



FLASHA
Florida Association Of Speech-Language
Pathologists & Audiologists

FOTA
Florida Occupational Therapy Association

FPTA
FLORIDA PHYSICAL THERAPY ASSOCIATION



July 23, 2019

Ms. Beth Kidder
Deputy Secretary for Medicaid
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Cc: Mary Mayhew, AHCA Secretary

Dear Ms. Kidder,

On behalf of the Florida Association of Speech-Language Pathologists and Audiologists (FLASHA), Florida Occupational Therapy Association (FOTA), Florida Physical Therapy Association (FPTA) and the Alliance for Pediatric Therapies, we are contacting you regarding AHCA's current methodology for ensuring equitable provision of Medicaid therapy services to Florida's children with special needs as administered by the contracted Managed Medical Assistance Program Providers (MMAPs).

Our concerns include:

1. **EPSDT**--Children are not receiving the necessary amount, duration, and/or scope of services, as defined by the federal guidelines, to produce the intended outcomes.
2. **Utilization Management Master Contract Provision**--Although prohibited by the Master Contract, third-party contractors, such as ATA/HN1, may profit financially by denying, limiting, or discontinuing medically necessary therapy services.
3. **Violation of Due Process**--Despite the provider's contractual obligation in addition to the training ATA/HN1 provides, ATA/HN1 will attest that providers are allowed to appeal to the MMA plan. Yet, in practice, this process is kept at the ATA/HN1 level, as a peer-to-peer review with ATA/HN1, and not with the plan. Therefore, parents do not receive a "Notice of Adverse Benefit Determination" (NABD) from ATA/HN1.
4. **Reporting of Network Adequacy/Erroneous Provider Directories**--From the inception of the Medicaid Medical Managed Care Program, there have been indications of MMAP provider directory inaccuracies regarding therapists.
5. **Conflict of Interest**--The policies and actions of ATA/HN1 are consistent with a conflict of interest to ensure profit over the quantity and intensity of services provided to the child.
6. **Capitation/Prospective Payment Model and Encounter Data Requirements**--The lump sum reimbursement amounts that ATA/HN1 pays to providers are not adequate relative to the costs of service delivery.

Specifics are addressed in detail in the attached document following this letter. For many years, these and other concerns have been reported to AHCA and the MMAPs by our state organizations, as indicated by the supporting documents which are listed and **available by request**.

FLASHA, FOTA, FPTA, and the Alliance for Pediatric Therapies jointly declare that these concerns are a priority and need to be addressed by AHCA at this time. In particular, we believe that a review of the use of third-party networks by MMAPs is essential to ensuring that all of Florida's most vulnerable children are receiving therapy services that are equal and appropriate



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to best meet their needs, and that access to these medically necessary services is not restricted under the law. We request that a meeting, with the relevant parties within AHCA and the Medicaid Managed Care Program administration, be arranged as soon as possible, so that we can discuss resolutions together. Statewide, our organizations, therapy providers, and families look forward to your response. To arrange for a meeting, please contact Tad Fisher, CEO of the Florida Physical Therapy Association at tfisher@fpta.org or call cell: (904) 219-7226 office: 850-222-1243, Address: 800 North Calhoun Street, S-1-A, Tallahassee, FL 32303

Sincerely,

Shannon Hall-Mills, Ph.D., CCC-SLP
President- Florida Association of Speech-Language Pathologists and Audiologists

Douglene Jackson, PhD, OTR/L, LMT, ATP
President- Florida Occupational Therapy Association

Jamie Dyson, PT, DPT
President- Florida Physical Therapy Association

Jan L. Wooten, OTRL
President- Alliance for Pediatric Therapies



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LETTER ATTACHMENT

Among our concerns are:

1. EPSDT

Many children are not receiving the necessary amount, duration, and/or scope of services, as defined by EPSDT, to produce the intended results. EPSDT has a broad mandate to provide medically necessary services to children covered under Medicaid. A number of the MMAPs have embraced this mandate and have facilitated provision of appropriate level of services to Florida's vulnerable children. However, some MMAPs have delegated the provision of therapy services (occupational, physical, speech-language) to third party therapy networks, specifically ATA of Florida, Inc. (ATA/HN1), that utilize prospective payment systems resulting in restricted access to medically necessary therapy services. Consequently, children enrolled in some MMAPs receive fewer services than they would if they were enrolled in other MMAPs or if exempt (in full Medicaid).

