



# **STAR Kids Managed Care Advisory Committee Report**

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**As Required by  
Title 1, Part 15, Texas Administrative  
Code, Section 351.823(d)**

**STAR Kids Managed Care Advisory  
Committee  
December 2021**

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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 (S.B.) 7, 83<sup>rd</sup> 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), 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.

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:** Assessment and Service Delivery

**Subcommittee 3:** Transition from Pediatric System to Adult System

# 1. Introduction

S.B. 7, 83<sup>rd</sup> 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 9 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.

The STAR Kids Managed Care Advisory Committee was originally set to expire December 2017, one-year post STAR Kids implementation. In 2017 under the authority granted the HHSC Executive Commissioner by Texas Government Code Section 531.012, the committee was extended until December 31, 2019. S.B. 1207, 86<sup>th</sup> Texas Legislature, Regular Session, 2019 extends the committee until December 2023.

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

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

The committee established three subcommittees to develop improvement recommendations. This is the fourth report of the committee. The first report was submitted to the Executive Commissioner in January 2019, the second in January 2020, and the third in January 2021.

The STAR Kids Advisory Committee continues to be an active stakeholder in the process. Members of our committee serve as liaisons to other HHSC Advisory Committees including the State Medicaid Managed Care Advisory Committee's

subcommittees on administrative simplification, clinical oversight, network adequacy, and service coordination, and the Intellectual and Developmental Disabilities System Redesign Advisory Committee. We are committed to continuing our work with HHSC to improve the STAR Kids service delivery system and to making sure the system results in meaningful outcomes for children.

## **2. Committee Activities**

### **List of Meeting Dates**

The STAR Kids Managed Care Advisory Committee met on the following dates:

- January 6, 2021
- March 10, 2021
- June 9, 2021
- September 22, 2021
- December 8, 2021

All meeting minutes except for the December 8, 2021, meeting minutes which have not yet been approved can be found in Appendix C.

### **Committee Members' Attendance Records**

A quorum was present for all the meetings during this reporting period. The committee is made up of 17 members. One member rotated off the committee in March of 2021 and two new appointments were made in June of 2021. A copy of committee members' attendance records is available in Appendix C, as part of the meeting minutes.

### **Brief Description of the Actions Taken by the Committee**

Below is a high-level list of actions taken by the committee at each meeting. A more detailed summary is available for review in each meeting's official minutes, Appendix C.

In addition, the three subcommittees invested a significant amount of time providing input to HHSC on coordination of benefits, alternative care models and value-based payment for health care transition. This work is described in detail in the report immediately following this section.



## January 6, 2021

- Review and approval of recommendations for the January 2021 annual report.

## March 10, 2021

- Review and discussion of HHSC's COVID-19 response including current Medicaid and CHIP flexibilities and extensions as well as Families First Coronavirus Response Act and continuation of Medicaid coverage.
- Review and discussion of implementation of legislative requirements from the 86<sup>th</sup> Texas Legislature including service delivery, coordination of benefits, and autism benefits.
- The subcommittee on Assessment and Service Delivery provided detailed written feedback to HHSC on HHSC's draft policy guidance on coordination of coverage with other insurance, UCM Chapter 16.2.8 which can be found in the next section of this report.
- ACE Kids Act presentation with a discussion led by Dana Danaher with the Children's Hospital Association of Texas, Dr. Rahel Berhane who is the STAR Kids Advisory Committee's subcommittee on Health Homes and Quality Measures, and Hannah Mehta with Protect Texas Fragile Kids.
- Review and discussion of HHSC's long-term services and supports MDCP utilization review.
- Presentation and discussion on network adequacy and durable medical equipment led by committee members Terri Carriker and Josh Britten.
- Review and discussion of the movement of non-emergency medical transportation to the managed care organizations.

## June 9, 2021

- Review and discussion of HHSC's COVID-19 response including current Medicaid and CHIP flexibilities and extensions as well as Families First Coronavirus Response Act and continuation of Medicaid coverage.
- Review and discussion of implementation of legislative requirements from the 87<sup>th</sup> Texas Legislature including telehealth/telemedicine, continuous Medicaid eligibility, Medicaid waiver interest lists and interest list questionnaires, coverage of certain collaborative care management services, Applied

Behavior Analysis, managed care directories, continuity of care and coordination of benefits, and feasibility of providing Medicaid benefits to children in STAR Kids through an Accountable Care Organization or another alternative model.

- Review and discussion of HHSC’s Medically Fragile Policy.
- Review and discussion of the 2019 and 2020 External Quality Review Organization’s Summary of Activities report.

## **September 22, 2021**

- Review and discussion of HHSC’s COVID-19 response including current Medicaid and CHIP flexibilities and extension as well as Families First Coronavirus Response Act and continuation of Medicaid coverage.
- Review and discussion of implementation of legislative requirements from the 86<sup>th</sup> and 87<sup>th</sup> Texas Legislatures including S.B. 1207 and S.B. 1648 regarding specialty provider and coordination of benefits, House Bill (H.B.) 4 telehealth/telemedicine, H.B. 2658 regarding parental consent for billing SHARS, and S.B. 2658 interest list study.
- Review and discussion of HHSC’s Autism Services Applied Behavior Analysis service.
- Review and discussion of HHSC’s 2021 Medically Dependent Children Program Utilization Review.
- Submitted response to a request from Attorney General Ken Paxton regarding input on definition of specialty provider and coordination of benefits which can be found in the next section of this report.

## **December 8, 2021**

- Review and discussion of HHSC’s COVID-19 response including current Medicaid and CHIP flexibilities and extensions.
- Review and discussion of the Medically Dependent Children Program renewal. The committee recommended a few changes including:
  - ▶ Examine and update the definition of medical fragility found in the MDCP limited nursing facility stay section of the handbook to better capture the needs of children whose health would be compromised by a nursing facility stay.

- ▶ Remove the requirement that a child with medical fragility must enter a nursing facility to access MDCP limited stay and instead create a reserved capacity in the waiver for nursing facility diversion for a targeted group of children determined to be medically fragile and at imminent risk of nursing facility admission.
- Review and discussion of implementation of legislative requirements from the 86<sup>th</sup> and 87<sup>th</sup> Texas Legislatures including S.B. 1207 and S.B. 1648 regarding specialty provider and coordination of benefits, H.B. 4 telehealth/telemedicine, H.B. 2658 regarding parental consent for billing SHARS, and S.B. 2658 interest list study.
- Presentation by Dr. Berhane on the whole child visit and the subcommittee on Health Home and Quality Measures recommendations to HHSC on an alternative model for STAR Kids. The subcommittee’s formal response to HHSC is included in the report in the section titled Request for Information for Alternative Payment Model.
- Presentation and discussion of the health care transition technical assistance project with the National Alliance to Advance Adolescent Health.<sup>1</sup>
- Review and discussion of H.B. 4 Medicaid and CHIP Teleservices implementation. The subcommittee on Health Homes and Quality Measures met with HHSC on November 15, 2021 and provided feedback on the use of telehealth in STAR Kids.
- Review and discussion of the Texas Healthcare Learning Collaborative Portal and the use of the portal for STAR Kids.

## Subcommittee Meetings

The three subcommittees met on multiple occasions throughout the year and worked on the following.

- STAR Kids Screening and Assessment Instrument – provided feedback to HHSC on items that needed to be included in the manual that accompanies the tool.

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<https://static1.squarespace.com/static/5871c0e9db29d687bc4726f2/t/62a1430da00186530349c9fc/1654735630307/Guide+for+Designing+VBP+Initiative+for+HCT+-+Updated.pdf>

- Coordination of Benefits and Continuity of Care – provided oral and written feedback to HHSC on the draft Uniform Managed Care Manual policy and on the rules related to Specialty Provider.
- Community First Choice and task-based assessments – provided feedback to HHSC on concerns about task-based tools for determining Community First Choice.
- Community First Choice and children with mental health conditions – worked with HHSC to better understand the low utilization of the benefit by children with mental health conditions and potential issues with identification of who might need the benefit.
- Alternative Care Model – provided significant feedback to HHSC on the development of an integrated home health model of care for children with medical complexities in STAR Kids utilizing ACE Kids and other resources.
- Workforce Shortage – provided information to HHSC on potential solutions to the overwhelming direct care and nursing workforce shortage in Texas including Parents as Certified Nurse Aids and value-based payment arrangements.
- Health Care Transition – assisted in the development of comprehensive recommendations to improve health care transition as children move from pediatric to adult care.
- Provided timely information to HHSC on issues with HHSC medical policy guidance around durable medical equipment and private duty nursing.

### **3. Coordination of Benefits Policy and Rules**

The committee provided both written and oral feedback to HHSC on Coordination of Benefit policy and rules.

#### **Policy Guidance on Coordination of Coverage with other Insurance**

On March 11, 2021, the committee provided written comments to HHSC in response to a request for comments on HHSC's draft policy guidance on coordination of coverage with other insurance, UCM Chapter 16.2.8.

#### **Overarching Comments**

- The guidance for coordination of coverage with other insurance should provide a clear and easy process to be used by Medicaid Managed Care Organizations when paying for services for children with other insurance. Having other insurance allows families to expand access to care while reducing the cost to the state. The guidance should encourage families to maintain other insurance for their child and provide ease in access. While we appreciate the many nuanced scenarios that might arise, the guidance is quite complicated and difficult to follow. It must be simplified and clearer than it currently is. If a child has other insurance, then that insurance should be billed first, and Medicaid should pay the remaining portion up to the agreed upon negotiated rate. If the other insurance denies coverage, then Medicaid should go through the process of prior authorizing and paying for the service.
- Dual coverage of a Medicaid recipient is a win for the state because the cost of the child's medical care is shared by his/her private insurance. The intent of the policy is to assist in the coordination of benefits, but some aspects of this policy do the opposite and lead to access to care barriers for children with dual coverage. The ability for Medicaid to deny coverage of a medically necessary benefit because the family has been denied coverage by their private insurance due to having an Exclusive Provider Organization (EPO) or Health Maintenance Organization (HMO) that prevents the child from accessing out of network specialty care physicians or providers is wrong and needs to be remedied.

- Due to the rising cost of health insurance, some employer sponsored policies are forcing individuals into limited “skinny networks” that do not meet all the needs of individuals with complex care. While the family will more than likely be able to get their basic preventative healthcare needs covered, there may be a need to seek care outside of the network for their child. This guidance will only serve to encourage families of children with unique specialty needs to drop their private coverage and solely rely on Medicaid.
  - ▶ Example – child has a unique need for a tracheal slide procedure due to atresia and the only surgeon who can perform the procedure is in Houston. The child has private insurance through his/her parent’s employer, but the network is limited (EPO) and there is no provision for going out of network. The private insurance denies, and Medicaid denies as well saying that the private insurance should have covered it even though it is not part of the policy. This leaves a child with dual coverage without the critical service he/she needed because the insurance companies are pointing fingers at each other and denying the service. The only option for the family is to decline their private insurance and leave the Medicaid paying for the entire cost of care. A denial of coverage from the other insurance (OI) is all that should be needed for Medicaid to cover the medically necessary service.
  - ▶ Example – child has a unique need for a Dynavox speech generating device, but Dynavox is not in the EPOs skinny network so the OI denies coverage. It is a medically necessary adaptive aid. Given that OI denied, does this mean that Medicaid denies coverage as well?
- How can a Medicaid beneficiary be denied access to a Medicaid covered service provided by an MCO enrolled health care provider simply because the provider is not in network with the child’s private insurance? The denial of payment equals denial of access.
- While there is a clear federal guidance for the state or its subcontractor to ensure cost recovery or “pay and chase” from the other insurance, the draft policy places the burden directly and indirectly on the families. The guidance says that “pay and chase happens when the State or its contractors pay submitted claims and then attempt to recover payments from OI.” Texas Health Steps medical and dental services are included in the services where Medicaid should pay and then recover costs. There is no evidence of recovery in the document. The vast majority of the scenarios place the burden on the families and provider

- While the guidance has a placeholder for specialty provider, it does not address the intent of S.B. 1207 for a child to be able to continue to receive care from that provider and to use Medicaid to pay for the wrap around coverage. There should be no requirement in Coordination of Benefits for the child to have established their other insurance prior to enrollment in Medicaid.

