

From Policy to Bedside Medicaid's Role in Supporting Children with Medical Complexity - Pediatric Grand Rounds-20260814_073006-Meeting Recording

August 14, 2026, 12:30PM

1h 6m 7s

● **Calderon, Delia** started transcription



Sutter, Deena E 0:07

All right.

Hi everyone, welcome to Pediatric Grand Rounds. Today it is my honor to introduce one of our own, Dr. Ryan Van Ramhorst. He is the Chief Medical Director for Medicaid and CHIP Services at the Texas Health and Human Services Commission, and he serves as the lead physician for the Texas Medicaid Program.

which provides needed health services to over 4 million Texans. He supervises the Office of the Medical Director, which is responsible for providing clinical direction and oversight of managed care and pay for service programs. His policy interests include improving care for children with medical complexity, enhancing the behavioral health

continuum of care and addressing non-medical drivers of health. And he has held this role since February of 2019. Dr. Van Ramhorst completed his undergraduate studies in biology and Spanish at Chapman University in Orange, California. He went to medical school at the Baylor College of Medicine in Houston, and he completed his internship residency and chief residency in pediatrics

at UT Health San Antonio, and then he completed fellowship in academic general pediatrics here as well. He also holds a master's degree in public health, which was completed here at the University of Texas School of Public Health. His work and experience includes practicing in underserved communities, on the south side of San Antonio as part of a National Health Service Corps scholarship service commitment, and he completed an externship as a uniformed officer in the Commission Corps of the United States Public Health Service. There he served in the Office of Research Integrity for the U.S. Department of Health and Human Services.

His professional interests include health policy, clinician leadership, and medical

education. He is a board certified in general pediatrics and in healthcare quality and management. He is a fellow of the AAP, fellow of the American College of Healthcare Executives, deployment of the American Board of Quality Assurance and Utilization Review.

physicians. He also sees patients on a part-time volunteer basis here as adjunct faculty at UT San Antonio. He holds the rank of Adjunct Associate Professor of Pediatrics. He also teaches part-time, providing guest lectures on the US health care system and clinician leadership at the Long School of Medicine.

 **jeannine kaufmann** 2:22
And.

 **Sutter, Deena E** 2:31
and the Army Baylor MHA MBA program and other forms. He's been married to his wife Christine for over 16 years. She is an OBGYN in private practice. His personal interests include spending time with his wife. There are three cats, soccer, fitness, traveling, cooking, and I can get on board with this one, anything to having to do with Star Wars. No wonder I like you so much.

 **jeannine kaufmann** 2:52
The.

 **Sutter, Deena E** 2:53
Today, he's going to be talking to us. His talk is about children with medical complexity, and the title is From Policy to Bedside Medicaid's Role in Supporting Children with Medical Complexity. So please join me in welcoming Dr. Ryan Van Ramhorst.

 **Van Ramshorst, Ryan D (HHSC)** 3:12
Dr. Sutter, thank you so much. Ms. Calderon, thank you for all the support. Really appreciate the invitation to come spend some time with you on a wonderful Friday morning. I am more caffeinated than I normally am because I definitely got in my car this morning and pulled out of the garage, headed to the medical school campus when I reminded myself that this was virtual. So I think I'm on my 4th cup of coffee. I'm ready to go. So buckle up. Before I bring up my slides, I just want to say thank

you. Whether you realize it or not, you are part of a community of roughly 120,000 providers that serve vulnerable Texans that are covered by Texas Medicaid and CHIP. And that is a really important thing. So thank you for all that you do to serve children, to serve families, to serve our community members.

And as you know, pediatrics has a really important role when it comes to Medicaid because so many children in Texas and in the United States receive coverage through Medicaid and CHIP. In fact, Medicaid and CHIP combined represents the single largest insurer of children in Texas and in the United States. So thank you for what you do. I also want to say that it's really a privilege for me



Cortes, Lindsey R 4:19

Hold on.



Van Ramshorst, Ryan D (HHSC) 4:20

to have trained at UT Health San Antonio, where I received a wonderful background in general pediatrics training and subspecialty, but more than anything, received mentorship from some of these wonderful pediatricians, some of which were on the call, who gave me the flexibility and inspiration to pursue a career in advocacy with a lowercase a,

and health policy. I know that Dr. Lukafer is on this call, which as you know, was a longstanding member of our Child Abuse Pediatrics Division, who took me to Austin for the very first time as part of a Texas Pediatric Society Advocacy Day, where we met with our state representatives and state senators about Medicaid payment rates for pediatrics. And so

It's been a journey, but I see so many faculty on this call that have been so impactful in my career. And again, would not be here without y'all. And then the last thing I'll say before I pull up the slides and we get into the meat of the presentation is I certainly hope that there's residents and medical students tuning in. I hope that this is somewhat inspirational to you, that it'll make you want to learn more about the health system, more about health policy.

and how the system at large impacts your ability to take care of your future patients and what we all can do better to make things a little bit easier for children and families. So let me pull up the slides and like I said before, buckle up.

Alright.

So the focus of today's presentation is about what Texas Medicaid does to serve

largely in collaboration with providers like you, children with medical complexity. But first, I'll say as a good faculty member that I don't have any financial or commercial conflicts to disclose. We're not going to be discussing the off-label use of products that are not approved by the FDA.

And here's really our learning objectives. We'll start with an overview of the Medicaid program. Again, I know the focus is going to be on children. We'll talk about the managed care service delivery model and how that compares with the older, what some of you know as traditional Medicaid or fee for service model. And then we'll spend kind of the second-half of the presentation

kind of zooming in on services for children with medical complexity and how we all can work together to streamline that care and make sure that our kids are living their best lives.

All right. So what is Medicaid? Medicaid is a jointly funded state and federal health care program that serves low-income individuals, individuals with disabilities, and otherwise vulnerable citizens. CHIP is a very similar program with a somewhat different legislative history that we may have time to get into that was really designed in the late 90s. Medicaid came into existence around 1965.

