



**Texas Medicaid Managed Care
STAR Kids Program Focus Study
STAR Kids Managed Care Organization
Interviews**

Contract Years 2017 and 2018

**The Institute for Child Health Policy
University of Florida**

**The External Quality Review Organization
for Texas Medicaid Managed Care and CHIP**

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Executive Summary

The STAR Kids program, implemented in November 2016, provides managed care services to Medicaid members 20 years of age and younger who receive Supplemental Security Income (SSI) benefits or benefits through state programs for children with disabilities, such as waiver programs for home and community-based services (HCBS). As the external quality review organization (EQRO) for Texas Medicaid managed care, the Institute for Child Health Policy at the University of Florida is conducting a multi-year focus study to evaluate implementation of STAR Kids and develop a performance measure set that is appropriate to the STAR Kids population. This report describes the methods and findings of interviews conducted with STAR Kids managed care organizations (MCOs) to assess their experiences in the first year of implementation and to collect information on MCO structure and processes relevant for ensuring high quality of care for STAR Kids members. This is one of several reports being produced for the STAR Kids focus study, and complements the survey work the EQRO is also conducting to understand caregiver experiences and satisfaction with the care their children receive.

Methodology

The STAR Kids MCO interviews included a set of open-ended questions regarding challenges and successes encountered during implementation, resources for care coordination, methods for monitoring enrollment, concerns from parents and disability advocates, network adequacy, and continuity of care. All ten STAR Kids MCOs provided written responses to the questions. The EQRO reviewed responses and drafted follow-up questions for the MCOs, which were posed in-person during site visits (August to December 2017) or via teleconferences (January and February 2018) with key MCO staff. All site visits and teleconferences were audio recorded and transcribed for analysis.

The EQRO used grounded theory to develop a codebook through review of written responses, producing 80 distinct codes that were grouped into six general theme categories: (1) barriers; (2) complaints; (3) goals; (4) networks; (5) services; and (6) strategies. Using this codebook, the team then conducted a content analysis of all interview transcripts, allowing for identification of the most common and salient themes. Review of findings focused on both common experiences and unique or innovative approaches to care.

Summary of Findings

Common areas of concern regarding STAR Kids program implementation included resistance to the program on the part of families and providers, changes or reductions in services, medical necessity denials, and issues with scheduling and completing the STAR Kids Screening and Assessment Instrument (SK-SAI).

- Many MCOs reported that early resistance to the program by families and providers occurred in part due to critical reports by news organizations and advocacy groups. Fears about service reductions under STAR Kids have lessened as members and providers developed relationships with their service coordinators and gained experience with the program.

- Poor contact information for members leads to challenges in scheduling initial visits for screening and assessment. Once visits are scheduled, completing the SK-SAI can be a challenge due to its length and format.
- MCOs found that some families of low-risk members, who have fewer needs for long-term services and supports (LTSS), such as private-duty nursing (PDN) or personal care services (PCS), may be less likely to schedule appointments for the SK-SAI because they are not aware of the need for assessment, are self-sufficient, or are accustomed to the less-involved level of assessment under traditional fee-for-service (FFS) Medicaid.
- Some MCOs reported denials of medical necessity for the Medically Dependent Children's Program (MDCP), which may result because the SK-SAI allows for a more detailed and appropriate assessment of needs for children than the more adult-focused Medical Necessity and Level of Care (MN/LOC) assessment that was used under traditional FFS Medicaid.
- Most MCOs reported that members experienced changes or reductions to certain service types – in particular, PDN. These typically represented partial denials of PDN services (reduction of authorized PDN hours) from what was previously authorized and provided under traditional FFS Medicaid. In many cases, the MCOs reported that reduction of PDN hours was replaced with increases in other service types, such as PCS.

The interviews also revealed several promising strategies taken by the STAR Kids MCOs to ensure effective care coordination and service delivery, including stakeholder engagement, strategies to improve transition of members from pediatric to adult care, and methods for building provider networks and ensuring continuity of care.

- Engagement of member, family, provider, community, and advocacy stakeholders was the most common strategy employed by STAR Kids MCOs. Stakeholder engagement strategies fell into six main categories based on the goal of engagement: (1) addressing barriers to service delivery and quality; (2) providing better services for STAR Kids members in schools; (3) improving relationships or sharing information with members; (4) improving relationships or sharing information with providers; (5) listening to member or family concerns; and (6) training MCO staff members.
- To improve transition of members to adult care, MCOs stressed the importance of beginning the transition process early. Keys to successful transition include establishing transition specialists, educating families on the process of transition, and working with providers and other health plans on specific cases.
- MCOs noted that issues of network access or adequacy were similar to those experienced in other lines of business, and included shortages of behavioral health providers (in particular, pediatric psychiatrists) and other specialists. Keys to successful recruitment of providers include hiring talented marketing staff, negotiating reasonable and appropriate payment rates, and establishing a reputation for having sufficient membership, reducing administrative burden, and maintaining good provider relations.

- Continuity of care provisions required STAR Kids MCOs to honor existing authorizations and pay for services rendered by members' previously established out-of-network providers for six months after implementation. This period was extended an additional six months voluntarily by some MCOs. To ensure continuity of care beyond this period, STAR Kids MCOs identified these providers early – either directly through members' families, or indirectly through the use of claims data.

Recommendations

Based on findings from the STAR Kids MCO interviews, the EQRO makes the following recommendations as the STAR Kids program moves into its third year of operation:

- 1) STAR Kids MCO service coordinators should prepare families in advance during annual reassessments for MDCP eligibility determination. Families should be informed on steps to take if they are denied medical necessity, including their right to a fair hearing. Service coordinators should also help families identify alternative services in the event they lose their fair hearing.
- 2) STAR Kids MCOs should continue to monitor participation of new members in low-risk groups, educate families on the value of service coordination, and prepare for longer and more intensive relationship-building with these families.
- 3) To update contact information for new members, STAR Kids MCOs should continue practices such as driving to listed addresses after telephone and mailed correspondence attempts are unsuccessful, and using claims data to identify providers who can help locate new members. Notably, a potentially significant proportion of unreachable members may have no claims data available. Texas Health and Human Services (HHS) should consider further study into these cases to address why members do not have claims, and whether and where these members might be receiving care.
- 4) The full SK-SAI may not be necessary for families of members with fewer needs. Texas HHS and STAR Kids MCOs should consider changes to the assessment process, such as populating demographic fields prior to the visit, modifying how specialized modules are triggered, and reviewing the functionality of data entry systems and procedures.
- 5) STAR Kids MCOs may consider several promising approaches to stakeholder engagement, including: (a) partnering with Texas community and disability advocacy organizations to train MCO service coordinators in skills for communicating with families of children with special health care needs; (b) embedding service coordinators in health homes to engage providers; and (c) establishing or improving upon online portals to engage members.
- 6) STAR Kids MCOs may also consider innovative approaches to improving transition services, such as making home visits with STAR+PLUS service coordinators, implementing the Got Transition program within provider networks, and establishing transition centers.

- 7) In rural areas, where shortages of behavioral health and specialist providers are common, MCOs should improve access to care through transportation assistance and telemedicine services.
- 8) Continued monitoring of use of out-of-network providers is important. Some out-of-network providers of existing STAR Kids members may be concerned about their capacity to take on additional members; STAR Kids MCOs may consider allowing these providers to close their panels after joining the network.

Next Steps

Several other efforts for the STAR Kids focus study are underway, with results to be reported to Texas HHS in the coming months and in 2019.

The STAR Kids post-implementation survey is a follow-up telephone survey study of caregivers who participated in the STAR Kids pre-implementation survey, allowing for a comparison of caregiver experiences and satisfaction before and after their children enrolled in the STAR Kids program. This survey captures several important dimensions of care, including access to urgent, routine, and specialized services; timeliness of care; and care coordination.

