STAR+PLUS Transition Plan Recommendations for HHSC
February 7, 2024

In anticipation of the new STAR+PLUS contract going live on September 1, 2024, the MCOs have developed the following recommendations to ensure reassessments and other activities are completed in a timely manner without putting members at risk for service gaps. If adopted, these recommendations will help ensure a successful implementation for HHSC, MCOs, and most importantly, members.

Texas MCO's are committed to ensuring the care of newly enrolled members is not disrupted or interrupted during transition and will take special care to provide continuity in the care for members whose health or behavioral health conditions have been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted. A clear and defined transition plan is key to ensuring there are no disruptions in service for members and that MCOs have the necessary staff and direction to ensure no gaps in care.

Note that the following recommendations are for the service areas in which there is an exiting MCO and new MCO entering the service area. For service areas with no changes, MCOs will follow the September 1, 2024, contract requirements.

Assessments and Reassessments

Assessments and re-assessments are extremely important to ensure that members are receiving the care they need. Assessments require extensive work by the MCOs to schedule and complete. Scheduling is also dependent on the responsiveness, schedules and preferences of the member and their support systems.

Section 2.6.61.3 of the STAR+PLUS Exhibit B – STAR+PLUS Scope of Work (SOW) includes the following timeframes for annual assessments for members seeking or needing STAR+PLUS HCBS services:

- No later than 30 days before the end date of the ISP, the MCO must complete the activities detailed in Section 2.6.59.2 by conducting a reassessment to determine and validate each Members' continued eligibility for STAR+PLUS HCBS and submit the Member's ISP to HHSC.
- The annual reassessment expires 90 days from the assessment date if not approved by HHSC's enrollment broker, and STAR+PLUS HCBS services have not been authorized.

The following recommendations are developed to ensure continuity of care while also recognizing that without staggering assessments, MCOs will end up with a large number of members having annual reassessment due dates fall during the same month moving forward, resulting in staffing issues, an inability to comply with the contract timelines and the potential for disruption in services for members.

Recommendations:

- **MCOs will contact and evaluate all members within 6 months of the Operational Start Date** (September 1, 2024 – February 28, 2025). Within that six-month period, MCOs will follow the prioritization levels recommended below.
- The MCOs propose that HHSC allow flexibility for STAR+PLUS MCOs to **conduct reassessments by telehealth for 6 months after the Operational Start Date,** on a case-by-case basis based on member preference and when clinically appropriate. This will help ensure members do not go without a reassessment and allows MCOs to focus their workforce on initial assessments and assessments due to a change in condition.

Table 1: Reassessments for MCOs in new Service Areas		
New MCO	9/1/2024-2/28/2025	In Person or Telehealth
New MCO	3/1/2025	In Person Only

- The MCOs propose the following priority levels.
- Notwithstanding the member's priority level, MCOs will assess any member who has experienced a significant change in condition and contacts the MCO to request assessment within **14 business days** or in accordance with standard procedures.

Table 2: Proposed Priority Levels	
Priority Level 1	1. Those who become new STAR+PLUS Members to the MCO after the Operational Start Date (i.e., on September 1, 2024 or after) and request immediate services. 2. STAR Kids members transitioning into STAR+PLUS. 3. Nursing Facility members in the process of relocating (MFP).
Priority Level 2	1. Members with unmet needs for services.
Priority Level 3	1. Members receiving HCBS STAR+PLUS and non-HCBS services, other LTSS in order of the end date of current authorization/s.

Interest List Releases (ILRs)

HHSC maintains an interest list for Medical Assistance Only (MAO) applicants seeking STAR+PLUS HCBS services. MAO applicants become eligible for Medicaid based on the STAR+PLUS HCBS eligibility determination and are enrolled in STAR+PLUS as interest list slots become available.

Once the name of an MAO is released from the HCBS interest list, the HHSC Program Support Unit (PSU) has 14 days to obtain the individual’s MCO selection and process a referral to the MCO. The MCO then has 45 days to process the ILR, for an effective date on the first day of the month following the HCBS eligibility determination.

In previous managed care transitions, HHSC has reduced or suspended ILRs for a period of time leading up to the operational start date. This policy helps ensure newly- eligible members are not assigned to an MCO that is about to exit the market and helps ensure a more even distribution of new members on the operational start date.

Recommendations:

- **Pause interest list releases for 4 months beginning 120 days before the Operational Start Date** to allow MCOs to focus on the transition of existing members (May 2024 – August 2024).
- HCBS STAR+PLUS waiver interest list releases, **through April 30, 2024, will be completed by the current MCO.**
- HHSC staggers interest list releases beginning in September 2024.

Table 3: Proposed ILR Transitions

ILR Received and Processed by	HHSC Releases ILRs and Refers to MCO	MCO ILR Processing Complete	STAR+PLUS Enrollment Date
Incumbent MCO	Prior to 5/1/2024	Prior to 6/14/2024	7/1/2024 (last possible enrollment date)
New MCO	9/1/2024 or later	10/15/2024 or later	11/1/2024 (first possible enrollment date)

Individual Service Plans (ISPs)

In the STAR+PLUS program Individual Service Plans (ISPs) are used to identify a member's short term and long-term needs and are driven by assessments. It is important that steps are taken to preserve ISPs when a reassessment has not taken place which could happen due to various scenarios.

