

Utilization Review in STAR+PLUS Managed Care

**As Required by
Government Code Section 533.00281**

**Texas Health and Human Services
December 2021**



TEXAS
Health and Human
Services

Table of Contents

1. Executive Summary	1
2. Introduction	3
3. Background	5
4. Fiscal Year 2021 HCBS Utilization Review Activities	8
5. Utilization Review Findings	9
Assessment-Driven Service Planning.....	9
Completing Assessments	10
Timeliness	11
Referrals	14
Corrective Action Plans	16
6. Recommendations	18
7. Conclusion	19
List of Acronyms	21

1. 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 who are eligible for supplemental security income (SSI) and those over age 65. 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 utilization reviews annually to determine if MCOs are correctly assessing and enrolling members in STAR+PLUS HCBS and providing needed services.

For fiscal year 2021, HHSC's HCBS review focused on members with the lowest acuity levels, as determined by the Resource Utilization Group (RUG) classification, including members with reduced physical function. Members who were reviewed in fiscal year 2020 were excluded from this review. HHSC modified the review process due to the novel coronavirus (COVID-19) public health emergency by conducting 100 percent telephone interviews and ensuring proper implementation of the COVID-19 flexibilities.¹

The fiscal year 2021 HCBS reviews use five standards, encompassing a total of 14 performance measures, to ensure consistency in the review process, the ability to identify compliance with contractual requirements by use of an established

¹ HHSC implemented various flexibilities to allow for the continuation of services during the COVID-19 public health emergency.

threshold of 80 percent for compliance, and compare performance individually and across all STAR+PLUS MCOs. The standards require 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 or received, and
5. Ensure coordination of benefits and delivery of services were in place to prevent access to care or health and safety issues.

MCOs showed continued compliance with the STAR+PLUS HCBS program criteria related to completion of the contractually required assessments and service planning documents (completion of assessment) and documenting justification for at least one waiver service (assessment-driven service planning). MCO compliance with completing assessments and service delivery were above the 80 percent benchmark. As a result of MCO performance in the fiscal year 2021 review, HHSC closed all prior year corrective action plans (CAPs). However, MCO performance in timeliness of follow-up to determine whether medically and functionally necessary services identified in the assessment process are in place remains an area of concern.

This report contains final findings of the fiscal year 2021 reviews. Based on the findings in fiscal year 2021, HHSC recommends:

- MCOs continue to implement CAPs to ensure coordinated care for members.
- MCOs perform follow-up and document attempts to ensure services are delivered.
- HHSC increase the compliance threshold from 80 percent to 85 percent in fiscal year 2022.

2. Introduction

Texas Government Code Section 533.00281 requires HHSC to conduct utilization reviews (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 for the UR process.

HHSC began conducting reviews of the STAR+PLUS HCBS program in fiscal year 2014. Over time, the reviews have changed in size and scope based on review findings and identified issues. In fiscal year 2020, HHSC focused the HCBS review on members whose assessments indicated they have the highest needs as determined by the top two Resource Utilization Group (RUG) categories: (1) Extensive Services (SE) which include SE1, SE2 and SE3 RUGs; and (2) Special Care (SS), which include SSA, SSB and SSC RUGs. The review also included a risk-based sample of members in each of these groups, as determined by each MCO's historic rate of complaint referrals.² For the fiscal year 2021 HCBS review, HHSC's primary focus was on members with the lowest acuity levels, as determined by the RUG classification, as well as assessing MCO compliance with COVID-19 flexibilities for conducting assessments via telehealth and assessments related to member change in condition.³ The sample size has increased over the past four fiscal years: 175 members for 2018, 355 for 2019, 813 for 2020, and 1050 for 2021. Because of

² 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 Compliance and Operations unit for resolution of identified issues.

COVID-19, HHSC made changes to the review process; however, COVID-19 did not impact the focus of the review.

3. Background

The STAR+PLUS program integrates the delivery of acute care, pharmacy and long-term services and supports through an MCO. STAR+PLUS serves individuals who:

- Are age 65 or older,
- Are age 21 and older with a disability who receive supplemental security income (SSI) or SSI-related Medicaid,
- Are enrolled in the Medicaid for Breast and Cervical Cancer program,
- Are residing in a nursing facility and eligible for Medicaid, or
- Meet the income and eligibility requirements for the STAR+PLUS HCBS program.

