ASD Advisory Committee Notes

10/28/2015

I. Welcome and Intros
II. Discussion about data requested from AHCCCS
    a. Q and A
        i. Q: Total Summary count? A: = distinct member count b/t two groups.
        ii. Q: At risk? A: Might present and on AHCCCS. If there are other types please advise ASAP.
        iii. Q: What is code for insurance…. A: ???, 313.9 and 783.42
        iv. Q: In claims with RBHA, might only bill under one. A: If member had other claims with PCP, would've been caught.
        v. C: Limitation in data. Q: What's the total of those under 21 and what % does this represent?
        vi. Q: Is this for all of 2014? A: Yes
        vii. Q: Done by PCP? A: Yes during EPSDT
        viii. Q: So does it mean that for 0-2, there's only 15? A: Only for those who were selected for ASD group. AHCCCS working to get screenings up.
        ix. C: Code is a screening and trying to get screened earlier for those who don't have diagnosis yet. Get them and get them screened and further evaluated with something more thorough than just a screening.
        x. C: One reason # is so low, since pediatricians not getting paid for this, it's likely they didn't submit code b/c nothing came of it. Now that we're working to get 96110 screening, might see it more. AHCCCS wants to incentivize providers and get them reimbursed. Encourages PCP to do developmental screening. AHCCCS implementing a PIP to drive performance up for 0-2 age range.
        xi. Q: Are pediatricians being paid now? A: Yes, once they have a certificate of training.
        xii. From Mercy Care HP, it started out for NICU and had to have training and use EP modifier. Now, it's changed…not just NICU, but paying out immediately and looking for training requirement after on the back end.
        xiii. AHCCCS previously shared when they started reimbursing.

    b. PT, OT: How far back to look after developmental screening for these services? A: What's the purpose? If to see how soon getting services, look at 1 month, 2 month, 3 months. Sharon will look to see the context of how this question came up. Consider how it will be used in forming recommendations.
        i. Consider some kids are getting these through AzEIP so perhaps not all claims would be captured. Curious if all the kids with developmental screening and determination that they needed therapies actually got therapies. Only way to do that is through a chart review.

ii. The issue is that kids are getting therapies but not further evaluation. There should be further evaluation as they get older.
iii. The issue is when you go to school the assumption is school will provide therapy when they actually provide minimal therapy. Also, when looking at data you have ASD kids and at-risk kids. Imagine there are very few ASD kids who would not require Speech and OT. If they have diagnosis they should be referred to therapy.
iv. Recommendation: Use diagnosis codes not the screening. Using encounter system, based on diagnosis set, see if speech, OT, PT and behavioral therapies are being delivered.
v. Think the intention is to see if they're getting diagnosed and if the screening efforts work to help get them services needed.
vi. Think about what you want to see happen and have recommendations around that.
vii. Helpful to see if they are DD/ALTCS
viii. Regardless if they get into DD/ALTCS, health plans should still be providing services. If Medicaid eligible would get through the HP or BH.
ix. If they get a developmental screen, how long does it take to get a diagnosis?
x. Also, confusion whether they can get service through the HP. Interesting to compare and see if they're getting different services.
xi. C: Let's also not forget CRS and Foster Care. A: they're included. C: But let's separate them out to compare.
xii. FC: Important to capture but keep in mind we want to be able to say: "This is how it should be and what we want to see. Don't keep waiting for data to decide how to move forward. It goes back to asking, how will this drive decisions about recommendations from the Committee?
xiii. C: Data helps show where problems are and how recommendations are important.
xiv. C: Remember there are limitations to the data. Being in the group has helped to find things to correct. Understand there are breaks in the system and can still improve.
xv. Summary: Want to make sure that recommendations are tied to data.
    1. Data on all kids who have autism who are ALTCS/DDD approved and had to apply more than once. Should also consider how many times reapplied for Medicaid. But it happens more on the DDD side vs. Medicaid…the PAS tool in general. It's not targeting DDD, but the PAS tool is a problem.
    2. Compare ALTCS/DDD to Medicaid
    3. Of 10,000 how many are ALTCS/DDD?
    4. Any member diagnosed with ICD9 ASD diagnosis, the quantity of PT, OT and speech received
    5. How long it takes to get an evaluation after screening. 96110 and 97

6. Use discrepancy to show it's taking extra time
7. Lots of anecdotal information, also and take into consideration the experience in the room.

