



Quarterly Therapy Access Monitoring Report

**As Required by
Senate Bill 1, 85th Legislature,
Regular Session, 2017 (Article
II, Health and Human Services
Commission, Rider 57)**

**Health and Human Services
Commission**

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1. Executive Summary

This report fulfills the requirement in the 2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission [HHSC], Rider 57), for HHSC to analyze selected data related to pediatric acute care therapy services (including physical, occupational, and speech therapies) for negative impact on access to care. HHSC must submit quarterly reports to the Legislative Budget Board and the Governor beginning December 1, 2018.

This initial Rider 57 report includes the following findings:

- The volume of substantiated¹ provider and member complaints and appeals for December 2017 through August 2018 increased over the prior 12 months, but remains low compared to the overall numbers of members receiving therapy services. The total number of substantiated complaints and appeals represented less than one percent of those members.
- Between September 2016 and September 2018, the total number of Medicaid-enrolled pediatric therapy providers declined by about 4.5 percent. The primary driver for the reduction was the federal requirement for all Medicaid providers to re-enroll by February 2017 or be dis-enrolled. This resulted in one-time decreases in all provider types, not only those providing therapy services. While the number of home health agency and other therapy provider types has not rebounded, enrolled independent therapists have surpassed their pre-February 2017 numbers in recent months.
- Managed care organizations (MCOs) reported 53 therapy provider terminations on average per month from December 2017 through August 2018 (total of 480). The reasons for therapy providers terminating from MCO networks included individual providers leaving a group practice (33 percent); credentialing or re-credentialing (26 percent); failing to maintain active provider number (13 percent); and termination of contract (17 percent). If provider participation is terminated in one MCO's network, the provider could

¹ A complaint or appeal where research clearly indicates HHSC policy was violated or HHSC expectations were not met.

continue to participate in Medicaid as a provider in another MCO's network, unless their participation in the Medicaid program has been terminated.

- From fiscal year 2016 through March 2018, utilization of pediatric therapy services has been trended down. Average speech and occupational therapy utilization rates per 1,000 members per month have declined 10 and 11 percent, respectively; the physical therapy utilization rate decrease by 7 percent. These decreases appear to begin with the therapy policy changes implemented in May through December 2016, after which utilization rates appear to stabilize. While the utilization data show that the number of clients receiving therapy services has decreased, it does not indicate whether the level of clients served is appropriate or not.
- For December 2017 through August 2018, 4 MCOs reported waiting list information for 313 unique members. Eighty-six percent of these members were reported by one provider. When individuals are placed on a waiting list, they may still have access to or receive services from another therapy provider. MCOs reported that another provider was available for 94 percent of these individuals and that they were working on resolution for the other 6 percent, at the point-in-time of the reporting.

HHSC continues to strengthen its clinical, policy, and operational oversight to ensure Medicaid members have appropriate and timely access to medically necessary services, with specific actions aimed at therapy services. HHSC actions include:

- Confirming all MCOs' processes for notifying providers of how to report waitlist data and that they are not accepting new patients.
- Validating the reporting chain to ensure that when providers report information to MCOs it is also reported by MCOs to HHSC.
- Performing quality assurance of the MCO reported data and addressing any identified issues.
- Reviewing utilization data for the individuals reported to be on a waiting list to determine if they are receiving therapy services.
- Collecting therapy prior authorization data from the MCOs for future analysis.
- Hiring additional therapists for utilization review and including a focus on the medical necessity of therapy services in operational and targeted reviews. Expanding the scope of these reviews to include physical and occupational therapy, in addition to speech therapy which is currently included.
- Updating therapy policy to clarify the benefit and contract provisions to implement appointment availability standards.

- Developing additional training and webinars on therapy services for providers and MCOs.
- Improving complaints trending and analysis, including through standardizing complaint definitions and categories; streamlining processes; and enhancing education.

These efforts, which will be implemented over the short and long term, will help HHSC to identify and address any systemic access to care issues, including for therapy services.

2. Legislation

Per Rider 57, the 85th Texas Legislature directed HHSC to do the following:

Out of funds appropriated above in Strategy L.1.1, HHS System Supports, HHSC shall submit, on a quarterly basis, the following information related to pediatric acute care therapy services (including physical, occupational, and speech therapies) and whether the items below negatively affect access to care:

- a. Provider and member complaints by disposition received by the Office of the Ombudsman and HHSC Health Plan Management;
- b. Provider and member complaints by disposition reported by Medicaid Managed Care Organizations;
- c. The number of pediatric acute care therapy provider terminations and the reason for identified terminations;
- d. The utilization of pediatric acute care therapy services;
- e. The number of members on a waiting list, unable to access pediatric acute care therapy services due to insufficient network capacity; and
- f. The number of pediatric acute care therapy providers no longer accepting new clients and the reason for identified panel closures.
- g. HHSC shall submit the quarterly reports to the Legislative Budget Board and the Governor in a format specified by the Legislative Budget Board beginning December 1, 2018.

This is the first quarterly report for Rider 57.

3. Background

Medicaid Coverage for Pediatric Therapy Services

Medicaid covers medically necessary physical, occupational, and speech therapy for enrolled children.

- Physical therapists provide interventions to reduce the incidence or severity of disability or pain to enable, train, or retrain a person to perform the independent skills and activities of daily living. Physical therapy (PT) services included measurement or testing of the function of the musculoskeletal, or neurological system and rehabilitative treatment concerned with restoring function or preventing disability caused by illness, injury, or birth defect. Physical therapy services are provided by physical therapists and physical therapy assistants who are licensed under the Executive Council of Physical Therapy and Occupational Therapy Examiners.
- Occupational therapy (OT) uses purposeful activities to obtain or regain skills needed for activities of daily living (ADL) and functional skills needed for daily life lost through acute medical condition, acute exacerbation of a medical condition, or chronic medical condition related to injury, disease, or other medical causes. OTs use therapeutic goal-directed activities to evaluate, prevent, or correct physical dysfunction and maximize function in a person's life. OT services are provided by occupational therapists and occupational therapy assistants who are licensed under the Executive Council of Physical Therapy and Occupational Therapy Examiners. Physicians may also provide OT services.
- Speech-language pathologists treat speech sound and motor speech disorders, stuttering, voice disorders, aphasia and other language impairments, cognitive disorders, social communication disorders and swallowing (dysphagia) deficits. Speech therapy (ST) may be provided by speech-language pathologists or speech-language pathology assistants who are licensed under the Texas Department of Licensing and Regulation. Physicians may also provide ST services.
- Children may receive therapy services through Medicaid fee-for-service (FFS) or managed care, including through the STAR, STAR Kids, and STAR Health managed care programs. Medicaid-covered services are the same whether provided through traditional FFS or managed care. Medicaid MCOs must

provide covered services in the same amount, duration, and scope as outlined in the Medicaid state plan. Medicaid MCOs may implement practices to promote appropriate utilization of medically necessary services, such as prior authorization.

Policy and Reimbursement Changes to Therapy Services

In 2015, the 84th Legislature² directed HHSC to achieve savings related to physical, occupational, and speech therapy services through rate reductions and medical policy initiatives. HHSC implemented reimbursement and policy changes for therapy services over the 2016-17 biennium.

- Fiscal year 2016 – In May 2016, HHSC instituted policy changes related to required documentation and prior authorization for OT, PT, and ST.
 - ▶ Policy changes included:
 - ◇ Added a claim modifier to track treatment provided by therapy assistants
 - ◇ Clarified medical necessity criteria
 - ◇ Defined therapy functional goals
 - ◇ Streamlined prior authorization form
 - ▶ These changes were made to help ensure that recipients of therapy services had a medical need for therapy and that the therapy delivered was effective and aligned with current standards of practice.
- Fiscal year 2017 – In December 2016, HHSC made reimbursement reductions for OT, PT, and ST. MCO capitation rates for fiscal year 2017 were adjusted to reflect the reduction.

