Utilization Review in STAR+PLUS Managed Care

As Required by
Texas Government Code,
Section 533.00281(d)

Texas Health and Human Services
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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, including the completion of functional assessments for that purpose and maintenance of records relating to those assessments.

The STAR+PLUS Medicaid managed care program serves adults with physical, intellectual and developmental disabilities or who are over age 65 years. STAR+PLUS provides acute care services, pharmacy services, and long-term services and supports (LTSS). Members eligible for the STAR+PLUS HCBS program receive enhanced LTSS in the community as an alternative to care in a nursing facility.

HHSC staff complete URs annually to determine if MCOs are correctly assessing and enrolling members in STAR+PLUS HCBS and providing needed services. Historically, the review included data from five contracted MCOs. However, one of the MCOs ended their contract with HHSC on December 31, 2022, therefore, the fiscal year 2023 report includes review findings from four MCOs.

For fiscal year 2023, HHSC's HCBS review includes two samples: 1) the highest resource utilization group (RUG) classification categories and 2) a risk-based sample using fiscal year 2022 referrals.[a] HHSC modified the review process to include precautions due to the novel coronavirus (COVID-19) public health emergency by conducting member interviews by telephone and telehealth, as well as in-person interviews.

The fiscal year 2023 HCBS review uses five standards, encompassing a total of 17 performance measures, which require MCOs to:

1. Complete all required assessment documentation and forms.

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[a] 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 Contracts and Oversight unit for resolution of identified issues.

2. Ensure assessment information drives the development of the service plans.
3. Conduct and submit assessments to HHSC in a timely manner.
4. Conduct service coordination follow-up requirements to ensure identified services were initiated or received.
5. Ensure coordination of benefits and delivery of services were in place to prevent access to care or health and safety issues.

To ensure consistency in the review process, HHSC uses a benchmark of 90 percent to identify compliance with contractual requirements. HHSC compares performance for each MCO across fiscal years and against statewide MCO performance.[b] Table 1 shows statewide MCO performance for fiscal year 2023.

Table 1. Statewide MCO Performance

Fiscal Year	Assessment Driven-Service Planning	Completion of Assessments	Timeliness – Assessments and Reassessments	Timeliness – Contacts	Service Delivery
2023	89.61%	99.50%	97.58%[c]	92.59%	92.23%

As a result of MCO internal reports and fiscal year 2023 review findings, HHSC closed the two remaining fiscal year 2021 corrective action plans (CAPs), closed two of the three fiscal year 2022 CAPs, and requested new CAPs for two MCOs.

MCO performance in the following areas was identified as areas of concern, because some MCOs performed below the 90 percent benchmark:

- Documentation of identified needs in the required service planning; and
- Timeliness of completing required initial assessments.

Based on the findings in fiscal year 2023:

- HHSC will continue to review agency policies and guidelines to ensure clear direction to MCOs regarding assessments and required documentation of service delivery.

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[b] The benchmark for compliance increased to 90 percent in fiscal year 2023. The benchmark was previously 85 percent.
[c] The score of this requirement is comprised of two performance measures: one for initial assessments and one for reassessments. MCO compliance with the performance for initial assessments was 85.85 percent and compliance for reassessments was 99.05 percent.

- HHSC will update performance measures and contractual requirements based on clarification obtained during the review.
- HHSC recommends that MCOs present evidence of compliance to ensure adherence with contractual requirements specific to coordinating care for members.
- HHSC recommends that MCOs improve the rate of contractually required timely follow-up and documentation of efforts to ensure services are delivered.
- HHSC will increase the compliance benchmark from 90 percent to 95 percent in fiscal year 2024, as MCOs continue to demonstrate the ability to surpass compliance with the current 90 percent benchmark.

1. Introduction

Texas Government Code, Section 533.00281 requires HHSC to conduct UR in STAR+PLUS. These reviews focus on the 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 UR conducted during the preceding fiscal year;
- Provides analysis of errors or issues by each reviewed MCO; and
- Extrapolates findings and makes recommendations for improving the efficiency of the program.

The statute requires HHSC to investigate each MCO's procedures for determining whether an individual should be enrolled in STAR+PLUS HCBS, including the completion of assessments and related records. It also grants HHSC the discretion to determine focus of the UR process.

HHSC began conducting reviews of the STAR+PLUS HCBS program in fiscal year 2014. Each year the reviews change in size and scope based on review findings and identified issues. In fiscal year 2022, HHSC focused the HCBS review on a statistically valid random sample of all RUG classifications, as well as a risk-based sample using fiscal year 2021 referrals. For fiscal year 2023, the HCBS review was based on the highest RUG classification categories, and a risk-based sample using fiscal year 2022 referrals. The sample size for the fiscal year 2023 review was 950 members.

