



**STAR Kids Advisory
Committee Report to
the Health and Human
Services Commission**

**As Directed by
HHSC Executive Commissioner**

STAR Kids Advisory Committee

January 2019

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Disclaimer

This report was not authored by and does not reflect the views and opinions of the Texas Health and Human Services system, its component agencies, or staff.

Executive Summary

The STAR Kids Managed Care Advisory Committee was established by Senate Bill 7, 83rd Texas Legislature, Regular Session, 2013 and in compliance with Texas Government Code Section 533.00254 to advise the Texas Health and Human Services Commission (HHSC) on the establishment and implementation of the STAR Kids managed care program.

Members of the committee include a variety of stakeholders including families of children with disabilities receiving services under STAR Kids, physicians, home health providers, managed care organizations (MCO), school personnel and organizations representing children with disabilities. The diversity of the committee lends a unique perspective on how the program is functioning across Texas and generates ideas and recommendations for improvements. The committee has been a critical partner to HHSC and has identified and advised HHSC on issues that have led to policy changes and improvements to the program. For a full roster of representatives, please see Attachment A.

The committee established three subcommittees each tasked with developing the recommendations contained in this report. All of the recommendations are aimed at improving the program for children and families.

Subcommittee 1: Health Homes and Quality Measures

Subcommittee 2: Screening and Assessment Instrument (SK-SAI), Prior Authorizations, Medically Dependent Children Program (MDCP), and Intellectual and Developmental Disabilities (IDD) Waivers

Subcommittee 3: Transition from Pediatric System to Adult System

Introduction

The STAR Kids Managed Care Advisory Committee was originally set to expire December 2017, one-year post STAR Kids implementation, however under the authority granted the HHSC Executive Commissioner by Texas Government Code Section 531.012, the committee was extended until December 31, 2019.

HHSC directed the committee to provide a formal report with recommendations for improving the program. HHSC sought advice and recommendations on:

1. The optimization of the STAR Kids Screening and Assessment Instrument;
2. Options for enhancing service coordination requirements and delivery including the development of health homes;
3. Development of quality measures appropriate to the STAR Kids population;
4. The development of sound transition processes for children aging out of STAR Kids and entering adult provider networks;
5. The development of a plan for inclusion of other long-term services and supports waivers into STAR Kids; and
6. Other recommendations the committee deemed necessary to the overall improvement of the program.

The committee broke into three subcommittees to develop the recommendations which are detailed in this report.

Background

Senate Bill 7, 83rd Texas Legislature, Regular Session, 2013 directed HHSC to establish a mandatory STAR Kids capitated managed care program tailored to provide Medicaid benefits to children with disabilities. Texas Government Code 533.00253 required that the STAR Kids managed care program must:

1. provide Medicaid benefits that are customized to meet the health care needs of recipients under the program through a defined system of care;
2. better coordinate care of recipients under the program;
3. improve the health outcomes of recipients;
4. improve recipients' access to health care services;
5. achieve cost containment and cost efficiency;
6. reduce the administrative complexity of delivering Medicaid benefits;
7. reduce the incidence of unnecessary institutionalizations and potentially preventable events by ensuring the availability of appropriate services and care management;
8. require a health home; and
9. coordinate and collaborate with long-term care service providers and long-term services and supports outside of the managed care organization.

When HHSC crafted the original STAR Kids Request for Proposal, with input from a variety of stakeholders, they envisioned a person-based approach to holistically address the needs of persons and required care utilizing a Medical Health home model. The program required a Standardized Assessment Instrument (SK-SAI) to be performed annually with an Individual Service Plan (ISP) to guide the care planning and implementation process. Personalized Service Coordinators were required to serve as a single point of contact for the family and they were required to be allocated a case load at ratios commensurate with the level of complexity of the children. For some children with complex medical and behavioral support needs, the model has not worked as originally envisioned and families and providers are struggling.

STAR Kids was implemented throughout the state on November 1, 2016 and serves approximately 162,000 Medicaid eligible children across Texas age 20 or younger

who due to their disability receive Supplemental Security Income, are enrolled in a Medicaid Home and Community-Based waiver, or who have a disability and qualify for Medicaid due to Medicaid Buy-In or an Adoption Subsidy. The children in the program represent a diverse and heterogeneous group of children, some are medically fragile, some have an intellectual or developmental disability, and some have a significant mental health condition.

Currently HHSC contracts with 10 MCOs for the delivery of STAR Kids Medicaid services. The state is divided into 13 managed care service delivery areas (SDA). Eleven SDAs have 2 managed care organizations while 2 of the larger SDAs have 3.

Recommendations

Subcommittee on Health Homes and Quality Measures

The ideal model of service delivery for children with complex healthcare needs is one where the Primary Care Provider(PCP) and parents engage in a person-centered process of goal setting and shared decision making to allow appropriate allocation of resources and services. To achieve this in this population, we need to encourage close collaboration and integration of processes between providers, parents and MCOs. This was specifically stated as a desired goal by HHSC when STAR Kids was being designed and is the goal of this subcommittee's recommendations. We have reviewed the literature on examples of similar approaches to innovation and have included it in Appendix B.

1.1 Topic/Issue: Problems related to heterogeneity of STAR Kids population and the need to define population sub-groups

Background: The STAR Kids program includes approximately 162,000 children with special healthcare needs including children who are medically fragile, children with IDD and children who have mental health conditions. Thus, it includes a heterogeneous population of children with varying degrees of complexity and need which likely require different approaches to care. To develop viable improvements and recommendations, the subcommittee on Health Homes and Quality Measures, identified two distinct sub-populations within the total STAR Kids population.

