Attachment 1 to Attachment to Block 7 of CMS Form 179

Introduction

In state fiscal year (SFY) 2014, the Texas Health and Human Services Commission (HHSC) spent $722.4 million all funds (AF) on acute care therapy services, including speech, physical and occupational therapies, which represents a 66 percent increase from SFY 2009 expenditures. During the same period (SFY 2009 to SFY 2014), the number of clients receiving acute care therapies grew at a rate of 42 percent, from 170,128 clients to 242,364 clients, while the number of clients enrolled in Texas Medicaid overall increased by only 25 percent[1].

In response to the rising expenditures for acute care therapy services, Senate Bill 1, 83rd Legislature, Regular Session, 2013 (Article II, Health and Human Services Commission, Rider 51) directed HHSC to explore cost saving options. HHSC commissioned a study to gather and review rate data that would enable HHSC to make recommendations regarding cost containment initiatives. Comparisons of Texas Medicaid acute care therapy rates to rates paid by Medicare, other states' Medicaid programs, and Texas commercial insurers for the same services all reveal that Texas' rates, in the aggregate, significantly exceed rates paid by these other payers.

The primary acute care therapy procedure code driving this aggregate excess is 92507 (*Treatment of speech, language, voice, communication, and/or auditory processing disorder, individual*). The Texas Medicaid rate for this procedure code is based on a 15-minute increment (which can be billed up to four units for a single visit) for comprehensive outpatient rehabilitation facilities and outpatient rehabilitation facilities (CORF/ORFs) and independent speech therapy providers, two of the three primary provider types providing acute care therapy services. The April 30, 2016, 15-minute increment rate for procedure code 92507 was $39.78 for CORF/ORFs, $33.79 for independent therapists providing services in the clients' homes, and $31.25 for independent therapists providing services in their offices.

Home health agencies (HHAs), the third primary provider type providing acute care therapy services, are reimbursed per visit for procedure code 92507 with an assumption that a visit lasts for one hour; therefore, the reimbursement for a 92507 HHA visit on April 30, 2016, was $135.14 (approximately four times the 15-minute increment rate for independent therapists providing services in the clients' homes). By way of comparison, the Texas commercial insurance median rate per visit for this code is $68.24, approximately half the reimbursement for HHAs; the median of other states' Medicaid rates from an 11-state sample is $66.89 per visit; and the Medicare rate per visit is $79.73. See Table 1.

Table 1. Comparison of Texas' Medicaid Visit Rate for 92507 (*Treatment of speech, language, voice, communication and/or auditory processing disorder, individual*) to Texas Commercial, Other States' Medicaid and Medicare Visit Rates

Procedure Code	Texas HHA Visit Rate	Median Texas Commercial Visit Rate	Median of Other States' Medicaid Visit Rates	Medicare Visit Rate
92507	$135.14	$68.24	$66.89	$79.73

[1] HHSC Strategic Decision Support, April 9, 2015.

This state plan amendment proposes to reduce rates for 92507 for CORF/ORFs by 27.93 percent, for HHAs, by 25.75 percent, for independent therapists providing services in the client's home by 15.15 percent, and for independent therapists providing services in the office by 8.26 percent in order to bring the rates to 150 percent of the median of other states' Medicaid rates based on an 11-state sample as presented by Truven Analytical. All other procedure codes that are currently above 150 percent of the median of other states' Medicaid rates are proposed to be adjusted to 150 percent of that median, with the reductions capped at 25 percent, except that reductions to procedure codes 92526 (*Treatment of swallowing dysfunction and/or oral function for feeding*) and 92610 (*Evaluation of oral and pharyngeal swallowing function*) are limited to 3.45 percent. Procedure codes that are currently below 150 percent of the median of other states' Medicaid rates and procedure codes that did not have a median of other states' Medicaid rates data point are reduced by 3.45 percent. Overall, this State plan amendment proposes to reduce Medicaid acute care therapy reimbursements by 15 percent, assuming a static caseload.

This document presents evidence that Texas' proposed Medicaid acute care therapy rates comply with the statutory requirements of Section 1902(a)(30)(A) of the Social Security Act (pertaining to methods and procedures relating to the payment for care and services available under the State plan) and 42 Code of Federal Regulations (C.F.R.) §§447.203-204 (pertaining to documenting and informing access to care and service payment rates). The document is divided into ten parts as follows:

- Introduction
- Statutory and Regulatory Requirements
- Concerns Regarding Compliance with Efficiency and Economy Requirements of Section 1902 and Evidence of Adequacy of Current Medicaid Payment Rates as Required under §447.204(b)(1) and (3) including Actual or Estimated Levels of Provider Payment Available from Other Payers
    - Comparisons to Medicare Rates
    - Medicare Low Utilization Payment Adjustment
    - Comparisons to Other States' Medicaid Rates
    - Comparisons to Texas Commercial Insurance Rates
    - Stacking
    - Conclusion
- Compliance of Proposed Rates with the Requirements of Section 1902 and 42 CFR §447.204(b)(2) including an Analysis of Effect of the Change in Payment Rates on Access
    - Analyses of Proposed Rates to be Effective July 15, 2016
    - Adequacy of Rates based on Analysis of Therapist Salaries
    - Comparison to Long Term Services and Supports Therapy Costs
    - Comparison to Texas Medicaid Managed Care Plans' Therapy Reimbursement Rates
    - Conclusion
- CMS HHA Enrollment Moratoria and Pre-Claim Review Demonstration of Home Health Services

- Texas Medicaid Acute Care Therapy Metrics and Further Evidence of Adequacy of Current Medicaid Payment Rates as Required under 42 CFR §447.203(b)(4) and §447.204(b)(1)
  - Beneficiary Characteristics
  - Program Metrics
  - Provider Metrics
  - Geo-mapping
- Analysis of the Information and Concerns Expressed in Input from Affected Stakeholders as Required under 42 CFR §447.204(a)(2) and §447.204(b)(3)
- Access Monitoring Review Plan as Required under 42 CFR §447.203(b)(6)(ii)
- Mechanisms for Ongoing Beneficiary and Provider Input on Access to Care as Required under 42 CFR §447.203(b)(7)
- Overall Conclusion

Statutory and Regulatory Requirements

Rate determination for Medicaid state plan programs is governed by Section 1902(a) of the Social Security Act (the Act) which states that a state plan for medical assistance must "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a (a)(30)(A).

