Superior STAR+PLUS

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LTSS integration is the integration of medical, behavioral health and LTSS benefits in a single capitated program. This case study is part of a larger research project that hypothesizes that LTSS integration has the potential to improve outcomes and lower overall costs of care for people with substantial functional limitations and complex care needs. This body of research is intended to inform business decisions by health plans and other at-risk organizations considering LTSS integration, and to contribute to policy discussions on financing LTSS.

Ten programs that are experienced and successful in integrating medical care and LTSS were selected for this study. The programs vary in structure, population served, and geography in order to reflect the diversity of successful approaches to LTSS integration. Each case report provides an in-depth description of program characteristics and operations, as well as a discussion of key integration strategies and outcomes.

Background Information

STAR+PLUS is Texas's Medicaid MLTSS program for people age 21 and older with disabilities and those age 65 and older. STAR+PLUS is a mandatory program, which means that eligible individuals must enroll in a managed care plan in order to receive Medicaid benefits. The program covers a comprehensive benefit package that includes medical, LTSS, and behavioral health. Institutional LTSS was carved into the STAR+PLUS program in early 2015. LTSS for individuals receive IDD-waiver services are carved out and managed by the state.[1]

Superior HealthPlan, a Centene subsidiary, has participated in the STAR+PLUS program since 2007, and in 2015 had approximately 148,000 members in the plan.[2] About half of the plan's members are dual eligible, but only a few hundred have Medicare coverage with Superior. Most of Superior's dual eligible STAR+PLUS members receive their primary medical coverage from Original Medicare (i.e., fee-for-service) or from Medicare Advantage plans operated by other organizations.

For medical services, Superior operates a preferred provider network that helps members choose higher quality and lower cost physicians and hospitals. The plan cannot operate a preferred provider network

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[1] Please refer to Appendix B for more information on the STAR+PLUS Medicaid MLTSS program in Texas.
[2] As of June 2015. Author calculations from *Texas Medicaid and CHIP Financial Statistical Reports for 2015*. Available at: http://www.hhsc.state.tx.us/medicaid/managed-care/financial/

for LTSS, because the state has required the plan to contract with all traditional providers during the first few years of the program. Under these rules, even terminating a contract for poor performance can be challenging.

Care Management and Provider Organization

The core care team for STAR+PLUS members receiving LTSS consists of the member and their informal caregivers, their service coordinator (a Superior staff member), their PCP, and paid caregivers (Superior contractors). Members who have primary medical coverage with Superior (i.e., non-duals) are required to select a network PCP when joining the plan, who is then responsible for authorizing services. The service coordinator is responsible for communicating with the other members of the team, and may also draw on the expertise other specialists on Superior's staff as needed, including behavioral health specialists, health coaches, pharmacists, and medical directors. Engaging PCPs in the LTSS care plan is a major challenge for the plan, especially for dual eligible members who have primary medical coverage through Original Medicare or another Medicare Advantage plan. For these individuals, members may not have a PCP, or may see a PCP who is not in Superior's network. It can be very difficult to engage non-network providers in care management.

Medicaid MLTSS in Texas	
Program Name	STAR+PLUS
Year Established	1998
Covered Populations	Disabled adults age 21 and older
	All Medicaid beneficiaries age 65 and older
Population Carve-Outs	None
Enrollment Approach	Mandatory
Statewide Enrollment	524,730[3]
Covered Benefits	Comprehensive (medical, behavioral, and LTSS)
Benefit Carve-Outs	IDD Waiver services
Dual Eligible Population	214,328[4]
Population Using LTSS	71,239[5]

Superior's care management process (also known as "service coordination") is largely organized around fulfilling state contract requirements.[6] The state has specified three tiers of complexity for managing members. The most intensive tier—Level 1—includes any individual who is receiving a waiver-covered

[3] Texas Health and Human Services System (2015) *2015 Texas HHS Fact Book*, page 40. Available at: http://www.hhsc.state.tx.us/reports/2015/fact-book.pdf

[4] Texas Health and Human Services Commission (2012) *Texas Dual Eligibles Integrated Care Demonstration Project: Application*, page 7. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXProposal.pdf

[5] As of June 2012. B. Jackson et al. (2013) *Quality in MLTSS Programs* Report for ASPE Office of Disability, Aging and Long-Term Care Policy. Available at: https://aspe.hhs.gov/report/quality-managed-long-term-services-and-supports-programs

