DOCUMENT HISTORY LOG

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Baseline	2.0	March 1, 2023	Initial version Uniform Managed Care Manual Chapter 16.7, "Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot Program." Chapter 16.7 applies to participants of the Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot Program.

1. Status should be represented as "Baseline" for initial issuances and "Revision" for changes to the Baseline version.
2. Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "2.2" refers to the first version of the document and the second revision.
3. Brief description of the changes to the document made in the revision.

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I. APPLICABILITY OF CHAPTER 16.7

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR Kids Program who choose to participate in the Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot.

II. PURPOSE

This chapter establishes the participation and reporting requirements for the CHIC Kids Pilot program (the "Pilot").

III. STATUTORY AUTHORITY

Statutory authority for this chapter includes, without limitation:

- Texas Government Code Chapter 531, including §531.0605

IV. BACKGROUND

Texas Government Code Section 531.0605 requires HHSC to collaborate with the STAR Kids Managed Care Advisory Committee (SKMCAC), Medicaid recipients, family members of children with complex medical conditions, children's health care advocates, Medicaid MCOs, and other stakeholders to develop and implement a pilot program that is substantially similar to the program described by Section 3, Medicaid Services Investment and Accountability Act of 2019 (Pub. L. No. 116-16), to provide coordinated care through a health home to children with complex medical conditions.

The Pilot is being piloted within the STAR Kids program to model the effectiveness of enhanced care coordination provided through Health Homes designed specifically to support Children with Medically Complex Conditions and their families.

MCOs and their contracted providers who choose to participate in the Pilot must create or enhance an innovative health home model that provides enhanced care coordination through a Health Home for Children with Medically Complex Conditions. Participation in the Pilot is voluntary for Health Home provider participants and Medicaid members. The Pilot will run from December 1, 2022 through September 1, 2025.

A. Program Goal

The goals of the Pilot are to:

- improve care coordination for Children with Medically Complex Conditions;
- improve access to care, health outcomes, and member satisfaction; and
- reduce administrative burden for MCOs and providers.

V. PILOT PARTICIPATION REQUIREMENTS

The requirements described in this section must be applied to each Pilot Project individually.

A. Member Participation Requirements

The MCO must ensure the following member participation requirements are met:

- Children and youth enrolled in STAR Kids who are determined to need nursing care at home based on either the results of the STAR Kids Screening and Assessment Instrument (SK-SAI) or an MCO authorization for nursing care at home if the member has opted out of the service coordination and SK-SAI process.
- Must consent to participate
- Must meet definition of "Child with Medically Complex Conditions" as defined in this document, in Appendix II.

B. Health Home Provider Participation Requirements

The MCO must ensure the following Health Home participation requirements are met:

- Have at least 150 patients in active treatment under their care, 80% of whom must be Children with Medically Complex Conditions. This minimum patient quota is not limited to Medicaid clients and is subject to HHSC's discretion.
- Coordinate prompt care for member participants, including pediatric emergency services and 24/7 access to the member's Health Home providers.
- Provide a core team to coordinate care for member participants that includes, at minimum, a primary care provider (PCP), nurse case manager or nurse navigator, dietitian, and social worker.
- Develop individualized, comprehensive, pediatric-appropriate, family-centered Care Plans for member participants. Designated multidisciplinary care team members must communicate regularly to create and update a shared integrated Care Plan. The Care Plan and the member's current individual service plan maintained by the MCO must be aligned. Care Plans must include, as medically appropriate:
  - ongoing home care,
  - community-based pediatric primary care,
  - pediatric inpatient care,
  - palliative services,
  - social support services, and

    - local hospital pediatric emergency care.
- Educate and encourage self-management and shared decision-making through member participant and family coaching and peer support services.
- Coordinate access to subspecialized pediatric services and programs for member participants, including the most intensive diagnostic, treatment, and critical care levels as medically necessary.
- Coordinate member transition from pediatric to adult care providers, as medically appropriate, and as applicable.
- Coordinate care for member participants with out-of-state providers furnishing care to children with medically complex conditions where medically necessary and appropriate, and as applicable.

Note: Care Plans must accommodate member participant preferences to the extent practicable and must be developed with families in a culturally, spiritually, and linguistically appropriate manner.

