

Evaluation of the Comprehensive Health Homes for Integrated Care Kids Pilot Program

**As Required by
Government Code, Section 531.0605**

**Texas Health and Human Services
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Executive Summary

[Texas Government Code, Section 531.0605](#), Advancing Care for Exceptional Kids Pilot Program, as added by [Senate Bill 1648, 87th Legislature, Regular Session, 2021](#), requires the Texas Health and Human Services Commission (HHSC) to develop and implement a pilot program to provide coordinated care through a health home for children with medically complex conditions. HHSC launched Texas' pilot program, the [Comprehensive Health Homes for Integrated Care \(CHIC\) Kids Pilot program](#), on December 1, 2022. This voluntary pilot program is similar to the U.S. Health and Human Services' [1945A Health Homes program](#), also known as "ACE Kids", and is tailored to Texas Medicaid's managed care model. Through 11 self-funded collaborations between a STAR Kids managed care organization (MCO) and a health home for children with medically complex conditions, there are 1,163 STAR Kids members served by the pilot program as of December 1, 2024.

As further required by Section 531.0605, HHSC must submit a report to the Legislature that summarizes HHSC's implementation of the pilot program and, if sufficient data is available, provide a summary of the effect of the pilot program on the coordination of care for participants and a recommendation on whether the pilot program should continue beyond the statutory expiration on September 1, 2025.

HHSC submitted the first of two installments of the report in December 2024. The first installment, [Comprehensive Health Homes for Integrated Care \(CHIC\) Kids Pilot Program](#), focused on development and implementation of the pilot program.

This report is the second installment and includes an evaluation of participants' care coordination and health care services, outcomes, surveys of participating families, health homes, MCOs, operational savings and costs, and MCO performance on contractual requirements for service coordination. The second installment covers data from December 1, 2022, through February 29, 2024, and provides preliminary data demonstrating the pilot program facilitated enhanced care coordination, increased access to health care services, improved health outcomes, and was a positive experience for caregivers, health homes, and MCOs.

This report also notes that HHSC support for the CHIC Kids Pilot program will end September 1, 2025, in accordance with Texas Government Code, Section 531.0605. Based on the pilot, additional administrative resources would be needed to support continuing the existing pilot operations.

1. Introduction

HHSC launched the CHIC Kids Pilot program to improve care coordination for children with medically complex conditions. Nine health homes and eight STAR Kids MCOs volunteered to collaborate in testing enhanced care coordination models.

This report covers data gathered from December 1, 2022, through February 29, 2024, and provides a preliminary evaluation of the impact of the pilot program on participants and their families, health homes, and MCOs. The pilot program's guiding goals served as a foundation for HHSC's analysis:

1. **Enhance care coordination for children with complex medical conditions through a health home:** HHSC analyzed Medicaid-paid and health home-reported care coordination activities, and developed surveys to gauge families' experience with care coordination.
2. **Improve participants' access to services and outcomes:** HHSC reviewed participants' use of prescription drug services, therapy services, and home-based care services in the six months prior to and six months after enrollment in the pilot program. Utilization outcomes included emergency department (ED) visits, inpatient hospitalizations, and outpatient encounters. HHSC also reviewed the percentage of participants with progress made on personal goals and caregivers' perspectives on improvements in their child's health. HHSC's targeted review focused on MCO performance on contractually-required service coordination.
3. **Increase member and family satisfaction:** HHSC assessed results of a pre-pilot and mid-pilot family experience survey (FES) that included questions related to caregivers' satisfaction with their child's care team and services and supports their child receives.
4. **Identify opportunities for efficiencies:** Surveys of health homes and MCOs captured views on administrative, operational, clinical, and staffing challenges. Pilot sites reported the impact on resource needs across four domains: administrative, care coordination, personnel, and technology.

Evaluation results are provided in the body of the report and appendices. HHSC concludes the report with a summary of the impact of the CHIC Kids Pilot program. HHSC notes the CHIC Kids Pilot program will terminate in accordance with authorizing legislation but health homes and MCOs may continue their collaborations. If the legislature extends the pilot program, HHSC will need resources to administer the pilot program.

2. Background

See HHSC's [first installment](#) of this report for background information on the STAR Kids managed care program, service coordination, health homes, and the development and implementation of the CHIC Kids Pilot program, including details on pilot sites.

3. Pilot Program Evaluation

HHSC's evaluation of the CHIC Kids Pilot program's impact on children with complex medical conditions is organized by five topics:

1. Pilot program participants.
2. Care coordination.
3. Access to care.
4. Health outcomes.
5. Pilot participant experience.

Definitions and source details are provided in Appendix A. Supplemental findings not presented in this section are provided in Appendix B.

Evaluation Methods

The evaluation relied on two quasi-experimental study designs: (1) a one-group posttest only design, in which study participants were examined only after pilot program implementation and (2) a one-group pretest-posttest design, in which participants were examined prior to and after pilot program implementation. The primary study population was pilot participants; however, HHSC also relied on perspectives of caregivers, health homes, and MCOs for a more comprehensive understanding of the pilot program's impact. The evaluation focused on pilot implementation and operations through February 29, 2024, but the study period was truncated for certain measures (see Appendix A).

Data Sources

HHSC examined administrative data sources including Medicaid administrative data (e.g., member enrollment date and health care services rendered) and the Health Home Data Reporting Tool submitted quarterly by pilot sites, which included participant rosters and aggregated data on enhanced care coordination services and care goals. Where applicable, HHSC conducted the evaluation at a health home level (nine health homes), rather than a pilot site level (11 collaborations), as services and experiences were not expected to be substantially different at one health home collaborating with two MCOs. HHSC also created surveys for caregivers, health homes, and MCOs to assess their experience in the pilot program (see Appendix A).

Analytic Methods

For all evaluation measures, HHSC used descriptive statistics such as central tendency and dispersion estimates. For outcome measures, HHSC used Chi-square tests of independence and Mann-Whitney U tests. For measures using Medicaid administrative data, HHSC used hierarchical linear regression models to determine whether changes in measures from pre- to post-implementation were statistically significant, net of participant- and health home-level characteristics.^{1,2} In addition, HHSC conducted sensitivity analyses using t-tests to examine whether outcomes differed based on participants joining a health home before or after pilot program implementation.³ Lastly, HHSC used Cohen’s *d*, where applicable, to assess the magnitude of effects.

Evaluation Results

Pilot Program Participants

Enrollment in the pilot program increased over time, especially during the first three quarters of implementation. From December 2022 through February 2024, 1,290 STAR Kids members have participated in the pilot program (see Table 1).

Table 1. Number of CHIC Kids Pilot Program Participants Per Quarter

Quarter	Timeframe	Number of Pilot Health Homes	Number of Participants
Quarter 1	12/01/2022-02/28/2023	5	342
Quarter 2	03/01/2023-05/31/2023	8	862
Quarter 3	06/01/2023-08/31/2023	9	1,083
Quarter 4	09/01/2023-11/30/2023	9	1,134

¹ Due to study periods and measure criteria, Medicaid administrative data was analyzed for a subset of pilot participants. Refer to Appendix B for additional information on the Medicaid administrative data sample.

² Participant- and health home-characteristics varied across individuals in the Medicaid administrative data sample. HHSC added control variables to the model to ensure changes over time were not influenced by differences in participant characteristics. Control variables included sex, race/ethnicity, age, whether participants joined a health home before or after pilot implementation, whether the health home and MCO collaboration was new or existing, and whether the health home provided enhanced care coordination prior to the pilot or not.

³ Individuals who joined a health home prior to pilot implementation are overrepresented in the Medicaid administrative data sample (73% versus 55% among all pilot participants). Refer to Appendix B for additional information.

Quarter	Timeframe	Number of Pilot Health Homes	Number of Participants
Quarter 5	12/01/2023-02/29/2024	9	1,150
Unduplicated Total	12/01/2022-02/29/2024	9	1,290

Notes: Table 1 reflects the number of pilot program participants each quarter. Some participants disenrolled during the study period and are not included in the counts for subsequent quarters but are included in the Unduplicated Total row. Refer to Appendix A for source details on Figures and Tables.

Among participants in the Medicaid administrative data sample, the most common diagnosis codes associated with chronic conditions (see Appendix A and B) were:

- Artificial opening status (84 percent)
- Challenges with food and fluid intake (70 percent)
- Developmental disorders of speech and language (64 percent)
- Dependence on machines and devices (59 percent)

Care Coordination

Enhanced Care Coordination Services

Figure 1 presents a comparison between the percentage of participants receiving specific enhanced care coordination services during the first quarter of their health home’s pilot implementation (baseline quarter)⁴ and Quarter 5 of the pilot program (December 2023-February 2024). The most common enhanced care coordination service was a core health home team (>97 percent) that includes a primary care provider, nurse case manager or navigator, dietitian, and social worker.

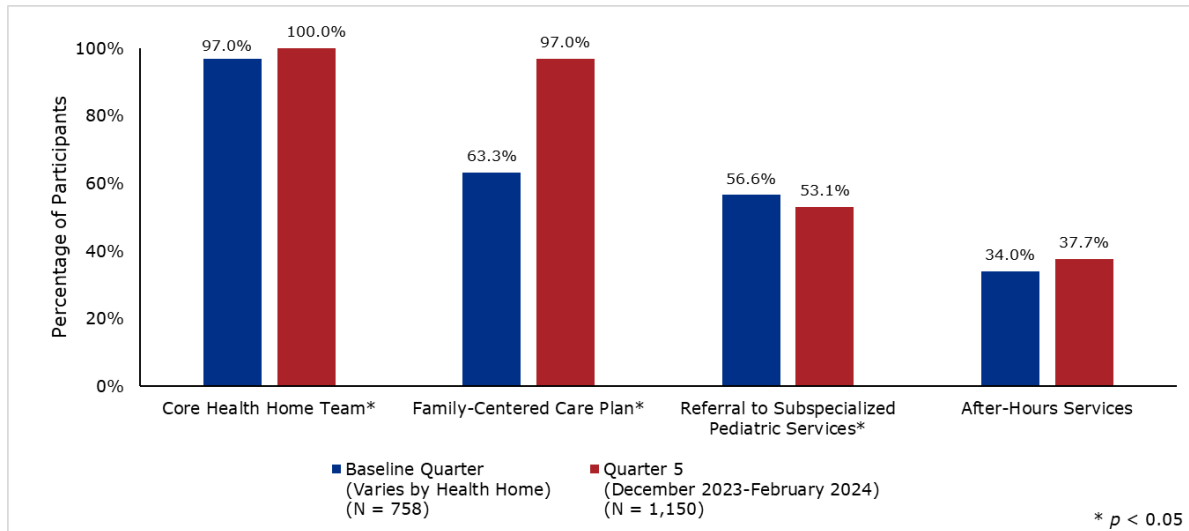
From baseline to Quarter 5, there was a statistically significant increase in the percentage of participants with a family-centered care plan.⁵ Referrals to subspecialized pediatric services decreased, but this difference was negligible and

⁴ All health homes were delivering pilot program services by June 2023 (beginning of Quarter 3).

⁵ Family-centered care plans must be individualized and developed with the participant and family or legally authorized representative (LAR) and incorporate preferences and needs.

not practically meaningful. After-hours care coordination services did not significantly change from baseline to Quarter 5.

Figure 1. Percentage of Participants who Received Enhanced Care Coordination



Notes: The baseline quarter reflects the first quarter of data available for each health home. Chi-square tests were used to determine if there was a significant difference in the proportion of participants receiving each care coordination activity between the baseline quarter and Quarter 5. Refer to Appendix A for definitions and source details on Figures and Tables.

Experience with Care Coordination

Caregiver experience with care coordination included assessing the time they spent on care coordination activities. In the mid-pilot FES, caregivers reported less time making appointments or coordinating with providers but more time contacting their health plan. These changes were not statistically significant (see Appendix B).

"Having the care coordination happen at the same place and time as my child's regular care has been game changing for my family. It has saved us hours of coordination and explaining. I'm able to focus on work and family life instead of feeling like I am working a part time job to coordinate my son's care."

– Family Experience Survey Participant

Health home and MCO survey respondents reported favorable experiences with enhanced care coordination delivered through the pilot program. Over 70 percent agreed the pilot program improved care coordination and helped members (see Appendix B).

"Care coordination has improved through focused collaboration with MCO [Service Coordination] team and the Health Home staff. The organization has also enhanced the [electronic health record] application leveraging best practice processes with both MCO and Health Home teams."

