Utilization Review in STAR+PLUS Managed Care

As Required by
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 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. 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 2022, HHSC's HCBS review includes two samples: 1) a statistically valid random sample of all resource utilization group (RUG) classifications, and 2) a risk-based sample using fiscal year 2021 referrals.[a] HHSC modified the review process due to the novel coronavirus (COVID-19) public health emergency by conducting member interviews by telephone and telehealth rather than in-person.

The fiscal year 2022 HCBS reviews use five standards, encompassing a total of 19 performance measures, which 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.

[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 Compliance and Operations unit for resolution of identified issues.

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 threshold of 85 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 2022.

Table 1. Statewide MCO Performance

Fiscal Year	Assessment-Driven Service Planning	Completion of Assessments	Timeliness – Assessments and Reassessments	Timeliness - Contacts
2022	94.4%	99.5%	93.6%	82.5%

As a result of MCO performance in the fiscal year 2022 review and MCO internal monitoring reports, HHSC closed three of the five fiscal year 2021 corrective action plans (CAPs) and requested new CAPs for three MCOs. HHSC continues to work with the MCOs on the remaining two open CAPs.

MCO performance in the following areas were identified as areas of concern, because some MCOs performed below the 85 percent benchmark while the state-wide performance was over 85 percent:

- Documentation of identified needs in the required service planning;
- Timeliness of completing required initial assessments; and
- Service coordination activities, including member contacts to ensure timeliness of follow-up to determine whether medically and functionally necessary services identified in the assessment process are in place and identify any changes in condition, as appropriate.

Based on the findings in fiscal year 2022, HHSC recommends:

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

[b] The threshold for compliance increased to 85 percent in fiscal year 2022. The threshold was previously 80 percent.

- HHSC update performance measures and contractual requirements based on clarification obtained during the review.
- MCOs present evidence of compliance to ensure adherence with contractual requirements specific to coordinating care for members.
- MCOs improve the rate of contractually required timely follow-up and documentation of efforts to ensure services are delivered.
- HHSC increase the compliance threshold from 85 percent to 90 percent in fiscal year 2024, as MCOs continue to demonstrate the ability to surpass compliance with the current 85 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 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 2021, HHSC focused the HCBS review on members with the lowest acuity levels, as determined by the RUG classifications, as well as assessing MCO compliance with COVID-19 flexibilities for completing assessments via telehealth and assessments related to member change in condition.[c] For fiscal year 2022, the HCBS review was based on a statistically valid random sample of all RUG classifications, as well as a risk-based sample using fiscal year 2021 referrals. The sample size has increased over the past four fiscal years: 355 members for 2019, 813 for 2020, 1,050 for 2021 and 1,350 for 2022. HHSC made changes to the review process because of COVID-19; however, COVID-19 did not impact the focus of the review.

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

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 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.

3. Fiscal Year 2022 HCBS Utilization Review Activities

In fiscal year 2022, HHSC's review consisted of 1,350 members with an individual service plan (ISP) start date of November 1, 2021. This represents an increase of almost 30 percent in the number of reviews conducted from fiscal year 2021. Desk reviews and member interviews were conducted between January 19, 2022, and June 9, 2022, by 41 nurses. HHSC suspended all face-to-face home visits in March 2020 and, for the fiscal year 2022 review, performed telephone and telehealth interviews with members as a precaution to protect member and staff health.

The standard for MCO compliance for all performance measures in fiscal year 2022 is 85 percent. The standard for MCO compliance in all previous reviews was 80 percent. HHSC intends to increase the compliance threshold by five percent in the next two fiscal years as part of our commitment to continuous quality improvement.

Throughout the review period, HHSC met with the MCOs to communicate findings of the reviews and provide technical assistance to facilitate improvement. Following those meetings, MCOs have two weeks to submit additional documentation to rebut identified issues. Based on the review of the documentation, HHSC may adjust the findings and/or make recommendations for HCBS or internal UR policy changes.

4. Utilization Review Findings

HHSC completed all review activities prior to the publication of this report. Complete UR findings from fiscal year 2022 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
2019	98.0%	355
2020	99.1%	813
2021	98.8%	1,050
2022	94.4%	1,350

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. Table 2 shows findings for the HCBS reviews for the past four years.

