

Children's Policy Council Recommendations to HHSC/Medicaid StarKids Model

March 2014

The Mission of the Children's Policy Council is to promote and advocate for public policies that support families of children with disabilities, enabling their children to grow up in families, be an integral part of their communities, and meet their potential.

Statutory Authority

The Children's Policy Council, statutorily authorized by HB 1478 (77th Legislature, 2001), is charged with assisting the Texas Health and Human Services Commission (HHSC) in developing, implementing, and monitoring long-term supports and services programs providing support to children with disabilities and their families. The Council works to assist the state in improving Texas' systems of supports and services for children with disabilities and their families by offering recommendations to improve access to appropriate services, improve the quality of services, and maximize cost efficiencies. The primary goal of these recommendations is to promote healthy families and ensure that children with disabilities have the opportunity to grow up in safe and nurturing families.

During this past legislative session, the HHSC Commissioner was charged with consulting with the CPC in the implementation of the STARKids managed care program. SB 7(83rd Legislature, 2013)

Background

The Children's Policy Council has been working for 13 years to help improve the systems of supports and services for children with disabilities and their families. The Council has historically focused on the following principles:

- All children should grow up in families.
- Institutionalization of children negatively impacts all areas of the child's development. We must provide the services and supports families need to prevent the institutionalization of children with disabilities.

CPC believes these key principles should drive the development and implementation of STARKids.

Children who are medically fragile, mechanically dependent, chronically ill, and with long-disabilities have a broad range of medical, therapeutic, and supportive care needs, and a key issue in the application of managed care models to this population is what part of the care spectrum should be "managed." It is important to note that within the population of children with high health care needs, there is a subset of children with extremely severe medical conditions that require continuous and highly specialized care that also must be considered in a managed care program. To conceptualize the most important managed care recommendations for the special needs population that will be a part of STAR Kids, it is critical to have a fundamental understanding of this defined population, and how the structure and incentives of a managed care model for children may impact access, cost and quality outcomes for children with severe and chronic disabling conditions.

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HHSC identified three areas for CPC input into the development and implementation of STARKids:

**SERVICE COORDINATION
DEVELOPMENT OF COMPREHENSIVE ASSESSMENT
PRIVATE INSURANCE COORDINATION**

As requested, the CPC STARKids Workgroup is providing recommendations on these areas first, then also made recommendations as to the other core components of STAR Kids.

1. SERVICE COORDINATION

Parents take an active role in negotiating the health care system for their children. In brief, many parents take on the "coordination of care" role that is generally lacking in the fee-for-service system. Consequently, their interactions with the care coordination function of a managed care system may require a new accommodation of respective roles in managing the care of the child with a disability.

Service Coordination Description

Comprehensive service coordination enables people with special health care needs, especially children with chronic conditions, to navigate through complex Medicaid managed care systems. Service coordination can include brokering for social support and medical services, breaking down boundaries between systems of care, assisting families with transportation and telephones—in short, whatever it takes to keep children at home and healthy. For the Medicaid managed care population, service coordination must be broader than simply expanding case management to include referrals for social services. Creative problem-solving, through advocacy, is an important new role for service coordinators.

Recommendations

In 2013, Colorado developed a care coordination resource guide that is intended for three distinct audiences: 1) families/consumers of care coordination-related services; 2) care coordinators and providers of services; and 3) systems-level agencies that develop policies and programs. The guide was developed by Colorado's Care Coordination Community of Practice whose mission is to offer a definition, values, functions and outcomes of care coordination across all sources of service. Members of the Care Coordination Community of Practice included JFK Partners with the University of Colorado School of Medicine, Department of Health Care Policy and Financing, Department of Public Health and Environment, Family Voices, Denver Health and Hospitals, Jefferson County Public Health and Special Kids, Special Care.

Star Kids should model service coordination on the definition, values, functions and outcomes developed by this group.