We just celebrated our 61st birthday. So happy birthday, Medicaid. CHIP actually came into existence in the late 90s when health care was really being discussed at a national level. And this program was created to serve children who live in families that made too much money to qualify for Medicaid, but for whatever reason, were not able to obtain

private or commercial insurance, either because of finances or they worked at a place that didn't offer health insurance. Now, why is Medicare on here? You're probably thinking, Dr. Van Ramshorst, Medicare is for elderly individuals, and you would be correct, but we do have a population of individuals served by Texas Medicaid that are what we call dually covered, are dually enrolled. So they receive coverage from both Medicare, which is a federal health care program, and Medicaid. And these are some of our most vulnerable and complex individuals. Most of them are over the age of 21, and again, receive some services from either program.

So this is just an impact perspective. So as of fiscal year 2025, our program covers over 4 million Texans. That's 13% of all Texans. You're probably familiar with the statistic that over half of births in the state of Texas are covered by Medicaid. 40% of kids are covered by Medicaid or CHIP.

And something that I really didn't realize until I started to work at the Health and

Human Services Commission is the high percentage of individuals that are in nursing facilities that are also covered by Medicaid. And we'll talk about our eligibility and who qualifies in just a few slides.

So we're not going to take too much of a deep dive here. As we say in the policy world, this gets really, really wonky, really, really quick. But what I wanted to point out here is our relationship with the federal government. Just like our agency has a role in regulating managed care organizations, which we'll talk more about, the Center for Medicare Medicaid Services, of which the current administrator is Dr. Oz, regulates Medicaid and CHIP programs for states. And so we have a partnership, a collaboration with CMS, as it's called, the Center for Medicare Medicaid Services, that really provides oversight of our agency and our program's operation. And so as an example, if we want to change a benefit, if we want to create a new waiver, We have to ask CMS for permission, answer their questions, thinking through things like how is it going to be administered? What are the financial implications? What are the program requirements? But at the base of it all, Medicaid programs have what is called a state plan. And this is kind of our base contract with the federal government. that outlines the basic services that all individuals enrolled in Medicaid are entitled to receive.

So in terms of funding, as I mentioned before, Medicaid and CHIP are partnerships between the federal government and states. And the way that I like to think of it is for, at least in Texas, for every Medicaid dollar, the federal government puts in 60 cents

and the state of Texas puts in 40 cents. And so that dollar is really split. Now that way that it's split is called the FMAP, the Federal Medical Assistance Percentage. This is different for every state, but it has to do with the per capita personal income and other factors. Many states are around that 60% mark, and you can see that there's a slightly higher match rate for the CHIP.

program. Actually, when CHIP was first authorized, the match rate was over 90% to try and incentivize states to enroll children in CHIP. I also want to call out here that we do have a few other programs that are actually part of Medicaid or are very similar to Medicaid in that they're administered by our agency, the Health and Human Services Commission.

the family planning service, Medicaid for breast and cervical cancer, as well as our community first choice program, which is attendant care services.

Now, I also want to take a moment here and just talk a little bit more about dollars

and cents. One of the most difficult jobs that our state representatives and state senators have to do is pass a balanced budget. In fact, that is the only law that they must pass during a Texas legislative session, of which the 90th is going to begin in January of next year.

Medicaid makes up between 1/3 to 1/4 of the entire state of Texas budget, depending on the biennium. That's largely because we cover so many vulnerable Texans. But if you're an appropriator, if you have to make those difficult decisions, Medicaid is always something that's going to be considered just because of the impact that it has on our state budget.

When you look at spending in Medicaid at a national level, in 2024, national Medicaid spending was around \$920 billion with a B, and in Texas for that same year, it was around \$50 billion.

LS Leigh Shapleigh 12:06
Hey.

VD Van Ramshorst, Ryan D (HHSC) 12:19
I also want to pause here and talk a little bit about the enrollment nationally. We said a few slides ago that in Texas Medicaid, we have around 4.1 million individuals. When you look nationally, 88 million individuals across the country are covered by Medicaid. And when you look at Medicare, there's 66 million individuals that are covered.

LS Leigh Shapleigh 12:27
How did you do last night? In 1.2 episodes. I heard she's blowing in the early of the night. Yeah.

VD Van Ramshorst, Ryan D (HHSC) 12:41
So I said the word entitlement a few minutes ago, and sometimes that's said, and it is kind of a bad word, and it's not. What that means here is that if someone is eligible for the program, they are going to receive the services. And so Medicaid is an entitlement program. So again, if someone meets the eligibility,

LS Leigh Shapleigh 12:43
Ohh, it's okay, so I want another, we hang up with adjusting that.

I think that's...

The nature of things that sometimes it bother you and something that doesn't.

VD **Van Ramshorst, Ryan D (HHSC)** 13:01

they must be enrolled in the program and receive services. And again, this has a tremendous impact on state budgets. If all of a sudden a national disaster were to occur or a natural disaster, and many, many individuals lost their jobs and became eligible for Medicaid, they would all potentially be enrolled. And again, that has a large budgetary impact. So

That's what we mean when we say that Medicaid is an entitlement program. CHIP is not an entitlement program, but it operates very similarly. I mentioned in the last slide that the match rate is a bit higher, but funds are technically capped. The way that I like to think of this is the federal government gives states kind of a bucket of money to spend on CHIP.

And when that money is gone, there's no additional federal matching dollars. And so states would then have the ability to say, we're not going to enroll any more CHIP clients. We're going to change the benefits. And those are things that we have not done in the state of Texas, but just a nuance between the funding of those programs. So let's talk about

eligibility. I feel like some of the most common questions that we get from providers, advocates, and clients alike are eligibility. So Medicaid, again, was passed into federal law as part of the Social Security Act back in 1965. That's where kind of a bulk of the provisions live in terms of what defines eligibility.

Really 2 buckets of things. There's the financial criteria, which we'll talk through shortly. That has to do with the federal poverty level. And then there's non-financial criteria like age, residency, citizenship, or alien status. And you can see at the bottom the categories of individuals that we cover in Texas.

Now, it's not on the slide, but I wanted to pause and take a moment to talk about HR1, otherwise known as the One Big Beautiful Bill Act. I think one of the other very common questions that we get is, will Texas be implementing work requirements for our Medicaid program? As you know, Texas is one of nine or 10 states that elected not to expand Medicaid. So our eligibility is a bit different

that it is in expansion states, Texas does not have to implement work requirements as called for by One Big Beautiful Bill Act. You probably read articles in the national media or Kaiser Family Health News about this, but that is something that Texas does

not have to do in case you were wondering. Certainly there are other provisions of One Big Beautiful Bill Act that will have an impact on things like directed payment programs, but as it goes for work requirements, again, not something that Texas will have to do.

