HHSC: STAR Kids Managed Care Advisory Committee, January 28, 2020

The **STAR Kids Managed Care Advisory Committee** advises on the establishment and implementation of the STAR Kids Medicaid managed care program which 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. **Members include:**

Elizabeth Tucker, Chair
Advocate for children with special healthcare needs
Austin, TX
Rahel Berhane, M.D.
Physician Provider
Austin, TX
Josh Britten
Durable Medical Equipment and Services Representative
Amarillo, TX
Rosalba Calleros
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Catherine Carlton
Family Member
Arlington, TX
Tara Hopkins
Managed Care Organization Representative, Dental
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Diane Kearns
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Alice Martinez
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Angela Trahan
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Houston, TX
Shawnett Viani
Advocate
Denton, TX
Beanca Williams
Home and Community-Based Provider
Stafford, TX

Call to order. The meeting was called to order by the Chair, Elizabeth Tucker. It was a "call-in meeting" with the express purpose of voting on the recommendations found in the draft report.

Roll Call. In person and on the phone, a quorum was established.

STAR Kids Advisory Committee Annual Report. The recommendations were reviewed at the previous meeting and minor directed changes were made and are presented in this document. Members were given an opportunity to make additional changes, but no changes were forthcoming.

MOTION: *Approval of the draft with recommendations and furthermore authorizing the Chair to finalize the committee report - prevailed*.

Public Comment. No public comment was offered.

Adjourn. Next meeting is on March 4th. There being no further business, the meeting was adjourned.

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Please note that the contents included herein are in DRAFT form.

Recommendations

Subcommittee on Health Homes and Quality Measures

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

1.1 *Topic/Issue:* **Problems related to heterogeneity of STAR Kids population and the need to define population sub-groups**

Background*:* The STAR Kids program includes approximately 162,000 children with special healthcare needs including children who are medically fragile, children with IDD and children who have mental health conditions. Thus, it includes a heterogeneous population of children with varying degrees of complexity and need which likely require different approaches to care.

Recommendation: **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 (Examples – 1) A medically fragile subgroup of children on MDCP and/or children who have PDN. 2) A behaviorally complex subgroup of children with IDD/Behavioral disorders/Autism Spectrum Disorders (ASD) 3) Children with serious and persistent mental illness.

Standardized sub-stratification will allow for more homogeneous care pathways; meaningful outcome tracking and potentially value-based contracting.

