

## **ASD Advisory Committee – Reducing System Complexity Work Group — 9/30/15**

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Cross-workgroup team has begun developing a matrix provider services: who provides what and where.

The effort is designed to get a clearer picture of what services are being offered to individuals with ASD.

As a result of getting a grasp on the entire system, a map of sorts will be created and compared with 4 or 5 other states that have similar maps.

In an effort to reduce system complexity, all the health plans should consider covering a line of services that are not being currently covered through DDD or DDD-ALTCS – or in conjunction with the RBHAs as many of the missing services seem to be behavioral in nature.

Gaps are present because of the need to be enrolled in a specific plan – streamlining all the plans and services will aid the effort in reducing system complexity.

PCPs and therapists are having a difficult time understanding the authorization process for habilitative and rehabilitative services – with a universal assessment process, this confusion could be eliminated since the PCP and therapists would know what the child needs.

Where does ASD fit into AHCCCS policies in terms of medically necessary habilitative and rehabilitative services? Need to define this.

In terms of a recommendation for a systems-level change, a collaborative plan would include an all-inclusive list of entities and services that a child assessed with having ASD may need now and in the future – the acute plan would somewhat cocoon and facilitate an appropriate treatment plan that includes a full line of clinical determinations by the individual's providers or an interdisciplinary team.

The Department of Education is going to be critical in aiding the process of getting children the necessary services.

There is no approval code available to get an interdisciplinary team together to discuss treatment plans of specific individuals. Care coordinators may also be an appropriate alternative.

A value-based purchasing solution may be created in order to fulfill the need of coordinating care.

The current carve-outs are not helpful.

Health plans should be able to appropriately coordinate a treatment plan for child based on eligibility for the various programs.

For this population, the work groups need to be cognizant of what the population is wanting. The systems are so rigid, there is no flexibility. If for example, a plan gets a request from a physician, the plan will simply deny and send them to DDD, rather than attempting to coordinate with DDD. This results in members and families not knowing what door to use in order to appropriately navigate the system.

If a member is enrolled in DDD, the plans should take the lead. But, if the member's level of need is elevated to ALTCS, then DDD should be taking the lead given DDD contracts with the plans.

A comprehensive assessment, diagnosis, and treatment plan with care coordination would significantly reduce system complexity.

A global assessment would incorporate parent's most urgent concerns, assessment, diagnosis, and treatment plan with ongoing treatment to determine the level of need of the member. A form or template may be required in developing the globalized assessment.

Identifying who does what is equally confusing for not only members, families, and advocates, but also to the individuals who work within the system. Additionally, it is not clear as to where autism fits within the AHCCCS Medical Policy Manual (AMPM). Because of this uncertainty, the actions of health plans and others is adversely affected.

It is difficult for plans to coordinate with DDD if a referral for treatment is denied because of the amount of denials taking place, and the amount of effort/time to comply with AHCCCS requirements in regards to notifications. This takes into account the timeframes for the appeals process.

A team of individuals will need to meet regularly in order to maintain the progress that may be made.

Defining the correct terminology so everyone is on the same page is necessary – Early Identification & Referral work group is creating a “crosswalk.” For example, “assessment” is defined differently by different agencies.

A concrete list of mandatory, as well as optional, services for those diagnosed with ASD is necessary.

Differentiating between “care coordination” and “support coordination” is vital. The line of services is completely unknown to parents – professional input and communication is necessary and the ability for providers to get paid to coordinate care is also necessary to apply accountability.

Health plans may be contracted with DDD, but the plans do not even know who is or is not DD targeted. DDD would appreciate the opportunity to give the plans the ability to authorize all EPSDT services.

Mercy Care Plan has done analysis on the cost of services actually being utilized to treat ASD, compared with the cost of individuals roaming the system in an effort to treat ASD.

Uniform policies need to be implemented across the state in order to reduce system complexity.

When individuals read the AMPM, it is unclear where ASD fits – should simply state it is covered if medically necessary, rather than the rehabilitative piece.

All entities involved need to agree on the accuracy of the diagnosis.

DDD has the Early Childhood Autism screening that should be available to anyone thought to have ASD.

Parents are having difficulties navigating the system and coordinating behavioral health/acute care. Having co-morbid conditions, including ASD, make the process even more difficult – DDD is able to understand the needs of the child from a support coordination standpoint.

PAS tool is a perceived barrier and not believed to be appropriate for individuals with ASD.