The guide can be found at the following link:

http://www.ucdenver.edu/academics/colleges/medicalschoo/programs/JFKPartners/products/Documents/CareCoordination_Resource-Guide_FINAL%2010-5-13.pdf.

We have also included a portion of the guide as an addendum to these recommendations.

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Care Coordination Values (as written by Colorado's Care Coordination Community of Practice)

- To provide a team-based, partnership approach
- To make a commitment to provide family-centered care
- To build on the strengths of the family in developing the plan
- To share pertinent and appropriate information (between all provider and the family)
- To provide accurate and understandable information to everyone involved in the care coordination plan
- To utilize culturally responsive practices
- To recognize that families have different levels and types of care coordination needs
- To match the type and timing of care coordination to the family's needs
- To recognize that parents are the continuity between, and have the authority of, managing the services and supports they receive
- To involve the family in contributing to the description of specific activities
- To be available and accessible as needed over time

Additional Recommendations

- Immediately upon enrollment all children should be provided with a short-term service coordinator who is available until a permanent service coordinator has been named.
- Families should be given the opportunity to change service coordinators. Requirements to conduct this process should be communicated directly to families.
- Because managed care organizations receive flat, all-inclusive monthly payments for services rendered, they have an inherent incentive to limit the range and intensity of services to plan enrollees. For this reason, service coordination should be provided by an independent entity not affiliated with the MCO.
- Options for independent service coordinators can include:
 - DSHS case managers under the CPW program
 - Texas Medicaid Wellness Program
 - Health Homes - may have to come later when we have a more developed system of health homes.
 - Encourage the use of parents as paid care coordinators, navigators, parent liaisons, parent trainers, outreach specialists, etc.
 - Allow for the use of independent advocates

Service Coordination must:

- Build on family strengths and be guided by a comprehensive, standardized assessment of needs
- Support and rely on team care
- Plan for the transition of youth from pediatric to adult systems of care
- Ensure the provision of child/youth and family education to build self- management skills
- Equip families with the skills needed to navigate a complex health care system
 - Link children and families to the medical, behavioral and community supports and services needed
 - Develop, implement and monitor a proactive child and family centered individual plan of care
 - Build strategic relationships across a community that support integration of care
 - Ensure effective communication and collaboration among all team members

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- Ensure access to timely and appropriate medical, behavioral and community supports

Service Coordinator Competencies

- Children with complex chronic medical, physical and behavioral health conditions should be assigned a service coordinator with specialized knowledge and experience in assisting people with disabilities
- A service coordinator must be able to develop and sustain caring relationships among children, youth, and families, as well as members of the community-wide support system. These competencies need to be held individually or collectively by all clinicians, nurses, social workers, and allied health care professionals who are engaged as a team supporting families.
- Additional competencies must include:
 - Building partnerships that foster family-centered, culturally effective care;
 - Familiarity with and understanding of the medical complexity and care needs of children with complex medical and behavioral conditions;
 - Knowledge of family support for families of children with special needs;
 - Well trained with extensive knowledge of long term services and supports;
 - Knowledge of child development, family dynamics, and disability;
 - Knowledge of best practices in community supports and inclusion;
 - Proficiency in interpersonal communication and interdisciplinary communication;
 - Use of team-based, child and family centered assessments that identify strengths and needs of the families through a person centered planning process;
 - Care planning skills promoting shared decision-making and child/family self-management, with thorough follow-up;
 - Integration and shared use of accumulated medical, educational, and community resource information;
 - Efforts and attitudes that are goal and outcome oriented and promote community inclusion;
 - Flexibility and adaptability to the fluctuating needs of children, youth, and families in the context of a changing health care environment;
 - Continuous learning skills and team leadership sharing new knowledge;
 - Capacity to participate in organizational quality improvement activities;
 - A skilled problem solver and negotiator;
 - Resourcefulness in the use of information technologies (e.g., tracking and monitoring functions, electronic care plan development and oversight) for optimal care coordination; and
 - Service coordinators should receive ongoing training that is tailored to the level of need of those they serve.