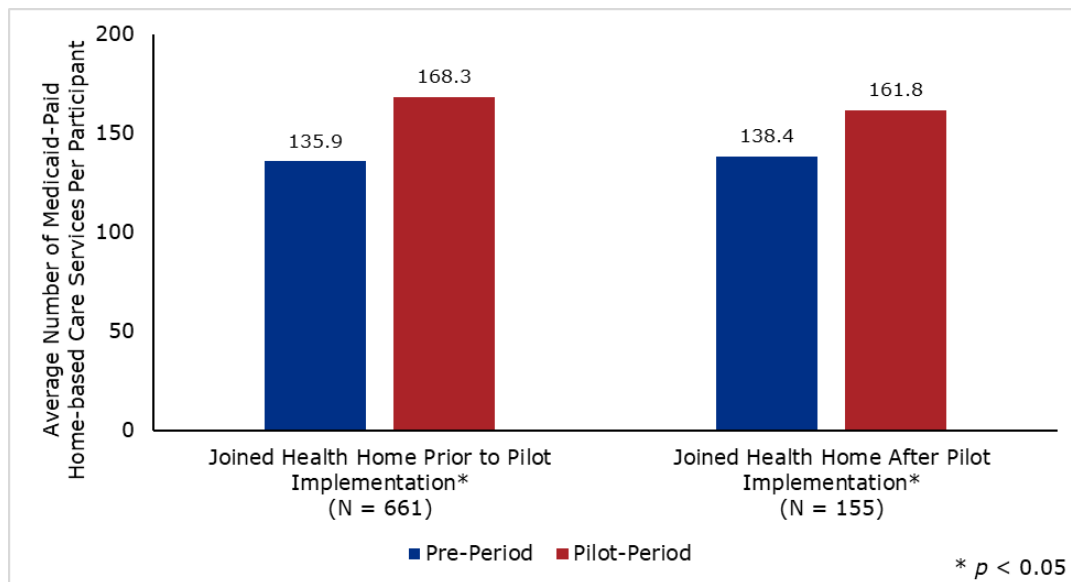
– MCO Experience Survey Participant

Access to Care

The average number of Medicaid-paid prescription drug and therapy services did not change after pilot enrollment (see Appendix A for procedure codes).

A statistically significant increase in home-based care services ($M_{diff} = 28.2$, $d = 0.26$) was driven by an increase in respite services (see Appendix B). Participants who joined a health home before the pilot program experienced a larger increase in home-based care services ($M_{diff} = 32.4$) than those who joined a health home after pilot implementation ($M_{diff} = 23.3$; $d = 0.15$; $p = 0.008$; see Figure 2).⁶ This suggests the pilot yielded distinct benefits independent of a health home alone.

Figure 2. Average Number of Medicaid-Paid Home-based Care Services Per Participant by Whether Participants Joined a Health Home Prior to or After Pilot Implementation



⁶ Effect size calculations used Cohen's d , in which $d < 0.2$ is a negligible effect, $d \geq 0.2$ and < 0.5 is a small effect, $d \geq 0.5$ and < 0.8 is a medium effect, and $d \geq 0.8$ is a large effect.

Notes: Participants without a health home entry date were excluded from this figure. Refer to Appendix A for source details on Figures and Tables.

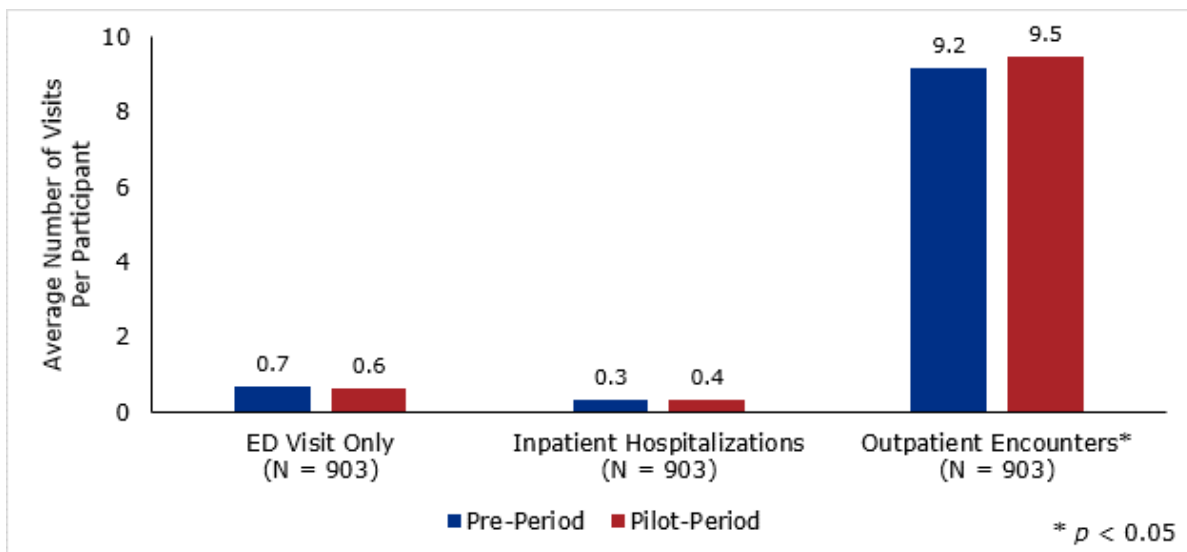
Health Outcomes

HHSC evaluated participant outcomes on multiple fronts. HHSC analyzed utilization-centered measures such as services and costs as well as participant-centered measures including care goals and family impact.

Utilization of Medicaid-Paid Emergency Department Visits, Inpatient Hospitalizations, and Outpatient Encounters

A small, yet statistically significant, increase was seen in the average number of outpatient encounters per participant after joining the pilot program ($M_{diff} = 0.3$, $d = 0.05$; see Figure 3). Participants did not experience a statistically significant change in the average number of inpatient hospitalizations or ED visits not associated with an inpatient hospitalization or outpatient encounter.

Figure 3. Average Number of Medicaid-Paid Emergency Department Visits, Inpatient Hospitalizations, and Outpatient Encounters per Participant

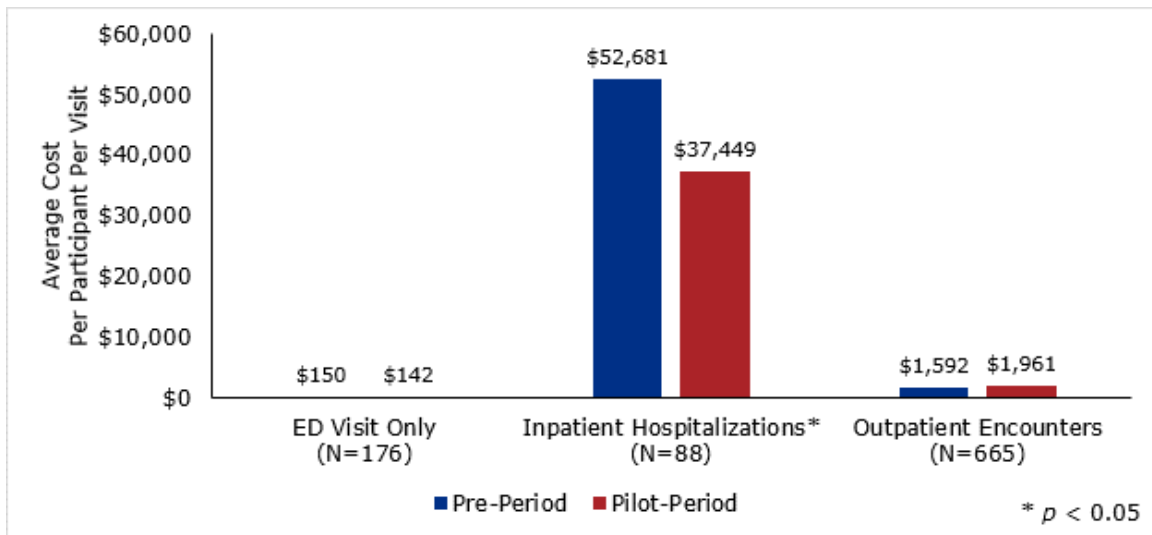


Notes: The “ED Visit Only” category does not include ED visits associated with an inpatient hospitalization or outpatient encounter. Refer to Appendix A for source details on Figures and Tables.

Participants with the respective type of visit in both their pre-period and pilot-period experienced similar average costs for ED visits and outpatient encounters after joining the pilot, but there was a statistically significant decrease in the cost

per inpatient hospitalization ($M_{diff} = -\$15,231.30$, $d = 0.30$; see Figure 4).⁷ This decrease equates to approximately \$2 million in total savings for MCOs on inpatient hospital expenditures among these 88 participants.

Figure 4. Average Cost Per Participant Per Medicaid-Paid Emergency Department Visit, Inpatient Hospitalization, and Outpatient Encounter

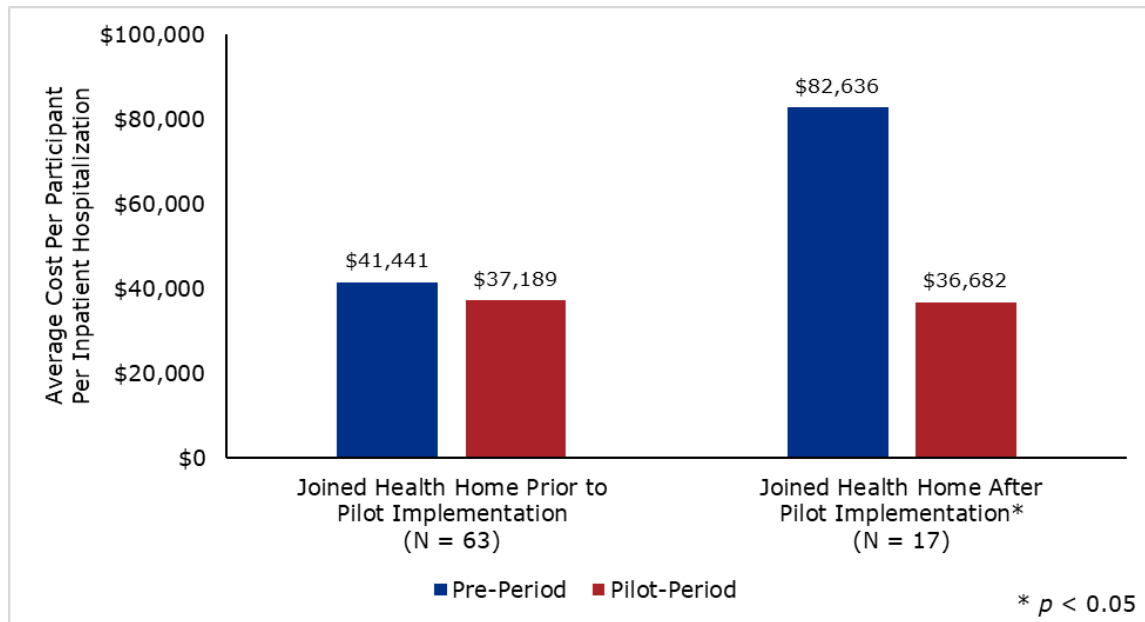


Notes: Figure 4 reflects participants who experienced the respective type of visit in both their pre- and pilot-periods. The “ED Visit Only” category is limited to ED visits not associated with an inpatient hospitalization or outpatient encounter. Refer to Appendix A for source details on Figures and Tables.

Cost savings for inpatient hospitalizations were substantially larger for participants who joined a health home after pilot implementation than for those who joined a health home before the pilot program (see Figure 5). This suggests the bulk of cost savings may be associated with joining a health home itself, rather than the pilot program, though even pre-pilot health home members had notable declines in inpatient costs (approximately \$4,000 per visit) after pilot implementation.

⁷ Costs varied by visit type. ED visits cost the least (average approximately \$150 per visit), and inpatient hospitalizations cost the most (average approximately \$45,000 per visit).

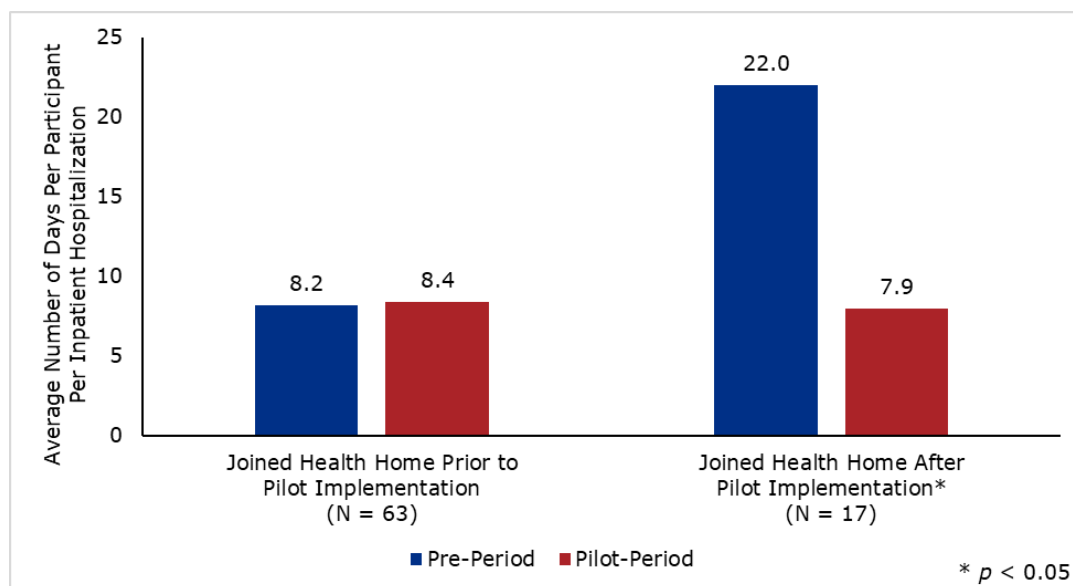
Figure 5. Average Cost Per Participant Per Inpatient Hospitalization by Whether Participants Joined a Health Home Prior to or After Pilot Implementation



Notes: Figure 5 reflects participants who experienced an inpatient hospitalization in both their pre- and pilot-periods. Participants without a health home entry date were excluded from this figure. The number of participants who joined the health home after pilot implementation and who had an inpatient hospitalization was small (17 members), so results may not be generalizable to all pilot program participants. Refer to Appendix A for source details on Figures and Tables.

