HHSC: STAR Kids Managed Care Advisory Committee, June 10th, 2020

The STAR Kids Managed Care Advisory Committee, created by Senate Bill 7 of the 83rd Texas Legislature (Regular Session), advises HHSC on the establishment and implementation of the STAR Kids Medicaid managed care program. The STAR Kids Medicaid managed care program is legislatively mandated to provide services for children with disabilities who have Medicaid coverage to improve coordination and customization of care, access to care, health outcomes, cost containment and quality of care. The STAR Kids model must require a health home, care management, and provide comprehensive coordination of acute care and long-term service benefits.

Elizabeth Tucker, Chair Advocate for children with special healthcare needs Austin, TX **Rahel Berhane, M.D.** Physician Provider Austin, TX **Josh Britten** Durable Medical Equipment and Services Representative Amarillo, TX **Rosalba Calleros** Family Member Austin, TX **Catherine Carlton** Family Member Arlington, TX **Terri Carriker** Family Member Austin, TX **Tara Hopkins** Managed Care Organization Representative, Dental Austin, TX **Alice Martinez** Advocate San Antonio, TX	**Glen Medellin, M.D.** Physician San Antonio, TX **Ricardo Mosquera** Family Member Houston, TX **Katherine Ostermaier, M.D.** Managed Care Representative Houston, TX **Jose Pereida** Parent Robstown, TX **David Reimer** Pediatric Therapy Provider, PDN Dallas, TX **Blake Smith** Therapy Provider Denison, TX **Shawnett Viani** Advocate Denton, TX **Beanca Williams** Home and Community-Based Provider Stafford, TX

Call to order and Roll Call. The meeting was called to order by Elizabeth Tucker, Chair. A quorum was established.

Approval of March 4, 2020, meeting minutes. The minutes were approved as written.

COVID-19 update. Links to key information can be found at the following links:
Client Information on HHSC Website
Provider COVID Section on the HHSC Website

Provider COVID information on TMHP Website

Dr. Van Ramshorst provided a brief update with Michelle Erwin. He provided some high-level world-wide statistics. For more detailed information, see *Texas Insight's COVID-19 Reports.*

As of June 10, 2020:

- 77,253 cases in Texas
- 1,526 new cases per day, up from 1,300 the week prior
- Steady increase in hospitalizations
- Deaths: 1,853 as of June 9, 2020

Dr. Van Ramshorst provided an update on testing, vaccination, and treatment nationally. He mentioned Pediatric Inflammatory Multisystem Syndrome Temporally associated with SARS-CoV-2 (PIMS-TS). See: https://www.news-medical.net/news/20200608/New-syndrome-associated-with-SARS-CoV-2-is-new-and-distinct-from-Kawasaki-disease.aspx

Ms. Erwin covered some of the flexibilities implemented by HHSC. (See *Texas Insight COVID-19* reports for further detail on HHSC actions). These could be extended through July.

- Appeals and fair hearings and continuation of benefits, including more time to request or investigate related a fair hearing; follow-up changes;
- Service Coordination activities have been allowed through telehealth;
- Program assessment waivers;
- Children that are aging out will stay in STAR Kids for now (EPSDT access);
- Interest lists releases are being examined;
- Extend electronic visit verification (EVV) flexibilities;
- Extension of prior authorizations (PAs) for 90 days (as of end of June);
- Client signature not required for DME;
- Extend MDCP program eligibility for 90 days with a plan set to expire at the end of June;
- Provider enrollment flexibilities allowed;
- Continuing remote delivery through telemedicine;
- Allow initial assessments for MDCP through telehealth, but not reassessments;
- Ensuring continued access to services; and
- Allow Texas Health Steps visits via telemedicine as long as the child is over 24 months.

HHSC is taking these extensions on a month-by-month basis.

Questions/Answers/Comments

In response to a question about critical needs patients and prior authorizations (Title XIX evaluation), HHSC stated they are not considering changing the six-month period requirement to 12 months. They are supportive of expanding telemedicine/remote services.

DME providers experience huge amounts of new title XIX assessments that may not be conducted now. There is ongoing conversation regarding prior authorizations.

In response to a question about special needs children and COVID-19, HHSC stated that they do not have the numbers on children with special needs. HHSC will check with DSHS on this.

The Chair stated that as we move forward, things are changing. Families will be scared to take their children out in public. Does the state have the ability to implement flexibilities even if there is no emergency declaration in place? HHSC stated that they have authority for certain actions. It depends on the flexibilities being pursued. Sometimes, administrative rules are waived. For others, CMS approval was required. HHSC is looking at places where programmatic changes should be made. There is a way to get authority for changes from the federal government outside of the pandemic. The Chair stated that this advisory committee could make recommendations regarding the flexibilities that might need continuation. The 90 days means that the extensions will be good through the end of September in most cases or three months after the authorization was to expire.

Durable Medical Equipment Administrative Simplification Pilot in STAR Kids. Dr. Van Ramshorst stated that we are still in the planning phases. He stated there is a new team member who has joined the team, bringing an academic and scientific rigor to the work, looking at outcomes.

The pilot looks at the authorization period for a specific service in a specific population. They are looking at enteral feeding supplies and tubing supplies for managing a D-tube. They are looking to change authorization to 12 months from six. They are working with OIG and federal partners. They cannot eliminate the Title XIX form.

The pilot will be voluntary and could be region-specific. They want to look at outcomes for suppliers, families, and others in the service chain. They also want to look at client satisfaction. The pilot would go on for 18 months. There would be a pre- and post-study.

They are hoping to have the pilot proposal for the next STAR Kids Advisory Committee meeting.

An HHSC staff member stated that it is important to maintain an adequate network of providers.

Questions/Answers/Comments
West Texas volunteered to be involved in the pilot.

On the Medicare side, there has been price-cutting in DME. Texas Medicaid is hurting on DME providers.

The Chair asked what voluntary means. Dr. Van Ramshorst stated that they are thinking about asking to see who wants to participate. They would find a way if people do not want to participate.

Health and Human Services Commission (HHSC) Updates. For the detailed tables discussed, please follow the link. Michelle Erwin and staff provided the information.

Stephanie Stephens is the new Medicaid Director.

Procurement in the Dallas Area. Children's Medical Center Health Plan pulled out of STAR Kids (serving slightly half of the children with 640 MDCP Children). There was an emergency procurement effort and Aetna Better Health of Texas will be under contract by October 1, 2020. Families will receive an information letter and can choose between Amerigroup or Aetna. There will be targeted outreach during the transition. Members can switch at any time consistent with established processes. They are ensuring continuity of care through exchange of information between the former MCO and Aetna including provisions for out-of-network providers.

Questions/Answers/Comments
Concern was expressed about workflow and authorization of services related to behavioral health services. (This was not included in the agenda and it can be added to the next agenda.) The Chair asked HHSC to look into this.

The Chair inquired about continuity of care for the 640 children on MDCP and transition. HHSC stated that they are addressing this.

Legislative Updates:
MDCP Peer to Peer review SB 1207 requirements. Staff read quickly through their process.

Bill Summary: Many children enrolled in the Medically Dependent Child Program (MDCP) are also covered by commercial primary insurance or another primary insurance, meaning the Medicaid managed care program provides secondary coverage. In these situations, Medicaid is always the payer of last resort. Before a managed care organization (MCO) will act on a claim or an authorization, it must first be acted upon by the commercial primary if there is one. This can create significant delay between the determination on the part of the primary, notification to the provider, re-submittal by the provider to the MCO, and the time the MCO processes the claim. Many times these authorizations are time-sensitive, and children have had major surgeries cancelled, critical medications denied, and medically necessary services or equipment significantly delayed, resulting in the child's condition deteriorating and causing further complications or increased ER visits.

S.B. 1207 puts in place parameters and framework to remove some of the barriers that are causing delays, conflicts, and lack of coordination, and will require the agency and managed care organizations to implement policies and procedures that will (1) allow maximum utilization of commercial insurance coverage, thus increasing cost-effectiveness; and (2) reduce unnecessary delays and conflicts in processing the child's Medicaid claims under the managed care program.