## **Managed Care and Third-Party Liability (TPL) and Recovery**

1. This requirement is very confusing and needs to be reworded. What is the intent of the requirement?
  - A. Is the intent simply that an MCO with a written reimbursement arrangement with an in-network or out of network provider must pay the difference between the reimbursed amount from other insurance up to the agreed upon MCO contracted rate for service? If so, it should be stated clearly.
  - B. The second part of number 1 is confusing and should be addressed separately because it is addressing a service that has been denied by the other insurance. If the OI denies coverage of a medically necessary service, then does not Medicaid have an obligation to pay as the wrap around insurer? Does this mean that the child will be penalized if they have private insurance and use a provider that is in network with the MCO and out of network with their other insurer? This does not make sense.
  - C. If a Medicaid MCO prior authorizes a service and then discovers the individual (member) has other insurance, then is it not incumbent on the MCO to pay the claim and then seek recovery from the OI? The MCO who authorized payment should pay regardless of whether the provider is OON with the OI.
2. This requirement should be simplified to state that an MCO must pay the unpaid balance remaining after the OI has paid for covered services that are determined to be medically necessary by the OI whether the provider is in network with the Medicaid MCO or not.
3. This requirement is clear and straight forward.

## **Deductible, Copayment and Coinsurance**

While it is understood that a provider cannot bill Medicaid-eligible children for copayments, deductibles, or coinsurance for Medicaid-covered services, it is often

the family that gets billed for the amount and must spend hours trying to get the claim paid. This should be the responsibility of the MCO with clear instruction from HHSC.

## **Billing Scenarios Uniform Managed Care Contract**

While the scenarios might assist some people, they might lead to greater confusion and prevent or delay access to care.

### **Scenario 1 – Service not covered by OI but covered by Medicaid. Provider in network for OI and Medicaid.**

It is important to allow for evidence of non-coverage from the OI other than just an Explanation of Benefit.

### **Scenario 2 – Service covered by OI and Medicaid. Provider OON for OI but in network for Medicaid MCO. OI approved OON provider.**

Payment on the part of the OI should be sufficient documentation that the OI approves the claim. The MCO should not be required to receive confirmation that the OI approved the OON provider in order to reimburse the MCO Network provider.

### **Scenario 3 – Service covered by OI and Medicaid, but OI did not approve OON provider.**

A denial of coverage from the OI should be sufficient for Texas Medicaid to reimburse the provider. If it is not, then the MCO should pursue recovery and the child should not be penalized. This scenario removes the obligation of the MCO for cost recovery. It also ignores the fact that the OI denied and is not an available source of payment.

- What is meant by approval? Does this mean prior authorization?
- Why would secondary not cover if it is a covered service under Medicaid? OI was attempted and denied. There is no other available source of payment.

### **Scenario 4 – Service covered by OI and Medicaid, but provider OON for both.**

Again, the MCO should be required to pay for covered services even if the provider is out-of-network. There is a provision for an MCO to use out-of-network providers



including out of state providers through single case agreements and out-of-network rates. This scenario contradicts this ability.

### **Scenario 5 – Part of service is covered by OI and Medicaid.**

What if there is no “contractually agreed upon rate?”

### **Scenario 6 – MCO knows member has OI, but provider bills MCO first.**

What if the MCO already prior authorized the service? They should not then deny the claim and instruct the provider to bill the OI first. This scenario will delay payment and unduly penalize the provider.

### **Prior Authorizations**

No questions or comments.

### **Ordering, Referring or Prescribing Providers**

No questions or comments.

### **Single Case Agreements and Network Adequacy**

This section is good in theory but does not always work well. MCOs should have an incentive to negotiate single case agreements with necessary providers that are not in network. Further explanation is needed on this for continuity of care. The intent is for a child to be able to remain with a provider (specialty, therapist, DME, etc.,) with whom there is a relationship. It should not impact payment or services to require a single-case agreement.

### **Specialty Providers**

Specialty providers should include Speech Therapists, Occupational Therapists, Physical Therapists, Specialty DME including Complex Rehab Technology and Specialty Pharmacy.

Our desire is to have a coordination of benefits policy that:

- Is clear and easy to understand.
- Encourages families to retain their private coverage if possible.
- Strengthens MCOs ability to recover costs when possible.

- Provides clear guidance to Medicaid MCOs on paying for medically necessary co-pays, deductibles and other costs denied by the private insurer.
- Takes the burden of coordination off the plate of families.
- Saves Texas money by encouraging the use of private coverage.
- Ensures access to care by children with dual coverage.

## Response to Request from Attorney General

The following is the committee's September 24, 2021, response to a request from Attorney General Ken Paxton regarding input on definition of specialty provider and coordination of benefits.

Re: The meaning of specialty provider and other terms for purposes of implementing S.B. 1207 from the 86th Legislature (RQ-0420-KP)

Dear Attorney General Paxton,

The Star Kids Medicaid Managed Care Advisory Committee received your letter requesting input on the definition of specialty provider and coordination of benefits. This follows the 86th Legislative Session bipartisan S.B. 1207. The advisory committee provided recommendations on this topic in May of 2020 as well as in the committee's January 2021 Legislative Report.

1. In **May 2020**, HHSC asked the committee for feedback on the following draft language for Coordination of Benefits:

*The MCOs must allow any member receiving Level 1 Service Coordination [or Service Management] to remain under the care of a specialist provider with which the member is receiving care on the date of enrollment into the plan, even if that specialist provider is out-of-network with the MCO. The MCO must comply with out-of-network provider reimbursement rules as adopted by HHSC until:*

- *An alternate reimbursement agreement can be reached with the members specialist provider*
- *The member or legal representative agree to select an alternate specialist provider, or*
- *The member is no longer enrolled in the MCO, whichever is shorter.*

The STAR Kids Advisory Committee responded on May 15, 2020, with the following recommendation.

It is very difficult to comment on rule language that addresses only one small subsection of a bill without fully understanding how the proposed language is going to work with existing and new rules related to continuity of care and coordination of benefits. We believe S.B. 1207 in its entirety was intended to complement and work hand in hand with existing requirements to ensure and expand access to medical care for children with unique and significant needs. Therefore, this language should be developed and implemented in conjunction with the language for all of Section 533.038 and current continuity of care provisions and not modeled after language developed for an entirely different population.

The intent of this legislation was to expand and enhance access to care for all STAR Kids members, whether new or existing. Peer-reviewed research has shown that access to appropriate tertiary specialty care and centers of excellence actually improves long-term outcomes and reduces mortality rates in children with complex medical needs, and also typically improves long-term costs.

Below are suggested changes to HHSC's proposed language.

The MCOs must allow any STAR Kids member to access and remain under the care of a specialty provider with whom the member is receiving care, even if that specialty provider is out-of-network with the MCO, to ensure that continuity of care is not disrupted, compromised, or interrupted. The MCO must comply with out-of-network provider reimbursement rules as adopted by HHSC until:

- ▶ An alternate reimbursement agreement can be reached with the members specialist provider;
  - ▶ The member or legal representative agree to select an alternate specialist provider; or
  - ▶ The member is no longer enrolled in the MCO, whichever is shorter.
2. In **January 2021**, the advisory committee addressed both Coordination of Benefits and Continuity of Care in its January 2021 STAR Kids Managed Care Advisory Committee Legislative Report. Below are some of the recommendations related to these areas. A full copy of the report is attached to this email.

## **2.5 Topic/Issue: Preferred Provider (page 61-1)**

HHSC should retain the allowance in STAR Kids for a member to opt out of a preferred provider arrangement and choose a different provider. Members should

continue to have a choice of providers for specialty services and DME, including non-preferred provider arranged services.

### **Recommendations:**

1. HHSC should require in contract that 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. HHSC should monitor to ensure the preferred provider opt out process is working and easy for families to access and use.

## **3.1 Topic/Issue: Coordination of Benefits, Continuity of Care, and Alternative service delivery model for children in Medically Dependent Children Program (page 24-1)**

Some families of children in the STAR Kids MDCP waiver 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. Approximately 50 percent of children receiving services through MDCP have third- party insurance.

### **Recommendations:**

1. Prioritize the development of clear and standard policies around coordination of benefits for those with third-party insurance.
2. Define specialty providers broadly to include providers of therapy and durable medical equipment
3. HHSC should work to develop a list of services that are rarely provided via commercial insurance and allow MCOs to authorize services without waiting on Explanation of Benefit from a commercial carrier.
4. Ensure the continuity of care provision is a minimum of 90 days.
5. Allow families to access out of network providers with no penalty to MCOs.
6. Exempt the MDCP population from any out of network utilization benchmarks placed on MCOs.

7. Improve access to single-case agreements and make the process easier for families to access and physicians to accept.
8. Investigate alternative models of service delivery for children in MDCP such as Primary Care Case Management, Fee for Service, or an Accountable Care Organization.

Thank you for the opportunity to provide input and for your consideration of our combined input. The Star Kids Medicaid Managed Care Advisory Committee is composed of clinicians, providers, parents, and advocates. The committee has discussed the complex issues of implementing managed care for children with developmental disabilities as well as medically fragile conditions

## **4. Request for Information for Alternative Payment Model**

The subcommittee on Health Homes and Quality Measures met on multiple occasions to develop a response to HHSC's request for information on an alternative payment model for children in STAR Kids. Below is the response submitted to HHSC on October 27, 2021.

### **Executive Summary**

This proposal reflects the recommendations of several stakeholder groups involved in the care of children with medical complexity (CMC) including providers, parent advocates, and experts in state health policy and value-based health care. The group was convened by the STAR Kids Advisory Committee's Subcommittee on Health Homes and Quality in response to an RFI by Texas HHSC to propose an alternative model for children with medical complexity.

We recognize that CMC as a group is ill-served by the current system of care and a model of care that best meets their needs can be developed through continued partnership and collaboration. We believe the right system will allow significant improvement of care and health without much need for additional dollars. We see this proposal as the beginning of a process to reallocate existing resources to work toward this change in a phased approach and commit to readily engaging in it beyond the submission of this proposal.

### **Overall Care Structure**

The best approach to meeting the needs of Texas' children with medically complex conditions (CMC) is to develop a pediatric comprehensive complex care "system of care" that supports all qualifying children in the state as well as those transitioning into adulthood. The foundation for this system of care should be a network of provider-led "enhanced" or "integrated" health homes - health homes composed of full teams of health care professionals as described in the ACE Kids Act.

The core requirements for the 'integrated health home' include: primary care provider (PCP) as a quarterback; integrated visits to include specialists and other providers by maximally utilizing telemedicine; incorporating the child/family as full partners; care coordination embedded within the health home and designed to build

longitudinal relationship; 24/7 access; full delegation of authority to the health home in determining appropriate treatment plan including home support, therapy supplies and equipment (within Texas Medicaid guidelines); integrated assessments and single care plan with fully shared accessible technology for both care and analytics; and a payment system that incentivizes evidence generation and quality improvement.

We believe existing complex care clinics in the state can be strengthened and be the primary loci of implementation of this model with support from the hospital systems that they are currently attached to with flexibility built in to allow other iterations to emerge. If organized as hubs ('centers of excellence'), a system by which these centers support smaller clinics that serve this population in rural and semi-rural settings can also be worked out.

As traditionally operated, ACOs are inappropriate as the structure to serve this population. While intended to sensitize physicians and other key professionals to cost and risk, most still have payment structures and financial incentives that are encounter based. They also generally employ telephonic or other more remote care coordination services along with case management authorization procedures similar to MCOs. Care decisions should be delegated to the integrated health home team so that necessary services, equipment, and supplies can be provided in a timely way.

The size and scale required for a traditional ACO model simply is a bad fit for this population. It may be possible to envision an ACO that is adapted to this population, but that would require a complete reengineering of the concept and a reorientation to the unique needs of this population.