Service Coordination Teams

Managed care organizations are generally not used to the level of advocacy and health care system knowledge exhibited by parents of children with disabilities. Since families have historically coordinated the care for their child, they should be assisted in further developing their competencies to be an active leading member of their child's care team.

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The Service Coordinator must be responsible for leading a team of individuals with specific expertise to develop and implement a comprehensive service plan. Teams must possess expertise in:

- Durable Medical Equipment
- Behavioral Supports including Positive Behavior Support
- Transition from pediatric to adult based services
- Supported employment
- Complex medical conditions
- Seating and Positioning
- Augmentative Communication and Assistive Technology
- Understanding of supports for individuals with dual diagnosis IDD/MH
- Family Support
- Home and Community Based services and waivers

Service Coordination Levels

- The delivery of care coordination services needs to be flexible, varying by location, encounter type, timing, intensity, and duration.
- All members must have a face to face visit every year.
- Individuals with the most significant behavioral and medical care needs including those receiving private duty nursing, those who receive the MDCP level of care and those children who experience inpatient psychiatric hospitalization should receive 4 face to face visits and calls every month when there is not a visit
- One of the quarterly visits conducted by the service coordinator for the children with the most significant needs should take place at the doctor's office so that the doctor is familiar with the child's plan of care and the service coordinator develops a relationship with the child's physician.
- Caseloads should be based on level of need but should not exceed 40 per service coordinator for children in the highest level of need category.

Development of Individual Service Plan

The Service coordinator must develop an Individual Service Plan that:

- Links children and families to necessary external supports including, but not limited to: school districts; ECI; developmental disability service organizations; diagnosis-and disability-centered organizations; parent support groups; children care providers; and behavioral support organizations.
- Assessments need to assess and plan for not just the medical/behavioral needs of the child, but the social and habilitative needs as well.
- Children should be assessed in the context of family.
- Plans must be person and family centered.
- Service plans must address the provision of all needs identified in the assessment process. Needs may include access to medical supplies and equipment, specialty therapy services; health homes; specialty care providers; behavioral health; social and family support services and transportation.

Quality Assurance

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Service coordinators should also monitor for quality assurance. If quality standards are not met, the service coordinator should work with the health plan and provider to improve the quality of care or assist the family in securing alternative care.

2. DEVELOPMENT OF COMPREHENSIVE ASSESSMENT

MCO's must ensure that a standardized comprehensive pediatric assessment is utilized by providers to assess and document all current and potential care needs. Performing providers should conduct the assessment. The assessment should capture the complexity and intensity of the individual's varying physical, medical, mental, social, developmental, and behavioral needs.

Assessments should result in the development of comprehensive service plans that justify the amount and types of services to be delivered upon initiation of services, with significant changes in condition, and to determine the need to continue services as needed, but no less than annually.

The following should be included in a comprehensive pediatric assessment:

- an individual's pertinent medical history with current diagnoses and history of procedures
- current health status with a review of body systems,
- cognition,
- nutritional status and diet,
- current medications and treatments,
- developmental and functional status,
- psychosocial status,
- sensory and communication needs,
- level of medical necessity,
- current family support,
- Family strengths and needs
- health care access,
- safety, and
- other referral needs

Rationale: A standardized pediatric comprehensive assessment for skilled and non-skilled services documents an individual's health history, current health status, and level of medical necessity to determine current and potential health care needs. Data from the assessment is necessary to develop and establish the individual's plan of care. Standardization of the assessment will provide quantitative data for this medically fragile population to establish normative values that in turn can be utilized to establish criteria for medically necessary services under STAR Kids.