So this is kind of the breakdown of eligibility, and we will pause here for a second. So on the y-axis, you have the percentage of federal poverty level. And I think ballpark federal poverty level, 100% is around \$30,000 for a family of four. And so 200% or 198% is

of \$60,000 for a family of four. And obviously, the federal poverty level changes according to family size. The larger your family, the larger the number. And so again, our eligibility is largely determined by an individual's percentage of federal poverty level. And so let's walk through the categories on the bottom of the slide. These are the groups that you saw on the prior slide that we cover. So

To the far left are pregnant women and infants, which are children up to one year of age. The dark blue is the federal minimum. Again, Medicaid, joint federal state partnership, the federal government dictates kind of the basics. Texas in the gray coverage has elected to provide more generous coverage.

to pregnant women and infants in this category. I'll also mention that a few years ago, our legislature directed our agency to extend postpartum coverage from 60 days to a full year. So for those of you that are doing well child visits and that baby is insured with Medicaid or CHIP,

I think it's a best practice to remind that mother that she will have full-fledged Medicaid for an entire year after that baby's delivery. And it's full-fledged Medicaid ranging from behavioral health services to prescription drugs to checkups. But I know that was very, very impactful for our program.

and something that advocates had been looking for for a very long time. Next categories are children between ages 1 to 5 and 6 to 18. You're probably wondering why is the percentage different there? I don't have a great answer. I just know that health care is complicated. We'll come back to those two middle categories. And then on the far right are those individuals being served in nursing facilities.

And here you can see that this is some of the most generous coverage that we offer, all the way up to 222% of federal poverty. And you can see that some of our lowest eligibility, if you will, is for parents and caretaker relatives. So able-bodied working adults, as some people refer to them, are not eligible for Medicaid in Texas. Again, we are not an expansion state.

But parents and individuals who are caring, for example, for an ill or disabled relative are able to get Medicaid so long as their income is at or below 13% of federal poverty, which is roughly \$300 for a family of three, just to put a number on that. The last thing that I'll bring up here is where is CHIP? So if you look at the children ages one through 5 and 6 to 18, CHIP takes that coverage up to 198% of federal poverty. So when you're getting asked questions about eligibility or wondering if a patient or a family member is eligible, this is ultimately what that is based on. So let's talk a little bit more about spending. So caseload simply means that the individuals that we currently have, so that larger bucket of 4 million Texans, and then you can see spending on the right. Now, this should make sense, especially to this audience. So that's 73% of our caseload. Most of our caseload are healthy, typically developing, low-income children.

And we have smaller categories of non-disabled adults and those with disabilities, including kids. And not surprisingly, the kids that are in the bulk of the caseload only account for about a third of the spending. And we know why. It's because healthy, typically developing kids really don't need a lot when it comes to health care.

Of course, they need checkups. They need those routine immunizations. They need developmental screenings, all of the things that our general pediatrics division does a great job at teaching our medical students and residents, but they're generally not expensive to cover. But when you start thinking about a child with complex medical needs that's on multiple medications,

that receives G-tube feeds that might be on a ventilator. Obviously, the cost is higher. And so that is why the bulk of spending is on individuals with disabilities.

So let's talk for a second about what is covered. And so I am always surprised by the breadth of services that Medicaid covers, especially as compared to commercial insurance. And we'll speak a little bit more about that in a second. So we cover acute care services, which is policy speak for things like doctor's visits, hospital services, laboratory radiology.

We cover what are called long-term services and support, sometimes abbreviated LTSS. I know when I was a trainee, this was not something that I was familiar with in terms of the name, but I was familiar with the service. And these services are generally unique to Medicaid. These are things that commercial insurance policies do not cover. These are things like attendant care to help someone with disabilities do basic activities of daily living. This could be a private duty nurse that, again, is supporting that child with complex medical needs, addressing their ventilator,

assisting with gastrostomy feeds, and a variety of other services, again, that we call LTSS. And again, these are generally services that are not covered. covered by commercial insurance. We cover what I think is an increasingly broad array of behavioral health services. Now, why do we say behavioral health? Behavioral health in health policy world means mental health services as well as substance use disorder services. So we cover a range of things. On one end of the spectrum would be inpatient psychiatric hospitalization,

You probably have cared for patients that do require that level of care. And then we cover all of the things on the other side of the spectrum, like outpatient visits with a psychiatrist, medication management. Now, we don't do as good of a job at covering the things that are in the middle of that continuum, things like partial hospitalization and intensive outpatient. But our program has made some really good strides in the right direction. And we'll have time a little bit later.

later to talk about that. We cover transportation services. I know that one of the biggest barriers for our families is transportation. And so all of the managed care companies and our fee for service members have the ability to get a ride to doctor's appointments, et cetera. And I feel like there's lots of opportunity there.

for providers to remind families of that benefit. And then as you know, we do cover a broad array of prescription drugs with a formulary that is likely larger than what most commercial insurances would ever consider offering.

So 2 service delivery models. So on the right, again, is what some might call traditional Medicaid. And this is the Medicaid that existed kind of pre-1994 and still exists to a small extent. And this is where a provider simply has a contract with the state of Texas to deliver health services.

If you do 10 well-child checks, you're going to get paid for 10 well-child checks. If you order more tests, if you prescribe more medicine, if your visit is more complex, you're going to get paid for that. And so this is kind of a basic fee for service process that really all types of payers are kind of shifting away from over time, shifting to things like the managed care model, value-based payment, alternative payment models, et cetera.

Now, we still have about 3 to 5 percent of our enrollees that are in our fee for service program, and those are largely newborns that have not yet been assigned to a managed care organization or MCO, or individuals that are transitioning between programs, but it is an increasingly small percentage of our program.