MCOs will continue to conduct assessments, will review ISPs to ensure services are being provided, update ISPs as necessary, update service authorizations, and conduct all activities necessary to ensure access to care but to ensure there are no gaps in services (including extremely important waiver services), need flexibility regarding ISP dates.

Recommendations:

- As a safety net for members, HHSC should allow for ISP extensions for **up to one year following the Operational Start Date**.
    - We recommend HHSC work with the MCOs to develop a process for an MCO to request an ISP extension.
- MCOs will work with HHSC to develop a process to monitor the progress of current ISPs with upcoming expiration dates.
    - We recommend the process include a requirement that the exiting MCO continue to conduct assessments and **provide monthly updates to HHSC starting May 2024**.
    - HHSC will use the monthly updates to monitor and hold the exiting MCO accountable and can assess damages if necessary to ensure a smooth transition.
- HHSC should temporarily waive the following contract requirement (Section 2.6.61.3 of the STAR+PLUS Exhibit B – STAR+PLUS Scope of Work (SOW) so that work can begin as early as possible to help with workload during the transition: *The MCO must not initiate or submit the community medical necessity and level of care assessment earlier than 90 days prior to the expiration of the ISP.*
- As seen in Table 4, to ensure transition activities are completed in a timely manner, Texas MCOs propose requiring all incumbent MCOs, including MCOs that are exiting the market, to **post all reassessment forms to the LTC portal no later than 60 days prior to the ISP expiration date** (instead of 30 days).

Table 4: Proposed HCBS Membership Assessment Timelines

Responsible Party	ISP Expiration Date	Reassessment Forms Posted to LTC Portal Date	ISP and Reassessment Extensions Granted if Activities Not Complete
Incumbent MCO	8/31/2024	6/30/2024	Yes
Incumbent MCO	9/30/2024	7/31/2024	Yes
Incumbent MCO	10/31/2024	8/31/2024	Yes
New MCO	11/30/2024	10/31/2024	As needed

Individuals Turning Age 21 and Transitioning to Adult Services

Young adults in STAR Health and STAR Kids begin the processes for transitioning to adulthood well in advance of their 21st birthday and normally transition to STAR+PLUS on the first of the month following their 21st birthday. The "age out" transition process generally begins five months before the member's 21st birthday and includes selecting a STAR+PLUS MCO. Once the STAR+PLUS MCO receives the referral for the transition assessment for HCBS services, the MCO has 45 days to complete assessment activities.

STAR Kids and STAR Health members receiving the following services who are turning 21 may transition to STAR+PLUS HCBS without having to be on an interest list:

- Medically Dependent Children Program (MDCP);
- Private duty nursing (PDN); and
- Prescribed Pediatric Extended Care Center (PPECC).

The standard HCBS eligibility process applies to STAR Kids and STAR Health members who are not receiving MDCP, PCS, or PPECC services.

It is extremely important that there is no disruption in this process for these young adults and their families. To reduce abrasion, we have developed the following recommendations.

Recommendations:

- Assign age outs new plan months in advance of the transition to allow sufficient time for assessment and transition on 21st birthday.
- Transitions with birthdays **on or after August 1, 2024 should be routed to new MCO**.
- All assessment activities will need to be **completed and processed through the online TMHP portal by 8/31/2024.**
- The new MCO will need **to assume service initiation by September 1, 2024** and will be responsible for all age-out assessment activities for individuals turning 21 on or after **December 1, 2024.**

Table 5: STAR Kids and STAR Health Members Turning 21	
Incumbent MCO	Prior to 11/1/2024
New MCO	12/1/2024 or later

Nursing Facility Members and MFP

The Money Follows the Person (MFP) procedure allows Medicaid-eligible nursing facility residents to receive services in the community. One of the eligibility requirements for MFP is that the individual be approved for the STAR+PLUS HCBS program prior to leaving the NF. Once the assessment process has been completed and the resident is determined eligible, the MCO must be prepared to initiate the ISP.

There will be members that are in the process of transitioning to the community and in the relocation process (MFP) but are not scheduled to relocate until after September 1, 2024. The following recommendations were created to ensure very complex and important relocation processes are not disrupted.

Recommendations:

- Individuals seeking HCBS STAR+PLUS services through the MFP process, **through June 30, 2024, will be**

completed by incumbent MCO.

- Incumbent MCO will complete and transmit relocation packets for members that requested relocation prior to August 2024 cutoff date.
- Individuals seeking HCBS STAR+PLUS services through the MFP process **from July 2024 – September 2024 will be on hold during the MCO transition phase.**
- For members requesting relocation assistance after the August 2024 cutoff and are transitioning to a new MCO, current MCO will provide newly assigned MCO with all agreed upon documentation and information using an established collaborative process and format unless otherwise directed.
    - The MCOs will work with HHSC to identify information that needs to be transmitted to new MCO.