Participants who had an inpatient hospitalization in both time periods (88 members) experienced a small, yet statistically significant, decrease in the average number of inpatient hospitalization days between the pre-period and pilot-period ($M_{diff} = -3.3$; $d = 0.23$; see Appendix B). However, this decrease was only seen among participants who joined their health home after pilot implementation (see Figure 6). This suggests that the decrease in the average length of stay may be associated with joining a health home itself, rather than the pilot program.

Figure 6. Average Number of Days Per Inpatient Hospitalization per Participant by Whether Participants Joined a Health Home Prior to or After Pilot Implementation



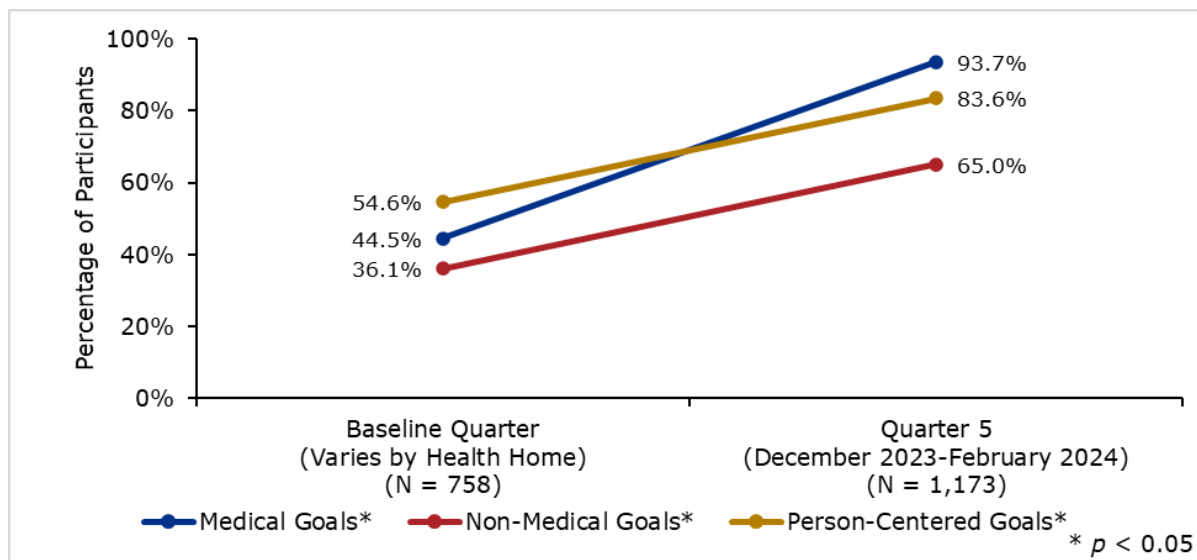
Notes: Figure 6 reflects participants who experienced an inpatient hospitalization in both their pre- and pilot-periods. Participants without a health home entry date were excluded from this figure. The number of participants who joined the health home after pilot implementation and who had an inpatient hospitalization was small ($N = 17$), so results may not be generalizable to all pilot program participants. Refer to Appendix A for source details on Figures and Tables.

Care Goals

Health homes reported the total number of care goals among all pilot participants and the number of medical, non-medical, and person-centered goals with progress made during each quarter. A medical goal was defined as an acute, short-term, or long-term objective that is clinical or medical in nature. A non-medical goal was defined as an acute, short-term, or long-term objective that is person-centered, such as an educational or social goal. Person-centered care goals, which may be medical or non-medical, incorporate individual perceptions and experiences, personal preferences and choices, and outcomes important to the participant for the quality of life and level of independence they desire.

The percentage of participants who made progress on care goals significantly increased. Specifically, by Quarter 5, 94 percent of participants made progress on their medical goals (up from 45 percent in the baseline quarter), 84 percent made progress on their person-centered goals (up from 55 percent), and 65 percent made progress on their non-medical goals (up from 36 percent; see Figure 7).

Figure 7. Percentage of Participants Who Made Progress on Care Goals



Notes: The baseline quarter reflects the first quarter of data reported by each health home. Chi-square tests were used to determine if there was a significant difference in the proportion of participants who made progress on each type of care goal between the baseline quarter and Quarter 5. Refer to Appendix A for source details on Figures and Tables.

Caregiver Perception of Health

Most caregivers indicated the CHIC Kids Pilot program had a positive impact on their child’s health. Specifically, three-quarters of mid-pilot FES respondents believed the pilot helped them care for their child’s medical needs at home, and helped their child and family live a better life (see Appendix B). Over half indicated the pilot program helped their child’s mental health.

"This program is a must have for all families that have a child with complex health conditions. I am very resourceful but I do not possess the physical, mental, or emotional capacity to handle all that’s needed for my child to have the best care/outcomes. Nor would I be able to hold my job or care for my other minor child. This program has been a blessing and a life saver that my family is grateful for and do not take for granted."

– Family Experience Survey Participant

Pilot Program Experience

In the mid-pilot FES, almost all caregiver survey respondents (>80 percent) were satisfied with the way their child's care team worked together, as well as the services and help their child received. Additional survey results are in Appendix B.

"Our nurse and the whole team really listen and ask great questions to probe for more details on my child's well-being and how our family lives could be better."

– Family Experience Survey Participant

Half (50 percent) of health home and MCO survey respondents indicated they were satisfied with the pilot program (see Appendix B) while 40 percent of health homes and MCOs reported neutral opinions. The majority of health homes and MCOs felt that the pilot increased administrative challenges, which may be a result of additional reporting requirements. However, most health homes and MCOs indicated that the pilot either reduced or maintained operational, clinical, and staffing challenges.

"The pilot has been helpful to work through the health home coordinators on referrals, which has led to faster referrals for Members needing additional services. Improved coordination through the health homes has also made it more efficient to get orders from providers, which has improved timely access to services. The pilot has provided opportunities for improved coordination between the service coordination and utilization management teams internally. The pilot has also improved external collaboration with providers in ways that facilitate faster reviews."

– MCO Experience Survey Participant

Limitations

The results of the evaluation should be interpreted alongside several key limitations:

Existing care coordination services

Most notably, some health homes provided enhanced care coordination services before the pilot program's launch. Existing care coordination operations as well as existing arrangements with MCOs to provide care coordination may have limited the types and amount of change after a health home's baseline quarter. Also, STAR Kids MCOs are contractually required to offer service coordination to all members.

Relatedly, pilot design flexibility allowed variation in care coordination services not contractually required. Pilot sites built upon existing services and were not required to implement a standard set of care coordination services under the pilot program, thereby making it difficult to isolate and evaluate the effects of specific care coordination services under the pilot program.

Study period

Many measures lacked pre-period data, which creates difficulty for determining the extent to which results are due to the pilot program specifically, or if health homes or participants would have shown similar outcomes in the absence of the pilot program. Pilot sites with different implementation dates resulted in shorter or longer study periods. Shorter periods for some health homes may have limited the ability to detect differences associated with the pilot program. Where pre-period data were not available, HHSC instead used the beginning of the pilot as a proxy for pre-existing services, supports, and experiences.

Due to the nature of complex medical conditions, participants may have lifelong service needs and chronic acute episodes. The full impacts of providing enhanced care coordination through health home and pilot MCO collaborations may take longer to be realized for children with medical complexity.

Data sources

In addition, each data source had its own set of limitations including the sample size reflecting a subset of pilot participants with some observable differences relative to the full sample. These are discussed in Appendix A.

4. Savings and Costs

Pilot sites were required to submit a report to HHSC on the administrative, care coordination, personnel, and technology resources that were used or saved as a result of participating in the pilot program from December 2022 to December 2023 (see Appendix B for full results). No pilot sites reported cost savings in these categories during the reporting period. All pilot sites used existing funding and did not receive supplemental funding from the state.

Administrative

Ten out of 11 pilot sites reported an increase in administrative resources needed to meet pilot program requirements. The most common need was staff for pilot reporting, including data analytics, documentation retrieval, and report building. New collaborations required additional administrative support for implementation.

Care coordination activities

- Both new and existing pilot sites reported a decrease in time spent to resolve a prior authorization request.
- Contacts with pilot participants and time spent helping participants with transition between care sites and transition between managed care programs increased in nine out of 11 pilot sites.
- Nine pilot sites reported an increase in internal meetings within the health home and MCO, as well as an increase in meetings between the health home and MCO. Two collaborations were existing arrangements with no change.
- MCOs noted the per member per month payment to health homes as a new or increased cost to provide additional care coordination. However, one health home noted, “this is a significant movement toward creating a sustainable model of care for [children with medically complex conditions].”

Personnel

Six out of nine health homes hired direct member care staff, such as core care team members, or dedicated operational staff for pilot project management. Three MCOs hired staff while others used existing staff. No health home or MCO reported a decrease in staffing needs.

Technology

Health homes and MCOs reported increased costs to create or adapt technology for the pilot program. Updating electronic health record capabilities and building documentation platforms were the most common costs. Other technology investments included remote patient monitoring systems and telemedicine equipment to enhance participant consultations.

5. MCO Contract Performance Review

HHSC conducted a targeted review of MCO performance on service coordination requirements in the STAR Kids Managed Care Contract. HHSC selected a statistically valid, random sample of seven MCOs' CHIC Kids Pilot program participants enrolled in the pilot through June 2024.⁸ HHSC reviewed 387 member-level case files and interviewed 340 participants or their LAR between December 2023 and February 2024. 217 participants were enrolled in the Medically Dependent Children Program (MDCP), a waiver program for high acuity, high-needs STAR Kids members, and 170 members were not.

HHSC evaluated 20 performance measures across five categories. To be considered compliant on a measure, 95 percent of an MCO's sample must have met the contract requirement. Results of HHSC's review and additional information on targeted reviews is provided in Appendix C. One MCO exceeded the 95 percent threshold across all performance measures. Individual MCOs' scores ranged from 90 percent to 98.6 percent.

Notably, targeted reviews of MCO performance on contractually required service coordination have traditionally focused on only STAR Kids MDCP members or members of STAR+PLUS, Texas Medicaid's managed care program serving adults with physical, intellectual, or developmental disabilities and adults who are over 65 years of age.

As the pilot program's review was the first of its kind to include both MDCP and non-MDCP STAR Kids members, a baseline was not available. However, the pilot program showed similar performance on many common measures.

⁸ The targeted review excluded pilot sites categorized as a case study.

6. Conclusion and Recommendation

HHSC's analysis provides preliminary evidence the CHIC Kids Pilot program provided enhanced care coordination, increased access to health care services, and improved outcomes for children with complex medical conditions. Overall, the pilot was a positive experience for members and caregivers, health homes, and MCOs. However, several health homes noted challenges related to pilot-specific reporting. More specifically, health homes and MCOs indicated that in the first year after the pilot program's launch, pilot operations have required new and ongoing costs without direct savings in administrative, care coordination, personnel, or technology resources. Collectively, the evaluation suggests there is value in operating models like the ones demonstrated in the pilot program, but additional data would support decision-making.

As a result of the CHIC Kids Pilot program, HHSC updated the [Texas Managed Care Quality Strategy](#) in September 2024 to include an Alternative Payment Model - Performance Framework that rewards MCOs for meeting contractual requirements related to alternative payment models through participation in HHSC pilot and pilot-like programs. With this addition, MCOs are encouraged to continue collaborating with health homes to improve the outcomes and experience of care for children with complex medical conditions and their families.

HHSC support for the CHIC Kids Pilot program will end September 1, 2025, in accordance with [Texas Government Code, Section 531.0605](#). Extending the pilot would require additional administrative resources for future operation, however HHSC could use the knowledge gained from the pilot program to continue assessing approaches that best serve children with complex medical conditions.