S.B. 1207 amends current law relating to the operation and administration of Medicaid, including the Medicaid managed care program and the medically dependent children (MDCP) waiver program.

Fiscal Analysis: The bill requires the Health and Human Services Commission (HHSC) to contract with an external medical review organization to review the resolution of certain appeals of a managed care organization's (MCO's) adverse determination on the basis of medical necessity or an HHSC denial of eligibility based on medical or functional need when the recipient or applicant affirmatively requests an external medical review and would require HHSC to conduct annual surveys and focus groups through the external quality review organization (EQRO) and to calculate an MCO's performance on performance measures using available data if HHSC determines through the EQRO's initial report on the STAR Kids managed care program that additional data and research are necessary to improve the Medically Dependent Children waiver program (MDCP). The bill would require HHSC to submit a quarterly report about access to care for recipients in MDCP. The bill also requires HHSC to develop and maintain a list of services that are not traditionally covered by primary health benefit plans (PHBP) and that a Medicaid managed care organization (MCO) may approve without coordinating with the issuer of the PHBP and that could be resolved through third party liability resolution. The bill would require HHSC to provide certain information on a recipient's third party insurance, including benefits, limits, copayments, and coinsurance. The bill requires HHSC to develop and implement a process to allow a provider who primarily provides services to a recipient through PHBP coverage to receive Medicaid reimbursement for services ordered, referred, or prescribed regardless of whether the provider is enrolled as a Medicaid provider.

The bill took effect September 1, 2019.

For MDCP only during the home visit, the reviewer will capture the information with the patient. The review of the results will not delay the start of services, and submission to TMHP will occur within 72 hours of assessment. MCOs will reach out to the TMHP nurse and determine why there was a denial. The MCO will share the results with the member and then a peer to peer review will occur if desired by the member(s). There is a section on the form for the treating physician of choice to clearly reach out for peer to peer. The MCO must ensure that this does not impair the right to an appeal.

Questions/Answers/Comments

The Chair stated that the 72 hours does not allow the family time to look at the assessment and make decisions. She encouraged making this longer.

A comment was made about allowing a patient stay with a provider. Ms. Erwin stated that this is a coordination of benefits issue and is a different part of SB 1207.

Section of 1207, Coordination of Benefits. HHSC has a draft version the chapter relating to coordination of benefits and will be provided to the group AFTER THE MEETING. It will include:

- Evidence of noncoverage
- Working the vendor drug and operations and inspector general
- DRAFT Language for section G provided to this committee after the March meetings. Feedback was collected from the committee and MCOs.

There are time limits they are trying to manage as well.

STAR Kids Quality Measures. The EQRO did a series of reports and they are working on implementing their recommendations and the part of 1207 that looks at quality monitoring

Purpose

- To provide committee members with an update on the proposed quality outcome measures for the STAR Kids program.
- To obtain feedback from members on the proposed measures.

Importance of the Measures

- Helps evaluate quality of the STAR Kids program
- Identify and fill gaps in the national standardized sets to ensure we are evaluating what is important to members

Texas's EQRO Study Purpose

- Evaluate the STAR Kids program
- Recommended quality measures for the STAR Kids population

Methods

- Assessed current STAR Kids measures
- Conducted extensive research and evaluated national measures with EQRO
- Collaborated with EQRO and external stakeholders for input

Sources for Measures

Multiple National Measures are Used

- Healthcare Effectiveness Data and Information Set (HEDIS) measures
- 3M Potentially Preventable Events (PPE) measures
- Agency for Healthcare Research and Quality (AHRQ) measures
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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- National Survey of Children's Health (NSCH) survey measures
- National Core Indicator (NCI) measures
- Screening Assessment Instrument (SK-SAI)

Proposed Measures (if there is not a national measure)

Domains

- Individual Characteristics
- Environmental Factors
- Utilization
- Person-centered care
- Care Coordination
- Managed Care
- Health and Social Outcomes

On the following charts, the question numbers might be off because of changes to the assessment.

Table 1. Individual Characteristics

Proposed	SAI Question
Race/ Ethnicity	A4
Functional status	D3

Table 2. Environmental Factors

Proposed	SAI Question
Other children in the household	E4a-b

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Table 3. Utilization

Proposed	SAI Question
Planned/unplanned physician visits	D10d, D10e
Planned/unplanned hospitalizations	D10a, D10b

Table 4. Person-Centered Care

Proposed	SAI Question
Medical home	A24a
Person-centered assessment	A6c, A6d, A6e
Meeting care goals	C3[R]
Tailored individual services plan	C5[R]

Table 5. Care Coordination

Proposed	SAI Question
Contact from service coordinators	C4[R]
Alternate plans for care	E6

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Table 6. Managed Care

Proposed	SAI Question
Primary care provider change	PCP_Changed

Table 7. Health and Social Outcomes

Proposed	SAI Question
Functional status ADL	F3
Functional status IADL	F2
Independence in making decisions	F4
Making self understood	F5
Comprehension in understanding others	F6
Employment Status	B11
Social relationship, participating in activities	E7
Caregiver well-being	E3
Schooling and day activities	B1
Special education in general education environment	B3a

Next Steps

- Obtain feedback from the committee

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- Edit and revise SAI measures based on input from stakeholders
- Collaborate with EQRO to:
    - Create an annual data feed of SAI and ISP results
    - Evaluate the care/outcomes domain

Resources:

- https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/External-Quality-Review/RPC-memo-2017-EQRO-summary-of-activities.pdf
- https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/STAR-Kids-Pre-Implementation-Report-052617.pdf

Questions/Answers/Comments/Input/Feedback

There are so many pieces of data in the SKSAI and the focus was on utility in service planning. And then also outcomes. Considerations have also been around

- Do the time frames need to be changed?
- Should rewording be considered

The partnership with the EQRO efforts is really appreciated

Dental Procurement Plan. Kate Layman made the presentation. HHSC is procuring the DMO contracts. The RFP was sent out and an announcement of awards was made in 2019. The two existing DMOs will be included with UnitedHealthcare Dental.

September 2020 is the operational start date. The change is that there will be a third choice. Continuity of care will be maintained and people will not be moved from one DMO to another unless they choose to move to another DMO. Letters have been sent out to this effect. There is a default methodology similar to the medical side. If no choice is made, there is a default process. For a limited period of time, new members will be enrolled by default with United (unless someone in the family already is enrolled with a DMO). This would be for people who have no connection with a DMO at present, and they are newly enrolled.

There is information on the HHSC website. Providers are encouraged to reach out to United.

HHSC Announcement: HHSC intends to award three dental managed care contracts to DentaQuest USA Insurance Company, Inc., MCNA Insurance Company, and United Healthcare Insurance Company for an initial contract period of three years. The award notices will be posted on the Electronic State Business Daily (ESBD) when the contracts are fully executed. That notice of award will trigger the period in which a protest may be filed in accordance with 1 T.A.C. §391.405.

The statewide Dental Program provides dental services to over 3 million Texas Children's Medicaid (Medicaid) and Children's Health Insurance Program (CHIP) eligible children. The principal objective of the Dental Program is to provide quality, comprehensive dental services in a manner that improves the oral health of the Members through preventive care, health education, early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target populations. Dental Members' primary and preventive Medicaid and CHIP dental services are provided statewide through dental contractors. Each dental contractor is responsible for contracting with general dentists, pediatric dentists and dental specialists to create a delivery network.

Desk reviews are underway for DMOs. There is a contingency plan being developed regarding onsite readiness activities due to COVID-19 issues. There are outreach activities underway and a robust communication strategy was developed. They are on track to reach the operational start date.

Questions/Answers/Comments
None offered.

Quarterly Therapy Access Monitoring Report. **Judy Temple and Jimmy Blanton made the presentation.**

Legislative Direction
The 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission [HHSC], Rider 15) requires:

- 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 to submit quarterly reports to the Legislative Budget Board and the Governor beginning December 30, 2019.