The bulk of our enrollees, in fact, the bulk of all individuals enrolled in Medicaid

across the US are in a managed care organization. The finance model is important. I've talked a bit about the Texas budget and state budgets and the impact of Medicaid. The way that this works is instead of the state contracting directly with providers,

The state has contracts currently with 16 different health insurance companies or HMOs or managed care organizations, and we pay those health insurance companies a capitated rate. Capitated rate is sometimes referred to as a per member per month. And so let's say that you have a health insurance company, your participating in Texas Medicaid, and you cover 100 healthy kids. And the state of Texas is going to pay you \$50 for each of those kids per month. And I think if I'm doing math correctly, that's going to be 50 times 100 is \$5,000 for a month. Now, if the cost of health care services for that group of kids is more than \$5,000, that's a loss for that health insurance company. But if the cost is less than \$5,000, that would represent a profit. And we have controls baked into our program that help make sure that if profits are above a certain percentage, that some of that actually has to be shared back with the state of Texas. But this model gives state budgeters

certainty, if you will, because that capitated rate, while it does change over time, it is helpful for two-year budgeting cycles, again, giving program certainty. And so we own the contracts with the MCOs. One of our agency's primary job is to provide oversight of those MCOs, make sure that they're doing right by providers, making sure that the clients enrolled in their programs, their members are getting the services that they need. One of the unique features of managed care is service coordination. So a great example are individuals, kids in our Star Kids program, which we'll talk about shortly.

Those kids should be receiving service coordination where at least once a year, depending on the child's complexity, they should have an in-person visit from a service coordinator from their managed care plan to identify their needs and make sure those needs are being met. And there's a few other nuances with managed care.

They're able to

provide things that we call value-added services. You may have seen billboards or emails about, you know, MCOs giving new families a baby shower, infant car seat, bicycle helmets. These are all value-added services that traditional Medicaid just wouldn't be able to offer.

Okay, so why managed care? Managed care emphasizes preventive care, which we all

know is very important. It improves access to care as opposed to the fee-for-service model. It ensures that services are being used appropriately, and that is perhaps more important than it ever has been, giving the national and state dialogue about waste, fraud, and abuse and social services programs to include Medicaid, and we'll talk about that later. In theory, there's improved client and provider satisfaction. There's a focus on medical homes and making sure that members have a primary care provider, be it a general pediatrician or a family physician. There's a direct tie to health outcomes. In fact, We have metrics and targets that we make the managed care companies hit. Otherwise, they will lose some of the money where the higher performing plans will take away some of that at-risk money or those at-risk dollars from the lower performing plans and promoting care in the least restrictive setting. And when I think of this, it's

individuals with disabilities that are able to be served in their home or in the community rather than in a hospital or institution. And our managed care companies are charged with making sure that that happens. Obviously, there is a cost effectiveness aspect of managed care that again is very important.

And just to put some numbers on that, when you look at the time period between 2012 to 2022, the average per capita, so per human cost of healthcare expenditures in the US has increased 52%. But when you look at Texas Medicaid specifically, it's only increased by 14%. And obviously, again, given that Medicaid has such a large large impact on our budget, this is very important for our appropriators with the managed care model.

So again, health care is complex. These are programs that you might have heard of before. The first thing that I'll tackle, though, is why is everything called STAR? I would like to think it's because we're the Lone Star State, but this actually harkens back to the legislation that was passed in the mid-90s.

that directed our agency to pursue a managed care model for Medicaid. And so it stands for State of Texas Access Reform. If you knew that, you get a bonus. That is not one of the CME questions, so don't worry about remembering that. Our largest program is STAR, which covers those low-income, healthy, typically developing kids, pregnant postpartum women.

Our Star Kids program, which we'll take a deeper dive on shortly, covers kids and youth with disabilities. We talked about the role of CHIP. Star Health, we cover every single child, adolescent, and young adult in our foster care system that are in foster

care, child welfare. And we have a single statewide managed care model that does that program because we know that youth in foster care move frequently. And so the idea is with one managed care company, they're able to better preserve access to primary care and behavioral health care. We also have a variety of foster care centers of excellence through Star Health throughout the state.

I'm very proud that in the School of Nursing at UT Health San Antonio, they have a clinic called Wellness 360. That is one of the foster care centers of excellence. And then lastly, the Star Plus program is for adults with disabilities. We do cover dental services for children. We have three dental maintenance organizations or DMOs. and there are some dental coverage for adults with disabilities, but primarily the dental benefit is for kids.

This is a scary looking map because we have divided the state into managed care service areas. Kind of at the bottom left in the yellow, you can see the bare service delivery area and which managed care companies are operating in which program in which area of the state. You can see that some MCOs only participate in one of the programs. Some of them participate in all of the programs. They have the ability to select when they're applying, essentially, to participate in Medicaid, which programs they want to be a part of.

So I'll talk a little bit about, again, what is one of our most important jobs as the Health and Human Services Commission. We are ultimately the regulator of the MCOs. We have to provide oversight of those very, very large contracts. And I failed to say earlier that the contracts that the state has with the managed care companies are some of the largest state contracts in the entire country.

So oversight is really, really important from a financial standpoint, but also to make sure, again, that the people that we serve are getting what they need. So I'll talk through some of the tools that we have to make sure that our managed care companies are doing what they are being paid with taxpayer dollars to do. So in terms of access to services, we have network

adequacy requirements where a client has to have, for example, a primary care provider within so many minutes of driving or so many miles. One of the biggest functions of the medical director's office is to provide utilization review. And so we have a team of roughly 250 individuals, many of which are nurses, behavioral health clinicians, and therapists.

JL Jennifer Talley, LMSW 31:38

What time? Are you good to take it down there, because then he can put it in his office.

VD Van Ramshorst, Ryan D (HHSC) 31:45

that will pull a statistically valid sample from some of our programs and make sure that our members are getting what they need. I mentioned earlier that we do have a variety of quality programs where the MCOs, again, are what we say are at risk for dollars, where if they're not performing well, they will actually lose out on some of those dollars.

JL Jennifer Talley, LMSW 31:49

What do you say?