This health home-led integrated delivery system needs some additional infrastructure to function effectively. Administrative support can be provided from other third parties (e.g., TMHP, MCO, ACO or hospital systems). The necessary infrastructure must have: technology for shared notes and shared care plans; telemedicine powered integrated visits; analytic support to thoroughly understand the longitudinal journey of each child and each subpopulation; 24/7 capacity to support access to the appropriate professional staff for their immediate issues; expertise on equipment and other specialized services, including adult practitioners who join the team when the young adult with CMC transitions from pediatric to adult care, embedded with the health team; and staff to coordinate care with community providers and social service agencies.

## Population Segmentation

In addition to defining “who belongs” in CMC, it is important to have a consistent approach to population segmentation within CMC. In value-based care models, segmentation refers to identifying patients with shared needs and designing care in a way that improves the outcomes for that particular segment of patients. This enables a more targeted and efficient use of resources instead of a “one-size fits all” approach. In the following pages we present some suggestions on how best to define sub-segments with shared needs. It is worth noting that this is not tailoring care to each individual patient, which we recognize as being extremely challenging to implement as well as cost prohibitive. Further benefits of population segmentation include:

- It helps sharpen the outcome measures to those that are relevant for the population subsegment under discussion, i.e., the outcomes that matter most to the patient and family.
- It enables deeper understanding of gaps in care specific to that subsegment and thus provides more information to the care team to act on and address those gaps. For example, further integration of behavioral health services may be required for the subsegment of children with Autism and IDD.
- It helps compare outcomes among like groups instead of comparing outcomes for all CMC when outcome trajectories are different based on medical condition and social factors.
- It makes it possible to more precisely account for the cost of care needed to achieve the health outcomes that matter most to patients and families within that subsegment. This enables the care team and other stakeholders to estimate the total cost of care and create the ‘cost bundles’ and pricing that more accurately reflects the care delivered.

## Payment Structure

There should be a phased approach in adopting value-based payment for this population and the proposed service delivery structure. A fee-for-service or clinic-based fee structure is not appropriate for this patient population.

The suggested phases in adopting value-based reimbursement are as follows:

**Phase 1** – The core of an integrated approach to care and the key structure in the service delivery model is the integrated health home for this complex population.



To create the necessary financial support for the model to be adopted, sufficient payment for the core health home team salaries and its functions is the starting point, for example, time spent by the integrated team (specialists, therapists) for care planning. We suggest a per member per month (PMPM) amount for the health home services, which includes creation of a dynamic care plan, ongoing care coordination, and other professional support services. The payment can be tied to quality or accountability metrics that might include evidence of a complete plan of care that includes goals set by the child/parent as necessary and some frequency of contact and support. During phase 1, more in depth total cost of care information can be gathered and analyzed for more sophisticated value-based reimbursement strategies.

**Phase 2** – Collect enough financial information to get to appropriate pricing for each bundle and price bundles that incentivize increasing integration. We strongly recommend that the cost analysis include comparable populations either not enrolled or prior to their enrollment in this improved service delivery system.

To provide greater financial assurance to state government, CMS has at least two opportunities for higher matching funding for health home demonstrations assuming that such a model is adopted. Planning grants for 2703 waivers or the ACE Kids Act provide federal matching funds at the services rate (67 percent in FY22) rather than the normal 50percent rate for most staff and contractors. Even better, when operationalized, 2703 waivers provide a 90 percent matching rate for eight quarters for health home services. The ACE Kids Act provides a plus 15 percent FMAP for two quarters for health home services. This minimizes the state general revenue commitment for a significant time.

Finally, this population impacts other governmental costs. Human service agencies and the education system both have linkages. The demands of caring for their children, which fall heavily to parents, impact their earnings capacity with one parent often needing to stay at home full-time.

## Contracting

We propose a contract that is directly between the alternative model, in this case, the integrated health home, and the state Medicaid agency. The benefit of this contracting arrangement is that the health home will be fully invested with the authority to truly manage the care. That includes capacity to authorize services that are often prior authorized as a utilization control. The health home should be the manager of care and that includes fully delegated authority for the necessity of

individual services. The payment structure should be paired with this delegated authority with a focus on the total cost of care.

## Quality Measures

Quality metrics for CMC are particularly challenging and we are not aware of reliable, standardized metrics. Utilizing HEDIS and other “healthy” population metrics has not been meaningful or useful. Meaningful metrics may need to span years of care as the payoff for some interventions may not occur in the short-term. The measure burden should also be kept minimal.

Development of a network of integrated health homes will allow for the development of potentially useful metrics. These quality measures should include child/family elements that directly address the experience of care and the family’s perception of the coordination of services. Are patients and families getting the services they need? Outcomes measures co-created with family members should be used.

A statewide specialized system of care calls for a consistent adjudication of claims and centralized analytic capacity. A data governing board is a must. Considering that UT School of Public Health in Houston is a partner in the External Quality Review Organization (EQRO) contract for Medicaid managed care quality evaluation and holds HHSC data, we propose working with this entity to develop the robust analytic infrastructure needed by the network that would include both clinical and claims data from available databases in Texas.

## Alternative Care Model

### Overall Care Structure

The best approach to meeting the needs of Texas’ children with medically complex conditions (CMC) is to develop a pediatric comprehensive complex care system that supports all qualifiable children in the state as well as those transitioning into adulthood. This system should be founded on a network of innovative **Integrated Health Homes (IHH)**. The IHH will be provider-led comprehensive teams composed of multidisciplinary health care professionals as described in the ACE Kids Act. Provider-led specifically means providers with expertise and passion in caring for vulnerable children with CMC.

**The core requirements of an Integrated Health Home (IHH) include:**

1. An integrated care team led by a PCP (either a pediatrician, family practitioner or advance practice nurse) with expertise in caring for CMC who can coordinate the full care team including medical specialists and subspecialists, an NP or PA, and a master's degree social worker. Other health professionals will be integrated based on the specific types of needs of the subpopulation of CMC. In some instances, key subspecialists may be co-leads on the team, e.g., for children with hypoplastic heart syndrome, a cardiologist would be a co-lead with the PCP on the core team. The core care team will be clearly defined for each subsegment of CMC (the concept of population segmentation is explained later in this proposal) and will collaborate with an open network to provide accessible services and follow the child longitudinally - even across state lines irrespective of affiliation to insurance or hospital systems.
2. Care coordination is embedded within the IHH and closely tied to the goals of care developed by the parent and families with the primary care team so that the planning for and provision of direct health care is integrated with the breadth of child and family needs (i.e., social, emotional, and financial) and may include the provision of home health and therapy services. This also includes coordinating and providing access to specialty and subspecialty providers as needed to address urgent medical events whether in the home, clinic or hospital setting. Embedding the care coordination function with the core team of providers recognizes the intensity and complexity of need of the child/family and the advantage of having care coordination fully integrated with the direct services rather than have some telephonic or other more distant method that is the norm for MCOs and ACOs. This both advocates for an integrated approach and highlights another reason that MCO/ACO structures are suboptimal.
3. Incorporating the child/family as full partners in the care planning process given their profound and direct responsibility for their child. This includes increasing autonomy to parents on how 'home support' dollars are to be used.
4. Providing multidisciplinary evaluation and support to include nurses, social workers and as needed by patient navigators, dieticians, respiratory therapists, rehabilitation therapists and mental health providers.
5. Full delegation of authority to the health home (within guidelines) in determining appropriate treatment plan (home support; therapy; equipment etc..).

6. The core care team has ready access to any EMR and /or ready access to the necessary digital information stored in the electronic health record via EMR agnostic applications to inform care planning and outcome improvement. Integrated care requires integrated record. As care integration includes more and more participants, such as specialty DME companies and home health, access to the CMC patient's

EMR becomes necessary. Such technology exists today and is currently used at the Dell Children's Comprehensive Care clinic with success.

The reality is that the resources to organize and support this comprehensive IHH model exist only in tertiary and specialty hospitals. The initial development of this system should harness the expertise and motivation of these institutions to provide the framework to extend these services to effectively meet the needs of CMC in rural and otherwise underserved areas. This initial framework does not preclude expansion of the model to other structures if shown to be viable.

CMC have intensive care coordination needs that span both specialized medical care and social determinants of health that intersect with child and family needs outside of "medical care". It is worth noting that the intense care coordination not only consists of the logistical aspects of coordinating care, but also requires complete and effective information transfer between the core health home team and subspecialists, therapists, home health service providers, etc. Most often, in today's paradigm, the parents of CMC are responsible for this knowledge transfer between all people caring for their child which brings unnecessary burden to them.

It is instructive that the ACE Kids Act definition of CMC begins with "one or more chronic conditions that cumulatively affect three or more organ systems". This effectively requires a care team that includes multiple physician specialists and subspecialists and they all must be active participants in the care, planning, and coordination functions. CMC have a wide variety of medical needs and require specialists with expertise in the unique and complex needs of these children. Many of the diagnoses experienced by CMC are rare leading to few providers with the experience and expertise to care for these children. This is why the ACE Kids Act has such an emphasis on ensuring access to out-of-state providers who may be the only experts in providing for these needs conveying the highly specialized nature of the health needs of many of these children. Texas has the size and resources that minimize the need for out-of-state care but that component of the ACE Kids Act highlights the complexity and unique nature of caring for this population as well as

the challenge in accessing a limited number of experts in caring for a particular constellation of conditions.

The **IHH** is by far the most effective model by having care coordination services embedded with the direct care team (references from experiences in Texas available upon request). This matches the intensity of needs directly with the full range of providers, including those that address social determinants. It is intuitive that CMC and their families would have more intensive social and emotional needs.

The legislative intent to better serve CMC through new structures is benefitted by health home care teams already in place in a few Texas pediatric complex care centers of excellence. They can serve as the first building blocks for the envisioned system of care and serve as the backbone for the network of care that is needed to care for children who live in parts of the state with accessibility issues to these health homes.

## **Description of the Integrated Health Home for CMC**

The American Academy of Pediatrics introduced the medical home concept in 1967 as a model of care. It puts patients at the forefront of care and tasks the health center with the responsibility for providing or arranging for all the care the patient may need, keeping in mind the medical, behavioral and life challenges a patient may be facing.

Over the years, systems have been put in place to make sure health centers and clinics get certified as “Patient Centered Medical Homes” (PCMH) around commonly accepted criteria. The most common certifying module through the National Center for Quality Assurance (NCQA) recognizes six criteria for certification (Patient-centered access; Team-based care; Population health management; Care management; Care coordination and care transitions; Performance Measurement and Quality Improvement).

Despite years of effort to strengthen Patient centered medical homes, most function in traditional high volume encounter-based fee-for-service paradigm. Despite aspirations to ‘population health management’ most certified medical homes serve as large clinics/FQHC that provide primary care to large populations with mixed needs.

“Enhanced Health Homes” for children with medical complexity have been growing in number over the last two decades, often around large children’s hospitals and academic centers.

We propose that to qualify as an IHH for CMC, clinics should serve as hubs for integrated care delivery as well as participate in learning collaboratives that work to continuously improve the quality of care delivered. Some key differentiators include: longitudinal relationship-based care; access to care team 24/7; maximal use of telemedicine for integrated care delivery; requirement for team members to follow patients across all settings (home, clinic, hospital, hospice); clinic design and processes that acknowledge the unique challenges of CMC.

