Comprehensive Health Homes for Integrated Care Kids Pilot Program

As Required by
Government Code Section 531.0605

Texas Health and Human Services
December 2024

TEXAS
Health and Human Services

Table of Contents

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:

- Collaborate with the STAR Kids Managed Care Advisory Committee (SKMCAC), Medicaid recipients and family members of children with complex medical conditions, and Medicaid managed care organizations (MCOs) to develop and implement a pilot program substantially similar to the health home program described in the Medicaid Services Investment and Accountability Act of 2019 (Pub. L. No. 116-16), also known as the Advancing Care for Exceptional (ACE) Kids Act, to provide coordinated care through a health home for children with complex medical conditions;
- Seek guidance from the Centers for Medicare & Medicaid Services (CMS) and the United States Department of Health and Human Services (HHS) regarding the design of the pilot program;
- No later than December 31, 2024, submit a report to the Legislature with a summary of HHSC's implementation and, if the pilot program has been operating for a period sufficient to obtain necessary data, an evaluation of the effect of the pilot program on coordination of care for children with complex medical conditions and a recommendation on whether the pilot program should be continued, expanded, or terminated; and
- Terminate the pilot program on September 1, 2025.

In response, HHSC created the Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot program which launched December 1, 2022. The pilot program focuses on enhancing care coordination through voluntary, self-funded partnerships between health homes with expertise in caring for children with complex medical conditions and STAR Kids MCOs. As of September 1, 2024, there are 11 pilot sites and a total of 1,175 members participating.

To meet the Legislature's deadline, HHSC is submitting the required report in two installments. This installment provides a summary of HHSC's development and implementation of the pilot program. The second installment will be submitted by March 1, 2025, and will include HHSC's evaluation of the pilot program and a recommendation on the future of the pilot program.

1. Introduction

Through stakeholder feedback, expert resources, and customization of the ACE Kids Act, HHSC developed and implemented a pilot program to improve care coordination for children with medically complex conditions through a health home. By leveraging the existing STAR Kids managed care program for children with disabilities, HHSC launched the CHIC Kids Pilot program on December 1, 2022.

As a voluntary program for MCOs, health homes, and members, HHSC allowed flexibility in pilot sites' design to encourage participation and innovation. Health homes and MCOs are testing a combination of collaborative, integrated, or delegated service coordination models. Nine health homes and eight STAR Kids MCOs co-lead one or more of the 11 pilot sites. These include five partnerships that pre-existed the pilot program and six partnerships that were created for the pilot program. All partnerships established an alternative payment model (APM) reimbursement arrangement between the health home and MCO rather than a fee-for-service model.

Despite advance notice of the pilot program's participation requirements and start date, some pilot sites experienced prolonged implementation due to unexpected challenges. Negotiating and finalizing contracts for APM arrangements and building data systems to collect and report data to HHSC were the most common reasons and resulted in the longest delays. Given that state funding was not allocated for implementation or operation of the pilot program, health homes and MCOs expressed dissatisfaction with the resources required to do manual chart review for care coordination not captured through billing codes. Conversely, factors that reduced the time for implementation included preexisting care coordination partnerships and data-sharing systems. All pilot sites were fully operational by July 1, 2023.

HHSC developed a comprehensive evaluation design to assess the pilot's impact on participants' access to services, outcomes, care coordination, and satisfaction. Evaluation measures use Medicaid data, pilot site-reported data, participant surveys, and a targeted review. HHSC will submit a second installment of this report to the Legislature by March 1, 2025, that will include a summary of HHSC's evaluation of the pilot program's impact on participants and a recommendation on whether the pilot program should be continued, expanded, or terminated.

2. Background

STAR Kids Program

Through the authority of Texas Government Code Section 533.00253, the STAR Kids program serves children and youth who are 20 years of age or younger with a disability, such as a physical, behavioral, developmental, or intellectual disability, or a complex medical condition. Texas implemented the STAR Kids program in 2016 through Medicaid managed care to improve health outcomes, access to care, care coordination, and cost-effectiveness of care. The program covers acute care and long-term services and supports and integrates service planning and coordination. As of February 2024, nine MCOs serve 144,117 STAR Kids members across Texas.