VD Van Ramshorst, Ryan D (HHSC) 32:05

We have value-based enrollment, which means that when someone does not elect which plan they want to choose, they will actually be defaulted to the higher performing plan. We have a large operations area that conducts what are called readiness reviews. And so as an example, if one of the MCOs would want to use a third-party vendor to do prior authorization, they would have to prove to us first that they understand our policy and they know how to do things and we ultimately have to sign off. And then I mentioned before that we have financial tools. Again, I'm going to very quickly get out over my skis. I don't know about you, but I didn't have any coursework in medical school on financial oversight of health insurance companies, but I know a lot more now. We have financial statistical reports where the MCOs have to report how much money they're spending on actual health care versus administration versus overhead. And again, we have built in profit limits where if an MCO is making over 3% of profit, they have to begin to share in a graduated manner back with the state some of their profits. So that's kind of a built-in protection from a financial standpoint. Now, because of the national discourse, I did want to spend a few minutes talking about waste, fraud, and abuse. Again, lots of conversation about waste, fraud, and abuse in Medicaid programs, in childcare programs, in applied behavior analysis for individuals with autism.

autism, and we work very closely with our Office of Inspector General, or OIG, which you're likely familiar with, to prevent, detect, monitor, enforce fraud. We work with the managed care companies. Each of them have what is called a special investigative unit, which is kind of a mini version of the OIG, where the MCOs are charged with also looking for waste, fraud, and abuse.

And then lastly, we do work with the Office of Attorney General's Medicaid Fraud Control Unit when there is a case of fraud that's being prosecuted from a legal standpoint rather than from an administrative standpoint. And what you don't see pictured here is you. You may know that as part of your Medicaid enrollment, you are obligated to report concerns about waste, fraud, and abuse. And that's one of the most critical ways

by which our agency becomes aware of bad actors. I think it's really unfortunate that there's a really, really small number or a smallish number of providers that are doing the wrong thing, where all of us are working very hard to serve vulnerable Texans.

But I think we all have a role in preventing waste, fraud, and abuse in Medicaid.

Just really quickly, I wanted to outline that when we are developing a policy, we're actually thinking about waste, fraud and abuse prevention or program integrity as it's called from the very inception. And so we will think about things like quantity limitations or diagnostic restrictions. Going back to the example of ABA, we require that to get ABA, a child has to have a confirmed diagnosis of autism.

Whereas other programs make other ABA for other diagnoses, we know that the evidence is strongest for kids with autism at younger ages, close to the time of diagnosis. And so we build those things into our policy. And I have to say, when I was in full-time clinical practice mode,

I had lots of thoughts and feelings and opinions about things like quantity limits and diagnosis restrictions, but sitting in the chair that I do now, I have a much richer understanding for why these things exist and why they need to exist. We have prior authorization tools, which I know that certainly is a bad word. I think

The health system in general can do a better job at balancing that. As an example, we require the health insurance companies we contract with to report to us every year prior authorizations that they are taking offline or putting online, and we'll work with them if they have a service where they're approving it 95% of the time is that prior authorization really needed anymore.

All right. We'll pause for a second about Medicaid waivers. I think the number two most common flavor of question that I get only second to eligibility is Medicaid

waiver. What is a waiver? So the word waiver actually has to do with waiving the section of the Social Security Act where the Medicaid law lives.

to give states permission or flexibility to do something novel. So there might be a specific provision that has to be waived to allow a state to provide a different kind of service. As an example, in one of our specialized waivers for youth with complex behavioral health needs, they can actually access equine therapy.

music therapy. Those are not services that Medicaid traditionally offers, but through a waiver, we're allowed to offer those services. And you can see some of the other reasons for which states seek waivers. The last one in terms of new service delivery and management models, some of you may remember what is called DSRIP.

The delivery system reform incentive payment program, which is what some others would refer to as our 1115 waiver, that's an example of a state, Texas, trying to do things novel and innovative through Medicaid.

And this is a bit of a scary chart, but it lists out all of the different waivers that we operate. We'll focus on the bottom shortly. Those are what we call our home and community-based services waivers. Again, 1915 refers to a specific provision of the law. And these waivers are

all about keeping individuals with complex needs out of institutions. And so I think that's a really good segue into our Star Kids program and then a little later, our medically dependent children program waiver. So I mentioned earlier that it's really at the direction of our legislature that we have moved to managed care, but we didn't start with everybody at once.

In the mid 90s, when we were directed to create the first managed care program, it was the STAR program. So it was those healthy, typically developing kids and pregnant and pre-partum women. STAR Kids is actually one of the more new programs, if I can use that word, where the legislature directed the state in 2013 to develop this novel Medicaid managed care program for children and young adults with disabilities. And that was really the birth of Star Kids, which first became active in 2016. And you can see that the mission of this program is really to help make sure that kids with disabilities can maximize their potential and live the best life they can. So who's eligible for Star Kids? There's quite a few categories here. I think the most common way is those kids that are receiving Supplemental Security Income, or SSI, which is a program by which individuals with disabilities can receive some additional dollars every month to help with other expenses.

I think another thing for providers to think about, especially when they're seeing a

patient with disabilities for the first time, is asking them, are you receiving SSI? Because if they get SSI and they're a child, they will be enrolled in Star Kids. SSI is actually determined by the federal government. That's its own complex process. But SSI has a really important role here. If you receive SSI in Medicare, you're eligible for Star Kids. If you're in the MDCP waiver or the Yes waiver, you're eligible for Star Kids, as well as if you were receiving other waiver services or if you're actively residing in a nursing facility.

So some of the unique features of Star Kids is a focus on health homes, our Texas Health Steps program, which is our well child program, which is actually available in all of our programs. But it's important here because all kids need routine well child care, regardless of what their needs are. And again, that's our Texas Health Steps program.

Disease management, service coordination, we talked about transition planning. I remember when I used to think that this was the cliff where a child would turn 21 and age out of Medicaid or age out of another program and trying to find an adult provider that is equipped to take care of a young adult with special needs is still very challenging regardless of what type of insurance you have.

but our Star Kids program requires the MCOs to have dedicated transition planning staff to help with that. I spoke earlier about those long-term services and supports. We know that many children in Star Kids are receiving nursing services, whether it's periodic skilled nursing service or private duty nursing.

There's A dedicated screening instrument. That's the one that's done once a year to identify needs. And it goes by social factors, mental health factors, organ system to identify needs. This was a tool that was developed in collaboration many years ago with Texas A&M University, and it is totally unique to Texas Star Kids program.

And every one of those children must have what's called an individual service plan, which outlines the services that they need. Now, in theory, if you are taking care of a Star Kids patient, you should be able to access the SKSAI through the managed care organizations portal.

