



**STAR Kids Managed Care
Advisory Committee
Report to the Executive
Commissioner**

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

**STAR Kids Managed Care Advisory
Committee
December 2023**

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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.

Letter from the Chair

Dear Health and Human Services Commission (HHSC) Executive Commissioner Cecile Young:

The STAR Kids Medicaid Managed Care Advisory Committee submits our sixth and the final committee report according to the traditions and the duties assigned by the HHSC Executive Commissioner.

This report is the culmination of years of experience, research, analysis, public input, stakeholder engagement and feedback on issues of importance to children with disabilities, their families and their providers. Many of the recommendations are ones that continue to be outstanding from previous reports, presentations, public comment, stakeholder meetings, provider feedback and interactions between Managed Care Organizations (MCO), family representatives, advocates and providers during the committee's 45 quarterly meetings.

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 while remaining vigilant to other issues that continue to exist and arise. Members of the committee include a variety of stakeholders including families of children with disabilities receiving services under STAR Kids, physicians, home health providers, MCOs, and organizations representing children with disabilities. STAR Kids Medicaid Managed Care Advisory Committee members have leveraged their own lived experiences, drawn upon the expertise of professional members, and sought input from subject matter experts to identify areas of concern impacting children with disabilities and their families in Texas. Subsequently, the STAR Kids Medicaid Managed Care Advisory Committee's recommendations bring attention to these critical issues and propose solutions to improve the care and well-being of children with disabilities.

The need for continual improvement in the STAR Kids program at a time when families are facing extremely diminished access to home health nursing, attendant care, therapy and key medical services is paramount. The work of the committee is far from done. System changes are needed to better support the health and long-term care of children. The care coordination and quality of life of children in STAR Kids depends on the choices made by you, HHSC leaders, lawmakers and policymakers, and how MCOs implement those choices and how their contractors deliver those services. These choices have far-ranging impacts that will either support or limit our most vulnerable babies, children, youth and young adults'

health, care coordination and quality of life. The committee unanimously voted to recommend HHSC extend the STAR Kids Medicaid Managed Care Advisory Committee during our September 13, 2023, meeting and received a letter from HHSC in October letting us know their decision to let the committee expire.

The STAR Kids Medicaid Managed Care Advisory Committee respectfully requests your consideration of and support for the recommendations included in this report. Implementing these recommendations will make it possible for our STAR Kids to have healthier, quality lives.

We want to thank all of the stakeholders, especially families, those who provided public comments, former and current STAR Kids Medicaid Managed Care Advisory Committee members and HHSC who are committed to improving Medicaid services for children in STAR Kids.

And finally, we dedicate the important and impactful work of the Star Kids Medicaid Managed Care Advisory Committee in honor of ALL STAR Kids, our most vulnerable Texans, especially the families of Senai Stephanos and Nathaniel Pereida.

Respectfully,

Catherine Carlton

Chair, STAR Kids Medicaid Managed Care Advisory Committee

Executive Summary

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

Members of the committee include a variety of stakeholders including families of children with disabilities receiving services under STAR Kids, physicians, home health providers, managed care organizations (MCO), 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 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

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. Senate Bill 1207, 86th Texas Legislature, Regular Session, 2019 recognized the continued need for improvements to the system and extended the committee until December 2023. In September 2023, HHSC decided not to extend the Advisory Committee and to let it expire in December 2023. The decision was opposed by the STAR Kids Medicaid Managed Care Advisory Committee and members of the public including families, advocates and complex care pediatricians.

1. Introduction

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

- provide Medicaid benefits that are customized to meet the health care needs of recipients under the program through a defined system of care;
- better coordinate care of recipients under the program;
- improve the health outcomes of recipients;
- improve recipients' access to health care services;
- achieve cost containment and cost efficiency;
- reduce the administrative complexity of delivering Medicaid benefits;
- reduce the incidence of unnecessary institutionalizations and potentially preventable events by ensuring the availability of appropriate services and care management;
- require a health home; and
- 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 160,000 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.

HHSC 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 sixth report of the committee. The first report was submitted to the Executive Commissioner in January 2019, the second in January 2020, the third in January 2021, the fourth in December 2021, and the fifth in December 2022.

Some of the recommendations in this report include:

Health Homes and Quality Measures

- Utilize data from the STAR Kids Screening and Assessment Instrument to better understand the needs of the children in the program, design systems that work and improve care through the creation of a data registry
- Reduce administrative burdens on providers, families, MCOs, and other system representatives

- Develop and implement sustainable integrated comprehensive health homes for children with medically complex needs
- Measure outcomes that matter to families and to children with complex needs

Assessment and Service Delivery

- Develop and implement creative solutions to address the home health care workforce crisis that is severely impacting the ability for children to get much needed Private Duty Nursing, Community First Choice, Personal Care Services, Respite and Increase crisis diversion slots for medically fragile children at risk of nursing facilities
- Improve the coordination of benefits and continuity of care
- Continue work on improvements to the STAR Kids Screening Assessment Instrument and to decrease duplication and the length of the assessment
- Improve assessment and delivery of Community First Choice for children in the program including children with mental health conditions

Transition

- Create additional and appropriate billing codes for health care transition
- Create and implement Value-based Payment Options, provider Incentives and quality measures for health care transition
- Improve the health care transition for young adults by creating Transition Specialists for adults between 21 to 23 in STAR Plus
- Improve network adequacy by ensuring a sufficient pool of adult providers for transition age youth with complex needs
- Implement managed care contract changes to promote improved transition processes

A compilation of the recommendations made in the six STAR Kids Advisory Committee reports is included as an addendum to this report.

2. Committee Activities

List of Meeting Dates

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

- March 8, 2023
- June 14, 2023
- September 13, 2023
- December 12, 2023

Committee Member' Attendance Records

A quorum was present for all the meetings during this reporting period. The committee is made up of 17 members. Two members rotated off the committee this year due to changes in their representation status. One resigned in September 2023 and the other in November 2023. A copy of the minutes is available in Appendix E.

