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

June 2019
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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 Rider 57 report includes the following findings:

- Consistent with the first two reports, the volume of substantiated provider and member complaints and appeals for December 2017 through February 2019 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 significantly less than one percent of those members.

- The HHSC contract with MCOs requires them to meet network adequacy standards for therapy providers. MCO network adequacy requirements may vary by county, based on its total population and population density. For fiscal year 2019, an MCO is considered compliant if they achieved these standards for at least 90 percent of their members within a county. It is possible for an MCO’s overall average compliance rate to be high yet still be below 75 or 90 percent in one or more counties. All but one instance of non-compliance occurred in rural counties.

- Between September 2016 and March 2019, the total number of Medicaid-enrolled therapy providers declined by about 4 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

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1 A complaint or appeal where research clearly indicates HHSC policy was violated or HHSC expectations were not met.
has not rebounded, the number of enrolled independent therapists has surpassed its numbers from before the reenrollment requirements deadline.

- Managed care organizations (MCOs) reported an average of 43 therapy provider terminations per month from December 2017 through February 2019 (total of 643). The main reasons for therapy providers terminating from MCO networks included individual providers leaving a group practice (40 percent); credentialing or re-credentialing (21 percent); failing to maintain active provider number (10 percent); and termination of contract (12 percent). 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, unless their participation in the Medicaid program has been terminated.

- For December 2017 through February 2019, 6 MCOs reported waiting list information for 748 unique members by 38 providers. The vast majority of these cases were for a limited number of providers in the Harris service area. Beginning June 1, 2019, providers have the option to report enrollees placed on waitlists directly to HHSC.

- A decrease in service utilization among clients less than 21 years old for all three therapy types is evident beginning in May 2016. Average speech and occupational therapy utilization rates per 1,000 members per month declined 16 percent from May to December 2016; physical therapy decreased 13 percent. Several events occurred during this period. HHSC implemented therapy policy initiatives effective May 2016 and STAR Kids was implemented in November 2016. In previous quarterly reports, HHSC observed that the utilization rates, beginning in December 2016, appeared stable. With one month of additional data to analyze (July 2018), HHSC continues to observe this stable trend.

- 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.

The following 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:

- Review utilization data for the individuals reported to be on a waiting list to determine if they are receiving therapy services.
- Collect therapy prior authorization data from the MCOs for analysis.
- HHSC hired four additional therapists (two speech therapists and two physical therapists) for MCO utilization management oversight including a focus on the medical necessity of therapy services in operational and targeted reviews. The expanded scope of these reviews includes oversight of MCO medical necessity evaluation of speech, physical, and occupational therapy in STAR, STAR+PLUS, STAR Kids, and STAR Health programs.
- Update therapy policy to clarify the benefit and contract provisions to implement appointment availability standards.
- Develop additional training and webinars on therapy services for providers and MCOs. For example, HHSC presented a live webinar in January 2019 (with 652 attendees) to assist physical, occupational, and speech therapists in writing therapy goals in accordance with Medicaid policy. Further, HHSC therapists presented “Implementing HHSC: Medicaid Therapy Policies” at the Texas Speech and Hearing Association Convention in Fort Worth on February 28, 2019.
- Improve complaints trending and analysis, including through standardizing complaint definitions and categories; streamlining processes; and enhancing education.
- Allow providers to submit waiting list information directly to HHSC, effective June 1, 2019.
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 third 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 Legislature\(^2\) 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 and 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.

\(^2\) 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, HHSC, Rider 50(c))
• Fiscal year 2018:
  ‣ In September 2017, HHSC restored approximately 25 percent of the therapy reimbursement reductions. HHSC also made changes to 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.

Give these myriad overlapping and/or consecutive changes, which directly and indirectly relate to therapy care, it is challenging — if not impossible — to distinguish how each event may or may not have impacted the provision of therapy services.
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 discipline 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**

*For this Quarter 3 report, data for Figures 1 and 2 and Tables 1 through 4 are through February 2019. The Quarter 2 report included data through November 2018.*

Figure 1 shows trends in substantiated complaints and appeals relating to pediatric therapy services from December 2017 through February 2019. For this period, there were an average of 82 substantiated complaints and appeals per month, including:

- 68 per month from providers, mostly payment related;
● 12 per month from members or persons representing members; and
● 2 per month from other sources.

These averages are very similar to ones reported in previous Rider 57 reports. In Figures 1 and 2, the spike in October 2018 was reported by one MCO in Harris County for one provider regarding their waitlist, and this issue has been resolved.