3. PRIVATE INSURANCE COORDINATION

MCO'S must ensure continuity of care for children who are beneficiaries of private insurance in addition to Medicaid

Children with disabilities differ from adults with disabilities in one other important respect-- children are more likely to receive their health care through a fragmented financing system. Expansions in SSI and Medicaid eligibility for children with disabilities often leads to children having both private health care insurance and Medicaid coverage. Since the Medicaid benefit package is more comprehensive than private health insurance coverage, children and families often use their Medicaid coverage to finance services that are supplemental to their private insurance benefits, particularly home and community-based services and extended therapies.

MCO Provider Network

- It is important that the Medicaid managed care program ensures an adequate provider network that matches or exceeds the local provider networks of private insurance plans. Rationale: Since the implementation of managed care systems generally occurs within payers, not across payers, these multiple financing streams for children with disabilities create special challenges for the managed care marketplace when it comes to using provider networks that may NOT include the same providers.
- Families should be allowed to choose a specialist if it is out of network for their primary insurance and the MCO should provide coverage if within the MCO network.

Coordination of Benefits (COB)

- Comprehensive case management should include help for families in coordinating access to, and payment for services.
- Dental procedures requiring hospital services are extremely complicated, to assure the medical portion of the treatment is paid. HHSC should assure that MCOs have a clear understanding of their responsibility for payment of the medical portion. Rationale: CSN may have private managed care coverage as their primary insurer and will have Medicaid managed care as their secondary insurer. This can be further complicated if the member also has dental managed care.

MCO Contracts

HHSC should define the process and requirements for coordination of benefits clearly in the MCO contract including:

- Adhering to multiple managed care networks to access services
- Requiring prior authorizations to access service from multiple managed care organizations
- Assuring copayments and deductibles are paid by the Medicaid managed care plan.
- Accepting denial of services from the primary MCO, especially if the service is a long term service such as supplies

4. ENSURE ACCESS TO AN ADEQUATE PROVIDER NETWORK

Persons with severe disabilities of all types require access to specialty services that may be limited under managed care approaches. Closed panel plans may have few or no physicians with expertise in the care of conditions with low prevalence rates in the general population. For this reason, it is very important for the MCO to ensure adequacy and access to all needed

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services. The MCO must ensure availability and access to all medical assistance benefits to meet the health care needs of children in Texas through a defined system of care. (MCO's should ensure that all needed medical services are available and accessible, so that ACA does not decrease benefits and access, but rather increases it...through plans that allow coverage for all needed services and supports and there is an adequate provider network) Provider network adequacy is not monitored with regard to specifically what services are provided by the MCO's network (adult v. pediatric services, etc.) MCO's often close their panels without having enough coverage for specialized services, such as pediatrics and pediatric specialties, to meet the needs of the number of Medicaid enrolled children in a specified service area. It will also be important to establish MCO accountability measures to demonstrate network adequacy.

- MCO's will ensure continuity of providers. A common concern of parents is the ability to maintain relationships with pediatric specialists, many of which have developed over the lifetime of the child, once the child is enrolled into a managed care plan. MCO's must be required to continue to pay for ongoing physician-patient relationships, even if the specialty physician is not otherwise enrolled in the plan. Continuity of care for children with long-term disabilities greatly contributes to preventing complications and promotes long-term stability, which in turn reduces the incidence of higher acute care costs.
- Networks should include a full range of primary, specialty, and ancillary pediatric providers, including mental health providers and ensure coordination and continuity of care among all providers
- HHSC must ensure that each MCO is contracted with an adequate number of primary and specialist physicians, therapists, and hospitals that care for children with disabilities over the age of 16, making certain that there is access to physicians who have experience and expertise in working with adults with chronic care needs.
- MCO's must provide a directory of medical personnel with information related to experience and expertise related to specific physical, behavioral, or cognitive diagnoses
- MCO's should require a complete listing of pediatric specialist and sub-specialists in provider directories
- Participating MCOs must provide services plans specifically for those in geographic regions that are more difficult to serve.
- MCOs must ensure access to an accessible provider network, including specialty providers with reasonable geographic proximity to the client. If requested, MCOs must help coordinate transportation to and from service providers, including the use of Medicaid transportation.
- MCO's should require all providers to provide access to children with special needs.
- Network adequacy standards must require an appropriate distribution of pediatric specialists. Limited networks can create barriers to appropriate care or lengthy disruptions of care.
- Children, especially those with chronic and complex conditions, must be allowed access to out-of-network providers at no additional cost.. Children with complex medical needs may need specialty care from a type of provider not in the network. There is a shortage of certain types of pediatric specialists nationwide. These services must be provided in a timely manner when it is determined that the care is appropriate.