2. Background

UR is a crucial oversight tool to ensure MCOs meet contractual obligations and provide members with the required standard of medically and functionally necessary services, including accurately determining whether members should be enrolled in STAR+PLUS HCBS. UR of STAR+PLUS HCBS is performed by registered nurses who have the same 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 an interview with the member and/or legally authorized representative to ensure identified needs are addressed, gauge member experience with the MCO, and determine the impact that delivered services have made relative to their quality of life. HHSC conducts quality assurance of UR data to ensure accuracy and consistency in UR oversight of MCO performance. This involves examining and reviewing UR outcomes to determine compliance with program regulations, internal policies and procedures and state and federal statutes, identifying inaccuracies, and correcting such inaccuracies.

3. Fiscal Year 2023 HCBS Utilization Review Activities

In fiscal year 2023, HHSC's review consists of 950 members with an individual service plan (ISP) start date of December 1, 2022. Desk reviews and member interviews were conducted between February 17, 2023 and May 15, 2023, by 41 nurses. For the fiscal year 2023 review, HHSC performed telephone and telehealth interviews with members.

The standard for MCO compliance for all performance measures in fiscal year 2023 is 90 percent. The standard for MCO compliance in the previous fiscal year was 85 percent. HHSC intends to increase the compliance benchmark by five percent in the next fiscal year as part of our commitment to continuous quality improvement.

Throughout the review process, HHSC communicated findings of the reviews to the MCOs to facilitate improvement. Following each communication of findings, MCOs had two weeks to submit additional documentation to rebut identified issues. Based on review of the documentation, HHSC may adjust the findings and/or make recommendations for HCBS or internal UR policy changes. At the end of the review, HHSC met with each MCO to communicate final findings and provide technical assistance.

4. Utilization Review Findings

HHSC completed all review activities prior to the publication of this report. Complete UR findings from fiscal year 2023 are discussed below.

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 to 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.

Table 2. Percent of Members in Annual Sample Meeting Standard for Assessment-Driven Service Planning

Fiscal Year	Percent Meeting Standard	Sample Size
2020	99.1%	813
2021	98.8%	1,050
2022	94.4%	1,350
2023	89.6%	950

To assess compliance with contractual requirements, HHSC reviewed justifications for at least one HCBS service for the member and development of the service plans. A list of HCBS services can be found in the STAR+PLUS Handbook. 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 a STAR+PLUS HCBS service. Table 2 shows findings for the HCBS reviews for the past four years.

In the fiscal year 2023 HCBS review, MCO compliance in meeting the STAR+PLUS HCBS program justification for at least one waiver service, as required by contract, was 89.61 percent. A list of long-term services and supports waiver services can be found in the STAR+PLUS Handbook. The decline in compliance with this standard is attributed to MCO performance in the development of service plans. MCOs provided feedback that the instructions for development of service plans were unclear. HHSC is working to clarify and update the instructions.

Completing 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. The development of the ISP is a holistic person-centered process including 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 guide the process and documents the planning steps. HHSC evaluates the MCO's completion of assessments through a desk review of the MCO's service coordination documentation.

As shown in Table 3, the statewide MCO average for this measure remains consistent over the past four fiscal years. Since fiscal year 2020, MCO completion of the contractually required assessments and service planning documents remains compliant at over 99 percent.

Table 3. Percent of Members in Sample Meeting Standard for Completing Assessments

Fiscal Year	Percent Meeting Standard	Sample Size
2020	99.6%	813
2021	99.6%	1,050
2022	99.5%	1,350
2023	99.5%	950

Timeliness

Timeliness of Assessments

HHSC sets forth specific timeframes for the completion of assessment activities in STAR+PLUS contracts to ensure timely access to necessary services. For individuals released from an interest list or requesting assessment for the HCBS program, MCOs 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. Table 4 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.

Table 4. Percent of Members in Sample with Timely Assessments

Fiscal Year	Percent Meeting Standard	Sample Size
2020	92.3%	813
2021	94.7%	1,050
2022	93.6%	1,350
2023	97.6%	950

HHSC not only assessed timeliness, but also whether the MCO documented a reason for a delayed assessment and service plan development. HHSC considers documentation as meeting the standard of timeliness if the documentation provided explains why a timeframe was not met. For example, for an initial assessment, a physician must certify the member requires nursing facility or alternative community-based services. If the MCO showed, through documentation to HHSC, it was unable to obtain a physician's signature after efforts were made to do so, HHSC did not take action against the MCO for failure to meet contractual timeframes. Over the past four years, MCOs compliance in timeliness has exceeded the required benchmark of 90 percent.