Brief Description of Activities of the Committee

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

In addition, the three subcommittees invested a significant amount of time providing input to HHSC on Community First Choice, alternative care models and health care transition. The work is described in detail in the recommendation section of the report.

March 8, 2023

- Presentation of the Multi-Assistance Center at Morgan's Wonderland and co-located and coordinated care for children with disabilities.
- Review and discussion of HHSC's work and policy on Coordination of Benefits and definition of specialty provider.

- Review and discussion of HHSC’s Comprehensive Health Homes for Integrated Care for Kids pilot program. Committee members provided input on the importance of ensuring the pilot streamlines processes and that oversight aligns with the new models. The pilot should not worsen the already existing paperwork burden. In addition, members commented that the pilot should look at outcome data and be careful when aggregating data since each pilot is targeting different aspects of care. HHSC should isolate each pilot’s goals, if possible, during the evaluation.
- Review and discussion on Medicaid Private Duty Nursing reimbursement rates and the ability of the MCOs to pay higher than the fee for service rate set by HHSC.
- Review and discussion of Community First Choice and whether the program is capturing all children who may need and qualify for the benefit.
- Review and discussion of issues related to access to Durable Medical Equipment (DME) and inclusion of DME providers as a specialty provider.
- Discussion about network adequacy and MCO directories.

June 14, 2023

- Presentation by HHCS on Alternative Payment Methodologies and discussion of APMs in STAR Kids and a question of whether Private Duty Nursing could be incorporated into the APM metrics. The committee also suggested measures that assess service fulfillment in long-term care, such as hours authorized versus hours delivered.
- Presentation by committee member, Dr. Rahel Berhane, on integrated health homes for children with medical complexity.
- Presentation by committee member, Dr. Glen Medellin, on administrative burdens in STAR Kids and the need for paperwork simplification.
- Presentation by committee member, Catherine Carlton, on issues faced by parents due to the required 6-month authorization of each supply and benefit leading to unnecessary office visits, delays in accessing needed supplies, and administrative burdens for prescribers, home health and other providers.
- Review and discussion of HHSC’s Utilization Review Department’s review of Medically Dependent Children. The committee provided input on future surveys of families that better capture what families are experiencing because of the workforce shortage and expressed concern that the survey did not fully reflect issues that families are facing.

- Review and discussion of the unwinding of continuous Medicaid coverage. The committee expressed concern about children on Medicaid HCBS waivers losing coverage. The committee recommended there be a dedicated team at HHSC working on eligibility for those who have Medicaid waivers. There were also concerns about young adults who aged out of foster care.

September 13, 2023

- Review and discussion about the extension of the STAR Kids Medicaid Managed Care Advisory Committee including comments from stakeholders about the importance of the committee given the small population and unique needs of the children services in the program.
- Discussion of the Community First Choice benefit and a recommendation by the committee that the assessment process be reviewed for duplication and potential streamlining.
- Review and discussion about MCO provider directories and network adequacy. Recommendation from the committee that HHSC consider service fulfillment standards when assessing network adequacy including hours authorized versus hours delivered. HHSC indicated they are conducting a project to formally collect prior authorization data.
- Presentation by HHSC on National Core Indicators (NCI) Child and Family Survey and Consumer Assessment of Healthcare Providers survey. The committee requested HHSC to look at all the different ways individuals are being surveyed and simplify the process of evaluating STAR Kids' performance. The committee also expressed concern about the results of the survey indicating individuals did not understand their service plans.
- Review and discussion of STAR Kids Pay for Quality 2024-2025 Measures. The committee expressed concern that the current measures do not fit the medically fragile population and that perhaps other measures might need to be added.

3. Committee Recommendations

Full Advisory Committee

Recommendation:

On September 13, 2023, the Committee voted to recommend to the Executive Commissioner that she extend the term of the STAR Kids Medicaid Managed Care Advisory Committee for two additional years to continue the work of the committee in ensuring the needs of children in STAR Kids Medicaid Managed Care are addressed and met. We received notice from HHSC on September 28, 2023, that HHSC will not be extending the committee.

Recommendation:

On July 14, 2023, the Committee voted to oppose HHSC's draft policy change to the Private Duty Nursing benefit that would limit providers from using the modifier when billing for care for individuals on ventilators who use a non-invasive mask.

Subcommittee on Health Homes and Quality Measures

The ideal model of service delivery for children with complex healthcare needs is one where the Primary Care Provider (PCP) and parents engage in a person-centered process of goal setting and shared decision making to allow appropriate 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.

Centralized, state registry for children with medical complexity.

Texas has a tremendous opportunity to build on the success and momentum of the work of complex care pediatricians, families, providers, advocates and others aimed at creating effective systems of care for children with medical complexity and their families. CMC are a subset of children with special health care needs who are the most medically fragile. Recent adverse experiences with disenrollment of CMC from Medicaid during the Medicaid Unwinding, highlighted the importance of a centralized data registry for children with medical complexity. One of the benefits of centralized data registry for children with medical complexity is mitigating loss of coverage and ensuring access to care for this vulnerable population.

Children with complex medical needs make up less than 1% of the total Texas Medicaid population but nearly 40% of the costs to our state. CMC account for some of the highest utilizers of health care system resources and are a population with the greatest potential to implement positive, evidence-based, and cost-saving measures. Identification and access to comprehensive data about this population, which is currently unavailable and inaccessible, through a centralized, statewide registry would:

- improve access to care and tracking of outcomes for children with complex medical needs;
- ensure more effective, data-driven designation and utilization of resources and state funds;
- allow tracking of evidence-based clinical care through relevant claims data and help identify opportunities for integration and standardization of best practice and minimum standards of care;
- help identify redundancies and deficits; and
- provide data to identify cost-effective efforts leading to decrease potentially preventable emergency department and other high-cost, resource utilization.

