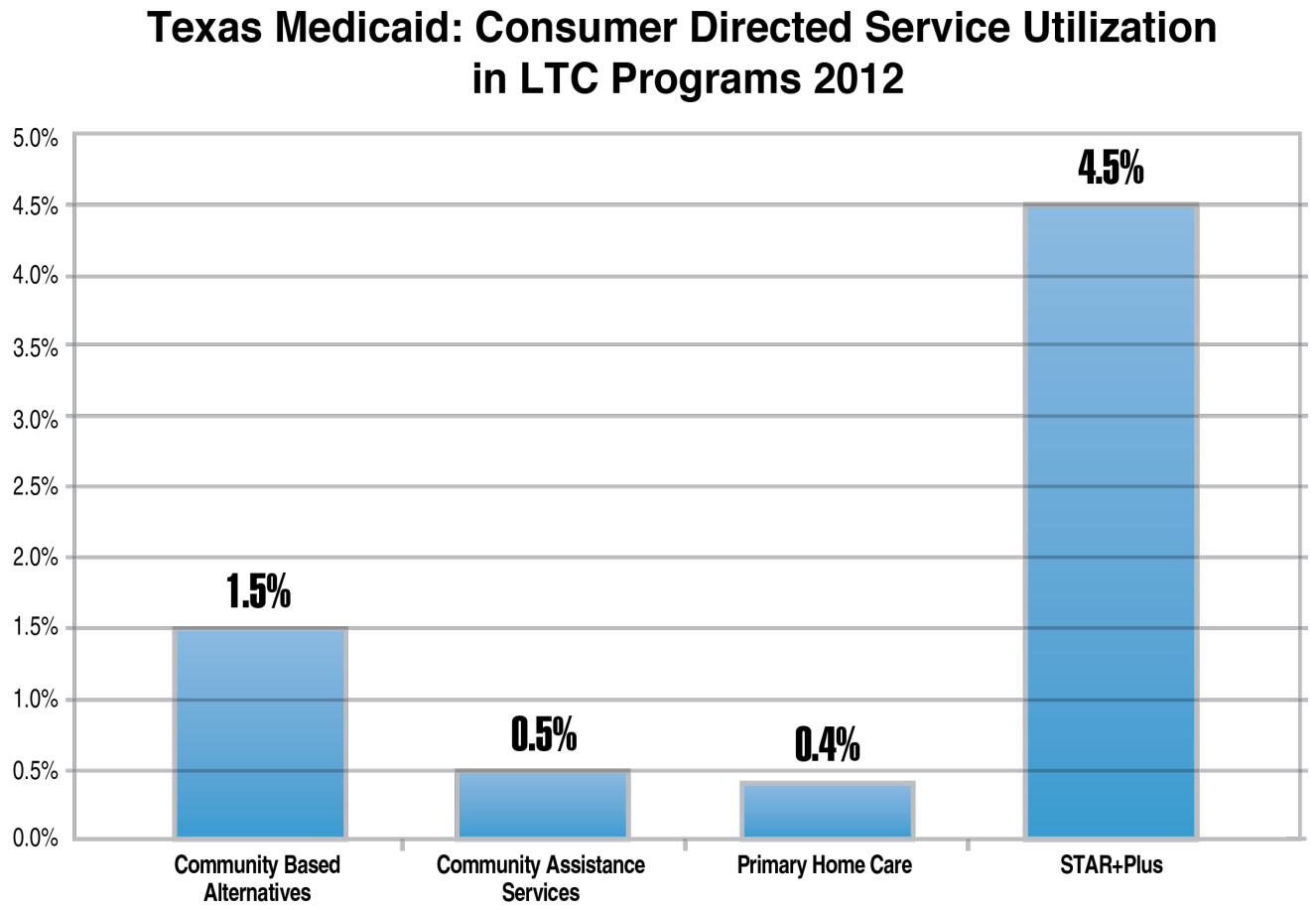
STAR+PLUS: Increased Access to Community Care



Source: Medicaid Managed Care in Texas. Sellers Dorsey. February 2015.