Service Coordination

The STAR Kids Managed Care Contract (SKMCC) Section 8.1.38 defines service coordination as a care management service to assist Medicaid members with identifying, selecting, and obtaining necessary services and supports that enhance the member's health, well-being, and care goals. All members of the STAR Kids program have access to a service coordinator through the member's MCO. The service coordinator is responsible for assessing the member's medical and non-medical needs, developing an individualized service plan for the member, and coordinating access to services. Service coordination is included in the capitated rate paid to MCOs. As an added value, service coordination teams provide a single point of access for members to receive multidisciplinary care coordination.

Health Home

A health home is a designated health care provider or team that uses a holistic and customized person-centered strategy to address the needs of a person with chronic or complex medical conditions. Studies have shown that health homes reduce health care costs and improve health outcomes and patient satisfaction by providing services that extend beyond what is normally offered by a primary care provider for children without complex conditions. In addition to expertise and infrastructure to support comprehensive care management and coordination for children with medically complex conditions, health home services include assistance with palliative care, transitional care after a hospitalization, and member and family

support such as educational consults and referral to community and social support services.

SKMCC Section 8.1.4.10.2 requires MCOs to provide health home access to any member the MCO determines would benefit from a health home and any member who requests a health home. Under SKMCC Section 8.1.38.6, STAR Kids MCOs are allowed to delegate a member's service coordination to an integrated health home and fulfill the MCO's contractual requirements for service coordination. If an MCO delegates service coordination to a health home, the MCO maintains responsibility for ensuring contract requirements around service coordination are met.

Advancing Care of Exceptional Kids Act

The ACE Kids Act of 2019 creates an opportunity for states to fund health homes designed for children with medically complex conditions. The program described in the ACE Kids Act, formally known as the Section 1945A Health Home program, intends to improve care for Medicaid-eligible children with medically complex conditions through coordinated care within a health home, reduce burdens on providers and families, and reduce emergency room visits and inpatient hospital stays.

As of October 1, 2022, a state can submit a state plan amendment to CMS to add health home services as a Medicaid benefit for children with medically complex conditions. The 1945A program gives states flexibility to reimburse health homes through a fee-for-service model or an APM, such as a per member per month (PMPM) rate. States that implement the program receive a six-month increase in Federal Medical Assistance Percentage funds, limited to health home services that are not already covered benefits under the state's Medicaid program. As of March 15, 2024, CMS reports there are no states with an active 1945A health home program.

3. Pilot Development

To ensure the pilot program provides value to children with medically complex conditions and their families, HHSC's development of the pilot program included consulting subject matter experts, the ACE Kids Act, and federal resources on health home programs. Similar to the ACE Kids Act, the pilot program's goals are to improve pilot participants' access to care, outcomes, and satisfaction through enhanced care coordination, as well as encourage efficiencies that reduce administrative burden for families, health homes, and MCOs. HHSC's pilot design offers a flexible structure for health homes and MCOs voluntarily partnering to improve care coordination for children with medically complex conditions.

Stakeholder Collaboration

STAR Kids

HHSC worked with STAR Kids program stakeholders including the SKMCAC, MCOs, family members of children with medically complex conditions, health care providers, physicians, durable medical equipment and services representatives, and member advocates. Stakeholders shared valuable insights on service and care coordination and health homes for children with medically complex conditions.

In August 2021, HHSC solicited stakeholder feedback for the STAR Kids Alternative Model Feasibility Report, required by Texas Government Code Section 533.00253, which was submitted to the Texas Legislature in December 2022. Members of the SKMCAC's Subcommittee on Health Homes and Quality Measures recommended a service delivery and reimbursement model in which health homes for children with medically complex conditions received funds directly from HHSC to manage a member's care. MCOs recommended continuing the MCO-led service coordination model but increasing APM partnerships between providers and MCOs.