EPSDT mandates, under Medicaid [USC 1396a(a)(10)(B) implemented by 42 CFR 440.230], that services "must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The Medicaid agency may not arbitrarily deny, reduce the amount, duration or scope of a required service..."

It could be reasonably argued that, based upon its payment model, ATA/HN1 encourages its contractors to reduce the amount, duration and scope of services. Consequently, children enrolled in MMAPs that utilize ATA/HN1 as their therapy network provider receive substantially fewer services as compared to those enrolled in MMAPs that do not use ATA/HN1. It follows that these MMAPs are in violation of the comparability provision of Medicaid statute [42 U.S.C. 1396a(a)(10)(C)i]. This provision requires that "all Medicaid services...be furnished equitably."

While the ATA/HN1 reimbursement model does not overtly limit services under EPSDT, the results of restricting payments to 4 or 5 tiers—with the highest tier representing only ~30% of the maximum reimbursement amount paid by Medicaid directly or by non-ATA/HN1 MMAPs for an equal level of service—effectively does restrict services as afforded by the individual providers. If data were available regarding frequency and duration of visits provided by the various MMAPs, this would show that children receiving medically necessary therapy services via the ATA/HN1 model receive substantially fewer services than from non-ATA/HN1 MMAPs or traditional Medicaid (FFS).

"EPSDT imposes requirements additional to those of the regular Medicaid program in that it is intended to produce results" [Band v Stanton, 655F2D 766 (7th Cir 1981). In another court case, it was found that EPSDT "imposes on states an affirmative obligation to see that minors actually receive the necessary services [Doe v Pickett, 480 F Supp 1218 (SD W VA 1979)]."



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2. Utilization Management Master Contract Provision

The Managed Care Plans [Sunshine, Humana, Amerigroup, Molina, etc.] must ensure that compensation to individuals or entities [ATA/HN1] that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, in accordance with 42 CFR 438.210(e) (AHCA Model Contract Attachment II, p. 71).

ATA/HN1 refers to themselves as a “provider network,” thereby conflating the contractual relationships between Medicaid, MMAPs, and therapists. This enables ATA/HN1 to assume the role of “provider.” In effect, therapists who sign contracts with ATA/HN1 are no longer providers—they become contractors to ATA/HN1 and not traditional Medicaid providers. Although ATA/HN1 makes decisions on behalf of each MMAP in the same manner that UM entities would, ATA/HN1 functions as a provider network, not a UM entity. And their compensation structure alone effectively results in reducing services to recipients in order for them to profit financially.

Prior to the implementation of the Medicaid MMC program, AHCA contracted with eQHealth Solutions as the Quality Improvement Organization (QIO) to perform utilization management for therapy services. Under this model, claims were reimbursed directly by Medicaid, not eQHealth, and the compensation structure was such that there were no incentives to deny, limit, or discontinue medically necessary services to an enrollee since the payment for services did not come from eQHealth’s company funds. Unlike eQHealth, ATA/HN1 contracts as the “UM” entity for various MMAPs. The MMA plans compensate ATA/HN1 to provide services to Medicaid enrollees through their provider network. The providers (therapists) contracted with ATA/HN1 are reimbursed by ATA/HN1 from their company funds, not Medicaid. It is apparent that this compensation structure between the MMAPs and ATA/HN1 creates circumstances that financially incentivize ATA/HN1 to deny, limit, or discontinue medically necessary therapy services to enrollees.

If the compensation/payment structure is such that the MMAPs pay ATA/HN1 on a scheduled, recurring payment, or capitated model, it is reasonable to expect that the greater the reductions of authorized services the greater the financial gain; thus creating a monetary incentive for ATA/HN1 to deny, limit, or discontinue medically necessary services to enrollees. Service delivery should be quantifiably monitored by AHCA to ensure compliance with EPSDT.