New Rider 15 Requirements (with new requirements)

15. Medicaid Therapy Services Reporting. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, the Health and Human Services Commission (HHSC) shall submit, on a quarterly basis, the following information related to pediatric acute care therapy services (including physical, occupational, and speech therapies) by service delivery area and information regarding 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 using a standard definition of complaint as defined by HHSC;

(c) Provider and member appeals by disposition received by HHSC Health Plan Management, and resolution of the appeals;
(d) The number of pediatric acute care therapy provider terminations and the reason for identified terminations;
(e) The utilization of pediatric acute care therapy services by therapy type and provider type;
(f) The number of members on a waiting list, defined as 1) those who have been referred to a provider or Medicaid Managed Care Organization, but there is not a treating therapist to perform an initial assessment, and 2) those who have been assessed, but are unable to access pediatric acute care therapy services due to insufficient network capacity; and
(g) The number of pediatric acute care therapy providers no longer accepting new clients and the reason for identified panel closures.

HHSC shall submit the quarterly reports to the Legislative Budget Board and the Governor in a format specified by the Legislative Budget Board no later than 30 days after the end of each fiscal quarter. HHSC shall ensure standardized collection of data to obtain all data used in the report. HHSC shall develop a process for pediatric therapy providers to submit data directly to HHSC for items (f) and (g), using feedback obtained from relevant stakeholders.

More granular reporting

- By Service Delivery Area (SDA)
- By provider type
- Appeals

Consistent definitions

- Standard definition of complaint
- Definition for "waitlist":
  - Member has been referred to a provider or Medicaid Managed Care Organization, but there is not a treating therapist to perform an initial assessment
  - Member has been assessed but is unable to access pediatric acute care therapy services due to insufficient network capacity
  - Providers may submit waitlist cases directly to HHSC

Recent Findings March 2020

This Rider 15 report includes the following findings:

- The volume of substantiated provider and member complaints and appeals remains stable and is low compared to the overall number of members receiving therapy services.
  - The total number of substantiated complaints and appeals represents significantly less than one percent of those members.
- HHSC's contract with MCOs requires them to meet network adequacy standards for therapy providers.

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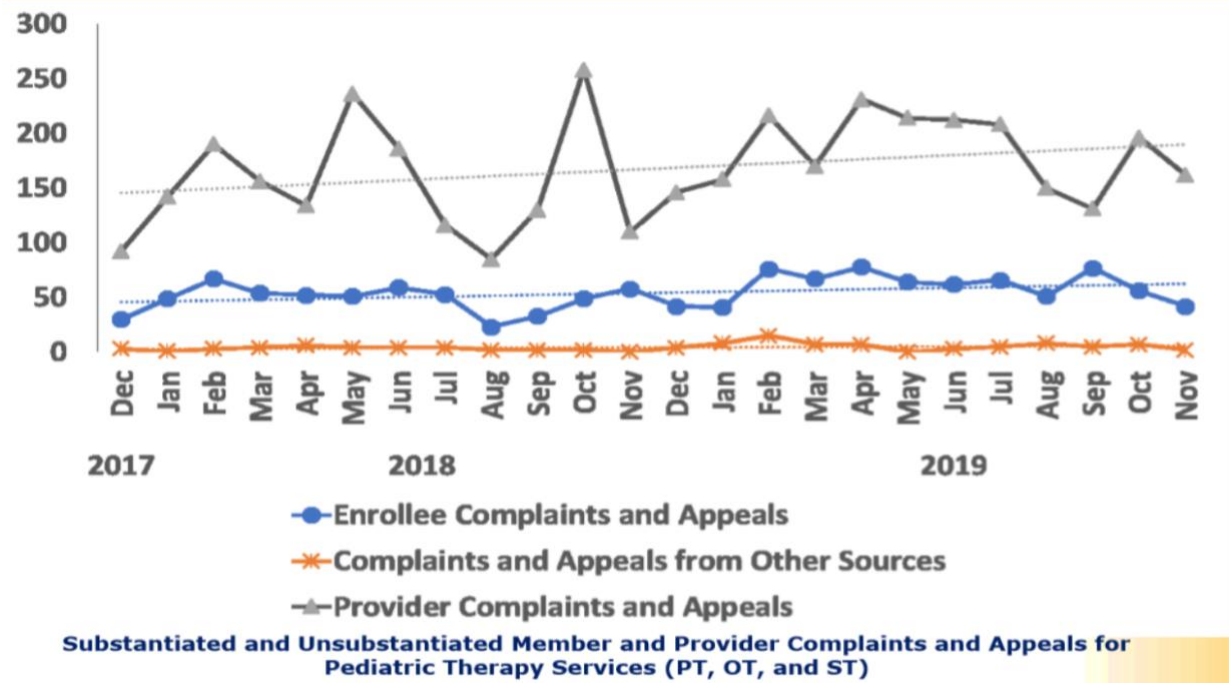
  - Overall, from fiscal year 2019 Quarter 2 through fiscal year 2020 Quarter 1, all programs (STAR, STAR+PLUS, STAR Kids, and STAR Health) met the 90 percent threshold.
  - Most instances of non-compliance occurred in the Medicaid Rural Service Area West (MRSA West).
- The number of enrolled therapy providers was stable until the deadline for Affordable Care Act (ACA) reenrollment in February 2017.
- In that month, the number of enrolled therapy providers decreased 13 percent.
- Therapy provider enrollment rebounded significantly by December 2019, to only one percent below peak.
- A decrease in active providers (providers who billed for services) began in May 2016 when therapy policy changes related to documentation and prior authorization were implemented.
  - The number of providers active each month decreased by 30 percent from April 2016 to December 2017, then stabilized before decreasing another 6 percent from December 2017 to June 2019.
  - The downward trend for active therapy providers mainly reflects the decrease in the number of active independent therapists; the trends for other provider types are flat since September 2014.
- MCOs reported an average of 42 therapy provider terminations per month from December 2017 through November 2019 (total of 1,003).
  - The main reasons therapy providers terminated from MCO networks include:
    - Individual providers leaving a group practice (41%)
    - Credentialing or re-credentialing (19%)
    - Termination of contract (15%)
    - Failure to maintain an active provider number (9%)

Note: If a provider leaves one MCO's network, the provider could continue to participate in another MCO network, unless their participation in the Medicaid program has been terminated.

- Beginning June 1, 2019, providers were given an option to submit waiting list data directly to HHSC, rather than MCOs, corresponding to a significant increase in reporting.
- Reports are now occurring from more providers and across more regions in Texas.
- HHSC is working to improve monitoring of MCO performance at following-up and resolving wait list cases
- Generally, the rate at which children receive a therapy service has remained near long-term historical trends, as measured from 2014, with volatility in the rate just prior to (upward) and for about two years after (mostly downward) May 2016.
  - HHSC began implementing therapy policy initiatives in May 2016 and rolled out the STAR Kids program in November 2016.
- Across program and therapy types, many fluctuations in utilization rates appear transitory, with three notable exceptions:

  - STAR Kids utilization rates declined 8 - 9 percent depending on the type of therapy service from June through September 2017, before leveling off.
    - This decline correlates with the end of a temporary policy extending the length of existing prior authorizations for individuals moving into the new program
- Across program and therapy types, many fluctuations in utilization rates appear transitory, with three notable exceptions (cont.):
  - Speech therapy rates remained below trend for most months spanning mid-year 2016 through mid-year 2018, before recovering
  - The utilization rates of speech therapy and occupational therapy for STAR and STAR Health are increasing as of June 2019.
- 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 2020-21 General Appropriations Act, House Bill 1, 86th Texas Legislature, Regular Session, 2019 (Article II, HHSC, Rider 47) provided funding to increase in-home pediatric therapy rates by 10 percent and to raise reimbursement for therapy assistants across all settings from 70 percent to 80 percent of the licensed therapist rate.
- The new rates were effective September 1, 2019.