The *first*, is the subpopulation that is most medically complex and fragile. This population includes most of the children covered by the MDCP program as well as children who are medically complex and receiving Medicaid Private Duty Nursing (PDN).

Within the broad population of children served under the STAR kids program, a smaller number of children are defined as children with medical complexity (CMC). A 2016 clinical report by the AAP characterizes CMC as children who

have “multiple significant health problems that affect multiple organ systems and result in functional limitations, high health care need or utilization, and often the need for or use of medical technology”

For this report, CMC refers to members of the STAR Kids cohort that are currently receiving MDCP benefits and/or receive PDN services in the home. This definition narrows the discussion to a relatively homogeneous cohort - defined by extreme medical fragility, technology dependence and significant functional impairment. HHSC uses a leveling system to stratify which children receive a higher level or must have access to more robust service coordination based on complexity. The criteria for service coordinator leveling in STAR Kids are not consistent but we believe, all of CMC are defined under the Level I service coordinator stratification; i.e. most complex.

The *second* sub-population are children with complex behavioral health conditions which might include some children with IDD/ Autism Spectrum Disorders (ASD) and children with a serious and persistent mental illness. The subcommittee did not have enough information on the number of children under this category. However, they constitute a subgroup with needs that are qualitatively different from the children who are medically fragile.

The subcommittee members realize that these two subgroups constitute a small fraction of the total STAR Kids population and today are children who are largely grouped in the Level 1 service coordination category. Data from HHSC (Table I) indicates about 15,000 children (or approximately 10% of the STAR Kids population stratify to Level 1 and only a fraction of those children meet the definition of children in subgroups 1 and 2 above.

Based on testimony from parents and providers, these two subgroups seem to have had the most challenges during the STAR Kids implementation.

Recommendations: We recommend a standardized sub-stratification for two of the most affected populations within STAR Kids. This will allow for more homogeneous care pathways; outcome tracking and potentially value-based contracting. These sub level I subgroups should be:

- i. A medically fragile subgroup of children on MDCP and/or children who have PDN.
- ii. A behaviorally complex subgroup of children with IDD/Behavioral disorders/Autism Spectrum Disorders (ASD) or serious and persistent mental illness with complex and significant need for behavioral health services.

1.2 Issue/Topic: Problems related to an unsustainable increase in administrative paperwork and administrative costs to providers

Background: The process of delivering care as it exists is fraught with redundant assessments and evaluations by different entities; repeated requests for justification of care and letters of medical necessity and several hours a week of parent and provider time spent complying with these paperwork requirements.

PCPs have experienced an overwhelming increase in paperwork- dealing with multiple MCOs processes for prior authorization. In addition, many of the MCO's have subcontracted their prior authorization process to multiple outside entities such as pharmacy benefit managers, behavioral health etc. which has led to a frustrating situation to providers. PCPs sometimes must do peer-to-peer consultations with three separate MCO medical directors, many of whom do not have any specific expertise with this population.

Recommendations: We recommend HHSC encourage and facilitate simplification of administrative paperwork as it relates both from provider to MCO as well as MCO to HHSC. For example:

- i. Identify children where certain services and supplies will be needed for the duration of the child's life through the SK-SAI. There should be a provision to auto-renew orders for incontinence supplies; supplies for enteral nutrition etc. without requirement for frequent paperwork and letters of medical necessity. Similarly, for a child with progressive condition with tracheostomy/ventilator – if stable, and the clinical condition deemed unlikely to change within the next year, waive the requirement to submit the nursing plan of care every 60-90 days and space out the intervals.
- ii. HHSC, MCOs and Providers should review and revise prior authorization requirements for appropriateness for this population.

Example: An MCO requires a hearing test and developmental screens before authorizing for speech therapy. This may be a reasonable requirement for the typical STAR population but for children who already have a diagnosis of moderate to severe cognitive impairment the screening is unnecessary.

- iii. HHSC should require MCOs to engage provider groups in value-based arrangements where trusted providers will have their orders (for labs, imaging and hospitalization) fast tracked without the need for extra justification provided there are periodic audits to keep each party accountable.

1.3 *Issue/Topic: Problems related to poor operational relationship between MCOs and providers*

Background: Although HHSC made great effort to include input from all the stakeholders during the planning of this project, the initial roll out and implementation of STAR Kids was a process that focused on the basic operational aspects of the transition to managed care such as contracting, network adequacy, and billing and cost containment. Conversations with MCOs and PCPs, specialist groups, hospitals, and other service providers typically were around contracting and cost containment and rarely involved collaborative efforts to co-manage and improve care for families.

It is understood that improvement in care occurs largely at the level of front line providers, especially the PCP, specialists, therapists and home health providers. However, much of the responsibility for ensuring service coordination and case management in STAR Kids was exclusively given to the MCO with very little guidance on how the MCO can delegate and streamline care coordination with clinics, hospitals and other provider entities.

Care delivery for this population at PCP offices, specialist practices and children's hospitals was badly in need of a process overhaul even before the STAR Kids roll out - a move from encounter-based care to a system that enables the PCP to be a partner in care plan development and shared decision making. The roll out process was a missed opportunity for improvement. MCOs had no template on how to engage with PCPs and specialists outside traditional contracting for in network services. There was

no direction or facilitation from HHSC on how to incentivize provider-MCO process integration.