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

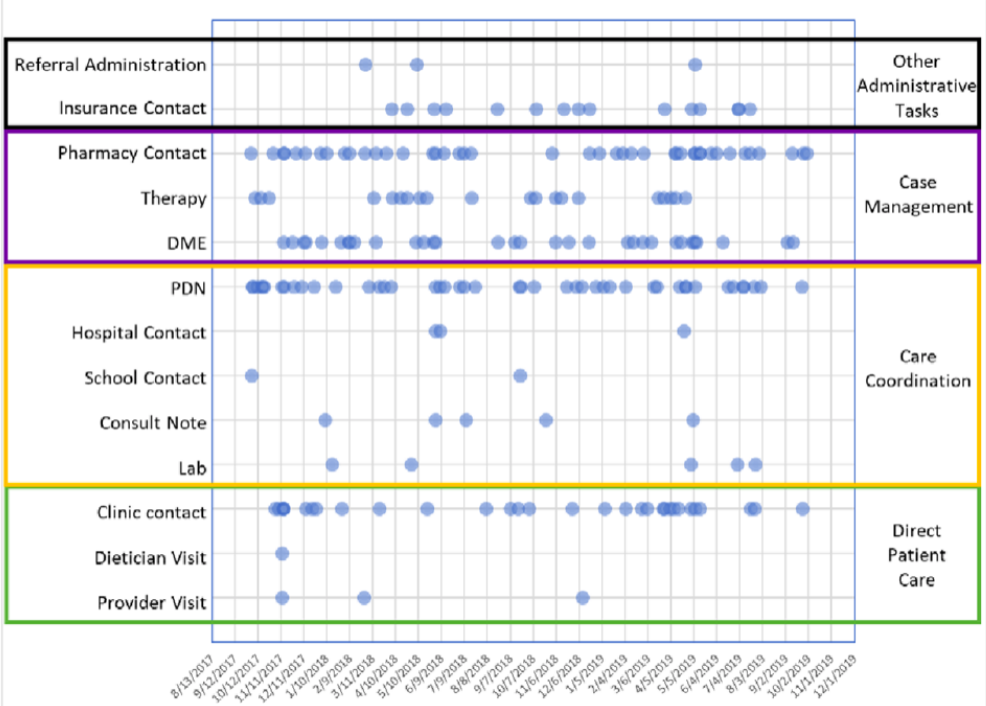

Assessment, Assessment, Assessment

Background*:* 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.

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.



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

Recommendations: 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:

i. Amend 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.**

ii. 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.

iii. 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.

iv. HHSC should require MCOs to engage provider groups in value-based arrangements where trusted providers will have their orders (for labs, imaging and hospitalization) fast tracked without the need for extra justification provided there are periodic audits to keep each party accountable.

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

Background:

In communities where there are enhanced health homes – dedicated to the medically fragile children as defined as subgroup 1 of our first recommendation, (Austin, San Antonio, Dallas, Houston), the opportunities for better integration of care coordination services with the MCO have not been adequately explored, utilized and incentivized. These clinics have a longitudinal relationship with the families and provide care coordination, social services and are well networked with the local specialist panels and children's hospitals. However, there is no template on how to fold this existing resource into a viable center of excellence. These centers could serve as bright spots for evidence generation on best practices. Absent any template for collaboration and no direction or incentivization from the state, leaders of most of these clinics spend a lot of time and energy trying to craft contracts with multiple MCOs. Reimbursement from MCOs for services in these centers covers only a small fraction of the center's budget. As most are supported by a combination of grants and subsidies, their financial viability is tenuous and will likely jeopardize care for hundreds of members.

Recommendations:

i. 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.
ii. 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.

iii. 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.

iv. Promote this collaboration through statewide pilot projects; participating actively in national innovative projects and focusing PIPs to address some of these processes.

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

Background*:* PCPs who have longitudinal relationships with families caring for children with complex needs recognize that health care outcomes are largely dependent on having quality home care services. Unfortunately, there is very little effort to improve the pool of qualified direct service workers. The two options offered to families are – Medicaid Private Duty Nursing which is expensive and increasingly limited or attendant care – which, while cheaper is difficult to access as there are very few qualified individuals willing to work for such low pay. PCPs and health homes can engage families in conversations about the most appropriate home health services, but this is not possible because the appropriate workforce is not available in most communities.

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

However, it incredibly difficult to find someone who will provide the support needed for $8.11 an hour.

Recommendations:

i. HHSC should closely evaluate through data collection whether individuals are being assessed for Community First Choice and Personal Care Services.

ii. 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.

iii. HHSC should include the following recommendations as strategies in the Rider 157 strategic plan related to the recruitment, retention and access to community attendants due to the legislature on November 1, 2020.

   a. Facilitate/incentivize the creation of community attendant registry to help families find direct service workers.
   b. 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;
   c. Increase the Medicaid fee schedule for Personal Care Services and Community First Choice.

1.5 Issue/ Topic: Measuring outcomes that matter

***Background**:* 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.

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:

i. 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.

ii. 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

iii. 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.

iv. 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.

v. 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 SK-SAI, Prior Authorizations, MDCP and IDD Waivers

The Texas Health and Human Services Commission contracted with Texas A&M University (TAMU) for a screening and assessment instrument to be used in STAR Kids. The STAR Kids Screening and Assessment (SK-SAI) instrument is divided into modules. All children must receive the core module. If triggered by the core, children are then assessed using one or more of the remaining modules; Personal Care Assessment Module (PCAM), Nursing Care Assessment Module (NCAM) and MDCP Module. The SK-SAI is intended to assess for eligibility for PCS, CFC for children who meet medical necessity for nursing facilities, PDN and the MDCP waiver. The assessment is also intended to serve as a trigger for referrals for additional services such as therapy, durable medical equipment (DME) and supplies, CFC for children with IDD or children with mental health conditions, IDD waiver services, and other mental health services.