Table 6: Proposed MFP

	MFP Members Eligible for STAR+PLUS HCBS
Incumbent MCO	Through 9/30/2024
New MCO	Starting 10/1/2024

Transitions and Continuity of Care for LTSS Services not Included in STAR+PLUS HCBS

This section outlines some of the state plan benefits (e.g., personal assistance services (PAS), day activity and habilitation services (DAHS), and Community First Choice (CFC) services) and coordination activities necessary to complete functional assessments in a timely manner. For CFC, the local intellectual and developmental disability authority (LIDDA) completes the functional assessment for individuals with an IDD level of care (LOC). The MCO completes the functional assessment for CFC for members with a medical necessity LOC or IMD LOC. The MCO must coordinate timely assessments to ensure members receive services.

Recommendation:

Table 7 outlines suggested timelines and responsible parties for functional assessment activates related to non-HCBS LTSS.

Table 7. Proposed non-HCBS LTSS

Responsible Party	Functional Assessment Due	Functional Assessment by MCO (or obtained from LIDDA)	Continuity of care
Exiting MCO	Prior to 9/30/2024	8/31/2024	Current authorized services continued until new assessment due or change in condition noted
New MCO	9/30/2024 or later	Timely	Current process for reassessments

Prior Authorizations

In previous transitions, HHSC has provided direction to MCOs to ensure a standardized approach to extending prior authorizations. These recommendations will ensure continuity of care during the transition, allow providers and families to know members will continue to be able to access services, and will reduce any gaps in care that could result in hospitalizations or other negative impacts to health outcomes.

Recommendations:

- To ensure that individuals continue to receive acute care or pharmacy services through a PA as of the Operational Start Date, new MCOs should continue authorization of those services for **the shorter of:**

    1. **6 months after the Operational Start Date,**
    2. **Until the expiration date of the current authorization, or**
    3. **Until the MCO does a new assessment.**
- To ensure that individuals who qualify for STAR+PLUS and are receiving LTSS through a PA (including PAS and CFC) as of the Operational Start Date, the new MCO continue authorization of those services **for the shorter of:**
    1. **6 months after operational start date, or**
    2. **Until the MCO does a new assessment.**
- The MCO **must pay a Member's existing Out-of-Network Providers** for Medically Necessary and Functionally Necessary Covered Services and equipment and supplies **for 6 months following the Operational Start Date** or until the member's records, clinical information, and care can be transferred to a Network Provider.
- If, at the time of enrollment, the member has an existing scheduled appointment with an Out-of-Network specialist physician, the MCO must authorize and pay the Out-of-Network specialist physician for any Covered Service provided to the member during that member's scheduled appointment with the Out-of-Network specialist physician.

Fair Hearings

Texas has policies in place for members to request appeals and state fair hearings when a member expresses dissatisfaction with an Adverse Benefit Determination (ABD). Members must file a request for an MCO Appeal within 60 days. To ensure continuation of currently authorized services the member must file the appeal within 10 days of the MCO sending the ABD or the intended effective date of the proposed ABD, whichever is later. These recommendations will allow for the continuation of Fair Hearing processes for members.

Recommendations:

- The MCO and PSU will follow established state fair hearing rules and policies for **request for hearings and hearings occurring on or after September 1, 2024.** The MCO representative who made the decision and the individual who conducted the assessment will attend the hearing, provide all necessary evidence, represent the MCO and in doing so, inform the hearings officer on the record that the case is in transition to another MCO.
- In those instances in which a fair hearing related to an individual transitioning to a new STAR+PLUS MCO continues after September 1, 2024, in which the appellant is receiving continuing benefits, services will continue to be provided by the Medicaid provider until the hearings officer has ruled in the case. The incumbent MCO will cover those continuing benefits until the hearings office has ruled in the case.

Table 8: Appeals and Fair Hearings

Responsible Party	Date of Action
Exiting MCO	Prior to 9/1/2024
New MCO	9/1/2024 or later

Utilization Review

UR helps ensure that STAR+PLUS members are receiving necessary services and supports. Individuals in STAR+PLUS that transition into a new MCO will have a new Service Coordinator and within the first 6 months

be reassessed and a new ISP developed. It is important that temporary waivers or allowances related to the transition are clearly documented to inform future audits.

Recommendations:

- We recommend HHSC clarify policy to ensure protection for UMR and consideration for ISP audit timelines.
- HHSC should pause UMR during the transition period.
- HHSC should defer UMR review under new contract to November ISPs.
- New members should not be audited during the first year of the new STAR+PLUS contract.

Enrollment

Current STAR+PLUS members enrolled in an exiting MCO will need to chose a new STAR+PLUS MCO. This process can be confusing to members and result in increased calls to the MCOs. It is important that communication is clear and consistent for members.

Recommendations:

- Clarify expectations for members that retain coverage with their existing plan.
- Stop enrollment into plans in markets that are being exited.

Additional parking lot items for discussion:

- Discuss process for handling in-flight members.
- Transition of data between plans
- Nursing facility payments
- Relocation contractors
- Meetings needed:
  - Maximus
  - TMHP

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