List of Acronyms

Acronym	Full Name
CHIC	Comprehensive Health Homes for Integrated Care
ED	Emergency Department
FES	Family Experience Survey
HHSC	Texas Health & Human Services Commission
ISP	Individual Service Plan
LAR	Legally Authorized Representative
MCO	Managed Care Organization
MDCP	Medically Dependent Children Program
NYU	New York University
SK-SAI	STAR Kids Screening and Assessment Instrument
TMHP	Texas Medicaid & Healthcare Partnership
UR	Utilization Review

Appendix A. Technical Notes

Surveys

Family Experience Survey

HHSC developed a survey tool called the Family Experience Survey (FES) to better understand the experience of caregivers participating in the pilot. Two iterations of the FES were administered to caregivers of participants enrolled in the CHIC Kids Pilot program. The baseline FES was administered between December 2022 and September 2023.⁹ As health homes and MCOs enrolled pilot participants, they asked caregivers to provide feedback on their experience prior to joining the CHIC Kids Pilot program. The mid-pilot FES, administered between October 2023 and February 2024, asked caregivers to provide feedback on their experience thus far with the CHIC Kids Pilot program. The baseline FES was available in English and Spanish, and the mid-pilot FES was available in English, Spanish, and Vietnamese. HHSC provided online links and paper versions of the surveys to health homes and MCOs, who distributed them to caregivers.¹⁰

A total of 185 caregivers responded to the baseline FES and a total of 132 caregivers responded to the mid-pilot FES. FES respondents are a subset of caregivers for the full pilot population, and therefore may not be representative of all caregivers.

Health Home and MCO Experience Surveys

HHSC administered a survey to health homes and MCOs to assess their experience participating in the CHIC Kids Pilot program. The surveys were available in English between October 2023 and February 2024 (using only one survey iteration). Multiple staff within each health home and MCO could respond to the survey. The Health Home Experience Survey received 19 responses and the MCO Experience Survey received 24 responses. For the purposes of data analysis, responses were collapsed within each health home (eight health homes)¹¹ and within each MCO

⁹ The deadline for the baseline FES was extended to capture as many new enrollees as possible; however, the majority of responses (>75 percent) were submitted by May 2023.

¹⁰ HHSC adapted the question wording between the baseline and mid-pilot iterations of the FES to be at a more accessible reading level; however, the meaning of each question remained the same. Where applicable, results show the language from the mid-pilot FES.

¹¹ One health home did not complete the Health Home Experience Survey.

(eight MCOs). Specifically, responses to each item were summarized across survey respondents so that each health home and MCO was represented only once in results. There was large agreement across various respondents from the same health home and MCO.

Study Periods

Table 2 details the study periods for each data source.

Pilot sites with a prolonged pilot implementation phase resulted in incomplete data on the Health Home Data Reporting Tool during the first two reporting quarters (Quarter 1: December 2022-February 2023; Quarter 2: March 2023-May 2023). All health homes were delivering pilot program services by the beginning of Quarter 3 (June 2023). For measures leveraging the Health Home Data Reporting Tool, HHSC compared the first quarter of data available for each health home (“baseline quarter”) to Quarter 5 (December 2023-February 2024; the most recent data available at the time of writing).¹²

For measures leveraging Medicaid administrative data, HHSC created a six-month pre-period and six-month pilot-period based on each participant’s unique entry date into the pilot.¹³ Due to data lags for claims and encounters adjudication, as well as time required to conduct analyses and write the report, the evaluation could only include Medicaid administrative data through December 30, 2023. Accordingly, participants must have joined the pilot by June 30, 2023 (six months prior to claims/encounters cut off), to be included in measures leveraging Medicaid administrative data, resulting in a full study period of June 1, 2022 (six months prior to pilot start) through December 30, 2023.

Table 2. Study Periods for CHIC Kids Pilot Program Evaluation

Data Source	Beginning of Study Period	End of Study Period
Health Home Data Reporting Tool	First quarter of pilot operations ¹ (quarter varies by health home)	Quarter 5 (December 2023-February 2024)

¹² The baseline quarter was Quarter 1 (December 2022-February 2023) for five health homes (56 percent), Quarter 2 (March 2023-May 2023) for three health homes (33 percent), and Quarter 3 (June 2023-August 2023) for one health home (11 percent).

¹³ For participants enrolled in the pilot program longer than six months, only their first six months of Medicaid administrative data were included in the evaluation.

Data Source	Beginning of Study Period	End of Study Period
Medicaid Administrative Data	Six months prior to pilot enrollment ² (date varies by participant)	Six months after pilot enrollment ² (date varies by participant)
Family Experience Survey	December 2022-September 2023	October 2023-February 2024
Health Home Experience Survey	N/A	October 2023-February 2024
MCO Experience Survey	N/A	October 2023-February 2024

Notes: ¹ All health homes were delivering pilot program services by the beginning of Quarter 3 (June 2023-August 2023). ² The full study period for Medicaid administrative data was June 1, 2022, to December 30, 2023.

Figure and Table Notes

Figures and tables included in this report were prepared by HHSC’s Office of Data, Analytics, and Performance in August 2024 and leverage the following data sources:

- CHIC Kids Pilot Program Health Home Data Reporting Tool, Quarters 1-5
- 8-Month Eligibility File (HHSC)
- Analytical Data Store (Texas Medicaid & Healthcare Partnership [TMHP])
- Vendor Drug SQL Server (HHSC)
- CHIC Kids Pre-Pilot Family Experience Survey
- CHIC Kids Mid-Pilot Family Experience Survey
- CHIC Kids Pilot Program Health Home Experience Survey
- CHIC Kids Pilot Program MCO Experience Survey
- ICD10_Decodes (HHSC)
- Healthcare Cost and Utilization Project’s Chronic Condition Indicator Refined for ICD-10-CM Diagnoses, v2024.1
- CHIC Medical Condition Dx List_OMD_20240318 (HHSC)

Medicaid Administrative Data Pulls

Most Medicaid administrative data was pulled from the Analytical Data Store (TMHP). Table 3 lists the filters for each data pull. Each data pull matched to a list of Medicaid patient control numbers for CHIC Kids Pilot program participants (903 participants). Encounters were later removed if they did not fall within a participant’s unique study period (six months prior to and after enrollment in the pilot). HHSC observed a six-month data lag, rather than the standard eight-month lag, to accommodate implementation delays and routing timelines.

Table 3. Filters for Data Pulls from the Analytical Data Store (TMHP)

Type of Visit/Service	Filters
Standard Filters	ADS_HDR.SBMT_MEMB_ID: [referenced list] ADS_HDR.CLM_PGM_CD: 100, 200, missing ADS_HDR.HDR_STS_CD: P, E ADS_HDR.HDR_FROM_SRVC_DT >= June 1, 2022 ADS_HDR.HDR_FROM_SRVC_DT <= December 31, 2023 ADS_HDR.HDR_PAID_AMT > \$0 ADS_HDR.MNG_CARE_PGM_NM: not CHIP
Medical Conditions	Standard filters
Care Coordination Services	Standard filters ADS_DTL.DTL_STS_CD: not D ADS_HDR.TRANS_TYPE_CD: P ADS_HDR.CLM_TYPE_CD: 020, 030, missing ADS_DTL.SBMT_PROC_CD: 99202-99205, 99212-99215, 99221-99223, 99231-99236, 99242-99245, 99252-99255, 99281-99285, 99304-99310, 99341, 99342, 99344, 99345, 99347-99350, 99358, 99366, 99367, 99374, 99375, 99377-99380, 99417, 99418, 99492-99494, 99499, G2214, G9012, T1017
Home-based Care Services	Standard filters ADS_DTL.DTL_STS_CD: not D ADS_HDR.TRANS_TYPE_CD: P ADS_HDR.CLM_TYPE_CD: 020, 030, missing ADS_DTL.SBMT_PROC_CD: G0100, G0101, G0171, G0197, G0121, S5150, T1000, T1005, T1019

Type of Visit/Service	Filters
Therapy Services	Standard filters ADS_DTL.DTL_STS_CD: not D ADS_HDR.TRANS_TYPE_CD: P ADS_HDR.CLM_TYPE_CD: 020, 030, <i>missing</i> ADS_DTL.SBMT_PROC_CD: 92507-92508, 92521-92524, 92526, 92610, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97110, 97112, 97113, 97116, 97124, 97140, 97150, 97161-97168, 97530, 97532, 97535, 97537, 97542, 97750, 97760, 97761, 97763, G0151-G0153, S9152
Teleservices	Standard filters ADS_DTL.DTL_STS_CD: not D ADS_DTL_IND.DTL_TELEMED_IND=Y
Emergency Department Visits	Standard filters OR statements ADS_DTL.SBMT_PROC_CD: 99281-99285 ADS_DTL.REV_CD: 450-459, 981, 0450-0459, 0981 ADS_DTL.TRANS_TYPE_CD: P and ADS_DTL.PLACE_OF_SRVC_CD: 23
Inpatient Hospitalizations	Standard filters ADS_HDR.INST_CAT_CD: I
Outpatient Encounters	Standard filters ADS_HDR.INST_CAT_CD: O

Notes: Some encounters fell into multiple categories. Teleservices often overlapped with other categories, so teleservices are not mutually exclusive with the other services listed in Table 3. Encounters that were flagged as ED visits and institutional visits (inpatient hospitalizations or outpatient encounters) were retained only as the latter.

Data Source(s): Analytical Data Store (TMHP).

Data on prescription drug services was pulled from the DrugClaimsEnc table in the Vendor Drug Program SQL server (HHSC). The following filters were used:

- RECIPIENT_NBR in [*referenced list*]
- TCN_ACTIVE: 1
- RX_FILL_DT >= June 1, 2022
- RX_FILL_DT <= December 31, 2023
- PROG: M

Additional Limitations

For measures leveraging the Health Home Data Reporting Tool, certain health homes were excluded from the first two reporting quarters due to prolonged pilot implementation. HHSC compared the first reporting period available for each health home (baseline quarter) to Quarter 5 (December 2023-February 2024; the most recent data available at the time of writing) to ensure measures captured the start of each health home's pilot. However, because the baseline quarter varied across health homes, the study period for these measures differed in length. For example, a health home with pilot services active on December 1, 2022 (Quarter 1) had a longer study period than a health home that began pilot services on June 1, 2023 (Quarter 3). The truncated reporting period for some health homes may have limited the ability to detect differences associated with the pilot.

Medicaid administrative data, which are designed and collected for billing purposes, were used to determine changes in access to care and health care outcomes. However, most measures derived from administrative sources in this evaluation are validated and widely used for evaluation purposes. Additionally, the sample for these data reflect a subset of pilot participants, so conclusions based on these data may not be representative of the full pilot program. Further, HHSC observed a six-month, rather than the standard eight-month, post-claim adjudication period to accommodate pilot implementation delays and report routing timelines. While most claims and encounters are final after six months, further adjudications could cause slight variations to the Medicaid utilization and cost results.

Survey data with caregivers, health homes, and MCOs are susceptible to common challenges to validity in survey samples, such as small sample sizes. Additionally, upon entry into the pilot program, caregivers were asked to provide feedback on care coordination received prior to the pilot for comparison purposes. Caregiver feedback on pre-pilot experiences is subject to recall bias. Moreover, each survey had additional limitations. The baseline and mid-pilot iterations of the FES could not be directly compared because questions were changed or added to further investigate the impact of the pilot. Also, the Health Home and MCO Experience Surveys were only administered once and had small sample sizes, which limited the statistical analyses that could be run.

For some measures leveraging the Health Home Data Reporting Tool and FES, HHSC employed statistical tests that assume independent samples, even though some participants and survey respondents were included in both samples (i.e., both quarters or survey iterations). This may have affected the conclusions drawn from each test.

Appendix B. Supplemental Results

Evaluation Results

This section includes additional findings not presented in the body of the report.

CHIC Kids Pilot Program Participants

From December 2022 through February 2024, 1,290 STAR Kids members participated in the pilot program. Approximately half of these participants joined the health home prior to the pilot implementation (see Table 4).

Table 4. Involvement with Health Home Prior to CHIC Kids Pilot Program (1,290 participants)

Date Participant Joined the Health Home ¹	Number	Percentage
Prior to Pilot Implementation	704	54.6%
After Pilot Implementation	439	34.0%
Not Reported by Health Home ²	147	11.4%

Notes: ¹ HHSC determined whether a participant joined a health home before or after pilot implementation (December 1, 2022) based on the participant’s health home entry date. ² Health homes did not provide an entry date for approximately 11 percent of participants. Refer to Appendix A for source details on Figures and Tables.

Pilot Participants in the Medicaid Administrative Data Sample

Measures using Medicaid administrative data focused on a sample of 903 participants who enrolled in the pilot program by June 30, 2023.¹⁴ The Medicaid administrative data sample is a subset of the full pilot population, and therefore may not be representative of all pilot participants. For example, approximately

¹⁴ Among children who joined the CHIC Kids Pilot Program by June 30, 2023 ($N = 968$), 50 were not enrolled in the CHIC Kids Pilot Program for at least six months, and 15 were not continuously enrolled in Medicaid for their full 12-month study period, leaving 903 remaining children.

three-fourths of the Medicaid administrative data sample joined the health home prior to pilot implementation (compared to half of pilot participants; see Table 5).