Effective January 4, 2016, states must comply with newly adopted federal rules at 42 C.F.R. §§447.203-204. These regulations outline a standardized, transparent, data-driven process for states to document that provider payment rates are consistent with Section 1902(a) of the Act and include special provisions for proposed provider rate reductions or restructuring. See 42 C.F.R. §447.203(b)(6). For rate reduction state plan amendments (SPAs) filed between January 4, 2016, and October 1, 2016, states must submit information and data to demonstrate that access is consistent with the Act before the rate reduction SPA is approved, an analysis of the effect of the change in payment rates on access, a specific analysis of the information and concerns expressed in input from affected stakeholders and an access monitoring review plan, and follow the procedures for public input process consistent with the requirements in the rules. See *Access Rule Implementation Frequently Asked Questions (FAQs) Issued; March 16, 2016*, FAQ #26.

Concerns Regarding Compliance with Efficiency and Economy Requirements of Section 1902 and Evidence of Adequacy of Current Medicaid Payment Rates as Required under 42 CFR §447.204(b)(1) and (3) including Actual or Estimated Levels of Provider Payment Available from other Payers

Texas has been concerned for a number of years that the Medicaid rates it pays for acute care therapies (physical therapy – PT, occupational therapy – OT and speech therapy – ST) are above a level that is consistent with efficiency, economy, quality of care, and access to care.[2] As described below, this concern is validated by comparisons of Texas' rates to rates paid by other payers for the same services.

Comparisons to Medicare Rates

Texas initially compared its Medicaid acute care therapy rates to rates paid by Medicare for similar services. Analyses revealed that, in the aggregate, the rates Texas Medicaid pays for acute care therapy services are significantly above Medicare rates for the same services.

[2] In 2015, the Texas Legislature directed HHSC to adjust these rates to be consistent with industry standards, policies, and utilization for acute care therapy services while considering stakeholder input and access to care and that in SFY 2016 and SFY 2017 at least $50 million in General Revenue Funds savings should be achieved each fiscal year through rate reductions. See 2016-2017 General Appropriations Act (House Bill 1, 84th Leg. R.S., art. II, Rider 50, at II-96 to 11-98 (Health and Human Services section, Health and Human Services).

Analyses performed in 2015 indicated that reducing Medicaid acute care therapy rates that are above Medicare to the Medicare rate for SFY 2016 would result in a savings of $313.4 million AF. These analyses showed that for procedure codes with both Texas Medicaid and Medicare rates, 94 percent of the Medicaid acute care therapy rates for CORF/ORFs, 80 percent of the rates for independent therapists, and 63 percent of the rates for HHAs exceeded the Medicare rates for the same procedure codes.

Attachment A shows a code-by-code comparison of Texas Medicaid acute care therapy rates to Medicare rates for the same procedure codes. Note that when the Texas Medicaid rate is based on a different unit of service than the Medicare rate, the Texas rate was converted to the Medicare unit of service for determining the difference between the Texas rate and the Medicare rate and for determining the Texas rate as a percent of the Medicare rate. For example, for code 92507 for CORF/ORFs, the Texas unit of service is 15 minutes while the Medicare unit of service is a visit. To compare the Texas rate to the Medicare rate, the Texas rate first must be multiplied by a conversion factor of 3.5.

Medicare Low Utilization Payment Adjustment

Texas HHAs have posited that the correct comparison to Medicare would be to compare the Texas Medicaid acute care therapy rates to the Medicare Low Utilization Payment Adjustment (LUPA) rate that was developed by Medicare as an alternative to its full 60-day episode rate of $2,138 for patients who receive attendant, nursing, and therapy for <u>four or fewer visits during a 60-day episode</u>. However, this comparison is problematic for several reasons. For example, analyses of Texas Medicaid HHA therapy utilization data indicated that the average Medicaid patient receives <u>one therapy service each week for 19 months</u>. Further, the LUPA rate was not developed to represent the costs of providing therapies to Medicaid children, but rather, to represent costs of providing therapy services to low utilizing elderly clients including the upfront loading into the rate of all administrative costs of taking on a new client to ensure the provider's overhead for the new client is covered with four or fewer payments. It does not make sense to load so much overhead into the rate for Medicaid because the average Medicaid client receives 76 billable services over the course of 19 months rather than four or fewer billable services over the course of 60 days. Using the LUPA rate for these Medicaid clients would result in upfront overhead costs being recouped by providers 19 times during the course of treating an average client.

Comparisons to Other States' Medicaid Rates

Responding to statements from HHAs that it was inappropriate to compare Medicaid acute care therapy rates to Medicare acute care therapy rates because the Medicare acute care therapy rates were not specifically developed for HHAs providing therapy services, and to direction from the Texas Legislature, HHSC commissioned a study to compare Texas' Medicaid acute care therapy rates to acute care therapy rates paid by other states' Medicaid programs and by Texas commercial insurers.

Medicaid rates paid by other states were determined through an analysis of the Truven Health Analytics MarketScan© Multi-State Medicaid Claims and Encounters Database (Truven), a

database developed for and relied upon by health-industry professionals to evaluate and benchmark financial and clinical performance. This database contains medical, surgical, and prescription drug claims and encounters for more than 35 million Medicaid enrollees from 11 states. It includes records of inpatient services, inpatient admissions, outpatient services (including therapies), and prescription drug claims, as well as information about long-term care and other medical care. Data on eligibility, service, and provider type, as well as standard demographic data are also included. All data are directly collected by Truven from participating state programs.

Analyses performed in 2015 indicated that reducing Texas' Medicaid acute care therapy rates that are above the 11-state Medicaid median rate as captured by the Truven database to the 11-state Medicaid median rate for SFY 2016 would result in a savings of $396.5 million AF. These analyses showed that for procedure codes with both Texas Medicaid and 11-state Medicaid median rates, 79 percent of Medicaid acute care therapy rates for CORF/ORFs, 73 percent of the rates for independent therapists, and 63 percent of the rates for HHAs exceeded the 11-state Medicaid median rates for the same procedure codes.