STAR+PLUS: Increased Focus On Community Care and Maintaining Independence

- **Community care has increased significantly at no additional cost to the state, while nursing home caseloads have stayed relatively flat**
- **Nursing home caseloads:**
  - 2003: 60K
  - 2013: 56K
- **Consumer directed services (CDS) has increased under managed care**
  - Allows individuals to directly hire and manage the people who provide their services
- **Focus on community care through STAR +PLUS has helped Texas address growing needs, without substantially adding new costs**



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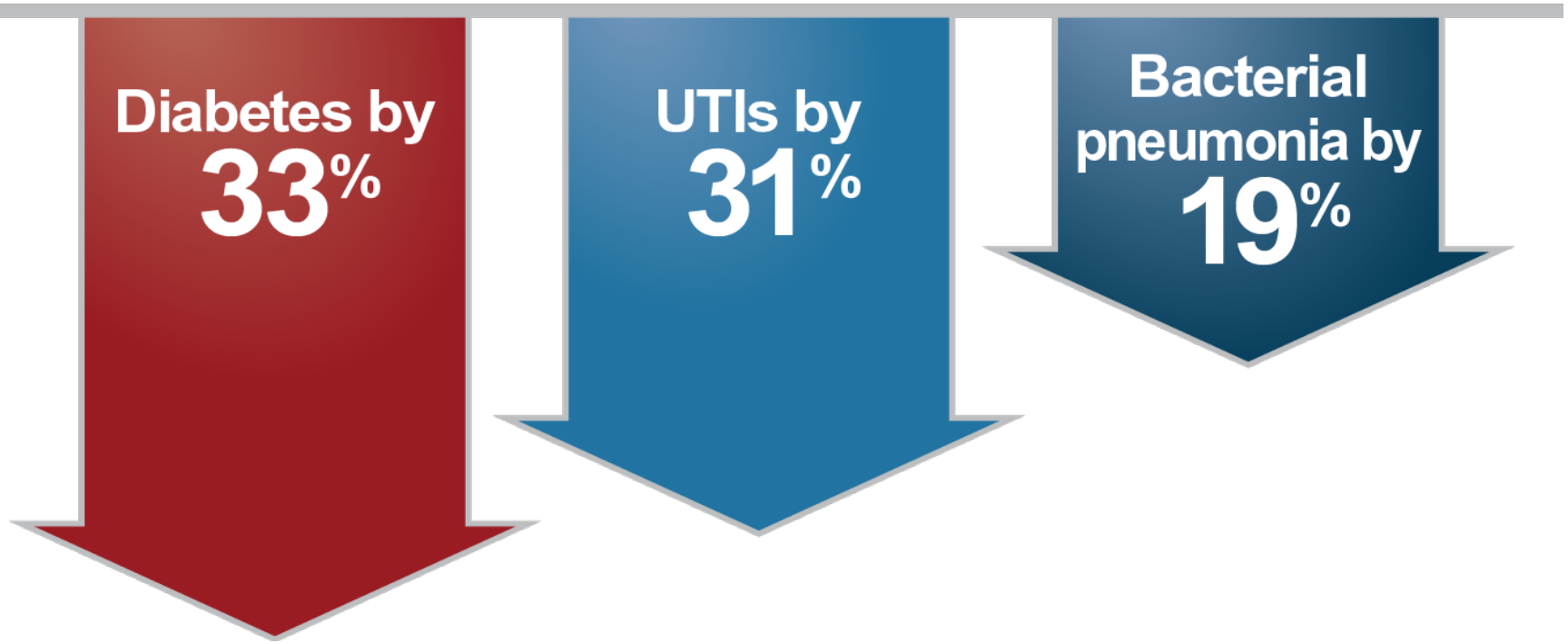
STAR+PLUS Improved Quality of Care

Between 2009 and 2011,
STAR+PLUS plans reduced hospital admissions for:



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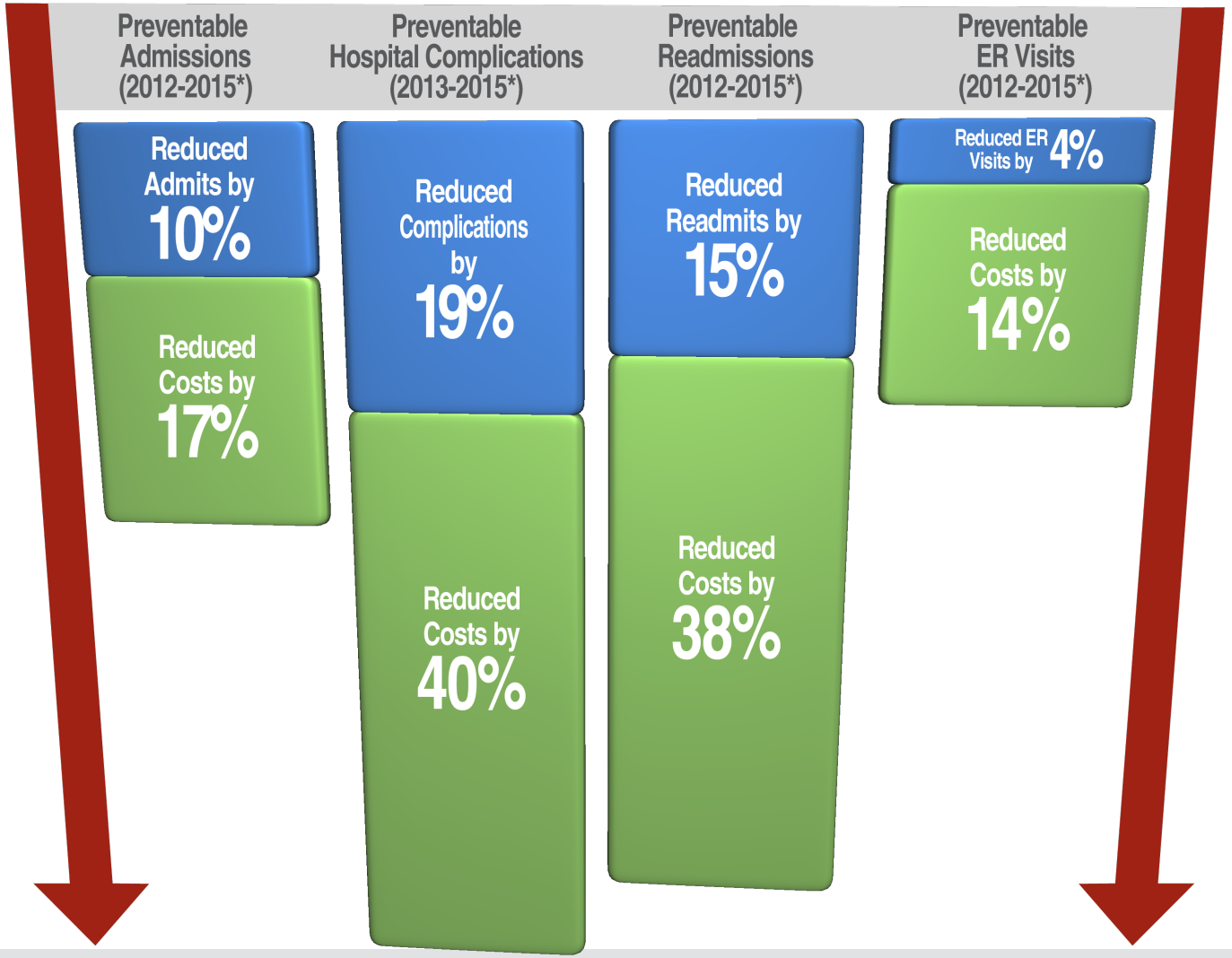
Texas Medicaid Managed Care: Pay-for-Quality (P4Q)

P4Q Program:

- Focuses on outcomes
- 4% of MCO premium payments at-risk for quality
- Focus on reducing Potentially Preventable Events (PPEs)

STAR+PLUS Plans Reduced Potentially Preventable Events



Source: HHSC Interactive MCO PPE Report CY 12- CY 15.

*2015 includes data through November 2015

STAR+PLUS NF Carve-In (March 1, 2015)

- **Nursing Facility Access Standard** – STAR+PLUS MCOs must ensure access to a Nursing Facility in the Provider Network within 75 miles of the Member's residence
- **Significant Traditional Provider (STP)/Any Willing Provider**
  - STAR+PLUS MCOs must contract with any NF that is a STP (as of Sept. 1, 2013), and any other NF that is willing to agree to the MCO's contract rates and terms (expires Feb. 28, 2018)
  - MCOs must use state identified credentialing criteria (NF must hold a valid certification and license and contract with DADS)
- **HHSC sets minimum reimbursement rate paid to NFs under STAR +PLUS (until September 1, 2021)**

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Service Coordination

Service Coordination is designed to:

- Ensure members are assessed to determine their medical, behavioral, functional and social needs.
- Develop service/care plans to identify how member's needs will be met.
- Provide members with individualized, comprehensive services, programs and benefits to help them live healthier lives.
- Provide members and their family/support system with education, support, advocacy, and coordination of services with empathy and care.
- Reassess members as needed to ensure services provided are meeting their needs, to include adjusting the care plan as needed when changes or additional needs are identified.

