STAR Kids Alternative Model Feasibility Report

As Required by
Government Code Section 533.00253

Texas Health and Human Services
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Executive Summary

The Texas Health and Human Services Commission (HHSC) submits the *STAR Kids Alternative Model Feasibility Report* in compliance with Texas Government Code Section 533.00253(l)[1] as added by House Bill (H.B.) 4533, 86th Legislature, Regular Session, 2019. Section 533.00253 requires HHSC, using existing resources and in consultation with the STAR Kids Managed Care Advisory Committee[2] (SKMCAC), to:

> Determine the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under: (1) an accountable care organization model in accordance with guidelines established by the Centers for Medicare and Medicaid Services; or (2) an alternative model developed by or in collaboration with the Centers for Medicare and Medicaid Services Innovation Center.

HHSC worked in consultation with the SKMCAC and obtained feedback from other stakeholders to determine the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under an accountable care organization (ACO) model or an alternative model developed by or in collaboration with the Centers for Medicare and Medicaid Services Innovation Center (CMMI). HHSC also analyzed ACOs, health homes, and other value-based care models implemented in other state Medicaid programs. These models operate as alternative payment models (APMs) in cases where a portion of a provider's payment is linked to pre-selected measures of performance.

To explore the feasibility of implementing the STAR Kids program under an ACO, health home, or other model, HHSC developed a Request for Information (RFI) to gather feedback from stakeholders. This report presents an overview of the STAR Kids program, ACOs, pediatric APMs already established by Texas Managed Care Organizations (MCOs) for members with complex needs, and the stakeholder feedback obtained through the RFI.

Based on the findings outlined in this report, HHSC determined it would not be feasible to provide Medicaid benefits to children enrolled in the STAR Kids managed care program under an ACO or an alternative model developed by CMMI at this

[1] GOVERNMENT CODE CHAPTER 533. MEDICAID MANAGED CARE PROGRAM (texas.gov)
[2] STAR Kids Managed Care Advisory Committee | Texas Health and Human Services

time. Texas does not have a regulatory framework for licensing ACOs and there are no ACOs operating in Texas with state oversight. There are a limited number of alternative models between MCOs and providers that involve a Medicare ACO, however HHSC does not contract with ACOs in Texas Medicaid. Considering CMMI's alternative model under the Advancing Care for Exceptional (ACE) Kids Act as required by Senate Bill (S.B.) 1648, 87th Legislature, Regular Session, 2021, HHSC implemented the Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot beginning in December 2022. The results of the CHIC Kids Pilot study may inform HHSC's consideration of a new model of care for the most medically complex STAR Kids members. A report on the implementation of the CHIC Kids Pilot is due to the Legislature by December 31, 2024.

HHSC is also focused on strengthening the STAR Kids program, encouraging STAR Kids MCOs to adopt more holistic care models, like health homes, and identifying alternative payment approaches to support these models within managed care.

1. Introduction

Texas Government Code Section 533.00253 requires HHSC, in consultation with the SKMCAC, to determine the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under an ACO model in accordance with guidelines established by the Centers for Medicare and Medicaid Services (CMS) or an alternative model developed by or in collaboration with the CMMI. HHSC must submit a written report to the Legislature by December 1, 2022, including a determination of feasibility.

To explore alternative models of care delivery, HHSC analyzed ACOs, health home models that are currently implemented in other state Medicaid agencies, and APMs already established by Texas MCOs. Additionally, HHSC developed an RFI to gather feedback from stakeholders. The RFI contained questions about ACOs and alternative models on topics including governance structure, payments, contracting, care structure, quality measures, data collection, and other general improvements that could be made to the STAR Kids program.

2. Background

Nationally, approximately four percent of all children have complex medical needs, as defined in Section 1945A(i)(1) of the Social Security Act,[3] and nearly two-thirds of those children are covered by Medicaid or the Children's Health Insurance Program (CHIP).[4] While only a small percentage of children enrolled in Medicaid in the United States have medically complex conditions, their care accounts for approximately 40 percent of total Medicaid spending for all children.[5] This is because children with complex medical conditions typically have higher and more specialized needs, resulting in higher use of health care services. As a result, many states, including Texas, are exploring care and payment models for this population to maintain a high quality of care while reducing health care spending.