Attachment A shows a code-by-code comparison of Medicaid acute care therapy rates to the 11-state Medicaid median rates for the same procedure codes. Note that when the Texas Medicaid rate is based on a different unit of service than the median of other states' Medicaid rates, the Texas rate was converted to the comparison unit of service for determining the difference between the Texas rate and the comparison rate and for determining the Texas rate as a percent of the comparison rate. For example, for code 92507 for CORF/ORFs, the Texas unit of service is 15 minutes while the comparison unit of service is a visit. To compare the Texas rate to the comparison rate, the Texas rate first must be multiplied by a conversion factor of 3.5.

Additionally, HHSC contracted with Navigant Consulting, Inc. ("Navigant") to gather, review and analyze high volume, HHA rate information from other states' Medicaid programs. Specifically, Navigant looked at six procedure codes, selected by determining which services made up at least one percent of the estimated statewide pediatric HHA volume and expenditures in calendar year 2015. Navigant compiled data from states in the same CMS region with Texas (CMS Region VI), from states with the largest Medicaid programs, and from states used in prior HHSC analyses, and used this data to make comparisons to current and proposed Texas Medicaid rates for HHAs. The analysis accounted for differences such as billing practices, service units, duration, and age, to name a few. Navigant made the following determinations:

- Among the fee schedules for states in CMS Region VI, Texas Medicaid's <u>proposed</u> rates are generally the highest payment amounts, with the exception of Arkansas for physical therapy services and New Mexico Developmental Disabilities Waiver payment rates *when* it includes the incentive.
- Among the fee schedules for states with the largest Medicaid programs, Texas Medicaid's <u>proposed</u> rates are the third highest payment amounts, with the exception of speech therapy, for which the rates are the fifth highest payment amounts out of 16 comparators.
- Among the fee schedules for states used in prior HHSC analyses, Texas Medicaid's proposed rates are the highest payment amounts, with the exception of New York's

maximum provider-specific fee schedule, as well as the New York LUPA rates and Arizona rates for speech therapy.

Comparisons to Texas Commercial Insurance Rates

The median Texas commercial rates were determined through an analysis of the Truven Health Analytics MarketScan© Commercial Claims and Encounters Database. This database contains medical and drug data from large employers and managed care organizations. The database includes geographic location (state, county, or metropolitan statistical area) which allows researchers to examine state specific commercial plans as well as national data. It contains data for several million individuals annually.

Analyses performed in 2015 indicated that reducing Texas Medicaid acute care therapy rates that are above the Texas commercial median rates as captured by the Truven database to the Texas commercial median rates for SFY 2016 would result in a savings of $380.3 million AF. These analyses showed that for procedure codes with both Texas Medicaid and Texas commercial median rates, 84 percent of Medicaid acute care therapy rates for CORF/ORFs, 82 percent of the rates for independent therapists, and 73 percent of the rates for HHAs exceeded the Texas commercial median rates for the same procedure codes.

Attachment A shows a code by code comparison of Medicaid acute care therapy rates to the Texas commercial median rates for the same procedure codes. Note that when the Texas Medicaid rate is based on a different unit of service than the median of Texas commercial rate, the Texas rate was converted to the comparison unit of service for determining the difference between the Texas rate and the comparison rate and for determining the Texas rate as a percent of the comparison rate. For example, for code 92507 for CORF/ORF, the Texas unit of service is 15 minutes while the comparison unit of service is a visit. To compare the Texas rate to the comparison rate, the Texas rate must be multiplied by a conversion factor of 3.5.

Stacking

Providers have told HHSC that comparisons to rates paid by other states and commercial insurers are not valid because Texas Medicaid does not allow "stacking" of codes. Stacking occurs when providers are allowed to bill under multiple procedure codes for services provided during the same unit of service. However, HHSC staff was unable to validate this provider claim.

Texas Medicaid does not allow for an evaluation or a re-evaluation to be billed on the same date as a therapy treatment service. This is an appropriate policy limitation because the evaluation and re-evaluation should be used to develop a treatment plan that is then used to determine appropriate services for a client. Therefore, claims with evaluation and re-evaluation codes 92521, 92522, 92523, 92524, or S9152 will be denied when billed by any provider for the same date of service as treatment procedure codes 92507 and 92508. There are, however, no limitations on billing speech therapy treatment codes 92526 and 92507 on the same day. These codes can be billed together on the same day up to one hour, or four 15-minute units.

Texas Medicaid staff believes providers are claiming that Texas Medicaid does not allow "stacking" because Texas limits reimbursement to one hour for treatment services per day per type of therapy (e.g., PT, OT and/or ST). Providers have stated that commercial payers allow a speech therapist to provide two speech treatment modalities in a one-hour session and, for example, bill for one hour of 92526 and one hour of 92507 even though they only worked with the client for one hour. Medicaid staff researched commercial policies to substantiate this claim and found that United Healthcare's commercial policies do not support the providers' claims. The policies of Blue Cross/Blue Shield are less clear but may also prohibit stacking. Research showed that the industry standard of practice for the majority of clients is one hour of speech therapy.

Conclusion

The comparisons of Texas Medicaid rates for acute care therapy services to rates paid for these same services by Medicare, other states' Medicaid programs, and Texas commercial insurers provide strong evidence that Texas' rates in effect as of June 15, 2016, are not consistent with efficiency and economy because rates paid by those other payers are significantly lower than Texas Medicaid rates. These same comparisons also provide strong evidence of the adequacy of Texas' current Medicaid rates for acute care therapy services as they significantly exceed rates paid by other payers (e.g., Medicare, other states' Medicaid programs and commercial insurance in Texas) which are assumed to support adequate access to care for those consumers whose care is paid for by these other payer types.

Compliance of Proposed Rates with the Requirements of Section 1902 and 42 CFR §447.204(b)(2) including an Analysis of Effect of the Change in Payment Rates on Access

Analyses of Proposed Rates to be Effective July 15, 2016

As stated earlier, this state plan amendment proposes to reduce the Medicaid acute therapy rates using the 11-state Medicaid median rates as a basis for comparison. This comparison was used in compliance with the Texas Medicaid state plan that provides that the fee schedule for services, including therapy services, may be based on review of Medicaid fees paid by other states. *See, e.g.,* Section 4.19-B.8(a)(2).

Attachment B presents a comparison of the rates proposed to be effective July 15, 2016, to the 11-state Medicaid median rates as captured by the Truven database. A review of this attachment shows that out of 514 codes for which an 11-state Medicaid median rate was available, 67.1 percent of the proposed Texas Medicaid rates exceed the 11-state Medicaid median rates for the same codes.