For the CHIC Kids Pilot program specifically, HHSC consulted the SKMCAC and sought expertise from pediatric complex care clinics in Texas that provide integrated care coordination as a health home for children with medically complex conditions. The clinics elaborated on their health homes' approach to member wellness and care coordination. Clinics shared best practices and areas of success as well as challenges including qualified staff for operations, evaluation measures, and payment models for comprehensive care coordination.

HHSC incorporated STAR Kids stakeholders' feedback in setting the pilot program's goals, participation criteria, care coordination reporting, and selecting evaluation measures meaningful to families. As a result, HHSC created an opportunity for health homes and MCOs to partner in creating or enhancing an integrated health home to improve care coordination through collaboration.

Centers for Medicare and Medicaid Services

HHSC leveraged HHS and CMS resources in development of the pilot program including reviewing existing health home programs and participating in a CMS stakeholder call. Although formal guidance on implementation of a Section 1945A program was not available during the development phase, HHSC incorporated key elements of the program detailed in the ACE Kids Act including definitions, eligibility criteria, participation and reporting requirements, and evaluation measures. CMS provided guidance on the implementation of section 1945A in August 2022, the same month that HHSC received CHIC Kids Pilot program plans co-developed by health homes and MCOs.

Texas Government Code Section 531.0605 authorizes HHSC to seek federal funding to implement the pilot program based on guidance from HHS and CMS. HHSC did not pursue federal funding because grants available through the ACE Kids Act are for planning and development of a state plan amendment and not available for a pilot program. The grants also require state matching funds, and no state funding was allocated for planning or operating the pilot program.

Participation Requirements

In alignment with the ACE Kids Act and stakeholder input, HHSC established participation criteria for Medicaid members, health homes, and MCOs volunteering to participate in the pilot program. Requirements and definitions are published in the Uniform Managed Care Manual Chapter 16.7, Comprehensive Health Homes for Integrated Care (CHIC).

Medicaid Member

In addition to being enrolled in the STAR Kids managed care program and having a complex medical condition, the pilot program includes a measure recommended by SKMCAC members to further stratify medical complexity. A participant must be determined to need nursing care at home based on the results of the member's

STAR Kids Screening and Assessment Instrument or an MCO authorization for nursing care at home.

Health Home

Following standards outlined in the ACE Kids Act, a health home must provide participants 24/7 access to the health home, and staff a core team to coordinate participants' care, including a primary care provider, nurse case manager or nurse navigator, dietitian, and social worker. A health home must also help coordinate prompt access to medical specialists, pediatric emergency services, and help participants transition from pediatric to adult care providers, as applicable.

HHSC collaborated with the SKMCAC on a recommendation that a health home must demonstrate expertise and capacity for care coordination by having a minimum number of patients in active treatment who are children with medically complex conditions. While the SKMCAC suggested a minimum of 120 patients, HHSC expressed flexibility in Chapter 16.7 of the Uniform Managed Care Manual.

Managed Care Organization

An MCO must collaborate with its partnering health home including support for pilot site operations and reimbursement to the health home for care coordination provided to pilot participants. An MCO must work with the health home to identify opportunities for efficiencies such as reducing unnecessary duplication of services and facilitating administrative simplification for providers. To promote sustainability, if an MCO identifies cost savings attributed to pilot activities, funds saved must be reinvested into pilot site operations.