In communities where there are enhanced health homes – dedicated to the medically fragile children as defined as subgroup 1 of our first recommendation, (Austin, San Antonio, Dallas, Houston), the opportunities for better integration of care coordination services with the MCO have not been adequately explored, utilized and incentivized. These clinics have a longitudinal relationship with the families and provide care coordination, social services and are well networked with the local specialist panels and children’s hospitals. However, there is no template on how to fold this existing resource into a viable center of excellence. These centers could serve as bright spots for evidence generation on best practices. Absent any template for collaboration and no direction or incentivization from the state, leaders of most of these clinics spend a lot of time and energy trying to craft contracts with multiple MCOs. Reimbursement from MCOs for services in these centers covers only a small fraction of the center’s budget. As most are supported by a combination of grants and subsidies, their financial viability is tenuous and will likely jeopardize care for hundreds of members.

Recommendations:

- i. Incentivize value-based payment arrangements that are designed to address the special effort required to meaningfully develop comprehensive person-centered care plans and adequately reimburses providers for non-encounter-based processes that lead to better outcomes.
- ii. Incentivize MCOs to create fast tracking processes for trusted provider groups to certain service coordination and case management functions. Specifically, this may involve embedding service coordinators in health homes or delegating service coordination to health homes with adequate capacity.
- iii. Pay providers a higher rate for these two subgroups of individuals. Some mechanisms for this payment may involve -designating consult level billing or an extra payment category for preparing and producing a detailed care plan. Care Plan preparation and discussion is largely a non-reimbursed service currently even though it takes more than two hours of time; a large part of it may not be a face-to-face encounter.

1.4 Issue/Topic: Limited pool of qualified direct service workforce

Background: PCPs who have longitudinal relationships with families caring for these children recognize that health care outcomes are largely dependent on having quality home care services. Unfortunately, there is very little effort to improve the pool of qualified direct service workers. The two options offered to families are – Medicaid PDN which is expensive and increasingly limited or attendant care – which, while cheaper is difficult to access as there are very few qualified individuals willing to work for such low pay. PCPs and health homes can engage families in conversations about the most appropriate home health services, but this is not possible because the appropriate workforce is not available in most communities.

The current Medicaid system does not fully support nurse delegation. The rate paid to direct service providers through Medicaid Personal Care Services (PCS) is low, which results in high turnover and reluctance on the part of nurses to delegate. Families are reluctant to use nurse delegation because of their child's medical fragility and because attendants are hard to find, and turnover is very high. More training needs to be provided to families, providers and members on nurse delegation and what is safe and appropriate. Also, home health agencies and nurses need a rate and mechanism that supports the training of unlicensed attendants. Transition from PDN to delegated attendant services will result in overall cost savings to the state.

The problem of access to qualified attendant care services is perhaps most acutely felt by families raising children with IDD and ASD. There are many examples of families of children with behavioral health challenges who find themselves in public places and schools without adequate attendant support – where aggression and destructive behavior leads to involvement of law enforcement and a requirement for hospitalization. Families resort to limiting their activities in the community for fear of behavioral escalation in an environment where they have little support. Given the absence of adequate inpatient facilities around the states, these children often languish in emergency departments for several days. The lack of a pool of well trained,

professionalized Direct Service Workforce has led to unnecessary medicalization of care and is likely to drive up costs much higher.

For children with significant behavioral health challenges (IDD; ASD), there was a lot of expectation that staffing by habilitation specialists through Community First Choice (CFC) would greatly decrease the burden of care to parents and minimize episodes of crisis that lead to hospitalization and institutionalization. Unfortunately, the process of accessing CFC is very complex and involves layers of authorization by separate entities with redundant assessments. Even when families overcome the process and qualify for CFC, the rates are so low that they are unable to find qualified individuals.

Recommendations: We recommend HHSC closely evaluate and streamline the Direct Service Workforce for both subgroups to improve the pool of individuals available to provide home care. This would include:

- i. Simplifying the process to access services – (Parents are unable to adequately evaluate the individuals who can work with their children because there is no database that has the profile of individuals working through the different staffing agencies. HHSC should facilitate/incentivize the creation of such a resource by community organizations such as Texas Parent to Parent – (similar to Angie’s list but for direct service providers for children with complexity)
- ii. Incentivizing development of specifically trained attendants to care for children who have medically complex conditions or who have behaviorally complex support needs by allowing for increased payment for individuals with more skills and certifications as well as increased administrative payments to home health agencies;
- iii. Allowing supervised delegation of nursing; parents as CNAs (similar to existing models in Colorado) etc.
- iv. Increasing base payments for attendants/habilitation specialists.

1.5 Issue/ Topic: Measuring outcomes that matter

Background: The federal government mandates that State Medicaid Managed Care Programs be regularly evaluated by an External Quality Review Organization (EQRO). We appreciate the effort by HHSC and EQRO to come up with a set of outcome measures to track and assess the

implementation of STAR Kids. Given the challenges in data collection, many of the measures rely on administrative and claims data and are focused on process measures derived from a universe of validated measures used in other populations.

Texas is unique among states in mandating a standardized comprehensive assessment of the health status of all children served under this program. The STAR Kids Screening and Assessment Instrument (SK-SAI) offers an opportunity for longitudinal tracking and the development of robust measures of the health status of children and families.