Table 5. Characteristics of Medicaid Administrative Sample (903 participants)

Date Participant Joined the Health Home ¹	Number	Percentage
Prior to Pilot Implementation	661	73.2%
After Pilot Implementation	155	17.2%
Not Reported by Health Home ²	87	9.6%

Notes: ¹ HHSC determined whether a participant joined a health home before or after pilot implementation (December 1, 2022) based on the participant’s health home entry date. ² Health homes did not provide an entry date for approximately 10 percent of participants. Refer to Appendix A for source details on Figures and Tables.

Chronic Medical Conditions

To assess the prevalence of chronic conditions among pilot participants, HHSC identified participants in the Medicaid administrative data sample with any diagnosis code categories associated with chronic medical conditions throughout their six month pre-pilot and pilot-periods.¹⁵ The three most common diagnosis code categories were (1) artificial opening status, (2) symptoms and signs concerning food and fluid intake, and (3) developmental disorders of speech and language (see Table 6).

Table 6. Top 20 Diagnosis Code Categories Associated with Chronic Conditions

Diagnosis Code Category Description	Diagnosis Code Category	Percent of Participants
Artificial opening status	Z93	84%
Symptoms and signs concerning food and fluid intake	R63	70%
Specific developmental disorders of speech and language	F80	64%
Dependence on enabling machines and devices, NEC	Z99	59%

¹⁵ HHSC focused on chronic condition diagnoses that may qualify participants for the pilot program, rather than incidental diagnoses that may occur during the study period. Chronic medical conditions were defined using the Healthcare Cost and Utilization Project’s Chronic Condition Indicator Refined for ICD-10-CM Diagnoses, v2024.1, accessible via https://hcup-us.ahrq.gov/toolssoftware/chronic_icd10/chronic_icd10.jsp, and key diagnosis code categories determined by HHSC in March 2024.

Diagnosis Code Category Description	Diagnosis Code Category	Percent of Participants
Unspecified urinary incontinence	R32	58%
Body mass index [BMI]	Z68	52%
Gastro-esophageal reflux disease	K21	50%
Other disorders of psychological development	F88	50%
Sleep disorders	G47	47%
Asthma	J45	47%
Epilepsy and recurrent seizures	G40	46%
Cerebral palsy	G80	46%
Respiratory failure, not elsewhere classified	J96	39%
Vasomotor and allergic rhinitis	J30	38%
Other disorders of brain	G93	34%
Other disorders of urinary system	N39	32%
Problems related to care provider dependency	Z74	32%
Scoliosis	M41	31%
Specific developmental disorder of motor function	F82	25%
Pervasive developmental disorders	F84	25%

Notes: Table 6 reflects participants who joined the pilot by June 30, 2023, were enrolled in the pilot for at least six months, and were also continuously enrolled in Medicaid for six months before and after entering the pilot (903 participants). Participants could have more than one diagnosis code category, so percentages do not sum to 100 percent. Refer to Appendix A for source details on Figures and Tables.

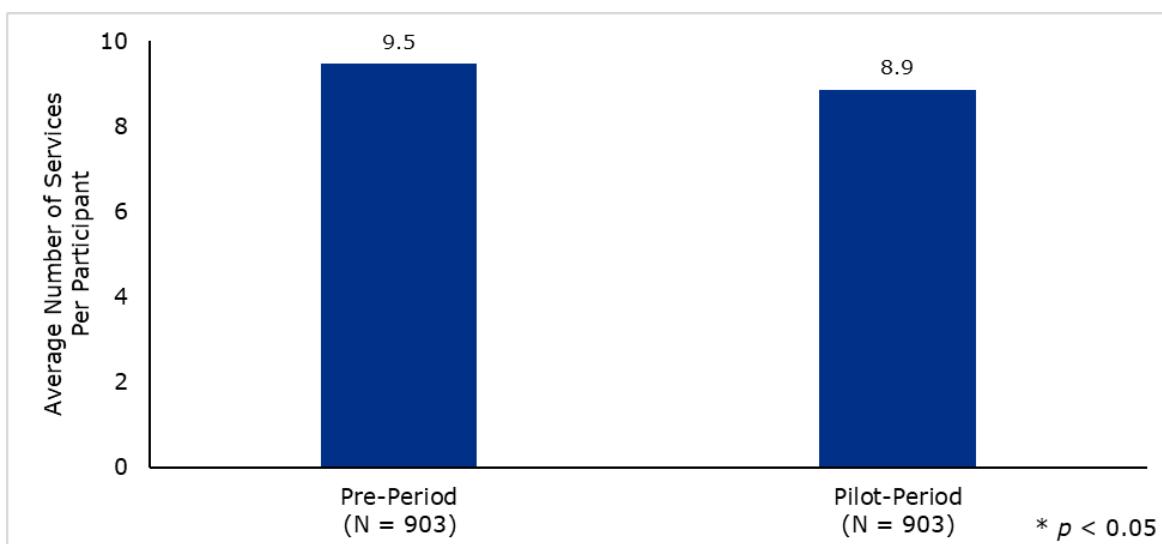
Care Coordination

HHSC examined health home-reported enhanced care coordination services, utilization of Medicaid-paid care coordination services, and experience with care coordination among caregivers, health homes, and MCOs participating in the pilot.

Medicaid-Paid Care Coordination Services

Among the Medicaid administrative data sample, HHSC examined utilization of Medicaid-paid health care services related to care coordination.¹⁶ Pilot participants utilized approximately nine care coordination services, on average, in the six months prior to and after entering the pilot. Differences in the number of care coordination services after entering the pilot were not statistically significant ($M_{diff} = -0.6$, $d = 0.04$; see Figure 8). A reduction in billed care coordination services may be an outcome of health homes using a per member per month alternative payment model.

Figure 8. Average Number of Medicaid-Paid Care Coordination Services Per Participant



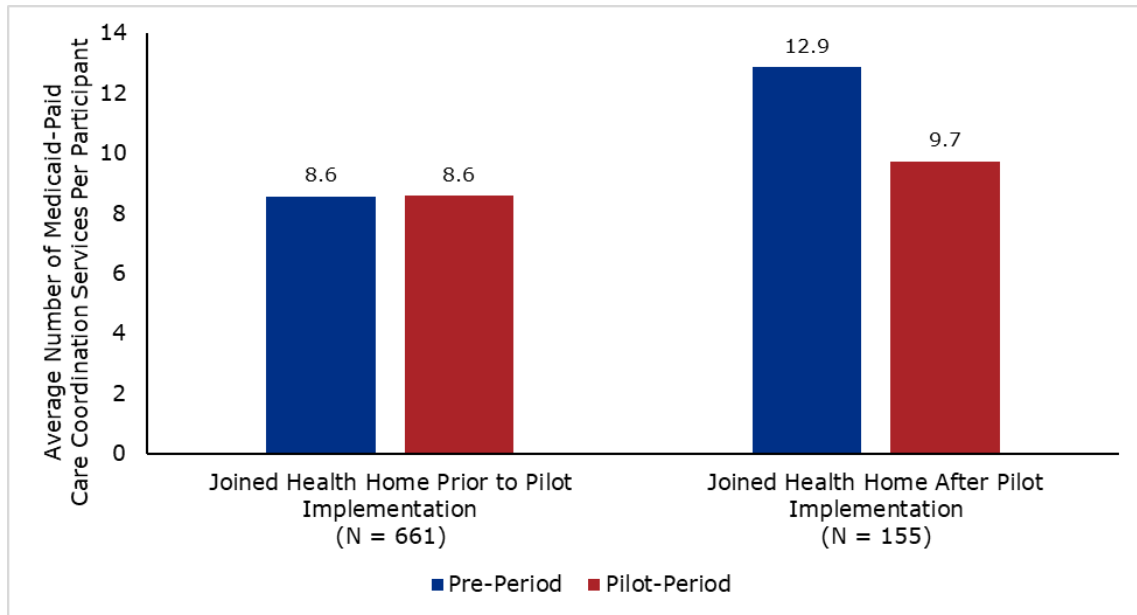
Notes: A hierarchical linear regression model was used to determine if Medicaid-paid care coordination services significantly varied after entering the pilot, after accounting for grouping of participants within health homes, and other participant-level characteristics; no significant differences emerged. Refer to Appendix A for source details on Figures and Tables.

Figure 9 shows the number of Medicaid-paid care coordination services per pilot participant by whether participants joined a health home before or after pilot implementation. Participants who joined a health home after pilot implementation were slightly more likely to experience decreases in the number of Medicaid-paid

¹⁶ The procedure codes used to identify Medicaid-paid care coordination services are provided in Appendix A.

care coordination services ($M_{diff} = -3.1$) than participants who joined a health home before pilot implementation ($M_{diff} < 0.1$; $d = 0.16$; $p < 0.001$); however, this difference did not remain significant after accounting for grouping of participants within health homes and other participant-level characteristics.

Figure 9. Average Number of Medicaid-Paid Care Coordination Services Per Participant by Whether Participants Joined a Health Home Prior to or After Pilot Implementation



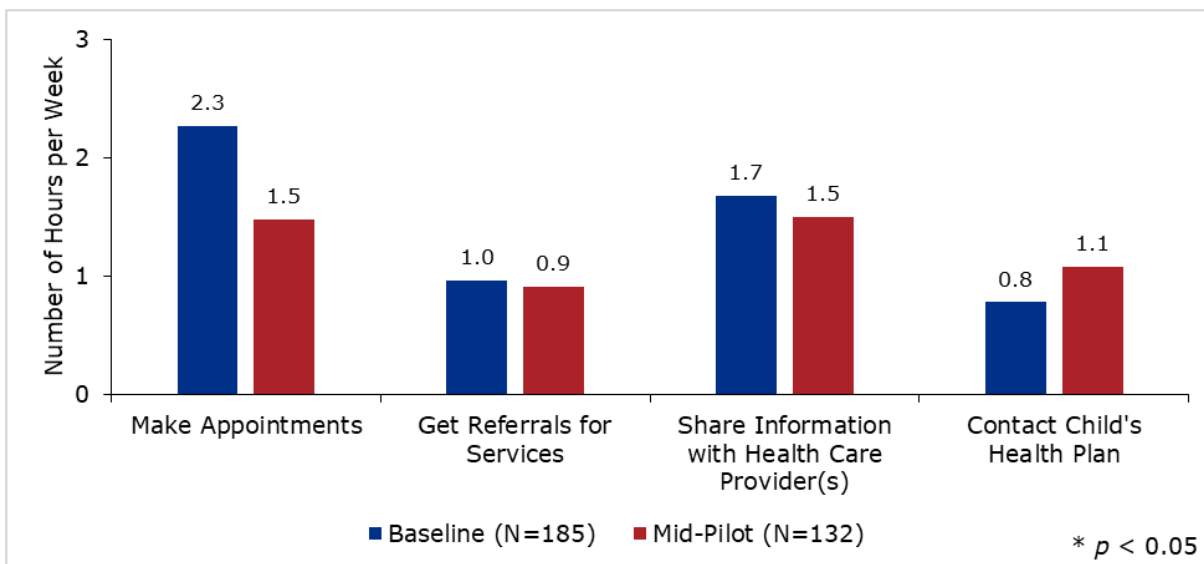
Notes: Participants without a health home entry date are excluded from this figure. An independent samples t-test was used to determine if the number of services significantly varied by whether participants joined a health home before or after pilot implementation; the difference between the two groups was significant with $p < 0.05$. Refer to Appendix A for source details on Figures and Tables.

Experience with Care Coordination

Caregivers

Between pilot enrollment and the mid-pilot survey, caregivers reported small changes in time spent per week on care coordination activities. Caregivers spent slightly less time on making appointments, referrals for services, and coordinating with providers. Caregivers reported more time contacting their health plan (see Figure 10). The largest change was a decrease time spent making appointments; however, no changes were statistically significant.

