Star Kids Recommendations

Children's Policy Council

Star Kids Workgroup

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Children's Policy Council

- Statutorily authorized by HB 1478 (77th Legislature, 2001) and SB 50 (83rd 2013)
- Charged with assisting the Texas Health and Human Services Commission (HHSC) in developing, implementing, and monitoring long-term supports and services programs providing support to children with disabilities and their families.
- Offers recommendations to improve access to appropriate services, improve the quality of services, and maximize cost efficiencies.

We work for children with disabilities in Texas!

Areas of Recommendation

- Service Coordination
- Patient-Centered Medical Home
- Medical Transition
- Outreach and Education
- Private Insurance Coordination
- Development of Comprehensive Assessment
- Prior Authorization Process
- Ensure Access to an Adequate Provider Network
- Oversight

Service Coordination

Why Service Coordination?

- Comprehensive service coordination enables people with special health care needs, especially children with chronic conditions, to navigate through complex Medicaid managed care systems. Service coordination can include brokering for social support and medical services, breaking down boundaries between systems of care, assisting families with transportation and telephones—in short, whatever it takes to keep children at home and healthy.

Service Coordinators

- Competencies:
  - assigned to families based on their level of experience
  - Develop and sustain long-term caring relationships
  - Depending on the needs of the child service coordination will have multiple levels.
    - Contacts (by phone)
    - Visits (face-to-face)
    - Caseloads (vary according to acuity levels)

Service Coordination Teams

- Service coordinator leads a team of individuals based on the individual's needs
- Comprehensive Service Plan
- Teams must possess experience in various specialties (DME, Behavioral Health, Transitions, Employment, etc.)

Different Approach's to Service Coordination

- Short term service coordination (transition)
- Permanent service coordination
- Independent Service Coordination (not MCO affiliated)
  - DSHS Case Managers under CPW program
  - Health Homes
  - Independent Advocates
  - Experienced parents as paid coordinators (not on their own child, Ex. Halli project)

Patient Centered Health Home

Why a Patient-Centered Medical Home?

- Components of a Patient-Centered Medical Home
  - Care coordination and Case Management
  - Health Supports
  - Transitional Care
  - Patient and Family Supports
  - Referrals for Community Services
  - Information Technology

Recommendations for Patient-Centered Medical Home

- Every client to have access to a health home
- PCP's, Specialists, behavioral health, ancillary health services, family centered care, and data management
- MCO's to employ or contract to train and support network providers
- MCO's expand by 5% each year
- HHSC develop a list of standards
- MCO's pay a higher rate
- Lifetime Continuity of Care
- Electronic Health Record

Medical Transition

“Transition from childhood to adulthood is a life-long process across developmental stages that must be well-planned and started early to be successful.
Therefore, a plan must be implemented that will ensure that children with disabilities remain connected to appropriate primary care physicians, specialists, and therapists as they age out of pediatric into adult care.”

Medical Transition Pediatric to Adult

Why Medical Transition?

- HHSC leads the way
- Medical Transition plan developed within comprehensive case management
- Require MCO's to develop and implement a transition plan
  - To begin no later than 15 years of age
  - With family approval, prepare transition for youth aging out of Texas HealthSteps and the private duty nursing care provided through CCP

Medical Transition Recommendations

- MCO's are contracted with an adequate number of providers for children over the age of 16
- Portal of communication between pediatricians and adult care physicians
- MCO's provide a directory of medical providers with information and experience related to specific diagnoses
- CCM must provide parent and YSHCN with information about prescription coverage changes
- CCM assist in getting prescription refill management changed from one physician to another
- Rule language must prohibit MCO's from discriminating access to medically necessary services based on homebound or other criteria

Private Insurance Coordination

Why Private Insurance Coordination?

- MCO Provider Network
  - Must have Adequate Network
    - Matches or exceeds local provider network
  - Out of Network specialists for primary insurance should be paid by secondary insurance
- Coordination of Benefits
  - Comprehensive case management
  - Dental Procedures
    - MCOs have clear understanding of their responsibility

Outreach and Education

Why we need Outreach and Education?

- MCO's must notify families of changes at least 6 months prior to change
- MCO's should build a coalition of groups to successfully reach families
- MCO's must provide linkages when necessary to external supports

Outreach and Education Recommendations

- MCO's must provide access to multi-lingual staff who are knowledgeable about working with families of children with special needs

- Written materials must be appropriate to the level of education of the caregiver (min. 5th grade)
- Must communicate to the level of education of the client or caregiver.
- Must ensure that the client and their family have a good understanding of the services before they choose an MCO

Adequate Provider Network

Why ensure access to an Adequate Provider Network?

- Continuity of Care
- Full Range of Services
- Access to children's services in all service areas (Network Adequacy Standards)
- Geographic proximity to clients
- Out-of-network access with Single Case Agreements
- Current provider directory, allow specialists to serve as PCP's

Development of a Comprehensive Assessment

Why the Development of Comprehensive Assessment?

- to assess significant medical history, current status and LMN
- Identify potential care needs
- Allows for family input
- standardized documentation
  - Gathers quantitative data to establish LMN norms
  - Guides providers to address the "whole patient"
  - Necessary to develop care plan

What should a Comprehensive Assessment look like?

- Strengths-based vs. deficit based
- Designed for children of all ages
- Capture complexity and intensity of varying needs
- Identify care needs, referrals
- Consider family and caregivers strengths, circumstances, and needs
- Assesses Quality of Life

Who, What, Where, When, and How?

- Competent, experienced Assessors
- The whole child
- Performed face-to-face, child and family
- Initially and at regular intervals (allow more frequent intervals if needed)
- Comprehensively and standardized (across a complex medical population)

Prior Authorization Process

What should the Prior Authorization Process look like?

- Streamlined, transparent, with reasonable timeframes
- Not so burdensome or complex
- Non-discriminating
- Consistent access between MCO's

What is the Rationale behind having a Prior Authorization Process for all to follow?

- Non-discriminating
- Eliminates the client choice of an MCO based on differing processes
- User friendly, simplifies the process
- Minimizes administratively-driven delays to initiate or continue care
- Allows for metrics across the board on the PA process

Oversight and Accountability

Why Oversight and Accountability?

- Allows us to measure quality
- Ensures contract compliance
- Biannual contract monitoring
  - For network adequacy standards specific to access to pediatric services
  - Contract compliance
  - Protects clients

Oversight and Accountability

- Contract monitoring by an external group
- Ongoing assessment of “emerging issues” by the CPC to identify gaps and barriers in services within MCO’s
- Transparency with complaints
- Allow families to proactively discuss MCO issues and concerns