The opportunity of such a statewide registry for children with medical complexity to help inform future policy and system improvements through data-informed and data-driven best practice standards and quality outcome measures is great. The potential collaboration and work with a qualified health-related institution, the state's existing All Payor Claims Database, and an advisory board to inform the creation and long-term sustainability of a data registry for CMC are opportunities that are welcome and need to be explored.

Recommendation:

Develop a statewide data registry for children with medical complexity.

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. Over the course of the last ten years, the subcommittee has worked closely with HHSC to delineate a model of care for children with medical complexities.

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.

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.

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.)

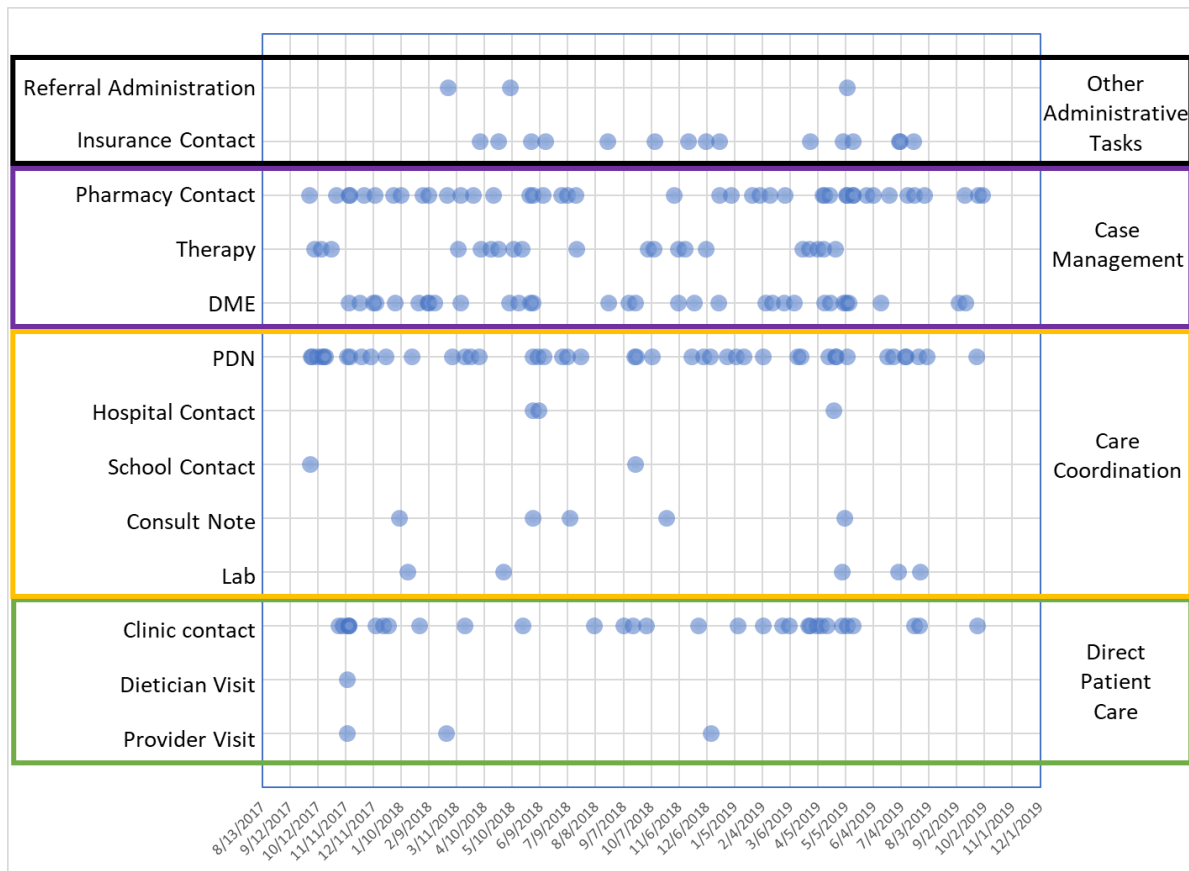
Assessment, Assessment, Assessment



Examples of assessments a single individual could undergo over the course of a year: Physical Therapy Evaluation, Occupation Therapy Evaluation, SK-SAI STAR Kids-Screening and Assessment Instrument, Intellectual Disability Condition (IDRC) Assessment, Client Assessment of Needs and Strengths (CANS), Early Childhood Intervention Intake assessment, Speech Therapy Evaluation, Developmental Screening, Preschool Program for Children with Disabilities intake assessment, and Neuro-psychological testing.

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.



Contact points for a single patient receiving care at a comprehensive care clinic over the course of two years: Direct patient care including clinic contact, dietician visit and provider visit. Care Coordination including PDN, Hospital Contact, School Contact, Consult Note, and Lab. Case Management including Pharmacy Contact, Therapy and DME. Other Administrative Tasks including Referral Administration and Insurance Contact.

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 are currently underway at HHSC. It is our understanding that HHSC is working on a mechanism to allow for the authorization of certain services for a longer period, i.e., six months to a year for children whose needs have not changed.

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 SB 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.

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 consider 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.
- 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.
- 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 med 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

Children need timely access to acute care and long-term services and supports to maintain health and safety and to be included as valued members of their families and communities. Families need access to critical information and support to care for their children with medical, physical, developmental and behavioral

complexities. It is critical that assessments accurately identify and authorize services. It is also imperative that children and families have a service delivery system with an adequate network of providers and a mechanism to address concerns through appeals and complaints.