In the fiscal year 2022 HCBS review, MCO compliance in meeting the STAR+PLUS HCBS program justification for at least one waiver service, as required by contract, was 94.4 percent. The decline in compliance with this standard is attributed to a performance measure for MCO documentation of all items/services identified as medically and functionally necessary on the service plan. Confusion with new ISP addendum form instructions led to all MCOs omitting third-party payor services the member would be using in the plan year. HHSC worked with the MCOs to update form instructions. No CAPs were requested for this standard in the fiscal year 2022 review.

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 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 three 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
2019	96.9%	355
2020	99.6%	813
2021	99.6%	1,050
2022	99.5%	1,350

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
2019	95.2%	355
2020	92.3%	813
2021	94.7%	1,050
2022	93.6%	1,350

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 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.

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. In fiscal year 2022, HHSC's review included both initial assessments and reassessments. Over the past four fiscal years, MCOs compliance in timeliness has exceeded the 85 percent threshold.

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 review requirement to ensure MCOs

conducted at least two annual face-to-face visits (in person or via telehealth) with members.[d]

Table 5 shows MCO compliance with timeliness of contacts which measures whether the MCO contacted the member within four-weeks for the ISP start date and conducted the two required annual face-to-face visits. MCO compliance with this requirement improved from 67.5 percent in fiscal year 2021 to 82.5 percent in fiscal year 2022. This improvement is attributed to MCO implementation of system updates for tracking and monitoring the tasking and completion of service coordination visits and additional MCO manager-level reviews of reports to ensure compliance.

Table 5. Percent of Members in Sample with Timely Contacts

Fiscal Year	Percent Meeting Standard	Sample Size
2019	51.0%	355
2020	58.0%	813
2021	67.5%	1,050
2022	82.5%	1,350

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 percent of the UR sample that resulted in a referral for fiscal years 2019-2022.

Table 6. Percent of Referrals

Fiscal Year	Percent of Referrals at the Sample Level	Sample Size
2019	26.2%	355
2020	17.0%	813
2021	7.8%	1,050
2022	10.4%	1,350

A referral can result in 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

[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.

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.

HHSC conducts quality assurance reviews of 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 and state and federal statutes, identifying inaccuracies and correcting such inaccuracies.

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 2021, HHSC processed 128 access to care issues and three health and safety issues. In fiscal year 2022, HHSC processed 346 access to care issues and four health and safety issues.

Table 7 shows the number of referral issues by category for fiscal years 2019 – 2022. The increase in access to care issues are attributed to this fiscal year's sample of individuals with higher acuity. This population historically has a higher need for services, specifically durable medical equipment, compared to the population reviewed in fiscal year 2021. In addition, two out the five MCOs had an increase in access to care issues from the prior year. 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
2019	93	0
2020	224	0
2021	128	3
2022	346	4

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

Corrective Action Plans

As a result of MCO performance in the fiscal year 2022 review and MCO internal monitoring reports, HHSC closed three of the five fiscal year 2021 CAPs. CAPs were closed for two MCOs 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. A CAP was closed for one MCO for failure to provide administrative service of the required face-to-face annual service coordination visits. One of the MCOs has two remaining open CAPs: one 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 and one for failure to provide administrative service of the required face-to-face annual service coordination visits.

HHSC required the following CAPs as a result of the fiscal year 2022 review:

- One of the five MCOs received a CAP request for failure to submit the service plan to the state within 45 days from the identified need or request for waiver services and a CAP request for failure to submit the service plan to the state 30 days prior to the end date of the annual ISP.
- One of the five MCOs received a CAP request for failure to submit the service plan to the state within 45 days from the identified need or request for waiver services and a CAP request for failure to provide a covered service that was determined medically or functionally necessary.
- One 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.
- Two 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.

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 Contracts and Oversight
MCO	Managed Care Organization
RUG	Resource Utilization Group
SSI	Social Security Income
STAR	State of Texas Access Reform
UR	Utilization Review