TEXAS
Health and Human Services

Cecile E. Young, Executive Commissioner

Request for Information (RFI) For

STAR Kids Accountable Care Organization (ACO)

RFI No. HHS0010969

Date of Release: August 27, 2021

Responses Due: September 27, 2021 by 10:30 a.m. Central Time

948 – 48 Managed Health Care Services

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1. Introduction

The Texas Health and Human Services Commission (HHSC) is requesting information about options for providing Medicaid benefits to children enrolled in the STAR Kids managed care program under an accountable care organization (ACO) or another value-based alternative payment model. The information gathered will inform HHSC's determination of the feasibility of using these alternative models of care for children enrolled in the STAR Kids program.

This is a Request For Information (RFI). HHSC is not seeking proposals for services.

1.1 Purpose

The purpose of this RFI is to solicit information and to obtain stakeholder feedback about ACOs and alternative models and the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids program under these models. HHSC will use the information derived from responses to this RFI and guidance provided by Centers for Medicare and Medicaid Services (CMS) regarding the Advancing Care for Exceptional (ACE) Kids Act of 2019, in a report due to the Texas Legislature in December 2022, in accordance with Texas Government Code 533.00253 (f) and (g) added by House Bill 4533, 86th Legislature, Regular Session, 2019.

1.2 Background

Texas House Bill 4533, 86th Legislature, Regular Session, 2019, requires HHSC, in consultation and collaboration with the STAR Kids Managed Care Advisory Committee (SKMCAC), to determine the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under an ACO in accordance with guidelines established by CMS, or an alternative payment model developed by or in collaboration with the CMS Innovation Center. The data collected from this RFI will also assist HHSC in the development and implementation of an ACE Kids pilot program, which is directed by Texas Senate Bill 1648, 87th Legislature, Regular Session, 2021.

Accountable Care Organizations

An ACO is defined by CMS as "groups of doctors, hospitals and other health care providers, who come together voluntarily to give coordinated high-quality care to their patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the program." 1 CMS has implemented Medicare ACO programs such as: the Medicare Shared Savings Program, the ACO Investment Model, Advance Payment ACO Model, Next Generation ACO Model, and the Pioneer ACO Model. These programs all focus on increasing quality of coordinated patient care and lowering health costs. Payment models vary by:

- Providing financial incentives for meeting quality standards;

[1] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO

- Investing in care coordination infrastructure through up front monthly payments that could be fixed or variable;
- Offering a population-based model to coordinate with private payers and align provider incentives;
- Setting and predicting financial targets to coordinate care; and
- A pre-paid shared savings model that encourages participating ACOs to transition to arrangements with greater financial risk.

Alternative Pediatric Models

CMS has implemented pediatric health home care models through the Integrated Care for Kids (InCK) Model. Additionally, the opportunity for states to choose to implement the ACE Kids Act will begin October 1, 2022.

The InCK Model is "a child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid through prevention, early identification, and treatment of behavioral and physical health needs."2 The model provided funding to eight awardees (states and organizations) starting on January 1, 2020 to design and implement a pilot program over a seven year time period.3 States are no longer able to apply for InCK funding. CMS is providing guidance to the awardees on the implementation of alternative payment models for pediatric care. The model aims to identify and treat children and youth who may have complex physical and behavioral health conditions, coordinate their care across physical and behavioral health settings, develop alternative payment models tied to improving the health of children, and reduce or avoiding inpatient stays and out-of-placement homes.

In the spring of 2019, the Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16) included the ACE Kids Act as part of a package of Medicaid bills. The ACE Kids Act provides an optional Medicaid state plan benefit with the focus on Medicaid health homes to improve care for children with medically complex conditions beginning October 1, 2022. The emphasis is on enhancing and expanding care and service coordination, reducing costs, easing access to out-of-state care, providing comprehensive transitional care, providing patient and family support, and making referrals to community and social support services. If states choose to implement the optional benefit under the ACE Kids Act, they must determine payment methodologies in accordance with specified requirements, and also temporarily qualify for an enhanced federal matching rate.[4]

1.3 Definitions

The following defined terms have the meaning described in this section and are used throughout this RFI.