In 2017, Rider 59 partially restored rates for therapy services, provided direction on reimbursement rates for therapy assistants, and Rider 57 directed HHSC to analyze and report quarterly on data related to pediatric acute care therapy services.

- Fiscal year 2018:
 - ▶ In September 2017, HHSC restored approximately 25 percent of the therapy reimbursement reductions. HHSC also made changes to

² 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, HHSC, Rider 50(c))

- standardize billing practices for therapy treatment across provider types. These changes required most occupational and physical therapy services to be billed in 15 minute increments and for all speech therapy services to be billed as an encounter consistent with standardized coding and billing guidelines. The Health Insurance Portability and Accountability Act (HIPAA) requires standard billing and coding practices.
- ▶ In December 2017, HHSC implemented reimbursement reductions for therapy assistants to 85 percent of the rate paid to a licensed therapist.
 - ▶ MCO capitation rates for fiscal year 2018 were adjusted to reflect the restoration of the therapy reimbursement reductions and the implementation of the therapy assistant reimbursement reductions.
 - Fiscal year 2019:
 - ▶ In September 2018, HHSC implemented additional reimbursement reductions for therapy assistants to 70 percent of the rate paid to a licensed therapist.
 - ▶ MCO capitation rates for fiscal year 2019 were adjusted to reflect the reimbursement reduction.

Other significant program changes also occurred during the 2016-17 biennium that impacted pediatric therapy services and providers.

- Fiscal year 2017:
 - ▶ In November 2016, approximately 180,000 children transitioned from Medicaid FFS to the new STAR Kids managed care program. Prior authorizations for these children, previously conducted by the FFS claims administrator, are now performed by the MCOs.
 - ▶ The deadline for provider reenrollment pursuant to the Affordable Care Act occurred in February 2017, resulting in at least a temporary decline across all provider types in the Medicaid network.

Many consecutive changes, directly and indirectly related to therapy services, make it challenging to distinguish how each event may have impacted the number of clients receiving a therapy service.

4. Therapy Data Trends and Analysis

Data collection and analysis for Rider 57 is intended to detect potential signs of systemic issues with access to pediatric occupational, physical, and speech therapy services. To collect certain elements required by Rider 57, HHSC provided the Medicaid MCOs a tool for reporting data on complaints, waiting lists, providers that are not accepting new members, and provider terminations for therapy services beginning December 2017. Appendix A shows the timeline for HHSC stakeholder engagement efforts for development and implementation of the data collection and reporting process. MCOs report this data to HHSC each month on an ongoing basis. HHSC also obtains complaints data from internal agency sources, including the HHSC Office of the Ombudsman and HHSC Medicaid and CHIP Services. Each month, HHSC reviews the data for quality assurance and addresses any identified issues, as needed.

HHSC also reviews Medicaid provider enrollment and utilization data by therapy type to help identify trends in how many therapy providers are enrolled and providing services in Medicaid, and how many individuals are receiving therapy services. Utilization data includes FFS claims and managed care encounters.

These data types and sources provide different information about access to pediatric acute care therapy services and have unique considerations and limitations. HHSC monitors and analyzes the data holistically to identify trends, assess access to pediatric therapy services, and appropriately address any issues.

Therapy Provider and Member Complaints and Appeals

Figure 1 shows trends in substantiated complaints and appeals relating to pediatric therapy services from December 2017 through August 2018. For this time period, there were an average of 70 substantiated complaints and appeals per month, including:

- 13 from members or persons representing members;
- 56 from providers, mostly payment related; and
- 1 per month from another source.

The total number of substantiated complaints and appeals increased over the prior 12 months but is still low relative to the number of individuals served. From

December 2016 through November 2017, there was an average of 46 substantiated complaints and appeals per month for pediatric therapy services, including 7 from members or persons representing members and 39 from providers.

Figure 1: Substantiated Member and Provider Complaints and Appeals for Pediatric Therapy Services (PT, OT, and ST)

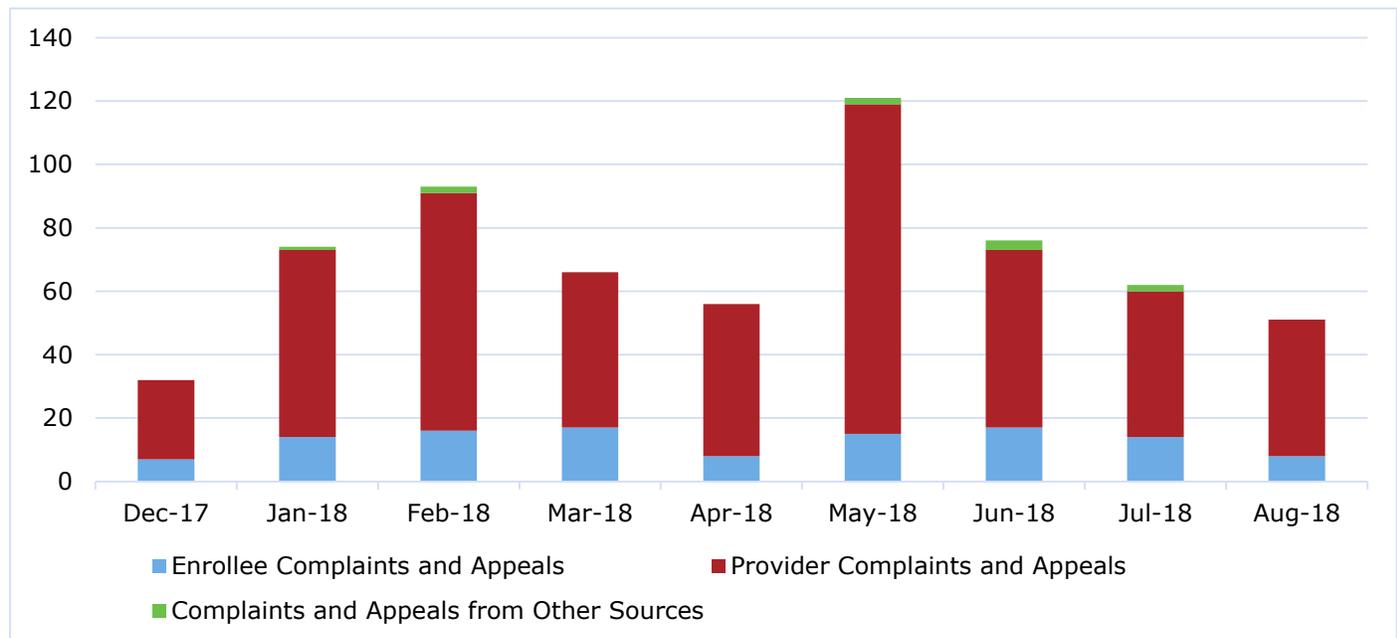
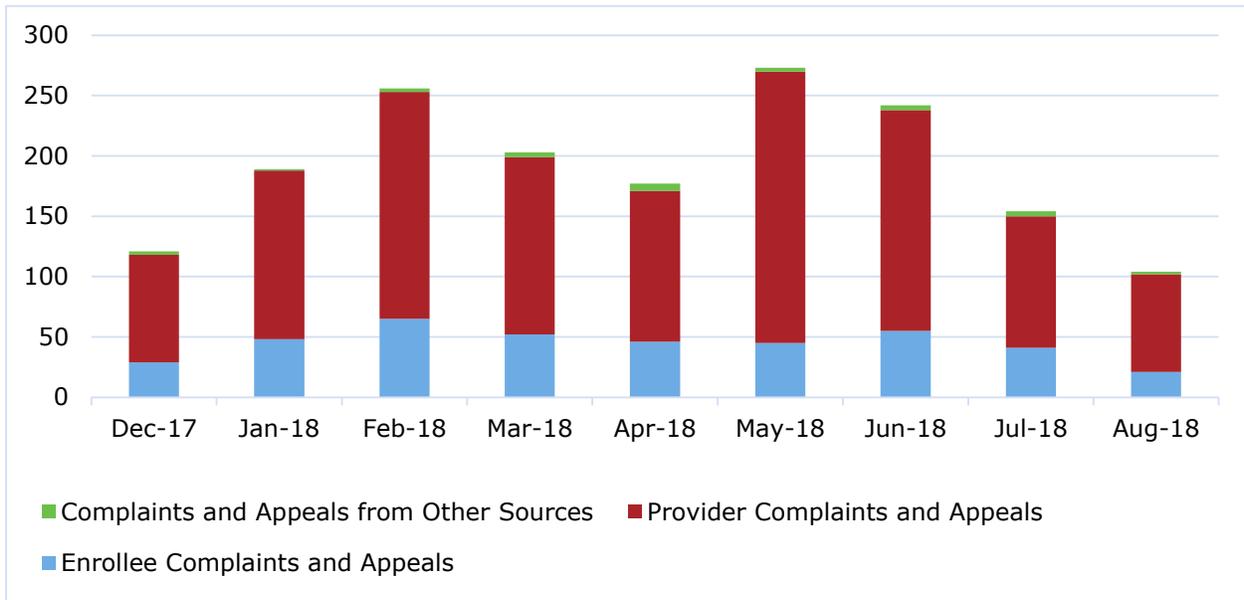