Figure 10. Number of Hours Per Week Caregivers Spent on Care Coordination

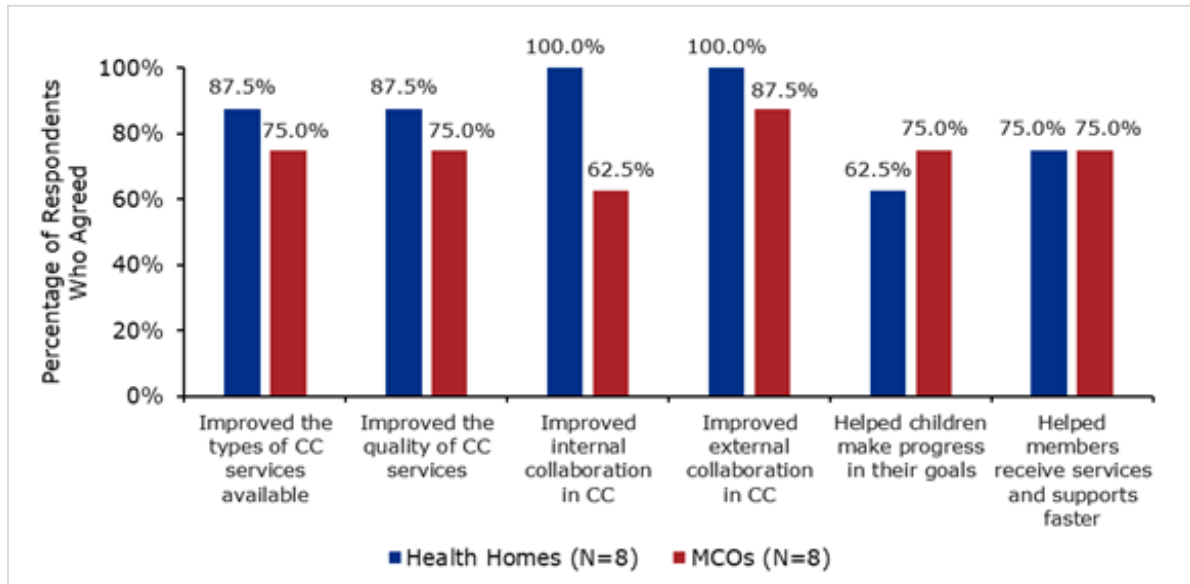


Notes: Baseline survey responses were collected between December 2022 and September 2023. Mid-pilot survey responses were collected between October 2023 and February 2024. Mann-Whitney U tests determined no significant differences between baseline and mid-pilot responses. Refer to Appendix A for source details on Figures and Tables.

Health Homes and MCOs

Health home respondents generally had more favorable experiences with care coordination than MCO respondents, especially regarding improvement to internal collaboration on care coordination (see Figure 11). Survey questions included whether respondents agreed the pilot program improved the types of care coordination services available, improved the quality of care coordination services, improved internal collaboration on care coordination, improved external collaboration on care coordination, helped children make progress in their goals, and helped members receive services and supports faster.

Figure 11. Percentage of Health Home and MCO Survey Respondents Who Agreed on Experiences with Enhanced Care Coordination



Notes: Survey responses were collected between October 2023 and February 2024. Significance testing was not conducted due to small sample sizes. CC=Care Coordination. Refer to Appendix A for source details on Figures and Tables.

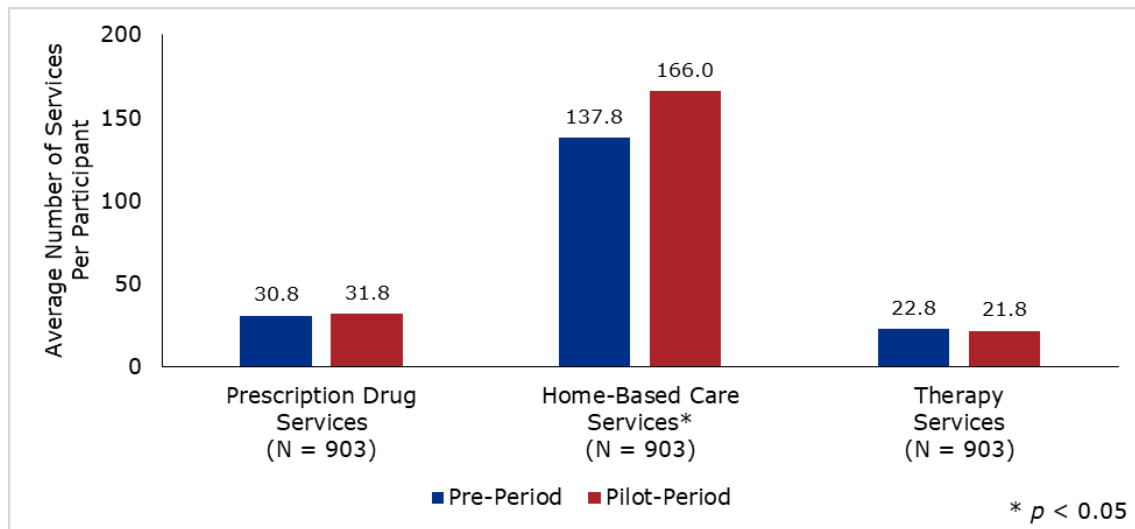
Access to Care

Medicaid-Paid Health Care Services

HHSC evaluated participant utilization of prescription drug, home-based care, and therapy services during the six months prior to and six months after enrollment in the pilot program (see Figure 12).¹⁷

¹⁷ The services analyzed reflect services commonly used by children with complex medical conditions.

Figure 12. Average Number of Medicaid-Paid Health Care Services Per Participant

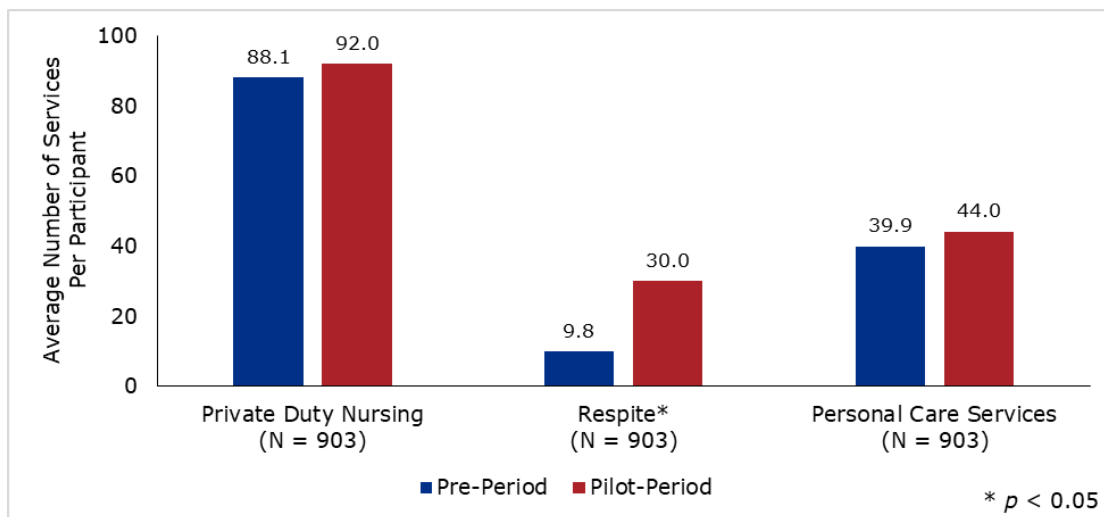


Notes: A hierarchical linear regression model was used to determine if Medicaid-paid health care services significantly varied after entering the pilot, after accounting for grouping of participants within health homes, and other participant-level characteristics. Refer to Appendix A for source details on Figures and Tables.

Home-based Care

HHSC examined utilization of three types of home-based care services: private duty nursing, respite, and personal care services. In both the pre-period and the pilot period, the most common type of home-based care service was private duty nursing, followed by personal care services and then respite. Participants experienced similar utilization rates of private duty nursing and personal care services after joining the pilot program, but there was a statistically significant increase in the utilization of respite services after entering the pilot program ($M_{diff} = 20.1, d = 0.51$; see Figure 13).

Figure 13. Average Number of Medicaid-Paid Home-based Care Services Per Participant



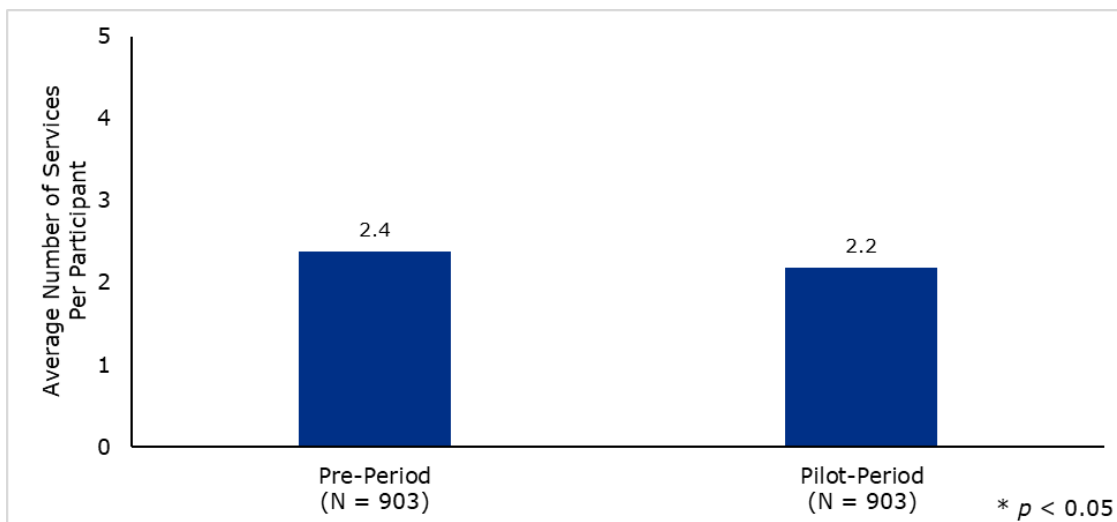
Notes: A hierarchical linear regression model was used to determine if Medicaid-paid home-based care services significantly varied after entering the pilot, after accounting for grouping of participants within health homes, and other participant-level characteristics. Refer to Appendix A for source details on Figures and Tables.

Health Information Technology

Medicaid-Paid Teleservices

During the six months prior to and six months after pilot enrollment, participants did not experience a statistically significant change in the number of Medicaid-paid teleservices after entering the pilot ($M_{diff} = -0.2$, $d = 0.03$; see Figure 14). Procedure codes and modifiers used to identify Medicaid-paid teleservices are provided in Appendix A. These services were not specific to care coordination.

Figure 14. Average Number of Medicaid-Paid Teleservices Per Participant

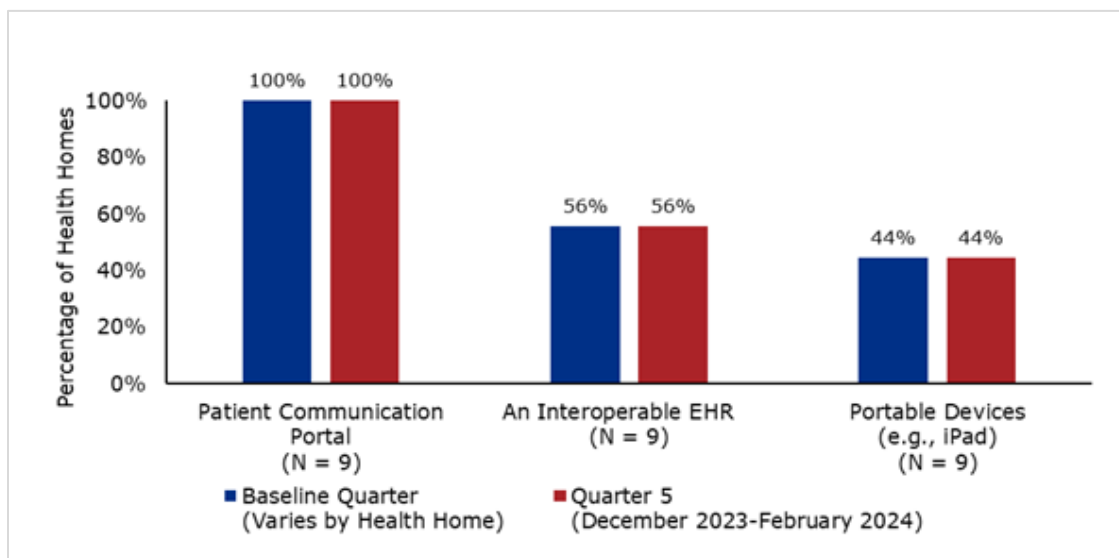


Notes: A hierarchical linear regression model was used to determine if Medicaid-paid teleservices significantly varied after pilot enrollment, after accounting for participant grouping within health homes, and other participant-level characteristics; no significant differences emerged. Refer to Appendix A for source details on Figures and Tables.

Health Information Technology

Use of health information technology did not vary between pilot implementation (baseline quarter) and Quarter 5 (December 2023-February 2024). All health homes reported using a patient communication portal or platform facilitating two-way communication for care coordination between the MCO, health home, providers, and member participant or family. In contrast, approximately half of health homes used a portable device such as a smart phone, tablet, or laptop to interact from a remote location, and half had an interoperable electronic health record, defined as a single system with functionality or information accessible by the MCO and health home (see Figure 15).

Figure 15. Percentage of Health Homes Using Health Information Technology



Notes: EHR=Electronic health record. The baseline quarter is the first quarter of data available for a health home. There were no changes from the baseline to Quarter 5. Significance testing was not conducted due to small sample sizes. Refer to Appendix A for source details on Figures and Tables.