**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 February 2019. For this period, there was an average of 205 substantiated and unsubstantiated complaints and appeals per month, including:

● 155 per month from providers;
● 46 per month from members or persons representing members; and
● 4 per month from other sources.

As presented in prior Rider 57 reports, the number of complaints and appeals relative to the numbers of persons served remains very low, even when unsubstantiated complaints are included.
The total number of substantiated complaints and appeals represents significantly 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 average number of complaints and appeals per month are for the period from December 2017 through February 2019. The average 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 encounters data, from December 2017 through November 2018. Due to a lag in the processing time needed for claims and encounters data, a shorter period range is used for the estimated average number of members served.

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

<table>
<thead>
<tr>
<th>Medicaid Therapy Type</th>
<th>Average Monthly Number Members Served, &lt;21</th>
<th>Complaints / Appeals Rate per Member Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>OT</td>
<td>24,706</td>
<td>0.0008</td>
</tr>
<tr>
<td>PT</td>
<td>19,520</td>
<td>0.0013</td>
</tr>
<tr>
<td>ST</td>
<td>48,662</td>
<td>0.0012</td>
</tr>
</tbody>
</table>

*Note: Does not include open issues.*
Table 2: Rate of All Substantiated and Unsubstantiated Complaints and Appeals per Member Receiving Pediatric Therapy Services (OT, PT, and ST)

<table>
<thead>
<tr>
<th>Medicaid Therapy Type</th>
<th>Average Monthly Number Members Served, &lt;21</th>
<th>Complaints / Appeals Rate per Member Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>OT</td>
<td>24,706</td>
<td>0.0023</td>
</tr>
<tr>
<td>PT</td>
<td>19,520</td>
<td>0.0032</td>
</tr>
<tr>
<td>ST</td>
<td>48,662</td>
<td>0.0028</td>
</tr>
</tbody>
</table>

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 (88 percent) of substantiated complaints and appeals relate to authorization of and payment for pediatric therapy services. Whereas, ten percent of substantiated complaints and appeals relate to availability and access to pediatric therapy services. The categories and percentages for combined unsubstantiated and substantiated complaints and appeals closely mirror the same as substantiated complaints and appeals.

Table 3: Categories of Substantiated Complaints and Appeals, December 2017 - February 2019

<table>
<thead>
<tr>
<th>Category of Complaints and Appeals</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization Related (Authorization Delays and Denials)</td>
<td>53.7 percent</td>
</tr>
<tr>
<td>Availability and Access Related (Travel Distance, Limited Provider Numbers, Wait Times for Providers)</td>
<td>10.0 percent</td>
</tr>
<tr>
<td>Claims Payment Related</td>
<td>34.6 percent</td>
</tr>
<tr>
<td>Other</td>
<td>1.8 percent</td>
</tr>
</tbody>
</table>

Note: Due to rounding, totals may not exactly equal 100%.
### 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 program for the last four quarters are shown in Table 5. In Quarter 1 of fiscal year 2019, STAR Health was at 87 percent or just...
below the new compliance threshold of 90 percent but became compliant in Quarter 2, at 92%.

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

<table>
<thead>
<tr>
<th>Program</th>
<th>FY 2018 Quarter 3</th>
<th>FY 2018 Quarter 4</th>
<th>FY 2019 Quarter 1 *</th>
<th>FY 2019 Quarter 2 *</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR (18 MCOs)</td>
<td>89%</td>
<td>96%</td>
<td>98%</td>
<td>91%</td>
</tr>
<tr>
<td>STAR+PLUS (5 MCOs)</td>
<td>96%</td>
<td>93%</td>
<td>94%</td>
<td>94%</td>
</tr>
<tr>
<td>STAR Kids (10 MCOs)</td>
<td>96%</td>
<td>90%</td>
<td>93%</td>
<td>96%</td>
</tr>
<tr>
<td>STAR Health (1 MCO)</td>
<td>97%</td>
<td>85%</td>
<td>87%</td>
<td>96%</td>
</tr>
</tbody>
</table>

* Note: For SFY 2019, the compliance standard increased from 75% to 90%.


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 or 90 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 2019, Quarter 2 are:

- STAR: 3
- STAR+PLUS: 5
- STAR Kids: 3
- STAR Health: 1

All instances of noncompliance were in rural counties, with one exception. The total number of counties in which there was noncompliance was considerably lower than in Quarter 1, as follows:

- STAR: 66 rural counties, and 1 micro county
- STAR+PLUS: 33 rural counties
- STAR Kids: 22 rural counties
- STAR Health: 10 rural counties
Therapy Providers Currently Enrolled in Texas Medicaid

For this Quarter 3 report, data on enrolled providers is included through March 2019. The Quarter 2 report included data through December 2018.