Figure 2 shows the trends in both substantiated and unsubstantiated complaints and appeals relating to pediatric therapy services for December 2017 through August 2018. For this time period, there was an average of 191 substantiated and unsubstantiated complaints and appeals per month, including:

- 45 from members or persons representing members;
- 143 from providers; and
- 3 from another source.

Even when unsubstantiated complaints are included, the number of complaints and appeals relative to the numbers of persons served is still very low.

Figure 2: Substantiated and Unsubstantiated Member and Provider Complaints and Appeals for Pediatric Therapy Services (PT, OT, and ST)



The total number of substantiated complaints and appeals represents less than 1 percent of the approximate number of members receiving pediatric therapy services. Tables 1 and 2 show complaints and appeals per member receiving pediatric therapy services. The approximate number of members served by therapy type is based on an average monthly number of children who received therapy services, using the most recent complete claims and encounter data, which is for August 2017 through January 2018.

Table 1: Rate of Substantiated Complaints and Appeals per Member Receiving Pediatric Therapy Services (OT, PT, and ST)

Medicaid Therapy Type	Approx. Average Number Members Served, <21	Complaints/Appeals Rate per Member Served
OT	24,313	0.0051
PT	19,192	0.0082
ST	46,766	0.0074

Note: Does not include open issues

Table 2: Rate of Substantiated and Unsubstantiated Complaints and Appeals per Member Receiving Pediatric Therapy Services (OT, PT, and ST)

Medicaid Therapy Type	Approx. Average Number Members Served, <21	Complaints/Appeals Rate per Member Served
OT	24,313	0.0155
PT	19,192	0.0225
ST	46,766	0.0193

Note: Does not include open issues

In addition to data on volume, HHSC monitors data on the reasons for complaints and appeals. The vast majority (93 percent) of substantiated complaints and appeals relate to authorization of and payment for pediatric therapy services. Whereas, four percent of substantiated complaints and appeals relate to availability and access to pediatric therapy services. The categories and percentages for unsubstantiated complaints and appeals are close to substantiated complaints and appeals.

Table 3: Categories of Substantiated Complaints and Appeals, December 2017-August 2018

Category of Complaints and Appeals	Percent of Total
Authorization Related (Authorization Delays and Denials)	58 percent
Availability and Access Related (Travel Distance, Limited Provider Numbers, Wait Times for Providers)	4 percent
Claims Payment Related	35 percent
Other	3 percent

Table 4: Categories of Substantiated and Unsubstantiated Complaints and Appeals, December 2017-August 2018

Category of Complaints and Appeals	Percent of Total
Authorization Related (Authorization Delays and Denials)	63 percent
Availability and Access Related (Travel Distance, Limited Provider Numbers, Wait Times for Providers)	5 percent
Claims Payment Related	29 percent
Other	3 percent

Therapy Provider Participation in Medicaid

To ensure members have access to an adequate network of therapy providers, HHSC monitors and analyzes data on enrolled and active Medicaid therapy providers, as well as data reported by the MCOs on therapy providers that are no longer participating in an MCO's network or have a waiting list for services.

Network Adequacy Contract Requirements

The HHSC contract with MCOs requires them to meet network adequacy standards for OT, PT, and ST providers. MCO network adequacy requirements may vary by county, based on its total population and population density. For all therapy provider types, members must have access to at least one network provider within the following number of miles or travel time of the member's residence:

- Members residing in a Metro County: 30 miles or 45 minutes.
- Members residing in a Micro County: 60 miles or 80 minutes.
- Members residing in a Rural County: 60 miles or 75 minutes.

For fiscal year 2018, an MCO was considered compliant if they achieved these standards for at least 75 percent of their members within a county. For fiscal year 2019, this standard increased to 90 percent.

Average MCO compliance rates per product for the last four quarters are shown in Table 5. MCOs overall are compliant with network adequacy contract requirements for therapy providers for each of the last four quarters for which data are available.

Table 5: Average MCO Network Adequacy Compliance Rates for OT, PT, and ST Providers by Program

Program	FY 2017 Quarter 4	FY 2018 Quarter 1*	FY 2018 Quarter 2	FY 2018 Quarter 3
STAR (18 MCOs)	84%	N/A	88%	89%
STAR+PLUS (5 MCOs)	91%	N/A	93%	96%
STAR Kids (10 MCOs)	93%	N/A	94%	96%
STAR Health (1 MCO)	93%	N/A	94%	97%

*Network adequacy analysis for OT, PT, and ST providers was not completed for fiscal year 2018, Quarter 1.

The evaluation of network adequacy compliance occurs at the county level. It is possible for an MCO's overall average compliance rate to be high yet still be below 75 percent in one or more counties. The number of MCOs per program that did not meet the standard in at least one county for fiscal year 2018, Quarter 3 are:

- STAR: 3
- STAR+PLUS: 4
- STAR Kids: 4
- STAR Health: 1

All instances of noncompliance were in rural counties. The total number of counties in which there was noncompliance follows:

- STAR: 62 rural counties
- STAR+PLUS: 21 rural counties
- STAR Kids: 19 rural counties
- STAR Health: 9 rural counties

Therapy Providers Currently Enrolled in Texas Medicaid

Figure 3 shows the number of providers enrolled in the Medicaid program with a therapy provider or specialty type from September 2016 to September 2018. The number of providers was relatively stable until the deadline for the Affordable Care

Act (ACA)³ reenrollment requirement in February 2017. In that month, the number of enrolled therapy providers decreased from 6,913 to 5,999 or 13 percent. The overall number of enrolled therapy providers had gradually and partially rebounded, gaining back approximately 400 of the 900 providers lost and totaling 6,393 by September 2018.

An HHSC analysis of encounters shows that the therapy providers who did not reenroll were less actively serving clients to begin with compared to therapy providers who reenrolled. Prior to the reenrollment requirement deadline, the providers who reenrolled served over four times as many clients and about double the number of services per client, on average, as the providers who subsequently disenrolled.

The trend in enrollment after the ACA deadline varies by therapy provider type. Figure 4 shows the trend in enrollment for the two main therapy provider types, home health agencies and independent therapists, which comprise almost 90 percent of therapy providers. After a 21 percent decrease following the ACA reenrollment deadline, home health agency enrollment has remained flat. In contrast, independent therapists have not only rebounded but have surpassed their pre-February 2017 numbers.

³ The ACA is a federal law that required state Medicaid agencies to revalidate the enrollment of all providers in state Medicaid programs.