Complaints/Appeals



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

Complaint Categories

Category	Percent of Total
Authorization Related (Delays and Denials)	60.5%
Availability and Access (Travel Distance, Limited Providers, Wait Times)	5.2%
Claims Payment Related	32.5%
Other	1.8%

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

Time and Distance

Program	FY 2019 Q2	FY 2019 Q3	FY 2019 Q4	FY 2020 Q1
STAR (18 MCOs)	91%	92%	93%	92%
STAR+PLUS (5 MCOs)	94%	94%	91%	92%
STAR Kids (10 MCOs)	96%	90%	96%	96%
STAR Health (1 MCO)	96%	95%	94%	96%

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

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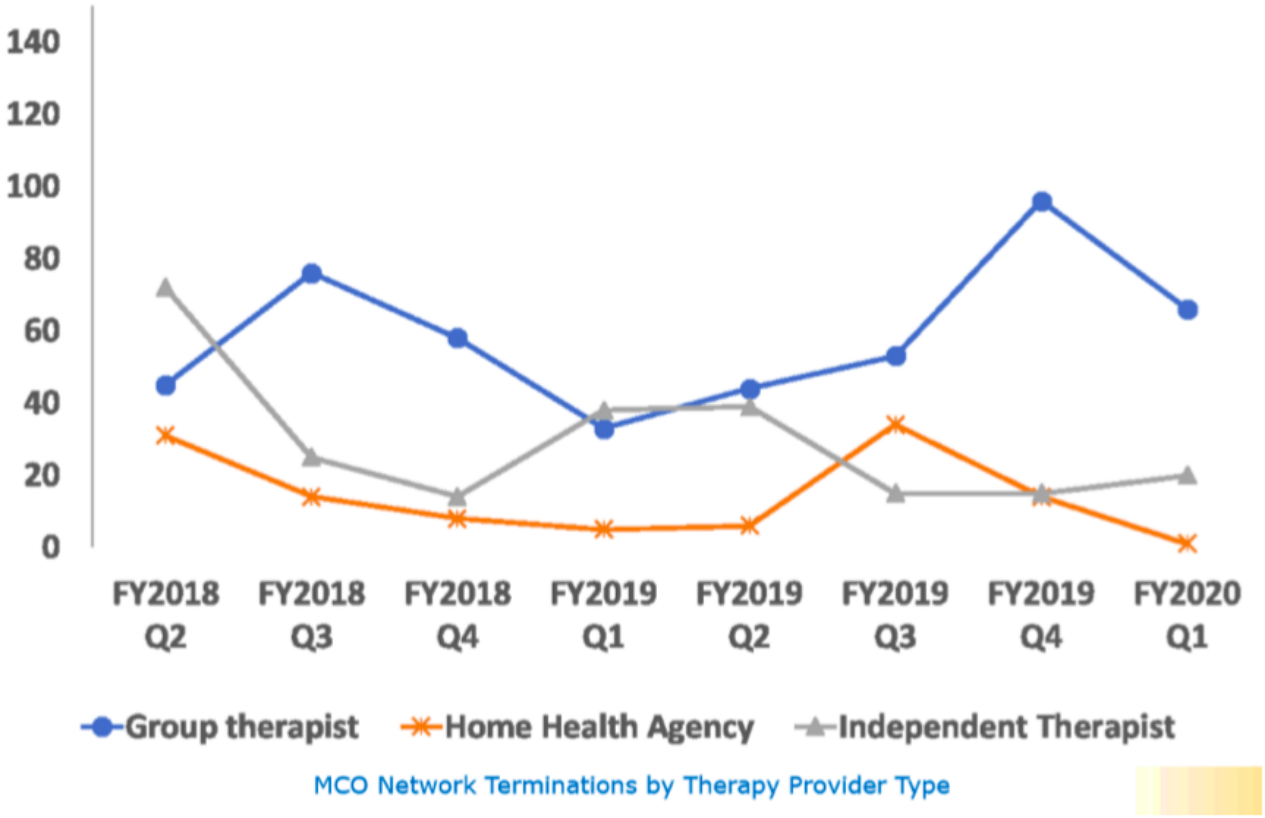
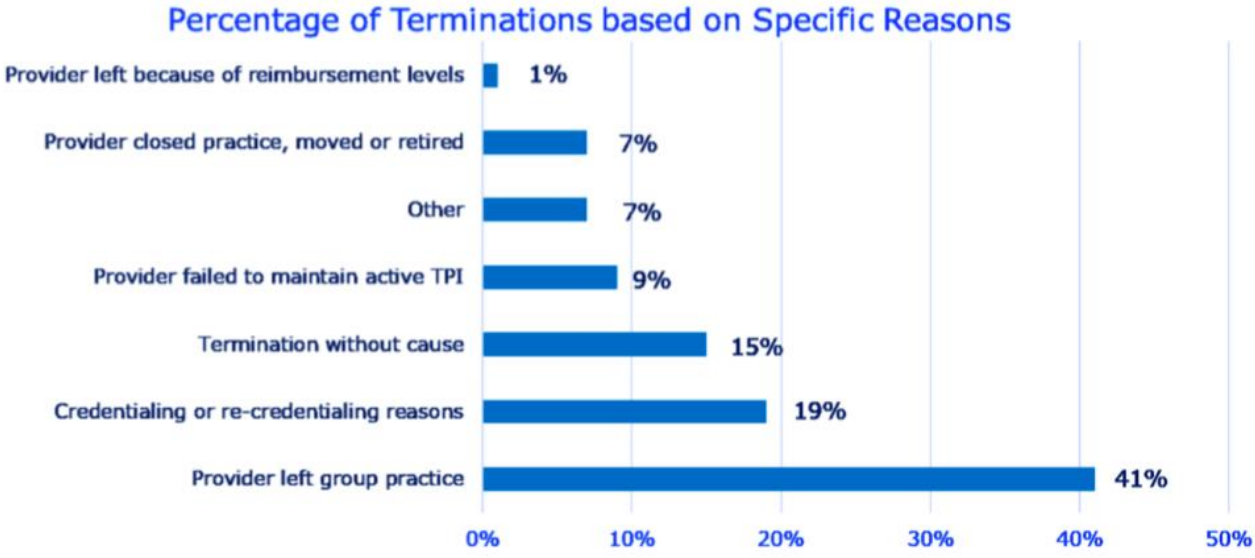
Terminations



Termination Reasons



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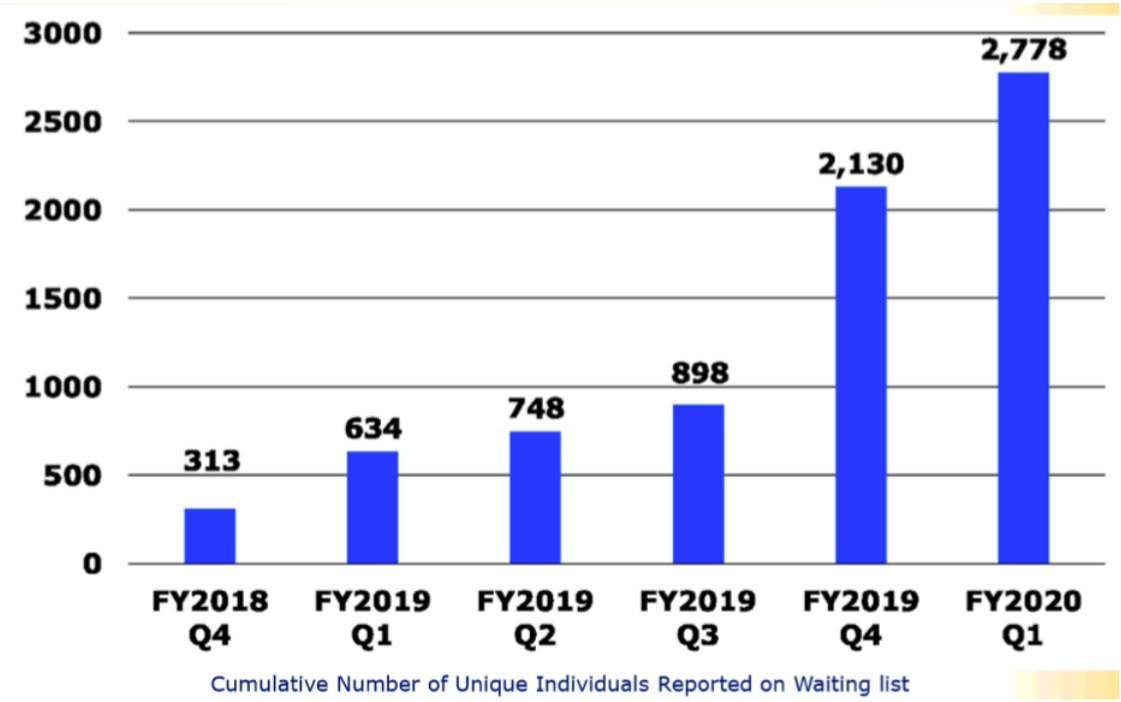
Waitlist Reports



Cumulative Number of Unique Individuals Reported on Waiting list

Waitlist Resolutions

Resolutions for Individuals Placed on Waiting lists.