HHSC staff also compared information available from on-line sources for 11 states' Medicaid programs while developing the proposed rates (there may be some overlap with the states included in the Truven database since the list of states included in that database is proprietary information not available to HHSC). The states separately examined by HHSC comprised Alabama, Arizona, Florida, Georgia, Illinois, Louisiana, Minnesota, New York, Ohio, Oklahoma and Washington. Analysis of this information revealed that for 68.8 percent of codes, the

median of other states' Medicaid rates as captured by the Truven database was greater than the median of the additional states' Medicaid rates (see Attachment C). This analysis indicates that, in general, the Truven database represents higher Medicaid rates than those paid in some of the most populous states in the nation.

Together, the data and analyses presented in Attachments B and C indicate that the proposed Texas Medicaid rates for acute care therapies are not out of the norm for Medicaid rates paid for these services across the nation and which have been approved by CMS.

Adequacy of Rates based on Analysis of Therapist Salaries (Margins Analysis)

Attachment D presents a margins analysis for occupational, physical and speech therapy in Texas' Medicaid acute care therapies program.

For each type of therapist, the median Texas annual wage was determined from the Texas Workforce Commission – Occupational Employment Statistics Program. Median annual wages were increased by 25 percent to account for additional costs associated with payroll taxes and benefits.

For each type of therapy, the most commonly billed code was identified. For speech therapy, the most commonly billed code was 92507 (*Treatment of speech, language, voice, communication, and/or auditory processing disorder, individual*). This code represented 54 percent of all billed Texas Medicaid acute care therapy units of service. For physical and occupational therapy, the most commonly billed code was 97530 (*Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes*). This code represented 24 percent of all billed Texas Medicaid acute care therapy units of service. Together, the two codes represented 78 percent of all billed Texas Medicaid acute care therapy units of service.

For each identified procedure code, annual income generated by a therapist billing that code exclusively was calculated assuming that a therapist provided 20 hours of billable services every week and worked 50 weeks per year. For example, for 92507 for a CORF/ORF, the current Medicaid rate was determined to generate an annual income to the provider of $39.78 × 4 × 20 × 50 = $159,120. Annual incomes generated were determined using the Medicaid rate in effect on June 15, 2016, and the final proposed Medicaid rate represented in this state plan amendment to be effective July 15, 2016.

Excess revenue beyond that required to pay for the therapist's annual salary, payroll taxes, and benefits was then calculated for each therapist type, procedure code, and rate option (Medicaid rate as of June 15, 2016, and proposed Medicaid rate as of July 15, 2016). Excess revenue could be used to cover administrative overhead, facility costs, supplies, and profit. The results of this analysis show that, under the proposed Medicaid rate, for the code representing 54 percent of all billed units of service (92507), excess revenue above that required to cover the therapist's salary, payroll taxes, and benefits ranged from a low of 15.1 percent to a high of 25.7 percent. For 97530 for occupational therapists, excess revenue ranged from a low of 9.6 percent to a high of

29.0 percent, and for 97530 for physical therapists, excess revenue ranged from a low of 8.8 percent to a high of 28.4 percent.

It is important to note that this analysis is based on the assumption that all Texas Medicaid acute care therapies are provided by licensed therapists. In discussions with some therapy companies, HHSC's primary Medicaid managed care organization (MCO) for children in the Harris County area found 50 percent or more of these companies' speech therapy staff consisted of therapy assistants who have significantly lower salaries than licensed therapists. Anecdotal evidence indicates that the use of therapy assistants is common throughout the state. Use of therapy assistants in place of licensed therapists would significantly increase the margins reported above.

A review of the results of this analysis indicate that the rates proposed to be effective July 15, 2016, are adequate to cover provider expenses in providing Medicaid acute care therapies.

Comparison to Long-Term Services and Supports Therapy Costs

HHSC collects and analyzes annual cost reports from its long-term services and supports (LTSS) providers. Providers in the Community Based Alternatives (CBA)[3], Community Living Assistance and Supports Services (CLASS), Home and Community-based Services (HCS) and Texas Home Living (TxHmL) waiver programs provide therapy services to clients and report the costs of those services along with overhead on their cost reports. These services are primarily provided in the clients' homes. An examination of 2012 cost report data inflated to the 2016-17 state biennium indicated that the weighted median costs for an hour of therapy services, including overhead, were as follows: $79.19 for PT; $76.46 for OT; $81.59 for ST. By way of comparison, Texas Medicaid acute care therapy rates in place on June 15, 2016, for the most highly utilized PT, OT, and ST procedure codes paid between $125.00 and $159.12 per hour depending on provider type. Proposed Texas Medicaid acute care therapy rates to be effective July 15, 2016, for the most highly utilized PT and OT procedure codes will pay between $120.68 and $153.64 per hour depending on provider type, and the most highly utilized ST procedure code will pay $100.34 to $114.68 per hour depending on provider type.

This analysis, presented in Table 2 below, shows that the proposed Texas Medicaid acute care therapy rates exceed the median LTSS PT and OT cost by 152 to 213 percent depending on provider type and exceed the median LTSS ST cost by 146 to 182 percent depending on provider type.

[3] CBA has since been totally carved in to managed care.

Table 2. Comparison of Texas Medicaid Acute Care Therapy Rate Options to LTSS Cost Report-based Therapy Costs, including Administrative Overhead

Occupational Therapists	97530	Converted Unit of Service	9/30/15 Rate	Proposed 10/1/15 Rate	LTSS Hourly Cost	Proposed as % of LTSS Cost
CORF/ORF	97530	1 hour	$159.12	$153.64	$71.95	213.5%
HHA	97530	1 hour	$135.14	$130.48		181.3%
Indep - Home	97530	1 hour	$135.16	$130.48		181.3%
Indep - Office	97530	1 hour	$125.00	$120.68		167.7%
Physical Therapists	**97530**					
CORF/ORF	97530	1 hour	$159.12	$153.64	$79.19	194.0%
HHA	97530	1 hour	$135.14	$130.48		164.8%
Indep - Home	97530	1 hour	$135.16	$130.48		164.8%
Indep - Office	97530	1 hour	$125.00	$120.68		152.4%
Speech Therapists	**92507**					
CORF/ORF	92507	1 hour	$159.12	$114.68	$78.37	146.3%
HHA	92507	1 hour	$135.14	$100.34		128.0%
Indep - Home	92507	1 hour	$135.16	$114.68		146.3%
Indep - Office	92507	1 hour	$125.00	$114.68		146.3%

Comparison to Texas Medicaid Managed Care Plans Therapy Reimbursement Rates[4]

Texas' MCOs contract independently with Medicaid acute care therapy providers, typically based on a percentage of the Texas Medicaid fee-for-service (FFS) rate. MCOs have consistently indicated to HHSC that Texas Medicaid acute care therapy FFS rates are too high.