Figure 3: Enrolled Medicaid Therapy Providers, September 2016-September 2018

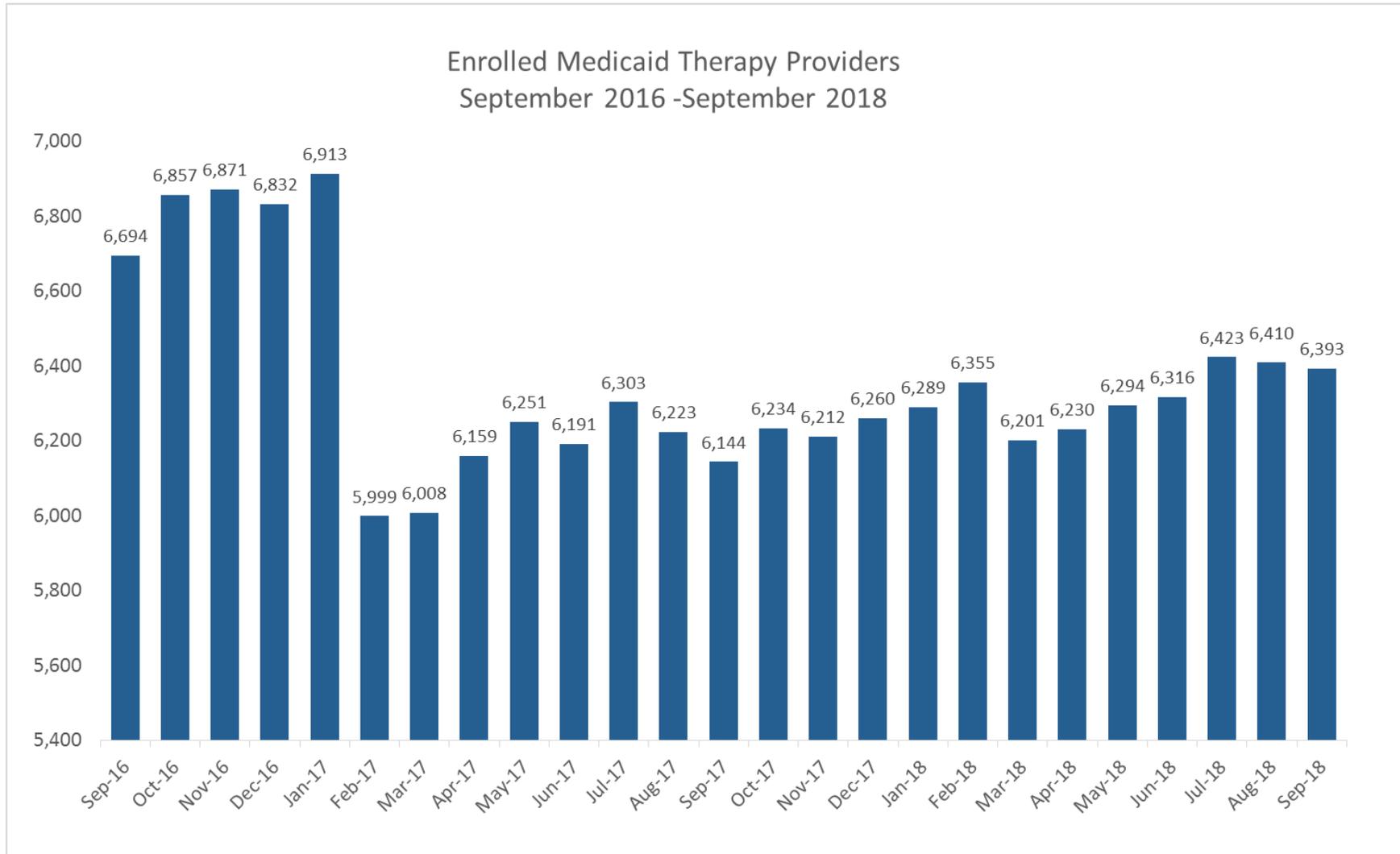
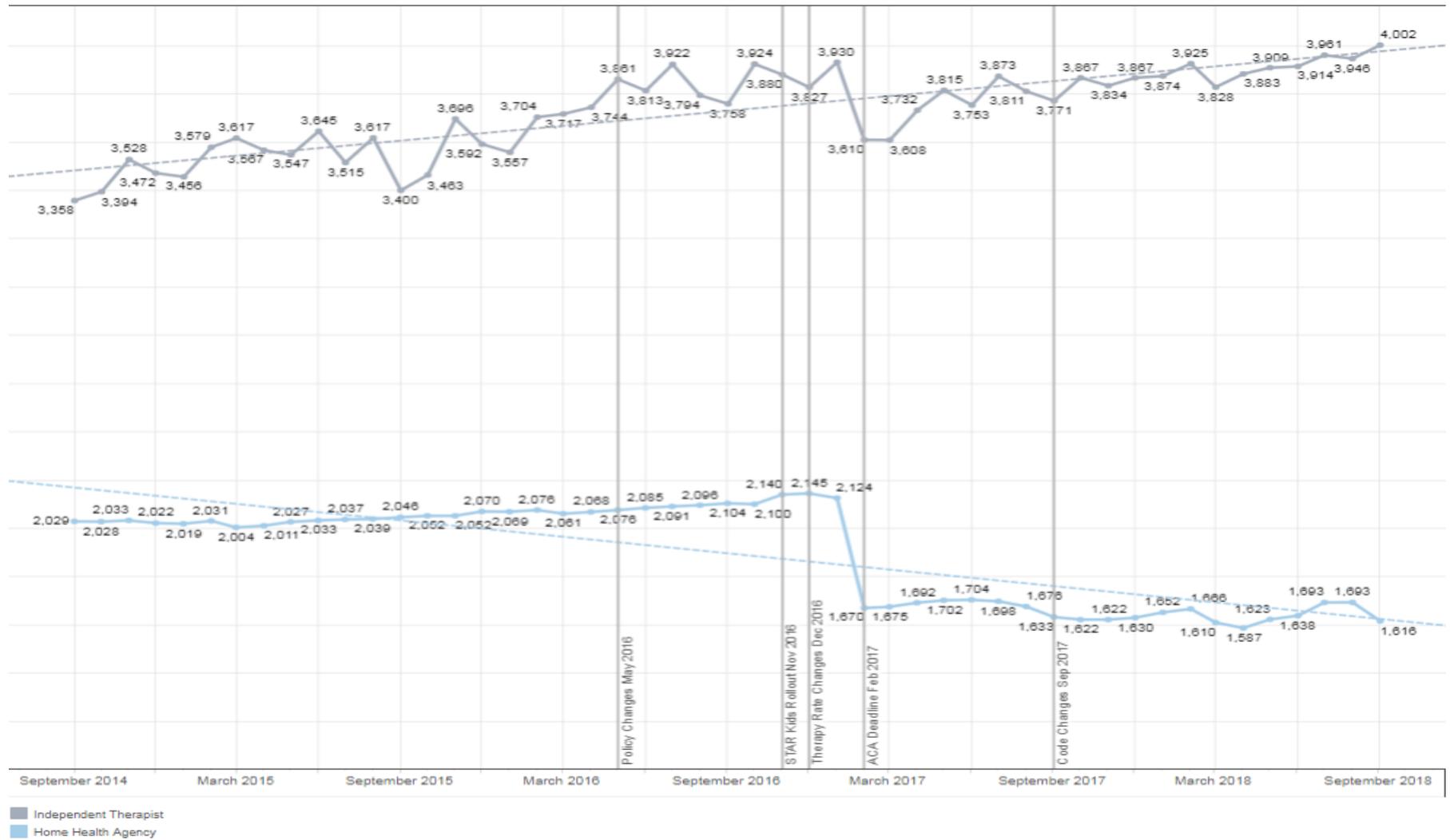


Figure 4: Enrolled Medicaid Independent Therapists and Home Health Agencies, September 2016-September 2018



Therapy Providers Active in Texas Medicaid

Although monitoring enrolled providers allows HHSC to look at the most up-to-date provider data available, it does not indicate how many providers are actually serving clients. Analyzing encounters offers a proxy for monitoring “active” providers, defined as billing for at least one encounter in a given time period. Because of retroactivity in the claims and encounters, however, analysis cannot be conducted until at least 8 months after the service is delivered to ensure accurate data. Therefore, the results discussed below only reflect data from fiscal year 2016 through fiscal year 2017, a full year earlier than the data analyzed for the enrolled providers.