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- MCO's should allow appropriate specialist to serve as the PCP Health Home for all children with special needs.
- MCO's should allow for single case agreements
- Network adequacy standards specific to children should be developed with input from providers and families in order to ensure that children have access to needed services without unreasonable delay.
- Networks should be adequate to provide services to children with special needs statewide, especially in rural areas
- To the extent possible, rural service plans should address the following specialized training and outreach opportunities for rural service providers: telehealth strategies that engage urban centers of excellence and specialty care providers; and use of mobile clinics and behavioral health intervention teams. MCOs should also work with service coordinators to create linkages between locally based practitioners and specialty providers to facilitate coordinated care plans.

Cultural Competency

- Network adequacy standards and assessments should assure access for children with limited English proficiency.
- Pediatric provider network standards should specifically reflect the challenges that especially vulnerable populations, such as children with special health care needs, including those with complex conditions, or limited English proficiency, face in securing the care they need.
- Provider networks must include providers who offer services in the appropriate languages to serve the population.

Mental Health Adequacy

- The MCO's mental health benefits must not be significantly weaker than other benefit categories
- Mental health services should be in the same system as other services MCO's should ensure a sufficient number of mental health providers is available to enrollees to ensure adequate choice
- B. Certified Behavioral Analysts should be qualified providers under Medicaid

Dental network adequacy

- Dental provider networks must be adequate to assure that oral health services will be accessible to children without unreasonable delay.
- All dental provider networks must be assessed as rigorously as medical care provider networks for children.
- MCO's must provide sedation benefits
- Marketplaces should have an initial standard for dental network adequacy and have a system to monitor access to dental care for children
- States should continue to study the issue of meaningful dental adequacy standards

Network Adequacy Transparency and Oversight

- Networks for children must be regularly and continually assessed to identify gaps in access to care, accompanied by a plan to remedy those gaps and monitor access to care in those areas.
- MCO policies and rules for accessing out-of-network care must be understandable to consumers.
- The state's network adequacy standards, assessment procedures and data documenting compliance should be clear and transparent to public.
- Assessment results and data on network adequacy for children should be publicly disclosed. Additionally, the MCO's should be required to report publicly on the impact of their provider networks on children's access to care.
- MCO's should allow for consumer input and provider ratings

EMS Transports, Emergency Room Departments and Minor Emergency Facilities

- MCO's should add an indicator to their Provider Directory that indicates which facilities equipped for children
- Ambulance transport should be made to an appropriate facility instead of the closest facility. EMS should transport to the nearest hospital for children that meets the child's needs
- EMS personnel should be trained on issues facing children with special needs. Ambulance vehicles should be equipped for children with special needs.
- Network must have a hospital with pediatrician available 24/7

5. PATIENT-CENTERED MEDICAL HOME

MCO's will ensure a comprehensive Patient-Centered Medical Home (PCMH) for children with medical complexity.

Definition of Patient-Centered Medical Home

A patient-centered medical home, defined by S.B. 7, 82nd Legislature, First Called Session, 2011, is a medical relationship between a primary care physician and a child or adult patient in which the physician provides comprehensive primary care to the patient, and facilitates partnerships between the physician, the patient, acute care and other care providers and, when appropriate, the patient's family. A patient-centered medical home also must encompass the following primary principles:

- *The patient has an ongoing relationship with the physician, who is trained to be the first contact for the patient and to provide continuous and comprehensive care to the patient.*
- *The physician leads a team of individuals at the practice level who are collectively responsible for the ongoing care of the patient.*
- *The physician is responsible for providing all the care the patient needs or for coordinating with other qualified providers to provide care to the patient throughout the patient's life, including preventive care, acute care, chronic care, and end-of-life care.*
- *The patient's care is coordinated across health care facilities and the patient's community and is facilitated by registries, information technology, and health*

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information exchange systems to ensure that the patient receives care when and where the patient wants and needs the care and in a culturally and linguistically appropriate manner.