Previously, they would fax you the 100 page long instrument, which was not very user friendly. But again, all of us in theory have access to that SKSAI through the managed care organization portal. So you can see what the assessment yielded.

So we'll talk for a second about one of those 1915C waivers or MDCP. So this is a specialized waiver for children, adolescents, and young adults that essentially require a nursing facility level of care. And services can be delivered either through Star Kids

or Star Health. And so

It's interesting. There's kind of two populations that make up our MDCP program. And let me back up. Star Kids, the enrollment is roughly 150,000 children and youth. MDCP is roughly 6,500. So it is a subset. One of the groups are those kids that are already in Star Kids because of SSI or already in Star Health because they're having an interaction with the child welfare system. And the other group of kids are actually kids that live in families that might have commercial insurance. They might have a parent that's a lawyer and the other is a teacher. These are families that are more well off than the average family enrolled in Medicaid, but they can get Medicaid for their child with special needs.

through MDCP. Now, they're going to have access to the specialized waiver services that I'll tell you about shortly, but they really have access to full-fledged Medicaid. And so an example of what we see is take a child with cystic fibrosis who is now on a life-changing medication that costs thousands of dollars a month.

their private insurance plan can say, we're not going to cover that. But that is not an option in Medicaid. Medicaid must cover all medically necessary services for children. And so that child, even though they have commercial insurance, is able to get that drug. Another example, a child on a ventilator in a G-tube.

that commercial insurance can say, we're not going to pay for nursing services, but through this waiver, they're able to access all Medicaid services, including private duty nursing, et cetera. And so here you can see the eligibility, which we won't dive into. We already talked about it. These are some of the unique services that come with MDCP. So this is what

we really needed the waiver for, or at least partially. So things like adaptive aids or communication devices. There's actually built-in employment assistant for families, flexible family support, minor home modifications, whether that's a wheelchair ramp, that's a bar in the shower, there's a budget for that, respite services to help give the family an ability to take a breath.

and meet their own needs while their child is safely cared for in another environment. We have an entire supported employment program and again, a specialized transition services program. Now, one thing that I wanted to point out as something that is new, and this is a bit in the weeds, but I think providers especially, and in particular our complex care pediatricians, of which we have some amazing complex care pediatricians here in faculty that have actually helped provide input into this process have a really important role. And so there is a way, let me first pause by go

over the ways that you can get into the waiver. So there is an interest list where there is a bit of a period an individual will have to wait to get a slot on the waiver.

There's money follows the person where someone is in a nursing facility for 30 days or more and they can get the waiver. And we currently and soon will not have what is called the limited stay option, where if a child meets complexity criteria and stays overnight in a nursing home, they're able to essentially jump to the front of the line. And we are eliminating that program and creating these diversion slots. And so this is a way for children who are the most complex of the most complex to get to the top of the MDCP list and actually get a slot without having to do that overnight stay in a nursing facility. And so this is a group of kids

that are so complex, it would not be safe for them to have a 30 day stay in a nursing facility. And the new process will go into effect on December 1st. So we are rapidly approaching that. And the certification of whether or not the child meets certain medical criteria are the forms that you would have a role in talking through and working through and ultimately signing if you feel is it appropriate. So here are the clinical criteria of which a child must meet two to qualify for one of these slots. We've received lots of input from families, from advocates for complex care pediatricians to help us create this list.

But at the end of the day, it is our office that will be making these determinations. And of course, our medical directors have the right to still approve a case, even if a child does not necessarily meet these criteria. But we feel that these are kind of some of the highest priority criteria, again, for a child to bypass that interest list and get an emergency slot.

So let's talk for a second about value-based care. So you may be familiar with this framework of alternative payment models. And so on the far left is fee for service. I described this earlier. A physician gets paid for the number of patients they see, the more lab tests they order, the more prescriptions they write.

they write, the more surgeries they do, there's really no connection to quality or value. And then as you move to the right, there's a connection built on quality. And then ultimately there's dollars on the line that are tied back to those quality metrics. And so in category two, for example, let's say you have your own private practice pediatric office.

You might get paid a bonus, as it were, to report your metrics to the health insurance company. You might enter a shared savings agreement where if you take your population of kids with asthma and you can prove that you can decrease the

emergency room visit rate, that's going to represent a savings for the health insurance company and they will share some of that savings back.

And then on the far right is really risk-based or capitated models where the practice takes on all of the financial risk.

We have been in a journey with value-based payment back since 2012 and are actually one of the leading states when it comes to this. We have a dedicated framework by which we incentivize the managed care companies to prioritize the issues you see on the screen. I would say almost all of which have a direct impact on the kids with medical complexity that are

served by our Star Kids programs. But I want to zoom in just briefly on comprehensive health homes. So let's talk about the Chic Kids pilot. I did not come up with that acronym, but it is what we have. So this is the Comprehensive Health Homes for Integrated Care Kids pilot. We're Texas, we have to do our own thing. You may remember that back in 2019, at the federal level, there was something called the ACE Kids Act, or Advancing Care for Exceptional Kids, which was about specially designed health homes for children with medical complexity. There were additional dollars for states to share with providers. Texas did not elect to participate in that. Most states did not, as a matter of fact.

But in 2021, our state leadership wanted Texas to do our own version. And so we developed the Chic Kids pilot. So I want to quickly talk to you about what that model is and what some of our outcomes were. So what this really is, is a partnership between

a managed care organization that does star kids and our complex care pediatric providers. Very, very proud that our own complex care clinic was part of this, thanks to the leadership of Dr. Medyin, Dr. Wu, and Dr. Lubrin. And it was really about making sure that that service coordination was happening in a robust manner. And so the goals were to improve care coordination, improve access, improve outcomes, improve satisfaction and stress levels for families, and also, and perhaps most importantly to providers at times, is reduce administrative burden. So the pilot ran for just about three years. There were 11 collaborations, including eight of the MCOs and nine of the health homes. Almost 1300 unique Star Kids members participated, of course, with consent. And

There were clinics in Austin, Corpus, Dallas, Houston, and in San Antonio, as I said. And we did a quasi-experimental study to see if this actually worked. So when it came to care coordination, there was a statistically significant increase in the use of

that child's core health team.

and the use of a family-centered care plan. And we all know those are both very important. There actually was a decrease in the time making appointments or coordinating, which certainly was good for families and good for providers. There was a statistically significant increase in the use of home-based care services, largely driven by respite. And what this told us was that perhaps this model was helping families identify

identify those ultra specialized services that they might not be aware of, but they can certainly take advantage of. And I think respite is one of those services. There was an increase in outpatient encounters, which again, I would like to think is a good thing. And that suggests that they're getting those checkups, they're getting their follow up care, which is certainly much better than receiving that care in an emergency room. There was no change, interestingly, to the number of inpatient hospitalizations or the number of visits, but we did see a statistically significant decrease in the cost per inpatient hospitalization.