From fiscal year 2016 to fiscal year 2017, there was a 20 percent decrease among active therapy providers serving children, from 4,328 to 3,477 distinct providers with at least one encounter during the fiscal year. The largest decreases were among independent therapists (15 percent) and the small group of other providers (43 percent), which includes provider types like Texas Health Steps. In comparison, the number of physicians with at least one encounter for therapy services increased 7 percent. Meanwhile, therapy providers who were serving clients in fiscal year 2017 were serving higher numbers; the ratio of clients to active providers increased from 39 in fiscal year 2016 to 47 in fiscal year 2017.

Since the encounter data reflect billing only to August 2017, they do not include the entire time period during which the number of enrolled providers rebounded after the ACA reenrollment requirement. An analysis of fiscal year 2018 encounter data when available later this year will help determine if the number of services billed increases with the reenrollment of more providers.

MCO Network Terminations of Therapy Providers

Each MCO recruits and contracts with their own network of providers. Providers may choose to stop participating in Medicaid or in an MCO network or may be involuntarily terminated by the state or an MCO. If provider participation is terminated in one MCO’s network, the provider could continue to participate in Medicaid as a provider in another MCO’s network.

MCOs reported 53 therapy provider terminations on average per month from December 2017 through August 2018 (total of 480). As shown in Figure 5, the majority of terminations were for independent therapists (70 percent) and

therapists providing services through a home health agency (13 percent). The percentage of terminated independent and group therapists (individual and group) was higher than the percentage of Medicaid-enrolled independent therapists (62 percent). Whereas, the opposite was true for home health therapy providers. Home health therapy providers comprise 26 percent of Medicaid-enrolled therapy providers.

The reasons for therapy providers terminating from MCO networks varied, but the most common involved individual providers leaving a group practice (33 percent). Other reasons included 26 percent for credentialing or re-credentialing (either the MCO did not choose to re-credential the provider or the provider did not respond to requests for re-credentialing), 17 percent related to termination of contract, and 13 percent for failing to maintain active provider number. The groupings of termination reasons are listed in Figure 6.

Figure 5: MCO Network Terminations by Therapy Provider Type

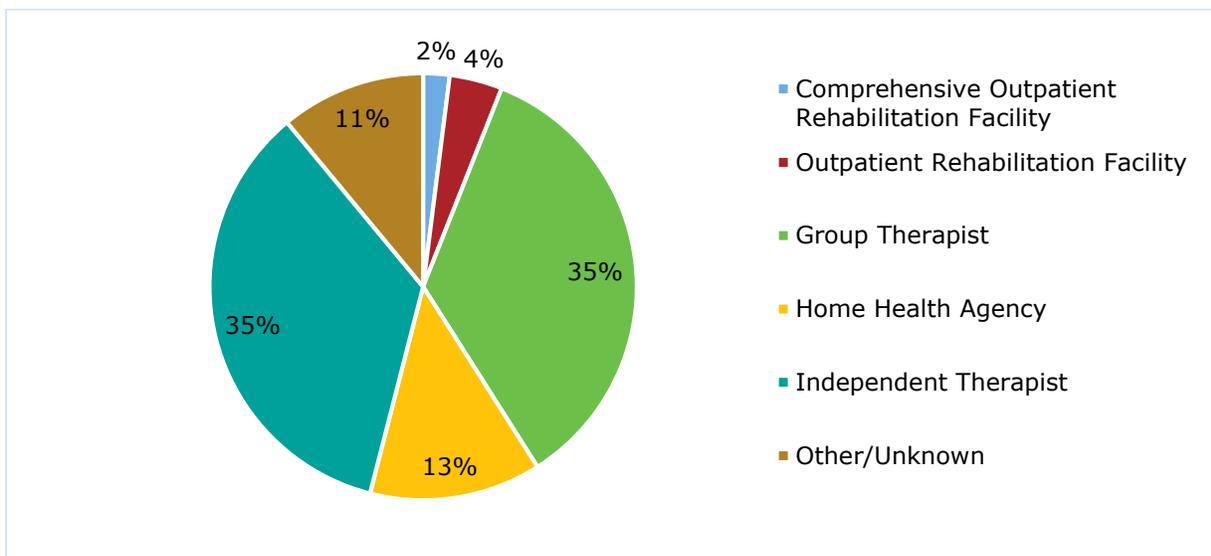
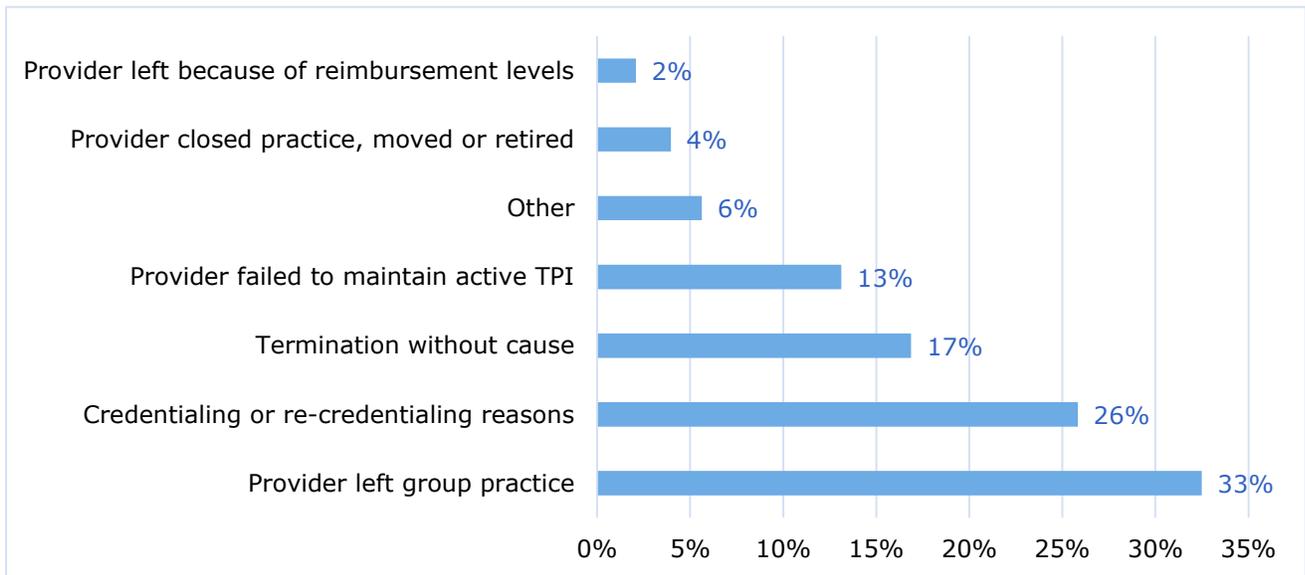


Figure 6: MCO Network Termination Reasons



Provider Wait Lists for Therapy Services

For Rider 57, MCOs report monthly to HHSC on provider waiting lists for therapy services. Waiting list is defined by HHSC as when a patient is unable to access a provider and is placed on a list of patients seeking access to that same provider and/or has been referred for therapy services but is unable to receive an initial evaluation. For each individual that is placed on a waiting list, the MCO reports: program type (STAR, STAR Kids, STAR Health); member service area; provider name and type (PT, OT, or ST); reason for the waitlist placement; whether another provider is available; and how the issue was resolved.