3. Violation of Due Process

As evidenced by the attached document, dated February 22, 2006, written by Catherine McGrath (AHCA Medical/Health Care Program Analyst, Medicaid Program Compliance Unit), and sent to Michael Turrell (Wellcare, VP of Regulatory Compliance), the concerns regarding ATA/HN1’s compliance with due process are longstanding. In this letter, it was stated that “ATA’s grievance process omits the Medicaid Fair Hearing system and continued treatment under contract.” Although it was required by AHCA that this issue be remedied in order for ATA/HN1 to become an approved MMAP vendor, to date, we are not aware that it was addressed or reviewed further.

The duality of roles for ATA/HN1 is that they present both as a therapy network but also as a third party administrator since they make UM decisions.

If ATA/HN1 is a network of therapy providers, then it would be inappropriate for them, as the administrator of the therapy network, to dictate how services are to be rendered by therapists



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within ATA's own network. ATA/HN1 enlists clinicians within their network to provide services based on ATA's own recommendations, given ATA's capitated/lump sum structure, and not the clinical decisions of the practitioner; this creates direct conflict.

"Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements (EPSDT: A Guide for States, 2014).

In the structure of a typical therapy practice, decisions about the scope of services a child receives remain within the hands of clinicians who directly provide services, not the managers of their practice.

If ATA/HN1 is functioning as a utilization management company, then their contract mandating treating providers accept ATA/HN1's decisions as "final" would be in opposition to Medicaid Guidelines allowing for appeals and Fair Hearings.

Due process is meant to ensure that parents and guardians have explicit rights and procedures. As evidenced above, ATA/HN1 may be in violation of 59G-1.100 Medicaid Fair Hearings (3) Jurisdiction and Right to a Hearing (b) Notice of Plan Appeal:

1. A notice of plan appeal resolution indicating that the plan appeal did not result in the reversal of a prior denial of a new service, or the reduction, suspension, or termination of a previously authorized service, if timely challenged by the enrollee in accordance with the plan appeal procedures following the timely issuance of the plan's Notice of Adverse Benefit Determination (NABD) to the enrollee, 2. The failure of the plan to adhere to notice and timing requirements applicable to plan appeals, and/or 3. The failure of the plan to timely notice the enrollee through a NABD, subsequent to the plan's failure to provide medically necessary services requested by the enrollee to the enrollee with reasonable promptness.

From ATA/Provider Contract:

3.10 Administration- "(a) PROVIDER agrees to cooperate, participate in, and **comply with** Payer's or **ATAHN1's UM/QI Program**, including peer review and/or provider or Beneficiary grievance programs, if and when applicable, external audit systems and administrative programs as may be established by ATA. **PROVIDER shall comply with all final determinations rendered pursuant to the UM/QI program.**"

From ATA/HN1/Provider Training Tool, 12.18.17, page 9:

*"...based on ATA delegated responsibilities, **the case will either be denied by ATA or referred to the health plan with recommendation for denial.**"*

Despite the provider's contractual obligation in addition to the training ATA/HN1 provides, ATA/HN1 will attest that providers are allowed to appeal to the MMA plan. Yet, in practice, this process is kept at the ATA/HN1 level, as a peer-to-peer with ATA/HN1, and not with the plan. Therefore, parents do not receive a "Notice of Adverse Benefit Determination" (NABD) from ATA/HN1. Unfortunately, most therapists are unaware that, per AHCA guidelines, ATA/HN1 is not allowed to deny or reduce services--only the MMAP is permitted to do so. To date, we have only found a few rare cases in which appeals have made it to the plan level since ATA/HN1 reductions and denials are rarely allowed to be appealed through a Fair Hearing.



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In addition, ATA/HN1's procedural requirements make it difficult for providers (and parents) to understand what the authorizations for services actually are. For example, ATA/HN1 will not allow frequency/duration ranges to be recommended by the provider in the POC (e.g., x1-2/week, 30-60 minutes). Yet, ATA/HN1's "Levels", as specified in their model, are correlated to a range of visits that they stipulate their payments will cover. To illustrate, the authorization range for a "Level 5" is 37 visits up to 78 visits within a six-month time period. A provider's reimbursement is the same whether they provide the minimum ATA/HN1 requires, 37 visits, or the maximum the child requires, 78 visits. As a result, ATA/HN1 avoids issuing adverse determination/reduction of service notifications.