SK-SAI Tool Improvements

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 SK-SAI is intended to assess 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 embarked on an internal review of the SK-SAI for optimization and improvement and rolled out a revised assessment tool recently. The STAR Kids Advisory Committee offered numerous improvement recommendations to the assessment and is planning to work with HHSC on continued improvements to the process.

Recommendations:

- Continue to work with knowledgeable stakeholders on improvements to the SK-SAI.
- Evaluate and monitor the revised tool triggers for referrals for Community First Choice, durable medical equipment, Personal Care Services, and therapy are working.
- Provide ongoing training and 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.
- Continue to assess if the reassessment tool 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.

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% in 2016 to 14.1% in 2017 and 8.7% in 2018 and approximately 4% in August 2022. While the decrease is a substantial improvement over the initial 2017 and 2018 numbers, they continue to be higher than the number denied prior to the use of the new tool. 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 parts of the tool and is subject to interpretation by the state's third-party contractor. The reviewers at TMHP often lack a common understanding of what is or is not nursing and that medical necessity for MDCP and nursing facility care is the same. It sometimes appears that reviewers are applying a higher standard in considering medical necessity for MDCP, namely the standard for private duty nursing services.

Recommendations:

- 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.
- HHSC should issue ascertainable standards on medical necessity criteria for nursing facility admission, as opposed to private duty nursing, and train TMHP reviewers on these standards.

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 previous Committee reports 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 has undertaken significant utilization review initiatives of children receiving services through the Medically Dependent Children's

Program. We recommend that during future reviews HHSC monitor whether training on portal access is occurring.

Recommendations:

- HHSC should monitor the MCOs to ensure MCOs have provided access in the health portal for families to timely view:
 - ▶ SK-SAI
 - ▶ Individual Service Plan (ISP)
 - ▶ Authorizations, claims, 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

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.

Senate Bill 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. Senate Bill 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 SB 1207. Publicly post data related to external medical reviews including number of denials overturned and number sustained.

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.

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 previous reports. While a template was designed and provided to the MCOs to use, the language provided by the MCOs continues to be written in a way that is not clear or easy to understand. 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.

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.

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% 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.
- Improve outreach to families about the Health Insurance Premium Payment (HIPP) as a cost-effective alternative to higher Medicaid expenditures.

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 \$10.60 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 \$10.60 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 a service fulfillment strategy as a measure of adequacy for long-term services and supports, i.e., hours authorized versus hours delivered.
- HHSC should include the following recommendations as strategies for the recruitment, retention, and access to community attendants.
 - ▶ 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 and ensuring that Managed Care Organizations who participate in such initiatives are not financially penalized including during capitation rate setting and procurement.

- ▶ Increase the Medicaid fee schedule for Personal Care Services and Community First Choice to a minimum of \$15.00 per hour.
- ▶ Explore models that allow families to be providers of care such as the Parents as Certified Nurse Assistants program in Colorado and the Licensed Health Aide program in Arizona.

Inclusion of IDD Waivers into STAR Kids

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

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.

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.¹ 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.² 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.³

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' 2022 Medicaid fee schedule, the transition-related codes below are not recognized. These codes support the preparation of medical summaries/emergency

¹ 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.

² Six Core Elements of Health Care Transition 3.0. Washington, DC: Got Transition. Available from: <https://www.gottransition.org/six-core-elements/>

³ Schmidt A, McManus M, White P, Slade R, Salus T, Bradley J. 2022 Coding and Payment Tip Sheet for Transition from Pediatric to Adult Health Care. Washington, DC: Got Transition, May 2022. Available at <https://gottransition.org/resource/2022-coding-tip-sheet>

care plans, care coordination needed for transition, transition readiness assessments, consultation between pediatric and adult health care providers, and hospital-to-home transitional care. For a medically complex patient population, having a joint telehealth visit with the sending and receiving doctors, the patient/caregiver, and care manager can help to ensure continuity of care, reduce worry, and improve the integration into a new adult system of care.

According to the AAP, telehealth visits can be coding using existing office visit codes with a telehealth modifier (for pediatric provider, it would be an established patient and for the receiving adult provider, it would be a new office visit). Medicaid and its contracted MCOs would have to allow this same day visit by two providers to be recognized. Another strategy used by other states is to allow complex patients by two PCPs (pediatric and adult) for a limited time to ensure that there is a smooth handoff, and that the patient/caregiver feels comfortable with their new adult PCP.

Recommendations

- Recommend recognition of the following transition-related CPT codes in Texas' Medicaid fee schedule:
 - ▶ Health and behavior risk assessment (96160)
 - ▶ Prolonged services before and/or after direct patient contact for physicians caring for patients ages 21 and older (99358, 99359)
 - ▶ Interprofessional telephone/internet/electronic healthrecord consultations (99446-99449, 99451, 99452)
 - ▶ Care management services (99487, 99489, 99490, 99439, 99491, 99437, 99424-99427)
 - ▶ Transitional care management services (99495, 99496)
- Allow for STAR Kids members to have two assigned pediatric and adult primary providers for a limited period (e.g., up to 1 year) to facilitate shared care management and a smooth handoff.
- Allow for health care providers to bill for a joint telehealth visit with sending pediatric provider, receiving adult provider, and young adult who is transferring, with caregiver and care manager, as needed. Use existing office visit codes for the two providers to see the same patient on the same day.

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 21st birthdays thus extending the window of opportunity for STAR Kids and STAR Plus MCO's to collaborate and coordinate services to better prevent any gaps in care or services.
- The age out preselection of a STAR Plus plan should be transmitted to the receiving STAR Plus plan at the time it is sent to the enrollment broker instead of waiting for the enrollment broker to complete their process.
- Allow the STAR Kids MCO, at the direction of the member, to send the transition packet to the receiving STAR+PLUS MCO without waiting for the enrollment brokers process to complete. 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.

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 21st 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, finding additional health care providers as needed, assisting with adult public program benefits and community-based supports, 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 each year.
- 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.