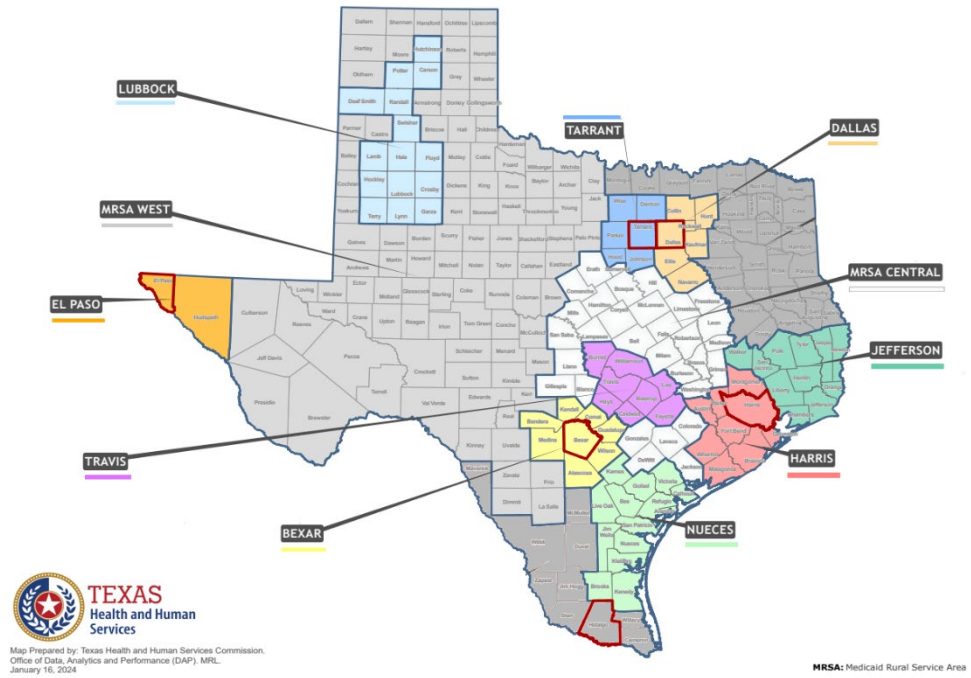
Chapter 16.7 of the Uniform Managed Care Manual also requires an MCO to report pilot site data to HHSC and ensure participants receive HHSC-developed experience surveys. These are discussed further in the Pilot Evaluation Design section of this report.

4. Pilot Implementation

In June and July 2022, HHSC posted announcements inviting health care providers and STAR Kids MCOs to participate in the voluntary CHIC Kids Pilot program by jointly developing projects to provide enhanced care coordination through health homes for children with medically complex conditions. HHSC required a description of how the partners would meet program goals and participation requirements but encouraged innovation by offering autonomy for partners' design of pilot projects given that pilot sites would not receive state funding. As echoed by the Center for Health Care Strategies, health home programs must have design flexibility because of "variation among health home providers, beneficiaries, and health system infrastructures and the unique needs of different patient subpopulations."

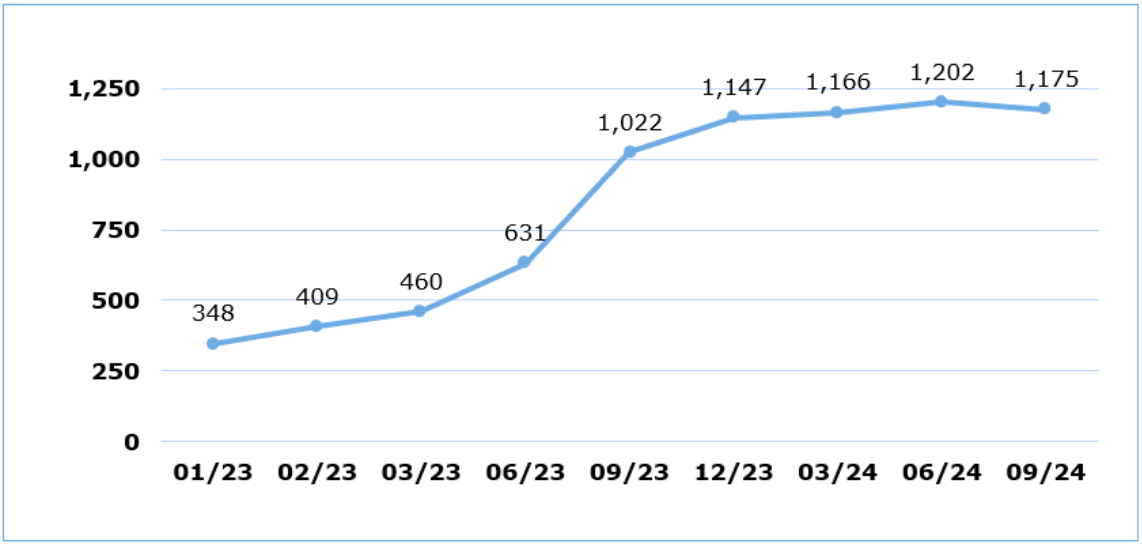
In August 2022, HHSC received 11 proposed pilot projects from eight different STAR Kids MCOs. Partnerships include nine health homes shown in Appendix A, Pilot Partnerships and MCO Service Delivery Areas (SDAs). HHSC formally launched the pilot program on December 1, 2022. However, several pilot sites needed more time to begin pilot operations. All sites were fully operational by July 1, 2023. Figure 1 shows the location of pilot sites within Texas' managed care SDAs. Out of 13 SDAs across the state, 11 SDAs have one or more pilot sites.