In addition, the EQRO is conducting a measures feasibility study, focusing on several potential sources of performance measures for the STAR Kids program, including:

- 1) measures from the Healthcare Effectiveness Data and Information Set (HEDIS®), calculated using claims and encounter data from calendar year 2017;
- 2) the first biennial STAR Kids caregiver survey, which includes several measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, the National Survey of Children with Special Health Care Needs (NS-CSHCN), and the National Survey of Children's Health (NSCH);
- 3) the National Core Indicators Child and Family Survey (NCI-CFS), using secondary data collected by the state in 2015; and
- 4) the STAR Kids Screening and Assessment Instrument (SK-SAI) and Individual Service Plan (ISP) forms completed for STAR Kids members in 2017 and 2018.

Lastly, the EQRO will conduct a longitudinal analysis of administrative measures (e.g., HEDIS®) for the STAR Kids population, allowing for a comparison of rates on selected measures before and after program implementation.

Findings on both the STAR Kids post-implementation survey and the STAR Kids measures feasibility study will be reported to Texas HHS in November and December 2018. Findings for the longitudinal analysis of administrative measures will be reported to Texas HHS in February 2019. Together, the findings from this report and the other studies being conducted will provide a comprehensive view of implementation of the STAR Kids program.

Introduction

The STAR Kids program was implemented on November 1, 2016, to provide managed care services to Medicaid members 20 years of age or younger who receive SSI benefits or benefits through any of several state programs for children with disabilities, including members living in long-term care facilities or enrolled in a waiver program for HCBS.¹ The majority of members who transitioned into STAR Kids were previously enrolled in either traditional FFS or STAR+PLUS. Less than 10 percent of STAR Kids members are also enrolled in an HCBS waiver program, including waivers for individuals with intellectual or developmental disabilities (IDD) (4 percent), MDCP (3 percent), and the State Youth Empowerment Services (YES) program (1 percent).¹

STAR Kids is administered by ten MCOs, with members in each service area (SA) in the state having at least two MCOs available to them (**Table 1**). Members receive acute care services through STAR Kids, including primary and specialty care, preventive care, hospital visits, and prescription drugs, as well as certain types of LTSS such as PCS and PDN.ⁱⁱ Each MCO also provides service coordination for members and their families, based on needs identified using the SK-SAI. Service coordinators work with members and their families to develop an Individual Service Plan (ISP) and connect them with needed services and providers.

Table 1. STAR Kids Managed Care Organizations and Service Areas

STAR Kids MCOs	Service Areas
Aetna Better Health of Texas, Inc.	Tarrant
Amerigroup	Dallas, El Paso, Harris, Lubbock, MRSA West
Blue Cross and Blue Shield	MRSA Central, Travis
Children's Medical Center	Dallas
Community First Health Plans	Bexar
Cook Children's Health Plan	Tarrant
Driscoll Health	Hidalgo, Nueces
Superior Health Plan	Bexar, El Paso, Hidalgo, Lubbock, MRSA West, Nueces, Travis
Texas Children's Health Plan	Harris, Jefferson, MRSA Northeast
United Healthcare	Harris, Hidalgo, Jefferson, MRSA Central, MRSA Northeast

In 2017, the University of Florida Institute for Child Health Policy, which is the EQRO for Texas Medicaid managed care, began work on a multi-year focus study to evaluate implementation of the STAR Kids program and develop a set of quality of care measures appropriate to the STAR

ⁱ Percentages are based on STAR Kids enrollment data from October 2017. The IDD waivers include Community Living Assistance and Support Services (CLASS), Deaf-Blind with Multiple Disabilities (DBMD), Home and Community Based Services (HCS), and Texas Home Living (TxHmL).

ⁱⁱ Beneficiaries in the MDCP waiver also receive other types of LTSS through STAR Kids – including adaptive aids, minor home modifications, and respite services. Beneficiaries receiving LTSS through an ICF/IID, nursing home, IDD waiver, or the YES program continue to receive LTSS through these programs.

Kids population. The EQRO produced two technical reports based on this preliminary work: (1) *The STAR Kids Program Focus Study Measures Background Report* (Feb. 10, 2017); and (2) *The STAR Kids Program Focus Study Pre-implementation Descriptive Report* (May 26, 2017).

This report describes methods and findings for the continuation of the STAR Kids Program Focus Study in Contract Years 2017 and 2018. The study reviews written and verbal responses to administrative interviews the EQRO conducted with STAR Kids MCOs regarding components of MCO structure and process relevant for ensuring high quality of care in the STAR Kids population. These findings provide an understanding of common challenges that STAR Kids MCOs experienced during the first year of implementation, strategies the MCOs have employed to address these challenges, and future directions for quality assessment and improvement. The findings, which are based on responses to open-ended questions, can also be used to develop structured questions specific to the STAR Kids population for upcoming evaluations of MCO structure and process.

Methodology

Protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid and the Children's Health Insurance Program (CHIP) managed care include the use of administrative interviews to assess health plan compliance with relevant state and federal regulations. As part of its overall evaluation of MCOs participating in Texas Medicaid and CHIP, the EQRO regularly conducts an administrative interview (AI) evaluation, in which MCOs provide information on the structure and process of their operations through web-based tools and site visits. Through the AI, the EQRO collects important information on MCO organizational structure, member enrollment and disenrollment, children's programs and preventive care, care coordination and disease management, member services, member complaints and appeals, provider networks and reimbursement, authorizations and utilization management, information systems, and data acquisition.

In consultation with the EQRO Evaluation team, a preliminary set of open-ended questions for STAR Kids MCOs was developed and approved by Texas Health and Human Services (HHS) for use in the 2017 AI evaluations. The question set addressed several aspects of structure and process that are relevant for understanding the first year of implementation of STAR Kids, as well as actions the STAR Kids MCOs have taken to ensure effective program transition, access to care, timeliness of care, and care coordination.

These included, but were not limited to, questions about:

- Factors that have contributed to successful implementation
- Barriers and challenges encountered in implementation
- Personnel and resources dedicated to care coordination
- Monitoring and evaluation of member enrollment
- Receiving and responding to concerns from parents and disability advocates
- Methods for measuring network adequacy
- Preparing for the end of continuity of care provisions

The full question set is provided in the **Appendix**.

The STAR Kids question set was administered by the EQRO Quality Improvement team during AI site visits with five STAR Kids MCOs (Aetna, Blue Cross and Blue Shield of Texas, Children’s Medical Center, Driscoll, and Texas Children’s) from August through December 2017. To supplement this information for the STAR Kids Focus Study, and to ensure complete representation of all STAR Kids MCOs, the EQRO Evaluation team fielded the question set with the remaining STAR Kids MCOs (Amerigroup, Community First Health Plans, Cook Children’s, Superior, and United Healthcare) via teleconferences in January and February 2018. **Table 2** lists the ten STAR Kids MCOs interviewed, along with the EQRO team conducting the interview, and the mode and location of the interview.

Table 2. STAR Kids MCO Interviews

STAR Kids MCO	EQRO team	Mode	Location
Aetna Better Health of Texas, Inc.	Quality Improvement	Site visit	Dallas
Amerigroup	Evaluation	Teleconference	-
Blue Cross and Blue Shield	Quality Improvement	Site visit	Austin
Children's Medical Center	Quality Improvement	Site visit	Dallas
Community First Health Plans	Evaluation	Teleconference	-
Cook Children's Health Plan	Evaluation	Teleconference	-
Driscoll Health	Quality Improvement	Site visit	Corpus Christi
Superior Health Plan	Evaluation	Teleconference	-
Texas Children's Health Plan	Quality Improvement	Site visit	Houston
United Healthcare	Evaluation	Teleconference	-

All MCOs provided written responses to the questions, which were reviewed by the EQRO teams prior to their scheduled site visits or teleconferences. Based on these reviews, the EQRO developed follow-up questions tailored for each MCO to collect additional details on topics of interest and address points of clarification. The number of MCO participants ranged from 4 to 16, and typically included at least one individual responsible for STAR Kids program direction or management, as well as staff members in quality management or improvement, clinical or health services, case management or service coordination, compliance or regulatory oversight, and health plan operations. Medical directors were present in half of the MCO interviews. Other functions less commonly represented (fewer than half of MCOs) included member services/advocacy; special programs or populations; complaints, grievances, and appeals; network management or oversight; population health management; provider relations; community outreach; utilization management; fee management; accreditation; customer service; and marketing/communications.