Figure 3 shows the number of providers enrolled in the Medicaid program with a therapy provider or specialty type from September 2016 to March 2019. 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 has gradually and partially rebounded to 6,401 by March 2019.

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 relatively flat. In contrast, independent therapists have not only rebounded but have surpassed their pre-February 2017 numbers.

In the past several months (January to March 2019), enrollment for independent therapists increased modestly from 3,914 to 4,017 (2.6%), whereas home health agency enrollment decreased modestly from 1,651 to 1,599 providers (3.1%)

\(^3\) 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 - March 2019
Figure 4: Enrolled Medicaid Independent Therapists and Home Health Agencies, September 2016 - March 2019
Therapy Providers Active in Texas Medicaid

Changes were not made to this section of the report because updated data is not available until Summer 2019.

Although monitoring enrolled providers allows HHSC to look at the most up-to-date provider data available, it does not indicate how many providers actually serve clients. Analyzing encounters offers a proxy for monitoring "active" providers, defined as billing for at least one encounter in a given 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 period during which the number of enrolled providers rebounded after the ACA reenrollment requirement. An analysis of fiscal year 2018 encounter data when available (Summer 2019) will help determine if the number of services billed increases with the reenrollment of more providers.

MCO Network Terminations of Therapy Providers

For this Quarter 3 report, data on terminated providers is included through February 2019. The Quarter 2 report included data through November 2018.

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.

On average per month, MCOs reported 43 therapy provider terminations from December 2017 through February 2019 (total of 643). As shown in Figure 5, the terminations by provider type were 40 percent for independent therapists, 32 percent for group therapists, and 10 percent for therapists providing services through a home health agency. The percentage of terminated independent and group therapists combined (72 percent) was very close to the percentage of all Medicaid-enrolled independent therapists (71 percent). Whereas, home health therapy providers comprise 29 percent of Medicaid-enrolled therapy providers yet were only 10 percent of terminated therapists.

**Figure 5: MCO Network Terminations by Therapy Provider Type, December 2017 - February 2019**

The reasons for therapy providers terminating from MCO networks varied, but the most common involved individual providers leaving a group practice (40 percent). Other reasons included 21 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), 12 percent related to termination of contract, and 10 percent for failing to maintain active provider number. The groupings of termination reasons are listed in Figure 6.
Figure 6: MCO Network Termination Reasons, December 2017 - February 2019

Provider Wait Lists for Therapy Services

For this Quarter 3 report, data on provider wait lists is through February 2019. The Quarter 2 report included data through November 2018.

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 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.

A total of 748 unique individuals were reported as being on a waitlist from December 2017 through February 2019. They were reported by 38 providers to 6 MCOs. Additional details on the reported waitlist data follow:

- 61 percent of individuals were in STAR Kids and 38 percent were in STAR
- 95 percent of the individuals were in the Harris Service Area, and 4 percent in the Tarrant Service Area
- 41 percent of individuals needed speech therapy, 42 percent needed multiple therapies, 15 percent needed physical therapy, and 2 percent of individuals needed occupational therapy
When individuals are placed on a waiting list, they may still have access to or receive services from another therapy provider. MCOs reported that there was a referral, or the member was currently in services, for about 63 percent of these individuals. MCOs reported they were working on resolutions for 3 percent. For the remaining 34 percent, MCOs reported they were unable to reach the member, the member was ineligible for Medicaid, the member opted to remain on the waitlist, or other reasons. MCOs reported that there was another provider available in about 95 percent of the reported cases.

Figure 7 shows the reported resolutions for individuals placed on waiting lists for therapy services.

Figure 7: Resolutions for Individuals Placed on Waitlists

<table>
<thead>
<tr>
<th>Resolution</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to Another Provider</td>
<td>59.0%</td>
</tr>
<tr>
<td>Left Message</td>
<td>23.9%</td>
</tr>
<tr>
<td>Unable to Reach Member</td>
<td>4.4%</td>
</tr>
<tr>
<td>Currently in Services</td>
<td>4.0%</td>
</tr>
<tr>
<td>Working on resolution</td>
<td>3.3%</td>
</tr>
<tr>
<td>Member opted to remain on wait list.</td>
<td>0.8%</td>
</tr>
<tr>
<td>Member eligibility termed or not found in system</td>
<td>1.7%</td>
</tr>
<tr>
<td>Unknown</td>
<td>2.1%</td>
</tr>
<tr>
<td>Provider Education</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Note: Data complete through February 2019. Many smaller categories were grouped into broader 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.