The STAR+PLUS HCBS program is available to individuals enrolled in STAR+PLUS or who are released from the program's interest list and meet the following criteria: income requirements; level of care for a nursing facility admission; have an unmet need for at least one program service; and can safely be served in the community. Individuals enrolled in a STAR+PLUS MCO, referred to as members, or their legally authorized representative, can request an assessment. Alternatively, an MCO may determine the member would benefit from the program and initiate the assessment process with the member's consent. Individuals in the community, not otherwise eligible for Medicaid, can request to be assessed for the program by being placed on an interest list. Individuals on the interest list are assessed on a first-come, first-served basis when an opening for the program is available. STAR+PLUS HCBS is also available to members enrolled in the Texas Dual Eligible Integrated Care Demonstration Project (Dual Demonstration).

Service coordination, a contractually required key element of the STAR+PLUS program, is provided by a registered nurse for members in the STAR+PLUS HCBS program. The MCO service coordinator is responsible for assessing a member's needs, developing a service plan to address those needs, coordinating timely access to covered services for members, and coordinating services provided by third party resources.

For members in the STAR+PLUS HCBS program, covered services include enhanced LTSS such as:

- Personal assistance services, including protective supervision
- Respite in- or out-of-home
- Nursing services (in-home)
- Emergency response services
- Home-delivered meals
- Minor home modifications
- Adaptive aids and medical equipment
- Medical supplies
- Rehabilitative Therapies (physical, occupational, and speech)
- Dental services
- Supported employment
- Employment assistance
- Cognitive rehabilitation therapy
- Transition assistance services
- Financial management services
- Assisted living
- Adult foster care

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 to ensure identified needs are addressed.

If the MCO identifies a need for a service during the assessment and planning process and the need was not addressed by the MCO at the time of the HHSC home visit/member interview or a delay in initiation was identified, the HHSC nurse makes a complaint referral to the HHSC Managed Care Compliance and Operations unit to ensure follow up on the issue until it is resolved. If the HHSC nurse identifies a new issue during the home visit or member interview, such as a need for a new item or service, the HHSC nurse follows up in writing to notify the MCO service coordinator of the need for the member to be assessed and to address the newly identified issue.

4. Fiscal Year 2021 HCBS Utilization Review Activities

In fiscal year 2021, HHSC reviewed the STAR+PLUS HCBS program using the following sample criteria:

- A statistically valid random sample of lowest acuity levels, including members with reduced physical function.
- Exclusion of members who were included in the fiscal year 2020 review.

The review consisted of 1,050 members with an individual service plan (ISP) start date in October and November 2020. This represents an almost 30 percent increase in the number of reviews conducted (814) in fiscal year 2020. Desk reviews and member interviews were conducted between January 28, 2021 and April 29, 2021 by 44 HHSC nurses. HHSC suspended all face-to-face home visits in March 2020 and for the fiscal year 2021 review performed telephone interviews with members as a precaution to protect member and staff health.

The standard for MCO compliance for all performance measures is 80 percent. Throughout the review period, HHSC met with the MCOs to communicate findings of the reviews and provide technical assistance to facilitate improvement. Following these meetings, MCOs have two weeks to submit additional documentation to rebut identified issues. HHSC staff review all documentation submitted within the allotted timeframe. Based on the review of the documentation, HHSC may adjust the findings and/or make recommendations for HCBS or internal UR policy changes.