The following table summarizes the key differentiators between traditional primary care health homes and integrated health homes for CMC:

| <b>Traditional Medical Home</b>   | <b>Integrated Health home for CMC</b>   |
|---|---|
| Specialist services secured through referral; specialist inputs through consultation notes; require a coordinator to make sure all are on the same page | There is designated care team across multiple institutions that confer regularly to create and update a shared care plan  |
| No mechanism to encourage self-management and shared decision making  | Embed palliative principles; parent coaching in preparation for visits, shared decision-making and built-in services for peer support   |
| Focus on index patient  | Focus on the entire family. Care team trained to understand where the family is in their health journey; their process of meaning-making (cultural and spiritual dimensions included) focus on breaking isolation, loneliness and alienation from the health system |
| Information in multiple EMRs in multiple silos  | Full and easy shared access to all information necessary to plan care and improve outcomes; mechanism for all in the care team to contribute to the narrative   |

| <b>Traditional Medical Home</b>  | <b>Integrated Health home for CMC</b>   |
|--|---|
| Difficult for frontline providers to get population level data   | Robust analytics to provide meaningful data at the individual and population level. Data at the individual patient level will enable decision-making at the point of care in real-time. Data at the population level will enable the learning collaborative to see aggregate data and results across sites from which to learn and improve. Embedded expertise to understand population segments and their disease trajectory to generate new evidence and advance research |
| No mechanism to properly evaluate the level of habilitative services needed and progress toward goals, except rubber stamp plans of care from therapists | Embedded experts in occupational therapy, physical therapy, speech therapy, and Applied Behavioral Analysis to evaluate and recommend habilitative options and objectively assess progress  |
| No mechanism to properly evaluate and provide the level of home health services needed (both skill level and number of hours)                            | Care team determines level of care needed in consultation with families based on Medicaid guidelines  |
| No mechanism for medical home to contribute to improving the quality of direct service workforce   | Clinic serves as a hub to provide continuing education and even certify different levels of direct level workers  |
| No mechanism for medical home to serve in consultative capacity to rural or solo pediatricians   | Acts as a hub to support other practitioners in the community and in the region. This can be telehealth enabled. This hub also supports adult practitioners who are going to take over the care of the young person when they transition to adult based care.   |
| No mechanism to support parent leadership  | Embeds parent representatives at all levels to participate in design, quality improvement and outcome evaluation  |

| Traditional Medical Home  | Integrated Health home for CMC   |
|---|--|
| Improvement in patient outcomes is not consistently measured and most often do not reflect patient/family reported/centered outcomes. Quality measures are largely regulatory and process in nature. They do not directly inform patient care delivery, nor do they give insight into how patients are doing with their health. | Outcome measures are patient- centered and collected both at the individual patient level in the form of patient/family directed goals to inform care planning and measured in aggregate at the hub and network level to enable outcomes transparency and quality improvement. Process measures are carefully selected to track processes that directly impact patient outcomes. |

**Staffing Structure**

We believe the primary care provider (PCP) should serve as a quarterback and the leader of a core team organized around shared needs. The core team should be defined based on the needs of the population but often includes PCP, nurse case manager, social worker/child life/family liaison; dietitian). Determination of rehabilitation needs and assessment to goals should be done by an embedded therapist. Teams may include a pharmacist in the core group as appropriate.

Other staff members that function very closely to the core team include palliative medicine doctors, neuropsychologists, and rehabilitation medicine specialists.

Depending on the needs of the sub-segment of the population (more information about population definitions and sub-segmentation later in the report), some specialists may function within the core team (for instance - a hematologist for a sickle cell population; a pulmonologist for a cystic fibrosis subpopulation.)

The key to all of this is that the level of need and intensity of impact of these conditions on these children and families is such that the locus of care is the specialized resources that they require. For example, if you are a child (or adult) with hemophilia, you will rely on a specialized resource that starts with expert and specialized medical care. That is the foundation and the other resources to meet with breadth of other needs should be built around it. Obviously, there will need to be linkage with a range of community providers and resources but that is managed from the direct care team, with care coordination resources built in, that is implementing the care plan in partnership with the child/family.



## Staffing ratio

Ratios will depend on the complexity of the subsegment, but generally, the requirement that the PCP follow the patient across all settings and act as a chronicler of the patient's journey and care plan requires that the ratio be limited to not more than 1:200 with a primary nurse case management support at 1:50.

## Tasks traditionally not performed by health homes but would be appropriate to embed in an Integrated Health Home:

- **IHH** should have the authority to authorize supplies, equipment, nursing, and attendant hours and referrals as long as they are within Medicaid guidelines.
- **IHH** will track outcomes on their population both at the individual patient level and in a manner that allows for analysis of deidentified aggregated data from each hub. Healthcare utilization data, such as hospital and emergency room utilization, would be tracked and analyzed to determine optimal utilization and identification of any care gaps that should be resolved to ensure quality care.
- **IHH** should collaborate with community partners to ensure there is a trained high-quality direct workforce in their area by providing in-services and trainings to attendants; home health nurses and others.
- **IHH** will serve as a resource to small/rural practitioners by providing resources/know how and potentially allowing them to utilize the infrastructure to see their patients. Telehealth collaborations will be developed to increase accessibility of patients to care in their local community.
- **IHH** will develop care plans for young people transitioning from pediatric care to adult care including adding the adult practitioner as a member of the team prior to the transition.
- **IHH** will collaborate with local PCPs to serve as co-providers to allow local PCPs to manage the levels of care appropriate in their community and serve as local experts. IHH PCP's will coordinate and provide the multidisciplinary team care not possible in many local PCP offices.

## **Collaboration between hubs**

In Texas, there are currently 6-8 clinics dedicated to the care of CMC. Each clinic operates in a silo and there is very little collaboration among clinics. These clinics are under-resourced. It was hoped that STAR Kids would provide the support and coordination that would allow for more efficient patient care, but despite the significant investment in MCO's and the STAR Kids SAI, there has been very little innovation in the actual delivery of healthcare. Most innovations have been funded through the individual organization and clinical operations are subsidized by the affiliated hospital organization and cannot survive on billed income. This has limited the ability of the current CMC clinics to expand to meet the need. An innovative IHH model would redirect funding from the MCO-based care coordination to the IHH so that goal-oriented innovative care could be provided.

To be an effective 'statewide system', it is essential that the hubs closely collaborate and coordinate with each other. Uniformity in population selection and sub-segmentation, sharing of best practices, sharing resources for training and quality improvement are some of the areas where hubs should work together. The function of defining clear transparent guidelines - about home health and therapy needs also is best done collaboratively between the hubs.

## **Administrative Structure**

As traditionally operated, ACOs are inappropriate as the structure to serve this population. While intended to sensitize physicians and other key professionals to cost and risk, most still have payment structures and financial incentives that are encounter based. Furthermore, they require networks of hospital, clinic, SME and LTSS services. There is currently no organization in Texas that could provide the needed services to make the ACO model viable. They also generally employ telephonic or other more remote care coordination services along with case management authorization procedures similar to MCOs. ACO methods are far less effective for this heterogeneous population of children and families. The size and scale required for a traditional ACO model is simply a bad fit for this population. It may be possible to envision an ACO that is adapted to this population but that would require a complete reengineering of the concept and a reorientation to the unique needs of this population.

A Community Partner-led model is unlikely to be directly connected to the medical specialists and will have limited ability to coordinate the medical component of the care. While this model is advantageous in assembling and coordinating community

resources to meet social and other family needs, the urgency of the child's medical conditions requires more than can be offered here.

This **IHH** based system will need substantial infrastructure to function effectively. To be clear, we are not asking for additional funds for this infrastructure, instead, we are proposing a reallocation of resources to be closer to where patient care is being provided. Currently substantial expenditures are being made in MCOs for such infrastructure, yet these resources are not efficiently being used because the decision-making authority is too far removed from the front-line work of the care team. The necessary infrastructure must have: technology for shared notes and shared care plans; telemedicine powered integrated visits; analytic support to thoroughly understand the longitudinal journey of each child and each subpopulation; 24/7 capacity to support access to the appropriate professional staff for their immediate issues; expertise on equipment and other specialized services, including adult practitioners who join the team when the young adult with CMC transitions from pediatric to adult care, embedded with the health team; and staff to coordinate care with community providers and social service agencies.

While the system we recommend squarely keeps the responsibility about care plan development, allocation of resources such as home health, DME and therapy in the health home, and outcomes tracking, there are other functions for which outside partnership is needed. This includes financial management (allocating payments to the different members of the integrated team that participate in care plan development; contractual functions etc.). This partner may be an MCO or a state agency such as TMHP with very clearly outlined and only necessary administrative duties to enable the functions of the integrated health home

## **Population Definition, Sub-segmentation, and Eligibility**

Criteria for inclusion in the IHH will be based on medical, social, and emotional complexity. The network of IHH will develop standards for inclusion that will allow some flexibility to meet the needs of local communities and accommodate differences in hospital structures.

We propose the Integrated Health Home model for children with the most intensive needs, especially those with the very serious conditions as defined in the ACE Kids Act. That definition is as follows:

- One or more chronic conditions that affects three or more body systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink or breath independently) and which also requires the use of

medication, durable medical equipment, therapy, surgery or other treatments, OR

- One life-limiting illness or rare pediatric disease (as defined in the Federal Food, Drug, and Cosmetic Act), such as a form of cancer. The Secretary has the option to establish higher levels as to the number or severity of chronic, life-threatening illnesses, disabilities, rare diseases or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.
- Chronic condition is defined as a serious, long-term physical, mental or developmental disability or disease, such as: cerebral palsy, cystic fibrosis, HIV/AIDS, blood diseases (such as anemia or sickle cell disease), muscular dystrophy, spina bifida, epilepsy, severe autism spectrum disorder, or serious emotional disturbance or mental health illness.

## **Population Segmentation:**

In addition to defining “who belongs” in CMC, it is important to have a consistent approach to population segmentation within CMC. In value-based care models, segmentation refers to identifying patients with shared needs and designing care in a way that improves the outcomes for that segment of patients. This enables a more targeted and efficient use of resources instead of a “one-size” fits all approach. It is worth noting that this is not tailoring care to each individual patient, which we recognize as being extremely challenging to implement as well as cost prohibitive. Further benefits of population segmentation are outlined below:

1. It helps sharpen the outcome measures to those that are relevant for the population subsegment under discussion, i.e., the outcomes that matter most to the patient and family. These patient-centered outcome measures will assess whether the health goals of patients and families have been met and outcomes improved. These measures will inform quality metrics for value-based care.
2. It enables deeper understanding of gaps in care specific to that subsegment and thus provides more information to the care team to act on and address those gaps. For example, further integration of behavioral health services may be required for the subsegment of children with Autism and IDD.
3. It helps compare outcomes among like groups instead of comparing outcomes for all CMC when outcome trajectories are different based on medical condition and social factors. Having subsegment specific outcome

data tracked longitudinally will enable the generation of evidence to inform best practices that will help expand the knowledge base. The trained workforce that will develop expertise on the subsegment of children with medical complexity.

4. It makes it possible to more precisely account for the cost of care needed to achieve the health outcomes that matter most to patients and families within that subsegment. This enables the care team and other stakeholders to estimate the total cost of care and create the 'cost bundles' and pricing that more accurately reflects the care delivered.

## **How to achieve sub-segmentation**

In Texas, the SK-SAI is a statewide tool that with some revision can help in the process of segmenting the broader CMC population. All the hubs can work together to gain consensus around the definitions for subsegments of the CMC population using a Modified Delphi process. However, each clinic can choose which population to focus on based on the local need and resources. The need to intentionally structure a cooperative network of statewide clinics is important. Clinics can share technology infrastructure; organize trainings together and elevate the skill level statewide through conferences and participating in a learning collaborative.

Organizations such as Title V can support this networking effort as it is very much aligned with their mission.

An example of population sub-segmentation in CMC:

- Medically fragile+ neuro impaired/infant-toddler
- Medically fragile+ neuro impaired/ school age
- Medically fragile + neuro impaired/transition age
- Single diagnosis with existing multi-disciplinary team support, e.g., Cystic Fibrosis and Rett Syndrome
- Medically fragile - no neuro impairment
- IDD+ Autism

In the above example, for instance Medically fragile+ Neuro impaired; infant/toddler would include prototypic diagnoses such as congenital syndromes; severe hypoxic ischemic encephalopathy as well as undiagnosed conditions with severe neurological injury.

The journey as experienced by parents is similar - irrespective of the diagnosis. In the above example, the core medical team may include PCP, RN-Case Manager, neurologist, pulmonologist, therapists, and home support. Parental support, ECI coordination, sibling support are all shared elements that can be designed as part of the care structure.

An integrated health home model would need to have certain core requirements in terms of both provider composition (i.e., certain minimum resources) and functionality. Recognizing both the medical and functional heterogeneity of the population, there would need to be additional features that would be required based on the variance in the population and their needs. For example, if the major issue was serious emotional disturbance or mental illness, then the core team would need to have other specialized behavioral health resources added to complete the care team. If the child had a serious neurological problem, then certain medical subspecialists would need to be included.