STAR Kids Program

In 2016, Texas implemented the STAR Kids Medicaid managed care program under Section 533.00253, Texas Government Code, to improve health outcomes, access to care, care coordination, and cost-effectiveness of care for children with disabilities and complex medical needs. The program integrates the delivery of acute care, long-term services and supports (LTSS), and service coordination through a managed care organization (MCO).

STAR Kids serves people 20 years of age or younger who meet at least one of the following criteria:

- Receive Supplemental Security Income (SSI);
- Receive Medicaid and Medicare;
- Live in a community-based intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID) or nursing facility (NF); or
- Receive services through a 1915(c) Medicaid waiver program.

[3] Social Security Act §1945A (ssa.gov)
[4] https://nashp.org/wp-content/uploads/2018/04/Structuring-Care-Coordination-Services-for-Children-and-Youth-with-Special-Health-Care-Needs-in-Medicaid-Managed-Care.pdf
[5] Costs and Use for Children With Medical Complexity in a Care Management Program

As of September 2022, there were nine MCOs serving approximately 169,390 members in the STAR Kids program across the state of Texas.[6] Services provided to STAR Kids members include preventive care, primary and specialty care, hospital visits, prescription drugs, personal care services, and private duty nursing. STAR Kids members who require the level of nursing care provided in a nursing facility are eligible to receive Medically Dependent Children Program (MDCP) services. MDCP provides LTSS in home and community-based settings and is managed by the STAR Kids member's MCO. MCO service coordination is also provided to members and is a critical element of the STAR Kids program. All STAR Kids members are assigned or have access to an MCO service coordinator who is responsible for assessing a member's needs, developing a service plan, and coordinating access to services.

Accountable Care Organizations

An ACO is defined by CMS as a "group[s] of doctors, hospitals and other health care providers, who come together voluntarily to give coordinated high-quality care to their patients."[7] The goal of coordinated care is to ensure patients receive the care they need timely, while preventing medical errors and avoiding duplication of services. Providers that participate in an ACO agree to share responsibility for the health outcomes of a defined population. Successful ACOs deliver high-quality care while spending health care dollars more efficiently and sharing savings with participating providers.

CMMI has implemented Medicare ACO programs such as the Medicare Shared Savings Program, the ACO Investment Model, Advance Payment ACO Model, Next Generation ACO Model, and the Pioneer ACO Model.[8] These programs all focus on increasing quality of coordinated patient care and lowering health costs.

Payment models vary by ACO to include:

- Providing financial incentives for meeting quality standards;
- Investing in care coordination infrastructure through upfront monthly payments that are fixed or variable;

[6] https://www.hhs.texas.gov/about/records-statistics/data-statistics/healthcare-statistics
[7] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO
[8] https://innovation.cms.gov/innovation-models/aco

- Offering a population-based model to coordinate with private payers and aligning provider incentives;
- Setting and predicting financial targets; and
- Using a pre-paid shared savings model that encourages participating ACOs to transition to arrangements with greater financial risk.

There are currently 12 states with Medicaid ACO models that provide care to children with complex medical needs in a designated area or region of the state: Arizona, Colorado, Delaware, Idaho, Maine, Massachusetts, Minnesota, Nebraska, New York, Rhode Island, Vermont, and Virginia.[9] Medicaid ACO programs vary greatly by state, as there are no national standards or regulations. CMS has provided limited guidance, giving states the flexibility to design their own Medicaid ACO models.[10,11]

Some state Medicaid agencies contract directly with ACOs in a traditional fee-for-service model, while others contract with MCOs. Within a managed care model, MCOs can create special payment arrangements with ACO providers who are willing and have the capacity to assume financial risk and responsibility for care of targeted populations with the potential to receive financial incentives if certain care quality standards and health outcomes are met. Medicaid ACOs take a variety of forms. Colorado ACOs, known as Regional Accountable Entities, are led by community partners, such as federally qualified health centers and local behavioral health organizations.[12]

The main feature of Medicaid ACOs and ACO-like models, specifically for children with medically complex conditions, is comprehensive care coordination. However, given that ACOs are relatively new and vary in different states, research is lacking to demonstrate Medicaid ACOs improve quality of care and health outcomes while lowering the cost of care.