Figure 1. Map of Texas' managed care SDAs and pilot sites.



Member enrollment in the pilot program is ongoing. As of September 1, 2024, 1,175 STAR Kids members are participating in the pilot program. Figure 2 shows pilot participation growth over time.

Figure 2. Member participation in the CHIC Kids Pilot program.



Pilot Partnership Design

Partnerships

Of the 11 pilot plans submitted, nine pilot project plans met all participation requirements. Two pilot plans did not meet the health home requirements but were accepted as pilot case studies due to the pilot program being voluntary and pilot plans meeting the legislative intent of the pilot program to provide care coordination for children with medically complex conditions through a health home.

One case study is a partnership with a clinic that does not meet the minimum number of active patients with complex medical conditions because the clinic is not located in a major metropolitan area. However, this clinic is serving the greatest number of the partnering MCO's STAR Kids members. The second case study is a partnership with a home health agency. The agency does not meet the health home requirements characteristic of a clinic, which requires access to pediatric emergency services. However, the agency coordinates care for children with complex medical conditions and is thus an innovative approach to leveraging collaboration to enhance care coordination.

Six pilot sites were new partnerships initiated because of the pilot program opportunity. Five pilot site partnerships existed prior to implementation of the pilot program. For the pilot program, these sites enhanced existing operations through formalizing their partnership, increasing care coordination, or expanding the number of children receiving care coordination to include pilot program members.

Care Coordination Arrangements

HHSC identified three broad care coordination models being tested or enhanced through the pilot program: collaboration, integration, and delegation.

- Collaboration: Six partnerships focused on strengthening care coordination collaboration between the health home and MCO by implementing regularly scheduled meetings to discuss pilot participants or by the MCO providing resources to the health home to enhance care coordination.
- Integration: Three partnerships focused on care coordination integration through embedding an MCO service coordinator within the health home or through the MCO assigning a service coordinator to serve as a dedicated contact for the health home for pilot participants.
- Delegation: Two partnerships implemented full or partial delegation of MCO service coordination responsibilities to the health home. Delegation may include the pilot participant's service coordinator being an employee of the health home.

Financial Arrangements

Due to the pilot program being voluntary and no state funding allocated for implementation or operations, HHSC gave pilot sites flexibility to design their own payment arrangement between the health home and MCO as long as the health home was compensated for health home services provided to pilot participants. All pilot sites use a PMPM compensation arrangement, but pilot sites vary in payment add-ons to the base rate, such as compensation for additional reporting or better performance on quality measures.

Implementation Feedback

Since the pilot's launch on December 1, 2022, HHSC has solicited feedback from pilot health homes and MCOs through monthly meetings and regular status update requests. Pilot partners shared implementation challenges, as well as factors that helped expedite implementation.