Another critical issue is current eligibility criteria for STAR Kids. Many children with medical complexity are not enrolled, either because they had a different pathway to Medicaid eligibility or because their complex medical conditions didn't have the functional limitations that are the basis for SSI eligibility. There are children with medical complexity who are in STAR, CHIP, and STAR Health. It would be important to include these children into the system being proposed. If not in this phase, in subsequent phases of the implementation of the proposed **IHH** network model.

Constructing a more effective system of care for children with disabilities in Texas should be structured to maximize the number of children who can benefit. All children on Medicaid who meet the current STAR Kids definition, or the ACE Kids definition should be for the **IHH** model of care, regardless of the path they have taken to Medicaid enrollment. This major policy issue should be made a priority for change as this initiative moves forward

## **Payment Structure**

First and foremost, the payment structure should enable the most effective and efficient care delivery for CMC and their families that improve the outcomes that matter most to them. There should be a phased approach in adopting value-based payment for this population and the proposed service delivery structure. A fee-for-service or clinic-based fee structure is not appropriate for this patient population.

The goal of caring for these children is, at baseline, to avoid unnecessary clinic and acute care encounters. More importantly, the goal is to deliver care in a way that

allows children with CMC to thrive in their context. To note, this is again where population segmentation is critical – what success looks like for each subsegment of the CMC population differs.

Integrated care involves coordination of care through live discussions with other providers, review of therapy, nursing, and supply orders, maintaining accurate care plans, and documenting goals of care. None of these essential duties are reimbursed in the current fee structures, and yet they are necessary to provide the level of care needed. In addition, these children need access to a multidisciplinary team as previously discussed that needs to be funded. Trying to fund the team and non-reimbursed activities using a fee-for-service payment structure leads to inefficient care that is not patient-centered. The hope with STAR Kids was that the managed care organizations (MCO's) would develop innovative payment structures that allow the care team to allocate funds as needed to provide the necessary care and provide reimbursement for the non-reimbursed, but essential care activities described above. Unfortunately, the complex care clinics in the State have struggled to receive viable payments.

The suggested phases in adopting value-based reimbursement are as follows:

**Phase 1** – The core of an integrated approach to care and the key structure in the service delivery model is the integrated health home for this complex population. To create the necessary financial support for the model to be adopted, sufficient payment for the core health home team salaries and its functions is the starting point, for example, time spent by the integrated team (specialists, therapists) for care planning. We suggest a per member per month (PMPM) amount for the health home services which includes creation of a dynamic care plan, ongoing care coordination, and other professional support services. The initial payment month where the care plan is developed should be at a higher amount and then subsequent months should be paid at the same amount as an average for the resources necessary across the population subsegment and time. The payment can be tied to quality or accountability metrics that might include evidence of a complete plan of care that includes goals set by the child/parent as necessary and some frequency of contact and support. During phase 1, more in depth total cost of care information can be gathered and analyzed for more sophisticated value-based reimbursement strategies.

**Phase 2** – Collect enough financial information to get to appropriate pricing for each bundle and price bundles that incentivize increasing integration. We strongly

recommend that the cost analysis include comparable populations either not enrolled or prior to their enrollment in this improved service delivery system.

Obviously, there will need to be some negotiation around the particulars, but it is essential that there be some incentive for institutions that will see their revenue decrease from avoided inpatient hospital stays and other utilization.

While it may be possible to move to a full risk capitation model, it is not clear if that is really feasible. It is certain that some form of stop/loss and/or risk corridors would need to be included to help trim the impact of cost volatility. Also, there should be clarity on whether full risk capitation provides incentives for the effectiveness of the model.

## **Role of Children’s Hospitals – Data Collection**

Children’s hospitals are valuable resources that employ many of the specialists and clinicians for CMC in the area. A financial incentive that allows them to benefit from successful outcomes of the population served in their system will align them with the proposed **IHH** model.

A phased approach recognizes the wealth of information needed to set rates and introduce risk. The challenges posed by the amount and variation in utilization of services and their costs are formidable. The questions that need to be answered include the following:

- How do you set boundaries for the populations and costs that will be included in the reimbursement model? For instance, where do you draw the line on costs of the very young that might possibly still include neonatal intensive care?
- How do you set risk adjusters or otherwise group the population into segments for rate-setting purposes? Do you try to rely strictly on diagnosis codes and/or demographics like age? We might note here that we know of no model along these parameters that has been successfully implemented for this type of population. Do you include prior utilization in making the groupings?
- How volatile and predictable are the costs? Do you employ stop/loss or risk corridors to help manage the volatility?

This question includes more considerations than just payment structure. Building a system of care for CMC will require some consistency in the model(s) developed



across the state. There is no benefit to multiple negotiations with multiple MCOs as independent efforts. There also is the fundamental question of what functions an MCO can contribute that are beneficial to the care of these children. Our clear preference is for a robust statewide integrated health home model where there is direct payment from the Medicaid agency itself. If a constructive role for MCOs emerges, then there need to be incredibly strict contract requirements that mandate the coverage of these specialized health home providers and services and that include minimum reimbursement amounts.

The perspectives and motivations of the state Medicaid agency and all state and local government is quite different than an MCO or ACO. Given the intensity of need and enduring nature of these conditions, most of these children and families will be dependent on government support over many years, most likely the full lifespan. The most effective early intervention and provision of the most effective services is logically associated with decreased future services and costs but that can be many years out. An MCO or ACO has a much shorter time horizon that drives their service and cost decisions. They tend to look at the current period as their focus for cost for various institutional reasons, financial viability and for privately traded entities, their quarterly earnings and stock price. For this population, the Medicaid agency has a vested interest in imposing their longer-range cost perspective when building this system.

This is evidenced in various ways and can start with as basic an issue as the breadth of view on utilizations impacts. Specifically, the experience of most complex care service delivery systems around the nation is that health insurance payers, Medicaid agencies, HMOs, and ACOs look at the increased costs of the pediatric comprehensive complex care health home and tend to look past or minimize the impact on other forms of utilization like inpatient hospital stays. There seems to be an entrenched fear that the broader utilization impacts will not occur even when there is considerable evidence. The Medicaid agency is best positioned to reach beyond that narrow view and to apply it on a statewide basis. Convincing every HMO or ACO across the state is a nightmare scenario.

There is considerable evidence that pediatric comprehensive complex care health homes do profoundly impact service utilization patterns and costs. Texas has the advantage of having some of that evidence produced by its own homegrown programs at the University of Texas Health Science Center Houston and the University of Texas, Dell Children's Comprehensive Care clinic (references upon request). Each individual program/clinic should not be burdened with having to produce its own evidence on its own. The transferability of this evidence, both from

within Texas but also among other similar programs around the nation, should be recognized.

To provide greater financial assurance to state government, CMS has at least two opportunities for higher matching funding for health home demonstrations assuming that such a model is adopted. Planning grants for 2703 waivers or the ACE Kids Act provide federal matching funds at the services rate (67 percent in FY22) rather than the normal 50percent rate for most staff and contractors. Even better, when operationalized, 2703 waivers provide a 90 percent matching rate for eight quarters for health home services. The ACE Kids Act provides a plus 15 percent FMAP for two quarters for health home services. This minimizes the state general fund commitment for a significant time period.

Finally, this population impacts other governmental costs. Human service agencies and the education system both have linkages. The demands of caring for their children which fall heavily to parents impact their earnings capacity with one parent often needing to stay at home full-time. That assumes that the family is able to stay intact with the pressures of these demands. Family disintegration is a major risk and then the government finds itself needing to provide broader supports with higher costs. Finally, the need for and cost of special education is very much in play and can be mitigated by improved outcomes for these children. While there isn't much evidence of the cost impacts, it should be intuitively obvious that these broader cost implications are active. This should be considered and made a priority for study by state government.

Looping back to MCOs and ACOs, there is almost no practical way that their incentives can be designed to include the collateral cost impacts on other government systems. This is yet another argument to have this population administered directly by the Medicaid agency through a health home system of care.

## **Contracting**

We propose a contract that is directly between the alternative model, in this case, the **Integrated Health Home** and the state Medicaid agency or it's designee.

The benefit of this contracting arrangement is that the health home will be fully invested with the authority to truly manage the care. That includes capacity to authorize services that are often prior authorized as a utilization control. The health home should be the manager of care and that includes fully delegated authority for

the necessity of individual services. The payment structure should be paired with this delegated authority with a focus on the total cost of care.

We need to emphasize the dysfunction that has occurred with those institutions that have already developed robust health homes for this population and the existing MCOs. Some of the MCOs are interested and constructive, but they are invested in their care coordination models and structures. This poses a natural barrier and underlying conflict. Add to this, the fact that these negotiations are replicated across the state between different institutions and MCOs. This leads to both inefficiency and paralysis. The model of care that needs to be developed for CMC should be consistent across the state. The network of IHH should work collaboratively with HHSC to develop guidelines, policies and procedures that meet the needs of children with CMC.

## **Quality Measures**

Quality metrics for CMC are particularly challenging, and we are not aware of reliable, standardized metrics. Utilizing HEDIS and other “healthy” population metrics has not been meaningful or useful.

Development of a network of Complex Care integrated health homes will allow for the development of potentially useful metrics. These quality measures should include child/family elements that directly address the experience of care and the family’s perception of the coordination of services. Are patients and families getting the services they need? Outcomes measures co-created with family members should be used.

The best judges of quality care are often the parents of the complex children. A process will need to be developed where parents are highly involved in development of metrics that encapsulate their definitions of quality. Using a Delphi processes, experts in the field and children and/or parents could identify and prioritize initial and future metrics. These could then be compared across clinical sites in the state to monitor variations and determine the meaning and impact.

Meaningful metrics for these children often span years of care, so short term metrics for patients with complex, longitudinal health issues are rarely relevant. Measures should also account for social determinants of health. As stated above, outcome measures need to be developed based on subsegments of the CMC population that are more homogeneous to enable meaningful outcome comparisons.

Quality measures should be patient-centered and as applicable patient reported/proxy reported. The quality measures should focus on if the care delivery has improved patient outcomes. Patient outcomes defined using the Capability, Comfort, and Calm framework and measured by assessing progress towards goals/priorities for care set with patients and/or parents as needed (references provided upon request).

The measure burden should be kept minimal. Only process measures that enable patient/parent set goals to be achieved should be tracked. Tracking measures that do not give insight into how patient health outcomes are improved add excessive and unnecessary administrative costs to the system.

Measures should also be included that measure the quality of the discussion between the patient/parent and the care team. One such measure is the NQF “Heard and Understood” measure. Other measures include ones developed by families at the Dell Children’s Comprehensive Care clinic. Measures should also include measures of care team well-being. Such measures can provide insight into how efficiently and effectively the enhanced health home operates. An example of this tool is one used by UT Health Austin in their outpatient clinics.

Measures should be collected at two levels. The first level is the patient level and during the course of care. These outcomes are often expressed in terms of health goals and enable the care team to organize the care and resources needed to achieve these goals as well as closely monitor whether the care delivery interventions are improving outcomes or not. If not, why not, and the care team can adjust course as needed. An important note about gathering data at the individual patient level, who asks these questions matters. In today’s paradigm, it is not uncommon for parents to receive calls from MCO personnel about medications their child is on, services rendered, etc. without any questions related to if the medications or services helped the child achieve their health goals. This is another area where the integrated health home serves as a trusted collector of outcome data because both the team and family are coalesced around a common goal that is set and revisited until achieved.

The second level is at the integrated health home level. These data are aggregated data about the performance of the hub in achieving the outcomes that matter. The aggregated data also include emergency room and hospital utilization data.

As described earlier about the need to implement a phased approach to implementing value-based reimbursement, a phased approach will be necessary

when it comes to implementing quality, outcome, and value measurement both at the individual patient and family level and at the hub level. First, the necessary technical infrastructure will need to be established. This is not necessarily new infrastructure but could be through a partnership with an existing data warehousing and analytic entity. We propose using a third party to hold all quality, outcome, cost, and claims data that can be used by the integrated health hubs to measure their performance. These data would also be shared through the learning collaborative to drive continuous quality improvement within the network.