At the time of this report, Texas does not have a regulatory framework for licensing ACOs. Therefore, there are no ACOs operating in Texas with state oversight.

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[9] https://www.kff.org/medicaid/issue-brief/state-delivery-system-and-payment-strategies-aimed-at-improving-outcomes-and-lowering-costs-in-medicaid/
[10] https://www.medicaid.gov/federal-policy-guidance/downloads/smd-12-002.pdf
[11] https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-005.pdf
[12] https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/Ways%20of%20the%20RAEs_1.pdf

However, there are ACOs in Texas operating under the authority of federal Medicare requirements.

The closest equivalent to an ACO with state oversight in Texas is a Health Care Collaborative (HCC).[13] HCCs enter into payment arrangements with both public and private payers that incentivize improved quality and efficiency in the delivery of health care services.[14] Like ACOs, HCCs consist of physicians and other health care providers that assume responsibility for care delivery and improved health outcomes for members. A difference between ACOs and HCCs is the structure of their respective governing boards. The membership of an ACO governing board operating under federal regulations is based on the amount of capital a board member invests, while Texas HCC board members are elected by the health care providers who participate in the HCC. This may allow an HCC to be more tailored to the needs of the local community than a typical ACO. There is only one operational HCC licensed in Texas, and it is not contracted with HHSC or any Texas Medicaid MCOs.

CMMI Pediatric Alternative Payment Models

At the national level, CMMI has created various approaches for pediatric-focused value-based models, such as the Integrated Care for Kids (InCK) Model and the Advancing Care for Exceptional (ACE) Kids Act, with the aim of improving the quality of care while reducing the cost of care for children enrolled in Medicaid. As a result, many states, including Texas, are exploring approaches to achieve those same goals.

The InCK Model is "a child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid and CHIP through prevention, early identification, and treatment of behavioral and physical health needs."[15] CMMI provided funding to eight awardees (states and organizations) starting in January 1, 2020 to design and implement a pilot program over a seven-year period.[16] The InCK model aims to identify and treat children and youth who may have complex physical and behavioral health conditions, coordinate their care across physical and

[13] https://statutes.capitol.texas.gov/docs/IN/htm/IN.848.htm
[14] BILL ANALYSIS SB 7(texas.gov)
[15] https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model
[16] https://innovation.cms.gov/files/fact-sheet/inck-model-fs.pdf

behavioral health settings, and develop sustainable APMs tied to improving children's health and reducing inpatient stays and out-of-home placements.

In spring 2019, the ACE Kids Act was signed into federal law as part of the Medicaid Services Investment and Accountability Act of 2019 (Public Law 116-16).[17] The ACE Kids Act gives states the option to create specially designed health homes for children with medically complex conditions beginning October 1, 2022. Its purpose is to improve care for Medicaid-enrolled children with medically complex conditions through coordinated care within a health home, ease access to care from out-of-state providers, reduce burdens on providers and families, and reduce emergency room visits and inpatient hospital stays. States that opt to create the health homes through a Medicaid state plan amendment[18] will receive a higher federal medical assistance percentage that is 15 percent above the regular state matching rate, not to exceed 90 percent, for six months.[19] The ACE Kids Act also provides $5 million in state planning grants and allows states the flexibility to develop their own APMs.

Since the enactment of H.B. 4533 in 2019, S.B. 1648 (2021) requires HHSC to implement a pilot program that is substantially similar to the ACE Kids Act program to provide coordinated care through a health home to children with complex medical conditions. HHSC's Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot, as mandated by S.B. 1648, closely aligns with the ACE Kids Act and will study the effectiveness of enhanced care coordination through health homes that are specially designed for children with medically complex conditions.[20] The results of the CHIC Kids Pilot study may inform HHSC's consideration of a new model of care for the most medically complex STAR Kids members. A report on the implementation of the CHIC Kids Pilot is due to the Legislature by December 31, 2024.