All site visits and teleconferences were audio recorded and transcribed for analysis. Only portions of recordings related to the STAR Kids question set were evaluated for this study, with the final set of transcripts covering material lasting approximately ½ hour to 2 hours in duration

(mean duration 58 minutes). The longest transcript was for Children’s Medical Center (CMC), covering 110 minutes of interview content. CMC is a new MCO in Texas Medicaid and participates only in the STAR Kids program; as such, the full administrative interview site visit for CMC was considered relevant for this report.

The EQRO Evaluation team reviewed all MCO written responses, and developed a codebook for further analysis using grounded theory, in which themes or codes emerge from the data and are modified and grouped during the course of transcript review through constant comparison.² Themes were grouped into six major categories, producing a total of 80 unique codes, as shown on **Table 3**. Using this codebook, the team then conducted a more detailed analysis of the STAR Kids MCO transcripts using qualitative analysis software (Atlas.ti, Version 8). Content analysis included an assessment of the most common themes emerging in each of the six categories and their distribution across the STAR Kids MCOs.

Table 3. STAR Kids MCO Written Responses – Major Theme Categories

Category	Definition: Comments regarding...	Number of codes
Barriers	Barriers or challenges encountered by the MCO for effective care coordination and high-quality care in STAR Kids	17
Complaints	Complaints (whether formal or informal) received by the MCO from STAR Kids members, caregivers, providers, or advocates	8
Goals	The MCO’s goals or objectives for its STAR Kids line of business	8
Networks	The provider networks that serve the MCO’s STAR Kids members	12
Services	Services or care available to, or needed by, the MCO’s STAR Kids members or their families	13
Strategies	Strategies and practices the MCO employs to overcome barriers/challenges to STAR Program implementation, and to ensure effective care coordination and high-quality care	22

Findings

The STAR Kids MCO interviews revealed several common areas of concern regarding program implementation and quality assurance, which in some cases are unique to the STAR Kids population, and in other cases are consistent with experiences the plans have with child populations in other Medicaid managed care programs. The interviews also revealed many successful or promising strategies taken by the STAR Kids MCOs for addressing barriers and challenges, ensuring effective care coordination, improving quality of care, and increasing network adequacy.

With regard to service types (*Services* theme category), most discussions about STAR Kids implementation dealt with service coordination, transition of members from pediatric to adult care, behavioral health services, and LTSS. Nearly all plans addressed concerns and strategies

involving the assessment and authorization of PDN, which emerged as the most common type of service for which families experienced changes or reductions of services. Many MCOs reported that reductions in PDN were seen often in families of children enrolled in MDCP. Most plans also discussed services needed for transition of older STAR Kids members (18 to 20 years old) into adult care, emphasizing the need for more providers in their networks who are willing to treat young adults with complex conditions. These issues are discussed in greater detail in the sections below.

With regard to goals and objectives (*Goals* theme category), the most commonly mentioned goals were related to ensuring members receive appropriate levels of care, scheduling and completing SK-SAI and ISP forms, and meeting Health and Human Services Commission (HHSC) contract requirements for access, timeliness, and network adequacy. In particular, MCOs expressed appropriate care goals as a balance between meeting all of a member's needs for health and quality of life on the one hand, and avoiding duplication of services and potentially avoidable inpatient stays on the other. Participants in Community First Health Plan further connected the MCO's goal for appropriate care with its goal of increasing participation in the SK-SAI:

“The evidence that we have reviewed shows that members that participate in the SAI are able to then get LTSS. Once they have LTSS they tend to have fewer admissions into inpatient facilities, and even fewer visits to the ER because we're able to educate them on alternatives.”

Below we present more detailed findings for the two most salient theme categories: (1) *Barriers* to effective care coordination and high-quality care experienced by STAR Kids MCOs during the first year of implementation; and (2) *Strategies* the STAR Kids MCOs employ to overcome implementation challenges and ensure effective care coordination and delivery of care. A considerably smaller amount of interview content was directly related to *Complaints* or *Networks*; in most cases, quotations with codes in these two theme categories were also assigned codes in the *Barriers* or *Strategies* theme categories (and are therefore discussed in these respective sections). Findings largely focus on common areas of experience; in some cases, we highlight unique or innovative approaches to care that may be valuable to examine in future studies or disseminate for broader use.

Barriers to Effective Coordination and Delivery of Care

Table 4 presents the most common types of barriers and challenges elicited in the STAR Kids MCO interviews (those mentioned by more than half of the MCOs). Resistance to participate in the program on the part of members, providers, or communities was a very common theme, and was often mentioned as an example of an early-stage challenge. Many MCOs reported that parents of MDCP members, in particular, were opposed to the program through the first several months of implementation based on concerns that they would lose services, have their PDN or PCS hours reduced, or lose access to specific providers. The MCOs noted that these concerns had been disseminated through news reports and advocacy groups prior to implementation, which created a member relations challenge that was particularly difficult for the MCOs to overcome.

Table 4. Most Commonly Cited Barriers in STAR Kids MCO Interviews

Barriers code	Definition: Comments regarding...	Percentage of all interview quotations ^a	Number of MCOs citing
Resistance	Resistance to participate in the program on the part of members, providers, or communities	14%	9
Eligibility	Other problems related to confirming, determining, or maintaining program eligibility	9%	9
Early stage	Barriers encountered at start-up or in the early stages of implementation	9%	7
SAI/ISP (completion)	Difficulties in completing SAI or ISP forms with members/caregivers	8%	8
SAI/ISP (scheduling)	Difficulties in scheduling appointments for members/caregivers to complete SAIs or ISPs	8%	9
Contact information	Issues with the quality or completeness of member contact information	5%	7
Member awareness	Barriers that result from lack of/insufficient member awareness of the STAR Kids program	5%	7
Service reduction	Reduction or changes to specific types of services for new members after enrollment	5%	6
Data quality	Issues with data quality/accessibility and performance of data systems	4%	6
Contract	Barriers related to HHSC contract requirements ^b	4%	6
Rural areas	Barriers to care for members living in rural areas of the state	4%	8
Low-risk groups	Issues related to care coordination or service delivery for members in lower-risk groups	3%	7
Provider awareness	Barriers resulting from lack of/insufficient provider awareness of the STAR Kids program	3%	7

^a This represents the percentage of all coded interview quotations (regardless of the code/s used), across all transcripts, that had the indicated Barriers code. The number of all coded interview quotations was 307, which is the denominator used for all percentages in the table. These percentages represent the frequency at which each Barriers theme was mentioned generally, and provide information on the relative salience/importance of the theme to the MCOs.

^b References to contract-related barriers included administrative burden placed on providers (e.g., authorization process, reimbursement, paperwork), frequent changes to requirements for quarterly reporting, restrictive criteria for developing and implementing performance improvement projects (PIPs), difficulty meeting appointment standards, requirements for SAI administration, and lack of a provision for waiver of the MDCP interest/waiting list.

Changes or reductions of services and medical necessity denials

Most MCOs reported instances in which there were changes or reductions of certain services that members had been receiving under FFS. This occurred most frequently for PDN, in which skilled nurses provide care for individual clients in their homes. As noted by participants in the Amerigroup interview, reductions in PDN concerned both families and providers:

“There was and is a lot of concern around private-duty nursing and how the transition from fee-for-service to managed care was implemented. My medical directors really struggled with member expectations and provider expectations when we’re obligated to apply medical necessity criteria to these circumstances that really didn’t appear to have much medical necessity criteria applied to them in the fee-for-service environment.”