Accountable Care Organization (ACO) **-** CMS defines ACOs as "groups of doctors, hospitals,

[2] CMS website, InCK Model webpage: https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model.
[3] https://innovation.cms.gov/files/fact-sheet/inck-model-fs.pdf
[4] https://www.congress.gov/bill/116th-congress/senate-bill/317

and other health care providers, who come together voluntarily to give coordinated high-quality care to their patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the program." [5]

Community Partner – a health, civic, and/or consumer organization that contributes to Medicaid initiatives by providing community services with a goal of improving health outcomes and reducing health care costs and utilization. Community partnerships highlight a shared responsibility across different sectors for the overall health of the public.

Complex Need – a condition or situation resulting in a need for coordination or access to services beyond what a primary care provider would normally deliver, triggering the managed care organization (MCO) determination that care coordination is required.[6]

This term is being defined in lieu of medically complex need, medically complex conditions, and complex medical needs, as it is defined in the STAR Kids Contract Terms and Conditions.

Health Home – a primary care provider practice, or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under Medicaid.[7]

Managed Care Organization (MCO) - a health care organization that is a party to one or more MCO programs administered by HHSC and is an insurer licensed or approved by the Texas Department of Insurance as a health maintenance organization, a certified approved non-profit health corporation formed in compliance with Chapter 844 of the Texas Insurance Code or an Exclusive Provider Benefit Plan approved by the Texas Department of Insurance in accordance with 28 Texas Administrative Code §3.9201-3.9212.[8]

2. General Instructions and Response Requirements

HHSC is issuing this RFI for the sole purpose of obtaining information. HHSC encourages any party with direct experience in the subject matter of this RFI to submit a response.

All materials received by HHSC become the property of HHSC and will not be returned to the sender. There will be no acknowledgment by HHSC of receipt of the information. Acceptance of responses to this RFI places no obligation of any kind upon HHSC. Any information or ideas received from respondents to the RFI in any form may be used by HHSC without restriction for any purpose determined by HHSC.

If HHSC issues additional information relating to the RFI, it will be made available on the Electronic State Business Daily (ESBD). HHSC does not intend to respond to comments or questions it receives, and additional information should not be construed as such unless

[5] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO

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

[7] GOVERNMENT CODE CHAPTER 533. MEDICAID MANAGED CARE PROGRAM (texas.gov)

[8] https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf

specifically identified as responses.

The descriptions presented in this RFI are tentative and may undergo change prior to actual release of any potential solicitation related to the scope of this RFI.

2.1 Response to Questions

In developing an ACO or alternative model for individuals enrolled in STAR Kids, HHSC will need to consider the sustainability and long-term benefits of the model for providing care to children with complex medical needs. HHSC is gathering information on seven different elements to assess the potential options for pursuing an ACO or alternative payment model for STAR Kids.

Respondents' answers to the following questions can be about care models currently in operation or potential models for future implementation. HHSC welcomes responses to any of the questions in this RFI.

Overall Structure

When completing this section please describe if your answers to the questions are related to an ACO or an alternative payment model such as a robust health home model, and if the model is currently operational in another location, reimbursed through another payer, or only conceptual. Please provide an overview of the care model.

1. What structure would you consider optimal for an ACO or alternative model serving children with medically complex conditions who are enrolled in the STAR Kids program? (Choose one)
   a. Provider-led model;
   b. MCO-led model; or
   c. Community Partner-led model.

2. Please share why the structure you chose in Question 1 would be the most optimal.

3. For a Provider-led or Community Partner-led overall structure, who would be the key players to support the model? Please explain your reasoning. (You may select more than one)
   a. Potential Provider-led key players:
      i. Hospitals;
      ii. Providers (i.e., pediatricians, pediatric specialists, primary care clinicians);
      iii. Physician groups;
      iv. Federally qualified health centers (FQHCs); or
      v. Other (indicate).

   b. Potential Community Partner-led key players include:
      i. Local behavioral health organizations;
      ii. Schools;
      iii. Community-based organizations; or
      iv. Other (indicate).