Recommendations:

- i. We recommend inclusion of measures that are more focused on Outcomes than Process. The National Core Indicators (NCI) that are based on Child Family Surveys of households with developmental disabilities is a good resource.
- ii. We recommend HHSC promote evidence generation as to the best approach to service delivery by sponsoring and incentivizing statewide and national pilot projects to identify best practices. Some examples of such opportunities include are listed in Appendix B. 2. The state should use existing complex care programs and transition programs in large urban centers as laboratories for innovation and experimentation to test best practices and build an evidence base.
- iii. We recommend HHSC investigate and sponsor pilots where the patient centered medical home is a community integrated “Behavioral Health Home” to bring together social services and behavioral health. This may require a collaboration with MCOs, local mental health authorities and health homes. These health homes can utilize telemedicine to access psychiatric med management; utilize evidence-based family supports such as the Family Partner program by the National Alliance for Mental Illness (NAMI). Lessons from the two-year demonstration project for ‘Certified Community Behavioral Health Clinics (CCBHC) can serve as a model around which to organize the pilot.
- iv. We understand HHSC is working with the EQRO on this issue. We recommend that input from different expert groups and stakeholder groups such as Texas Pediatric Society, Texas Medical Association, STAR Kids Advisory Committee members, Disability Rights Texas, Value Institute at Dell Medical School and other state and National entities be included to come up with a set of measures that truly measure outcomes and allow true benchmarking of quality services.

Subcommittee on SK-SAI, Prior Authorizations, MDCP and IDD Waivers

The Texas Health and Human Services Commission contracted with Texas A&M University (TAMU) for a screening and assessment instrument to be used in STAR Kids. The assessment was never piloted and was tested on a very limited group of children prior to its use. The instrument was originally intended to be tested on 500 children who receive services through the Medically Dependent Children's Program (MDCP) waiver, however was ultimately tested on only about 300 children. Other children including children with Intellectual and Developmental Disabilities and mental health conditions were not included in the limited testing of the tool.

The instrument is divided into modules. All children must receive the core module. If triggered by the core, children are then assessed using one or more of the remaining modules; Personal Care Assessment Module (PCAM), Nursing Care Assessment Module (NCAM) and MDCP Module. The SK-SAI is intended to assess for eligibility for PCS, CFC for children who meet medical necessity for nursing facilities, PDN and the MDCP waiver. The assessment is also intended to serve as a trigger for referrals for additional services such as therapy, durable medical equipment (DME) and supplies, CFC for children with IDD or children with mental health conditions, IDD waiver services, and other mental health services.

The STAR Kids Advisory Committee has offered the state feedback on the tool throughout its development, testing and implementation. Feedback on the tool has resulted in some limited changes to the tool, increased training to managed care organizations and greater access to the tool by families. The committee is concerned that the tool has not resulted in a more coordinated, streamlined, comprehensive system of care for children. We are committed to working with HHSC on improvements to the process and offer the following recommendations regarding the SK-SAI.

2.1 *Topic/Issue: SK-SAI and loss of MDCP waiver eligibility*

Background: Since the inception of STAR Kids on November 1, 2016, the number of children on the MDCP waiver who were reassessed using the new SK-SAI and lost waiver eligibility increased from 3.1% in 2016 to 14.3% in 2017 and 8.3% in 2018. Many of these children are children who have been on the waiver for years and have not experienced a change in condition. With the loss of eligibility children are not only losing access to MDCP waiver services but are losing access to critical long-term services and supports and for some access to their health insurance; Medicaid.

Children who receive services under the MDCP waiver are required to meet the same medical necessity eligibility as children seeking admission to a nursing facility, adults seeking admission to a nursing facility, or adults seeking services under the STAR +Plus waiver. Prior to the implementation of STAR Kids, children in MDCP were assessed initially and reassessed annually using the Medical Necessity Level of Care (MN-LOC) tool. This is the same tool used for individuals over 21 years of age in the STAR + Plus nursing facility waiver. The MN-LOC tool was similar to the Minimum Data Set tool used to determine eligibility for adults and children in Texas nursing facilities. The new SK-SAI is a departure from the MN-LOC. The SK-SAI MDCP module only results in a determination of the MDCP budget based on the Resource Utilization Group. It does not determine nursing facility medical necessity. That determination is made using a variety of fields in other SK-SAI modules and is subject to interpretation by the state's third-party contractor. In addition, the nurse assessors with the MCOs who are completing the assessment are not allowed to do a physical nursing assessment of the child and are only going by information provided to them by the child's family or what is available through medical records.

Recommendations:

- i. Due to the significant number of MDCP denials at the annual reassessment, HHSC should revert to the MN-LOC tool to determine MDCP eligibility as opposed to the SK-SAI. This may require a statutory change by the legislature and may only be needed temporarily while the instrument is refined and optimized.

- ii. The MDCP eligibility tool should be administered by an assessor who can complete a hands-on nursing assessment, not the MCO nurse assessor who is prohibited from doing a thorough nursing assessment.
- iii. All MDCP assessments, including reassessments and change in status/need, should be completed by a team of two, including a registered nurse.
- iv. Children who were assessed using the new SK-SAI and who lost MDCP eligibility should be reassessed using the MN-LOC and if found eligible should be offered access to the waiver.
- v. Offer children who have lost eligibility for Medicaid due to loss of Medically Dependent Children Program eligibility in STAR Kids, access to another 1915(c) waiver such as Community Living Assistance and Support Services (CLASS) or Home and Community-based Services (HCS). This may require legislative approval.
- vi. Allow children who have experienced a long-term hospital stay to be assessed for MDCP in the hospital prior to being discharged home.
- vii. Because the MDCP waiver waives off both a hospital level of care and/or a nursing facility level of care, allow a child who meets the medical fragility eligibility for MDCP access to the waiver without a limited stay in a nursing facility. A child should not be discharged from a hospital setting to a nursing facility for a short stay and then to home. This is not good for the child's health and safety and leads to increased costs and administrative burdens.