Conversations with representatives from the MCO covering the majority of Medicaid children in the Harris County area indicate that the MCO's rates for acute care therapies for new and renegotiated contracts are already **below** the proposed Texas Medicaid FFS rates. This MCO indicates that it has not experienced any access issues to date and that it still gets between five and ten requests per month from new therapy providers requesting to join its network.

In addition, in April 2016, Texas' largest Medicaid MCO, Superior HealthPlan, told a state district judge that reducing payments to therapists would not stop Superior from providing children with "all of the services they need." Superior indicated that it had studied this rate cut independently of the state through its own market analysis of its network and is "absolutely convinced that there's going to be adequate access to the network."[5] As further support for its

[4] Currently approximately 50 percent of Texas Medicaid acute care therapies are provided through managed care; when StarKids rolls out in November 2016, that figure will increase to approximately 85 to 90 percent.
[5] April 1, 2016, correspondence from Superior HealthPlan Senior Vice President Mike Diel; Texas Tribune, "Budget Cuts for Therapy Won't Harm Kids, Judge Told," April 12, 2016.

position, a Superior representative testified that, in the last 12 months, Superior has turned away nearly 800 providers who are willing to contract at 50% of the current fee-for-service rates.[6]

Finally, the chief executive of the South Texas-based Driscoll Children's Health Plan has stated "We would have no problem with our Medicaid members accessing a therapist with the proposed rate cuts. We have plenty of therapists in our network."[7]

Conclusion

The analyses presented above that: 1) compare the proposed rates to other states' CMS approved Medicaid rates; 2) calculate available margins under current and proposed rates; and 3) compare Texas' cost report-based therapy rates to its proposed acute care therapy rates, as well as information pertaining to Texas Medicaid MCO acute care therapy rates, are offered by Texas as evidence that its proposed rates for Medicaid acute care therapies are low enough to achieve economy and efficiency and high enough to assure quality of care and adequate access to providers by Medicaid beneficiaries in compliance with the requirements of Section 1902(a)(30)(A) of the Social Security Act and §447.204(b)(2).

<u>CMS HHA Enrollment Moratoria and Pre-Claim Review Demonstration of Home Health Services</u>

HHAs are one of three primary provider types providing Medicaid acute care therapy services in Texas. While the CMS HHA moratoria and upcoming pre-claim review demonstration are not directly tied to Medicaid acute care therapy reimbursement rates, they enhance state concerns that overly generous Medicaid reimbursement formulae may have made this industry a profitable target for fraud, waste and abuse. As well, CMS' conclusions regarding the moratoria's and pre-claim review demonstration's impact on access to care illustrate CMS' approach when applying access to care requirements to its own actions which can be useful when evaluating the adequacy of Texas' approach to these requirements.

CMS has identified concerns with the provision of HHA services in a number of large Texas counties: Brazoria, Chambers, Collin, Fort Bend, Galveston, Dallas, Harris, Liberty, Denton, Ellis, Kaufman, Montgomery, Rockwall, Tarrant, and Waller. CMS imposed moratoria on the enrollment of new HHAs on July 31, 2013, for Medicare, Medicaid and CHIP. These moratoria remain in effect today.

CMS indicated that counties were identified for moratoria based on an analysis of certain key metrics, which it believes to be strong indicators of potential fraud risk. These metrics included factors such as the number of providers per 10,000 Medicare FFS beneficiaries and the compounded annual growth rate in provider enrollments. CMS also reviewed 2012 FFS Medicare payments to providers in the target locations based on the average amount spent per beneficiary who used services furnished by the targeted provider types. As per CMS, the

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[6] Jared Wolfe Dep. 86:9-13, April 20, 2016 ("We -- we reasoned that if we had providers knocking on the door at 50 percent, that moving [current providers] from 90 percent to 80 percent or 90 to 75 percent in their case -- or a hundred to 75 percent in their case, we would still have access.").
[7] Texas Tribune, "Budget Cuts for Therapy Won't Harm Kids, Judge Told," April 12, 2016.

locations subject to the temporary enrollment moratoria for HHAs are counties that contain or are adjacent to Medicare Fraud Strike Force locations and are also consistently ranked near the top for the identified metrics among counties with at least 200,000 Medicare beneficiaries in 2012. CMS indicates that it consulted with the Health and Human Services-Office of the Inspector General (HHS-OIG) regarding the extension of the moratoria on new HHAs in the moratoria counties, and that HHS-OIG agreed that a significant potential for fraud, waste, and abuse continues to exist in these geographic areas.

When questioned about the impact of these moratoria on client access to care, CMS indicated that it carefully evaluated access for the target moratorium locations. Prior to imposing and extending these moratoria, CMS consulted with the appropriate State Medicaid Agencies to determine if the moratoria would create an access to care issue for Medicaid and CHIP beneficiaries in the targeted locations and surrounding counties. All of CMS' state partners were supportive of CMS analysis and proposals, and together with CMS, determined that these moratoria would not create access to care issues for Medicaid or CHIP beneficiaries. CMS also reviewed Medicare data for these areas and found there are no current problems with access to HHAs.[8]

Regarding the pre-claim review demonstration to be phased in during 2016 and 2017, CMS has indicated that reports from the Office of Inspector General, the General Accountability Office, and the Medicare Payment Advisory Commission show evidence of fraud and abuse in Medicare's home health benefit and that Texas has been identified as a high-risk state under the moratoria discussed above.[9]

Texas Medicaid Acute Care Therapy Metrics and Further Evidence of Adequacy of Current Medicaid Payment Rates as Required under 42 CFR §447.203(b)(4) and §447.204(b)(1)

Texas Medicaid acute care therapy metrics are presented below to give reviewers a broad overview of Texas' acute care therapy program to use in evaluating this proposed state plan amendment.