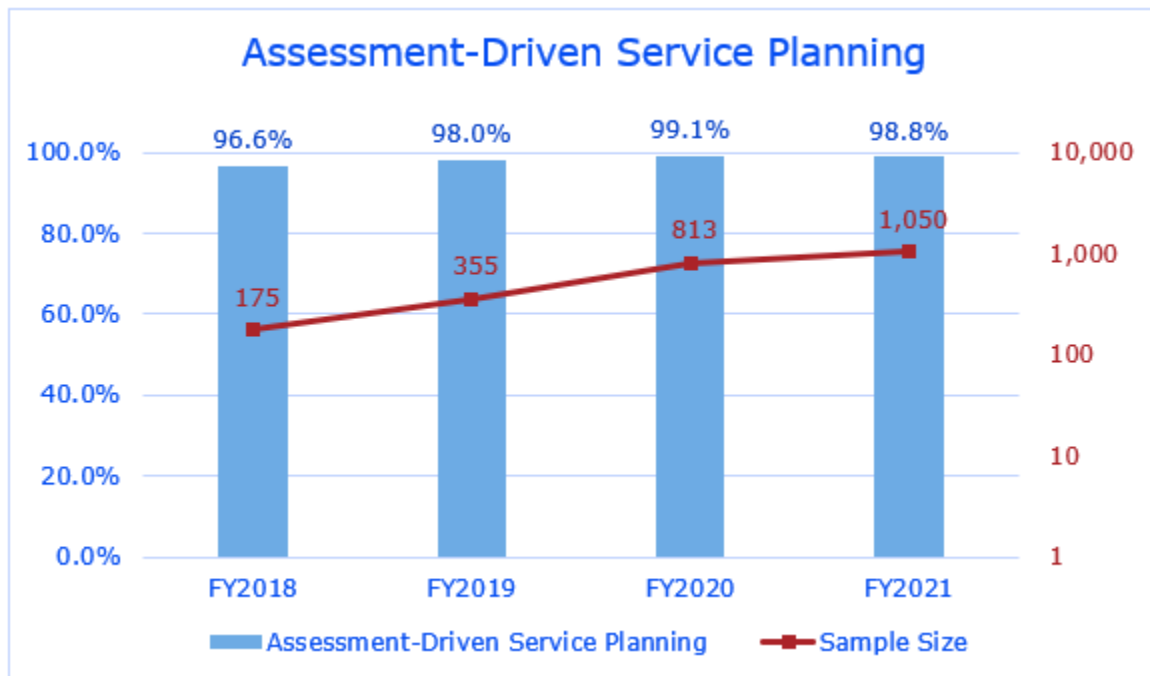
5. Utilization Review Findings

HHSC completed all review activities prior to the publication of this report. Complete UR findings from fiscal year 2021 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 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.

Chart 1. Percent of Members in Annual Sample Meeting Standard for Assessment-Driven Service Planning



For purposes of assessing compliance with contractual requirements, HHSC reviewed justifications for at least one HCBS service for the member. 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.

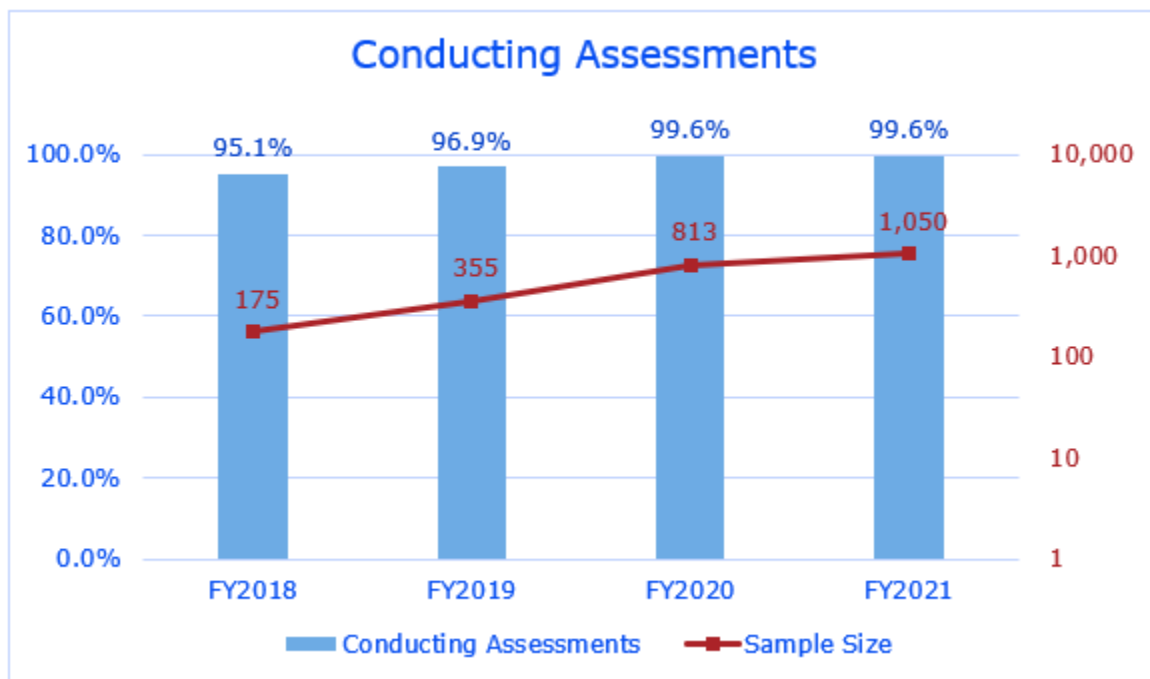
The fiscal year 2021 HCBS review showed continued compliance by all MCOs in meeting the STAR+PLUS HCBS program eligibility criteria of documentation a justification for at least one waiver service, as required by contract. Chart 1 shows findings for the HCBS reviews for the past four years, which indicates statewide performance by all MCOs near 100 percent compliance.