2.2 Topic/Issue: SK SAI Assessor and Tool Improvements

Background: HHSC has embarked on an internal review of the SK-SAI for optimization and improvement. The STAR Kids Advisory Committee along with the Star Kids Work Group would like to assist HHSC to improve the assessment process to ensure the process results in meaningful services and supports for children who are medically fragile, children with intellectual and developmental disabilities, children with mental health conditions and children with other disabling conditions. Each child should have an ISP that is a living breathing document that changes as the child's needs and circumstances change.

Recommendations:

- i. MCO nurse assessors are prohibited from completing a hands-on thorough nursing assessment, therefore the SK-SAI nursing module

- for children who need nursing services should be completed by an independent third-party, i.e. a medical home practice or clinic.
- ii. HHSC should closely monitor whether the triggers in the SK-SAI that are intended to result in referrals for services such as CFC for children with IDD or children with MH are resulting in referrals and receipt of services. Liquidated damages should be assessed for needed long-term services and supports needed but not identified or delivered.
 - iii. SK-SAI should be allowed to be completed in a hospital setting for children who need coordinated care in the home following a significant inpatient hospitalization to ensure services and supports are in place when a child transitions home.
 - iv. If a child scores between two levels of need on discrete questions in the SK SAI, the assessor should default to the higher level of need. This needs to be clearly outlined in the training and instructions. HHSC must provide additional guidance and training.
 - v. The SK-SAI should account for medical intervention as a contributor to how one answers the question. For example, is he in pain, no "because of medical intervention?" The same could be said for being "stable," due to medical intervention. The intervention must be accounted for because without it the child's condition could deteriorate.
 - vi. Parents and guardians should review the completed SK-SAI for accuracy before it is submitted to the state and should be able to disagree with the assessment answers prior to submission.
 - vii. The current lookback period in the tool is typically 7 to 10 days. This is not sufficiently long enough to account for the nature of many intermittent, chronic, or unstable pediatric conditions.
 - viii. HHSC's SK-SAI internal optimization group should be expanded to include external stakeholders, not just as reviewers of a new tool after the fact, but as contributors to the development of tool improvements.

2.3 Topic/Issue: SK SAI and Improved Communication and Transparency for Families

Background: Families must be the drivers of their children's health. For families to be actively involved and to ensure children achieve optimal outcomes, there must be clear, ongoing communication between the Star Kids MCOs and the families.

Recommendations:

- i. HHSC should require all MCOs to provide the following individualized training to families on how to access the health portal to:
 - a. View the SK-SAI
 - b. Review the Individual Service Plan (ISP)
 - c. Track authorizations, view claims and find information on the child's MDCP budget, and pending and final denials and reductions
 - d. Request an internal appeal
- ii. HHSC should require the MCOs to notify individuals via a text, email or call when a document has been uploaded to the member portal.
- iii. HHSC should develop a document that can be sent from the MCO to the family 120 days prior to the annual assessment informing them:
 - a. What to expect at the assessment
 - b. What documents to have ready

2.4 Topic/Issue: Clearer, Simpler and More Streamlined Authorization Process

Background: Certainty and clarity in the STAR Kids prior authorization process would not only benefit children and families but would ease administrative burdens currently experienced by physicians and other providers. Families and providers are working with multiple managed care organizations, each with their own set of authorization requirements and review processes, some of which are onerous and cause delays in authorization for needed services. Physicians, therapists, home health agencies, DME companies and others have reported an increase of up to 25% in their administrative costs due to paperwork requirements. DME companies have also reported a decrease in payment rates made by MCOs at 70% of the established Medicaid fee schedule, and a significant number of small providers closing their doors. In 2014 there were nine pediatric DME companies in the Texas Panhandle. In January 2019 there were only three, representing a 67% decline in the number of available providers.

Recommendations: The subcommittee on health homes and quality measures included some recommendations in 1.2 that go hand in hand with the following recommendations related to a more streamlined prior

authorization process for PDN, therapies, DME, PCS and other services and procedures.

- i. Decrease administrative burdens, prevent gaps in services and delays in authorizations, and ensure children have access to medically needed services without discrimination and inconsistencies across plans through the use of simpler, standardized forms and processes across MCOs.
 - a. Allow mid-level signatures on authorization requests.
 - b. Do not require redundant letters of medical necessity be attached to every request when the condition or need has not changed.
- ii. Increase authorization time frames for children with chronic conditions, which are not likely to change and decrease the frequency at which requests for authorizations must be made.
- iii. Ensure continuation of prior authorization of nursing services and other services when a child and family are pending a fair hearing and do not allow a plan to end the authorization before the case has been heard.

2.5 Topic/Issue: Medical Necessity and Treating Physician

Background: Families and physicians in STAR Kids have voiced their concern about medical necessity determinations being made by the MCOs that are contrary to the determinations made by the child's physician. Children are experiencing a reduction in authorizations for PDN, MDCP waiver eligibility, therapies and other procedures. HHSC has a definition of medical necessity and when there is a dispute, the determination and standard of medical necessity should default to the child's physician.