[6] For more details on the state's requirements for contractors, see the most recent STAR+PLUS contract available here: http://www.hhsc.state.tx.us/medicaid/managed-care/contracts/STARPLUS-MRSA-contract.pdf

service,[7] as well as all institutionalized members.[8] The middle tier—Level 2—includes members who are receiving any LTSS service. All remaining members are assigned to the least intensive tier—Level 3. This service-specific stratification process can sometimes lead to situations where relatively stable and low-risk individuals are assigned to the most intensive level of management because they have previously received a home modification, which is a waiver-covered service. Similarly, very complex individuals who are not receiving any services might be classified to Level 3 under these criteria. To remedy this situation, Superior assigns all individuals they identify as complex and high-risk to Level 1. A little less than half of Superior's STAR+PLUS population is in Levels 1 and 2, and a little more than half is in Level 3.

All Superior STAR+PLUS members are assigned to a service coordinator employed by the plan, whose background is determined by the tier in which the member is stratified. Level 1 individuals are managed by an RN, Level 2 by a social worker or an LVN, and Level 3 by an unlicensed coordinator with appropriate relevant experience. The plan further assigns members to service coordinators with special training (e.g., behavioral health specialists) as needed.

Outreach is attempted for all members to complete an initial health risk assessment (HRA) within 30 days of enrollment. In addition to this HRA, the state requires that Superior complete lengthy, paper-based, service-specific assessments in order for members to receive LTSS.[9] These forms are not designed to create a holistic view of member needs and goals, but are oriented more towards appropriately authorizing covered benefits. These assessments are conducted when members or their providers first request services, and reassessments are done annually as authorizations expire. A change in member condition or an acute event may lead to a provider or member request for additional services or hours, which will trigger a new assessment. For institutionalized members, the service coordinator's role is somewhat different. For these individuals, the service coordinator primarily reviews facility assessments and care plan. The service coordinator is also responsible for assessing members who are candidates for repatriation and ensuring that resources are in place members when they transition to the community.

For individuals who receive waiver-covered services, the state requires service coordinators to create an individualized service plan that lists all of the services the member receives. These service plans are created in an electronic record system and can be shared electronically with PCPs and other providers through a web-based portal. State assessments are attached to the record as scanned PDFs.

Service coordinators meet with members in accordance with state contract requirements. Institutionalized members must receive four face-to-face visits from the service coordinator annually, community-dwelling Level 1 members must receive two visits, Level 2 members receive one visit, and Level 3 members may be managed by telephone. Beyond these requirements, the service coordinator has discretion in how they manage the member, and may do more frequent outreach to coordinate the member's care. Service coordinators are also responsible for overseeing care, and follow-up with members directly to confirm that services are being delivered. The state requires the plan to submit

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[7] Many states offer Medicaid beneficiaries non-institutional LTSS through Section (§)1915(c) HCBS Waiver Programs, which enable states to target services by age and diagnosis and to offer them on a less than statewide basis. For more information on waiver programs, see J. O'Keeffe et al. (2010) *Understanding Medicaid Home and Community Services: A Primer* Report for ASPE Office of Disability, Aging and Long-Term Care Policy. Available at:
https://aspe.hhs.gov/sites/default/files/pdf/76201/primer10.pdf

[8] Institutional LTSS was carved into the STAR+PLUS program in early 2015, and administrative processes for these members continue to evolve and are still being integrated.

[9] The Texas basic Needs Assessment Questionnaire can be accessed here: https://www.dads.state.tx.us/forms/2060/

attestation forms for receipt of services signed by the member. Texas is also planning on implementing EVV for service monitoring, which will enable greater plan oversight of LTSS providers.

Superior has a more intensive level of care management for the most complex, highest-risk members. This care management process is not part of state contract requirements, but is something the play does to improve the quality and manage the cost of care for high-risk individuals. The plan's care model for this population follows NCQA's standards for complex care management. The plan identifies members for this level of management using predictive analytics and a risk stratification process. These high-need individuals are assigned to a Level 1 RN for care management, who completes a holistic assessment of the member and creates a comprehensive care plan organized around the member's needs. That member is then followed by the RN with a much higher level of outreach, coordination, and care management until they are stable. Most members in this intensive level of management are stabilized within six months, although some may need more or less time.

Transitions

Superior typically learns of hospitalizations fairly quickly for members who have medical coverage with Superior. For these members, hospitals contact the plan for admission authorization—Superior requires hospitals to preauthorize elective admissions and to report urgent/emergent admissions within one business day. If the member receives their primary medical coverage from Original Medicare or another Medicare Advantage plan, Superior may not be notified of hospitalizations.