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. 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 guides the process and documents the planning steps. HHSC evaluates the MCO's conduct of assessment through a desk review of the MCO's service coordination documentation.

As shown in Chart 2, the statewide MCO average for this measure has remained consistent over the past two fiscal years. In both fiscal year 2020 and fiscal year 2021, MCO completion of the contractually required assessments and service planning documents has remained compliant at 99.6 percent.

Chart 2. Percent of Members in Sample Meeting Standard for Conducting Assessments

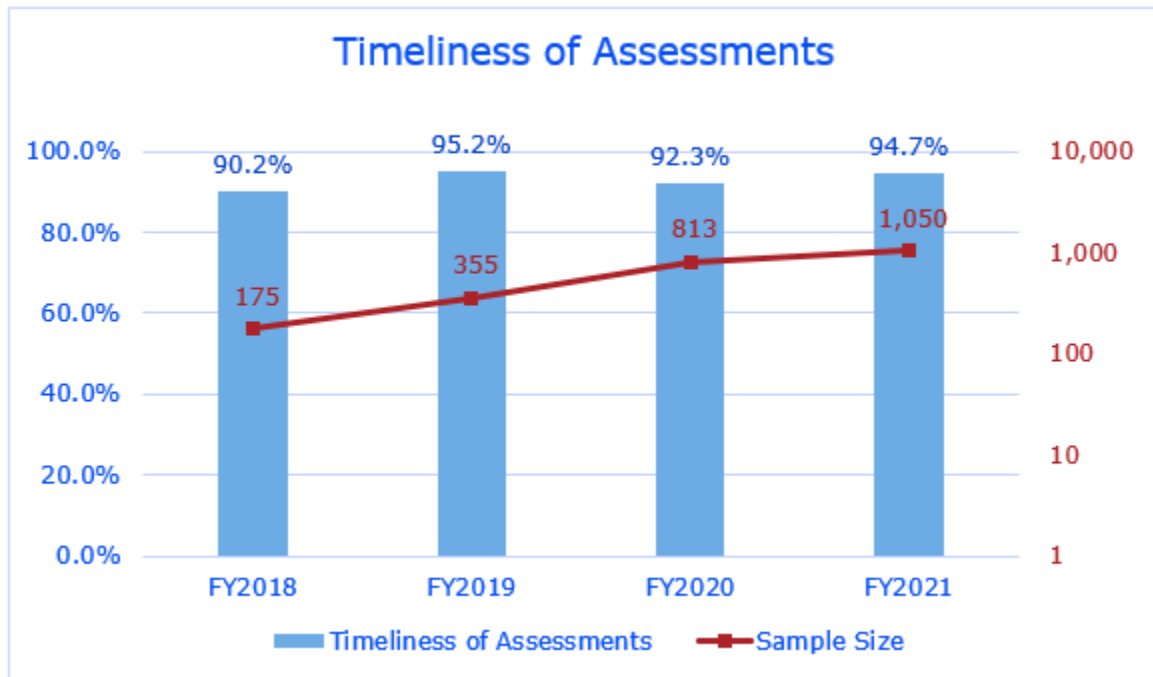


Timeliness

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. Chart 3 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.