As more innovative pediatric service delivery and payment models emerge nationally, states are rewarding and holding providers accountable for the quality and cost of health care they provide. State Medicaid agencies are implementing

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[17] https://www.congress.gov/116/plaws/publ16/PLAW-116publ16.pdf
[18] Medicaid State Plan Amendments | Medicaid.gov
[19] https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/star-kids/mar-2021-skmcac-agenda-item-5.pdf
[20] https://statutes.capitol.texas.gov/Docs/GV/htm/GV.531.htm. SB 1648 requires HHSC to develop and implement a pilot program that is substantially similar to the federal Advancing Care for Exceptional Kids Act program.

new service delivery and payment models, such as ACOs and APMs, to improve health outcomes and reduce costs.[21]

[21] https://www.chcs.org/media/ACO-Fact-Sheet-02-27-2018-1.pdf

3. Request for Information

HHSC developed an RFI, which was released on August 27, 2021, to further assess the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under an ACO or an alternate model. The goal of the RFI was to collect ideas and recommendations from stakeholders and subject matter experts to inform HHSC's assessment of potential improvements to the STAR Kids program. Topics included potential governance structures, payment methodologies, contracting arrangements, care structures, quality measures, and data collection and reporting.[22] The RFI was proactively shared with MCOs and stakeholder groups, such as the SKMCAC's Health Homes Subcommittee (Subcommittee).

The RFI closed for public feedback on October 27, 2021. Of the nine respondents to the RFI, seven were MCOs or MCO professional associations, one was the Subcommittee, and one was a consulting firm. Below describes feedback obtained from the RFI responses. The RFI provided valuable feedback that informed the development of the CHIC Kids Pilot.

Overall Structure

The RFI asked about the optimal structure for an ACO or alternative model to serve children with medically complex conditions enrolled in STAR Kids.

MCOs recommended an MCO-led model, due to the MCOs' established experience with the STAR Kids program. According to MCO responses, provider-led ACOs lack the complex infrastructure and ability to assume the amount of risk entailed to operate on their own. The MCO responses claim that ACOs cannot typically provide the breadth of services required to meet the needs of the STAR Kids population; therefore, to maintain uninterrupted access to care, any STAR Kids ACO model should operate within the current managed care structure. The responses also indicate MCOs have proven their ability to manage financial risk and budget predictability and are experienced in fully coordinating services and supports within a comprehensive provider network.

MCO respondents suggest the creation of a board of providers with decision-making authority as soon as the development of an ACO begins to help ease legal concerns about provider incentives. They also recommend that MCOs provide a broad range

[22] https://www.txsmartbuy.com/esbddetails/view/HHS0010969

of APMs for providers based on provider readiness to assume risk, capabilities, and infrastructure.

MCO respondents recommend HHSC not carve out STAR Kids members from managed care but rather augment the current STAR Kids program by incorporating requirements from the ACE Kids Act into STAR Kids MCO contracts. The consultant respondent expanded on this comment, noting that removing STAR Kids members from managed care could lead to a temporary loss of services and reduction in network adequacy.

When asked which STAR Kids members would benefit most from increased care coordination within an ACO or alternative model, some MCO respondents suggest the model should include all STAR Kids members, while others recommend only including the STAR Kids children with the most complex medical needs.

According to the Subcommittee's response, ACOs would be inappropriate for the medically complex population. In contrast to feedback from the MCOs, the Subcommittee asserts the optimal structure would be an integrated health home led and composed of providers with expertise in caring for children with medically complex conditions. For a truly integrated health home model, the Subcommittee acknowledges additional infrastructure would be needed. This would include third-party administrative support, shared electronic care plans, 24/7 capacity to support members, and staff to coordinate care with community providers and social service agencies. The Subcommittee suggests redirecting funds for care coordination from the MCO to the health home so that resources are allocated closer to where care is provided. The Subcommittee recommends including not only the most medically complex STAR Kids children, but all children in Medicaid who meet the definition of medically complex as described in the ACE Kids Act.

Payment Structure

The RFI asked which payment structures for an ACO or alternative model work best for the STAR Kids program. A few MCO respondents suggest a shared savings program, modeled after Medicare ACOs, where physicians are held accountable for coordinating care for children with medically complex conditions and manage hospital admissions, which are two of the biggest drivers of high costs for medically complex populations. Other MCO respondents indicate MCOs should be allowed to negotiate different payment structures with the ACO or providers based on their readiness and specific goals.