- *Quality and safe care is provided.*

The legislation requires HHSC, to the extent possible, to work to ensure that MCOs promote the development of PCMHs for Medicaid clients, and provide payment incentives for providers that meet the requirements of a PCMH.

Components of the Patient-Centered Medical Home

- care coordination
- comprehensive case management
- health promotion
- transitional care
- patient and family supports
- necessary referrals for community services
- social services
- use of information technology to link services and decrease
- duplication

MCO Recommendations

- Each client must have access to a health home.
- Health homes encompass primary care provider practices, or, if appropriate, specialty care provider practices, integrated behavioral health services, ancillary health services that incorporate: comprehensive care coordination, family-centered care, and data management.
- Health homes are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under the medical assistance program.
- MCO's should have Service Coordinators with experience serving children with complex medical needs and the Patient Centered Medical Home Model.
- Participating MCOs must employ or contract with health home specialists who can help train and support network providers who request assistance with improving their practice's functionality as a health home for children with special needs.
- MCO's should expand the number of physicians in their network with Patient Centered Home Health Experience by 5 percent each year.
- HHSC should develop a list of standards for physicians to be considered Patient Centered Home Health Physicians.
- MCO's should pay physicians a higher rate as a Patient Centered Home Health Physician.
- Continuity of care for children and throughout their lives
- No age limit for treatment
- Patients are transitioned within their own model of integrated care (Supports quality initiatives under 1115 transformation).
- Add LTSS information to Electronic Health Record so a complete history is available to providers

6. PRIOR AUTHORIZATION PROCESS

MCO's must follow a standardized prior authorization process for medically necessary services under STAR Kids that is streamlined, transparent, has reasonable timeframes, and is not so

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burdensome and complex to the extent that access to needed services are not impeded, delayed, or arbitrarily denied. The prior authorization process for medically needed services, supplies, and equipment should not vary from MCO to MCO to the extent that access is impeded or denied and those determinations vary from MCO to MCO. Access to medically necessary benefits under Medicaid or CCP should not be approved or denied based on chronological age, place of service, or other discriminating criteria.

Rationale: Documentation requirements for prior authorizations should be standardized so that an individual requiring medically necessary services may access those service without discrimination or inconsistencies between the different MCO's. Currently, MCO's are allowed to implement their own prior authorization requirements and delays in the initiation and continuation of services vary from MCO to MCO according to the level of difficulty providers experience obtaining prior authorizations. Members enrolled STAR Kids are predominantly characterized as a pediatric special needs population who should not have to choose an MCO or change to another MCO based on the level of difficulty they will experience in the prior authorization process for medically needed services. These individuals should not be subject to administratively-driven delays in accessing needed care, supplies, equipment, or other needed services due to complex and burdensome prior authorization processes.

7. MEDICAL TRANSITION

TRANSITIONAL CARE – PEDIATRIC TO ADULT: Transition from childhood to adulthood is a life-long process across developmental stages that must be well-planned and started early to be successful.

Therefore, a plan must be implemented that will ensure that children with disabilities remain connected to appropriate primary care physicians, specialists, and therapists as they age out of pediatric into adult care.