A common remark across MCOs was that determination of medical necessity for PDN was less restrictive under FFS than under STAR Kids managed care. In most cases, MCO participants felt that the reduction in PDN services was consistent with their review of the member’s medical needs provided in the prior authorization request; however, these reductions also warranted authorizations for other more appropriate service types, such as attendant care services. In Community First Health Plan, “there were examples where someone might’ve had...168 hours of PDNs in a week and that got changed to maybe 154 hours with 14 hours of respite or PCS.”

Additionally, some MCOs noted that they were able to accommodate some service needs that may have been overlooked in FFS. This resulted in more balance among families’ attitudes toward managed care. Comments from participants at Driscoll highlight this:

“Interviewee 1: We found one of our members who was getting one shot a week of their hemophilia drug and was getting 40 hours of private duty nursing to do that. You go, ‘Really? How’s that work? You need one skilled nurse for a half an hour.’

Interviewee 2: On the other side, you’ve identified members who weren’t receiving things that we felt they should’ve, and so we’ve increased the services that were available to them. So, we’ve had some very grateful parents that were the opposite of the more vocal group.”

In addition to experiencing reductions for specific types of services, some families also experienced denial of medical necessity for MDCP eligibility, which can occur both for existing MDCP members and members on the MDCP interest list. For MDCP members who are designated “MAO” (medical assistance only) status – meaning they do not have SSI and their families do not meet Medicaid income eligibility requirements – denial of medical necessity results in disenrollment from the STAR Kids program and loss of Medicaid benefits. Some MCOs observed that there may be an increase in MDCP medical necessity denials because the SK-SAI is more detailed than the assessment tool used under FFS. Participants in Superior provided an example specific to members who experienced seizures:

“The question that would be asked relating to seizures with the former tool... before the rollout of STAR Kids... just asked: ‘Does the member have seizures?’”

And so often, because of the ‘yes’ answer, that would trigger fairly significantly in, or appear to factor fairly significantly in the decision to go ahead and put a ‘yes’ on the qualifying criteria. So, when that same member was reassessed on the SAI, which asks I think seven additional questions about a member who has seizures; because of those additional questions, when that assessment was submitted it was indicated that not only ‘yes, the person had seizures’. When was their last seizure? 18 months ago. How severe are the seizures? Mild. Are they currently considered to be under control? Yes. So then, based on that or at least in part based on that, the new answer was a denial.”

Fears about service reductions and medical necessity denials under STAR Kids were found by some MCOs to lessen as members and providers developed relationships with their service coordinators and gained experience with the program. As one participant in CMC remarked: “One of the things we have with this population is trust. There was so much hype, there was so much in the news... So, now, going into Year 2, I am just seeing a total almost revamp of mentality with these families who trust us now.” However, this experience was not shared by all STAR Kids MCOs. Participants in the Driscoll interview, which was conducted one year following implementation (November 2017), remarked that parents of MDCP members still did not want their children in the STAR Kids program.

Scheduling and completing the SK-SAI

Another common set of challenges to care coordination cited by nearly all MCOs involved difficulty in scheduling and completing the SK-SAI. STAR Kids MCOs are contractually required to conduct an initial telephone screening of all new members, beginning with at least three call attempts and followed by written correspondence.³ This initial screening is intended to assess immediate needs, and allows MCOs to prioritize members for scheduling the in-person SK-SAI. An early challenge encountered by MCOs occurred during the initial screening process, as most MCOs related that member contact information they received in enrollment files from the state was often outdated or incorrect. The reported percentage of members whom MCOs were unable to reach (“UTR”) was as high as 52 to 56 percent in CMC.ⁱ

When initial contact attempts were unsuccessful, many MCOs adopted location strategies such as driving to a member’s listed address or using authorizations and medical or pharmacy claims to identify and contact the member’s providers for updated information. As participants in the Amerigroup interview noted:

“I think part of the difficulty... is we didn’t have good information. So we had to do every sort of research we could to reach them. Calling physicians.... Any physician that we had a claim for or had received claims for or we had any authorizations for, we used that as the pillar to get good contact information for those members.”

ⁱ Information on UTR rates was volunteered during interviews and not elicited from all STAR Kids MCOs.

Using a similar strategy for updating contact information, Community First Health Plan reported it was able to reduce the rate of unreachable members from 40 percent to 20 percent. However, not all members can be located using claims data. Participants in Driscoll and Cook Children's described sub-groups of unreachable members who did not have any claims data. In Driscoll, approximately 1,200 to 1,300 members could not be reached after one year of operation; among these members, one-third had no history of claims:

"We're at a year out now. Out of that group, there's still about 400 that have no claims; no pharmacy claims, no ER claims, no PCP claims, no specialist visits, no nothing... It's really odd to have a disabled individual who doesn't touch the medical system within a year."

A related challenge to SK-SAI scheduling, and one that was more difficult for MCOs to address, involved situations where member contact information was correct, but for various reasons the families were not responsive to outreach attempts. In some cases, families would avoid the MCO calls or refuse to schedule the in-person visit ("refusals"); in other cases they would schedule the in-person visit but be absent or unreachable at the agreed-upon time and location ("no-shows"). To a certain extent, refusals and no-shows were related to fears about the STAR Kids program, as noted above. In particular, some MCOs reported that MDCP families would repeatedly schedule and reschedule their appointments. Participants in Amerigroup suspected that these families were hoping the program would be "rolled back" and "they weren't going to have to do [the assessment] at all".

However, most MCOs observed that refusals and no-shows tended to be families of members in lower-risk groups, who had less need for LTSS. Participants had several explanations for this pattern. Families of members with lower levels of acuity may be less likely to schedule appointments for the SK-SAI because they are not aware of the need for assessment; they are self-sufficient, with high levels of family and social support; or they are not accustomed to the same level of assessment under FFS. Conversely, families of members in waiver programs are more likely to schedule appointments to ensure there is no gap in needed long-term services for their children. Community First Health Plan interview participants emphasized the need for member engagement and education by service coordinators to address this challenge:

"They are the ones that are going to have a mix of experience in accessing LTSS services. They're also going to have a mix of experience in whether they believe that they need assistance from service coordination. Whereas when you look and compare them against your MDCP child or your IDD waiver child, or children in your SSI categories that have accessed PDN since birth, those members understand what it is to have someone to help. These other members who have not engaged the system typically beyond acute care services don't necessarily understand yet the value of having a service coordinator, the value of having a comprehensive assessment, and therefore from an educational and outreach standpoint, it's a much lengthier relationship-building time than we experience with members who are very familiar with having people in their homes on a regular basis."

Even when attempts to schedule appointments for the SK-SAI were successful, MCOs often reported challenges in completing them. In particular, several MCOs cited the length of the SK-SAI as an issue. The Core Module, which is administered to all members, is nearly 20 pages long. Depending on the member's needs, service coordinators may also need to administer the supplementary Personal Care Assessment Module (PCAM), Nursing Care Assessment Module (NCAM), and MDCP Module – bringing the tool overall to more than 40 pages. According to participants in Amerigroup, Superior, and Texas Children's, administration of the SK-SAI could take 2 to 4 hours to complete in a single session; in cases where translation was necessary due to language barriers, this time could be doubled.ⁱ As a result, some MCOs noted the SK-SAI could be disruptive or "intrusive" to family life.