All MCOs allow for a peer-to-peer (medical director to child's physician) review when a treatment request is being disputed. Some MCOs have also established a process for reconsideration between evaluating therapists and MCO therapists. This process of peer-to-peer discussion among physicians, nurses, therapists, etc., provides for much better communication as both parties typically understand the nature of what is being requested and the appropriateness of the treatment as it relates to the child's condition.

Recommendations:

- i. Defer to the treating professional when determining medical necessity.

- ii. Prior to the issuance of a denial, require MCOs to allow for a process for reconsideration that also includes peer-to-peer review by physicians, therapists, nurses, etc.

2.6 Topic/Issue: Preferred Provider

Recommendations: HHSC should clearly define requirements on how preferred provider arrangements may be utilized ensuring:

- i. Members are given a choice of at least two, preferably at least three, providers for specialty services and DME, including non-preferred provider arranged services.
- ii. Members have the right to choose the best services or equipment that meet their medical necessity, regardless of provider arrangement with the MCOs.
- iii. MCOs submit all preferred provider arrangement contracts to HHSC for review and approval.
- iv. MCO call center staff inform members of non-preferred providers along with preferred providers available in the network, to enable members to choose the most appropriate services, providers and equipment

2.7 Topic/Issue: Notices of denials of services lack clarity and families need adequate notice of right to appeal

Background: Families and providers are reporting issues with timeliness and clarity in Medicaid appeal notices. For services to continue during the appeal process, an individual must request the appeal within 10 days from the date of the action notification letter. By the time the families receive the letter some of the 10 days have passed, leaving the family with a very small window of time for the actual filing of the appeal. In some cases, families have received notices well past the 10-day time frame. Notices sent using pre-paid postage do not contain a postmark date thereby leaving no documentation of when the notice was mailed.

It is imperative that the reasons cited in the appeal notice must be clear and written in plain language that is easily understood by families.

Recommendations:

- i. Provide families timely notice of their right to seek an internal MCO appeal and a Medicaid fair hearing when Medicaid services, including waiver services, nursing, PCS and therapy are reduced or denied.
- ii. Require MCOs send notifications for a denial or reduction in service within one day of the date on the notification.
- iii. Require the notice to be delivered via registered mail to ensure the time frame is followed.
- iv. MCOs who do not provide sufficient notice of denial and infringe on the family's ability to request continuation of services should be subject to liquidated damages.
- v. Ensure notices sent by HHSC and MCOs are written in plain language for families with detail on why the denial occurred, what is needed to meet medical necessity requirements, deadlines for the appeal, and information on maintaining the same level of service during the internal MCO appeal and Medicaid fair hearing process until a final determination is made.
- vi. Improve and coordinate MCO informal appeals and HHSC fair hearings, including consumer information that explains and assists with both processes and meets all state and federal due process requirements, such as proper notices and packets with complete and relevant information used to deny, suspend, or reduce services.

2.8 Topic/Issue: Transparency and timely response to member and provider complaints

Recommendations: Increase transparency and respond quickly, accurately and completely to issues generated through inquiries, complaints, conducting investigations, inspections and other contract compliance regulatory actions.

- i. Consolidate and streamline the complaints process and increase public awareness and outreach to MCO members about where to go for help and how to make a complaint.
- ii. Require state agencies and MCOs to track all instances of access to care issues as a complaint.
- iii. Require Ombudsman and Consumer Rights Services to keep individuals informed of agency action and findings about complaints regarding programs and services and elevate systemic issues with recommendations for improvement to HHSC leadership and the legislature.

- iv. Improve data integration and transparency to include information across systems relating to inquiries, complaints, informal MCO appeals, and Medicaid Fair Hearings that is publicly available.
- v. HHSC should continue the monthly in-person STAR Kids Work Group to provide ongoing communication among providers, MCOs, families, HHSC and other stakeholders to address questions, issues and opportunities for improvement.

2.9 Topic/Issue: Opt-Out Provision for Children in MDCP and Children with Private Insurance

Background: Two very small populations of children who have experienced issues in STAR Kids are children who are enrolled in the MDCP waiver and children who have third-party insurance. Families have reported a loss of providers, delays in authorizations, denials of service, inability to see physicians and specialists in other service delivery areas, and issues with the coordination of benefits with third-party insurers.

Recommendations:

- i. Provide an opt-out mechanism for STAR Kids members who have MDCP and STAR Kids members with third-party insurance rather than mandatory enrollment. Create an alternative MDCP fee for service (FSS) option and/or transition to a different waiver program such as HCS, CLASS or DBMD.
- ii. Consistent with 42 C.F.R. 438.56 (d) (2), facilitate information about and assistance with disenrollment of managed care members experiencing access to and quality of care barriers impacting health, safety and quality of life.

2.10 Topic/Issue: Immediate Access to MDCP Waiver Level Service with No Wait

Background: MDCP services, which can help prevent institutionalization, include: respite, minor home modifications, adaptive aids, flexible family supports, financial management, transition assistance services, supported employment, and employment assistance. The MDCP waiver provides a cost-effective alternative to the institutionalization of children. The individual cost of services is capped at less than 50% of what is paid to a nursing facility.