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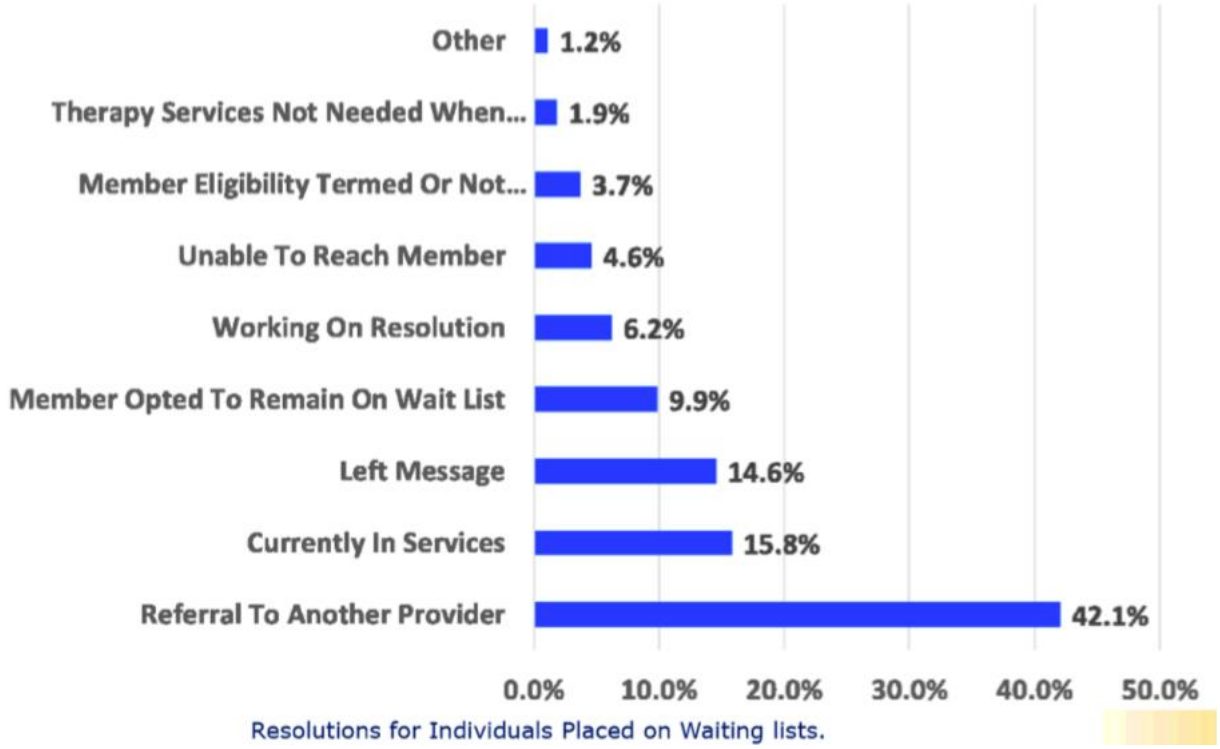
Resolutions (STAR Kids)



Service Utilization:

- Service utilization is reported as "rates," the number of unique members who received a service per 1,000 members.
- Big picture take-aways:
  - Significant increase in utilization for all 3 therapy types immediately prior to therapy policy changes in May 2016.
  - The rate quickly declined upon implementation.
  - For PT and OT, the rate settled at a level consistent with historical trends and has generally stayed in that range.
  - However, for ST, the rate declined below the previous trend and remained below trend nearly two-years before recovering.
  - The most currently available utilization rates are at or above trend for all three services.

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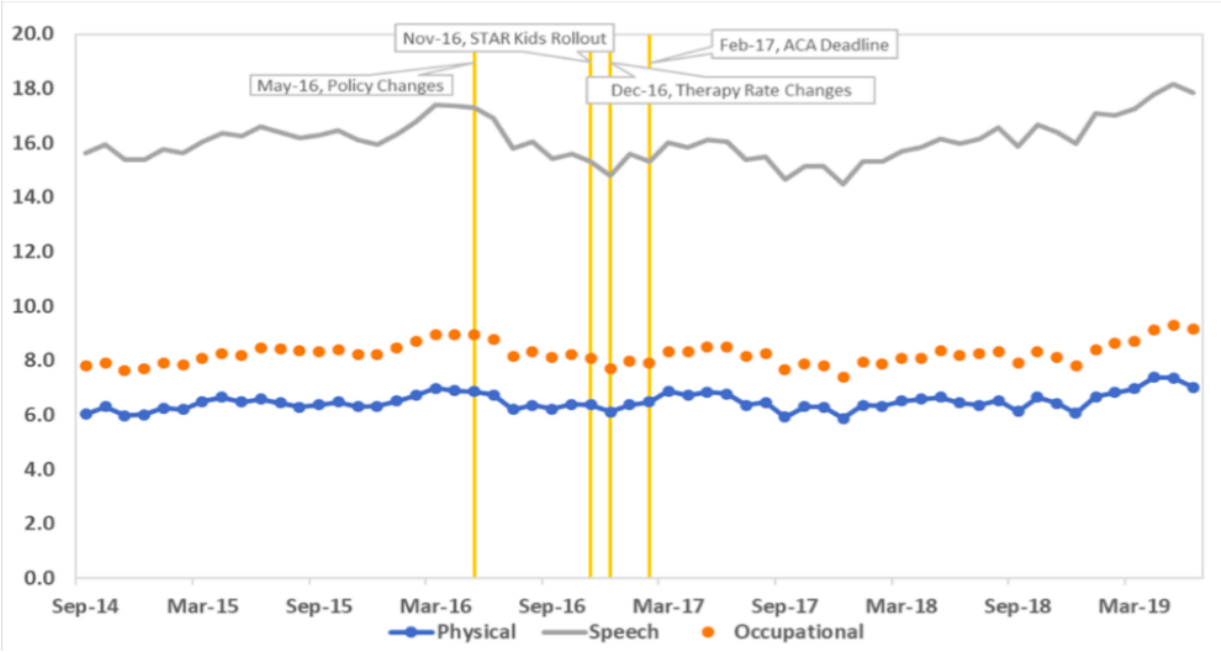
Service Utilization Rates Overall: Sep 2014 – Jun 2019



Service Utilization Rates STAR Kid

- As reported since the first Rider 57 report, from June 2017 to September 2017, STAR Kids showed a decline in utilization for all three therapy types.
- The timing of the decrease correlated with when extended prior authorizations ended for clients transitioning to STAR Kids from FFS.
- Since then, from September 2017 through March 2019, the utilization rates have remained level.

