Utilization Review in STAR+PLUS Managed Care

As Required by
Texas Government Code, Section 533.00281

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 enrollment in the STAR+PLUS Home and Community Based Services (HCBS) program is justified and supported by 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/or developmental disabilities or who are over 65 years of age. STAR+PLUS provides acute care services, pharmacy services, and long-term services and supports. Members eligible for the STAR+PLUS HCBS program receive enhanced long-term services and supports in the community as an alternative to care in a nursing facility.

HHSC staff complete URs annually to determine if MCOs are correctly assessing members in STAR+PLUS HCBS and providing appropriate services. The fiscal year 2024 report includes findings from the four participating MCOs.

For fiscal year 2024, HHSC's HCBS review includes a statistically valid random sample of all resource utilization group (RUG) classification categories with a focus on continuity of care during transition to new MCOs. HHSC has three ways of interviewing members in the sample: in-person (preferred), audio-only, and remote audio-visual.

The fiscal year 2024 HCBS review uses five standards, encompassing a total of 17 performance measures, which requires MCOs to:

1. Complete all required assessment documentation and forms.
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 and 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 95 percent to identify compliance with contractual requirements. HHSC compares performance for each MCO across fiscal years and against statewide MCO performance[1]. Table 1 shows statewide MCO performance for fiscal year 2024.

Table 1. Statewide MCO Performance

Fiscal Year	Assessment-Driven Service Planning	Conduct of Assessments	Timeliness – Assessments and Reassessments	Timeliness – Contact	Service Delivery
2024	92.9%	99.5%	98.6%	94.3%	94.8%

As a result of the implementation of new STAR+PLUS contracts following re-procurement, previous contracts ended on August 31, 2024, and any open corrective action plans (CAPs) were closed as part of the contract closure process. Because new CAPs cannot be started until non-compliance is identified in the new contract, which is operationally effective September 1, 2024, HHSC will not recommend any CAPs as a result of the fiscal year 2024 HCBS review.

MCO performance in the following areas was identified as opportunities for improvement, because some MCOs performed below the 95 percent benchmark:

- Documentation of identified needs in the required service planning documents;
- Timeliness and completion of the required individual service plan (ISP) follow-up contact; and
- Service delivery.

Based on the findings in fiscal year 2024:

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

[1] The benchmark for compliance increased to 95 percent in fiscal year 2024. The benchmark was previously 90 percent.

- HHSC will update performance measures and contractual requirements based on clarification obtained during the review.
- HHSC recommends that MCOs improve the rate of contractually required timely follow-up and documentation of efforts to ensure services are delivered.

Introduction

Texas Government Code Section 533.00281 requires HHSC to conduct UR of 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 enrollment in STAR+PLUS HCBS is justified and supported by the completion of assessments and related records. It also grants HHSC the discretion to determine the 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 2023, HHSC focused the HCBS review on the highest RUG classification categories, and a risk-based sample using fiscal year 2022 referrals. For fiscal year 2024, the HCBS review includes a statistically valid random sample of all RUG classification categories. The sample size for the fiscal year 2024 review was 1,194 members.

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 enrollment in STAR+PLUS HCBS is justified or supported through the assessment and service planning processes. 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.

Fiscal Year 2024 HCBS Utilization Review Activities

In fiscal year 2024, HHSC's review consists of 1,194 members with an ISP start date of November 2023. Desk reviews and member interviews were conducted between January 22, 2024, and May 17, 2024. For fiscal year 2024, HHSC performed either in-person, audio-only or remote audio-visual interviews with members. To allow for a larger number of members to be included in the review while working within the existing budget, HHSC targeted 25 percent of members for in-person interviews.

The standard for MCO compliance for all performance measures in fiscal year 2024 is 95 percent. The standard for MCO compliance in the previous fiscal year was 90 percent. HHSC intends to keep the standard at 95 percent in the next fiscal year as part of our commitment to continuous quality improvement.