Chart 3. Percent of Members in Sample with Timely Assessments



HHSC not only assessed timeliness, but also whether the MCO documented a legitimate 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 sign a form agreeing the member requires nursing facility or alternative community-based services. If the MCO documented issues obtaining the physician’s signature and the efforts to obtain the signature, HHSC did not consider this a failure to meet contractual timeframes.

In fiscal year 2020, MCO compliance with timeliness of completing both assessments and reassessments was 92.3 percent for the entire sample population. To comply with requirements of the Families First Coronavirus Relief Act, HHSC extended medical necessity and ISPs for individuals enrolled in the STAR+PLUS HCBS program. Therefore, the fiscal year 2021 review did not measure timeliness of reassessments since all reassessments were extended ISPs and the reassessment process did not take place. Of the 1,050 sample cases, 150 cases were new to the program and required an initial assessment. HHSC reviewed all 150 of those cases for timeliness. For initial assessments, all MCOs performed above 80 percent for timeliness.

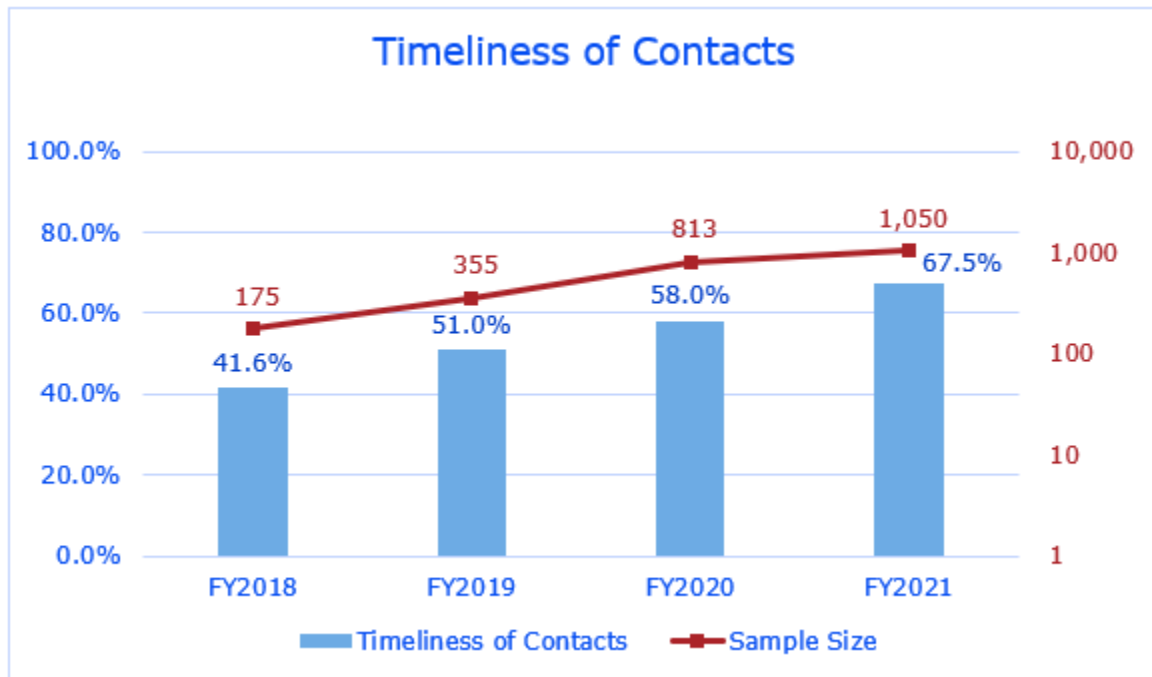
Timeliness of Contacts

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' 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 requirement for MCOs to conduct at least two annual face-to-face visits (in person or via telehealth) with members.⁴ Chart 4 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. Although MCO compliance with this requirement has improved, timeliness of contacts continues to be an area of concern.