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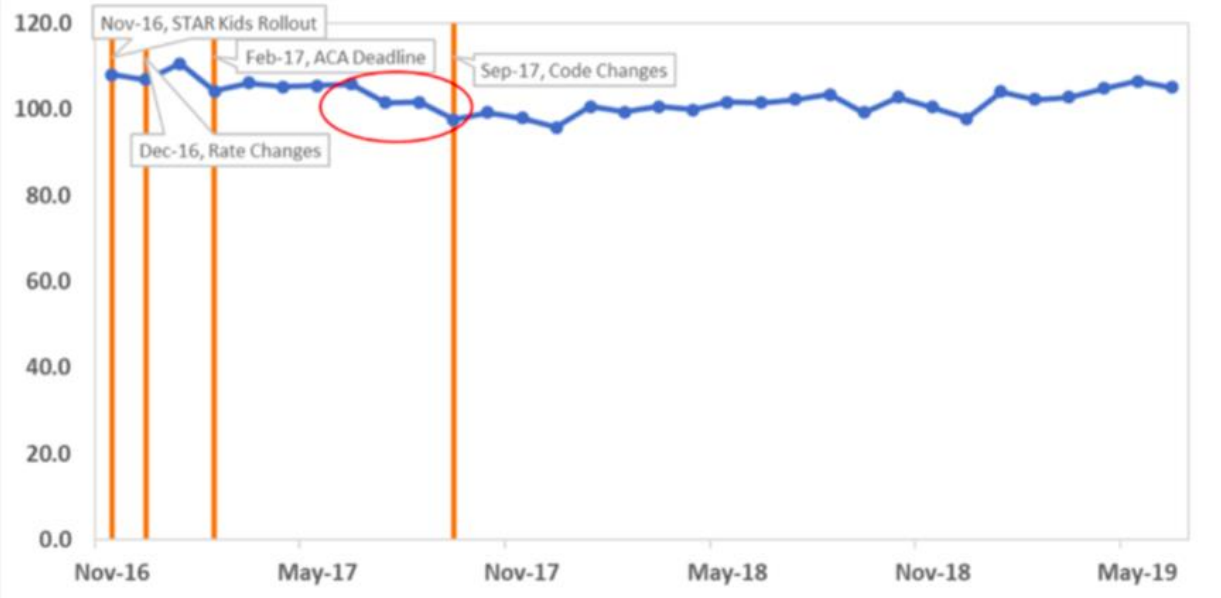
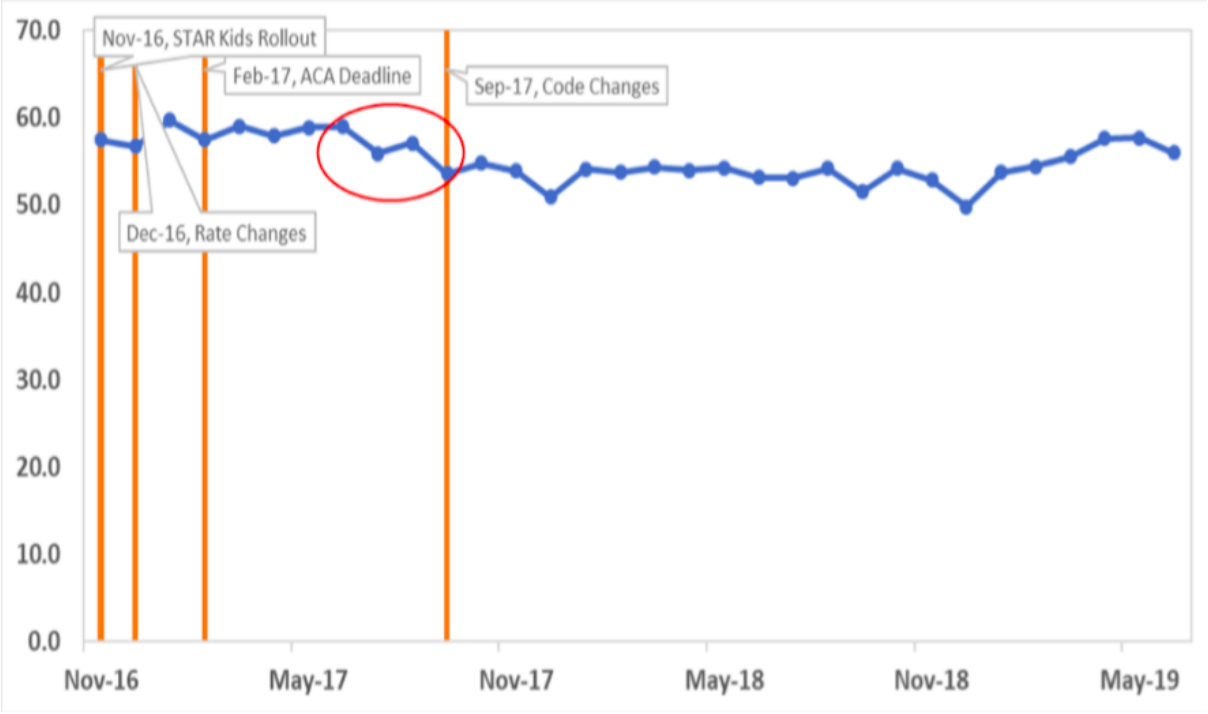
Service Utilization Rate STAR Kids: Speech Nov 2016 – Jun 2019



Service Utilization Rate STAR Kids: Physical Nov 2016 – Jun 2019



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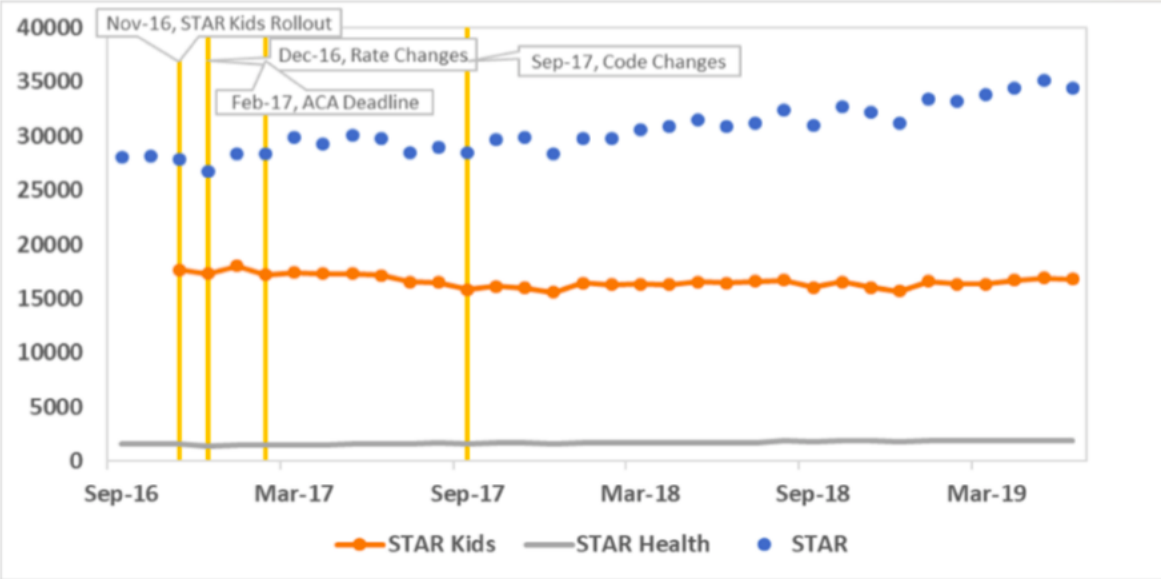
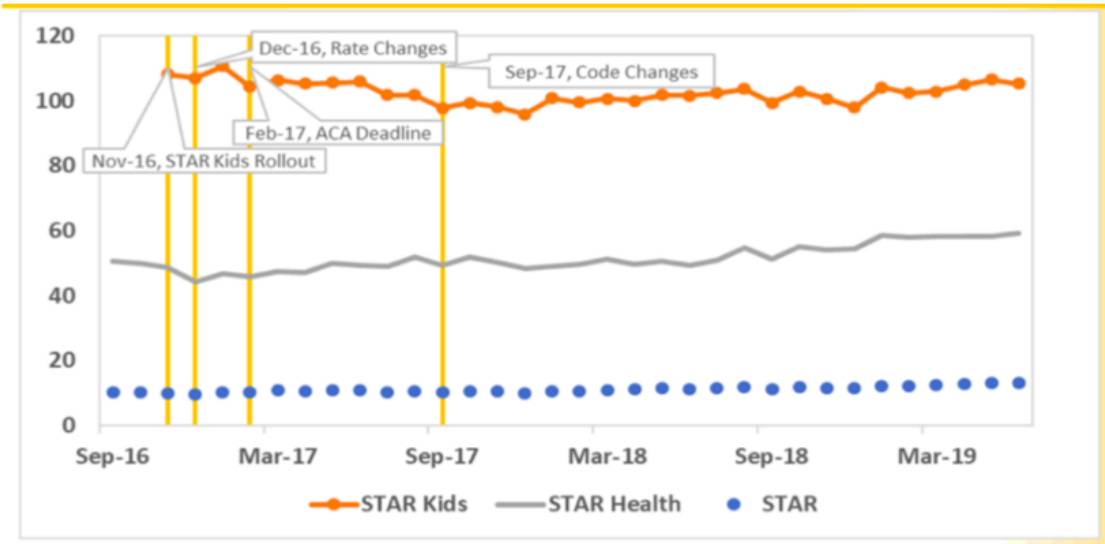
Service Utilization Rate STAR Kids: Occupational Nov 2016 – Jun 2019