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.⁴ 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 incorporated into EMRs 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 adult's 21st 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, including supported decision making
 - ▶ Adult disability Medicaid coverage and disability program options, including SSI/SSDI
 - ▶ Creative housing options including shared living arrangements and host homes
 - ▶ Supported employment

⁴ 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>

- ▶ 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.
- Mandate that each STAR Kids and STAR+PLUS MCO have a health plan- to-health plan transition phone line or dedicated email box that is published and provided to members.

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 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:

- 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.
- 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, including care coordination, 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.⁵

- ▶ a. The National Alliance to Advance Adolescent Health’s Guide for Designing a Value-Based Payment Initiative for Pediatric-to- Adult Transitional Care can be used as a resource when designing a pilot; it contains a step-by-step approach to designing a value-based payment initiative for transitional care.⁶

⁵ 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.

⁶ McManus M, White P, Schmidt A. A Guide for Designing a Value-Based Payment Initiative for Pediatric-to-Adult Transitional Care. Washington, DC: The National Alliance to Advance Adolescent Health, 2022.

4. 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 the following 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,
- Reduction in administrative burdens to providers,
- 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,
- An improved complaint process that does not require families to spend hours on the phone while trying to care for their children,
- A system that examines hours of service authorized to hours of service delivered,
- 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
CAN	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	Texas 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

- Catherine Carlton, (Presiding Chair), Arlington, MHMR of Tarrant County
- Terri Carriker, (Vice Chair), Austin, Parent Representative
- Elizabeth Tucker, 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
- Tara Hopkins, Austin, DentaQuest (resigned November 17, 2023)
- Dr. Glen Medellin, San Antonio, The University of Texas Health Science Center
- Blake Smith, Denison, Steps2Strides Therapy Center
- 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
- Belinda West, Thrive Skilled Pediatric Care
- Dr. Theresa Ruiz, Community First Health Plan (resigned September 11, 2023)

Letter from Complex Care Physicians in Support of Advisory Committee Continuation

August 29, 2023

Cecil Erwin Young
Executive Commissioner
Health and Human Services
4601 W Guadalupe St
Austin, Texas, 78751

Dear Ms. Erwin Young,

This letter expresses the views of physicians who lead the Complex Care Medical Homes for children with Medical Complexity and Medical Fragility. The majority of patients in our clinics participate in the STAR Kids Medicaid program since inclusion criteria for our clinics is very similar to criteria for the Medically Dependent Children's Waiver Program (MDCP). We have devoted our careers to providing care for this vulnerable population.

Supporting the health needs of these patients requires a comprehensive network of medical, pharmaceutical, transportation, durable medical equipment, medical supplies, LTSS and acute care services. Developing best models of care has been a challenge due not only to the complexity of coordinating care, but also the significant costs of these services. A review of the rate setting report on your website demonstrates the uniqueness of this population. The total per member per month (PMPM) for recipients of STAR Medicaid is \$359 and for STAR Kids is \$2130. Even more telling, though, is that children that qualify for STAR Kids through the MDCP waiver have a PMPM of as high as \$24,050. This huge cost differential highlights the differences in this population from other Medicaid populations.

Children with medical fragility are a vulnerable population due not only to their underlying medical conditions, but also to how society responds to them. A recent article in Pediatrics titled "Perceived Disability-Based Discrimination in Health Care for Children with Medical Complexity" (<https://doi.org/10.1542/peds.2022-060975>)

concludes that children with medical complexity face disability-based discrimination in health care. Caregivers of children with medical complexity report experiences of disability-based discrimination in the healthcare of their child. These experiences

are driven by provider knowledge, apathy, and assumptions, and manifest as lack of access to care, substandard care, and dehumanization.

To support this vulnerable and complex population, institutions across the state have developed medical homes championed by doctors who are passionate about ensuring that these children have the best life possible. These clinics are staffed by multidisciplinary teams that can manage the medical and social needs of these patients and their families. Models of care that work for healthier panels do not serve this population. In order to support the best health possible, our clinics collaborate with community agencies to ensure that patients get the medical equipment, supplies, nursing, and therapy that they need. We strive to find the right mix of services that optimizes health while avoiding unnecessary and avoidable expenses.

We have partnered with each other and with advocates for medically complex children across the state. The STAR Kids Advisory Committee has been an invaluable place to collaborate with each other and the state to identify barriers, to have our voices heard, and to propose solutions and to be a test bed of innovation. We are concerned about the decision not to extend the SKAC at a time when there is still so much work to be done. We feel that the SKAC has been diligent and fruitful in its charge. *"The STAR Kids Managed Care Advisory Committee, created by Senate Bill 7 of the 83rd Texas Legislature (Regular Session), advises HHSC on the establishment and implementation of the STAR Kids Medicaid managed care program. The STAR Kids Medicaid managed care program is legislatively mandated to provide services for children with disabilities who have Medicaid coverage to improve coordination and customization of care, access to care, health outcomes, cost containment and quality of care. The STAR Kids model must require a health home, care management, and provide comprehensive coordination of acute care and long-term service benefits."*

Although the STAR Kids Managed Care program was established, there are still significant concerns about implementation. Although discussions about MCO processes may be adequately addressed in other advisory committees, there remain significant issues with implementation that adversely affect this medically fragile and unique population. The breadth of discussions possible on the advisory committee due to the breadth and diversity of expertise of members will not be possible in any other venue.

We respectfully ask that you extend the term of the SKAC. We strongly feel that this is in the best interest of the children who experience Medical Fragility and Complexity, particularly the MDCP qualified children. There is no other comparable committee that can bring the wide scope of experience. Allowing the SKAC to expire will cause harm to these children and will deprive the state of passionate and highly

qualified advisors. Furthermore, it will continue the concerning discrimination that children with medical complexity experience in all aspects of their life.