C. MCO Participation Requirements

- Oversee, collaborate with, support, and reimburse the Health Home provider participant in the operation of the Pilot.
- Collaborate with the member participant's providers to identify data that will help support the Health Home provider in managing member care and provide the data in a timeframe that is determined to be meaningful for care management.
- Streamline service coordination through working with each member participant's Health Home to eliminate duplication of services.
- Funds not spent on MCO activities (e.g., activities delegated to the Health Home provider participant), cost savings from efficiencies gained, and other costs saved due to Pilot activities should be reinvested into the Health Home provider participant's operation of the Pilot.
- Utilize an existing or new alternative payment model or other reimbursement approach that complies with HHSC managed care contract requirements to appropriately incentivize and reimburse Health Home provider participants for the provision and coordination of care for member participants.
- With input from the Health Home provider participant, identify opportunities for provider administrative simplification to enhance the Health Home provider's ability to successfully carry out the responsibilities required of Health Home provider participants.

VI. DATA COLLECTION AND REPORTING REQUIREMENTS

Reporting and monitoring elements for the Pilot are modeled after the requirements in United States Code, Title 42, Section 1396w-4a, and based on recommendations from stakeholders during the Pilot development. Designated Providers working with MCOs must provide the MCO with the necessary data to allow MCO reporting to HHSC. As required by Tex. Gov. Code §531.0605, and to allow for HHSC to monitor the Pilot, MCOs must have a process for tracking and reporting the following evaluation measures for each pilot.

The Pilot MCO participants must report certain elements to HHSC as shown in Appendix I. An MCO participant that fails to report the required data will be determined out of compliance with the Pilot requirements and may be removed from the Pilot. If an MCO already reports data to HHSC that would satisfy a reporting requirement, the MCO must identify its availability so HHSC may determine if it is sufficient. For timeliness of pilot data collection, MCOs must submit data listed in Appendix I according to the frequency described. MCOs must submit the required data via an HHSC secure file transfer protocol. HHSC will create a deliverable reporting tool with detailed instructions for data submission.

During the Pilot, MCOs and Health Home provider participants must document all care coordination activities performed for each member participant.

The MCO must ensure distribution of a caregiver survey, developed by HHSC, to member participants to assist HHSC in measuring the family's experience of their child's care coordination during the Pilot period. The survey must be distributed at three distinct times within the duration of the Pilot: (1) within one week of the day the member consents to participate in the Pilot or within one week of receiving the survey, whichever comes first, (2) during December of 2023, and (3) during August of 2025. All responses to the survey questions will be kept anonymous.

In addition to the caregiver survey, HHSC will distribute a survey to Health Home provider participants and MCO participants in December of 2023 and again in August of 2025 to measure the Health Home provider and MCO's experience participating in the Pilot.

APPENDIX I. DATA COLLECTION

Name	Description	Submission Frequency	Reporting Level
Member participants	Members participating in the Pilot Project, reported using the template provided by HHSC.	Quarterly	Pilot Project
Medical conditions of member participants	Each member participant's chronic conditions, life-threatening illnesses, disabilities, or rare diseases	At the start of the CHIC Kids Pilot and when changes occur	Member
Care goals	Using the template provided by HHSC, the MCO must report member participant: • care goals; and • progress towards meeting care goals	Quarterly, and again 90 days after the conclusion of the CHIC Kids Pilot	Member
Health Home core team providers	The Health Home's core team provider types serving member participants, including those out of state, as applicable.	At the start of the CHIC Kids Pilot and when changes occur	Pilot Project
Health Home identifiers	The Health Home's name and ID (e.g., NPI and TPI)	At start of the CHIC Kids Pilot and when changes occur	Pilot Project
Access to out of state providers	The number of member participants who receive a service rendered by an out of state provider, if applicable. If no services were provided out of state to pilot member participants, the MCO must indicate so in the template provided by HHSC	Quarterly	Pilot Project
Use of electronic communication technology for care coordination activities not available in encounter data	Number and modality, reported using the template provided by HHSC.	Quarterly	Pilot Project

Name	Description	Submission Frequency	Reporting Level
Number and type of care coordination activities	Services not captured in encounter data, reported using the template provided by HHSC.	Quarterly	Pilot Project
Number of referrals	The number of referrals completed by the MCO or Health Home provider participant to a provider outside of the Health Home for each member participant, reported using the template provided by HHSC.	Quarterly	Pilot Project
Use of health information technology	The types of health information technology used in each Pilot Project, reported using the template provided by HHSC.	Quarterly	Pilot Project
Frequency of after-hours care	The frequency of after-hours care provided by the MCO or Health Home to member participants, reported using the template provided by HHSC.	Quarterly	Pilot Project
Participant education	The provision of education to member participants, reported using the template provided by HHSC.	Quarterly	Pilot Project
Unreported expenses	The MCO and Health Home provider participant must track the costs of each Pilot Project's operations and activities not reported elsewhere and report this to HHSC using the template provided by HHSC.	60 days following December 31, 2023, and again 90 days after the conclusion of the CHIC Kids Pilot	Pilot Project
Savings	Any reductions in total cost of care attributed to each Pilot Project's activities, reported using the template provided by HHSC. This includes reporting projected savings resulting over time due to better coordinated care.	60 days following December 31, 2023, and again 90 days after the conclusion of the CHIC Kids Pilot	Pilot Project