Considering that the UT School of Public Health in Houston holds the contract for Medicaid managed care quality evaluation and holds HHSC data, we propose working with this entity to develop the robust analytic infrastructure needed by the network that would include both clinical and claims data from all claims databases in Texas. The Texas Medicaid and Healthcare Partnership, a statewide specialized system of care, calls for a consistent adjudication of claims and centralized analytic capacity. A data governing board is a must and must include patients and families.

In the first phase, baseline quality, outcome (patient-reported), cost, and claims data needs to be gathered and analyzed. Currently, HHSC does not collect data at the right level and with the precision needed to assess quality of care for individual patients and families. This needs to be rectified in the data structure of the new analytic platform. Emergency room and hospital utilization data should be routinely monitored. These data should reflect visits to any and all emergency rooms and hospitals within Texas.

In addition to stratification by subsegments, additional risk stratification may be needed and would be developed alongside parents, CMC care providers, and statistical and/or actuarial experts.

Regarding incentive-based payments for quality, our experience has been that incentive-based programs are often not directly relevant to improving health outcomes of CMC patients and families. Some broad goals designed for healthy children are not achievable depending on the patient population.

## **Conclusion**

While there are some features of the STAR Kids model that help better coordinate services, the MCOs still operate what is essentially a fee-for-service system. The level of integration that is needed by this population calls for a different model of care, and we applaud you for issuing this RFI.

The children and families in the STAR Kids system, and particularly those that meet the ACE Kids definition of health complexity, need a high level of support. The daily burden of care can be crushing. An alternative robust health home model is certain to improve the coordination of medical services and the level of support experienced by these children and families. Team visits can simplify negotiating seeing different providers in different places at different times (and days). That reduces transportation and its challenges. Knowing care team staff more intimately means fewer needs being overlooked. Some providers in the care team can be deployed to do home visits to better understand the whole child/family situation.

Telehealth can be utilized after relationships are built. Specialists can be accessed immediately as urgent medical symptoms arise reducing the need for emergency department visits and the inevitable delays in getting to the appropriate specialist. Services such as wheelchairs can be prescribed and delivered on a timelier basis removing roadblocks in the current system. And on and on.

## 5. Value-Based Payments for Pediatric to Adult Value-Based Payments for Pediatric to Adult Health Care Transition

The subcommittee on transition has been working with HHSC and the National Alliance to Advance Adolescent Health to explore options to promote quality healthcare transition planning for young adults and improvements to the smooth transition of children from STAR Kids to STAR+Plus. The National Alliance to Advance Adolescent Health received funding from the Lucille Packard Foundation to provide technical assistance on health care transition to various states. Texas was offered the opportunity to participate and receive the valuable technical assistance from the nationally recognized group. We participated regularly in the calls with the National Alliance to Advance Adolescent Health to explore value-based payment options for transition as well as pay for quality measures.<sup>2</sup>

- Resources and Measures on Gaps in Care
- Health Care Transition Pay-for-Quality Bonus Pool Structural and Outcome Measure Options for Pediatric, Family Medicine, and Adult Practices
- Health Care Transition Pay-for-Quality Bonus Pool Structural and Outcome Measure Options for Pediatric and Adult Practices
- Suggestions for Texas STAR Kids CAHPS Survey
- EMR And Information Technology Workgroup to Better Support Pediatric-to-Adult Transitional Care
- Health Care Transition Contract Language and Quality Measures
- Pediatric to Adult Transitional Care Structural Measures
- Transitional Care Quality Measures
- Training Webinars
- Crosswalk of STAR Kids Recommendations for Options for MCO Contracting, Payment, and Quality Measurement
- Transition Value-Based Payment Options

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<https://static1.squarespace.com/static/5871c0e9db29d687bc4726f2/t/62a1430da00186530349c9fc/1654735630307/Guide+for+Designing+VBP+Initiative+for+HCT+-+Updated.pdf>

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Revised: 12/2021

## 6. Committee 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 Physician (PCP) and parents engage in a person-centered process of goal setting and shared decision making to allow appropriate access to and 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.

As in previous reports, recommendations and updates, stakeholder input (especially that from families, public comment, work groups and the Star Kids Advisory Committee meetings) has been incredibly beneficial and successful in improving efficiency, access, and care for children in Star Kids. The committee recommends ongoing use of stakeholder feedback to continue to improve, adapt and ensure coordinated care.

In the past year, healthcare delivery systems were forced to make dramatic adaptations in response to COVID. We will draw from these experiences as we make our recommendations as it relates to health homes and quality measures.

#### 1.1 Topic/Issue: Service fragmentation and potential opportunities from telemedicine

Children served in the STAR Kids program, especially children with medical complexity receive services from multiple providers, subspecialists, home



health agencies, durable medical equipment providers and personal care attendant services.

As these providers function as independent business entities, with no mechanism for data sharing; families are subjected to redundant assessments, evaluation and surveys necessitating additional layers (and time) and cost for care coordination and case management.

The COVID pandemic was particularly challenging for this population, but it has also allowed innovation - especially as it relates to efficiencies offered by telemedicine and the potential for telemedicine to enable true service integration and real-time multi-disciplinary collaboration in safe, timely way benefiting providers, families and MCOs.

The data from this experience is barely emerging around the country. Dr. Ricardo Mosquera – a member of our subcommittee has been a pioneer of telemedicine practices for this population and had performed a randomized controlled trial in the period just preceding the COVID pandemic (August 2018- April 2020). In a recent presentation to the Policy Council for Children and Families, his team showed the cohort served by telemedicine had a higher probability of decreased emergency room visits, decreased hospital days and decreased total days of care.

There is anecdotal evidence that shows benefits that derive from decreased exposure to illnesses in the waiting room and decreased cost of ambulance transport and missed work for in-person visit.

In addition, in an on-going pilot at the Children’s Comprehensive Care, the team is trying to leverage the virtual technology platform of telemedicine to have bi-annual health maintenance visit where all the care providers will participate in a virtual visit to allow for a coordinated assessment and care plan development.

Successful integration of service delivery and care plan development is dependent on three prerequisites.

- a common data platform that allows data sharing between the different provider entities.
- a payment scheme that incentivizes integration (e.g., a bundled payment for all participating entities) and
- an evaluation schema that assesses the effectiveness of the model as a ‘whole’ instead of separate schemes for each entity.

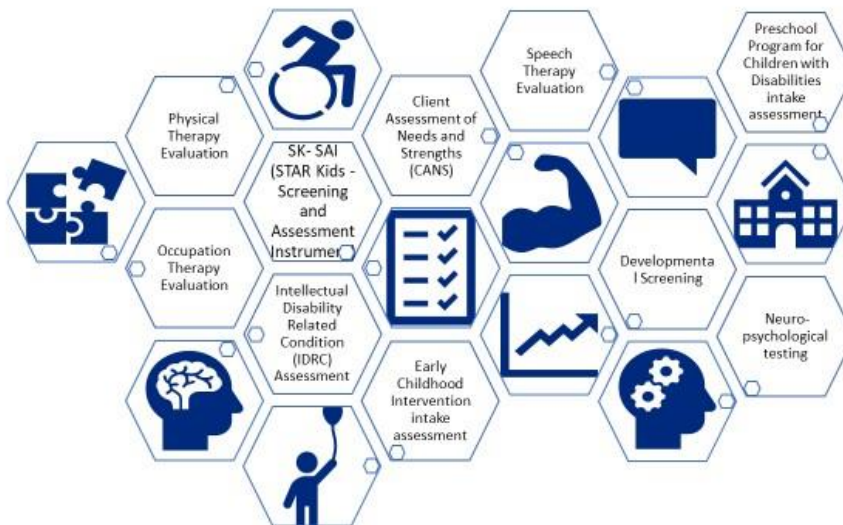
## Recommendation:

We recommend HHSC incentivize efforts to make these three pre-requisites possible. Given the unique nature of the STAR Kids population, the opportunities offered by telemedicine need to be carefully evaluated and expanded, as appropriate, even after the COVID crisis resolves.

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

The process of delivering care as it exists is fraught with redundant assessments and evaluations by different entities; (See graphics below for a representation of some of the assessments a single individual may undergo over the course of a year.)

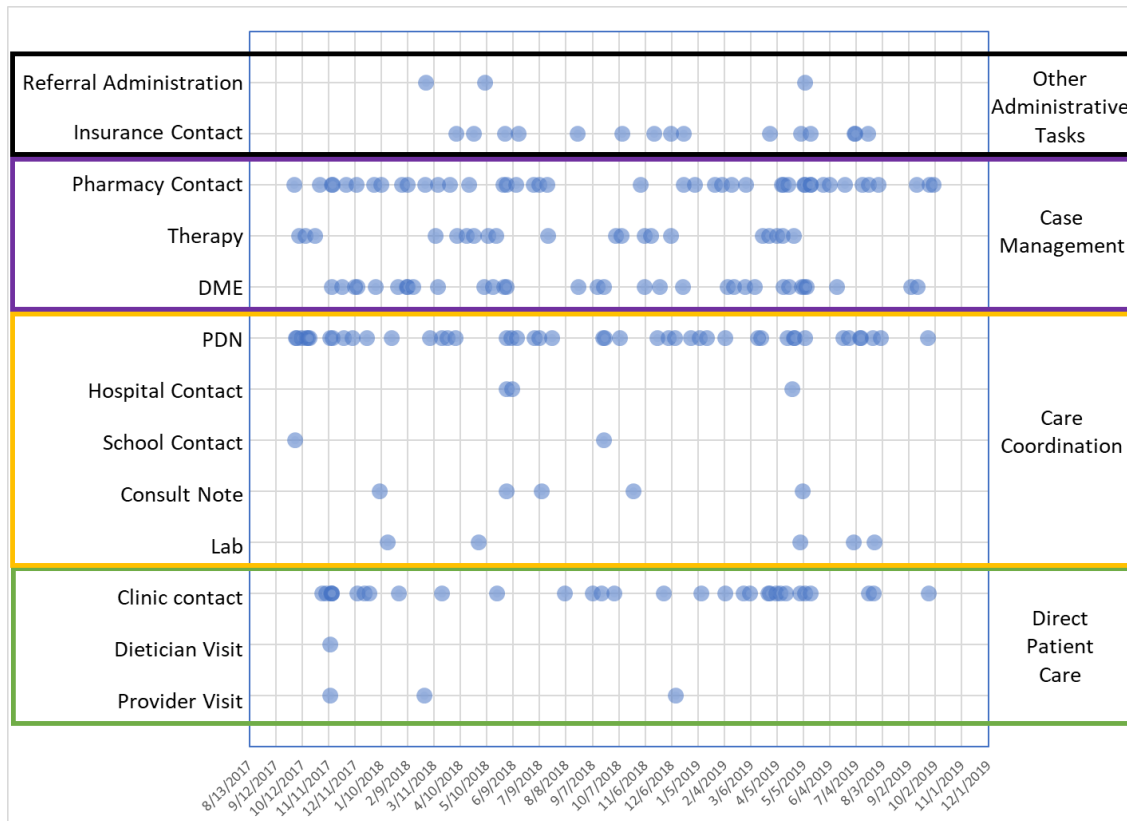
### Assessment, Assessment, Assessment



Many of the assessments are done by disparate entities that operate as silos and have no mechanism for data sharing and operational integration.

In addition, repeated requests for justification of care and letters of medical necessity result in several hours a week of parent and provider time spent complying with these paperwork requirements. The following graph represents the contact points for a single patient receiving care at a comprehensive care clinic over the course of two years. As the graph indicates, of the more than 200 contact

points, much of the time is spent on paperwork to justify care than actual care delivery.



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 which has led to a frustrating situation to providers. PCPs sometimes must do peer-to-peer consultations with MCO medical directors, many of whom do not have any specific expertise with this population.

Since the submission of our last report, several of our recommendations related to administrative simplification were initiated and are currently underway at HHSC. For example, HHSC is piloting with an MCO a mechanism to decrease administrative burdens related to medical supplies through a process of streamlined and longer prior authorization periods for children whose needs have not changed. See recommendation 1.2.i below. In addition, S.B. 1207 and 1096 as well as H.B. 3041 from the 86<sup>th</sup> Texas Legislature, Regular Session, 2019 required MCOs to annually review prior authorization requirements for relevance.