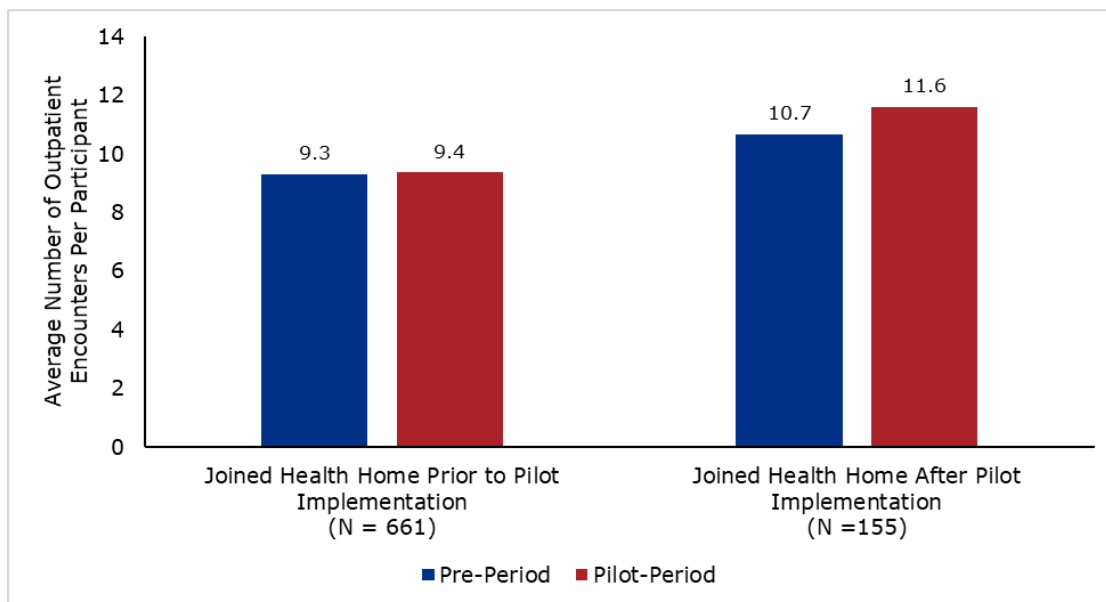
Health Outcomes

To assess whether the pilot program improved health outcomes, HHSC-examined ED visits, inpatient hospitalizations, outpatient encounters, care goals, and caregiver perceptions of their child’s health.

Emergency Department Visits, Inpatient Hospitalizations, and Outpatient Encounters

HHSC analyzed Medicaid-paid ED visits, inpatient hospitalizations, and outpatient encounters in the six months prior to and six months after pilot enrollment. Figure 16 shows the number of Medicaid-paid outpatient encounters per participant by whether the participant joined a health home before or after pilot implementation. Participants who joined a health home after the pilot implementation experienced slightly sharper increases in the number of outpatient encounters ($M_{diff} = 0.9$) than participants who joined a health home before pilot implementation ($M_{diff} = 0.1$; $d = 0.13$); however, the difference was not statistically significant.

Figure 16. Average Number of Medicaid-Paid Outpatient Encounters by Whether Participants Joined a Health Home Prior to or After Pilot Implementation



Notes: Participants without a health home entry date were excluded from this figure. An independent samples t-test was used to determine if the number of outpatient encounters significantly varied by whether participants joined their health home before or after pilot implementation; no significant differences emerged. Refer to Appendix A for source details on Figures and Tables.

Potentially Preventable Emergency Department Visits

HHSC investigated the percentage of ED visits that were potentially preventable using an algorithm originally developed by New York University’s (NYU) Center for Health and Public Service Research.¹⁸ This algorithm determines the likelihood that an ED visit or hospitalization truly required emergency care or was potentially preventable or avoidable. The NYU algorithm estimates the probability of each visit occurring across the following six categories based on diagnosis codes:

1. Emergent-ED care needed (not preventable or avoidable)
2. Emergent-ED care needed (preventable or avoidable)

¹⁸ The original NYU algorithm was created based on ICD-9 diagnosis codes available as of 2001. Johnston, Allen, Melanson, & Pitts (2017) created an updated algorithm for ICD-9 codes through 2012 and ICD-10 codes as of 2016.

3. Emergent or primary care treatable
4. Non-emergent
5. Other (mental health, alcohol, substance abuse, injury)
6. Unclassified

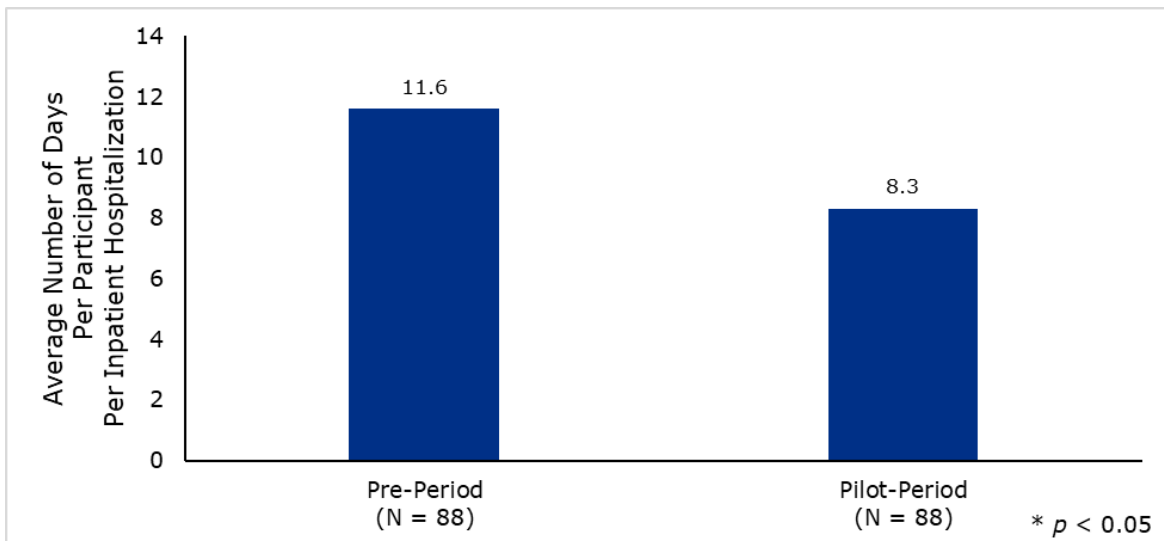
ED visits and hospitalizations are determined potentially preventable or avoidable when the summed probabilities of categories (2) emergent-ED care needed (preventable or avoidable), (3) emergent or primary care treatable, and (4) non-emergent exceed 50 percent.

Approximately 35 percent of ED visits in the six months after participants joined the pilot were potentially preventable according to the NYU algorithm. This percentage was not significantly different from the pre-period (34 percent; $\chi^2 = 0.21, p = 0.650$). However, a substantial proportion of ED visits fell into the “Unclassified” category (37 percent across the full study period), suggesting the true rate of potentially preventable visits may be higher than the percentage reported above. The relatively large number of unclassified visits may be because the algorithm is based on ICD-10 codes as of 2016 and cannot classify ICD-10 codes introduced after 2016.

Inpatient Hospitalization Days

Figure 17 shows the average number of days participants spent in an inpatient hospital during the six months prior to and six months after pilot enrollment.

Figure 17. Average Number of Days Per Participant Per Inpatient Hospitalization



Notes: Figure 17 reflects participants who experienced an inpatient hospitalization in both their pre- and pilot-periods. A hierarchical linear regression model was used to determine if inpatient hospitalization days significantly varied after entering the pilot, after accounting for participant grouping within health homes, and other participant-level characteristics; the difference was significant at the $p < 0.05$ level. Refer to Appendix A for source details on Figures and Tables.

Inpatient Admitting Diagnosis

The five most common inpatient admitting diagnosis codes among participants were the same in both the pre-period and the pilot-period (see Table 7).

Table 7. Top Five Inpatient Admitting Diagnosis Codes

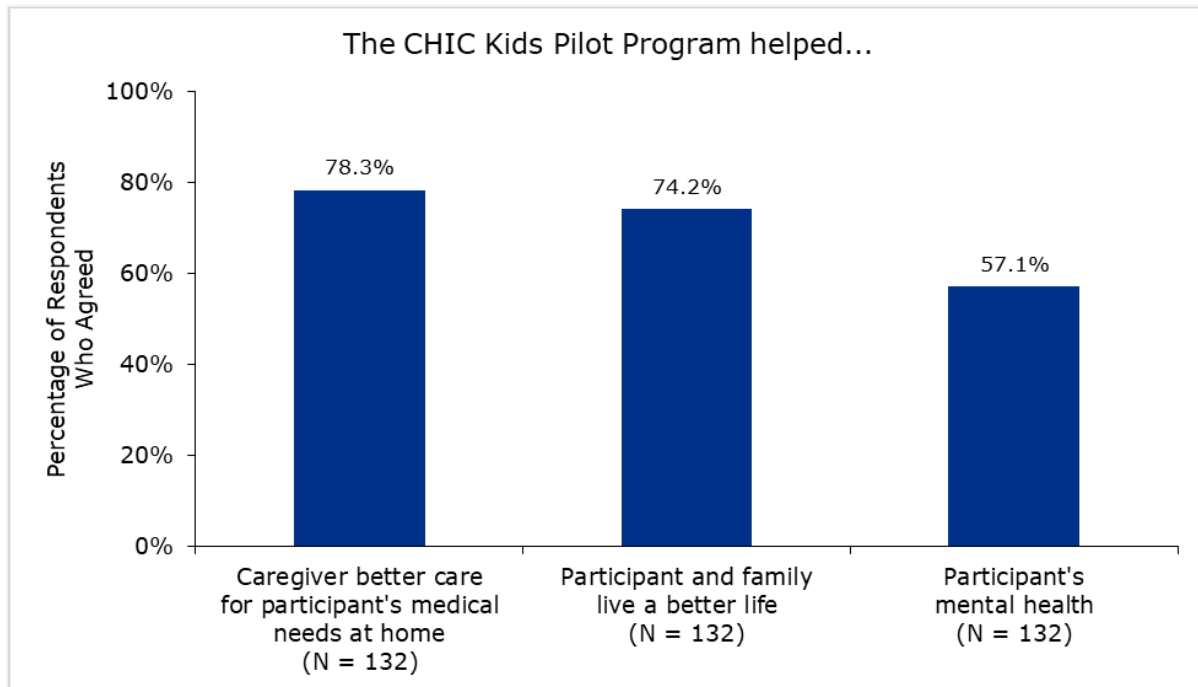
Diagnosis Code Description	Diagnosis Code	Percentage of Admissions: Pre-Period	Percentage of Admissions: Pilot-Period
Respiratory failure	J96	22.0%	16.6%
Other sepsis	A41	6.3%	10.3%
Abnormalities of breathing	R06	8.7%	7.5%
Fever of other and unknown origin	R50	4.9%	7.2%
Epilepsy and recurrent seizures	G40	5.2%	6.6%

Notes: Table 7 shows the five most common inpatient admission diagnosis codes among CHIC Kids Pilot program participants. Participants could have more than one diagnosis code, so percentages do not sum up to 100 percent. Refer to Appendix A for source details on Figures and Tables.

Caregiver Perceptions of Health

Most caregiver survey respondents indicated the CHIC Kids Pilot program had a positive impact on their child’s health. Caregivers indicated the pilot program helped them better care for their child's medical needs at home (78.3 percent), helped their child and family live a better life (74.2 percent), and helped their child's mental health (57.1 percent; see Figure 18).

Figure 18. Caregiver Perceptions of Child’s Health: Percentage of Respondents Who Agreed on the Pilot Program’s Impact on Their Child or Family



Notes: Survey responses were collected between October 2023 and February 2024. Refer to Appendix A for source details on Figures and Tables.