In its written response, Superior described challenges related to the "triggering" of supplemental modules, which may contribute to certain lower-risk members having unnecessarily lengthy assessments. As an example, if the Core Module determines that a member has been prescribed a nebulizer, this triggers the need to complete the NCAM to assess the member for skilled nursing needs. As Superior wrote:

"In practicality, we know that nebulizers are very commonly prescribed to children for very mild allergy/asthma issues, and could be said to yield easily to over-prescribing in the pediatric population in general. In the majority of cases, the presence of a nebulizer does not indicate the potentially significant type of medical need that would reasonably require completion of the NCAM module of the SAI."

Despite issues with the length of the tool, some MCOs also reported that the SK-SAI did not collect everything that was needed for a comprehensive assessment. Participants in CMC felt that information on certain types of acute conditions, such as urinary tract infections (UTIs) and gastrointestinal issues, would be useful to collect during the assessment – as these are frequently related to potentially avoidable visits to the emergency department. In the Cook Children's interview, participants noted that the SK-SAI does not collect specific details about the providers that a member has seen. If, for example, the assessment determines that a member has seen a specialist six times in the last year, there are no options for recording the type of specialist seen or the name of the specialist. Furthermore, participants felt the tool should collect more details on community services received by the family, such as food stamps or counseling services.

Lastly, MCOs discussed problems with the efficiency of the SK-SAI, including questions that were phrased poorly or out of sequence, data entry system issues, and sections of the tool that can only be completed by staff with certain credentials. In particular, service coordinators in Driscoll and Texas Children's reported difficulties entering SK-SAI data while in the field, which would sometimes result in missing or duplicate entries, or sometimes require them to record the SK-SAI on paper and then enter the assessment into the system later. Participants in the

ⁱ Information on duration of administering SK-SAI tools was volunteered in written responses and during interviews and was not elicited from all STAR Kids MCOs.

Superior interview observed that the NCAM and MDCP module could only be completed by nurse practitioners or registered nurses – a restriction that was related to Texas Board of Nursing requirements. In cases where licensed vocational nurses (LVNs) were conducting the assessment, a nurse practitioner or RN would need to be present – or scheduled for an additional visit – if the member required completion of these modules.

In light of these challenges, several MCOs provided suggestions for streamlining the SK-SAI. To address the length of the assessment, families could pre-complete the demographic portions – in electronic or mailed forms – or use the online portal (established by the MCO) to provide feedback and pre-populate some of the Core Module. A less intrusive, more conversational style of assessment might help build trust with families, and would be consistent with current care management models. Changes to optimize the layout of the tool would make it more user-friendly for both service coordinators and families, preventing situations where service coordinators must enter repeat data or return to previously-administered sections.

While challenges related to scheduling and completing SK-SAIs were both common and salient to MCOs, participants also noted that these challenges were lessening over time – as service coordinators gained experience with the assessment process and systems and built trust with STAR Kids families.

Strategies for Effective Coordination and Delivery of Care

Table 5 presents the most common types of strategies elicited in the STAR Kids MCO interviews for ensuring the effective coordination and delivery of care and for overcoming implementation challenges during the first year of operation (those mentioned by more than half of the MCOs). Stakeholder engagement – defined as any strategy intended to engage member, provider, community, or advocate stakeholders – was the most common strategy overall, mentioned by all 10 STAR Kids MCOs and included in nearly one-fifth of all coded interview quotations.

There was a high degree of co-occurrence between the *Stakeholder engagement* and *Partnerships* codes, meaning that many quotations described practices or strategies that fit into both categories. Among all quotations coded as relevant to stakeholder engagement, over one-quarter were also coded as relevant to partnerships. One commonly mentioned partner organization was Texas Parent to Parent – an organization developed by and for parents of children with special needs, which offers resources, education, and training for parents, family members, and professionals.⁴

For example, participants in UnitedHealthcare reported that they would attend annual conferences offered by Texas Parent to Parent, which include speakers on a variety of topics relevant to the STAR Kids population. Following the conference, the MCO would receive the list of speakers from the organization and select speakers to give additional training to their service coordination, transition, and school liaison staff. In addition, in its contract with Texas Parent to Parent, the MCO has specified the organization as an expert for its STAR Kids membership, which allows the MCO to include any of the organization's staff on teams that address issues for

specific members. Speaking of their Texas Parent to Parent partners, UnitedHealthcare participants stated:

“In case there’s a need that arises that we perhaps could use their additional support and knowledge for solutioning and problem-solving for that family... we do engage them from that element. They’ve just become a part of the service coordinators’ team made available to the family.”

Table 5. Most Commonly Cited Strategies in STAR Kids MCO Interviews

Strategies code	Definition: Comments regarding...	Percentage of all interview quotations ^a	Number of MCOs citing
Stakeholder engagement	MCO efforts to engage member, provider, community, or advocate stakeholders	19%	10
Partnerships	Partnerships established by MCOs with state, community, or advocacy organizations	13%	8
Member education	MCO efforts to educate members, typically about program benefits or complaints processes	11%	9
Member outreach	MCO efforts to reach out to members once located, typically for initial SK-SAI scheduling	11%	9
Staff engagement	MCO efforts to train or otherwise engage staff or employees	10%	9
Provider education	MCO efforts to educate providers, typically about program benefits or claims processes	8%	8
Member location	MCO efforts to locate members, typically for initial contact and SK-SAI scheduling	5%	9
Caregiver support	MCO efforts to support caregivers of STAR Kids members, including support for their health, economic, social, and other needs	4%	6

^a This represents the percentage of all coded interview quotations (regardless of the code/s used), across all transcripts, that had the indicated Strategies code. The number of all coded interview quotations was 307, which is the denominator used for all percentages in the table. These percentages represent the frequency at which each Strategies theme was mentioned generally, and provide information on the relative salience/importance of the theme to the MCOs.

Overall, stakeholder engagement strategies were grouped into six general categories, as shown on **Table 6**, below: (1) Addressing barriers to service delivery and quality; (2) Providing better services for STAR Kids members in schools; (3) Improving relationships or sharing information with members; (4) Improving relationships or sharing information with providers; (5) Listening to member or family concerns; and (6) Staff training.

Table 6. STAR Kids MCO Stakeholder Engagement Strategies

Stakeholder engagement strategy	Examples
Addressing barriers to service delivery and quality	<ul style="list-style-type: none"> - Working with vendors to create alternate programs to handle denials (CMC) - Encouraging providers to conduct same member education as MCO (Community First Health Plan) - Collaborating with nurse navigators in physicians' offices to ensure provision of primary care (Cook Children's) - Embedding service coordinators in medical homes to improve communication and service delivery (Driscoll)
Providing better services for members in schools	<ul style="list-style-type: none"> - Meeting with schools to promote adaptations and improvements to school programs for children with special health care needs (CMC)
Improving relationships or sharing information with members	<ul style="list-style-type: none"> - Having Member Advisory Committees to learn about issues experienced by members and share information on the program (Blue Cross Blue Shield, CMC, Community First, Superior, United) ^a - Managing an online portal that gives members access to program information, completed SAI/ISP forms, and a means to provide comments (Community First)
Improving relationships or sharing information with providers	<ul style="list-style-type: none"> - Having Provider Advisory Committees to learn about issues experienced by providers and share information on the program (Blue Cross Blue Shield, Texas Children's) ^a - Holding regular meetings with provider associations, such as the Texas Association of Home Care and Hospice (Amerigroup) - Conducting grand rounds (by MCO Medical Director) with providers to discuss patient needs (Driscoll)
Listening to member or family concerns	<ul style="list-style-type: none"> - Engaging families at public meetings moderated by the state (Amerigroup, Community First) - Encouraging families to engage with the MCO rather than news or advocacy groups when they have a service denial (Blue Cross Blue Shield) - Conducting member satisfaction surveys and outreach by nurse advice line staff (Community First Health Plan)
Staff training	<ul style="list-style-type: none"> - Inviting local judges to talk with service coordinators about topics, such as guardianship (Aetna) - Inviting speakers from Texas Parent to Parent to train staff on specific topics of interest (United)

^a It should be noted that establishing Member Advisory Committees and Clinical/Administrative (Provider) Advisory Committees are STAR Kids contract requirements; the listed MCOs in this table are those that specifically discussed their advisory groups in the interviews.