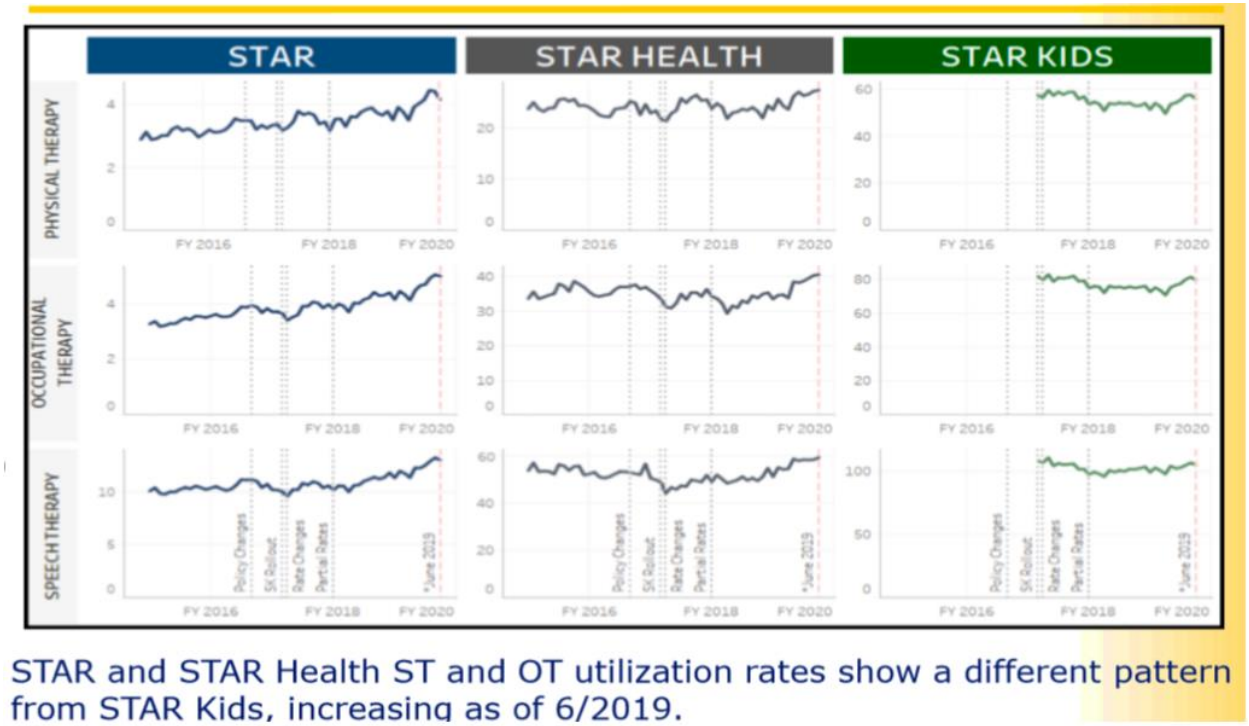
STAR has the highest numbers of clients receiving ST services, compared with STAR Kids, then STAR Health, driven by the relative number of members in each of the programs.

Service Utilization Rates by Program Speech Therapy Sep 2016 – Jun 2019



When you control for the relative size of the programs, STAR Kids has the highest utilization rate per 1,000 members, compared with STAR Health, then STAR.

Service Utilization Rates by Program Sep 2015 – Jun 2019



STAR and STAR Health ST and OT utilization rates show a different pattern from STAR Kids, increasing as of 6/2019.

Provider Network

- Report includes data on both enrolled and active providers.
- Overall numbers and by provider type.
- Monitoring enrolled providers offers more recent data but not all enrolled providers are active, i.e. encounters show a paid service.
- Monitoring active providers requires an 8-month lag because it is based on encounters which require run out time.
- However, offers more concrete look at network adequacy.

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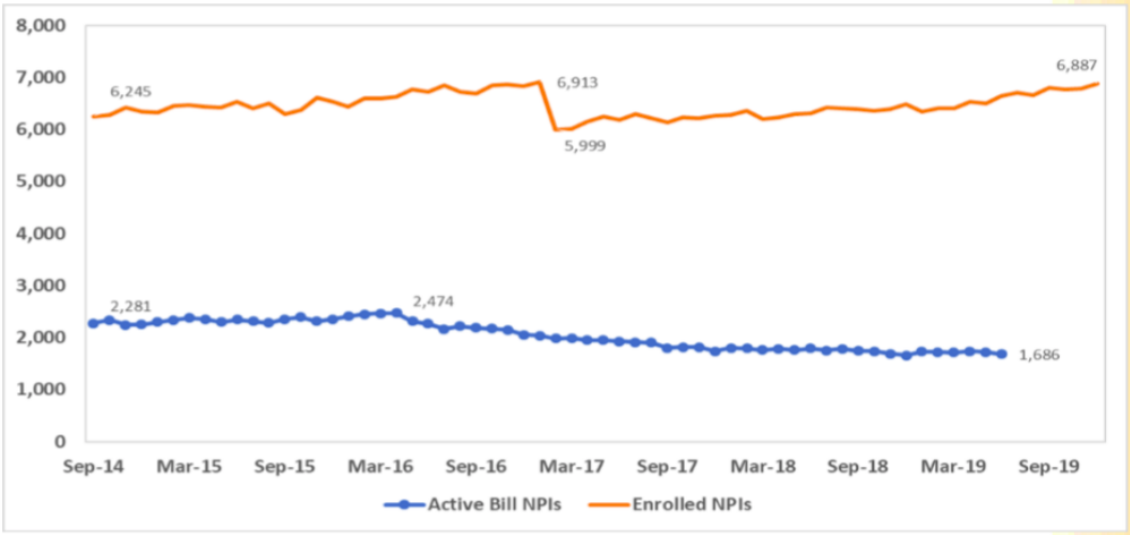
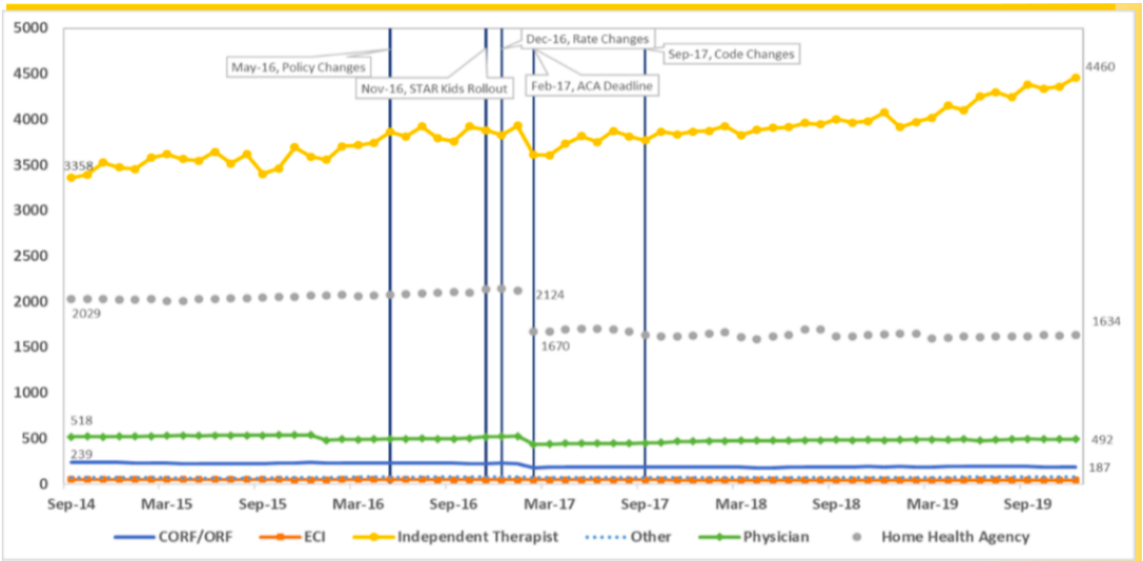
Enrolled vs. Active Therapy Providers* Sep 2014 – Dec 2019 (Active providers through Jun 2019