From December 2017 through August 2018, 4 MCOs reported waitlist information for 313 unique members. These members were reported to the MCOs by 8 therapy providers. The vast majority of these members (86 percent) were reported by one provider to two MCOs in the Harris Service Area.

Additional details on the reported waiting list data follow:

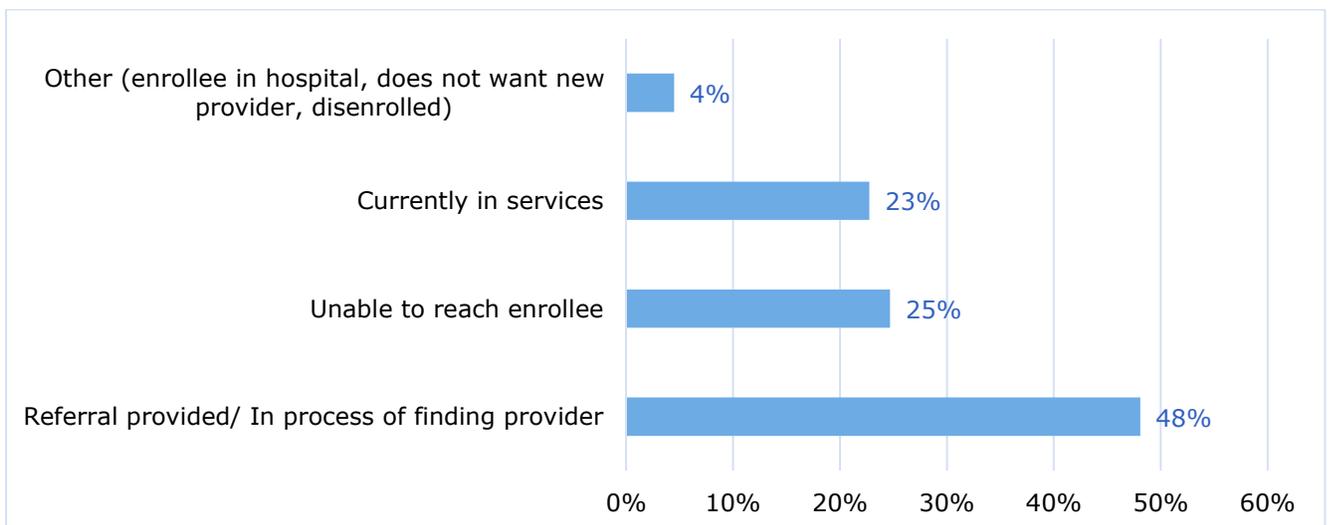
- 59 percent of individuals were in STAR Kids and 41 percent were in STAR.
- 96 percent of individuals were in Harris, 3 percent in Tarrant, and the remaining in Northeast Rural and Jefferson service areas.

- 39 percent of individuals needed speech therapy, 30 percent needed multiple therapies, 17 percent needed occupational therapy, and 14 percent needed physical therapy.
- As reported by the provider, the reason for placement on a waiting list for all individuals was lack of available staff to provide services to the enrollee.

When individuals are placed on a waiting list, they may still have access to or receive services from another therapy provider. For 94 percent of the individuals, the MCO reported that another therapy provider was available. MCOs reported that they were working on resolution for the other 6 percent of the reported cases. HHSC will review utilization data for the individuals reported to be on waiting lists to determine if they are receiving therapy services and will report on this information in the future. Typically, it takes at least 8 months for MCO encounter data to be complete and ready for analysis.

Figure 7 shows the reported resolutions for individuals placed on waiting lists for therapy services. Forty-eight percent of individuals placed on waiting lists were provided with a referral or a new provider was being located for them. Another 23 percent were receiving therapy services and for 25 percent, contact with the member had not been made by the MCO at the point-in-time of the reporting. Four percent were for other various reasons.

Figure 7: Resolutions for Individuals Placed on Waitlists



Notes: Data complete through August 2018. Many smaller categories were grouped into broad categories.

There have been challenges with collecting complete and accurate waiting list information. The process relies on MCOs communicating their waiting list reporting process to providers and therapy providers reporting to MCOs when they place an individual on a waiting list for therapy services. Some therapy providers may not be comfortable reporting this information to MCOs due to concerns that it will impact their relationships or contracts. However, it is important for the information to be reported by providers directly to the MCOs in order for the MCOs to identify the appropriate resolution and to ensure the adequacy of their networks.

There can also be consistency issues with self-reported data. While HHSC provided definitions for reporting, there may be differences across providers and MCOs in the reported waiting list data. For example, it appears there is a range of lengths of time an individual is reported to be on a waiting list from weeks to years, which makes it unclear if the waiting list data is current. HHSC will continue to work with providers and MCOs on reporting that is consistent and current.

In response to concerns from therapy providers and associations, HHSC recomunicated the process for reporting waiting list information in July and August 2018. HHSC shared with therapy provider associations the contact information for each MCO for therapy providers to use when reporting waiting list information. Many MCOs identified that web and/or fax notices had or would be sent to therapy providers on reporting waiting list information. HHSC is confirming all MCOs' processes for notifying providers of how to report any waiting list information.

HHSC is also currently working with a small number of therapy providers to validate waiting list information. These therapy providers are submitting to HHSC the waiting list information that they have reported to the MCOs. HHSC will validate that the information from the therapy providers matches the information submitted by the MCOs and reconcile any differences. HHSC will continue to work to identify any additional therapy providers that are interested in participating in the validation process.

Therapy Providers Not Accepting New Enrollees

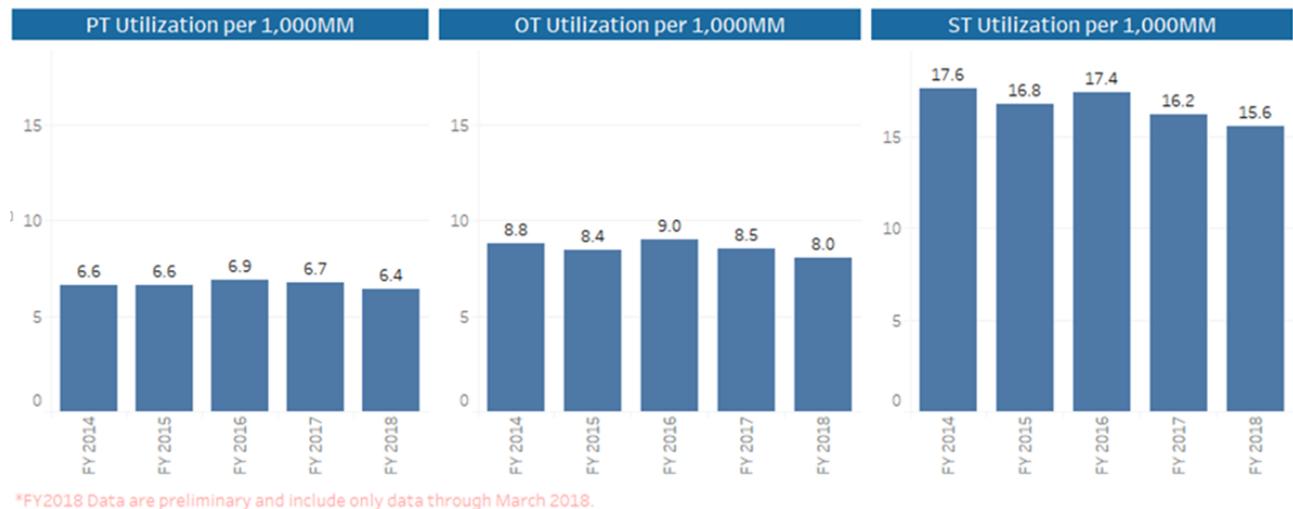
From December 2017 through August 2018, two MCOs reported that 13 therapy providers are not accepting new enrollees. Similar to waiting lists, HHSC is confirming all MCOs' processes for notifying providers of how to report this information.