## Recommendation:

We recommend HHSC encourage and facilitate simplification of administrative paperwork as it relates both from provider to MCO as well as MCO to HHSC and continue to include committee representation in the discussion. For example:

- Use the SK-SAI to allow for the identification of children where certain services and supplies will be needed for the duration of the child's life. 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. Expand the medical supplies pilot currently underway at HHSC to other MCOs and regions.
- 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. A pilot project with a Medicaid MCO and a comprehensive care clinic is currently underway to fast track authorizations and decrease administrative burden. The subcommittee will monitor the implementation and report to the full committee.
- HHSC should incentivize systems of care that allow for a coordinated review of needs at specified time points to streamline the approval and delivery of supplies and medications. Currently most authorizations for supplies, equipment and medications occur at desperate times in a very uncoordinated and haphazard manner. It is not unusual for a family to make a trip to the pharmacy every other day.
- 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. This recommendation is supported by S.B. 1207 which requires an annual review of prior authorization processes.
- 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: Improved care coordination through the development of health homes for children with medical fragility and serious mental health care needs**

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:**

- Incentivize the development of dedicated comprehensive service lines within FQHCs and large primary care practices and their collaboration with centers of excellence.
- 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.
- 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.
- Pay providers a higher rate for caring for children with complex medical needs and children with serious and persistent mental illness. 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.

- Promote this collaboration through statewide pilot projects; participating actively in national innovative projects and focusing Performance Improvement Projects (PIPs) to address some of these processes.
- HHSC should take full advantage and participate in the ACE Kids Act when it rolls out to states.

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

PCPs who have longitudinal relationships with families caring for children with complex needs 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 Private Duty Nursing 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.

Many families of children with medical complexities would be amenable to delegation of nursing tasks to a direct service worker through personal care services or Community First Choice if they were provided attendant care that was reliable and qualified. The current rate of \$8.11 an hour for a direct service worker is too low to support delegation. In addition, families of children with significant behavioral support needs had hoped that Community

First Choice would provide opportunities for support and a decrease in episodes of crises that lead to hospitalization and institutionalization. However, it is incredibly difficult to find someone who will provide the support needed for \$8.11 an hour. Finally, the recent implementation of Electronic Visit Verification for families using Consumer Directed Services and for individuals in waiver services has led to further disruption to this incredibly important support for families who want to keep their children at home instead of institutions.

## Recommendations:

- HHSC should closely evaluate through data collection whether individuals are being assessed for Community First Choice and Personal Care Services.
- HHSC should closely evaluate through data collection whether individuals who are receiving CFC or PCS are receiving the number of hours they have been assessed as needing.
- HHSC should include the following recommendations as strategies for the recruitment, retention, and access to community attendants.
  - ▶ Facilitate/incentivize the creation of community attendant registry to help families find direct service workers.
  - ▶ Encourage value-based payment models that incentivize the 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.
  - ▶ Increase the Medicaid fee schedule for Personal Care Services and Community First Choice.
  - ▶ Explore models that allow families to be providers of care such as Parents as Certified Nurse Assistants in Colorado.

## 1.5 Issue/Topic: Measuring outcomes that matter

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.

Unfortunately, validated measures that are specific to this population are very limited. Understandably, measures used in the general population (HEDIS) have been used in this population. Some of the limitations of using HEDIS measures in this population include the following:

- Requirement for UTD immunization - Some children with medical complexity have an immune deficiency syndrome that prohibits the use of any live virus

vaccines (e.g., DiGeorge's Syndrome). Some children are undergoing interventions that require delaying vaccination (e.g., children with complex congenital heart disease - delay immunizations for six weeks before and after bypass.

- Requirement for 'physical activity' and 'weight counseling' - The verification of these measures does not take into consideration the possibility that the child may be on an exclusively gastrostomy tube feeds that may be managed by a dietitian. In some instances (such as for children with cerebral palsy), the degree of physical activity and weight bearing allowed is determined by the physical therapist. Therefore, counseling on physical activity may be inappropriate. The verification of these measures does not consider the dietitian visits that provide rich documentation of their involvement and management.
- Follow up visit after ADHD; Lab monitoring with antipsychotics - Many of the children with behavioral challenges due to organic brain syndrome, children on the spectrum etc. are started on stimulant medications to help manage behavior. The guidelines do not take into account the complex polypharmacy that may be involved. The blood test requirements also tend to be very rigidly applied. For some of these children, conscious sedation is required for any medical procedure (including blood work). This rigid time interval for monitoring - with no regard for the risk of metabolic syndrome, exposes these children to more harm than good.

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:**

- HHSC should incorporate waivers for certain HEDIS measures to avoid unfairly penalizing practices that have a high proportion of children whose conditions do not comport with the HEDIS measures.
- Include 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.
- HHSC should pay particular attention to include outcome measures that directly measure the capability/comfort/calm of members – in the next



iteration of the SK-SAI. Collaboration with pilot projects such as COIIN (<http://cahpp.org/project/CoIIN-CMC>) and other groups working on improvement will be helpful

- HHSC should 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 <https://innovation.cms.gov/initiatives/integrated-care-for-kids-model/> and also <http://cahpp.org/project/CoIIN-CMC>.
- HHSC should participate in the implementation of the ACE-KIDS act (<https://www.congress.gov/bill/116th-congress/senate-bill/317>) and use opportunities such as the 1115 waiver to jump start innovation. 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. HHSC should begin mapping out what is needed prior to the next legislative session to avoid missed opportunities.
- HHSC should 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 authority and health homes. These health homes can utilize telemedicine to access psychiatric medication management; utilize evidence-based family supports such as the Family Partner program by the National Alliance of 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.

## **Subcommittee on Assessment and Service Delivery**

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 STAR Kids Screening and Assessment (SK-SAI) 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.

HHSC has engaged in an optimization project to improve the SK-SAI with the goal of improving data integrity and reporting; creating a more actionable assessment; ensuring assessor accuracy; and reducing assessment burden on families. The committee has worked diligently with HHSC since August 2019 to offer feedback to proposed changes to the SK-SAI. HHSC is still reviewing our feedback, including recommendations from MCOs before the changes are finalized. Our subcommittee is interested and committed to improving the assessment and reassessment of children and reducing assessment burden on families. 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 Tool Improvements**

HHSC has embarked on an internal review of the SK-SAI for optimization and improvement. The STAR Kids Advisory Committee has offered numerous improvement recommendations to the assessment and is planning to work with HHSC on changes to the reassessment process.

### **Recommendations:**

- Continue to work with the committee on improvements to the SK-SAI.
- Test the new assessment on a small sample of children, including children with medical complexities, children with intellectual and developmental disabilities and children with significant mental health needs prior to implementing the new tool. Include MCO assessors in the testing of the assessment and revise based on testing.
- Ensure the revised tool contains solid triggers for referrals for Community First Choice, durable medical equipment, Personal Care Services, and therapy.
- Provide guidance to the SK-SAI assessor directly on the tool for questions that require judgement such as questions that are those using a scaling system.
- Work with the committee on a reassessment tool that limits questions based on no change in condition and which focuses on assessing for improved outcomes for children.

- The SK-SAI should account for medical intervention as a contributor to how one answers the questions. 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. Families should be asked to what they attribute the change.
- Expand the HHSC Utilization Review Department’s operational review of STAR Kids to include children who are not in MDCP such as children with IDD and MH conditions and evaluate whether changes are needed in the SK-SAI to capture a child’s need for services.
- Monitor the testing of the new tool and make changes based on feedback from the families and MCOs.

## 2.2 Topic/Issue: MDCP SK-SAI

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 percent in 2016 to 14.1 percent in 2017 and 8.7 percent in 2018. Initial reports for the period of November 2018 to October 2019 show the number to be approximately 5percent which is a substantial improvement over 2017 and 2018. Many of the children who lost eligibility during the early implementation of STAR Kids 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:**

- Consider alternative options for assessing children for eligibility for the MDCP waiver, including requiring the assessment be done by an assessor who can do a hands-on nursing assessment, not the MCO nurse assessor who is prohibited from doing a thorough nursing assessment.
- Continue to monitor the number of MDCP denials at the annual reassessment and consider reverting to the MN-LOC tool to determine MDCP eligibility as opposed to the SK-SAI if the number increases.
- 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) with no wait.
- Amend the MDCP waiver to create reserved capacity for crisis diversion slots for a targeted group of children who are determined to be medically fragile and at imminent risk of nursing facility admission. Because the MDCP waiver waives off both a hospital level of care and/or a nursing facility level of care, a child who meets the medical fragility eligibility for MDCP and is at imminent risk of admission to a nursing facility should be able to access the waiver without a limited stay in a nursing facility. A child should not have to get 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.
- Allow children enrolled in STAR Kids who have SSI and meet the MDCP waiver eligibility immediate access to waiver services with no wait.
  - ▶ Create a similar allowance for children in STAR Health.

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

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. Based on recommendations in last year's report and legislative direction, HHSC added requirements in the STAR Kids contracts (8.1.39) that parents review the SK-SAI

prior to submission. HHSC also instructed MCOs to train members in the navigation of member portals and required them to submit education materials to HHSC for review. We understand HHSC is embarking on a significant utilization review initiative of children receiving services through the Medically Dependent Children's Program. We recommend that during the review HHSC monitor whether training on portal access is occurring.

## **Recommendations:**

- HHSC should monitor the MCOs to ensure MCOs have offered individualized training to families on how to access the health portal to:
  - ▶ See the SK-SAI
  - ▶ Review the Individual Service Plan (ISP)
  - ▶ Track authorizations, view claims and find information on the child's MDCP budget, and pending and final denials and reductions
  - ▶ Request an internal appeal
- HHSC should require the MCOs to notify individuals via a text, email or call when a document has been uploaded to the member portal. Parent contact information including email addresses can be updated at every reassessment for accuracy.
- HHSC should develop a document that can be sent from the MCO to the family 120 days prior to the annual assessment informing them:
  - ▶ What to expect at the assessment
  - ▶ What documents to have ready

## **2.4 Topic/Issue: Medical Necessity and Treating Physician**

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. Some children have experienced a reduction in authorizations for PDN, MDCP waiver eligibility, therapies and other benefits. 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.

S.B. 1207 required HHSC and the State Medicaid Managed Care Advisory Committee to develop a uniform process and timeline for reconsideration of an

insufficient prior authorization request and allow for a peer-to-peer review. Two of our committee members are serving on the subcommittee charged with developing the recommendations. S.B. 1207 also requires an external medical review process when a family or their child's treating professional disagree with an adverse benefit determination.

### **Recommendations:**

- Continue to develop uniform process and timeline for reconsideration of prior authorization requests prior to denial.
- Monitor the implementation and provision of external medical reviews as required by S.B. 1207. Publicly post data related to external medical reviews including number of denials overturned and number sustained.

## **2.5 Topic/Issue: Preferred Provider**

### **Recommendations:**

HHSC should retain the allowance in STAR Kids for a member to opt out of a preferred provider arrangement and choose a different provider. Members should continue to have a choice of providers for specialty services and DME, including non-preferred provider arranged services.

- HHSC should require in contract that 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.
- HHSC should monitor to ensure the preferred provider opt out process is working and easy for families to access and use.

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

Families and providers report 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.

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.

HHSC has undertaken several initiatives to improve notices of denials of benefits which were included in last year's report. We will continue to work with HHSC and the State Medicaid Managed Care Advisory Committee's subcommittees to ensure recommendations and on direction from the legislature.

### **Recommendations:**

- 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.
- Monitor whether denial notices are being sent out the same day the determination was made, and if there are significant violations, consider requiring the notice to be delivered via registered mail to ensure the time frame is followed.
- Require MCO service coordinators to contact families when an adverse determination is being sent and remind the family of their right to appeal the denial.
- 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.
- 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.

## **2.7 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.

- Require state agencies and MCOs to track all instances of access to care issues as a complaint.
- 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.