Medical Transition

- HHSC must take the lead in working with families, health plans and providers to develop a comprehensive pathway from pediatric to adult medical services.
- A medical transition plan must be developed within comprehensive case management.
- Require MCO's to develop and implement a transition plan for each youth transitioning from childhood to adult
 - Planning must begin no later than age 15.
 - With approval from the parent(s), require the CCM to initiate Personal Care Services in preparation for youth aging out of Texas HealthSteps (EPSDT) and the nursing care provided through CCP.
- HHSC must ensure that each MCO is contracted with an adequate number of primary and specialist physicians, therapists, and hospitals that care for children with disabilities over the age of 16, making certain that there is access to physicians who have experience and expertise in working with adults with chronic care needs. We encourage MCO's to develop a pool of transition specialists.

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- Develop a portal of communication between pediatricians and adult care physicians and the child's family to facilitate a smooth transition of the individual's medical history and pertinent health information.
- MCO's must add a member to their care coordination team that specializes in transitioning children with disabilities from pediatric to adult medical care no later than when the child turns
- MCO's must provide a directory of adult medical personnel with information related to experience and expertise related to specific physical, behavioral, or cognitive diagnoses. (Example: Dietician who has expertise in tube feeding formulas, not just weight management.)
- CCM must provide parent and YSHCN with information about prescription coverage changes. CCM must assist in getting prescription refill management changed from one physician to another.
- Rule language must prohibit MCO's from discriminating access to medically necessary services based on homebound or other criteria.

8. Outreach and Education

Each MCO has the responsibility to establish an ongoing commitment with the community and the recipients of STARKids. Their commitment is to ensure all participants and their families have a complete understanding of their services provided through the client's native language and level of education.

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- HHSC should inform people about the upcoming changes at least six months before roll out.
- Informational strategies should include email, text, mail, video conferences, as well as TV advertising, newspaper, support groups, schools, ECI, Social security offices, churches, hospitals and clinics ...etc.

All outreach efforts and education should be done in the native language of the client.

- Participating MCOs must provide access to multi-lingual staff who are knowledgeable about working with families of children with special needs. Service coordinators should be expected to assist with outreach, education of services and programs, and enrollment. Immediately upon enrollment all clients should be provided with a short-term case manager who is available until a permanent service coordinator has been selected. This is done to ensure the client has been educated properly of their services and to help them choose the best MCO who will fit their needs.
- All staff during outreach and education must provide all information in writing. All writing material must be appropriate to the level of education of the caregiver. The MCO staff has to communicate in the level of education of the client or their caretaker and must ensure that the client and their family has a good understanding of their services.

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- It's crucial for MCOs to understand that translating material is not enough. All translated material must be made at an elementary level or at a level appropriate to the individual.

9. Oversight

Contracts

- Create a specific department within TMHP that shall monitor contract compliance for all Medicaid Managed Care Plans. TMHP should meet with MCO's at least biannually to go over plans to ensure they are meeting contract requirements.
- Provide a sufficient network of doctors within each MCO. TMHP needs to review the adequacy of the plan's network of doctors in their biannual meeting with MCO's.
- Ensure in the contract that MCO's must allow patients to use out of network physicians for medically complex children. (Specialist, behavioral health)

Contract Quality and Performance

- An external group should be hired yearly to independently monitor the plans' quality of care.
- Create a subcommittee of the Children's Policy Council to monitor and go over patient satisfaction, as well as gaps or barriers in services within MCO's. TMHP should report biannually to CPC on status of MCO's.
- TMHP should create a system by email or phone where families can call with concerns about services from MCO's. A report of the calls or emails should be given to the subcommittee of CPC to review.
- A Committee should be created of families who use Medicaid Managed Care Services from around the state. They should meet at least quarterly to discuss issues and concerns within the Managed Care groups in their local areas.

Accreditation

- Contracts should be made with MCO's that have their accreditation with National Committee for Quality Assurance.
- The MCO's must have an overall score of 90 with NCQA.

10. Children Receiving MDCP Services

The CPC recommends that HHSC allow all SSI children and young adults under the age of 21 who meet the medically necessary level of care for nursing facility to automatically get the MDCP waiver level of services in Star Kids with no wait.