Other stakeholders, such as the consulting firm and MCO associations, suggest a phased approach regardless of which model is chosen, moving providers from per member per month payments to a shared savings model, and eventually transitioning to full-risk capitation. With a phased approach, stakeholders explain there would be a path for less mature provider organizations to eventually assume more risk.

The Subcommittee's response indicates a phased approach for value-based payment would work best for the STAR Kids program. In their response regarding a health home provider-led model, a phased approach would begin with payment for the salaries of the core health home team, time spent care planning, ongoing care coordination, and delivery of health home services. The Subcommittee proposed that the initial phase would include per member per month payments tied to quality metrics and the collection of data on the cost of care for medically complex children. The model would move to the next phase once there is enough financial information and ability to create bundled payments to providers. The Subcommittee pointed out that with this approach provider revenue would decrease up front because of reduced utilization. Therefore, there would need to be adequate incentives for providers that decide to participate. They suggested that eventually assuming full risk might not be feasible for the health home model and would likely not aid in the model's effectiveness. However, it is the Subcommittee's overall opinion that incentive-based programs are generally not relevant to the health outcomes of children with medically complex conditions, as the goals are often designed for a healthy population and are not as achievable for those with complex medical needs.

Contracting

The RFI asked about benefits and barriers to a contract between ACOs other alternative models, MCOs, and the state Medicaid agency. The Subcommittee's response suggests a statewide health home model that includes direct payment from HHSC to health homes would be best. Per the Subcommittee, this type of contract would require the health homes to be fully invested in realizing successful outcomes and to have the authority to manage care, including the ability to authorize services that normally would require pre-authorization. The Subcommittee also notes concerns that MCOs may have incentives to focus on short-term cost that are not aligned with the long-term cost focus that is more appropriate for the medically complex population.

In contrast to the proposal for HHSC to directly pay health homes, MCOs and the consulting firm highlighted the benefits of a contracting arrangement between the

ACO and an MCO or using an APM. They emphasize using the existing MCO infrastructure would reduce administrative costs for HHSC and build on existing partnerships that support the STAR Kids program. Also, they indicate an ACO has the potential to benefit financially through an MCO APM, compared to contracting directly with HHSC. MCOs also offer training, data sharing, support, guidance, and performance oversight, which may not be present within a typical ACO. The MCOs also mention challenges if HHSC contracts directly with a single ACO. One challenge is the need for a wide range of providers and specialists to meet the needs of children with medically complex conditions, as an ACO would likely reduce choice of providers for STAR Kids members. As another challenge, multiple contracts would be required to meet the needs of medically complex children across Texas.

Care Structure

The RFI asked about care coordination. All respondents agree care would be best coordinated by a multidisciplinary, integrated care team. The Subcommittee referenced the ACE Kids Act of 2019 as the best standard for a team of health care professionals with the expertise required to care for medically complex children. The Subcommittee also believes the child and family should be included as part of the care team. Additionally, they recommend adding a practitioner of adult medicine to the core team if a child is transitioning from pediatric to adult services. The Subcommittee thinks it would be helpful for the STAR Kids population to be organized into care subgroups, each with a core team appropriately defined. They also stress the importance of the entire care team having access to an electronic medical record.

MCO respondents suggest care team qualifications be at least as comprehensive as what is in the current STAR Kids contract, regardless of the type of model.[23] They also highlight every STAR Kids member will have different needs; therefore, there should be flexibility in care team structure. Additionally, MCOs note care team members should be chosen with careful consideration using the preferences of the child and their legally authorized representative.

Stakeholders express the importance of a care team that is driven by individual member needs. Per some MCOs, using provider-to-member ratios for care coordination is not a person-centered or efficient approach. MCOs also suggest using the current metrics and national standards that health plans are assessed by

[23] https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/star-kids-contract.pdf

so any new model can be accurately compared for effectiveness. Most stakeholders agreed that STAR Kids MCOs should begin planning for transition from pediatric to adult services when the child is around 15 years of age to encourage continuity of care. They highlighted that many MCOs have a wide network of providers that serve both children and adults, as well as established relationships with community partners and state agencies to help connect and support youth through the transition to adulthood.