## **2.8 Topic/Issue: Coordination of Benefits, Continuity of Care, and Alternative service delivery model for children in Medically Dependent Children Program**

Some families of children in the STAR Kids MDCP waiver 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.

Approximately 50 percent of children receiving services through MDCP have third-party insurance.

### **Recommendations:**

- Prioritize the development of clear and standard policies around coordination of benefits for those with third-party insurance.
- Define specialty providers broadly to include providers of therapy and durable medical equipment
- HHSC should work to develop a list of services that are rarely provided via commercial insurance and allow MCOs to authorize services without waiting on Explanation of Benefit from a commercial carrier.
- Ensure the continuity of care provision is a minimum of 90 days.
- Allow families to access out of network providers with no penalty to MCOs.
- Exempt the MDCP population from any out of network utilization benchmarks placed on MCOs.
- Improve access to single-case agreements and make the process easier for families to access and physicians to accept.
- Investigate alternative models of service delivery for children in MDCP such as Primary Care Case Management, Fee for Service, or an Accountable Care Organization.



## **2.9 Topic/Issue: Inclusion of IDD Waivers into STAR Kids**

The IDD System Redesign Advisory Committee created as part of S.B.7 by the 83<sup>rd</sup> 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.

### **Recommendation:**

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.

## **2.10 Topic/Issue: Evaluation of whether to move to STAR Kids to statewide MCO**

HHSC released a Request for Information asking for feedback on whether STAR Kids should move to one statewide service delivery area served by 2 or 3 statewide MCOs.

### **Recommendations:**

- Do not implement a statewide service delivery region for STAR Kids. A statewide model would potentially prevent community-based plans and small plans from participating and have a potential negative impact on promising practices. HHSC should continue to encourage competition among non-profit and for-profit models and the development of quality standards of care for vulnerable children.
- Consider allowing families who live on bordering regions to select the neighboring region if most of their health care providers are in that region.

# Subcommittee on Transition from Pediatric System to Adult System

According to the American Academy of Pediatrics, American Academy of Family Physicians, and the American College of Physicians 2018 Clinical Report on supporting health care transition (HCT) from adolescence to adulthood, evaluation studies document beneficial outcomes of a structured transition process in terms of quality of care, appropriate service use, and improved patient and family experience.<sup>3</sup> The goals of HCT are to 1) improve the ability of youth and young adults, including those who have special health care needs and those who do not, to manage their own health and effectively use health services, and 2) ensure a planned process for transition preparation, transfer of care, and integration into adult care. The recommended process called for by these medical professional organizations is the Six Core Elements of Health Care Transition, developed by Got Transition.<sup>4</sup>

**3.1 Topic/Issue: Medicaid fee schedule gaps impede the provision of recommended Health Care Transition services and collaboration between pediatric and adult providers for our STAR Kids population. It is important to have a mechanism to allow pediatric and adult providers to bill for professionally recommended health care transition-related services.<sup>5</sup>**

The medical complexity of our STAR Kids population necessitates a formal structured transition process from pediatric to adult health care with corresponding payment to recognize the added work and collaboration involved. According to Texas' 2020 Medicaid fee schedule, the transition-related CPT codes that are

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<sup>3</sup> White P, Cooley C, Transitions Clinical Report Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. 2018;142(5):e20182587.

<sup>4</sup> Six Core Elements of Health Care Transition 3.0. Washington, DC: Got Transition. Available from: <https://www.gottransition.org/six-core-elements/>

<sup>5</sup> McManus M, White P, Schmidt A, Kanter D, Salus T. 2020 Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care. Washington, DC: Got Transition, March 2020. Available at <https://www.gottransition.org/resource/2020-coding-tip-sheet>

currently covered for **all** patients include prolonged services with direct patient contact (99354, 99355). For physicians caring for **individuals under 21**, covered codes include care plan oversight services (99339, 99340) and prolonged services before and/or after direct patient contact (99358, 99359). The current Texas Medicaid fee schedule does **not** recognize several transition-related codes listed below in the recommendations. In addition, Medicaid does not allow a medically complex child to have both pediatric and adult providers for a limited period of time to ensure a smooth and continuous handoff nor does it allow for payment for joint telehealth or in-person visits with the pediatric and adult provider and the transferring patient/caregiver.

## Recommendations

- Recommend recognition of the following transition-related CPT codes in Texas' Medicaid fee schedule.
  - ▶ Health and behavior risk assessment (96160)
  - ▶ Care plan oversight services for physicians caring for patients ages 21 and older (99339, 99340)
  - ▶ Prolonged services before and/or after direct patient contact for physicians caring for patients ages 21 and older (99358, 99359)
  - ▶ Interprofessional telephone/internet/electronic health record consultations (99446-99449, 99451, 99452)
  - ▶ Care management services (99487, 99489, 99490, 99491)
  - ▶ Transitional care management services (99495, 99496)
- Allow for two assigned pediatric and adult providers to bill for the same patient to facilitate shared care management and a smooth handoff.
- Recommend a new HCPCS code for joint pediatric/adult/enrollee visit prior to the initial adult visit (in-person or virtual).

### **3.2 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.**

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:**

- Update the age out process to allow **all** members to receive STAR+Plus enrollment information packets 6-9 months prior to their 21<sup>st</sup> 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.
- 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.

### **3.3 Topic/Issue: Limited coordination of services between STAR Kids and STAR+Plus plans to ensure member receipt of recommended services for transition planning, transfer or care, and integration into adult care.**

Currently, STAR Kids contract has several requirements for the role of transition specialists in addition to and separate from their service coordination requirements. The STAR+Plus receiving plans do **not** include any contract requirements related to transfer and integration into adult care to help support the member/family upon their 21<sup>st</sup> birthday and to coordinate with STAR Kids for an effective transitional care process, ensuring continuity of care between pediatric and adult providers during this vulnerable period of time. Research shows that when Youth and Young Adults with Special Health Care Needs do not have access to a planned transition process, they have a higher likelihood of gaps in care, higher ER and hospital use, high levels of worry and stress, and higher rates of morbidity and even mortality.

## **Recommendations:**

- 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 to subsequently update over time.
- Add additional HCT contract requirements for both STAR Kids and STAR+Plus plans, consistent with the 2018 AAP/AAFP/ACP Clinical Report and the Six Core Elements of HCT and include the elements in MCO performance reports. These include: maintaining up-to-date listings of adult clinicians available to care for young adults with medically complex conditions, ensuring coordination between pediatric and adult providers regarding transfer to adult care and timely exchange of transfer package with a current plan of care and medical summary/emergency care plan, welcoming and orienting new members to adult practices and tracking completion of initial visits, conducting periodic transition readiness/self-care skills assessments and creating a plan for addressing prioritized self-care skill needs, and helping members identify adult public program services they are eligible for and facilitating connections.

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

Currently, only the STAR Kids contract has a requirement for the role of transition specialists. However, the standardization of Health Care Transition processes for these transition specialists requires additional training and support to ensure a consistent knowledge and application of transition requirements. With additional transition requirements in the STAR+Plus plans, new training will be needed for all transition specialists and plans.

## **Recommendations**

- Adopt and implement the 2018 AAP/AAFP/ACP Clinical Report on transition and Got Transition's Six Core Elements of HCT as best practices, as

summarized in the side-by-side.<sup>6</sup> This HCT approach can be customized for use by MCO plans and participating pediatric and adult provider networks. MCOs and provider networks can annually assess their level of HCT implementation using Got Transition's easy-to-use Current Assessment of HCT Activities.

- Develop a standardized template for transition plans that can be used across plans and that includes all required HCT elements.
- Ensure durable medical equipment is ordered and secured well before a transition to STAR+Plus, preferably 12 months prior to the young adults 21<sup>st</sup> birthday.
- Require training of MCO transition specialists on
  - ▶ Got Transition's Six Core Elements (for use in STAR Kids and STAR+Plus)
  - ▶ Alternatives to guardianship
  - ▶ Supported decision making
  - ▶ Creative housing options including shared living arrangements and host homes
  - ▶ Supported employment
  - ▶ Utilization of the Navigate Life web reference
- Promote best practice sharing among MCOs by hosting regular transition planning conferences and trainings for MCO transition specialists and care coordinators.

### **3.5 Topic/Issue: Lack of Medicaid adult primary and specialty care providers available to care for complex patients aging out of pediatric care.**

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. As a result, many young adults are remaining with pediatric providers when they should be seeing adult care providers. In

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<sup>6</sup> Six Core Elements of Health Care Transition 3.0: Side-by-Side Comparison. Washington, DC: Got Transition, July 2020. Available at <https://www.gottransition.org/6ce/?side-by-side>

addition, many adverse and preventable complications for medically complex individuals result when the handoff to adult care is not carefully coordinated and planned for.

## **Recommendations:**

- Design, pilot, and evaluate innovative value-based transition payment pilots to 1) increase the availability of participating adult physicians in the geographic areas of concern, 2) strengthen the coordination and communication between pediatric-sending and adult-receiving practices, 3) expand the level of HCT support available to medically complex youth and young adults and their caregivers in both pediatric and adult sites, and 4) improve appropriate use of health care among this vulnerable population. Such innovative VBP transition pilots shall consider the payment and quality options in The National Alliance to Advance Adolescent Health's Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems: A Leadership Roundtable Report.<sup>7</sup>
- HHSC should require MCOs to regularly survey their adult provider network to assess the availability of open panels for transitioning youth/young adults with medical complexity, intellectual and developmental disability, and serious mental/behavioral health conditions.

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<sup>7</sup> McManus M, White P, Schmidt A. Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems: A Leadership Roundtable Report. Washington, DC: The National Alliance to Advance Adolescent Health, 2018.

## 7. 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,
- Strengthened transition processes for children as they enter adulthood.



## List of Acronyms

| Acronym | Full Name   |
|---------|---|
| AAP     | American Academy of Pediatrics                    |
| AAFP    | American Academy of Family Physicians             |
| ACP     | American College of Physicians                    |
| ADHD    | Attention-Deficit/Hyperactivity Disorder          |
| ASD     | Autism Spectrum Disorder                          |
| CFC     | Community First Choice                            |
| CLASS   | Community Living Assistance and Support Services  |
| CMC     | Children with Medical Complexity                  |
| CNA     | Certified Nursing Assistant                       |
| CoIIN   | Collaborative Improvement and Innovation Networks |
| DBMD    | Deaf Blind/Multiple Disabilities                  |
| DME     | Durable Medical Equipment                         |
| EQRO    | External Quality Review Organization              |
| ER      | Emergency Room                                    |
| FQHC    | Federally Qualified Health Center                 |
| HCS     | Home and Community-based Services                 |
| HCT     | Health Care Transition                            |
| HEDIS   | Healthcare Effectiveness Data and Information Set |
| 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                             |
| PIP     | Performance Improvement Project                   |
| 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                      |
| TAMU    | Texas A&M University                              |
| UTD     | Up-to-date  |
| VBP     | Value Based Payment                               |

# **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
- Rosalba Calleros, Austin, Texas Parent to Parent
- Catherine Carlton, Arlington, MHMR of Tarrant County
- Tara Hopkins, Austin, DentaQuest
- Dr. Glen Medellin, San Antonio, The University of Texas Health Science Center
- Blake Smith, Denison, Steps2Strides Therapy Center
- Angela Trahan, Houston, United Healthcare Community Plan – served until March 2021
- Terri Carriker, Austin, Parent Representative
- Dr. Kathryn Ostermaier, Houston, Texas Children’s Health Plan
- Alice Martinez, San Antonio, Clarity Child and Guidance Center
- Shawnett Viani, Denton, Member Representative
- Beanca Williams, Houston, Volunteers of America
- Dr. Ricardo Mosquera, Houston, University of Texas Health Science Center
- Jose Pereida, Robstown, Parent Representative
- Iris Gutierrez, Driscoll Health Plan – new member as of June 2021
- Belinda West, Thrive Skilled Pediatric Care – new member as of June 2021

# Minutes from Committee Meetings

Link to past meeting minutes:

<https://www.hhs.texas.gov/about/leadership/advisory-committees/star-kids-managed-care-advisory-committee>