Utilization of Therapy Services

Figure 8 below shows, by therapy type, the five year trends in utilization rates for individuals under 21 years old. These utilization rates reflect the number of children who received a paid therapy service relative to the counts of persons enrolled in Medicaid. Counts are represented by 1,000 member months. For example, in fiscal year 2017, there were on average approximately 16 Medicaid enrollees under 21 years old who received at least one speech therapy service per month for every 1,000 persons under 21 years old enrolled in the Medicaid program. Please note that for Figures 8, 9, and 10 the data are 8 months old to ensure that the encounters have had enough time to stabilize.

Since fiscal year 2016, the utilization rate for all three therapy types has decreased. Speech therapy and occupational therapy utilization rates have declined 10 and 11 percent from fiscal year 2016 to fiscal year 2018 to date, respectively; the PT utilization rate decrease was smaller at 7 percent. Although fiscal year 2018 is incomplete and only presents data through March, a comparison with data through March fiscal year 2016 and fiscal year 2017 shows a similar pattern.

Figure 8: Utilization by Therapy Type



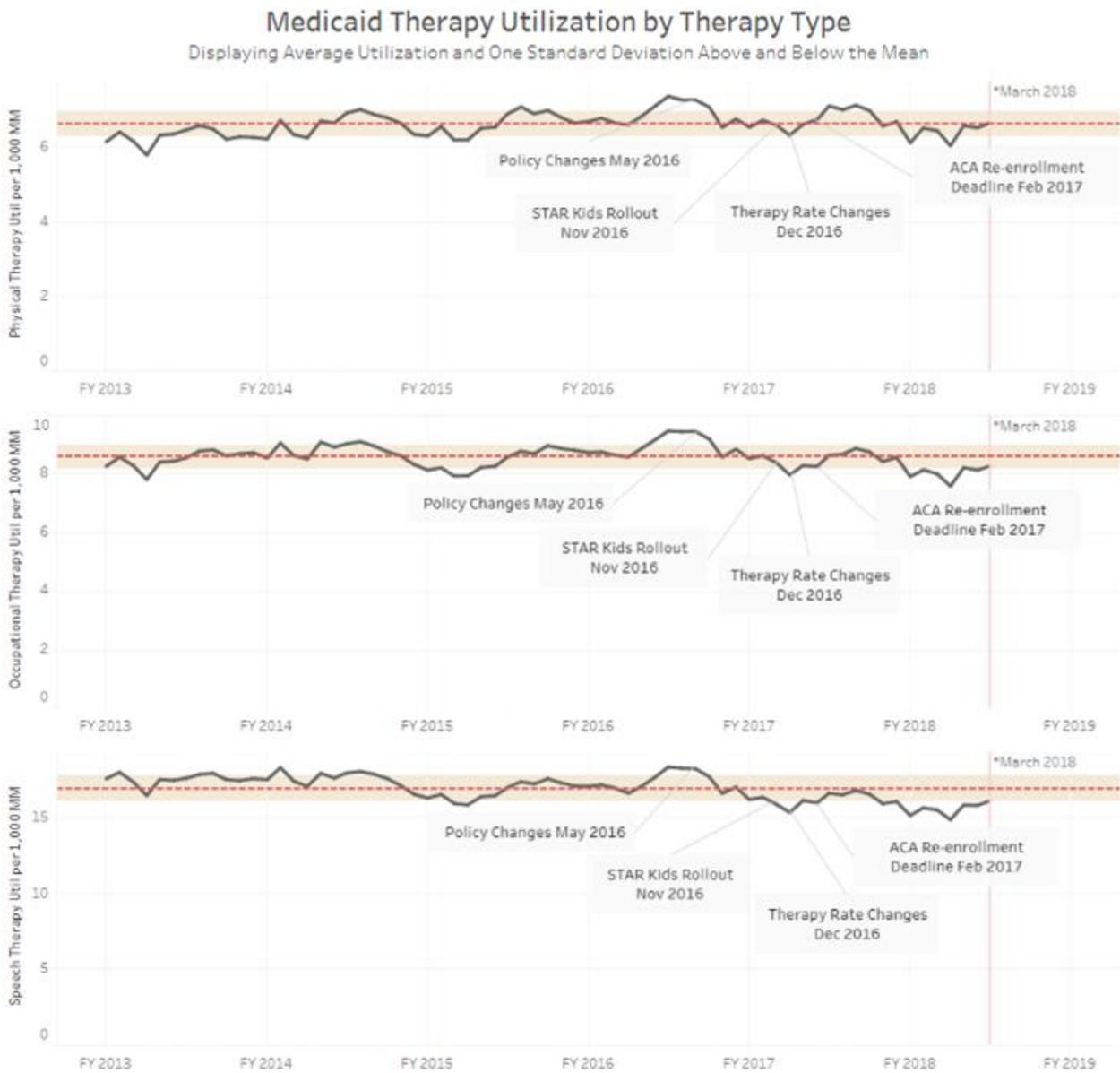
The three line graphs in Figure 9 show the utilization trends at a more detailed level, by month. Markers highlight program changes with potential impact on utilization rates. A decrease in service utilization among all three therapy types is

evident beginning in May 2016. Speech therapy and occupational therapy service utilization rates decreased 16 percent from May to December 2016; physical therapy decreased 13 percent. Not shown but analyzed as well, the total paid, paid per client, and paid per service all decreased accordingly and services per client remained relatively stable.

Several events occurred during this time period. As described previously, HHSC implemented therapy policy initiatives effective May 2016 and STAR Kids was implemented in November 2016. Although the FFS rate changes were not officially in place until December 2016, some managed care companies reduced their provider reimbursement rates in September 2016, introducing another potential contributor to the decreased utilization during this period.

Seasonality is also evident in the data, with services tending to peak in the spring-summer months and decrease in the winter. However, even accounting for seasonality, the decline for speech therapy and occupational therapy is somewhat steeper than would be expected, which suggests that policy changes during that time period may have impacted utilization levels. In general, the utilization rates since then, from December 2016 through March 2018, seem to be stabilizing.

Figure 9: Trend in the Numbers of Persons < 21 years old who Received Therapy Services per 1,000 Persons Enrolled in Texas Medicaid



* All March 2018 data are preliminary.

Data include FPS and Managed Care clients who are under the age of 21. SHARS Excluded. Submitted procedure codes excluded. The Utilization per 1,000 Member Months calculation is based on the point-in-time client eligibility from the MED ID table.

Data sources:

Eligibility: Med_ID_Full_ST/DA_Production.Eligibility_PIT_since_201109, CADS/HHSC
 PTOTST Claims: DIM_THERAPY.THERAPY_COMBINED, CADS/HHSC