Once an individual is hospitalized, they are followed by Superior's medical management team. This team also manages discharge planning and transition services, but will involve the service coordinator to the extent that new assessments and additional LTSS are required following the hospitalization. The named service coordinator assists in discharge planning and resumes full responsibility for the member at discharge.

Plan Incentives and Financial Results

For the STAR+PLUS plan, Superior receives a two funding streams from the state: one payment for medical and LTSS, and a separate payment for pharmacy benefits. The plan is at full risk for providing medical, behavioral, and community-based LTSS. For community-dwelling members, there are four different rate categories: dual eligible receiving waiver services, other dual eligible, non-dual eligible receiving waiver services, and other non-dual eligible. The rate is based on encounter data from the previous year, trended forward based on the growth in medical costs and adjusted to incorporate any provider rate enhancements and benefit package changes. The medical part of the premium is risk adjusted based on the plan's population acuity, but the LTSS part of the premium is community-rated—every plan receives the same rate, regardless of how many of their members require LTSS or the intensity of their LTSS need. The plan reimburses providers on a fee-for-service basis using Medicaid rates set by the state, and does not sub-capitate or otherwise share financial risk with providers.

Texas carved institutional LTSS benefits into the STAR+PLUS program in 2015. The state pays a separate capitation rate for institutionalized members than those receiving community-based LTSS. If an individual moves from one setting to another, the capitation payment is adjusted the following month. Because of this rate structure, there is no financial incentive for plans to keep individuals in the community or to move individuals out of institutions and back into the community. However, the state

does offer some incentives for HCBS through the quality incentive program—one of the measures plans are accountable for is nursing home admissions.

Texas has an experience rebate program with managed care plans that limits profit margins. The state evaluates Superior's margin across all products, with a target of a pre-tax net income of two percent. The plan can keep the first three percent of profits, but must return a share of any profit above that. The share returned to the state increases on a sliding scale until 12 percent profit, at which point the plan must rebate all additional earnings. If Superior is unprofitable, however, the state does not share in any downside risk.[10] This program limits plan incentives to invest in cost-saving innovations, as the state quickly captures most of the financial benefits. Additionally, the state limits plan administrative expense, both setting a cap on total expense and specifying categories of allowable and non-allowable expenses. This further influences plan behavior by limiting investment in services that might be considered administrative but that ultimately increase cost-effectiveness.

Superior has experienced strong enrollment growth since joining STAR+PLUS, and is now one of the largest plans in the program with 27 percent market share.[11] Plan leadership also notes that the organization has succeeded in slowing the capitation growth rate without sacrificing quality of care. In the recent past, Superior's rates have risen more slowly than average healthcare costs in the state.

Utilization Management Strategy

Superior's overarching utilization management goal is to shift spending away from hospital and the emergency department care and toward primary care, preventive care, LTSS and other lower cost services. The plan has a range of utilization management strategies, including preauthorizations for inpatient admissions and other high-cost outpatient services (e.g., outpatient surgery, high-tech imaging, therapies, etc.). The plan also uses concurrent review, discharge planning, and transition management as tools to improve the quality of care.

Superior's LTSS utilization management strategy is predicated on matching services to unmet needs— this requires not only identifying member needs but also evaluating which needs are already being met through personal and community resources. The plan also uses a cost threshold as a tool for limiting the total cost of LTSS service plans. Within the cost threshold, the plan allows service coordinators greater flexibility in authorizing additional services for the member. As the member approaches the threshold, the service coordinator can leverage additional resources from the community and informal caregivers. Above the cost threshold, the plan may strategically provide services on a case-by-case basis to avoid hospitalization, delay institutionalization, or improve quality of life for the member. Regardless of the results of the cost threshold analysis, members always receive the necessary services to remain healthy and safe in the community.

The plan's intensive care management approach for high-risk individuals described above is an important tool for managing costs and improving outcomes. The plan analyzes financial and clinical data to identify

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[10] For more details on the experience rebate program, see this policy brief: http://www.ahcancal.org/advocacy/issue_briefs/Issue%20Briefs/MLR_IB_final.pdf

[11] Texas Health and Human Services Commission (2015) *Texas Healthcare Transformation and Quality Improvement Program: Section 1115 Quarterly Report,* page 6. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-qtrly-rpt-oct-dec-2015.pdf

members at the highest risk of high-cost outcomes, and then targets greater levels of outreach, care coordination, and services to these individuals. These members' service coordinators work to proactively identify interventions that improve the quality and reduce the cost of care. Data sources for risk stratification include HRAs, medical and pharmacy claims, authorizations, and quality gaps in care. This strategy relies on access to medical data, and is consequently not feasible for dual eligible members who do not have Medicare coverage with Superior.

