



AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION

June 4, 2018

Ms. Pam Hull  
Administrator  
Agency for Health Care Administration  
Bureau of Plan Management Operations  
2727 Mahan Drive, MS #50  
Tallahassee, FL 32308

Dear Ms. Hull:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the document entitled, “Enhanced Utilization Model for Physical Therapy, Speech Therapy, and Occupational Therapy,” issued by the American Therapy Administrators of Florida (ATA/HN1) to therapy providers in Florida.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 198,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA opposes State Plan Amendment (SPA) waiver proposals that would restrict access to Medicaid services by accepting the proposals from Medicaid Managed Care Organizations (MCOs) that limit enrollment and access to care for individuals with disabilities or those with low incomes. Therefore, we are concerned that the processes described in the document will result in restricted services provided to these individuals.

ASHA supports the letter submitted to the Agency for Health Care Administration (AHCA) on May 15, 2018, by the Florida Association of Speech-Language Pathologists and Audiologists (FLASHA).<sup>1</sup> We also appreciate the response that you provided to FLASHA. While FLASHA’s comments go into extensive detail, ASHA wants to highlight the following three issues of concern:

- **Medical Necessity:** As it pertains to Early, Periodic, Diagnosis, Screening, and Treatment (EPSDT) services for children, the Centers for Medicaid & Medicare Services (CMS) notes that beyond the screening and preventive health services covered under EPSDT, the Medicaid benefit for children and adolescents diagnostic and treatment services are also covered to correct or ameliorate a child’s physical or mental condition(s). In general, *states must ensure the provision of, and pay for, any services, including treatment, in accordance with mandatory and optional benefits identified in section 1905(a) of the Social Security Act, determined to be “medically necessary” for the child or adolescent. The determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account the particular needs of the child. States are permitted (but not required) to set parameters that apply to the determination of medical necessity in individual cases, but those parameters may not contradict or be more restrictive than the federal statutory requirement.*

ATA's utilization management (UM) model is contrary to the provisions identified in the italicized sections above because it restricts provision, makes blanket assignment of how much treatment is to be provided, and establishes criteria that are more stringent than those established under EPSDT guidance.

- Authorization and Appeal of Decisions: The multi-layered process for authorizing services is cumbersome, and may lead to delays in needed services because the provider is required to go through numerous steps prior to initiating treatment. Capitating the amount of treatment that can be provided means that qualifying for additional benefit periods is nearly impossible, and yet, based on the EPSDT criteria that decisions are made on a *case-by-case* basis would mean that some individuals should qualify for additional episodes of care. Any interruption to treatment while awaiting authorization is in violation of established plans of care. It is important to note that the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) includes a measure for timely access to care as a key component in the delivery of quality health care.<sup>2</sup>
- Access and Adequate Provider Network: The UM model describes plans where providers are adequately compensated for provision of treatment, but only if a limited number of treatment sessions are provided. The amortized payment per session decreases when more sessions are provided. This does not recognize the individualization of treatment plans of care. While the Supreme Court ruling in the *Armstrong v. Exceptional Child Services, Inc.* case determined that providers could not sue states for increased Medicaid rates, the subsequent regulation (42 CFR 447.203-4) includes requirements that states provide information to help CMS determine whether pay cuts impact access to care. These decreases in payment that result when a rate is set for a condition would discourage a provider from participating in the plan and subsequently limit access to providers for beneficiaries.

ASHA requests that AHCA reconsider this model in light of the impact it has on the most vulnerable individuals. ASHA greatly appreciates your response to the FLASHA letter and would be happy to provide any additional information that would assist AHCA regarding this issue. If you or your staff have any questions please contact Laurie Alban Havens, ASHA's director, health care policy, Medicaid and private health plans, at [labanhavens@asha.org](mailto:labanhavens@asha.org).

Sincerely,



Elise Davis-McFarland, PhD, CCC-SLP  
2018 ASHA President

cc: Charlene Westman, FLASHA  
[charlenewestman@yahoo.com](mailto:charlenewestman@yahoo.com)

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<sup>1</sup> Florida Association of Speech-Language Pathologists & Audiologists. (2018). *ATA/HN1 and EPSDT*  
[https://cdn.ymaws.com/www.flasha.org/resource/resmgr/FLASHA\\_Medicaid\\_Task\\_Force\\_L.pdf](https://cdn.ymaws.com/www.flasha.org/resource/resmgr/FLASHA_Medicaid_Task_Force_L.pdf).

<sup>2</sup> Medicaid and CHIP Payment and Access Commission. (2017). *Monitoring Access to Care in Medicaid*. Retrieved from  
<https://www.macpac.gov/wp-content/uploads/2017/03/Monitoring-Access-to-Care-in-Medicaid.pdf>.