Service Coordination is an integral service and the main feature of the STAR+PLUS program

Service Coordination Goals

The Goals of the Service Coordination Program are to:

- Ensure LTSS and clinical programs are in place according to members' functional, medical, behavioral and social status.
- Support members' desires to live in the least restrictive setting possible.
- Promote independence and self-direction in meeting member needs and facilitating healthier outcomes.

To Reach These Goals:

- The Service Coordinator is the member's point of contact with the health plan and is responsible for responding to member's needs and coordinating all necessary services.
- Members are provided the name of their Service Coordinator and instructed as to how to contact their Service Coordinator for assistance.

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Service Coordination

Service coordination is a specialized care management service that is performed by a Service Coordinator and includes (but not limited to):

- identification of needs, including physical health, mental health services and LTSS for STAR+PLUS members;
- development of a Plan of Care to address those identified needs;
- assistance to ensure timely and coordinated access to an array of providers and covered services;
- attention to unique needs of individual through person centered planning; and
- coordination of covered services with social and other services delivered outside the benefit plan as necessary and appropriate.

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Service Coordination Care Levels

The Service Coordinator has the primary responsibility of providing service coordination and care management to STAR+PLUS Members.

- **Level 1 Members:** Highest level of utilization. Includes members that are HCBS SPW, Nursing Facility member, members with complex medical needs and beginning 9/1 members with SPMI.
- **Level 2 Members:** Lower risk/utilization. Includes members receiving LTSS, CFC Services, or DAHS and Dual Eligible members, members with frequent BH/SA utilization and beginning 9/1 members with SPMI and BH issues.
- **Level 3 Members:** Those that do not qualify for level 1 or 2, and level 3 NF members that are receiving Hospice Services or residing in a NF outside of the MCO's Service Area.

Service Coordinators must possess knowledge of the principles of most integrated settings, including federal and state requirements.

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Service Coordinator Education and Experience Requirements

The Service Coordinator has the primary responsibility of providing service coordination and care management to STAR+PLUS Members.

- A Service Coordinator for our High Risk level members must be a registered nurse (RN) or nurse practitioner (NP). Licensed vocational nurses (LVNs) employed as Service Coordinators before March 1, 2013 are allowed to continue in that role.
- A Service Coordinator for a **low or moderate risk** member must have an undergraduate or graduate degree in social work or a related field or be an LVN, RN, NP, or physician's assistant (PA); or have a minimum of a high school diploma or GED and direct experience with the ABD/SSI population in three of the last five years.
- Service Coordinators for **low risk** members must have experience in meeting the needs of the member population served (for example, people with disabilities).

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Timeline of Service Coordination changes

Prior to 2013

-Stratification of members based on assessment and utilization

-Type and number of member contacts based on member needs and preferences

2013

-Contractually required member stratification and staffing credentials

-Mandated minimum contacts (type and number)

- Members with frequent BH or SA into Level 2

-SC Credential requirements

-Service Coordination line mandated

-The 83rd Texas Legislature passed SB 348 which directed HHSC to establish a review process for MCO's participating in STAR+PLUS with a focus on the Policies and Procedures for determining whether a member should be enrolled in HCBS STAR+PLUS waiver program

-Beginning of Pay for Quality Programs

2014

-Carve in of IDD members into Managed Care for Acute Services

-MRSA Expansion into Managed Care for STAR+PLUS

-All IDD Members must be assigned an SC

-Participation in reviews with UMR Team in addition to Readiness and Contract reviews

-The UMR Staff conducted desk reviews of 10 test cases from UHC, our policies and procedures, along with HHSC's contract and policy requirements.

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Timeline of Service Coordination changes

2015

-Carving in of NF Members into Managed Care

-Nursing Facility mandated quarterly contacts

-H2060 for all members receiving LTSS

-Addition of SPMI Category into Level 1

-Adding additional Telephonic contact for SPMI members

-Electronic Submission of ISP

-The UMR team reviewed 33 members out of sample size of 272 members who were upgraded to HCBS STAR+PLUS Waiver. During this review period, case records were examined along with home visits conducted with these members.

2016

-All SPW members must have a H2060 or H6516

-Services must be in place within 7 days of identification

-SC follow up within 4 weeks to ensure services in place

-Monitoring of claims to match authorized services

-Requirements related to Abuse, Neglect and Exploitation

-Additional mandatory training sessions related to UMR, above required training hours

-UMR Plans to conduct follow up reviews based on the technical assistance provided to each MCO and expand the review protocols to include sampling of anyone receiving HCBS STAR+PLUS Waiver program services without exception