Sincerely,

Glen Medellin, MD San Antonio, TX

Rahel Berhane, MD Austin, TX

Adam Rosenbloom, MD Austin, TX

Ricardo Mosquera, MD Houston, TX

Christine Murphy, MD Galveston, TX

Compilation of Prior Committee Recommendations

Issue 1: Problems related to heterogeneity of STAR Kids population and the need to define population sub-groups

Recommendations (2018): We recommend a standardized sub-stratification for two of the most affected populations within STAR Kids. This will allow for more homogeneous care pathways; outcome tracking and potentially value-based contracting. These sub level I subgroups should be:

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

Recommendation (2019): We recommend HHSC use data from the SK-SAI to identify distinct subpopulations and where there is insufficient data, change the SK-SAI to better identify subpopulations.

- A medically fragile subgroup of children on MDCP and/or children who have PDN.
- A behaviorally complex subgroup of children with IDD/Behavioral disorders/Autism Spectrum Disorders (ASD)
- Children with serious and persistent mental illness.

Issue 2: Service fragmentation and potential opportunities from telemedicine

Recommendation (2020, 2021 and 2022): 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)
- an evaluation schema that assesses the effectiveness of the model as a 'whole' instead of separate schemes for each entity

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.

Issue 3: Unsustainable increase in administrative paperwork and administrative costs to providers

Recommendations (2018 and 2019): We recommend HHSC encourage and facilitate simplification of administrative paperwork as it relates both from provider to MCO as well as MCO to HHSC. For example:

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

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

Recommendation (2019): Allow some of the data on the SK-SAI to be completed from existing database (Claims, EMR) and encourage the use of the ISP in the MCO Utilization Review Process. This will decrease the paperwork burden and will also make the SK-SAI a more useful tool in the care delivery process.

Recommendation (2019, 2020, 2021 and 2022): 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.

Recommendation (2020, 2021 and 2022): 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.
- 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 **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 SB 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.

Issue 4: Improved care coordination through the development of health homes for children with medical fragility and serious mental health care needs

Recommendations (2018 and 2019):

- 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 these two subgroups of individuals. Some mechanisms for this payment may involve -designating consult level billing or an extra payment category for preparing and producing a detailed care plan. Care Plan preparation and discussion is largely a non-reimbursed

service currently even though it takes more than two hours of time; a large part of it may not be a face-to-face encounter.

Recommendation (2019, 2020, 2021, 2022):

- 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.

Recommendations (2020, 2021 and 2022):

- 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.
- HHSC should take full advantage and participate in the ACE Kids Act when it rolls out to states.

Issue 5: Measuring outcomes that matter

Recommendations (2018, 2019, 2020, 2021 and 2022):

- 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 collaboration with MCOs, local mental health authority and health homes. These health homes can utilize telemedicine to access psychiatric med management; utilize evidence-based family supports such as the Family Partner program by the National Alliance 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.
- We understand HHSC is working with the EQRO on outcomes. We recommend that input from different expert groups and stakeholder groups such as Texas Pediatric Society, Texas Medical Association, STAR Kids Advisory Committee members, Disability Rights Texas, Value Institute at Dell Medical School and other state and National entities be included to come up with a set of measures that truly measure outcomes and allow true benchmarking of quality services. (2018)

Issue 6: SK-SAI Tool Improvements

Recommendations (2018):

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

Recommendations (2019 and 2020):

- 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.
- 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.

Recommendation (2020):

- Monitor the testing of the new tool and make changes based on feedback from the families and MCOs.

Recommendations (2020, 2021 and 2022):

- Continue to work with the committee on improvements to the SK-SAI.
- Solicit family and Service Coordinator (MCO assessors) feedback from the new tool.
 - Review feedback specifically, including children with medical complexities, children with intellectual and developmental disabilities (IDD) and children with significant mental health needs.

- ▶ Evaluate and monitor the revised tool triggers for referrals for Community First Choice, durable medical equipment, Personal Care Services, and therapy are working.
- Provide ongoing training and 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.
- Continue to assess if the reassessment tool 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.

Issue 7: MDCP SK-SAI and Loss of Eligibility

Recommendations (2018):

- Due to the significant number of MDCP denials at the annual reassessment, HHSC should revert to the MN-LOC tool to determine MDCP eligibility as opposed to the SK-SAI. This may require a statutory change by the legislature and may only be needed temporarily while the instrument is refined and optimized.
- The MDCP eligibility tool should be administered by an assessor who can complete a hands-on nursing assessment, not the MCO nurse assessor who is prohibited from doing a thorough nursing assessment.
- All MDCP assessments, including reassessments and change in status/need, should be completed by a team of two, including a registered nurse.
- Children who were assessed using the new SK-SAI and who lost MDCP eligibility should be reassessed using the MN-LOC and if found eligible should be offered access to the waiver.

- Offer children who have lost eligibility for Medicaid due to loss of Medically Dependent Children Program eligibility in STAR Kids, access to another 1915(c) waiver such as Community Living Assistance and Support Services (CLASS) or Home and Community-based Services (HCS). This may require legislative approval.
- Allow children who have experienced a long-term hospital stay to be assessed for MDCP in the hospital prior to being discharged home.
- Because the MDCP waiver waives off both a hospital level of care and/or a nursing facility level of care, allow a child who meets the medical fragility eligibility for MDCP access to the waiver without a limited stay in a nursing facility. A child should not be discharged from a hospital setting to a nursing facility for a short stay and then to home. This is not good for the child's health and safety and leads to increased costs and administrative burdens.

