Service Coordination in STAR+PLUS

Presentation to HHSC
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Challenges in STAR+PLUS – Flexibility Eroding

- **Initial Design:** STAR+PLUS aimed to personalize service coordination to each member's unique needs. That flexibility has eroded over the past decade.
- **Current Challenge:** Over time, increased prescriptiveness has reduced the flexibility to tailor service coordination, and as a result, has increased cost.
- **Examples:** Stricter requirements for service coordinator credentials and the addition of member acuity levels, touch points, and other administrative processes.
- **Impact on MCOs:**
  - **Increased Staffing:** Necessity to hire more nurses and staff.
  - **Higher Costs:** Escalated administrative burdens leading to increased program costs.
- **Member Burden:** STAR+PLUS members also bear the burden of additional service coordination requirements that may be inappropriate for their care needs.
- **Key Point:** Managed care excels with outcome-based contracting—flexibility is crucial for MCOs to innovate and design effective programs.

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2024 STAR+PLUS Contract Changes: Major Changes

- **Population Classifications Changing:** 6 existing level 2 populations will move up to level 1
  - 75-100% increase in the level 1 population
- **Touchpoints Going Up:** Minimum 2 face-to-face and 4 telephonic visits annually, except for NF populations (already receive 4 face-to-face visits).
- **Net Increase on Touchpoints (140% or 453,000 touch point increase):**
  - 3x increase in touchpoints for new level 1 populations (2 to 6)
  - 2x increase in touchpoints for existing SPMI population (3 to 6)
  - 3x increase in touch points for all other existing populations (2 to 6)
- **Qualifications Going Up:** RUG-certified RN or NP required (the 6 populations moving to Level 1 are currently served by LSW, LVN, RN, NP, or PA; or people with a high school diploma/GED and direct experience).
- **New ISP Member Signatures:** A signature mandate creates an added burden and potentially an added unnecessary in-person visit just for a signature.

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2024 STAR+PLUS Contract Changes: Our Concerns

- **Exacerbates Nursing Shortage:** MCOs already face challenges in meeting demand for qualified RNs/NPs. Furthermore, these new requirements further shift nurses from clinical work as MCOs staff up to meet the new mandates.
  - An additional estimated 400 RNs/NPs—nearly a 50%-75% increase in nursing staff at MCOs
  - Touch points increase from 327,000 to 780,000, marking a 453,000 (140%) increase (increase of 360,000 calls and 60,000 in-person visits
- **Runs Counter to Maximizing Health Care Workforce:** Efforts to address workforce challenges are in part focused on maximizing the training and education of other health care professionals like LVNs.
- **Increases Administrative Burden and Costs to Taxpayers:** Two and threefold increases in visits mean more administrative tasks and costs—without a clear clinical benefit.
  - **Cost Implications:** Projected annual cost increase of $20-30M.

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2024 STAR+PLUS Contract Changes: Our Concerns, cont'

- **Operational Complexity:** Coordinating this massive increase in visits within newly prescribed, tight deadlines is a significant undertaking.
- **Unique Demands:** Unlike members in FNs where service coordinators can easily make quarterly visits to many members in one location, these members require complex scheduling. Schedule changes and significant drive time must also be considered.
- **Balancing Changes:** MCOs must attempt to coordinate routine visits (6 touch points) with added visits that crop up when health care needs change. This may include:
  - A change in condition
  - When an ISP requires a change but the signature cannot be collected electronically
  - Discharge planning
  - Home modification
  - Requesting an increase in PAS

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2024 STAR+PLUS Contract Changes: Our Concerns, cont’

- **Spacing Complexity:** Adding these additional touch points on top of spacing requirements makes this nearly impossible to achieve and unnecessarily complex.
- **Member Demands:** We respect the goal of spacing out member visits, but MCOs must also respect member schedules and schedule changes. Adding more visits on a stringent timeline with mandated spacing creates likely unachievable challenges.
- **Service Quality Concerns:** Respectfully, we are also concerned about the quality of service coordination visits given these stringent timelines and added demands on service coordination staff. Service coordination should first be meaningful.