Beneficiary Characteristics

Current data (June - August 2015) regarding FFS beneficiary characteristics indicates the following:

- Out of 56,766 acute care therapy clients served, 40.95 percent were adults (21 years of age or older) and 59.95 percent were children (< 21 years of age).
- Expenditures for these clients totaled $105,816,270. Adults accounted for 0.84 percent of expenditures and children accounted for 99.16 percent of expenditures.

[8] Federal Register / Vol. 80, No. 144 / Tuesday, July 28, 2015 / Notices.
[9] CMS.gov Fact Sheet: "Pre-Claim Review Demonstration of Home Health Services (CMS-6069-N); https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08-2.html.

- Out of 56,766 acute care therapy clients served, 77.68 percent were SSI, 18.18 percent were non-SSI and 4.40 percent were unknown.
- Out of expenditures of $105,816,270, 90.79 percent were for SSI clients, 9.13 percent were for non-SSI clients and 0.08 percent were for clients where SSI/non-SSI status was unknown.

Program Metrics

As illustrated in Table 3, Texas' expenditures on Medicaid acute care therapy services increased by 66 percent from SFY 2009 to SFY 2014 while overall Medicaid caseload increased by only 25 percent. At the same time, rates for Medicaid acute care therapy services were reduced five times from September 2009 to September 2013. Reductions ranged from one percent to seven percent depending upon provider type (CORF/ORF, HHA and Independent) and therapy type (PT, OT and ST). Continued growth in utilization beyond the increase in overall Medicaid caseload provides an early warning signal that over-utilization might be occurring in this area. Increases in expenditures (and the number of providers as illustrated in Tables 4 and 5) in the face of Medicaid rate reductions provides evidence that the rates in effect during this time period were more than adequate to support a healthy provider base. Note that these statistics combine FFS and managed care.

Table 3. Texas Medicaid Acute Care Therapy Program Metrics

Program Metrics	2009	2010	2011	2012	2013	2014	% Increase 2009-2014
Amount Paid to Providers	$436,079,476	$563,885,791	$702,921,667	$759,300,994	$712,169,483	$722,363,905	66%
Number of Services Provided	4,830,918	6,050,755	7,008,935	7,446,128	7,000,398	7,033,930	46%
Number of Clients Served	170,128	211,276	235,133	248,472	241,964	242,364	42%
Medicaid Enrollment (Avg. Month)	3,005,620	3,298,099	3,543,057	3,655,930	3,658,629	3,746,124	25%
Client Served per 1,000 Enrolled	56.6	64.1	66.4	68.0	66.1	64.7	14%

Provider Metrics

HHSC's analyses of Texas Medicaid PT, OT, and ST provider counts from SFY 2009 to 2014 show a 30 percent increase in the number of providers over that six-year period even though rates for these services have been reduced five times since September 2009 with reductions ranging from one percent to seven percent depending upon provider and therapy type. Table 4 presents the number of active acute care therapy providers by provider type, and Table 5 presents the annual growth in the number of these providers.

Table 4. Active Texas Medicaid Occupational, Physical, and Speech Therapy Provider Counts by Provider Type – SFY 2009-2014[10]

Year	All Providers	CORF/ ORF	HHA	Hospital	Physician	Therapist	Nursing Home	Other
2009	5,168	237	1,090	407	742	1,638	744	470
2010	5,787	243	1,226	416	800	2,017	807	412
2011	6,062	255	1,399	420	632	2,229	819	445
2012	6,600	263	1,512	444	690	2,451	796	687
2013	6,610	264	1,568	456	613	2,421	788	747
2014	6,701	261	1,616	446	584	2,400	763	878

Table 5. Annual Growth in Texas Medicaid of Active Occupational, Physical and Speech Therapy Provider Counts by Provider Type – SFY 2009-2014[11]

Year	All Providers	CORF/ ORF	HHA	Hospital	Physician	Therapist	Nursing Home	Other
2010	12%	3%	12%	2%	8%	23%	8%	-12%
2011	5%	5%	14%	1%	-21%	11%	1%	8%
2012	9%	3%	8%	6%	9%	10%	-3%	54%
2013	0%	0%	4%	3%	-11%	-1%	-1%	9%
2014	1%	-1%	3%	-2%	-5%	-1%	-3%	18%
6-Yr Period	30%	10%	48%	10%	-21%	47%	3%	87%

Attachment E presents current data (June - August 2015) as follows.

- Tab 1 (PTOT Region) - For physical and occupational therapists:
  - The number of enrolled providers by provider type (e.g., CORF/ORF, HHA, Independent, other) and Region;
  - The number of clients receiving services by provider type and Region
- Tab 2 (ST Region) - For speech therapists:
  - The number of enrolled providers by provider type and Region;
  - The number of clients receiving services by provider type and Region

The data presented in Attachment E represents the baseline data for the access monitoring review plan required under 42 CFR §447.203(b)(6). Note that these statistics represent FFS clients only.

Geo-Mapping

Attachments F and G present the results of geo-mapping for all non-HHA therapy providers. HHA therapy providers are excluded because mapping would have to be based on the HHA provider's office location which is not representative of where the actual providers of service (the employed and contracted therapists) live. For example, while a HHA provider's office might be located in Ft Worth, it might have employed or contracted therapists living in counties distant

[10] Source: HHSC Strategic Decision Support, April 9, 2015.
[11] Source: HHSC Strategic Decision Support, April 9, 2015.

from Ft. Worth including counties in a different HHSC region. HHSC does not have information on the actual location of the HHA employed or contracted therapists.

Attachment F plots the locations of CORF/ORF and Independent providers of PT and OT services (blue circles) and PT and OT clients (red dots). Green areas represent areas within 30 miles of a PT/OT provider while tan areas represent areas more than 30 miles from a provider. Per these analyses, between June and August 2015 (the most recent time period for which complete data is available) 99.7 percent of PT/OT clients were within 30 miles of a PT/OT provider. PT and OT results are combined because these providers use the same codes for many services and it is not possible to identify specifically which providers and/or clients are solely receiving PT versus OT.

Attachment G plots the locations of CORF/ORF and Independent providers of ST services (violet circles) and ST clients (red dots). Green areas represent areas within 30 miles of an ST provider while tax areas represent areas more than 30 miles from a provider. Per these analyses, between June and August 2015, 99.8 percent of ST clients were within 30 miles of an ST provider.