III. ASD Services Chart- who provides what services and when for AHCCCS members with ASD. Aaron Blocher-Ruben, PhD, is coordinating this cross-workgroup project.
    a. Re chart #1,
        i. Clarify that DDD only can get services.
        ii. Missing CRS and Foster Care. But chart will lump and within it; differentiate. The way services are provided is different and distinction is important when considering provider network.
        iii. Clarify Medicaid vs. non Medicaid. Can use Medicaid chart to incorporate where services come from for individuals served with ASD.
        iv. Consider what other states doing - if you're CRS you had your own pamphlet so it makes more sense.
        v. Make info more family centered. Focus on child. It's not AzEIP, RBHA, etc. Have a template that puts that at the center of what they're seeking.
        vi. For children with multiple comorbidities, it becomes very difficult.
        vii. PCPs need this chart. But consider something else for families. HPs have to be the home. Start with AHCCCS Plan and if not, have a process to figure it out. Simplify.
        viii. Use tables/charts as a guideline. And there may be more than one table.
        ix. Add column on education. Purpose of the chart is for the committee.
        x. Still need system navigators who know how to get through the system.
        xi. What about non-ABA evidence based practices? For example, floor time, RDI, etc.
        xii. C: Early Diagnosis & Referral workgroup workingon something for families and roadmap for PCP.

Note: Aaron sent the following e-mail to the Committee after the meeting:

Thanks to everyone who came to the committee meeting yesterday and gave feedback for the chart! Here are a few updates that should help clarify our goals:

1. The intended use of the chart is for this committee. During the workgroups, there has been confusion about what AHCCCS actually covers, so this chart is designed to help with that. We all agree that a chart for parents and providers would be helpful, and maybe we can work on that once this is done. But for now, we just need a simple overview for ourselves to use.
2. The concept of "funding source" was confusing, because our funding streams are so complicated and. ..well…confusing! So a great suggestion was to change this to "provider network manager." That is, who manages the provider network? DDD, the RHBA, AZEP, etc…
3. We are going to add CRS to the provider network managers. We are also going to add a Floortime/etc. category to services.
4. We will remove "no funding source" and "private insurance" from the network managers. Although I thought this was a good idea initially to see what is only covered

outside of AHCCCS, I have changed my mind based on yesterday's input. It was also suggested to add Department of Education, but I am not sure if that fits for the purpose of this workgroup. All would certainly make sense if the chart were for parents and providers, but right now it's not.

If you have any further thoughts or suggestions please let me know. Otherwise, let's move on to Step 3 – filling in the cells! (the most important part).

It would be great if I could speak with someone at each of the network managers who knows these service guidelines very well. Please reply if you can do that for any service or network manager. Otherwise, I'll create a draft and we can do a conference call to go through each one for accuracy.

IV. Early ID and Diagnosis

No comments on slides.

V. Adults w/ ASD

a. In collaboration with ASU, workgroup conducted online survey on employment of adults with ASD. About 165 responses. Will review draft report and recommendations at next work group meeting.
b. C: DDD does a survey of its adults, is there any vocational rehabilitation info in there that would be helpful? DDD to provide info.
c. What about housing? Work group is addressing this.