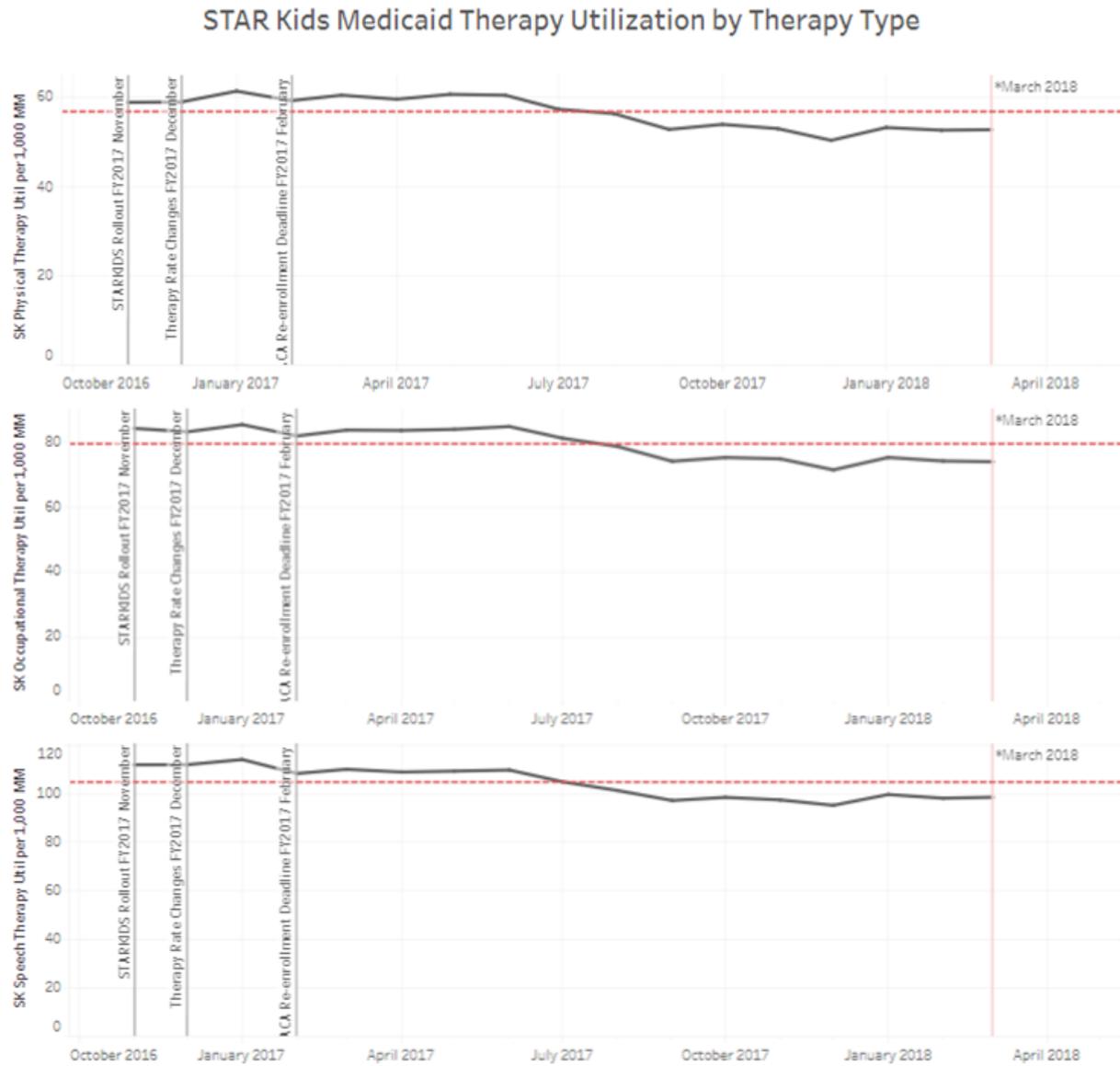
STAR Kids Utilization Rates

From June 2017 to September 2017, the rate of enrollees in STAR Kids receiving speech therapy per 1,000 members per month decreased 12 percent (109 to 97 members per 1,000 members). Similarly, both physical and occupational therapy utilization rates decreased 13 percent. Since then, from September 2017 through March 2018 (the last month for which final data are available), the utilization rates have stabilized.

The timing of the decrease in STAR Kids therapies correlates with when extended prior authorizations ended for clients transitioning to STAR Kids from FFS. When clients in FFS transitioned to STAR Kids, the end date for their prior authorizations that were active on the transition date were extended to ensure the continuity of their care. These extended authorizations ended in late spring 2017. In contrast, the utilization rates for clients under 21 years old in both STAR Health and STAR remained stable during the same time period.

Because this decrease in STAR Kids therapy utilization rates coincided with the end of extended prior authorizations, HHSC is exploring the possibility of increased service denials correlating with the observed service trends. Accordingly, HHSC recently initiated a request of therapy prior authorization data from the MCOs.

Figure 10: Trend in the Numbers of Persons <21 who Received Therapy Services per 1,000 Persons Enrolled in Texas Medicaid, STAR Kids program only



* All March 2018 data are preliminary.

Data include STAR Kids clients only. SHARS Excluded. Submitted procedure codes excluded. The Utilization per 1,000 Member Months calculation is based on the point-in-time client eligibility from the MED ID table.

Data sources:

Eligibility: Med_ID_Full_ST/DA_Production.Eligibility_PIT_since_201109, CAD5/HHSC
 PTOTST Claims: DM_THEARPY.THERAPY_COMBINED, CAD5/HHSC

5. Conclusion

Per Rider 57 requirements, HHSC has implemented a comprehensive data collection process for monitoring access to occupational, physical, and speech therapy services. The purpose of this data collection is to detect potential signs of systemic issues with access to pediatric therapy services.

The data show that there have been decreases in the total number of children receiving therapy services, which may relate to policy changes. To promote appropriate utilization, policy changes were made to ensure that recipients of therapy had a medical need for these services and that the therapy delivered was effective and aligned with current standards of practice.

The overall number of Medicaid-enrolled therapy providers has also declined, primarily due to the federal requirement for all Medicaid providers to reenroll by February 2017 or be disenrolled from the program. In recent months, independent therapists have rebounded and surpassed their pre-February 2017 numbers, while enrollment of home health agencies has remained flat at reduced levels.

Despite these trends, MCOs overall are compliant with network adequacy contract requirements for therapy providers (OT, PT, and ST) for each of the last four quarters for which data are available. In addition, member and provider substantiated complaints relating to pediatric therapy services are low.

To ensure access to and appropriate utilization of medically necessary services, HHSC is strengthening clinical oversight including for therapy services. HHSC is currently collecting therapy prior authorization data from the MCOs for future analysis. HHSC is also hiring therapists for utilization review and including a focus on the medical necessity of all types of therapy services in operational and targeted reviews.

Certain aspects of the data collection process, namely waitlist information and providers with closed panels, have been challenging. HHSC continues to work with therapy providers, MCOs, and encounters to validate data on providers that have waiting lists or are not accepting new members.

All data will continue to be collected, reviewed, and analyzed on a monthly basis. The next quarterly report will be completed by March 1, 2019.

List of Acronyms

Acronym	Full Name
ACA	Affordable Care Act
CHIP	Children’s Health Insurance Program
CORF/ORF	Comprehensive Outpatient Rehabilitation Facility/Outpatient Rehabilitation Facilities
ECI	Early Childhood Intervention
FFS	Fee-for-Service
HHSC	Health and Human Services Commission
HHS	Health and Human Services
ID	Identification
IG	Inspector General
MCCO	HHSC Managed Care Compliance and Operations
MCO	Managed Care Organization
MM	Member Months
OT	Occupational Therapy
PT	Physical Therapy
S.B.	Senate Bill
SLP	Speech-language Pathology
ST	Speech Therapy
STAR Kids	State of Texas Access Reform Kids
TPI	Texas Provider Identifier

Appendix A. Timeline of Stakeholder Engagement and Education

Month/Year	Activity
July-September 2017	HHSC developed a data collection tool that aligned with Rider 57 requirements through a stakeholder engagement process. HHSC presented and incorporated feedback, as appropriate, on the draft tool from stakeholders, including the STAR Kids Advisory Committee, Policy Council for Children and Families, Texas Autism Council, and therapy provider associations.
November 2017	<ul style="list-style-type: none"> • HHSC conducted 2 webinars for MCOs on the data collection and reporting process. • HHSC provided the final data collection tool to MCOs and stakeholders with direction.
December 2017	MCOs began reporting therapy data on a monthly basis to HHSC.
December 2017-ongoing	HHSC provides periodic technical assistance and consults with MCOs, therapy provider associations, and other stakeholders on the data collection and reporting process.
March 2018	HHSC met with therapy providers and associations who expressed concerns about aspects of data collection and reporting. In response, HHSC held a third webinar.
July-August 2018	HHSC collected from MCOs and shared with therapy provider associations how to report waitlist data and how to notify MCOs that they are not accepting new patients.
September-October 2018	HHSC worked with therapy providers to establish a process for validating the reporting chain to ensure that when providers report information to MCOs it is also reported by MCOs to HHSC.