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

2.1 Topic/Issue: SK-SAI Tool Improvements

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

Recommendations:

i. Continue to work with the committee on improvements to the SK-SAI.
ii. 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.
iii. Ensure the revised tool contains solid triggers for referrals for Community First Choice, durable medical equipment, Personal Care Services, and therapy.
iv. Provide guidance to the SK-SAI assessor directly on the tool for questions that require judgement such as questions that are those using a scaling system.
v. 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.

vi. 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.

vii. 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.

2.2 Topic/Issue: MDCP SK-SAI

Background: 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. Initial reports for the period of November 2018 to October 2019 show the number to be approximately 5% which is a substantial improvement over 2017 and 2018. Many of the children who lost eligibility during the early implementation of STAR Kids are children who have been on the waiver for years and have not experienced a change in condition. With the loss of eligibility children are not only losing access to MDCP waiver services but are losing access to critical long-term services and supports and for some access to their health insurance; Medicaid.

Children who receive services under the MDCP waiver are required to meet the same medical necessity eligibility as children seeking admission to a nursing facility, adults seeking admission to a nursing facility, or adults seeking services under the STAR +Plus waiver. Prior to the implementation of STAR Kids, children in MDCP were assessed initially and reassessed annually using the Medical Necessity Level of Care (MN-LOC) tool. This is the same tool used for individuals over 21 years of age in the STAR + Plus nursing facility waiver. The MN-LOC tool was similar to the Minimum Data Set tool used to determine eligibility for adults and children in Texas nursing facilities. The new SK-SAI is a departure from the MN-LOC. The SK-SAI MDCP module only results in a determination of the MDCP budget based on the Resource Utilization Group. It does not determine nursing facility medical necessity.

That determination is made using a variety of fields in other SK-SAI modules and is subject to interpretation by the state's third-party contractor. In addition, the nurse assessors with the MCOs who are completing the assessment are not allowed to do a physical nursing assessment of the child and are only going by information provided to them by the child's family or what is available through medical records.

Recommendations:

i. 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.
ii. 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.
iii. 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.
iv. 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).
v. 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.

vi. 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.

vii. Allow children enrolled in STAR Kids who have SSI and meet the MDCP waiver eligibility immediate access to waiver services with no wait.
    a. Create a similar allowance for children in STAR Health.

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

Background: Families must be the drivers of their children's health. For families to be actively involved and to ensure children achieve optimal outcomes, there must be clear, ongoing communication between the Star Kids MCOs and the families. Based on recommendations in last year's report and legislative direction, HHSC added requirements in the STAR Kids contracts (8.1.39) that parents review the SK-SAI prior to submission. HHSC also instructed MCOs to train members in the navigation of member portals and required them to submit education materials to HHSC for review. We understand HHSC is embarking on a significant utilization review initiative of children receiving services through the Medically Dependent Children's Program. We recommend that during the review HHSC monitor whether training on portal access is occurring.

Recommendations:

i. HHSC should monitor the MCOs to ensure MCOs have offered

individualized training to families on how to access the health portal to:
  a. See the SK-SAI
  b. Review the Individual Service Plan (ISP)
  c. Track authorizations, view claims and find information on the child's MDCP budget, and pending and final denials and reductions
  d. Request an internal appeal

ii. 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.

iii. HHSC should develop a document that can be sent from the MCO to the family 120 days prior to the annual assessment informing them:
  a. What to expect at the assessment
  b. What documents to have ready

2.4 Topic/Issue: Clearer, Simpler and More Streamlined Authorization Process

Background: Certainty and clarity in the STAR Kids prior authorization process would not only benefit children and families but would ease administrative burdens currently experienced by physicians and other providers. Families and providers are working with multiple managed care organizations, each with their own set of authorization requirements and review processes, some of which are onerous and cause delays in authorization for needed services. Physicians, therapists, home health agencies, DME companies and others have reported an increase of up to 25% in their administrative costs due to paperwork requirements. DME companies have also reported a decrease in payment rates made by MCOs and a significant number of small providers closing their doors. According to the American Association for Homecare November 2019 position statement, there are currently 40% fewer DME providers throughout the US and access to DME has become problematic especially in rural areas.