Quality Metrics and Performance Management

Texas has robust quality measurement and reporting programs for Medicaid managed care, including the STAR+PLUS program. MCOs must share encounter data, HEDIS measures, CAHPS survey data, and measures of potentially preventable admissions, readmissions, and emergency department visits. Measures specific to LTSS include the number of STAR+PLUS members entering a nursing facility as well as the number who return to community services. The state operates a web portal where MCO and state staff can view quality results by health plan, service area, provider, and demographic subpopulations. The state does not have this data for dual eligible individuals with Original Medicare coverage. Following a legislative mandate, the state began publishing MCO report cards on the state website.[12]

The state has established a number of financial incentives and penalties related to quality. A share of each MCO's capitation payment is placed at risk based on quality outcomes—in 2015 and 2016, four percent of Superior's STAR+PLUS revenue was at risk in the quality program. If any MCOs fail to earn back the full at-risk share of their capitation, the remaining amount is used to fund bonus payments to reward plans with higher performance.

Superior actively monitors financial, clinical, and member experience outcomes. The primary financial metrics of interest are the health benefits ratio and capitation growth rate. Clinical measures the plan tracks include hospitalizations, readmissions, potential preventable events, diabetes measures, medication adherence, and HEDIS scores. For member satisfaction, the plan relies on CAHPS data. The plan's quality management approach is not limited to compliance with state requirements. Superior also collects data on outcomes that are not required but are meaningful for the STAR+PLUS population like risk of falls, medication review, and pain management.

The state requires MCOs to conduct quality oversight of PCPs and other providers. Plans are required to create provider-specific reports, establish benchmarks, and provide feedback to individual providers on

their performance. Beyond this requirement, Superior has a program to reward physicians for managing key utilization measures for their patient panel, including their generic fill rate, emergency room use, and inpatient admissions.

The plan did not share specific information on how service coordinator performance is tracked and managed.

Superior promotes person-centeredness by developing comprehensive care plans for high-risk individuals in collaboration with the member. Assessments include questions about individual's goals, which serve as a way to engage members in the process. The plan believes that member buy-in is critical to the success of a care plan, and members who refuse to engage in the care planning process are closed

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[12] Superior's report card for the STAR+PLUS plan can be seen here: http://www.hhsc.state.tx.us/QuickAnswers/health-plans/STAR+/Superior-Health-Plan-Profile-StarPlus-English.pdf

out of intensive care management. Superior does not have an approach for systematically measuring person-centeredness.

Other Integrated Products

In addition to the STAR+PLUS plan—a Medicaid MLTSS product—Superior operates a D-SNP for dual eligible individuals. Superior first launched this product because Texas required all STAR+PLUS contractors to operate a D-SNP as a condition of participation. However, less than 5% of eligible members are enrolled plan. This is somewhat lower than it used to be because some D-SNP members have been moved into Superior's Duals Demonstration plans, but enrollment was never high.

In March 2015, Superior launched an MMP in their three largest urban counties as part of the Texas dual demonstration program. Statewide, there are 24,741 individuals enrolled in the demonstration,[14] about 9,500 of whom are in Superior's MMP.[15] Between March and October of 2015, the state Medicaid agency and CMS moved dual eligible STAR+PLUS members in the pilot counties to the MMP. Members receiving waiver services and those enrolled in Original Medicare (i.e., fee-for-service) stayed with Superior for the MMP. Members

Texas Duals Demonstration	
Program Name	Texas Dual Eligible Integrated Care Project
Initial Enrollment	April 2015
Covered Populations	Full dual eligibles age 21 and older in six participating counties
Population Carve-Outs	Individuals receiving IDD, HCBS, CLASS, DBMD, or TxHmL waiver services
Enrollment Approach	Passive with opt-out
Statewide Enrollment	24,741[13]
Covered Benefits	Comprehensive (medical, behavioral, and LTSS)
Benefit Carve-Outs	None

who had Medicare coverage through another plan participating in the pilot were enrolled in that plan's MMP. The benefit packages are very similar for MMP members and STAR+PLUS members who have both LTSS and medical coverage with Superior. Superior manages the MMP separately from the rest of the STAR+PLUS program, because they demonstration has a different set of requirements for the care model. In general, there are higher regulatory and administrative requirements for the MMP care model compared to STAR+PLUS.