Key Questions: Help MCOs Better Understand the Need for Changes

- **What is the problem we are trying to solve?** MCOs support identifying creative, workable, and affordable solutions. If we understand the problems identified by HHSC we are on board to help craft a solution.
- **Clinical Justification?** What is the clinical justification for a 3 fold increase in visits for individuals moving up from level 2 and a 2 fold increase for existing level 1 members?
  - The cost of contract changes are likely $20-30M a year.
- **Population Changes to Level 1:** How were the new populations identified and what was the rationale or problem identified?
- **Balancing Necessity v. Redundancy:** How has HHSC considered the appropriate level of service coordination visits to ensure an added benefit for the member and avoid redundancy or annoying the member?

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More Key Questions: Help MCOs Better Understand the Need for Changes

- **Credentialing Changes:** How many of these new level 1 members were previously required to have an NP/RN as a service coordinator? What wasn't working?
  - Why does HHSC think a pregnant woman is better served by RN service coordinator that does not provide hands-on care, versus an LVN or a social worker?
- **What Changed?** What is the clinical justification for restricting the flexibility of RN/LP credentials if the populations currently served under level 2 are well served now by other types of health care professionals?
- **Signature Reasoning?** What is the impetus for a new signature requirement? Has HHSC considered the cost impact vs the benefits of visiting a member in-person strictly to gather a signature?
- **Why RUG certification for everyone?** RUG certification is only necessary for assessments. What is the impetus for mandating broad RUG certification?

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Recommendations

#1. Flexibility in credentials:

- TAHP supports guaranteeing RNs/NPs for members in level 1 that require an MNLOC or are in a NF.
- **For all other members receiving Level 1 care, TAHP recommends that MCOs be allowed to determine the credentials required for service coordination**; and where indicated, assign an RN or RN oversight.

#2. Frequency of visits: We appreciate the desire to increase service coordination visits. We suggest a more nuanced and workable approach to achieve this goal.

- **Create a sub-set of Level 1 members:** Allow members who are not receiving HCBS waiver services, complex medical needs, SPMI or in a NF to have a more flexible standard for touch points.
- Currently these new level 1 populations receive 2 total touch points per year.
- We suggest increasing the total touchpoints to 3 per year with 1 in-person and 2 telephonic visits.

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Recommendations, con't

#3. Electronic signature flexibility:

- MCOs support ensuring members give consent to services. However, strict signature requirements add additional administrative burden.
- In many cases, ISPs require service coordinators to complete plans after a member visit to ensure coordination with physicians and other needs. A strict signature mandate will force an additional visit just to obtain a signature.
- **TAHP recommends flexibility in obtaining consent for ISPs.** In circumstances where MCOs are unable to obtain a signature, MCOs should be allowed to document verbal consent or patient refusal or inability to sign.

Closing Considerations

- **Resource Restraints:** Moving additional, large population groups into level 1 who may not require level 1 care, reduces resources that should be dedicated to members with the highest needs.
- **Existing Flexibility:** Contract changes also do not consider the flexibility MCOs currently have to move an individual into a higher level of service coordination based on need—which is routinely done when needed.
- **Member Preferences:** Current level 2 members who are accustomed to and prefer receiving fewer touch points will now be required to interact with their service coordinators on a much greater frequency.
- **Practitioner Appropriateness:** Contract changes lack the flexibility for MCOs to consider each individual's specific level of need. For example, some members may have a need that can be better addressed by a social worker or other non-nurse health care professional. This proposal also runs counter to efforts to use practitioners to their highest level of training and education.

Considerations, cont'.

- **Workforce Strains:** The requirements eliminate the ability to leverage other health professionals and paraprofessionals and as a result, further reduce the available workforce for direct member care.
- **Reality of Care Delivery:** Service coordinators assist members in receiving appropriate services and navigating the health care system; managed care nurses do not provide hands-on clinical care.
- **Actual Visitation Needs:** While the contract requires a minimum number of face-to-face visits for each population, in practice many scenarios can trigger additional face-to-face visits, including:
  - A change in condition
  - An in-person signature to an ISP change
  - Discharge planning
  - Home modifications
  - Requesting an increase in PAS

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Considerations, cont'.

- **Unique Scenarios:** Contract changes will result in significant duplication, abrasion, and even member confusion for:
  - Members in level 1 who receive home health or attendant services and already frequently have someone in their home conducting health and safety assessments
  - Members who receive Nurse Family Partnership care to reference coordination
- **Bottom Line on Costs:** Finally, these policy changes will increase costs to the program without a clearly identified value proposition.
- **Our proposal re-establishes flexibility** while still ensuring additional service coordination visits.