As of May 2018, 16,840 children and young adults were waiting for the MDCP waiver. The wait for services is approximately five years. With the change in service delivery model for MDCP to the STAR Kids Medicaid Managed Care model, Texas has not changed the number of appropriated "slots" for the waiver. As such, entry to the waiver and access to waiver services is still managed by an interest list. Unlike STAR+PLUS waiver, children and young adults who have SSI and meet MDCP eligibility criteria may not access waiver services until they come to the top of the interest list.

The average percent of children who are determined eligible for MDCP when they reach the top of the interest list was approximately 10.4% the previous biennium and according to HHSC's Chief Financial Officer, the uptake rate for MDCP is estimated at 15%. Eligibility is determined when the child gets to the top of the list and not when their name is added. With a take up rate of 15% only 2,526 of the 16,840 children will be deemed eligible when they get to the top of the list. Approximately 1,170 of the 2,526 who would be eligible for the waiver and take the waiver if offered, have SSI.

The policy of allowing adults who have SSI and meet medical necessity having automatic access to waiver services in STAR + Plus has received overwhelming support. Approximately 99.6% of individuals without SSI who are waiting for STAR + Plus waiver services have been on the interest list for less than one year. If the state decided to implement the same policy that has been successfully implemented for the adult STAR+ Plus SSI waiver population, the MDCP interest list would decrease by more than 48% which is the percentage of children on the interest list who have SSI.

Recommendations:

- i. Allow children enrolled in STAR Kids who have SSI and meet the MDCP waiver eligibility immediate access to waiver services with no wait.
 - a. Create a similar allowance for children in STAR Health.
 - b. Maintain at least a current level of effort to offer children on the interest list who do not have SSI waivers.

2.11 Topic/Issue: Inclusion of IDD Waivers into STAR Kids

Background: The IDD System Redesign Advisory Committee created as part of SB7 by the 83rd Legislature is charged with advising HHSC on the implementation of acute care and long-term services and supports for individuals with IDD. The committee strongly recommended that HHSC delay the transition of IDD LTSS to a managed care model until necessary systems changes are accomplished. The committee requested HHSC evaluate the lessons learned from the STAR Kids IDD acute care carve-in and use those lessons to improve the system before any additional waivers are carved into Medicaid managed care.

Recommendations:

- i. Delay inclusion of all additional IDD waivers such as Texas Home Living, Home and Community-Based Services (HCS), Community Living Assistance and Support Services (CLASS), and Deaf Blind Multiple Disabilities (DBMD) into STAR Kids unless and until related evaluations and the IDD assessment pilot are completed, and access to and quality of care are resolved in current managed care programs and operational systems and providers are in place for a successful transition.

Subcommittee on Transition from Pediatric System to Adult System

According to the American Academy of Pediatrics (2002) consensus statement on health care transitions for young adults with special health care needs, "optimal health care is achieved when each person, at every age, receives medically and developmentally appropriate care. The goal of a planned health care transition is to maximize lifelong functioning and well-being for all youth, including those who have special health care needs and those who do not. This process includes ensuring that high-quality, developmentally appropriate health care services are available in an uninterrupted manner as the person moves from adolescence to adulthood." (See http://pediatrics.aappublications.org/content/pediatrics/110/Supplement_3/1304.full.pdf)

3.1 Topic/Issue: There are no codes for Medicaid providers to offer co-consult visits of STAR Kids members transitioning from pediatric to adult care providers.

Background: The medical complexity of our STAR Kids population necessitates a formal transition from pediatric to adult provider care. There are no procedure codes available to offer families and providers the chance to arrange for formal office visits to come together as a transition team of medical support.

Recommendations:

- i. Create a billable code to allow pediatric and adult care providers to bill for a collaborative office visit to review and discuss transition of care. An allowable offering of 1-3 visits is recommended to cover the medical complexity of the condition and history of our STAR Kids members.

3.2 Topic/Issue: Lack of Medicaid providers offering services to special needs transition age population (18-21 years of age).

Background: The geographic size and rural composition of much of Texas has created barriers for some children transitioning from pediatric to adult physicians. Rural areas often lack physician availability to accept complex medical cases while those who do often have lengthy new patient wait times. These barriers have negatively impacted the member's ability to receive care timely, make adult provider selections and have a seamless transition to adult services.

Recommendations:

- i. Develop an innovative provider Pay-for-Performance incentive program to increase the number of participating physician's offering services to special needs transition age population in the geographic areas of concern.
- ii. HHSC should require MCO's to have an addendum available specific to network provider listings for open panel transition age patients. This addendum can be present on the MCO's website for ease of transition planning.

3.3 Topic/Issue: Limited time to coordinate services with STAR Plus plans when a non- MDCP, PDN or Prescribed Pediatric Extended Care Center (PPECC) member ages out of STAR KIDS at age 21.

Background: Currently, members receiving MDCP, PDN or PPECC services receive STAR Plus Home and Community Based Services enrollment information approximately 6-9 months prior to their 21st birthday while all other STAR Kids members receive their STAR Plus enrollment information packets just 30 days prior to their 21st birthday. Members are given a 14-day window to make an MCO selection and then both the losing STAR Kids MCO and the gaining STAR Plus MCO learn of enrollment selections just days before the transition occurs. This does not allow for adequate collaboration and coordination of services to ensure there are no gaps in care.