The fact that Superior operates these three different products—the STAR+PLUS plan, the D-SNP, and the MMP—means that different subpopulations within their membership receive different levels of integration. Non-dual (i.e., Medicaid-only) STAR+PLUS members are fully financially integrated within one Superior product. Dual eligible individuals in the MMP, or who are enrolled in both Superior's STAR+PLUS plan and their D-SNP receive comprehensive coverage with Superior with two payers (the state for Medicaid benefits and the federal government for Medicare benefits). Finally, dual eligible members enrolled in STAR+PLUS who are enrolled in Original Medicare or another Medicare Advantage

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[13] Texas Health and Human Services System (2015) *2015 Texas HHS Fact Book*, page 40. Available at: http://www.hhsc.state.tx.us/reports/2015/fact-book.pdf

[14] Texas Health and Human Services System (2015) *2015 Texas HHS Fact Book*, page 40. Available at: http://www.hhsc.state.tx.us/reports/2015/fact-book.pdf

[15] As of December 1, 2015. Source: Communication with Superior HealthPlan.

plan are not financially integrated. This variation presents the opportunity to compare how financial integration affects care within a single organization.

Key Integration Strategies and Outcomes

Superior pursues three main goals for the STAR+PLUS program. First, the plan aims to address member needs holistically across medical, behavioral, and LTSS. Second, the organization seeks to balance cost and quality in member care. Finally, the plan hopes to shift spending from emergency department and hospital care to preventive care, primary care, LTSS and other lower cost services.

The plan pursues a range of integration strategies to achieve these goals. Leveraging data is a key element of their strategy. Superior analyzes financial, clinical, and other data to identify the highest-risk individuals in their plan and carefully target enhanced care coordination and services to these members. Lack of access to comprehensive data for members who receive Medicare coverage elsewhere is a critical barrier to achieving success with the dual eligible population. A second integration strategy is the plan's flexible benefit design. Once high-risk members have been identified, Superior can deploy a wide range of resources to support them in the community. The benefit package includes state Medicaid benefits (e.g., medical care, pharmacy, and care management), HCBS waiver services for institutionally-qualified members (e.g., home delivered meals, minor home modifications, and assisted living facility costs[16]), and plan-specific value-added services (e.g., emergency response services, phone minutes, and allowances for over-the-counter medications). Beyond this, the plan funds additional needs on a case-by-case basis out of the administrative budget to improve quality-of-life or avoid a hospitalization. Finally, the plan achieves financial results by being strictly needs-driven, calibrating the necessary services to support members without duplication or overprovision, and leveraging informal and community resources where available. Awareness of the total cost of care focuses the organization on providing a well-coordinated and cost-effective set of services to members.

Superior identifies the comprehensive care model that addresses high-risk members' medical, behavioral, and LTSS needs as the foundation of program success. In addition to the care model, the plan's health IT systems are critical in giving team members access to a wealth of member information (including service plans), and enabling team collaboration in member care.

Although the plan has compelling anecdotal cases of individuals whose quality and cost of care has improved through the program, they do not have data that demonstrates the aggregate impact of the program. The plan also lacks historical data on member outcomes prior to integration, hindering assessment program impact. However, the fact that member costs are better controlled with length of enrollment suggests that integration is succeeding. Despite the absence of direct evidence, Superior leadership believes that integration improves quality and helps to control costs, and that if outcomes could be adequately measured and risk-adjusted, populations for which they have full financial integration would have better results in terms of cost and quality.

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[16] For a complete list of STAR+PLUS HCBS Waiver services, see:
https://www.dads.state.tx.us/handbooks/sph/6000/6000.htm

Long-Term Quality Alliance

Long-Term Quality Alliance (LTQA) is a community of organizations aimed at improving outcomes and quality of life for persons and their families who are managing functional limitations due to chronic health conditions. It draws member organizations from the full range of health care and social services delivery systems involved in provision, administration, innovation, policymaking, and advocacy for quality long-term services and supports (LTSS).

Organizations come together in the Alliance to share knowledge and experience needed to advance development and continuous improvement of high-quality systems of integrated, person- and family-centered LTSS. The Alliance serves as a convener of disparate private-sector and governmental organizations, with an eye to identifying and resolving the most significant challenges and advancing the replication of successful models that demonstrate the potential for more widespread adoption of person-centered LTSS integration.

Acknowledgements

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*Advancing high-quality, person- and family-centered,
integrated long-term services and supports*