The focus of engagement strategies included providers, members, community members or organizations, or advocacy groups, depending on the purpose. In most cases, engagement involved meeting with stakeholders to share information, skills, and experiences. MCOs frequently cited the value of member advisory groups, which are a STAR Kids contract requirement, in promoting open communication with families of STAR Kids members, providing a forum for families to voice concerns, and offering opportunities to educate families on service coordination and other program functions.

Strategies also addressed specific issues discussed by the majority of STAR Kids MCOs. Below the report presents strategies relevant to two issues that emerged as particularly salient in the MCO interviews: (1) transition services for members “aging out” of the program and moving into adult care; and (2) adequacy of provider networks, including both issues related to specific provider types and to continuity of care.

Transition from pediatric to adult care

Most MCOs discussed issues related to transition of older STAR Kids members (18 to 20 years old) into adult care, and the strategies they use to minimize these issues. Although members do not “age out” of the program until they are 20 years old, many pediatric providers are not willing to treat patients 18 years of age or older. Conversely, many adult providers are unwilling to treat patients younger than 21 years old. This leaves STAR Kids members in the 18- to 20-year-old age group with a deficit in available providers, especially those in specialty areas such as psychiatry and endocrinology, who feel they do not have the proper training to treat this age group. Other transition-related issues focus on caregivers of STAR Kids members, who may not be aware of the challenges of transition or may require assistance with finding providers and addressing guardianship for their children as they themselves age. As participants in the Driscoll interview stated: “As their kids age, they also age... Who’s going to take care of them?”

By far the most common strategy mentioned by MCOs for addressing transition issues was to start the process early. Particularly for members with special needs – such as those receiving PDN – beginning the transition process early ensures there are no gaps in care and reduces the risk that members will have to switch providers multiple times. The STAR Kids contract requires MCOs to begin the transition planning process at age 15, although Driscoll acknowledged that during the initial implementation of STAR Kids the focus was on members approaching 21 years old, who had the greatest need for transition services. Participants in Cook Children’s interview noted they begin to implement transition plans for members at age 12.ⁱ

More specific strategies for facilitating transition include the use of transition specialists (a STAR Kids contract requirement), transition care teams, efforts to educate families of STAR Kids members on the transition process, and working directly with providers and other health plans to discuss both transition issues generally and issues dealing with specific members. In particular, CMC described a comprehensive approach to transition care that includes these strategies, as

ⁱ Information on the age at which MCOs implement transition plans was volunteered during interviews and was not elicited from all STAR Kids MCOs.

well as efforts to secure general revenue funds from the state for special cases, a transition counselor who works with specialty clinics and advises the MCO's transition specialists, and recruitment of adult specialty providers who are contracted with other MCOs. Participants in the CMC interview also described a strategy of making home visits alongside STAR+PLUS health plans to ensure a "smooth hand-off" and to streamline service plans for members in transition. The MCO cited a specific "success story" in which several of these strategies were used to assist a member receiving PDN who was having trouble finding an adult care physician:

"The families get to choose which STAR+PLUS plan 6 months out. They had already chosen a STAR+PLUS plan. We transitioned specialists and the services side, the service coordinator, RN. Also met with the RN service coordinator for the other STAR+PLUS health plan. We were going to have to get general revenue funds from the state because we knew... their option was to go to a nursing facility. We met actually with the state, as well, and we worked on a transition plan to get some of those GRE funds and have basically two managed care organizations working together to transition this member, but also the state to see the need of that child. Then, I believe, the general revenue funds were accepted and we had a really nice transition with all the adult providers, as well."

Another promising strategy involves implementation of the Got Transition program, which is a cooperative agreement between the Maternal and Child Health Bureau and the National Alliance to Advance Adolescent Health that promotes activities based on the Six Core Elements of Health Care Transition: (1) establishing a transition policy; (2) tracking progress; (3) administering transition readiness assessments; (4) planning for adult care; (5) transferring care; and (6) integrating into an adult practice.⁵ Cook Children's piloted the Got Transition program in specialty clinics that serve a large number of children with special needs – modified to meet the needs of the individual clinics – with the intent of spreading the program across its clinical health care systems and into the community. The MCO first began the program following conversations with a STAR Kids parent who was familiar with it, and who subsequently joined the committee to move the program through the pilot phase. Participants in the Cook Children's interview reported that the response from caregivers and providers on the program was "overwhelmingly positive":

"Every clinic that has implemented this has had nothing but positive feedback from the parents. It's much needed in the community. It was just a matter of I think just pulling people together to make it happen."

Texas Children's described two unique approaches to transition care to supplement the general strategies described above. First, in addition to a centralized team of transition specialists who work one-on-one with members and their families, the MCO has two transition centers that function as a "one-stop shop" for families needing transition assistance. Second, the MCO's network includes a physician "champion" for transition, whose clinic specializes in transitioning special needs patients from pediatric to adult care. Established by Cynthia Peacock, M.D., the Transition Medicine Clinic at Baylor College of Medicine employs specially trained physicians

and licensed clinical social workers to serve adolescents and young adults diagnosed with a chronic childhood illness or disability.⁶ Participants in Texas Children’s remarked on the value of having this level of specialized care available to STAR Kids members:

“She has done a good job of marketing within the local clinics to know that she has these resources, and that's been her focus for years... When we were working on the proposals for STAR Kids, they brought in Dr. Peacock and had her develop our transition program and make all the connections. That's really what it takes; this woman is so passionate about this particular population and everyone that interfaces with her gets it.”

Network adequacy and continuity of care

The adequacy of provider networks, especially for behavioral health providers, is an issue of particular concern for Medicaid programs. The Kaiser Family Foundation reported that, as of December 2016, the state of Texas had over 400 Health Professional Shortage Area (HPSA) designations for mental health care, which are areas and population groups within the state that experience a shortage of mental health care professionals.⁷ Based on this finding, 45 percent of mental health care needs were considered as being met. While this is approximately equal to the national average for the same time period (44 percent), it points to a larger issue of network adequacy for mental health care that affects both privately and publicly insured populations.

This provider shortage is more pronounced for pediatric care providers, and also extends to providers in other specialties. According to the Commonwealth Fund, potential reasons for reduced access to specialty care in Medicaid include low payment rates relative to Medicare and commercial insurers, and more challenging socioeconomic and health issues experienced by Medicaid patients.⁸ Consequently, the 2016 CMS Final Rule for Medicaid and CHIP managed care requires states to develop provider network standards based on reasonable travel time and distance from enrollee homes to provider sites, and to also set standards for pediatric primary care, behavioral health care, and specialist care provider types.⁹

In Texas, the HHSC contract for STAR Kids MCOs (Section 8.1.3.2) specifies provider network access standards for primary care physicians (PCPs); obstetrics/gynecology (OB/GYN) providers; prenatal care providers; outpatient behavioral health providers; several types of specialist physicians; occupational, physical, and speech therapists; hospitals; pharmacies; and other covered services that are not provided in the member’s residence.¹⁰ As shown in **Table 7**, the contract sets different distance and time standards for these provider types according to county, based on population density: (1) metro counties; (2) micro counties; and (3) rural counties. This information is provided to help put STAR Kids MCO interview findings on network adequacy into context. The strictest provider accessibility standards are for PCPs and prenatal care providers, followed by pediatricians and certain types of specialists. Standards are less strict for outpatient behavioral health, OB/GYN, and special therapy providers. Ninety percent of an MCO’s membership in any service area must be within 30 miles (or 45 minutes) of an acute care hospital, regardless of county type.