VI. Emerging recommendations

CARE COORDINATION

a. Consider having a medical home and DDD handle community therapy.
b. If someone is an acute member it would be HP. But if in DD/ALTCS, would be DDD, the way it is now.
c. If qualify for ALTCS, get employment, housing, etc.
d. When discussing agency, is the question about plan level, payor level or provider level? Best research shows that at PCP medical home ,there's lots of good work; that having people embedded in PCP offices is the way to go. So, the payor is the benefits manager and coordination takes place at provider level which is member driven. In the BH world, people are used to CHC so stay away from PCP and use the CHC. In contrast, general mental health goes to PCP. Translate that principle here.
e. American Academy advises the medical home be the PCP. In AZ, care coordination is not paid for at the PCP level. The pediatrician needs to be empowered and reimbursed for providing medical and therapeutic care coordination. The pediatrician is who this child sees the most and has good relationships with families
f. But rather than the physician, what about physician's assistant who has the time to talk to families. Need to pay salary of whoever is doing the coordinating. Should be reimbursed for that service. Would like to propose a pilot to see how it works.
g. From a consumer standpoint, with the different provider networks, wherever the care coordination is located they need a hammer. Dealing w/ institutional care for children w/ serious acute health care needs and the systems are broken. Can't get through the

to the doctor's nurse because of the big system. If someone from the Plan calls, they would respond. Wherever it is there should be a hammer so it is effective.

h. If they had the codes to be reimbursed would be likely to attend meetings and make the calls.
i. What about a 2 part approach - PCPs working on project through AzAAP for care coordination and seeing kids get more of what they need. Having care coordinator in PCP offices is a good idea but also think there needs to be someone at the HP level who will coordinate with the care coordinator.
j. FTF has also worked on this.
k. Thinking broadly…PCP, health plan and community. All 3 need to be part of the 3 legged stool.
l. How has BH moved toward of integration of PH; still a separate system from wherever the coordinator is.
m. Consider that folks with ASD have complex issues, and accept that multiple systems will be involved so have guidelines and procedures and establish who is responsible for what. Everyone is different and have unique needs.
n. Requirement for Care Coordination should be part of contracts that providers sign and there needs to be a point person at the institution who knows that their contract requires them to coordinate.
o. Survey families so they have input if they're getting good care or not. Make part of contract.
p. Do in a way that we insulate against retaliation by care providers. It is a serious problem and they don't understand that they are Medicaid providers, and they need to follow the Medicaid rules and regulations when providing services and can't discriminate and refuse services. Someone needs to ensure adhernence.
q. Consider rewarding and not punishing.
r. Re CRS and Foster Care: if member is in CMDP [Comprehensive Medical and Dental Program], that is the HP. Have tried to ensure that the acute care HP is on the hook. It starts w/ the HP to avoid finger pointing.
s. Re incentives, does it include what payment methodologies are used?

VALUE BASED PURCHASING

a. This may help with DDD low reimbursement rate.
b. Make sure it doesn't become the minimum, like cap or bundle rates.
c. Bundle rates are the all inclusive amount a provider would get, but there are positives and negatives.
d. Who decides rates for providers?

DDD Eligibility Clarification

No comments

EVIDENCE BASED PRACTICE

a. Create a checklist of comorbid conditions and push out to PCP and make part of EPSDT appointment.
b. There's guidance in policy re best practices for PCPs.
c. Study re comorbid conditions for ERs.

TECHNOLOGY

a. App re diagnosis…would DDD accept?
b. App is expense $500. SARRC would look at coders and licensed clinical psychologist review results.
c. PCH was going to partner and see them for medical exams and review all possible comorbidities.
d. Is there reimbursement from AHCCCS if a family can see a professional through Skype?
e. Telemedicine consults …billed through private insurance and AHCCCS the same as regular visit. If it's a billable service there's an adjustor as incentive.
f. Electronic portals also exist to apply for a contract and can change a contract or add a service to streamline the process.
g. Can we clarify for future meetings re the app, and Skype and telemedicine. Is that a method of identifying a member with ASD knowing there's a shortage of providers?
h. Also clarify if telemedicine happening in the home? Not sure if that's operationalized in the system. Per PCH, they're at medical clinics, NOT in the home.
i. Some funders are doing and others are not.