⁴ 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.

Chart 4. Percent of Members in Sample with Timely Contacts

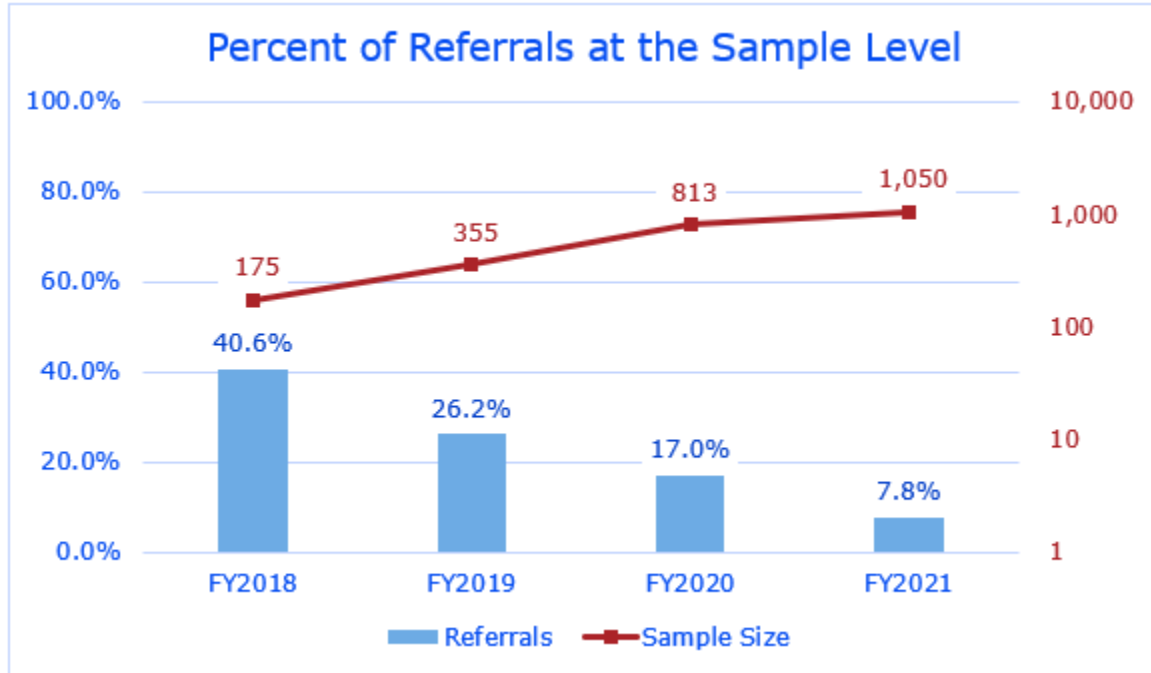


Referrals

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 Compliance and Operations (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. There are two categories of referrals: access to care and health and safety.

In fiscal year 2020, there were no referrals for health and safety issues, therefore UR only processed referrals for access to care issues. In fiscal year 2021, UR processed 128 referrals for access to care and three referrals for health and safety. Chart 5 shows the percent of the UR sample that resulted in a referral for fiscal years 2018-2020.