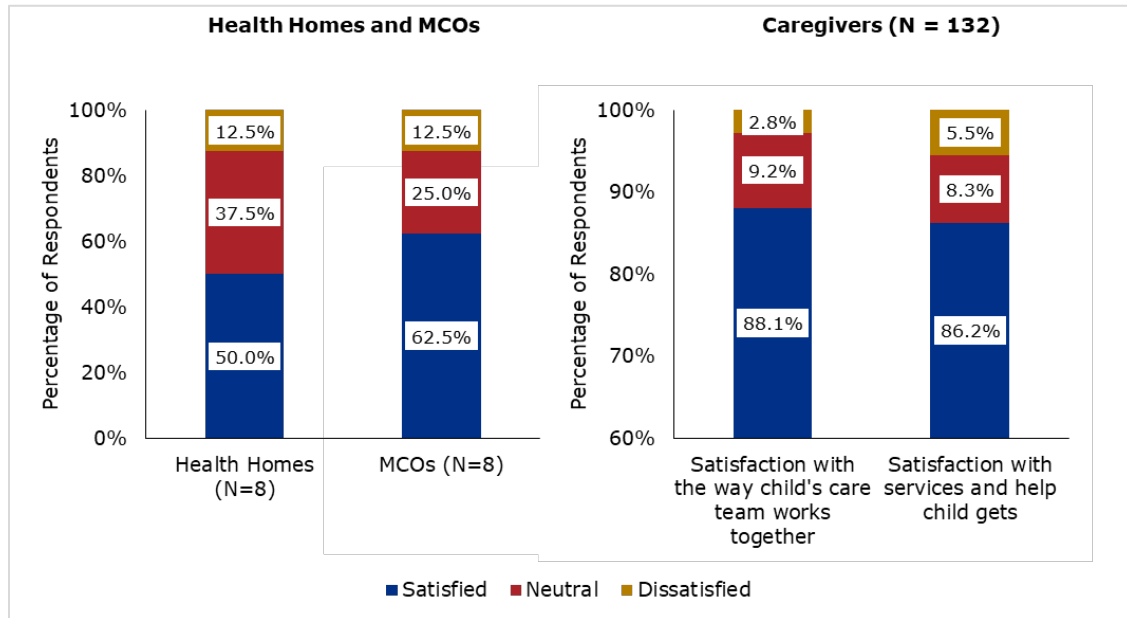
Pilot Program Experience

HHSC examined caregivers, health homes, and MCOs experience participating in the pilot program. This section presents findings on pilot satisfaction and whether the pilot helped address challenges or inefficiencies.

Satisfaction

Figure 19 shows health home, MCO, and caregiver satisfaction with the pilot program as reported on the FES, health home survey, and MCO survey.

Figure 19. Health home, MCO, and Caregiver Level of Satisfaction with the CHIC Kids Pilot Program

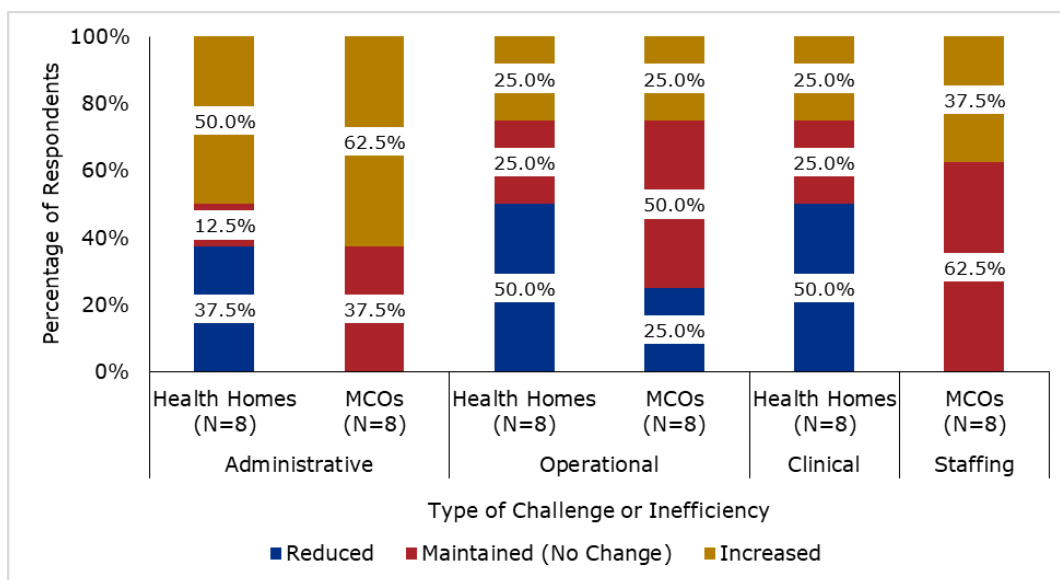


Notes: Survey responses were collected from October 2023 to February 2024. Significance testing was not conducted due to small sample sizes. Refer to Appendix A for source details on Figures and Tables.

Addressing Challenges and Inefficiencies

Health home and MCO surveys asked whether respondents felt the pilot program reduced, maintained, or increased challenges or inefficiencies in four domains: administrative, operational, clinical, and staffing. Notably, health homes were more likely to report reduced challenges or inefficiencies, whereas MCOs were more likely to report that challenges or inefficiencies were maintained (see Figure 20).

Figure 20. Percentage of Health Home and MCO Survey Responses on Whether the CHIC Kids Pilot Program Addressed Challenges and Inefficiencies



Notes: Survey responses were collected between October 2023 and February 2024. Health homes were asked about clinical, but not staffing, challenges and inefficiencies; MCOs were asked about staffing, but not clinical, challenges and inefficiencies. Significance testing was not conducted due to small sample sizes. Refer to Appendix A for source details on Figures and Tables.

Resource Utilization Report

Health homes and MCOs submitted a report to HHSC on resources required for pilot program operations between December 2022 and December 2023 to provide HHSC with information on costs and savings realized as a result of the pilot program and not otherwise captured. Tables 8, 9, 10, and 11 provide the resource utilization report’s four categories with respective subcategories, and number of pilot sites reporting an increase, decrease, or no change.

Table 8. Pilot Program Resource Utilization Report: Administrative Category.

Subcategory	Response
Time spent on duplicative processes	Increase = 3 Same = 4 Decrease = 3 Mixed = 1

Subcategory	Response
Time spent on documentation	Increase = 7 Same = 2 Decrease = 0 Mixed = 2
Other administrative (optional)	Increase = 8 Decrease = 0

Table 9. Pilot Program Resource Utilization Report: Care Coordination Activities Category.

Subcategory	Response
Time spent to resolve a prior authorization request (on average)	Increase = 0 Same = 5 Decrease = 6
Time spent to find services for a member (on average)	Increase = 3 Same = 3 Decrease = 5
Meetings between health home and MCO to coordinate care	Increase = 8 Same = 3 Decrease = 0
Meetings within health home or MCO to coordinate care	Increase = 8 Same = 3 Decrease = 0
Contact with members	Increase = 8 Same = 2 Decrease = 0 Mixed = 1
Time spent on member transitions between care sites (i.e., inpatient to home)	Increase = 6 Same = 5 Decrease = 0
Time spent on member transitions between Medicaid programs (i.e., STAR Kids to STAR+PLUS)	Increase = 6 Same = 5 Decrease = 0
Other care coordination costs/savings (optional)	Increase = 4 Decrease = 0

Table 10. Pilot Program Resource Utilization Report: Personnel Category.

Subcategory	Response
Administrative staff	Increase = 8 Same = 3 Decrease = 0

Core care team members (Primary care physician, specialists, service coordinator, nurse case manager or nurse navigator, dietician, or social worker)	Increase = 6 Same = 5 Decrease = 0
Other personnel costs/savings (optional)	Increase = 2 Decrease = 0

Table 11. Pilot Program Resource Utilization Report: Technology Category.

Subcategory	Response
Interoperability or access to systems	Increase = 6 Same = 5
Other technology costs/savings (optional)	Increase = 6 Decrease = 0

Appendix C. MCO Contract Performance Review

HHSC's targeted reviews, also known as utilization review (UR), are an important oversight tool to ensure MCOs meet contractual obligations and provide medically and functionally necessary services and required services, such as assessments and service planning, for Medicaid members. UR are performed by registered nurses who have the same certifications and person-centered planning training required for STAR Kids MCO service coordinators. UR include a desk review of a member's assessments, service planning documentation, and MCO records including case notes. HHSC conducts interviews with members and LARs to ensure member needs are addressed, ask about member experience with the MCO, and receive feedback on delivered services' impact on the member's quality of life. UR of programs, specific services, or MCOs may be required by statute, such as the annual [Utilization Review in STAR+PLUS Managed Care report](#), or be an agency directive.

Summary of Results

HHSC evaluated MCO performance on STAR Kids managed care contract requirements related to service coordination. HHSC assessed seven STAR Kids MCOs and 387 members participating in the CHIC Kids Pilot program. The UR covered 20 measures across five categories: conduct of assessments, assessment-driven service planning, timeliness, service delivery, and member experience.

Conduct of Assessments

All MCOs met the compliance threshold for completing participants' STAR Kids Screening and Assessment Instrument (SK-SAI) assessments and related documentation.

Assessment-Driven Service Planning

- All MCOs were at or above compliance thresholds for capturing participant and caregiver goals.
- Regarding documentation of participants' needs in the service planning documents, MCO performance varied. Individual MCO performance scores ranged between 52.4 percent to 92.7 percent.

Timeliness

- All MCOs were compliant with timely completion and submission of participants' SK-SAIs. Three MCOs scored 100 percent compliance.
- No MCO met the 95 percent threshold for documenting contact with a participant four weeks after the start of their Individual Service Plan (ISP). Documentation was either unavailable or lacked details confirming all identified service needs were reviewed.
- Similarly, four MCOs did not meet the threshold for frequency of outreach to members according to timelines in the contract or did not provide documentation of a member's request for less contacts.

Service Delivery

Performance measures focused on whether participants had outstanding needs noted in their SK-SAI or ISP or concerns with access to care or health and safety. MCO performance averaged 89.9 percent. Most access to care issues were related to delays in receiving durable medical equipment. Other prevalent issues were delays in receiving personal care services, therapies, and respite services.

Member Experience

- Over 95 percent of participants in four MCOs stated they felt their service plans adequately met their needs and that the services made a positive impact on their lives.
- MCOs also excelled in involving participants in the development of their service plan, honored the participant's preferences, and offered a choice of services and providers in more than 99 percent of cases reviewed.
- Some participants stated they did not know how to contact their MCO service coordinator; however, average performance across MCOs was 96.2 percent.

Performance Measure Descriptions

Tables 12, 13, 14, 15, and 16 provide descriptions of the evaluation measures in each category of HHSC's targeted review of MCO performance on contractually required service coordination.

Table 12. CHIC Kids Pilot Program MCO Performance Review Measures and Scores: Conduct of Assessment.

Performance Measure	Performance Measure Description	Average Score Across MCOs
1.1	Number of members for whom the required Form 2604, Individual Service Plan (ISP) Service Tracking Tool, was completed.	100%
1.2	Number of members for whom the required Form 2603, ISP Narrative, was completed.	99.7%
1.3	Number of MDCP members for whom the MCO provided the results of the initial assessment or annual reassessment of medical necessity to the member or LAR.	99.1%

Table 13. CHIC Kids Pilot Program MCO Performance Review Measures and Scores: Assessment-Driven Service Planning.

Performance Measure	Performance Measure Description	Average Score Across MCOs
2.1	Number of members initially assessed for MDCP with a justification or rationale noted for at least one waiver service.	100%
2.2	Number of reassessed MDCP members with a justification or rationale noted for at least one waiver service.	97.6%
2.3	Number of members whose identified needs were addressed in required service planning documents.	78.8%
2.4	Number of members whose goals listed on the SK-SAI were also found on Form 2603, ISP Narrative.	100%
2.5	Number of members whose primary caregiver goals listed on the SK-SAI were also noted on Form 2603, ISP Narrative.	97.9%

Table 14. CHIC Kids Pilot Program MCO Performance Review Measures and Scores: Timeliness.

Performance Measure	Performance Measure Description	Average Score Across MCOs
3A.1	Number of members for whom the initial MDCP enrollment process was completed within 60 days following the initial HHSC notification, or with a documented reason otherwise.	100%

Performance Measure	Performance Measure Description	Average Score Across MCOs
3A.2	Number of members for whom the reassessment process was completed within required contractual timeframes, or with a documented reason otherwise.	97.8%
3B.1	Number of members for whom the MCO documented follow-up no later than four weeks following the ISP start date.	64.6%
3B.2	Number of members/LARs who received contractually required phone calls, unless otherwise requested.	91.5%

Table 15. CHIC Kids Pilot Program MCO Performance Review Measures and Scores: Service Delivery.

Performance Measure	Performance Measure Description	Average Score Across MCOs
4A.1	Number of members for whom the MCO did not have any referrals (complaints filed on behalf of the member due to concerns with access to care or health and safety) during the reporting period.	89.9%
4B.1	Number of members whose services were delivered according to their ISP.	93.8%

Table 16. CHIC Kids Pilot Program MCO Performance Review Measures and Scores: Member Interview on MCO Experience.

Performance Measure	Performance Measure Description	Average Score Across MCOs
5.1	Number of members who report being offered a choice of services.	99.1%
5.2	Number of members who report being offered a choice of providers.	99.1%
5.3	Number of members/LARs who report knowing how to contact their MCO Service Coordinator.	96.2%
5.4	Number of members who report a change in Service Coordinator assignment and received notification from the MCO in writing (or their preferred method of contact).	100%
5.5	Number of members who report their Service Coordinator asked about their preferences.	99.4%
5.6	Number of members/LARs who reported helping develop the ISP.	99.7%