Recommendations: The subcommittee on health homes and quality measures included some recommendations in 1.2 that go hand in hand with the following recommendations related to a more streamlined prior authorization process for PDN, therapies, DME, PCS and other services and procedures. The recommendations are currently being worked on in HHSC's subcommittee on administrative simplification with representation and input from our committee.

i. 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. Work with CMS to allow mid-level signatures on authorization requests where mid-level signatures are not allowed.
    b. Do not require redundant letters of medical necessity be attached to every request when the condition or need has not changed.

ii. 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.

iii. 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.

iv. 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.

2.5 Topic/Issue: Medical Necessity and Treating Physician

Background: 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:

i. Defer to the treating professional when determining medical necessity.
ii. Continue to develop uniform process and timeline for reconsideration of prior authorization requests prior to denial.
iii. 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.

2.6 Topic/Issue: Preferred Provider

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

i. MCO call center staff inform members of non-preferred providers along with preferred providers available in the network, to enable members to choose the most appropriate services, providers and equipment

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

Background: Families and providers report issues with timeliness and clarity in Medicaid appeal notices. For services to continue during the appeal process, an individual must request the appeal within 10 days from the date of the action notification letter. By the time the families receive the letter some of the 10 days have passed, leaving the family with a very small window of time for the actual filing of the appeal. In some cases, families have received notices well past the 10-day time frame

It is imperative that the reasons cited in the appeal notice must be clear and written in plain language that is easily understood by families.

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

Recommendations:

i. 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.
ii. 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.
iii. 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.
iv. 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.

v. Improve and coordinate MCO informal appeals and HHSC fair hearings, including consumer information that explains and assists with both processes and meets all state and federal due process requirements, such as proper notices and packets with complete and relevant information used to deny, suspend, or reduce services.

2.8 Topic/Issue: Transparency and timely response to member and provider complaints

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

i. Require state agencies and MCOs to track all instances of access to care issues as a complaint
ii. Improve data integration and transparency to include information across systems relating to inquiries, complaints, informal MCO appeals, and Medicaid Fair Hearings that is publicly available.

2.9 Topic/Issue: Alternative service delivery model for children in Medically Dependent Children Program

Background: 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:

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

2.10 Topic/Issue: Inclusion of IDD Waivers into STAR Kids

Background: 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.

Recommendations:

i. Delay inclusion of all additional IDD waivers such as Texas Home Living, Home and Community-Based Services (HCS), Community Living Assistance and Support Services (CLASS), and Deaf Blind Multiple Disabilities (DBMD) into STAR Kids unless and until related evaluations and the IDD assessment pilot are completed, and access to and quality of care are resolved in current managed care programs and operational systems and providers are in place for a successful transition.

2.11 Topic/Issue: Evaluation of whether to move to STAR

Kids to statewide MCO

Background: HHSC recently 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:

i. 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.

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]

3.1 ***Topic/Issue:*** **Medicaid fee schedule gaps impede the provision of recommended Health Care Transition services and collaboration between pediatric and adult providers for our STAR Kids population. It is important to have a mechanism to**

allow pediatric and adult providers to bill for collaborative office visits to review and discuss transition of care.

Background: 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' 2019 fee schedule, the transition-related CPT codes that are currently covered for all patients include prolonged services with direct patient contact (99354, 99355). For physicians caring for patients under 21, covered services include care plan oversight services (99339, 99340) and prolonged services before and/or after direct patient contact (99358, 99359). In addition, the current Texas Medicaid fee schedule does not allow a medically complex child to have both pediatric and adult providers for a limited period of time to ensure a smooth and continuous handoff nor does it allow for payment for joint visits with the pediatric and adult provider.*

[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. Washington, DC: Got Transition. Available from: http://www.gottransition.org/resources/index.cfm