Chart 5. Percent of Members in the Sample with Referrals

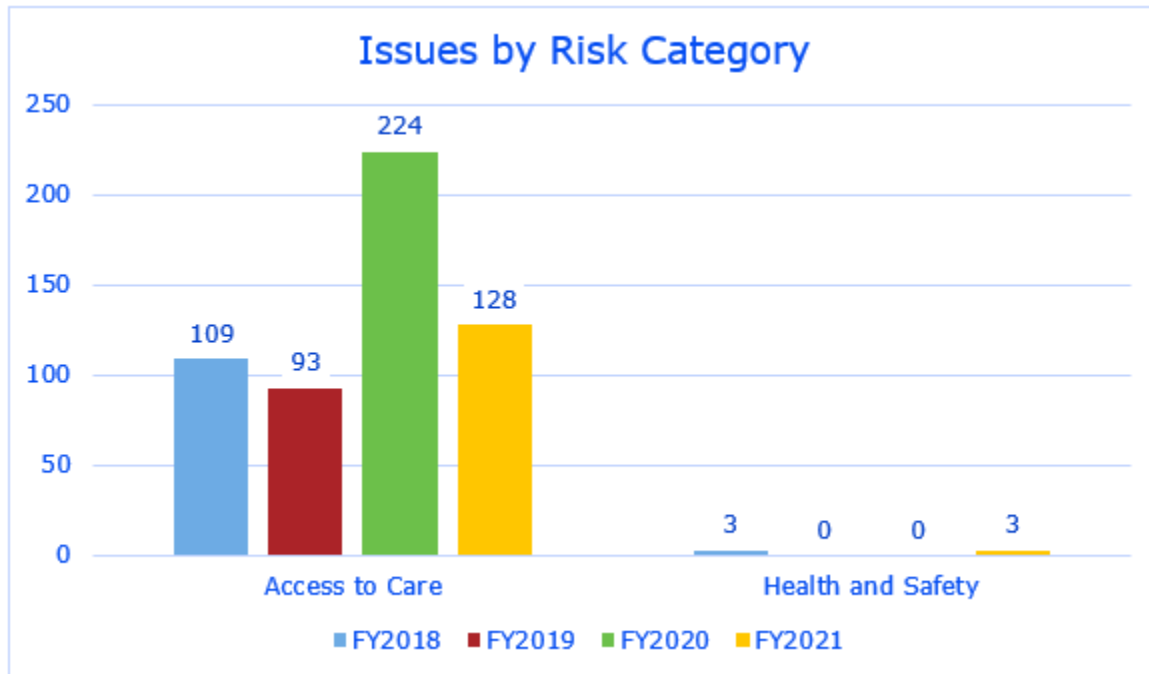


An access to care referral could be generated if the MCO does not assist a member in finding a provider, such as a dentist who could perform sedation dentistry, or if service initiation is delayed beyond HHSC's required time frames. A referral for a health and safety issue could be generated if delay 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.

Beginning with fiscal year 2018 reviews, HHSC implemented an internal process improvement which included quality assurance (QA) reviews of all sample member cases. Analysis is performed to assess the accuracy of UR oversight of MCO performance. This involves examining and reviewing UR outcomes to determine compliance with program regulations, internal policies and procedures, state and federal statutes, identifying inaccuracies, and correcting such inaccuracies. Beginning in fiscal year 2021, HHSC is reporting the number of issues by access to care and health and safety since a referral can include more than one issue per

member.⁵ As a result of the QA process, there has been an increase in access to care issues as shown in Chart 6. The increase in access to care issues, as well as the low number of health and safety issues, are attributed to the internal process improvements implemented by HHSC. HHSC worked with the MCOs to resolve the complaint to member satisfaction; however, resolution will not prevent HHSC from enforcing contract actions related to referrals.

Chart 6. Number of Referral Issues by Type and Year



Corrective Action Plans

HHSC required the following CAPs as a result of the fiscal year 2021 review:

- Three out of the five MCOs received a CAP request for failure to provide administrative service of the required four-week follow-up member contact to ensure all medically and functionally necessary services identified in the assessment process are in place.

⁵ Issue is defined as MCO failure to provide an item or service within contractual timeframes.

- Two out of the five MCOs received a CAP request for failure to provide administrative service of required face-to-face annual service coordination visits.
- Two out of the five MCOs did not receive any requests for CAPs.