Enrolled providers impacted by ACA reenrollment in February 2017; active providers by therapy policy changes in May 2016.

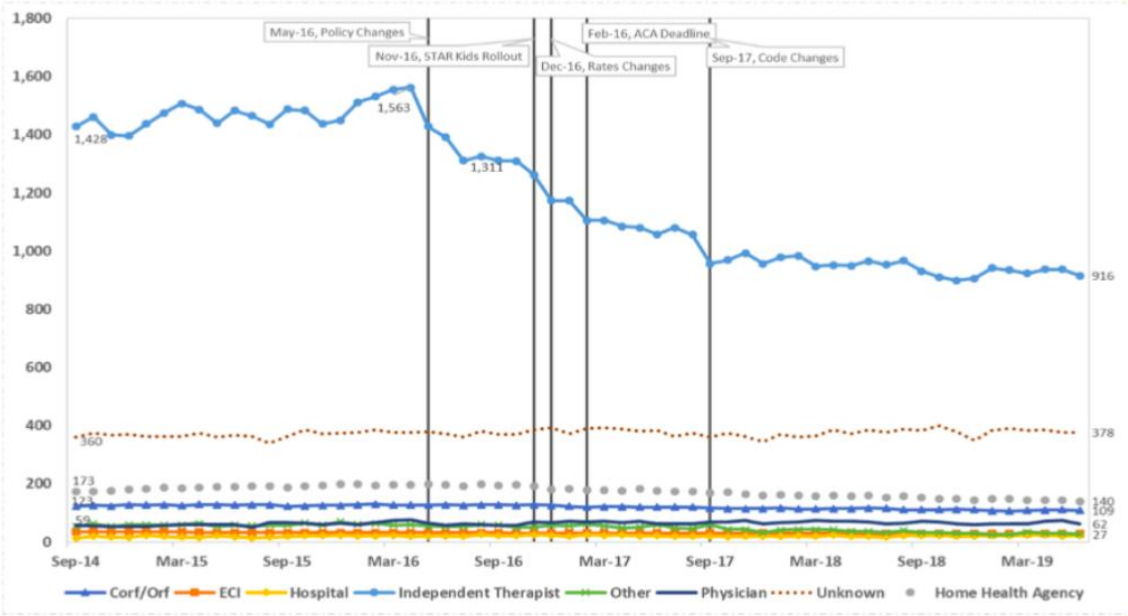
*Active providers are those who have been paid for a billed service

Enrolled Providers by Type Sep 2014 – Dec 2019



Home health agency enrollment has remained flat, while independent therapists have surpassed pre-February 2017 numbers.

Active Providers* by Type Sep 2014 – Jun 2019



The trend of overall number of active therapy providers mainly reflects the number of active independent therapists.

***Active providers are those who have been paid for a billed service**

Questions/Answers/Comments

What is the response if a provider does not report? HHSC stated that providers are informed about the opportunity of reporting directly. They are getting a lot more providers reporting. Changes in data collection may be made in the future, to improve the template.

When these are compared to MCO networks, is correlation between enrolled and active used in analyzing MCO networks? HHSC stated that they have the ability to do that.

What about telemedicine/telehealth for therapy services? HHSC stated that this has proven effective during the COVID-19 emergency. They will be looking at telehealth utilization in future reports.

Public Comment.

Linda Litzinger, Texas Parent to Parent, commented on COVID-19. There are reports about children's fragility and families desperately need PPE. There should be a separate meeting for CDS members. CDC changed their March definition, taking out conditions that make a person vulnerable for COVID-19. Physicians were alarmed by this. It eliminated almost all the children who have fragile health conditions.

Mr. Chacon read public comments that were sent in. Summary comments are included below:

- Concern about the change in Dallas and the new procurement and capitation rates. HHSC stated that they will follow up.
- Concern about travel to out-of-state provider which they have to constantly fight for. He cited funding constraints and resulting cutbacks in service
- Concern about self-quarantine due to child's health condition (MDCP client). They have not been able to receive medical help and therapy in their home. There was concern about maintaining services and PDN hours once the long quarantine period has ended.
- In the Rio Grande Valley, rates are too low. Adding the cost of PPE to the equation exacerbates the problem. What is being done to ensure a process looks at this entire low-rates situation?

Kate Harrison, Music therapist, stated that United included Music Therapy as a Value-Added Service. There was a limit to ten treatments and that was a step in the right direction. Music therapy is a medically necessary service. These services were eventually dropped. (UnitedHealthcare responded that music therapy has always been provided on a case-by-case determination and continues to be so.)

Vicki Gilani, pediatric therapy provider, stated that telemedicine is critical to continuing care. She requested an extension of teletherapy for 90 days.

Susan Murphree, Disability Rights Texas, commented on the therapy presentation. She commented on the speech therapy slide between STAR and STAR Kids, and the need for information for parents who are SSI-eligible. She would like to have information from HHSC on this. The ABA benefit for children as well as the status (policy and rates). The Chair stated that the ABA item could be placed on the next agenda.

Hannah Mehta, Protect Texas Fragile Kids, requested an extension of the flexibilities, and that there be no unnecessary delay in making the extension available. She also inquired about the one-hour respite care requirement. Families have been stuck in limbo when it comes to qualifying for the Money Follows the Person funding and waiver. There is an overnight stay needed that cannot occur because of the Virus.

Jennifer Hall, Parent, provided their family's challenges in access to care, involving out-of-state travel for care during the pandemic. There were difficulties transitioning to a new

substitute (in-state) team. Aetna was not responsive to their provider (Texas Children's) reaching out related to prior authorization. Aetna should not be taking on a new service area when they can't manage what they have. We need better communication and accountability.

Steve Shankle, Apple Homecare Medical Supply Inc., stated that the pre-authorizations are working. They contract with Aetna and Amerigroup. They received a letter from Texas Children's Health Plan that their contract was cancelled. This will impact 400 families. He stated that this is an emergency. There is miscommunication with families about the Dallas transition.

Review of Action Items and Agenda Items for Future Meeting. Next meeting is September 23rd.

- Input from all the members and subcommittees on COVID-19 flexibilities and what should be continued;
- Mental health retrospective review;
- Follow-up on coordination of benefits draft;
- Meeting with EQRO to go through the quality measures by subcommittee;
- Look at therapy data collection;
- Clarification of utilization of one hour of respite;
- ABA benefit update;
- Consumer-directed services and PPE (DME providers stated they can dropship PPE to families if Medicaid approves); and
- Formally recommend extension of telehealth.

MOTION: *Recommend to HHSC the Extension of Telehealth flexibility through the end of September – prevailed.*

Adjourn. There being no further business, the meeting was adjourned.

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