Recommendations

i. *Recommend recognition of the following transition-related CPT codes in Texas' Medicaid fee schedule.*
    a. *Health and behavior risk assessment (96160)*
    b. *Care plan oversight services for physicians caring for patients ages 21 and older (99339, 99340)*
    c. *Prolonged services before and/or after direct patient contact for physicians caring for patients ages 21 and older (99358, 99359)*
    d. *Interprofessional telephone/internet/electronic health record consultations (99446-99449, 99451, 99452)*
    e. *Care management services (99487, 99489, 99490, 99491)*

ii. *Allow for two assigned pediatric and adult providers to bill* *for the same patient to facilitate shared care management and a smooth handoff and also to allow for joint visits, if feasible.*

3.2 *Topic/Issue:* Limited time to coordinate services with STAR Plus plans when a non- MDCP, PDN or Prescribed Pediatric Extended Care Center (PPECC) member ages out of STAR KIDS at age 21.

Background: 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:

i. 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.
ii. The age out preselection of a STAR Plus plan should be transmitted to the receiving STAR Plus plan at the time of enrollment broker receipt. This early selection and notification to the current STAR Kids MCO and receiving STAR Plus plan can be used to allow the STAR Kids and STAR Plus plans to share HIPAA information by supporting coordination of transition of care prior to the STAR Plus effective date. This HIPAA barrier removal would be beneficial to the plans, families and physicians involved in the transition of care and allow more time to process transfer related requests prior to the age out effective date.

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

Background: Currently, STAR Kids contract has a requirement for the role of transition specialists in addition to and separate of the service coordination. The STAR Plus receiving plans do not possess like roles to help support the member/family upon 21st birthday. Further, STAR Kids and STAR Plus plans do not include contract provisions pertaining to defining additional HCT service responsibilities, such as clarifying and informing members about their HCT policy or approach, proactively tracking members ready to transfer to adult care, conducting periodic transition readiness/self-care assessments, ensuring that a medical summary and emergency care plan has been prepared, and tracking that initial and follow-up appointments with the adult providers are scheduled and kept. Research shows that when Youth 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:

i. **Add transition specialists to the STAR Plus waivers to coordinate with the STAR Kids transition specialist and support the 21-year-old member up to age 23.** The receiving transition specialist for STAR Plus can help the member navigate the changes of adulthood, employment, higher level education supports etc. and be the recipient of the plans of care from the STAR Kids transferring plan.

ii. 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.

3.4 ***Topic/Issue*: Improve the healthcare transition of children**

from childhood to adulthood through the adoption of transition standards and best practices.

Background: Currently, only the STAR Kids contract has a requirement for the role of transition specialists. However, the standardization of Health Care Transition knowledge is not present to offer consistent direction and support to members across both STAR Kids and STAR Plus plans.

Recommendations

i. 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.[3] This HCT approach can be customized for use by MCO plans and participating pediatric and adult provider networks. MCOs and provider networks can assess their level of HCT implementation using Got Transition's easy-to-use, Current Assessment of HCT Activities.

ii. Require training of MCO transition specialists on
   a. Got Transition's Six Core Elements
   b. Alternatives to guardianship
   c. Supported decision making
   d. Creative housing options including shared living arrangements and host homes
   e. Supported employment
   f. Utilization of the Navigate Life web reference

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[3] Six Core Elements of Health Care Transition Side-by-Side Version. Washington, DC: Got Transition, 2014. Available from https://www.gottransition.org/resourceGet.cfm?id=206

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

Background: 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.

Recommendations:

i. Design, pilot, and evaluate innovative value-based transition payment pilots to 1) increase the availability of participating adult physicians in the geographic areas of concern, 2) strengthen the coordination and communication between pediatric-sending and adult-receiving practices, 3) expand the level of HCT support available to medically complex youth and young adults and their caregivers in both pediatric and adult sites, and 4) improve appropriate use of health care among this vulnerable population. Such innovative VBP transition pilots shall consider the payment and quality options in The National Alliance to Advance Adolescent Health's Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems: A Leadership Roundtable Report.[4]

ii. HHSC should require MCOs to regularly survey their adult provider network to assess the availability of open panels for transitioning youth/young adults with medical complexity, intellectual and developmental disability, and serious mental/behavioral health conditions.

[4] 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.

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