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

6. Recommendations

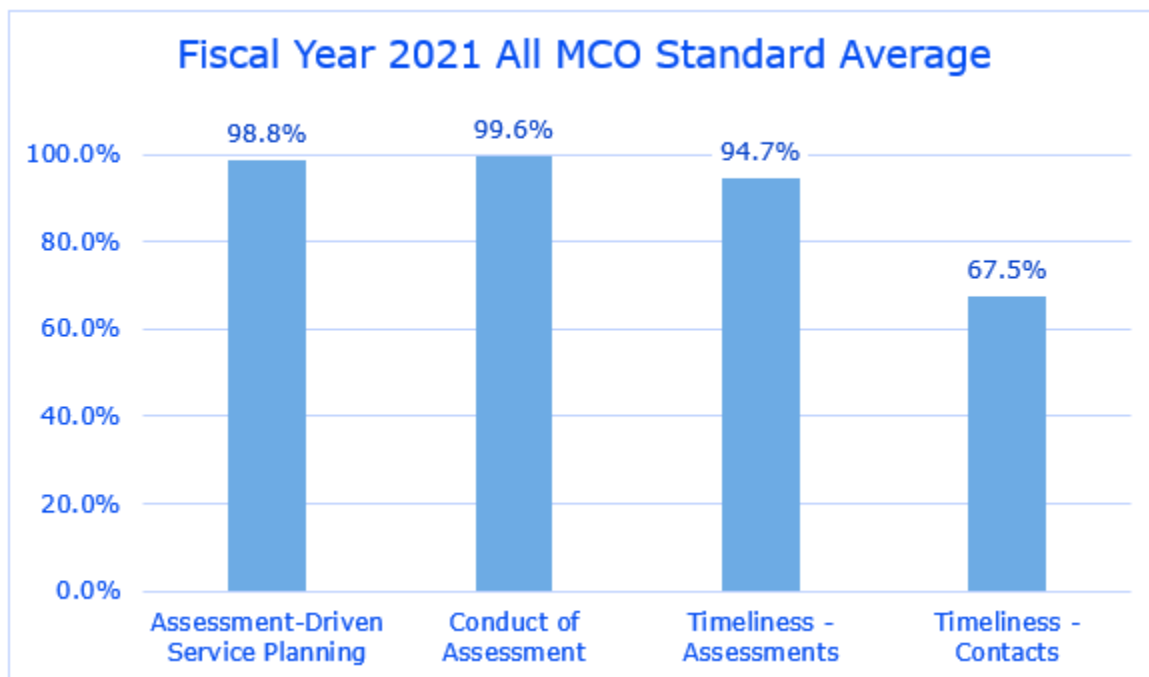
HHSC recommends the following to continue improving quality and efficiency in the program:

- MCOs should review their findings for all performance measures, perform a root cause analysis, and implement interventions to correct any identified issues.
- HHSC will continue to review agency policies and guidance to ensure clear direction to MCOs regarding the delivery of services.
- HHSC will revise the compliance threshold to 85 percent in fiscal year 2022 as MCOs have continued to demonstrate the ability to surpass compliance with the current 80 percent benchmark.

7. Conclusion

Fiscal year 2021 UR reviews showed improved MCO compliance in most areas. As illustrated by Chart 7, MCO performance in the areas of assessment-driven service planning, conducting assessments, and timeliness of assessments continues to surpass the 80 percent compliance benchmark. MCOs have shown improvement in the area of follow-up to ensure items/services are provided timely according to contract requirements; however, this remains an area of concern.

Chart 7. Statewide MCO Performance



HHSC provides technical assistance and education to the MCOs, and reviews agency policies to ensure clear guidance for MCOs to operationalize in the delivery of services. The combined efforts of HHSC and the MCOs have improved performance and improvements should continue. HHSC refines procedures and protocols related to reviews of MCOs delivering HCBS services on an ongoing basis. Beginning in fiscal year 2020, HHSC increased the frequency of reporting to MCOs to allow for timely resolution of compliance issues. MCOs indicate the increased frequency of reports from UR is beneficial and the information contained within the reports is well-received. Also, the reports create meaningful, continuous discussion about programmatic concerns specific to an MCO. HHSC meets with each MCO individually

to review findings and provide technical assistance, including clarifying contract and policy language as needed to facilitate improvement. The collaboration between HHSC and the MCOs continues to improve the program and delivery of services.

List of Acronyms

Acronym	Full Name
CAP	Corrective Action Plan
COVID-19	Coronavirus Disease 2019
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 Compliance and Operations
MCO	Managed Care Organization
QA	Quality Assurance
RUG	Resource Utilization Group
SE	Extensive Services
SS	Special Care
SSI	Supplemental Security Income
STAR	State of Texas Access Reform
UR	Utilization Review