4. Identify and describe the STAR Kids populations that could most benefit from coordinated

high-quality care with an ACO or alternative model.

5. Describe how features of an ACO or alternative model can ensure care that is highly coordinated and tailored to the variety of needs of the STAR Kids population.

Payment Structure

1. In considering payment structures for an ACO or alternative model, what would work best for the STAR Kids program?
   a. Shared savings model – Savings is shared between the state Medicaid agency or MCO and the ACO if certain quality metrics are achieved;
   b. Per-member-per-month for care coordination – ACOs receive a set payment each month per patient to coordinate services;
   c. Full-risk capitation model – Providers assume full financial risk for cost and quality of care to members (please include any details related to MCO or provider capitations);
   d. Phased approach: transition to a full-risk capitation model after a set period; or
   e. Other (indicate)

2. Please indicate what you think is beneficial about the payment structure(s) you chose in Question 1.

3. Describe any benefits or barriers that should be considered around the development of each of the following payment management structures:
   a. ACO or alternative model is paid directly by the state Medicaid agency;
   b. ACO or alternative model is paid by an MCO; or
   c. Other (indicate)

Contracting

1. In an effort to ensure best practices in delivering services through an ACO or alternative model, what do you feel would be the benefits or barriers to a contract that is:
   a. Between the ACO or alternative model and the state Medicaid agency;
   b. Between the ACO or alternative model and an MCO; or
   c. Other (indicate)?

2. Please share any additional considerations to contracting through the models listed in Question 1.

Care Structure

Care structure questions are focused on an ACO or alternative model for the STAR Kids program.

1. Should care coordination be provided by individuals or care teams?
   a. If an individual, what qualifications should the staff hold?
   b. If a team, who should be on a care management team and what qualifications should the staff hold?

2. For best practice, what are optimal provider to member ratios for care coordination? Specify if you are referring to a certain type of provider (i.e., physicians, social workers,

and/or nurses) or all types of providers.

3. Describe how data elements would be used to determine whether collaboration among providers meets the following measures:
    a. Improves access to care, including access to out-of-state providers for children with complex medical needs;
    b. Provides higher quality, coordinated medical care;
    c. Establishes flexibility to tailor care to the diverse needs of the STAR Kids population;
    d. Integrates with hospital admissions and referrals;
    e. Addresses mental health coordination;
    f. Addresses members' non-Medicaid services that impact their health; and
    g. Addresses acute care and long-term services and supports (LTSS) coordination.

4. How would you ensure coordination around transition planning from child to adult services?

5. How would medical records and other data be stored? How would medical records across the team of clinicians and others who provide care be maintained?
    a. Electronic Medical Record;
    b. Patient Portal; or
    c. Other (indicate).

6. Which entity should be responsible for the coordination and development of a shared electronic medical record or patient portal?
    a. Managed care organization (MCO) internally; or
    b. External contracted technology resource.

7. Would additional policy and procedure guidance be developed and provided by physicians and specialists for all who provide care within the model? How would these be shared and how would follow-up be provided to ensure the delivery of quality care?

8. Provide any additional considerations in developing a care structure to improve member health outcomes, and be sure to address:
    a. Connection to Electronic Health Records;
    b. Care Coordination;
    c. Flexibility in how providers are organized;
    d. Flexibility in the level of integration; and/or
    e. Other.

Quality Measures

1. How should quality measures be developed and selected to ensure that quality care is provided to improve a STAR Kids member's health outcome?

2. Which of the following quality measures are most important and why?
    a. Agency for Healthcare Research and Quality's Pediatric Quality Indicators;
    b. Medicaid Children's Health Care Quality Measures (Child Core Set);
    c. National Quality Forum;
    d. National Core Indicators (NCI);

e. Measures related to neonatal intensive care days, emergency department visits, and/or level of engagement of the patient and family; and/or
f. Other (indicate).