Timeliness of Contacts

MCOs must 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 are given flexibility to tailor their program to the communities they serve, therefore, MCOs' approach to this requirement varies considerably. For example, one MCO dedicates a team to conduct the four-week follow-up and another MCO's service coordinators follow up one week after the ISP start date and then again four weeks after the ISP start date. MCOs develop reports to document follow-up calls and the quality of documentation varies from service coordinator to service coordinator. Beginning in fiscal year 2020, HHSC added a review requirement to ensure MCOs conducted at least two annual face-to-face visits (in-person or via telehealth) with members.[d]

[d] As a precaution to protect member and staff health during the public health emergency, MCOs had the flexibility to conduct the annual face-to-face visits via telehealth and telephone.

Table 5 shows MCO compliance with timeliness of contacts which measures whether the MCO contacted the member within four-weeks of the ISP start date and conducted the two required annual face-to-face visits. MCO compliance with this requirement improved from 82.5 percent in fiscal year 2022 to 92.6 percent in fiscal year 2023. This improvement is attributed to MCO implementation of system updates for tracking and monitoring the tasking and completion of service coordination visits, additional MCO manager-level reviews of reports to ensure compliance, and the addition of service coordination staff by some MCOs.

Table 5. Percent of Members in Sample with Timely Contacts

Fiscal Year	Percent Meeting Standard	Sample Size
2020	58.0%	813
2021	67.5%	1,050
2022	82.5%	1,350
2023	92.6%	950

Referrals

Upon identification of an issue related to access to care or member health and safety, an HHSC nurse submits an internal complaint referral to the HHSC Managed Care Contracts and Oversight (MCCO) unit for resolution of identified issues. This process ensures an issue is logged as a complaint, tracked, and resolved to the member's satisfaction. Table 6 shows the percentage of the UR sample that resulted in a referral for fiscal years 2020-2023.

Table 6. Percent of Referrals

Fiscal Year	Percent of Referrals at the Sample Level	Sample Size
2020	17.0%	813
2021	7.8%	1,050
2022	10.4%	1,350
2023	7.8%	950

A referral can include one or more issues. There are two types of referral issues: access to care and health and safety. An access to care referral could be generated if the MCO does not assist a member in finding a provider, such as a dentist who could perform sedation dentistry, or if service initiation is delayed beyond HHSC's 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 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 identifies a potential need for physical therapy, but the member's physician does not agree and will not sign orders for physical therapy, HHSC will not make a referral to MCCO.

In fiscal year 2021, HHSC began reporting the number of issues by access to care and health and safety since a referral can include more than one issue per member.[e] In fiscal year 2022, HHSC processed 346 access to care issues and four health and safety issues. In fiscal year 2023, HHSC processed 128 access to care issues and zero health and safety issues.

Table 7 shows the number of referral issues by category for fiscal years 2020-2023. Fiscal year 2022 saw an increase in access to care issues because the sample for this review included individuals with higher acuity. This population historically has a higher need for services, specifically durable medical equipment, compared to the population reviewed in prior fiscal years. HHSC works with MCOs to resolve the complaint to member satisfaction; however, resolution will not prevent HHSC from enforcing contract actions related to referrals.

Table 7. Number of Referral Issues by Type and Year

Fiscal Year	Access to Care	Health and Safety
2020	224	0
2021	128	3
2022	346	4
2023	128	0

Corrective Action Plans

As a result of MCO internal reports and fiscal year 2023 review findings, HHSC closed the two remaining fiscal year 2021 CAPs and two of the three fiscal year 2022 CAPs. The following fiscal year 2022 CAPs were closed for:

- One of the four MCOs, for failure to submit the service plan to the state within 45 days from the identified need or request for waiver services and failure to submit the service plan to the state 30 days prior to the end date of the annual ISP.
- One of the four MCOs, for failure to provide an administrative service of the required four-week follow-up member contact to ensure all medically and

[e] Issue is defined as MCO failure to provide an item or service within contractual timeframes.

functionally necessary services identified in the assessment process are in place.

One of the four MCOs has a remaining open CAP. The open CAP is a result of the MCO's failure to provide a covered service that was determined medically or functionally necessary.

HHSC recommended the following CAPs as a result of the fiscal year 2023 review:

- Two of the four MCOs received a CAP request for failure to document the follow-up of service initiation within four-weeks of the start of the ISP.
- Two of the four MCOs did not receive any requests for CAPs.

HHSC received CAP responses from the MCOs, and MCOs are implementing interventions to correct the areas on non-compliance.

List of Acronyms

Acronym	Full Name
CAP	Corrective Action Plan
COVID-19	Novel Coronavirus
HHSC	Health and Human Services Commission
HCBS	Home and Community-Based Services
ISP	Individual Service Plan
LTSS	Long-term Services and Supports
MCCO	Managed Care Contract and Oversight
MCO	Managed Care Organization
RUG	Resource Utilization Group
STAR	State of Texas Access Reform
UR	Utilization Review