Conclusions

Taken together the various metrics presented in this section indicate adequate access to Medicaid acute care therapies under the current rates. The growth in the number of providers in comparison to the growth in the number of recipients over the past five years indicates a strong possibility of over-capacity under the current therapy rates. As well, currently, Texas has not received any verifiable complaints from clients and/or client guardians indicating inability to access medically required therapy services. While claims of lack of access have been raised during litigation, to date no evidence to support these claims has been provided.

Analysis of the Information and Concerns Expressed in Input from Affected Stakeholders as Required under 42 CFR §447.204(a)(2) and §447.204(b)(3):

Since publishing notice of the proposed rate change on September 4, 2015, HHSC has received hundreds of written comments (via mail, email, and fax) from Medicaid providers, Medicaid beneficiaries and parents of beneficiaries, and others. HHSC has also received letters from members of Texas' legislature and congressional delegation. Additionally, at the rate hearing on September 18, 2015, 182 individuals registered to testify and 147 individuals offered oral testimony. All comments have been in opposition to the proposed rates. In general, commenters indicate that the proposed reductions will have severe negative impacts on client access to care and provider financial viability. The comments are summarized below, followed by a summary of HHSC's response to the comments.

Summary of Comments

- CORF/ORF – The Outpatient Independent Rehabilitation Association (OPIRA), the trade association for CORF/ORF providers, submitted comments that the proposed rate reductions are greater than necessary to cut $50 million GR from the budget; will not allow providers to stay operational; and suggest that a significantly smaller reduction would achieve the savings required by Rider 50.
- HHA – The Texas Association for Home Care & Hospice (TAHCH) submitted comments stating that the proposed rates will result in little to no access to medically necessary home care therapy services for children with special needs and adults as providers will not have appropriate time to adjust their business practices to the reduced funding levels. TAHCH requested an analysis of access to care, evaluation of clinical impact on patients, small business impact, and evaluation of economic impact. The difference in operating costs between urban and rural providers was emphasized in some of the testimony. Providers also commented that Medicaid clients often have unreliable personal transportation (or none at all) so driving to a clinic to receive services may not be an option.
- Independent Therapists – The Independent Therapy Providers Association (ITPA) submitted comments against the reductions recommending that HHSC adopt the Medicare rate structure including the Physician Fee Schedule. In addition, HHSC should ensure the National Correct Coding Initiative (NCCI) standards are observed related to timed and untimed procedure codes. This would achieve savings consistent with industry standards.
- Early Childhood Intervention (ECI) – a number of the ECI-contracted providers submitted comments against the rate reduction. Comments emphasized that ECI is different than other Medicaid therapies because it is an entitlement program required to provide services by the federal government. Commenters asserted that ECI uses standardized testing to qualify children for services and is a cost effective model that delivers results with fewer total visits because they train families to be the primary therapist. ECI providers are nonprofit and local governmental entities. Comments asked for ECI to be excluded from the reductions.
- The National Association of Social Workers submitted testimony against the rate reductions stating that this change would create a therapy workforce shortage.

- Other commenters opposed to the proposed reductions asserted the following:
  - Therapy services are critical in allowing clients to develop and become productive members of society;
  - The process for setting the rates lacked transparency and stakeholder input;
  - MCOs are already paying less than FFS;
  - Hospitalization and costs could increase without therapy services if the reduction is implemented;
  - The reimbursement rates will create access to care issues.

Texas' Response to Stakeholder Input

HHSC has been working with stakeholders regarding the proposed rates since early 2015. An earlier rate proposal was the subject of a July 20, 2015, public hearing. HHSC's responses to stakeholder input received at the July 20 and September 18, 2015, public hearings as well as throughout this process are summarized below.

- Commenters at the July 20, 2015, public hearing indicated that the proposal to reduce Medicaid rates to 150 percent of Texas commercial insurance rates did not comply with Texas' reimbursement methodology, which does not include commercial insurance rates as an allowable point of comparison. In response to these and other comments, HHSC withdrew the July 20, 2015, proposal and developed a new proposal that bases proposed rates on Medicaid fees paid by other states and previous Medicaid payments for Medicaid-reimbursable therapy.
- In response to stakeholder concerns expressed at the July 20, 2015, public hearing, HHSC limited rate reductions for certain services. Specifically, after hearing comments regarding the medical fragility of clients receiving therapy for swallowing dysfunctions, HHSC limited the proposed reductions to rates for procedure codes 92526 (*Treatment of swallowing dysfunction and/or oral function for feeding*) and 92610 (*Evaluation of oral and pharyngeal swallowing function*) to 3.45 percent.
- In response to stakeholder concerns regarding access to care, HHSC has developed a monitoring plan, described below under Access Monitoring Review Plan.
- In response to stakeholder statements by some providers during one-on-one meetings that they cannot afford to provide services under the proposed rates, they were asked to provide cost models justifying the rates they indicated were required to maintain access to care. To date, the providers have not submitted the cost models requested by HHSC.
- HHSC performed the numerous analyses which are summarized throughout this document to determine the validity of general comments that the proposed rates are inadequate to support access to care and a healthy provider base. In general, the analyses indicated that the proposed rates are adequate to support access to care provided by economic and efficient providers.

<u>Access Monitoring Review Plan as Required under 42 CFR §447.203(b)(6)(ii):</u>

In an effort to ensure appropriate therapy services are available to Medicaid clients, and in accordance with the requirements of 42 CFR §447.203(b)(6), HHSC will carefully monitor

provider availability and access to care for at least three years after the effective date of the proposed rate reductions. The frequency of monitoring will occur no less than annually. Indicators include:

- Monitor client complaints, including analysis of reported versus substantiated complaints
- Monitor utilization patterns of clients served by affected therapy providers, including discrete provider types and patterns across different client groups.

Mechanisms for Ongoing Beneficiary and Provider Input on Access to Care as Required under 42 CFR §447.203(b)(7):

In an effort to inform access to care and in accordance with the requirements of 42 CFR §447.203(b)(7), HHSC will establish and/or continue to utilize existing ongoing mechanisms for beneficiary and provider input on access to care including the following.