Table 7. STAR Kids Contractual Provider Network Access Standards

Provider type ^a	Metro Counties ^b		Micro Counties ^b		Rural Counties ^b	
	Distance (miles)	Time (minutes)	Distance (miles)	Time (minutes)	Distance (miles)	Time (minutes)
PCP	10	15	20	30	30	40
OB/GYN	30	45	60	80	75	90
Prenatal	10	15	20	30	30	40
Outpatient BH	30	45	30	45	75	90
Pediatrician ^c	20	30	35	50	60	75
Specialist physician (1) ^c	20	30	35	50	60	75
Specialist physician (2) ^c	30	45	45	60	60	75
Specialist physician (3) ^c	30	45	60	80	75	90
Special therapies ^d	30	45	60	80	60	75
Acute care hospital	30	45	30	45	30	45
Other covered services	75	-	75	-	75	-

^a This table shows provider access standards listed in the STAR Kids MCO contract for all provider types except pharmacy. For each provider type, MCOs must ensure access to at least 90 percent of members in a service area according to the specified standard. Refer to the STAR Kids MCO contract for pharmacy access standards; these follow a different geographic grouping (based on designations by the Office of Management and Budget) and apply to varying percentages of the STAR Kids MCO populations.

^b County designations used in the STAR Kids MCO contract represent groupings of Medicare Advantage county designations. Refer to Attachment B-5 in the STAR Kids MCO contract for more information.

^c The STAR Kids contract specifies standards for specialist physicians in three groups: (1) cardiology/cardiovascular disease, general surgery, ophthalmology, and orthopedics/orthopedic surgery; (2) Psychiatry and urology; and (3) Otolaryngology and other specialties not listed. While access standards for pediatricians (of the member's/family's choice) are grouped under specialist physicians in the contract, they have been specified separately in this table.

^d "Special therapies" includes occupational, physical, and speech therapy provided in an outpatient clinic or facility.

In general, feedback from STAR Kids MCO interview participants regarding provider shortages reflect what has been reported in the state and nationally. By far, the specialty for which provider shortages were most commonly reported was psychiatry – in particular, child psychiatry. Other behavioral health provider types, such as licensed professional counselors (LPCs) and social work therapists, were also cited as under-represented. This finding is of concern given the high level of need for behavioral health care in the STAR Kids population generally, as reported by caregivers surveyed in the EQRO's second STAR Kids Focus Study report.¹¹ Some STAR Kids MCO interview participants mentioned other specialties that required improvements in network adequacy, including cardiovascular, dermatology, endocrinology, gastroenterology, oncology, orthopedics, neurology, neurosurgery, pain management, and rheumatology. Several participants also stressed the need for behavioral health and other

specialist providers in rural areas, as well as those with training on treating individuals with IDD. Of note, participants in Cook Children's discussed the need for crisis respite care, which functions as an alternative to emergency admissions for individuals experiencing a psychiatric crisis. The plan's behavioral health organization found a solution to the issue, although they acknowledged it could not necessarily be applied to all network access issues:

"There's also a deficit for crisis respite. So, any child that needs more than partial hospitalization but not an inpatient space, historically they had to go inpatient. There was nothing else for them to do. So, [Beacon Health Strategies] actually created a home that's run by one of our providers where they can have that crisis intervention that is not the level of inpatient. But that's just one example. We can't build every provider type that's not here."

With regard to strategies for recruiting providers, MCOs generally reported similar methods as those used in other lines of business. Providers were identified and recruited in informational sessions held by the state, through the state board for physician licensure, and by assessing the networks of other plans in the same service area. Keys to successful recruitment included ensuring that network, provider relations, and contracting departments were staffed with talented individuals "who know the market"; negotiating appropriate and reasonable payment rates (in some cases above the Medicaid rates); and establishing a reputation for having sufficient membership, reducing administrative burden, and maintaining good provider relations. For CMC, which is new to Texas Medicaid and participates only in STAR Kids, the latter strategy was essential for network-building:

"We had a real hard time because we were a brand-new plan. So, when you send out contracts, it is like, 'Why do I have a contract with you? You have no members. How many members do I think you are going to get? Yeah, I am not too sure...' So, now that we actually do have members, we can go back to them and we have had some really good success, especially out in the smaller communities and with the larger provider groups that are here in the Dallas area now to say, 'We have membership. We pay our claims on time. Our authorizations are processed' and those types of things, and they are more willing now to talk to us."

A particularly salient theme relevant to provider networks was ensuring continuity of care for STAR Kids members. Prior to implementation of STAR Kids, the state and participating MCOs anticipated that many members – particularly the majority moving in from FFS – would have established and trusted primary care and specialty providers who were not part of the MCOs' networks. To ensure new members did not experience gaps in service during the transition, the state mandated a continuity of care provision, which required STAR Kids MCOs to honor existing authorizations for acute care services and LTSS and pay out-of-network providers with whom members had a previously established relationship. The original continuity of care period was set for six months after implementation; it was voluntarily extended by some MCOs for an additional six months, until October 31, 2017.

Most MCO discussions about provider networks focused on efforts to recruit and contract with these established, out-of-network providers prior to the end of the continuity of care provisions. Identifying these providers was largely a matter of finding out who their new members had been seeing. The MCOs cited passive methods of identifying providers, such as through complaints or lists received from STAR Kids families, as well as more proactive methods, such as using service coordinators to contact and ask families about their providers or generating utilization lists and reports.

After identifying the established providers of new STAR Kids members, MCOs would then make efforts to recruit the providers into their networks. In addition to the standard recruitment strategies described above, MCOs would educate providers on the STAR Kids program. As the end of the continuity of care period approached, providers were informed that their patients in STAR Kids would be moved to a different provider if they remained out-of-network. Participants in the Texas Children's interview also reported allowing certain providers to close their panels to encourage them to contract:

“What they're afraid of is, because of the population type, they don't want too many members that they can't do a good job. What we've done is allowed them to close their panels but at least continue to see the existing members that they're currently seeing now... We've reached out to them and said, ‘We see that you're currently seeing these members. We would like to contract with you because of that, and we don't mind if you want to close your panel. We just want to make sure that they're getting the service and the same care that they've been receiving from you currently.’”

When these efforts fail, many MCOs reported using a single case agreement, which allows an out-of-network provider to continue treating a single STAR Kids member as if the provider were contracted with the MCO. In some cases, MCOs are successful at getting providers with extended single case agreements to eventually join their network. As one Blue Cross and Blue Shield of Texas participant remarked: “All it took was, ‘Shouldn't we stop the paperwork on this? Are you ready to contract?’” As a last resort, MCO service coordinators will work to identify different in-network providers who can serve the member's needs. However, this scenario can potentially result in a gap in services. Furthermore, introducing a new provider can be particularly disruptive for the population of special needs children, who typically rely on established and trusted providers for their primary care and LTSS.

Summary and Recommendations

Overall, the STAR Kids MCOs had several common areas of concern regarding program implementation and quality assurance – in particular, resistance to the program on the part of families and providers, changes or reductions of services, medical necessity denials for MDCP eligibility, and issues with scheduling and completing the SK-SAI. The interviews also revealed several promising strategies taken by the STAR Kids MCOs to ensure effective care coordination and service delivery, including stakeholder engagement, strategies to improve transition services, and methods for building provider networks and ensuring continuity of care.

The MCOs noted early resistance to the program by families and providers, which occurred in part due to critical reports by news organizations and advocacy groups. Fears about service reductions under STAR Kids have lessened as members and providers developed relationships with their service coordinators and gained experience with the program. However, denials for medical necessity for MDCP eligibility may continue to occur due to a more detailed assessment process than that which was used under FFS.

Recommendation: STAR Kids MCO service coordinators should prepare families in advance during annual reassessments for MDCP eligibility determination. Families should be informed on steps to take if they are denied medical necessity, including their right to a fair hearing. Service coordinators should also help families identify alternative services in the event they lose their fair hearing.