Costs

MCOs and health homes were required to implement their pilot programs using existing resources, as no additional state funding was appropriated. Hiring qualified staff and updating health home and MCO data systems to document and report care coordination activities were among the most common implementation costs reported by the pilot sites. Health homes shared that APMs are necessary to capture staff time and resources required to provide individualized and comprehensive care coordination for a child with medically complex conditions and noted that Texas Medicaid covers only some care coordination procedure codes.

One-time costs included upgrades to internal systems to capture data for reporting, updating clinical workflows, cross-training staff, and purchasing equipment to enhance care coordination such as devices enabling telemedicine capabilities at the health home and telemonitoring equipment for participants. Ongoing costs include the PMPM reimbursement rate for health homes, health homes dedicating or hiring core team staff to serve pilot participants, MCOs hiring or assigning staff to be the health home's single point of contact, and staff time for pilot reporting.

Challenges

Pilot sites expressed a desire to have more lead time to implement and operationalize their pilot plans, especially after encountering unexpected barriers and delays in finalizing contracts and configuring data access for reporting.

Contracts

The most common reason for prolonged implementation was the extensive time for a health home and an MCO to execute a contract for pilot operations due to negotiations and legal team review. For both new partnerships and existing partnerships, development of an APM and determining a PMPM reimbursement rate required extensive time. For example, an existing partnership renegotiated the terms of its APM to account for additional care coordination activities for the pilot program.

Data Systems

Prior to the pilot program's launch, HHSC consulted health homes and MCOs on the measures and feasibility of reporting care coordination activities. However, once pilot sites were operational and began collecting data for submitting required reports to HHSC, health homes and MCOs shared administrative burden and difficulty with data collection. Aggregating care coordination activities conducted by

health home and MCO staff required manual review of health home records and MCO records for each participant. The respective data systems did not have automated search functions for care coordination activities that were not billed procedure codes.

Most health home and MCO data systems are not interoperable. Even if both subscribe to the same electronic health record (EHR) provider or are within the same organization, MCO access to health home records is subject to data privacy laws like the Health Insurance Portability and Accountability Act of 1996. Health homes and MCOs spent time and resources developing selective sharing permissions for EHR access or identifying other secure means for increased information sharing.

One pilot site stated the buildout of their data system required 2,000 hours of time between information technology, health home, and MCO staff. Several pilot sites stated they had to hire or reassign staff to collect and report care coordination data. Manual review of member records compounded by no state funding for staff time was reported as a major driver of dissatisfaction for both health homes and MCOs. Multiple sites noted they may have reconsidered participating in the pilot program if they had known the time and costs required for reporting.

Recruitment

Health homes and MCOs said identifying pilot-eligible members also required manual record review and member-by-member reconciliation. For example, health homes and MCOs use different patient identification numbers. Health homes' clinical records did not have a tie to MCOs' member management systems to automate identifying patients for whom the MCO determined a need for nursing care at home based on the results of the member's STAR Kids Screening and Assessment Instrument assessment or an MCO authorization for nursing care at home.

Given that the CHIC Kids Pilot program was new to MCO and health home staff, members, and families, pilot sites also had to create internal and external communication materials and train staff to educate members on the pilot program. This was particularly confusing for members who were already receiving care coordination services through a health home. Pilot sites noted that member education as well as obtaining participant consent to participate in the pilot program delayed enrolling participants in the program.

Factors Supporting Implementation

Despite the aforementioned challenges, pilot sites noted that existing infrastructure and partnerships contributed to accelerating implementation. Others appreciated the pilot program's flexibility for health homes and MCOs to customize their pilot site operations.

Health homes that were providing comprehensive care coordination prior to the pilot program were pre-positioned to meet pilot program goals and requirements. One health home noted they were "able to leverage existing workflows to launch the pilot quickly with minimal changes in clinician workflows, therefore focusing on reporting needs, including documenting differently in order to capture the data."