- HHSC Ombudsman Office. HHSC's Office of the Ombudsman is comprised of a team of professionals committed to a high level of customer services. Staff take in, refer and respond to calls and correspondence from the public, working closely with health and human services agencies' leadership, management and program staff.

  The Office of the Ombudsman helps people when the agency's normal complaint process cannot or does not satisfactorily resolve the issue. The Office of the Ombudsman's services include:
  - Conducting independent reviews of complaints concerning agency policies or practices;
  - Ensuring policies and practices are consistent with the goals of HHSC;
  - Ensuring individuals are treated fairly, respectfully and with dignity; and
  - Making referrals to other agencies as appropriate.

- Complaints, Appeals and Provider Resolution Division. Medicaid fee-for-service providers must exhaust the administrative and medical appeals provider resolution process with the HHSC claims administrator contractor before filing an appeal or complaint with HHSC. There is a monitored internal mailbox where complaints and issues received from throughout the HHSC enterprise (e.g., Health Plan Management, Ombudsman, Policy, etc.,) are compiled. All issues and complaints are tracked in a database.

- Rate Hearing Comment and Resolution Process. The HHSC Rate Analysis Department (RAD) holds quarterly and, if required, special rate hearings to obtain public comment on proposed rate reimbursement adjustments.
  - Notices announcing the rate hearings with instructions for accessing the rate hearing packets and public comment procedures are published in the *Texas Register* and on HHSC websites.
  - Prior to the rate hearing, rate hearing information packets are posted on the RAD website and an email notice that the packets are posted is sent to stakeholders.
  - Rate hearings are video broadcast live and are archived on the HHSC website for public viewing.
  - Written comments are accepted prior to the rate hearing via email, fax, and mail. Spoken testimony comments are recorded on the day of the rate hearing. Commenters have the

opportunity document and discuss their support for the proposed rate actions or how the proposed rate actions will specifically create an access to care issue for their Medicaid clients.

- All comments are reviewed and summarized on a spreadsheet
- After the rate hearing and prior to making a final recommendation, RAD staff review and analyze all submitted comments and documentation. Staff will consult with clinical, policy and other appropriate HHSC staff regarding any access to care issues raised through the rate hearing comment process and the merit of such comments. After such consultation, RAD staff may either recommend to HHSC leadership support for the original recommendations or develop alternative rate adjustment recommendations.
- The summarized comments, analysis and RAD recommendations are presented to HHSC leadership for review, discussion and a decision.
- Once a decision is finalized, RAD directs HHSC's claims administrator to implement the new rates and publish provider notifications regarding the adopted rates and their effective date. This information is published and available to the public on the claims administrator's website.

Overall Conclusion

The preponderance of evidence presented in this document indicates that the proposed rates comply with Section 1902(a)(30)(A) of the Social Security Act and 42 CFR §§447.203-204. This evidence includes:

- Analyses performed in 2015 that indicated SFY 2016 payments made under existing Texas Medicaid acute care therapy rates would exceed payments that would have been made had Texas used Medicare's fee schedule rates by $313.4 million AF. These analyses showed that for procedure codes with both Texas Medicaid and Medicare rates, 94 percent of Medicaid acute care therapy rates for CORF/ORFs, 80 percent of the rates for independent therapists, and 63 percent of the rates for HHAs exceeded the Medicare rates for the same procedure codes.

- Analyses performed in 2015 that indicated SFY 2016 payments made under existing Texas' Medicaid acute care therapy rates would exceed payments that would have been made had Texas used the 11-state Medicaid median rate as captured by the Truven database by $396.5 million AF. These analyses showed that for procedure codes with both Texas Medicaid and 11-state Medicaid median rates, 79 percent of Medicaid acute care therapy rates for CORF/ORFs, 73 percent of the rates for independent therapists, and 63 percent of the rates for HHAs exceeded the 11-state Medicaid median rates for the same procedure codes.

- Analyses performed in 2015 that indicated SFY 2016 payments made under existing Texas' Medicaid acute care therapy rates would exceed payments that would have been made had Texas used the Texas commercial median rate as captured by the Truven database by $380.3 million AF. These analyses showed that for procedure codes with both Texas Medicaid and Texas commercial median rates, 84 percent of Medicaid acute care therapy rates for CORF/ORFs, 82 percent of the rates for independent therapists, and 73 percent of the rates for HHAs exceeded the Texas commercial median rates for the same procedure codes.

- A comparison of the Texas rates proposed to be effective July 15, 2016, to the 11-state Medicaid median rate as captured by the Truven database that shows that out of 514 codes for which an 11-state Medicaid median rate was available, 67.1 percent of the proposed Texas Medicaid rates exceed the 11-state Medicaid median rates for the same codes.

- A separate comparison conducted by HHSC Rate Analysis staff of information available from 11 states' Medicaid programs (Alabama, Arizona, Florida, Georgia, Illinois, Louisiana, Minnesota, New York, Ohio, Oklahoma and Washington) to the 11-state Medicaid median rate as captured by the Truven database that indicated that, in general, the Truven database represents higher Medicaid rates than those paid in some of the most populous states in the nation.

- A margins analysis that presents evidence that the rates proposed to be effective July 15, 2016, are adequate to cover provider expenses in providing Medicaid acute care therapies.

- Analyses of LTSS therapy costs as captured by Texas Medicaid cost reports that show the proposed acute care PT and OT rates exceed median LTSS PT and OT therapy costs by 152 to 213 percent depending on provider type and exceed the median LTSS ST costs by 146 to 182 percent depending on provider type.

- Evidence provided by the predominant Texas Medicaid MCO for pediatric clients in Harris County that it is able to recruit an adequate number of therapy providers while offering rates for acute care therapies that are below the proposed Texas Medicaid FFS rates.

- Evidence provided by Texas' largest Medicaid MCO (Superior) that reducing payments to therapists would not stop it from providing children with "all of the services they need."

- Evidence from analyses of Texas Medicaid acute care therapy metrics, including geo-mapping, that indicate adequate access to Medicaid acute care therapies under the current rates and provide evidence indicating a strong possibility of over-capacity under the current rates.

While Texas is confident that the proposed rates are more than adequate to meet the financial requirements of an economic and efficient provider, in recognition of the critical nature of some Medicaid acute care therapy services, Texas will diligently monitor its program on a regular basis to ensure that Medicaid clients continue to have appropriate access to therapy services, and the appropriate state leadership will be notified if any concerns arise.