At the end of the review, HHSC communicated the findings of the review to the MCOs. MCOs had an opportunity 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. HHSC met with each MCO to review final findings and provide technical assistance.

Utilization Review Findings

HHSC completed all review activities before this report's publication. Complete UR findings from fiscal year 2024 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, choose the STAR+PLUS HCBS program as an alternative to nursing facility services, and have a documented need for at least one HCBS service. 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 which includes member preferences, strengths, and health and wellness needs to develop short-term objectives and action steps to ensure personal outcomes are achieved within the most integrated setting. The ISP is supported by the results of the member's program-specific assessments.

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.

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

Fiscal Year	Percent Meeting Standard	Sample Size
2021	98.8%	1,050
2022	94.4%	1,350
2023	89.6%	950
2024	92.9%	1,194

In the fiscal year 2024 HCBS review, MCO compliance in meeting the STAR+PLUS HCBS program justification for at least one waiver service, as required by contract, was 92.9 percent. A list of long-term services and supports waiver services can be found in the STAR+PLUS Handbook. While the fiscal year 2024 compliance with this

standard increased from the prior year, the overall compliance was below the 95 percent benchmark. This is attributed to all four MCOs' failure to document the members' needs identified in the assessment process on the service plan. The MCOs provided feedback that the HHSC form instructions were unclear. HHSC is developing an MCO communication to clarify the expectation and form instructions.

Completing Assessments

The MCO is responsible for completing the required program-specific assessment to determine eligibility, level of care, and all applicable service planning documents. 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 2021, 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
2021	99.6%	1,050
2022	99.5%	1,350
2023	99.5%	950
2024	99.5%	1,194

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. 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 shows MCO performance in completion of both initial assessments and reassessments.

Table 4. Percent of Members in Sample with Timely Assessments

Fiscal Year	Percent Meeting Standard	Sample Size
2021	94.7%	1,050
2022	93.6%	1,350
2023	97.6%	950
2024	98.5%	1,194

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.

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 coordinator's 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 by service coordinator. HHSC requires MCOs to conduct at least two annual face-to-face visits (in-person or via remote audio-visual means) with members. For any visits where an assessment is completed, they must be conducted in person.

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 92.6 percent in fiscal year 2023 to 94.3 percent in fiscal year 2024. HHSC identified that two of the four MCOs failed the performance measure for the ISP follow-up call, resulting in the total score being below the 95 percent benchmark. HHSC provided technical assistance to the MCOs to clarify expectations of this performance measure.

Table 5. Percent of Members in Sample with Timely Contacts

Fiscal Year	Percent Meeting Standard	Sample Size
2021	67.5%	1,050
2022	82.5%	1,350
2023	92.6%	950
2024	94.3%	1,194

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 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 2021-2024.

Table 6. Percent of Referrals

Fiscal Year	Percent of Referrals at the Sample Level	Sample Size
2021	7.8%	1,050
2022	10.4%	1,350
2023	7.8%	950
2024	5.2%	1,194

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 the 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 because they did not receive 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 such. 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 Managed Care Contracts and Oversight.

HHSC reports the number of issues by access to care and health and safety since a referral can include more than one issue per member. In fiscal year 2023, HHSC processed 128 access to care issues and zero health and safety issues. In fiscal year 2024, HHSC processed 95 access to care issues and zero health and safety issues.

Table 7 shows the number of referral issues by category for fiscal years 2021-2024. Fiscal year 2022 saw an increase in access to care issues because the same sample for the 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 other 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
2021	128	3
2022	346	4
2023	128	0
2024	95	0

List of Acronyms

Acronym	Full Name
CAP	Corrective Action Plan
HHSC	Health and Human Services Commission
HCBS	Home and Community-Based Services
ISP	Individual Service Plan
MCO	Managed Care Organization
RUG	Resource Utilization Group
UR	Utilization Review