Quality Measures

Stakeholders were asked about how quality measures for a STAR Kids program under an ACO or alternative model should be developed to ensure improved health outcomes for members. The Subcommittee states they are not aware of standardized metrics designed specifically for measuring outcomes for medically complex children, such as those enrolled in the STAR Kids program. They recommend parents of children with medically complex conditions be involved in the development of the metrics to encompass the family's definition of quality care more accurately. The Subcommittee also indicates a few sources to determine appropriate outcomes for this population. One suggestion is to use the outcomes defined in the *Capability, Comfort, and Calm* framework[24] developed by the Value Institute for Health and Care at The University of Texas at Austin's Dell Medical School.[25] Other suggestions from the Subcommittee included using a measure of the quality of interaction between patients and families and the care team; measures developed by children's hospitals; and a measure of the well-being of families. They also suggest collecting data both at the patient and health home level. Overall, the Subcommittee believes quality measures should determine if patients are getting the services they need and keep additional administrative burden on providers to a minimum.

MCO respondents highlight they already have the infrastructure in place to measure quality and outcomes at member and population levels. Some MCOs think only nationally accredited standards should be used for quality evaluation in the STAR Kids program, regardless of the type of model. They expressed that using national standards would allow more direct comparisons to the same populations in other states and programs. Additionally, they recommended using the CMS final rule on the Medicaid ACO quality measures, including 33 process and outcome measures,

[24] https://link.springer.com/content/pdf/10.1007/s11999-016-5205-5.pdf
[25] https://dellmed.utexas.edu/units/value-institute-for-health-and-care

by which performance is assessed.[26] Other MCOs added that any quality measures developed for the STAR Kids program should be pediatric-focused, modeled after the ACE Kids Act, and address the child and family experience. A popular opinion among the health plans was to align with existing MCO quality metrics to avoid additional administrative burden in MCO reporting. One MCO stated the MCO should have the flexibility to include additional measures the MCO deems appropriate for the population. They feel that with more flexibility, they would be able to prioritize measures in a more meaningful way, track provider progress, and intervene to support providers when necessary. All MCOs agree that quality measures could be used for incentive-based payments to providers by establishing benchmarks, examining trends, and adjusting, as necessary.

The consulting firm recommends specifically using the Texas Managed Care Quality Strategy[27] to solicit feedback from stakeholders on quality measures and identified the Medicaid Children's Health Care Quality Measures (Child Core Set) [28] as especially relevant to the STAR Kids population.

Claims and Data Collection

The RFI asked about the collection and handling of data for an ACO or alternative model. Multiple stakeholders recommend working with the University of Texas School of Public Health in Houston, as a partner to the external quality review organization, to validate claims data for clients. The Subcommittee stressed the importance of a third-party organization in maintaining all quality, cost, outcome, and claims data to measure provider performance in comparison to an established baseline. In the Subcommittee's opinion, the role of an MCO or state Medicaid contractor like the Texas Medicaid and Healthcare Partnership should be solely administrative. However, MCOs highlighted there are systems and staff already in place to adjudicate claims, suggesting that health plans should have access to all claims data for the purpose of quality measurement. Per the consulting firm, if HHSC were to contract directly with an ACO, then HHSC, would need to support the ACO with claims adjudication since ACOs usually have less experience and fewer systems in place for claims processing.

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[26] Federal Register :: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations
[27] https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/quality-strategy
[28] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html

General Information

Stakeholders shared their thoughts and suggestions for improving the current STAR Kids program. The Subcommittee reports that one of the original goals of the STAR Kids program was to allow MCOs to develop innovative payment models that reimburse complex care providers for providing services they consider essential to medically complex children. These services include care coordination among providers and maintaining accurate shared care plans. STAR Kids providers are not reimbursed for services that are not currently a benefit of Texas Medicaid.