STAR Kids MCOs found that some families of low-risk members, who have fewer needs for LTSS, are reluctant to participate in the program. These families may be less likely to schedule appointments for the SK-SAI because they are not aware of the need for assessment, they are self-sufficient, or they are accustomed to a less-involved level of assessment under FFS.

Recommendation: STAR Kids MCOs should continue to monitor participation of new members, particularly those in low-risk groups. Educating families on the value of service coordination, and preparing for longer and more intensive relationship-building with these families, are key to ensuring their engagement.

Poor contact information for members leads to challenges in scheduling initial visits for screening and assessment. Once visits are scheduled, completing the SK-SAI can be a challenge due to its length and format. While most MCOs reported that the tool can sometimes collect unnecessary or duplicate information, the tool also misses certain types of information – such as incidence of potentially preventable emergency department or inpatient admissions for acute conditions and details on specific providers seen by new members.

Recommendation: To update contact information for new members, STAR Kids MCOs should continue practices such as driving to listed addresses after telephone and mailed correspondence attempts are unsuccessful, and using claims data to identify providers who can help locate new members. Notably, a potentially significant proportion of unreachable members may have no claims data available. Texas HHS should consider further study into these cases to

address why members do not have claims, and whether and where these members might be receiving care.

Recommendation: The full SK-SAI may not be necessary for families of members with fewer needs. Texas HHS and STAR Kids MCOs should consider changes to reduce the length and improve the efficiency of the assessment process, including: (1) populating demographic fields prior to the visit; (2) increasing the functionality of member portals to allow families to populate certain fields online; (3) modifying how modules such as the NCAM are triggered; and (4) reviewing the functionality of data entry systems and procedures.

Engagement of member, family, provider, community, and advocacy stakeholders was the most common strategy employed by STAR Kids MCOs to ensure effective care coordination and service delivery. Stakeholder engagement strategies were important for addressing barriers to service delivery and quality, providing better services for STAR Kids members in schools, improving relationships or sharing information with members and providers, listening to member or family concerns; and training MCO staff members.

Recommendation: STAR Kids MCOs should consider several promising approaches to stakeholder engagement, including: (1) partnering with Texas Parent to Parent to train MCO service coordinators on topics of interest; (2) embedding service coordinators in health homes to engage providers, and improve service coordination and delivery; and (3) establishing or improving upon online portals to engage members, which can establish two-way communication and provide them access to needed program information.

MCOs also emphasized the importance of strategies to address two common issues -- improving transition services for members moving out of pediatric care, and strengthening provider networks to ensure access to needed services and maintain continuity of care. To improve transition services, STAR Kids MCOs should begin the process of transitioning members to adult care early. Keys to successful transition include establishing transition specialists, educating families on the process of transition, and working with providers and other health plans on specific cases.

Recommendation: STAR Kids MCOs should also consider innovative approaches to transition care, such as making home visits with STAR+PLUS service coordinators, implementing the Got Transition program within provider networks, and establishing transition centers. Finally, while clinics specializing in transition services are rare, MCOs may still identify providers in their networks who can “champion” efforts to improve transition services.

Building networks of behavioral health providers, particularly psychiatrists who treat children, is critical for the success of the STAR Kids program. Keys to successful recruitment include hiring talented marketing staff, negotiating reasonable and appropriate payment rates, and establishing a reputation for having sufficient membership, reducing administrative burden, and maintaining good provider relations.

Recommendation: In rural areas, where shortages of behavioral health and specialist providers are common, MCOs can improve access to care through transportation assistance and telemedicine services.

To address continuity of care for new members, it is important for STAR Kids MCOs to identify established and trusted providers early. Providers can be identified directly through families, or indirectly through the use of claims data.

Recommendation: Continued monitoring of use of out-of-network providers is important as MCOs move into the third year of implementation. Monitoring should include assessment of contracting rates and measuring utilization and quality of care for members who had to switch providers after joining the program. Some out-of-network providers of existing STAR Kids members may be concerned about their capacity to take on additional members; STAR Kids MCOs may consider allowing these providers to close their panels after joining the network.

In summary, this focus study report provides an understanding of barriers to care and offers practical recommendations for improving care for STAR Kids members, based on direct feedback from the STAR Kids MCOs obtained after the first year of implementation. As the STAR Kids program proceeds into its third year, the EQRO will continue to address important topics relevant to quality of care in STAR Kids, including focus study reports of measure feasibility and post-implementation findings on survey and administrative measures.

Appendix – Supplementary Material

Questions Included in STAR Kids MCO Site Visits

- 1) How would you describe the first year of implementation of your STAR Kids program with regard to program transition and quality of care?
 - a) What aspects of the program are successful?
 - i) How were these successes identified?
 - b) What challenges did you encounter?
 - i) How were these challenges identified?
 - ii) What is being done to address these challenges?
- 2) What personnel and resources are needed to help facilitate care coordination for STAR Kids members?
- 3) Are there any STAR Kids member groups, such as eligibility or service groups, or members with particular types of disabilities or conditions, for whom service delivery has been more challenging? If yes, please describe.
- 4) Describe how the health plan monitored and evaluated the process of enrolling STAR Kids members. What challenges have you encountered in scheduling and completing STAR Kids Screening and Assessment Instrument or Individual Service Plan forms?
- 5) Discuss your program goals and the progress toward achieving these goals.
- 6) Tell us more about your plan's infrastructure for receiving complaints/concerns from parents and caregivers of STAR Kids members.
 - a) How often do you receive complaints?
 - b) How do parents/caregivers contact the plan if they have complaints?
 - c) What resources have you employed to respond to complaints?
- 7) Discuss any concerns that may have been shared by disability advocates. If there are concerns, please discuss how the plan responds to their concerns. Please describe how discussions with advocates resulted in proposed or existing improvement activities.
- 8) Describe how the health plan measures network adequacy in STAR Kids. What has the health plan found in regard to network adequacy? Are there particular provider types for which network adequacy has been more difficult to ensure? What improvements in network adequacy do you propose to implement?
- 9) On November 1, 2017, the continuity of care provisions will end, which means that health plans will no longer cover services delivered by out-of-network providers that members had prior to implementation. How are you preparing for the end of continuity of care provisions? How is the health plan ensuring that PCPs and specialist doctors of all STAR Kids members are part of their networks?

Endnotes

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- ¹ HHS (Texas Health and Human Services). 2017. *STAR Kids Program Description*. Available at: <https://hhs.texas.gov/services/health/medicaid-chip/programs/star-kids>.
- ² Corbin, J., and A. Strauss. 2015. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory (4th Edition)*. Los Angeles, CA: SAGE.
- ³ HHSC (Texas Health and Human Services Commission). 2017. *STAR Kids Contract Terms*. Available at: <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/star-kids-contract.pdf>.
- ⁴ Texas Parent to Parent. 2018. Available at: <https://www.txp2p.org/>.
- ⁵ Got Transition. 2018. Available at: <http://www.gottransition.org/>.
- ⁶ Baylor College of Medicine. 2018. Transition Medicine Clinic. Available at: <https://www.bcm.edu/healthcare/care-centers/transition-medicine>.
- ⁷ KFF (Kaiser Family Foundation). 2018. *Mental Health Care Health Professional Shortage Areas (HPSAs)*. Available at: <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/>.
- ⁸ Felland LE, AE Lechner, and A Sommers. 2013. *Improving Access to Specialty Care for Medicaid Patients: Policy Issues and Options*. The Commonwealth Fund.
- ⁹ CMS (Centers for Medicare and Medicaid Services). 2017. *Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability*. Available at: <https://www.medicare.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf>.
- ¹⁰ HHSC. 2017.
- ¹¹ ICHP (Institute for Child Health Policy). 2017. *Texas Medicaid Managed Care: STAR Kids Program Focus Study Pre-implementation Descriptive Report*. Gainesville, FL: Institute for Child Health Policy.