ADDITIONAL CONCERNS

a. What about prevention? The absolute best treatment is to prevent. Taking a prenatal supplement at conception reduces by 40%. Should be preventing and doing education.
b. Create a workgroup to review research on prevention? At this point probably not possible but can include as part of one of the current workgroups. Could also be a recommendation from the committee. Health plans would be interested and try to identify pregnant women ASAP. Maternal and Child health and DHS public health.

NEXT STEPS

a. Will move forward to develop specific recommendations

ASD Advisory Committee Meeting

Session 5

October 28, 2015

Agenda

- Review of group norms, charge, and intentions
- AHCCCS Data—Lauren Prole
- Updates on work underway
- Emerging recommendations
- Next steps before Nov. 18 Committee meeting

Group Norms

- Help create an environment that allows all to speak freely and without concern:
    - Listen with an open mind and a collaborative mindset.
    - Speak concisely and respectfully.
    - One person speaks at a time, as called upon by the facilitator.
- The full Committee focuses on the overall goals—details and tactics will be handled by workgroups.
- Stay focused on the topic at hand and self-monitor to avoid tangents.
- When expressing agreement with other speakers, don’t use up time repeating what has been said.
- Work towards consensus on recommendations.

Charge to Committee

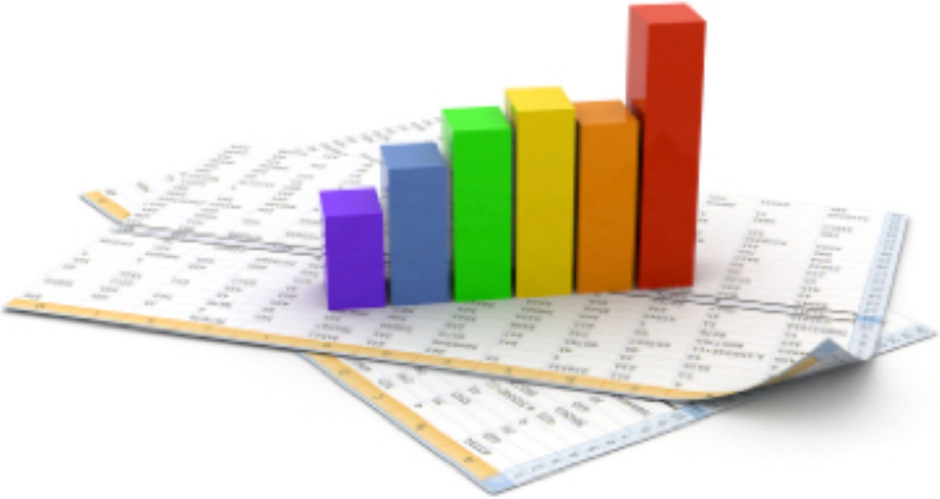
- Articulate a series of recommendations to the State for strengthening the health care system's ability to respond to the needs of AHCCCS members with or at risk for ASD, including those with comorbid diagnoses.
  - Focus on individuals with varying levels of needs across the spectrum, including those who are able to live on their own and those who may require institutional levels of care.
  - Address early identification of ASD and the development of person-centered care plans.

State of Arizona Intentions

- Break down silos in health care.
- Drive value-based purchasing efforts that reward quality over quantity.
- Bring together behavioral health and physical health.
- Reduce burdens on families of children with special health care needs in the CRS program.
- Coordinate care for people with behavioral health needs that interface with the justice system.
- Align care for dual-eligible members.

AHCCCS Data

Report from Lauren Prole



Update: ASD Services Chart

Cross-workgroup team is developing a simple chart to answer the question:

Who provides what services and when for AHCCCS members with ASD?

Report from Aaron Blocher-Rubin, Ph.D.

Design Approach

1. Identify all major treatments and services commonly recommended for ASD.
2. Identify all major funding sources that AHCCCS members *might* be able to get services from.
3. Create a chart to show which services are covered (and which ones aren’t) by each source, including age restrictions and other limitations.
4. Create 2 charts – one for children, one for adults.