Name	Description	Submission Frequency	Reporting Level
Implementation of Alternative Payment Model, if applicable	A description of the payment model(s) being tested in each Pilot Project, if applicable, including the service and reimbursement arrangements with each Health Home provider participant.	One-time	Pilot Project
Number and type of care coordination activities per member participant	Encounters received with applicable visit codes.	Monitored by HHSC	Member
Average monthly number of mental health visits per member participant	Encounters received with applicable visit codes.	Monitored by HHSC	Member
Utilization of pharmacy benefits	Encounters received with applicable visit codes.	Monitored by HHSC	Member
Utilization of home-based care	Encounters received with applicable visit codes for private duty nursing, respite services, and hospice.	Monitored by HHSC	Member
Number of ED visits	Encounters received with applicable visit codes.	Monitored by HHSC	Member
Average cost per ED visit	Encounters received with applicable visit codes.	Monitored by HHSC	Member
Number of hospitalizations	Encounters received with applicable visit codes. *Note: This will not include IMD admissions.*	Monitored by HHSC	Member
Average length of stay per hospitalization	Encounters received with applicable visit codes.	Monitored by HHSC	Member
Average cost per hospitalization	Encounters received with applicable visit codes.	Monitored by HHSC	Member

Name	Description	Submission Frequency	Reporting Level
Use of telehealth for services	Encounters received with applicable visit codes.	Monitored by HHSC	Member
Average Medicaid cost per member participant	Average amount paid by the MCO for Medicaid services for each member participant.	Monitored by HHSC	Member

Notes. HHSC= Texas Health & Human Services Commission; CHIC=Comprehensive Health Homes for Integrated Care; MCO=Managed care organization; ED=Emergency department

APPENDIX II. DEFINITIONS

In order to create a pilot that is "substantially similar" to the pilot described in 42 USC §1396w-4a, HHSC provides the following definitions that apply to the CHIC Kids Pilot only.

Care Plan: Individualized health record used to facilitate communication and shared between the patient, family or legally authorized representative, providers, and MCOs. Pilot participants and their families must have 24/7 access to the Care Plan. An individual service plan is included in the Care Plan.

Child with Medically Complex Conditions: Individual under 21 years of age who has at least one or more Chronic Condition that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning and that also requires the use of medication, durable medical equipment (DME), therapy, surgery, or other treatments; or one life-limiting illness or rare pediatric disease as defined in section 529(a)(3) of the Food and Drug Administration Safety and Innovation Act (21 U.S.C. 301).

Chronic Condition: Serious, long-term physical, mental, or developmental disability or disease, including, but not limited to:

- Cerebral palsy
- Cystic fibrosis
- HIV/AIDS
- Blood diseases, such as anemia or sickle cell disease
- Muscular dystrophy
- Spina bifida
- Epilepsy
- Severe autism spectrum disorder
- Serious emotional disturbance or severe and persistent mental illness

Designated Provider: Physician, hospitals, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, federally qualified health center, home health agency, or any other clinical entity or provider that is determined qualified to be a Health Home based on documentation that the entity has systems, expertise, and partnerships needed to serve children with medically complex conditions.

Health Home: Designated Provider or health team selected by the family of a Child with Medically Complex Conditions to provide Health Home Services.

Health Home Services: Comprehensive and timely high-quality services that are provided by a Designated Provider or health team. Services must include, but are not limited to:

- Comprehensive care management
- Care coordination, health promotion, and providing access to the full range of pediatric specialty and subspecialty medical services, including services from out of state providers as medically necessary
- Comprehensive transitional care, including appropriate follow-up from inpatient to other settings
- Patient and family support (including authorized representatives)
- Referrals to community and social support services, if relevant
- Use of health information technology (HIT) to link services and support integration, as feasible and appropriate

Pilot Project: Each individual Health Home model arrangement between MCO and Health Home provider participant

Self-Management: Ability to understand and effectively manage one's own chronic health condition, such as monitoring symptoms, avoiding triggers, administering medication, and preventing crises.