To help address these challenges, HHSC began allowing providers to report waitlist information directly to HHSC, effective June 1, 2019. HHSC will notify the appropriate MCO of any waitlist information received to facilitate appropriate MCO resolution. Providers also continue to have the option to report waitlists directly to MCOs.
HHSC has provided the following stakeholder communications about this option:

- May 23, 2019 – Notice sent to MCOs;
- June 3, 2019 – Provider notice posted on the Texas Medicaid Healthcare Partnership (TMHP) website;
- June 7, 2019 – Notice provided to therapy associations for distribution to their members.
- June 14, 2019-July 5, 2019 – Provider notice will appear on provider remittance and status reports.

Utilization Analysis of Individuals Reported to be on Waiting Lists for Therapies

The wait list data alone does not indicate whether clients may have received therapy services from an alternate provider while waiting for services from a particular provider. In the last quarterly report, HHSC examined the therapy encounters for 311 clients who were on a wait list through August 2018. For this report, HHSC conducted the same analysis for 630 clients on the wait list through November, which includes the clients in the original study.

Altogether, 29 providers provided data, with 2 providers contributing most of the clients in the sample. Because of the small number of providers participating in the survey and the fact that the providers are not randomly selected, this is not a representative sample of providers. Therefore, generalizing the results to all clients on wait lists for therapy should be done with caution.

Of the 630 children, 197 (31 percent) received services within 2 months, and 244 (39 percent), including the aforementioned 197, received services within 6 months of being placed on the wait list. These percentages are very similar to those calculated in the original study with approximately half of the clients.

HHSC will begin a process of sharing data with MCOs on members for which utilization data is not found and require MCOs to report their findings on these

4 Therapies received through the School Health and Related Services program (SHARS) were excluded from the analysis. If the client requested multiple services, as long as a portion of the request was met the client was considered to have received services.
members. While these results cannot be generalized to all providers, HHSC will continue to analyze utilization of individuals reported to be on waiting lists.

**Therapy Providers Not Accepting New Enrollees**

*For this 3rd quarterly report, data is through February 2019. The 2nd quarterly report included data through November 2018.*

From December 2017 through February 2019, 2 MCOs reported that 8 therapy providers are not accepting new enrollees.
Utilization of Therapy Services

For this Quarter 3 report, utilization data are through August 2018. The Quarter 2 report included data through June 2018.

Figure 8 below shows, by therapy discipline, 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.

Year over year, from fiscal year 2016 to fiscal year 2018 to-date (July 2018), average monthly utilization of pediatric therapy services has trended down. Speech therapy utilization rates per 1,000 members per month declined 7.5 percent, occupational therapy utilization rates declined 7.8 percent, and physical therapy utilization rates declined by 5.8 percent. Virtually all the decrease occurs from state fiscal year 2016 to 2017. With data for the entire fiscal year of 2018 data almost complete, thus included in the calculation, the decrease from fiscal year 2017 to 2018 is diminishing.
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 disciplines 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 period. 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, suggesting policy changes during that period may have impacted utilization levels. Utilization rates since then, from December 2016 through August 2018, have stabilized.
Figure 9: Trend in the Numbers of Persons < 21 years old who Received Therapy Services per 1,000 Persons Enrolled in Texas Medicaid

Medicaid Therapy Utilization by Therapy Type
Displaying Average Utilization and One Standard Deviation Above and Below the Mean

* All August 2018 data are preliminary.
Data includes FPS and Managed Care clients who are under the age of 21. SHARS 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/DM_Production/Eligibility_PIT_since_201105.CADSS/MHSC
PT07/PT Claims: DM_THERAPY_THERAPY_COMBINED.CADSS/MHSC
STAR Kids Utilization Rates

*For this Quarter 3 report, STAR Kids utilization data are through July 2018. The Quarter 2 report included data through June 2018.*

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 (110 to 97 members per 1,000 members). Similarly, both physical and occupational therapy utilization rates decreased 13 percent. Since then, from September 2017 through July 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 period.

Because this decrease in STAR Kids therapy utilization rates coincided with the end of extended prior authorizations, HHSC explored the possibility of increased service denials correlating with the observed service trends. Accordingly, HHSC collected and analyzed therapy prior authorization data from the MCOs described below.