Recommendations (2019):

- Consider alternative options for assessing children for eligibility for the MDCP waiver including requiring the assessment be done by a team of two and administered 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.
- Investigate the status of children who have lost eligibility for MDCP and for those who have also lost Medicaid to determine if there are immediate services needed.
- Allow children who have experienced a long-term hospital stay to be assessed for MDCP in the hospital prior to being discharged home with a follow-up home assessment scheduled within a week of their return.
- Because the MDCP waiver waives off both a hospital level of care and/or a nursing facility level of care, allow a child who meets the medical fragility eligibility for MDCP access to the waiver without a limited stay in a nursing facility. A child should not 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. SB 1207 states a child cannot be required to reside in a nursing facility for an extended period of time to meet MDCP eligibility. The committee wants to work with HHSC to come up with alternatives.

Recommendations (2019, 2020, 2021 and 2022):

- 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.
- HHSC should issue ascertainable standards on medical necessity criteria for nursing facility admission, as opposed to private duty nursing, and train TMHP reviewers on these standards.

Issue 8: Immediate Access to MDCP Waiver Level Service with No Wait

Recommendations (2018): 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.
- Maintain at least a current level of effort to offer children on the interest list who do not have SSI waivers.

Issue 9: SK SAI and Improved Communication and Transparency for Families

Recommendations (2018):

- HHSC should require all MCOs to provide the following individualized training to families on how to access the health portal to:
 - ▶ View 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.
- 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

Recommendations (2019, 2020, 2021 and 2022):

- HHSC should monitor the MCOs to ensure MCOs have provided access in the health portal for families to view:
 - ▶ SK-SAI
 - ▶ Individual Service Plan (ISP)
 - ▶ Authorizations, claims, 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

Issue 10: Medical Necessity and Treating Physician

Recommendations (2018):

- Defer to the treating professional when determining medical necessity.
- Prior to the issuance of a denial, require MCOs to allow for a process for reconsideration that also includes peer-to-peer review by physicians, therapists, nurses, etc.

Recommendations (2019, 2020, 2021 and 2022):

- 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 SB 1207. Publicly post data related to external medical reviews including number of denials overturned and number sustained.

Issue 11: Preferred Provider

Recommendations (2018): HHSC should clearly define requirements on how preferred provider arrangements may be utilized ensuring:

- Members are given a choice of at least two, preferably at least three, providers for specialty services and DME, including non-preferred provider arranged services.
- Members have the right to choose the best services or equipment that meet their medical necessity, regardless of provider arrangement with the MCOs.
- MCOs submit all preferred provider arrangement contracts to HHSC for review and approval.
- 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.

Recommendations (2019, 2020, 2021 and 2022): 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.

Issue 12: Notices of denials of services lack clarity and families need adequate notice of right to appeal

Recommendations (2018):

- Require MCOs send notifications for a denial or reduction in service within one day of the date on the notification.
- Require the notice to be delivered via registered mail to ensure the time frame is followed.
- MCOs who do not provide sufficient notice of denial and infringe on the family's ability to request continuation of services should be subject to liquidated damages.

Recommendations (2018, 2019, 2020 2021 and 2022):

- 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.

Issue 13: Transparency and timely response to member and provider complaints

Recommendations (2018): Increase transparency and respond quickly, accurately and completely to issues generated through inquiries, complaints, conducting investigations, inspections and other contract compliance regulatory actions.

- Consolidate and streamline the complaints process and increase public awareness and outreach to MCO members about where to go for help and how to make a complaint.
- Require state agencies and MCOs to track all instances of access to care issues as a complaint.
- Require Ombudsman and Consumer Rights Services to keep individuals informed of agency action and findings about complaints regarding programs and services and elevate systemic issues with recommendations for improvement to HHSC leadership and the legislature.
- HHSC should continue the monthly in-person STAR Kids Work Group to provide ongoing communication among providers, MCOs, families, HHSC and other stakeholders to address questions, issues and opportunities for improvement.

Recommendations (2018, 2019, 2020, 2021 and 2022): 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.

Issue 14: Opt-Out Provision for Children in MDCP and Children with Private Insurance

Recommendations (2018):

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

Issue 15: Alternative service delivery model for children in Medically Dependent Children Program

Recommendations (2019):

- Investigate alternative models of service delivery for children in MDCP such as Primary Care Case Management, Fee for Service, or an Accountable Care Organization.
- Prioritize the development of clear and standard policies around coordination of benefits for those with third-party insurance.
- 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.

Issue 16: Coordination of Benefits, Continuity of Care, and Alternative service delivery model for children in Medically Dependent Children Program

Recommendations (2020, 2021, 2022):

- 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 an 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.

Issue 17: Limited pool of qualified direct service workforce

Recommendations (2018): We recommend HHSC closely evaluate and streamline the Direct Service Workforce for both subgroups to improve the pool of individuals available to provide home care. This would include:

- Simplifying the process to access services – (Parents are unable to adequately evaluate the individuals who can work with their children because there is no database that has the profile of individuals working through the different staffing agencies. HHSC should facilitate/incentivize the creation of such a resource by community organizations such as Texas Parent to Parent

– (similar to Angie’s list but for direct service providers for children with complexity).

- ii. Incentivizing development of specifically trained attendants to care for children who have medically complex conditions or who have behaviorally complex support needs by allowing for increased payment for individuals with more skills and certifications as well as increased administrative payments to home health agencies.
- iii. Allowing supervised delegation of nursing; parents as CNAs (similar to existing models in Colorado) etc.
- iv. Increasing base payments for attendants/habilitation specialists.

Recommendations (2019, 2020, 2021 and 2022):

- 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 to a minimum of \$15.00 per hour. *(2019 and 2020 recommendation did not recommend an amount.)*

(2020, 2021 and 2022) Recommendation: Explore models that allow families to be providers of care such as the Parents as Certified Nurse Assistants program in Colorado and the Licensed Health Aide program in Arizona.

Issue 18: Inclusion of IDD Waivers into STAR Kids

Recommendations (2018, 2019, 2020, 2021, and 2022):

- 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.