Recommendations:

- i. Update the age out process to allow all members to receive STAR Plus enrollment information packets 6-9 months prior to their 21st birthdays thus extending the window of opportunity for STAR Kids and STAR Plus MCO's to collaborate and coordinate services to better prevent any gaps in care or services.
- ii. The age out preselection of a STAR Plus plan should be transmitted to the receiving STAR Plus plan at the time of enrollment broker receipt. This early selection and notification to the current STAR Kids MCO and receiving STAR Plus plan can be used to allow the STAR Kids and STAR Plus plans to share HIPAA information by supporting coordination of transition of care prior to the STAR Plus effective date. This HIPAA barrier removal would be beneficial to the plans, families and physicians involved in the transition of care and allow more time to process transfer related requests prior to the age out effective date.

3.4 Topic/Issue: Limited coordination of services with STAR Plus plans from STAR Kids transition specialists of age out members.

Background: Currently, STAR Kids contract has a requirement for the role of transition specialists in addition to and separate of the service coordinator. The STAR Plus receiving plans do not possess like roles to help support the member/family upon 21st birthday. Families have noted the changes in

insurance, school etc. are overwhelming and that doesn't end the day of the member's 21st birthday.

Recommendations:

- i. Add transition specialists to the STAR Plus waivers to coordinate with the STAR Kids transition specialist and support the 21-year-old member up to age 23. The receiving transition specialist for STAR Plus can help the member navigate the changes of adulthood, employment, higher level education supports etc. and be the recipient of the plans of care from the STAR Kids transferring plan.

3.5 *Topic/Issue: Improve the healthcare transition of children from childhood to adulthood through the adoption of transition standards and best practices.*

Background: Currently, STAR Kids contract has a requirement for the role of transition specialists; however, the standardization of knowledge requirements is not present to offer consistent direction and support to STAR Kids families/members across the MCO's.

Recommendations

- i. Adopt and implement the American Academy of Pediatrics consensus statement on transition and Got Transition's Core elements as best practices. Require training of MCO transition specialists to include:
 - a. Alternatives to guardianship
 - b. Supported decision making
 - c. Creative housing options including shared living arrangements and host homes
 - d. Supported employment
 - e. Utilization of the Navigate Life web reference
 - f. Got Transition Content

Conclusion

The STAR Kids Advisory Committee recognizes the work that has been done by HHSC and its employees to improve the STAR Kids program including improved communication to families through enhanced MCO member portals; the development of process improvements, policies, handbooks and training for the MCOs; and renovations to the complaint process.

While the recommendations offered in this report are largely recommendations that are focused on improving services and processes for a small subset of children with the most complex medical and behavioral needs, the changes would result in improved quality outcomes for all children served by STAR Kids.

- Access to comprehensive holistic integrated health homes and transition clinics for children with significant medical and behavioral health needs,
- Service coordination through integrated health homes whether delivered by the health home or embedded in the practice,
- Longer authorizations of long term services and supports for children with chronic conditions that are not subject to frequent changes,
- Payment to providers that allow them to support children with complex needs,
- Improvements to the SK-SAI that will ensure the tool results in referrals and better access to care including access to CFC for children with mental health conditions,
- Immediate access to MDCP waiver for children who have SSI, like the HHSC policy for adults in STAR Plus,
- Opt-out process for families of children in MDCP and families with third party insurance or access to another Medicaid waiver,
- Strengthened transition processes for children as they enter adulthood.

Acronyms

Acronym	Full Name
ASD	Autism Spectrum Disorder
CFC	Community First Choice
CLASS	Community Living Assistance and Support Services
CMC	Children with Medical Complexity
CNA	Certified Nursing Assistant
DBMD	Deaf Blind/Multiple Disabilities
DME	Durable Medical Equipment
EQRO	External Quality Review Organization
HCS	Home and Community-based Services
HHSC	Health and Human Services Commission
IDD	Intellectual and Developmental Disability
ISP	Individual Service Plan
LTSS	Long-term Services and Supports
MCO	Managed Care Organization
MDCP	Medically Dependent Children Program
MH	Mental Health
MN/LOC	Medical Necessity/Level of Care
NCAM	Nursing Care Assessment Module
NCI	National Core Indicators
PCAM	Personal Care Assessment Module
PCP	Primary Care Provider

PCS	Personal Care Services
PDN	Private Duty Nursing
PPECC	Prescribed Pediatric Extended Care Center
SDA	Service Delivery Area
SK-SAI	Star Kids Screening and Assessment Instrument
SSI	Supplemental Security Income

Appendix A. STAR Kids Advisory Committee Membership

Elizabeth Tucker, (presiding chair), Austin, EveryChild, Inc.

Dr. Rahel Berhane, Austin, pediatrician with Seton Health Care

Josh Britten, Amarillo, BritKare Home Medical

Dr. Ernest Buck, Corpus Christi, Driscoll Health Plan

Rosalba Calleros, Austin, Texas Parent to Parent

Catherine Carlton, Arlington, MHMR of Tarrant County

Dr. Jeanne Hines, Port Arthur, Education Diagnostician

Tara Hopkins, Austin, DentaQuest

Diane Kearns, Austin, parent

Stacey Mather, Austin, family member

Dr. Glen Medellin, San Antonio, The University of Texas Health Science Center

Holly Munin, Austin, Superior Health Plan

David Reimer, Dallas, Epic Health Services, Inc.

Blake Smith, Denison, Steps2Strides Therapy Center

Denise Sonleitner, Austin, parent

Angela Trahan, Houston, United Healthcare Community Plan

Rebecca White, Baytown, parent

Appendix B. References

Appendix II- Selected References

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<https://innovation.cms.gov/initiatives/integrated-care-for-kids-model/> and
also <http://cahpp.org/project/CoIIN-CMC>