STAR Kids Speech Therapy Prior Authorizations (PAs) and Denials

In October 2018, HHSC requested PA data for speech therapy from the MCOs serving STAR Kids and STAR Health members. Data were requested in aggregate form for the timeframe of September 2016 through February 2018. Because of the decrease in STAR Kids utilization of therapies, the findings described in this report focus on the STAR Kids speech therapy data.

Without member level data, it is not possible to verify the data or look at patterns of services delivered. That said, observations of interest include the following:

- Most of the requested services were approved: 87% in SFY 2018 Q2 (December 2017 through February 2018).
• Overall, the number of speech therapy PAs processed and the number denied were stable after the first quarter of data. (The first quarter is an outlier since STAR Kids rolled out in the last month.)

• The proportion of denials due to medical necessity, as opposed to administrative reasons, has been increasing for speech therapy, from 30% in SFY 2017 Q1 (September 2016 through November 2016) to 63% in SFY 2018 Q2 (December 2017 through February 2018).

• Most of the appeals and fair hearings related to speech therapy upheld the initial determination, which was in favor of the MCO’s decision (66% and 89%, respectively).

• In general, appeals for speech therapy denials increased over the analyzed time frame.
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 August 2018 data are preliminary.

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

Data sources:
Eligibility: Med_ID_FullST/DA_Production/Eligibility_PIT_since_2011103, CADS/HSC
PTTST Claims: DM_Therapy/Therapy_Combined, CADS/HSC
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. 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.

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 have been mostly compliant with network adequacy contract requirements for therapy providers (OT, PT, and ST) for each of the last four quarters. This is true even with the higher minimum compliance standard (raised from 75% to 90%) for the current and prior quarter. The counties where MCOs have difficulties meeting network adequacy standards are rural counties, but MCOs were non-compliant in fewer counties during the most recent quarter than in the prior quarter. 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 has hired four therapists (two speech therapists and two physical therapists) for utilization reviews with a focus on the medical necessity of all types of therapy services in operational and targeted reviews.

HHSC analyzed six quarters of STAR Kids speech therapy prior authorization data from the MCOs. Overall, the number of speech therapy PAs processed and the number denied were stable after the first quarter. However, the proportion of PA
denials due to medical necessity, as opposed to administrative reasons, increased over the study period. In the last quarter reviewed (December 2017 through February 2018), approximately 87% of requested services were approved.

Certain aspects of the data collection process, namely waitlist information and providers with closed panels, have been challenging. HHSC continues to work on validation processes to ensure accuracy of these data. This includes validation of information reported by therapy providers to MCOs, directly with MCOs on their reported data to HHSC, and crosschecking individuals on waitlists with utilization data. In this area, additional HHSC actions include:

- Allowing therapy providers to report waitlist information directly to HHSC, in addition to continuing to report it to MCOs.
- Performing quality assurance of the MCO reported data and addressing any identified issues.
- Sharing data with MCOs on members reported on waiting lists and for whom no utilization data is found. MCOs will report back to HHSC their actions on these members.
- Continued data quality checks on data received from MCOs.

All data will continue to be collected, reviewed, and analyzed monthly. The next quarterly report will be completed in September 2019.
# List of Acronyms

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

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Activity</th>
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<tbody>
<tr>
<td>July-September 2017</td>
<td>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.</td>
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<tr>
<td>November 2017</td>
<td>• 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.</td>
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<tr>
<td>December 2017</td>
<td>MCOs began reporting therapy data monthly to HHSC.</td>
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<tr>
<td>December 2017-ongoing</td>
<td>HHSC provides periodic technical assistance and consults with MCOs, therapy provider associations, and other stakeholders on the data collection and reporting process.</td>
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<tr>
<td>March 2018</td>
<td>HHSC met with therapy providers and associations who expressed concerns about aspects of data collection and reporting. In response, HHSC held a third webinar.</td>
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<tr>
<td>July-August 2018</td>
<td>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.</td>
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<tr>
<td>September-October 2018</td>
<td>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.</td>
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<tr>
<td>November 2018-February 2019</td>
<td>HHSC worked with stakeholders to ensure accurate submission of required data, and fielded information requests and general inquiries. 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.</td>
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<td>Month/Year</td>
<td>Activity</td>
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<td>June-July 2019</td>
<td>HHSC communicated to MCOs and therapy provider associations, as well as instructed TMHP to post a banner message, on the option for providers to directly report waiting list information to HHSC.</td>
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