3. What should be the mechanism to gather and validate the quality data through an ACO or alternative model?

4. Describe how you would evaluate and assess the effectiveness of the ACO or alternative model as a whole.

5. Describe how achievement of specific quality measures could be used for incentive-based payments to providers.

Claims and Data Collection

This section is focused on the collection and handling of data for an ACO or alternative model as is required by federal law.[9]

1. Which party should be responsible for validating and adjudicating claims submitted for clients under the STAR Kids ACO or alternative model?
   a. MCO;
   b. Texas Medicaid & Healthcare Partnership (State Claims Administrator);
   c. ACO Staff;
   d. Community Partner; or
   e. Other (indicate)

2. Does the party identified in Question 1 have staff and systems to validate and adjudicate claims?

3. Which party should be responsible for submitting data that complies with federal and state requirements?
   a. MCO;
   b. State (HHSC);
   c. ACO; or
   d. Other (indicate)

4. Does the party identified in Question 3 have staff to conduct data analyses and produce the required reporting?

General Information

1. Please share your thoughts on what is working well in the current STAR Kids model.

2. Please share your thoughts on what could be improved on in the current STAR Kids model.

3. Please share your thoughts on what outcomes for families and STAR Kids members you would like to see achieved through an ACO or alternative model.

[9] https://www.congress.gov/116/plaws/publ16/PLAW-116publ16.pdf

HHSC may, but is not obligated to, respond to questions submitted to the designated point of contact provided in Section 2.3, Designated Point of Contact, below.

2.2. Response Submission, Date, Time, and Location

HHSC welcomes written responses and comments related to this RFI by:

September 27, 2021, 10:30 am Central Time

Responses must be submitted via e-mail to HHSC's designated point of contact, as identified in Section 2.3 – Designated Point of Contact. Faxed responses or verbal inquiries will not be accepted. It is not the intent of HHSC to respond to comments or questions, and if HHSC issues additional information relating to the RFI it will be made available on the Electronic State Business Daily (ESBD).

2.3 Designated Point of Contact

HHSC's official single point of contact for this RFI and the delivery point for all responses and correspondence is:

Valerie Griffin
HHS Procurement and Contracting Services
Texas Health & Human Services Commission
e-mail: Valerie.Griffin@hhs.texas.gov

All communications relating to this RFI must be directed to the HHSC contact person named above. All communications between respondents and other HHSC staff members concerning this RFI are strictly prohibited.

2.4 Response Format

All responses must be:

- clearly legible;
- searchable pdf format;
- sequentially page-numbered and include the respondent's name at the top of each page;
- correctly identified with the RFI number and submittal deadline;
- in Times New Roman font, size 12 for normal text, no less than size 10 for tables, graphs and appendices;
- the page limit for the RFI written response is 20 pages, this does NOT include

attachments and/or reference material;
- respondents must respond by email; and
- HHSC will not accept any submission or portion of a submission containing a copyright.

All pages of the response should include the RFI title consistently in either the footer or header of each page. Vendor should submit supporting material, if any, as attachments along with RFI responses. All responses become the property of HHSC after submission.

2.5 Texas Public Information Act

A response submitted to this RFI is subject to the Texas Public Information Act (the Act), Texas Government Code, Chapter 552, and may be disclosed to the public upon request. Subject to the Act, respondents may protect trade secret and confidential information from public release. If the respondent asserts that information provided in the response is trade secret or other confidential information, it must be clearly marked such information in boldface type and include the words "confidential" or "trade secret" at the top of the page. Furthermore, the respondent must identify the trade secret or confidential information and provide an explanation of why the information is excepted from public disclosure.

HHSC will process any request from a member of the public in accordance with the procedures outlined in the Act. Respondents should consult the Texas Attorney General's website (www.oag.state.tx.us) for information concerning the Act's application to proposals and potential exceptions to disclosure.

2.6 Disclaimers

HHSC, at its sole discretion, may or may not issue a related solicitation or may issue multiple solicitations based on the responses to this RFI. Responding to this RFI is not a condition for eligibility to respond to any subsequent solicitation. Responses to this RFI will not have any bearing, positive or negative, on the evaluation and respondent selection resulting from any proposals that may be received in response to any subsequent solicitation.

Any information received from respondents to the RFI in any form may be used by HHSC without restriction for any purpose determined by HHSC.