Pilot sites with an existing partnership between the health home and MCO also implemented pilot projects more quickly. Some existing partnerships continued operations while others expanded upon care coordination operations. Pilot partners within the same organization were able to implement pilots sooner even if contracts were needed between the health home and MCO.

Using the same EHR software supported data access and exchange between health home and MCO staff. One pilot site noted that the integrated network allowed their teams to customize the EHR software's functionality specifically for pilot operations and reporting.

5. Pilot Evaluation Design

HHSC's evaluation design was developed to assess three major elements of the pilot program's impact on care coordination for pilot participants: participants' access to care, outcomes, and experience. As echoed in the Health Resources and Services Administration's Blueprint for Change, these elements are foundational for improving systems of care for children with medically complex conditions.

To ensure evaluation measures are meaningful for children with medically complex conditions and their families, HHSC consulted the aforementioned STAR Kids stakeholders and health homes. HHSC also sought feedback from pilot sites to ensure feasibility of reporting. Additionally, HHSC leveraged other state and national resources in developing the evaluation, including:

- The ACE Kids Act;
- CMS' core set of children's health care quality measures;
- CMS' health home quality measures;
- Texas Medicaid quality measures;
- STAR Kids Screening and Assessment Instrument measures and caregiver experience of care measures; and
- National care coordination standards for children and youth with special health care needs from the National Academy for State Health Policy.

The evaluation leverages Medicaid utilization data, care coordination activity submitted by pilot sites, a member-level targeted review of managed care contract adherence, and surveys of participating families, health homes, and MCOs.

HHSC's family experience survey was modeled after a family engagement survey developed by Texas families, clinicians, and collaborators in the Collaborative Improvement and Innovation Network to Advance Care for Children with Medical Complexity. HHSC's survey measures changes in caregiver experience with care coordination before and after joining the pilot program. HHSC also designed surveys for health homes and MCOs to measure the pilot program's impact on operational efficiencies and administrative burden.

As noted previously, prolonged implementation among some pilot sites impacted HHSC's ability to collect and analyze necessary operational data to provide a complete evaluation for the submission of this report. HHSC will include a summary of the program's impact in the second installment of the report.

List of Acronyms

Acronym	Full Name
ACE	Advancing Care for Exceptional
APM	Alternative Payment Model
CHIC	Comprehensive Health Homes for Integrated Care
CMS	Centers for Medicare & Medicaid Services
EHR	Electronic Health Record
HHS	U.S. Department of Health and Human Services
HHSC	Texas Health & Human Services Commission
MCO	Managed Care Organization
PMPM	Per Member Per Month
SDA	Service Delivery Area
SKMCAC	STAR Kids Managed Care Advisory Committee
SKMCC	STAR Kids Managed Care Contract

Appendix A: Pilot Partnerships and MCO Service Delivery Areas

MCO (8 MCOs)	**Health Home** (9 unique providers)	**Service Delivery Area**
Aetna Better Health of Texas	Children's Health Complex Care Medical Services Clinic	Dallas, Tarrant
Aetna Better Health of Texas	Children's Health Medical Group Pediatric Clinic	Dallas, Tarrant
Blue Cross Blue Shield of Texas	Dell Children's Comprehensive Care Clinic	Travis
Community First Health Plan	University Medicine Associates	Bexar
Cook Children's Health Plan	Cook Children's Complex Care Clinic	Tarrant
Driscoll Health Plan*	Coastal Children's Clinic	Nueces
Texas Children's Health Plan	Texas Children's Hospital Complex Care Clinic	Harris, Jefferson
United Healthcare	UTHealth Complex Care Program	Harris, Jefferson
Wellpoint*	Angels of Care Pediatric Home Health	Dallas, El Paso, Harris, Lubbock, Medicaid Rural Service Area (MRSA) West
Wellpoint	Children's Health Complex Care Medical Services Clinic	Dallas
Wellpoint	UTHealth Complex Care Program	Harris

* Pilot case study