Current providers have documented evidence indicating that when they were going to appeal directly to the MMAP, ATA/HN1 has revised/increased their "Level" authorizations, thereby preventing reduction notices from going to the plans. At times, ATA/HN1 appears to be more lenient when assigning "Levels" and approving upgrades, seemingly in order to avoid complaints or attempts from going through due process. ATA/HN1's deception becomes apparent when comparing authorizations for children with significantly different severity "Levels" of disability. Despite varying degrees of medical necessity, they are receiving authorizations at the same "Levels." This is in direct contrast to ATA/HN1's Training Tool and the Milliman Care Guidelines (MCGs) that they purportedly use.

Moreover, MCGs are being used to make authorization determinations. Yet, when therapists ask ATA/HN1 to provide these guidelines, in order to substantiate authorization decisions and review them in the context of an approval or denial, ATA/HN1 denies their requests, stating that the MCGs are "proprietary." However, there is precedence established that overrides ATA/HN1's position. Hearing officers have consistently sided with providers, requiring that the "proprietary" guidelines used in decision making be granted to providers.

ATA/HN1's lack of compliance with a client's due process rights, as well as their dual roles as a therapy network and third-party administrator, are not new. To the contrary, these concerns have been brought to the attention of AHCA more than ten years ago. Sadly, unless the concerns brought forth are addressed and resolved, the adverse long-term impact on our most vulnerable population will be felt for years to come.

4. Reporting of Network Adequacy/ Erroneous Provider Directories

From the inception of the Medicaid Medical Managed Care Program, there have been indications of MMAP provider directory inaccuracies regarding therapy providers. Often, providers are contacted by parents seeking therapy services for their children as per these directories; however, the provider is not in network or not accepting new patients with this plan.

Occasionally, therapists have searched provider directories in order to refer children, when they were no longer contracted with a particular plan. In some cases, providers have found that they are listed in a directory for a plan that they are *not* contracted with or, instead, they might be excluded from the directory for a plan that they *are* contracted with. During the Spring of 2018, numerous provider complaints were submitted to AHCA pertaining to the accuracy of provider directories in Region 9. Unfortunately, this looks to have been to no avail.



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In May of 2019, a concerned provider in Miami-Dade County requested public records information in regard to network adequacy data. The response to that request consisted of a summary report of the percentages/ amounts of required and registered providers per MMAP, per region and per specialty. The report showed no registered providers, in any region, for any plan, for any of the pediatric therapy specialties (occupational, physical, speech).

The agency response to this anomaly was that “this is a known error on the report that is currently under review.” It follows that this systems problem would impede AHCA’s ability to monitor provider network adequacies for therapy services. As required by Attachment II, Section VI. Provider Network - A. Network Adequacy Standards 3. Demonstration of Network Adequacy: “the Managed Care Plan shall submit a provider network file of all participating providers to the Agency or its agent(s) as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.”

The MMAPs are obligated to “enter into provider contracts with a sufficient number of providers to provide all covered services to enrollees and to ensure that each medically necessary covered service (as defined in Attachment II, Section I. A. Definitions) is accessible and provided to the enrollee with reasonable promptness (within the meaning of that term as set forth in 42 U.S.C. §1396a(a)(8).” As per the Master Contract Section VI Provider Network A. Network Adequacy Standards 1. General Provisions (a) and (b), “the Managed Care Plan shall develop and maintain a provider network that meets the needs of enrollees in accordance with the requirements of this Contract.” It also stipulates that “the Agency may impose sanctions and/or liquidated damages for failure to timely comply with the provisions of this section.”

5. Conflict of Interest

The policies of ATA/HN1 appears to be a conflict of interest to ensure profit over the appropriate quantity and intensity of services provided to the child. ATA/HN1’s need to reject recommendations for frequency and intensity by the individual with first-hand knowledge of the child’s abilities and needs is very striking. That alone violates the concept of an individualized plan of care.