I think this slide is really important and it's something that certainly at a health policy perspective, we don't think about nearly enough. And that is what is the experience for the family? Very proud that the results showed that this did help family care for their child's needs at home. Families reported that they felt like they were living a better life. It helped their child's mental health.

And again, it increased access to outpatient encounters. And almost all of the survey respondents, which again, were largely parents and guardians, were satisfied with the way that their care team was working together. Now, I wouldn't be a good academician by heart without talking about limitations. So the design was quasi-experimental. We didn't have a controlled control group, for example, the sample size was relatively small. It's 1300 kids, but 1300 out of a universe of 150,000 kids in Star Kids. We really did not power this for any more detailed analysis than what I showed. There were care coordination services that were existing before. And so to what degree did the pilot really impact that?

Again, we didn't have any pre-pilot data and the implementation dates of the pilots kind of varied throughout those three years. But very promising work. We thank the complex care clinics, the MCOs and advocates. And so I think we're wondering about things like how can we use these models now to expand care to specialists and other long-term services and supports.

How can a model like this support rural practices where perhaps it's one family doc that's still on paper records where he might only have one patient that has complex needs? How can a model like this support that provider? What happens when a youth ages out of pediatric care, that cliff that I talked about? What are the lessons learned from this model and how can we move forward?

So I want to share a few parting thoughts and a few helpful resources, and then happy to take whatever questions you might have. So this is a non-exhaustive list of what I'm calling challenges, but this is really a list of kind of things that keep me up at night. Program integrity is waste, fraud, and abuse. I think we've spoken about that today.

Lots of excitement about the Rural Health Transformation Program, which you're likely familiar with. Texas received one of the largest, if not the largest, amount of dollars from our federal partners to help improve rural health care. I talked a little bit about high-cost therapeutics. I don't know about you, but never in my life did I think we would have medications that could essentially cure conditions like

Duchenne muscular dystrophy, spinal muscular atrophy, sickle cell disease. These therapies cost millions of dollars per patient. And certainly if it were my child, I would want them to receive everything and anything they needed to live their life to their fullest. But we've talked about fiscal responsibility and the role of Medicaid and state budgets. And so certainly

These high cost therapeutics are something that we're thinking through and trying to learn from other states and making sure that at the end of the day, kids that need these therapies are able to get them in a timely manner. Genetic testing or biomarkers, as they're called, is an ever expanding group of tests that we have been directed to cover by our legislature.

some of which cost thousands of dollars per test. Lots of discussions about artificial intelligence, which I think will have implications on the next legislative session. I mentioned the behavioral health continuum of care. We've done some work that actually unlocks, if you will, partial hospitalization and intensive outpatient as in lieu of services, which we could have a whole other conversation about. I continue to be very concerned about individuals that have co-occurring intellectual developmental disability and behavioral health needs. It's just very, very difficult to find a provider that's equipped to care for them. And so what can we do as a system? And then the Aspire model, which you can see what that stands for. CMS, again, our federal partners have released a variety of innovation models to improve care. This

model is all about kids with medical and behavioral health complexity. And so we're eagerly awaiting additional information that I think will be released in 2027 to see if this model would be a good fit for the state of Texas.

You may know that we do have a very robust Texas Health Steps online provider education platform that has countless hours of free continuing education on topics ranging from sickle cell disease to sexually transmitted infection screening to routine well child care. The single best source of information, I think, about Texas Medicaid is this pink book,

which if you happen to have a hard copy, which is coveted, the cover is pink, but you can get this online and it has a really well done executive summary. And if you care to read it, we do have a 1600 plus page policy manual that outlines all of our policies. And that's also available on the web.

I think in terms of what you can do to engage with this system, I'd like to think that the hour you've spent with me this morning has helped you become a little bit more informed, being familiar with those community resources that are increasingly partnering with our managed care organizations, such as the San Antonio Food Bank, the San Antonio Housing Authority, actively seeking to collaborate with the service coordinator of the MCO or the child welfare caseworker to make sure that you're part of those conversations. I think I learn something new every day in this job, and it's something new that I can educate patients about when I'm in clinic. And we also have over 30 different advisory committees and councils, which periodically have openings for providers and physicians specifically. And some of those advisory committees are dedicated to infants, neonates, NICU care, specialized needs, and there's quite a few faculty on this call right now that have active roles in those committees. A few other things, and then I really will be done. The picture on the bottom is hilarious to me because I think this was taken in 2014 in my first year out of residency.

I was lighter. I had no gray hair. And while the receding hairline had started, it's much worse now. But again, very formative years at the Southeast Clinic off of Ada and South Cross. And then the top picture is a retirement ceremony for someone that had dedicated 30 years of her life to state service. For me, leadership has been a journey. I learned from



Arandes, Michelle 58:21

Good morning.

VD **Van Ramshorst, Ryan D (HHSC)** 58:23

all different types of individuals. Perhaps I thought when I took this job that I'm the physician in the room and I should be the one making the decisions and that has turned out not to be the case. I think one of the most challenging things for a leader is to communicate, but I think pediatricians are really good at doing that in general.

 **Arandes, Michelle** 58:24

No, don't.

I'm scared, and you stuck to me, sweet, my goodness.

I know, not again.

VD **Van Ramshorst, Ryan D (HHSC)** 58:43

I think about this a lot, and this is one of the reasons why I felt so strongly about continuing to see patients, is that to be able to bring the provider voice to the health policy discussion, you have to be an excellent clinician first. I think that's particularly important for the trainees on the call. It's a really small world. One of the managed care organization medical directors was my attending when I was a resident.