Issue 19: Evaluation of whether to move to STAR Kids to statewide MCO

Recommendations (2019, 2021 and 2022):

- 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. (2022)

Issue 20: Medicaid fee schedule gaps impede the provision of recommended Health Care Transition services and collaboration between pediatric and adult providers

It is important to have a mechanism to allow pediatric and adult providers to bill for professionally recommended health care transition-related services.

Recommendation (2018):

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

Recommendations (2019, 2021 2020, and 2022):

- Recommend recognition of the following transition-related CPT codes in Texas' Medicaid fee schedule:
 - ▶ Health and behavior risk assessment (96160)
 - ▶ 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, 99439, 99491, 99437, 99424-99427)
 - ▶ Transitional care management services (99495, 99496)
- Allow STAR Kids members to have two assigned pediatric and adult primary providers for a limited period (e.g., up to 1 year) to facilitate shared care management and a smooth handoff.
- Allow for health care providers to bill for a joint telehealth visit with sending pediatric provider, receiving adult provider, and young adult who is transferring, with caregiver and care manager, as needed. Use existing office visit codes for the two providers to see the same patient on the same day.

Issue 21: 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

Recommendations (2018):

- Update the age out process to allow all members to receive STAR Plus enrollment information packets 6-9 months prior to their 21st birthdays thus extending the window of opportunity for STAR Kids and STAR Plus MCO's to

collaborate and coordinate services to better prevent any gaps in care or services.

- 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.

Recommendations (2019, 2020, 2021 and 2022):

- Update the age out process to allow **all** members to receive STAR Plus enrollment information packets 6-9 months prior to their 21st birthdays thus extending the window of opportunity for STAR Kids and STAR Plus MCO's to collaborate and coordinate services to better prevent any gaps in care or services.
- The age out preselection of a STAR Plus plan should be transmitted to the receiving STAR Plus plan at the time it is sent to the enrollment broker instead of waiting for the enrollment broker to complete their process

Recommendation (2022):

- Allow the STAR Kids MCO, at the direction of the member, to send the transition packet to the receiving STAR+PLUS MCO without waiting for the enrollment brokers process to complete. 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. (2022).

Issue 22: 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

Recommendations (2018, 2019, 2020, 2021 and 2022):

- 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, finding additional health care providers as needed, assisting with adult public program benefits and community-based supports, 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 each year.

Recommendations (2020, 2021 and 2022):

- 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.

Issue 23: Improve the healthcare transition of children from childhood to adulthood through the adoption of transition standards and best practices

Recommendations (2018 and 2019):

- Adopt and implement the American Academy of Pediatrics consensus statement on transition and Got Transition’s Core elements as best practices. Require training of MCO transition specialists to include:
 - ▶ 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
 - ▶ Got Transition Content

Recommendations (2019, 2020, 2021 and 2022):

- 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. 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.
- Require training of MCO transition specialists on
 - ▶ Got Transition’s Six Core Elements (for use in STAR Kids and STAR Plus)
 - ▶ Alternatives to guardianship, including supported decision making
 - ▶ Adult disability Medicaid coverage and disability program options, including SSI/SSDI
 - ▶ Creative housing options including shared living arrangements and host homes

- ▶ Supported employment
- ▶ Utilization of the Navigate Life web reference

Recommendations (2020, 2021 and 2022):

- Promote best practice sharing among MCOs by hosting regular transition planning conferences and training for MCO transition specialists and care coordinators.

Recommendations (2021 and 2022):

- Mandate that each STAR Kids and STAR+PLUS MCO have a health plan-to-health plan transition phone line or dedicated email box that is published and provided to members
- Develop a standardized template for transition plans that can be used across plans and incorporated into EMRs 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 adult's 21st birthday.

Issue 24: Lack of Medicaid adult primary and specialty care providers available to care for complex patients aging out of pediatric care.

Recommendations (2018):

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

Recommendations (2019, 2020, 2021 and 2022):

- 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.

- 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, including care coordination, 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.
 - ▶ The National Alliance to Advance Adolescent Health’s Guide for Designing a Value-Based Payment Initiative for Pediatric-to-Adult Transitional Care can be used as a resource when designing a pilot; it contains a step-by-step approach to designing a value-based payment initiative for transitional care

Presentation by Complex Care Clinic Pediatrician on Administrative Burdens in STAR Kids

The following is a presentation by Dr. Glen Medellin, STAR Kids Medicaid Managed Care Advisory Committee member and complex care pediatrician with University Health Complex Care Clinic in San Antonio on administrative burdens in the STAR Kids.

Faxes Processed in 2022

- In 2022 – **16,763** faxes processed
- Average 65 faxes sent out per business day
- 1.3 provider FTE for 640 patients
 - 14,327 faxes/FTE/Year
- Clinic time/FTE assuming 10 minutes per fax
 - 2387 hours per year, 45 hours per week
- Provider time assuming 3 minutes per fax
 - 15 hours per week

Time Based on Patients

- Time based on patients
 - 26 faxes/patient/year
 - 260 min (4 hours)/patient/year
- This is unreimbursed time.
- This is not just “paperwork” but rather medical orders.

Volume of Faxes

- Volume of faxes examples
 - 44 faxes, 3 billed visits.
 - 43 faxes, 2 billed visits

Title 19 Forms Volume

- In 2022, out of 16,763 faxes we had 2013 Title XIX completed.

- If we estimate 15 minutes per Title XIX, we spent 503 hours or 10 hours per week.
- Providers spent on average 1.5 hours per week completing title 19 and supporting documentation if 3 minutes per fax.
- New forms every 6 months even when patient condition unchanged.
- Forms are not designed for complex medical conditions.
- CCP forms (Comprehensive Care Program) - 502 forms in 2022.
- These forms are not designed to support children. Example: oxygen form
- Letters of medical necessity
- Redundant entry of information
- Submitter certification statement