Finally, stakeholders were asked what outcomes for STAR Kids members and their families they would like to see achieved through an ACO or alternative model. MCOs and the consulting firm proposed multiple goals for a new model. These goals include improved quality and access to care, positive member outcomes, cost-efficiency, accountability of providers, improved health outcomes, integrated care, community-based supports and services, and family-centered care coordination. They are interested in seeing a reduction in potentially preventable events, emergency visits, and hospital admissions. Some of the MCOs stated that the ideal outcomes for STAR Kids members under an ACO or alternative model are already addressed through the current STAR Kids managed care model. MCOs reiterated that any new model of the STAR Kids program should continue to be MCO-led and should include transparent communication, real-time data sharing between providers, and more closely match enrollee needs with accessible services.

4. Feasibility Determination

Based on the findings outlined in this report, HHSC determined it would not be feasible to provide Medicaid benefits to children enrolled in the STAR Kids managed care program under an ACO or an alternative model developed by CMMI at this time. Some MCOs have adopted key features of ACOs through their APMs within the STAR Kids program and could be encouraged to strengthen these efforts.

Accountable Care Organizations

Without implementation of a Texas licensing structure, ACOs cannot operate in Texas Medicaid today. Additionally, ACOs typically lack the administrative infrastructure necessary to operate on their own, and only provide a limited set of services for a defined population in a regional or local area.

The Texas equivalent to ACOs are HCCs. Implementing HCCs in STAR Kids would require CMS approval because they do not meet the Medicare ACO requirements and structure. Implementation would also require policy changes and rule and contract amendments.

If HHSC were to contract directly with an ACO-like entity, such as an HCC, it would require multiple contracts with multiple HCCs to adequately meet the wide range of needs of the STAR Kids population. Transitioning STAR Kids members out of the current managed care model and into a provider-led HCC structure introduces risks such as impacts to choice of providers and access to care if a child were to experience a change in condition, depending on the breadth of services offered by the HCCs. It would also require HHSC to provide support to HCCs with claims processing; 24/7 capacity to support providers on immediate issues; fully integrated, shared, and accessible technology for care plans; and staff to coordinate care with social service agencies and community providers.

There is nothing under existing law or contracts that preclude MCOs from working with HCCs, as long as the HCC is licensed with the Texas Department of Insurance and as long as MCOs continue to fulfill current contract obligations. However, there are currently no licensed HCCs contracted with Texas Medicaid MCOs.

CMMI Alternative Models

Since the enactment of H.B. 4533 in 2019, S.B. 1648 (2021) requires HHSC to implement a pilot program that is substantially similar to the ACE Kids Act program

to provide coordinated care through a health home to children with complex medical conditions. HHSC's Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot, as mandated by S.B. 1648, closely aligns with the ACE Kids Act and will study the effectiveness of enhanced care coordination through health homes that are specially designed for children with medically complex conditions.[29] The results of the CHIC Kids Pilot study may inform HHSC's consideration of a new model of care for the most medically complex STAR Kids members. A report on the implementation of the CHIC Kids Pilot is due to the Legislature by December 31, 2024.

MCOs currently have the infrastructure and systems in place to assume risk, adjudicate claims, provide performance oversight, measure quality and outcomes at member and population levels, provide access to a network of providers and specialists for medically complex children, and to maintain established relationships with community partners to support youth through transition to adult care. MCOs also have the authority and ability to negotiate alternative models with providers based on their capabilities, infrastructure, and readiness to assume risk. HHSC is focused on strengthening the STAR Kids program, encouraging STAR Kids MCOs to adopt more holistic care models, like health homes, and identifying alternative payment approaches to support these models within managed care.

[29] https://statutes.capitol.texas.gov/Docs/GV/htm/GV.531.htm. SB 1648 requires HHSC to develop and implement a pilot program that is substantially similar to the federal Advancing Care for Exceptional Kids Act program.

List of Acronyms

Acronym	Full Name
ACE	Advancing Care for Exceptional
ACO	Accountable Care Organization
APM	Alternative Payment Model
CHIC	Comprehensive Health Homes for Integrated Care
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CMMI	Centers for Medicare and Medicaid Services Innovation Center
HCC	Health Care Collaborative
HHSC	Health and Human Services Commission
InCK	Integrated Care for Kids
LTSS	Long-term Services and Supports
MCO	Managed Care Organization
RFI	Request for Information
SKMCAC	Star Kids Managed Care Advisory Committee
Subcommittee	Star Kids Managed Care Advisory Committee Health Homes Subcommittee