And it's just fun to have those connections. And then just a reminder to take care of yourself. I think it's a really interesting time to be a pediatrician, be in health policy, be in Medicaid. And I can't say that enough. And with that, I'll take down the slides. And then Dr. Sutter, thank you again. Thanks to everybody. And I'm happy to take Questions.

 **Sutter, Deena E** 59:30

Thank you so much, Ryan. That was a great talk and it was so informative. And I think there's so much interest in this topic. I'm getting texts from people about, you know, this is a great, this is a great grand round while it's still going on. So that tells you something. So I'm going to read the questions from the chat. And if people have other questions or they want to jump on, raise their hand, add to the chat, all those are options. And then a reminder that the CME link is in the chat as well. So for those who want to claim CME, it's there. So the first question I see on here is from Dr. Janet Williams. If a parent responds they do not have SSI for the child, where should they be sent to enroll in that? Who is the contact? And does that refer them to getting star program access as well?

VD **Van Ramshorst, Ryan D (HHSC)** 1:00:18

Thank you, Dr. Williams. I would say two things. So there is a website. If you Google SSI, it'll have the information. The application is quite complex, but my best recommendation is having that family reach out to their service coordinator, assuming they're in Medicaid, and they are well equipped with helping them navigate that process. We are aware, though, that those determinations can take many, many months. There's often requests for additional information, but I would refer them to their service coordinator. If the family doesn't have one, I usually advise them to call their Medicaid number and I'll sometimes have them do that from the office to make sure that they get connected.

 **Sutter, Deena E** 1:00:58

Okay, great. And then Dr. Randas asked for the CHIP program, do you think that the reduced cost for inpatient encounters had something to do with improved unified treatment goals and more focused treatment plans during those admissions? And was there a reduction in length of stays?

VD **Van Ramshorst, Ryan D (HHSC)** 1:01:16

Yeah, thanks, Dr. Arandis. I don't believe there was a reduction in length of stay. I'd have to check that, but I agree with where you're going. I would like to think that that decreased cost per hospitalization was reflective of more coordinated care, really inpatient and also before the hospitalization and after. But I don't think the study was powered to really get at that, but that's certainly what we would like to think. And before I take the next question, I just want to acknowledge that I have a variety of team members from the Health and Human Services Commission that are on the call and just wanted to thank them for all that they do. And I love being a part of their team. Back to you, Dr. Sutter.

 **Sutter, Deena E** 1:01:51

Oh, that's great. So Dr. Fierro is asking what percent of the cost of pediatric care is behavioral health.

VD **Van Ramshorst, Ryan D (HHSC)** 1:02:01

Hey, Dr. Phelan, I don't have that number, but I do know that Medicaid is one of the

largest, if not the largest payer of behavioral health services in Texas and at a national level. But I can look that up and I know how to get a hold of you because I'm now interested in that percentage.



Sutter, Deena E 1:02:17

Okay, just to clarify, it wasn't Dr. Phelan, it was Dr. Fierro. So yeah, yeah. Just so you get back to the right person. Dr. Alice Gong is asking about can complicated NICU patients now transition into waiver to get



Van Ramshorst, Ryan D (HHSC) 1:02:20

Oh, sorry, Doctor Fierro.



Sutter, Deena E 1:02:35

To get to home care without the requirement for nursing home for nursing home.



Van Ramshorst, Ryan D (HHSC) 1:02:40

Hey, Dr. Gong. So yes, a child who is in the NICU, so long as they meet those criteria, would be able to be assessed for MDCP and get one of those crisis slots. We don't necessarily restrict it by their current care setting. It's whether or not they have those complex needs.



Sutter, Deena E 1:02:59

Okay, great. And then Dr. Pearlman is asking what happens when the... What's going to happen when, or sorry, try to clarify this question. What happens when the biggest impact on health is not the 100,000 med, but stable housing? Does Medicaid have any programs to address that for complex kids?



Van Ramshorst, Ryan D (HHSC) 1:03:24

Thank you, Dr. Pearlman. I can answer this more broadly. We, for the past eight years, have been working with the managed care companies on a non-medical driver of health initiative. A few years ago, we put out our first ever Texas Medicaid non-medical driver of health action plan, where we identified the top three needs that we wanted our MCOs to be addressing with all members, not just kids with medical complexity. And it will surprise nobody that those needs were housing, transportation, and food security. And so most of the

MCOs, if not all of them, do have dedicated programs where they're working with members in partnership with the housing authority. And again, I think the easiest way to access that would be going through the child service coordinator, but they're doing a lot of really

Work in that space.



Sutter, Deena E 1:04:14

Okay, great. Dr. Escaname is asking any recommendations for transition into adulthood for patients who are on expensive and specialty medications that aren't on STAR?



Van Ramshorst, Ryan D (HHSC) 1:04:26

Yeah, thanks, Dr. Escaname. I think this is a really, really challenging space. What I would say is that if the child is in regular Star, and you have a patient that is on specialty medication and does have complex needs, I think the question is why are they not in Star Kids? There might be a good reason for that, but again, helping them with their service coordinator figure that out, because if they are in Star Kids, kids, it's a bit easier to transition into the Star Plus program, which is the Star Kids equivalent for adults. But obviously there's other eligibility criteria. And if they were to lose Medicaid, I think the next best recommendation, especially here in San Antonio, would be to a program like CareLink. But that certainly doesn't have the same coverage that Medicaid would. I know that wasn't a great answer.



Sutter, Deena E 1:05:14

Okay, I mean, we're a little over, but I just want to give people a chance. If anybody else wants to ask a question, because this is such an important topic, I know there's so much interest in it. Also in the chat is a lot of kudos to you from Dr. Wu, Dr. Williams, Dr. Gong, other people. People are really appreciative. I'll give it another second.

Okay, well, thank you, Dr. Van Ramhorst. This was a great talk. We really appreciate this and we'll definitely be asking you to come back probably next year because the updates are super helpful for our faculty and all of our and all of our joining pediatricians. So thank you so much. We really appreciate you.



Van Ramshorst, Ryan D (HHSC) 1:05:58

Take care, y'all. Thank you so much.



Sutter, Deena E 1:05:59

Alright, bye.



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