This observation is strengthened by ATA/HN1’s insistence on assigning a level of reimbursement with no opportunities for appeal (and as noted earlier- with no variation between levels). Moreover, the lack of transparency surrounding ATA/HN1’s arbitration process (ATA/HN1 Peer-to-Peer review) is alarming. Florida’s Medicaid program require adherence with Florida Sunshine Laws on the actions of Medicaid-affiliated organizations. It appears as if ATA/HN1 is attempting to avert compliance with Sunshine law requirements.

6. Capitation/Prospective Payment Model and Encounter Data Requirements

The lump sum reimbursement amounts that ATA/HN1 pays to providers are not adequate relative to the costs of service delivery. Although a level 5 reimbursement of \$600.00 would appear to be a substantial payment, a closer look at the number of therapy sessions that need to be provided, as per a Plan of Care (POC), and the cost of service delivery per session, proves otherwise. The plan of care for a child with a severe disorder typically requires three (3) 60-minute sessions per week. As compared with the Medicaid rate schedule, in a two (2)-month period, comprised of 8-9 weeks, total reimbursement would be \$1714.56-\$1928.88. Dividing \$600.00 (ATA/HN1’s Level 5 reimbursement), by the number of sessions in a two (2)-month period, would be \$22.00-\$25.00 (for an hour session), as compared to the Medicaid rate of \$71.44 per hour session.



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This disparity is highly unreasonable given the costs associated with the provision of therapy services. It would appear as if this reimbursement rate comparison demonstrates that ATA/HN1 is acting in its own interest and not the interest of the Medicaid recipient. This significantly reduced rate clearly illustrates why providers would be unable to fulfill the therapy session frequency/duration as specified by the POC in accordance with the child's medical necessity.

Therapy providers have relayed that, in an attempt to recruit them for their network, ATA/HN1 has used the rationale "you win some, you lose some." In other words, if some children do not have good attendance, due to illness or other circumstances, the provider will benefit because the level payment (i.e., Level 5= \$600.00) reimbursement may turn out to be more than needed for the 2-month period. The premise is that this will offset the losses incurred by the provider when a child does have good attendance and all therapy sessions as per the POC are provided. However, contrary to their own recruitment philosophy, ATA/HN1 recently announced the implementation of "Encounter Data Submission Requirements," effective May 30, 2019. Following these new minimum encounter requirements, it will no longer be possible for providers to "win some."² As is outlined in Footnote 2, if a certain number of sessions are not met in each two month period, the payments will not continue. This creates a significant concern that these children will be dropped by providers who cannot continue to treat them without reimbursement. There are various reasons for absences in the pediatric population. Medically fragile children, as an example, could miss therapy sessions due to doctor's appointments, hospitalizations, or illnesses. The risk of them not having access to appropriate medical care would be high in this scenario.

Footnotes:

¹(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A) or (E), then—(i)the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups.

² ATA/HNI Prospective Payment/Encounter Models

- Level 1 \$72 is an Evaluation only
- Level 2 \$180 is for a mild impairment
- Level 3 \$320 is for a moderate impairment
- Level 4 \$420 is for a severe impairment
- Level 5 \$600 is for a profound impairment



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Assigned Impairment Level	Minimum Required Visit For First Payment	Minimum Required Visits from Evaluation Date for Second Payment with at least one visit occurring in the Second or Third Span	Minimum Required Visits from Evaluation Date for Third Payment
Level 2	1	6	11
Level 3	1	9	17
Level 4	1	11	21
Level 5	1	13	25

ADDITIONAL ATTACHMENTS AVAILABLE BY REQUEST

1. 2006 Wellcare ATA letter from AHCA discussing challenges with Fair Hearings
2. Humana Letter 2015- Corrective Action Plan
3. FLASHA Letter to AHCA addressing Corrective Action Plan 2018
4. FLASHA Letter to AHCA addressing UM Compensation 2018
5. ATA/HN1 Contract with Highlights
6. ATA/HN1 New Plan with Encounter Data Requirements
7. ATA/HN1 Case Scenarios from Training info on website indicating concerns with due process
8. ATA/HN1 Training info from website- entire document
9. News article pertaining to erroneous Centene directories
10. Provider example of New ATA/HN1 model communication with ATA/HN1