Chart #1: Children (ages 0-17) [first draft]

- Funding sources:
  - AZEIP
  - DDD/ALTCS
  - DDD without ALTCS
  - RBHA
  - AHCCCS medical plans
  - Private insurance
  - No funding source (private pay only)

But what about …

- EPSDT?
- CRS?
- DDD TCM?
- (etc. etc. …)?

To create a 1-page chart, content needs to be simplified. An appendix & glossary will be attached to explain systems in more detail.

Chart #1: Children (ages 0-17) [first draft]

Treatments & Services:

- Diagnosis
- Medical & Dental Care
- Comprehensive ABA
- Focused/Targeted ABA
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Social Skills Groups
- Habilitation
- Respite
- Attendant Care
- Residential Services

Chart #1: Children (ages 0-17) [first draft]

- Content to include in each cell (i.e., service provided through a funding source):
    - Name of service (if specific to funding source)
    - Any age restrictions
    - Common levels of service (e.g., hours/week)

Chart #1: Children (ages 0-17) [first draft]

- Content to include in appendix
    - Major points regarding eligibility criteria
    - Notable specifics regarding service model
    - Important points about provider network
    - Anything critical that relates to getting this service
    - How variations of service intensity are determined

	AZEIP	**DDD + ALTCS**	**DDD w/o ALTCS**	**RBHA**	**AHCCCS medical plans**	**Private insurance**	**None (private pay only)**
Diagnosis							
Medical & dental care							
Comprehensive ABA		*HBM/ECA*. Start before age 4, until about age 6.				Covered by some plans. May have restrictions.	
Focused/ Targeted ABA		*Hab Consultation* (not yet available). Ages 6+.		Some providers with BCBAs have a program using this.		Covered by some plans. May have restrictions.	
Speech Therapy	Ages 0-2. Typically 1 hour/ week.	Ages 3+. Typically 1 or 2 hours/week.				Covered by some plans. May have restrictions.	
Occupational Therapy		Ages 3+. Typically 1 hour/ week.					
Physical Therapy							
Social Skills Groups		Could be done using speech therapy hours.					
Habilitation		All ages. # hours varies based on need.					
Respite		All ages. 600 hours/year max.					
Attendant Care							
Residential Services							

Next Steps

- Finalize the services, funding sources, and content for each cell.
- Create an outline for points to cover in more detail in an appendix & glossary.
- Repeat the process to create a services chart for adults (ages 18+).

Update: Early ID & Diagnosis

Early Identification & Referral Workgroup, in collaboration with AHCCCS staff, is creating:

- “Cross-walk” of terms that are used in different ways by different agencies
- Flowchart that maps out the screening, assessment, and diagnosis process
- Components of a Communications Plan about early identification and diagnosis for multiple audiences

Update: Adults with ASD

Adults with ASD Workgroup is developing and implementing:

- Online survey on employment of adults with ASD (in collaboration with ASU Autism/ Aspergers Research Program) — questions about current job situation and job-related services from DDD and Vocational Rehabilitation
- Conversations at program sites with adults with ASD to gather their perspectives and ensure that their voices are part of the Committee's recommendations

Emerging Recommendations

Integration <u>and</u> Choice

- Support for an **integrated** system of physical and behavioral care, where the whole health of the child or adult is considered — an ASD Medical Home
  - Would address complexity, fragmentation, and Committee’s concerns about current carve-outs
- In an integrated system, **choice** is essential.
  - Range of services and providers needed to meet the needs of each individual.
  - Integration does not mean “one size fits all.”

Care Coordination

- Given the complexity of service needs, co-morbidities, and multiple providers, consistent care coordination is essential.
- Care coordination supports the delivery of a range of therapies and interventions, depending on the needs of the individual.

Coordination Questions

- Which agency would serve as the “home” or “cocoon” for integrated services and coordinate:
  - Screening, assessment, and diagnosis
  - Interdisciplinary ASD treatment and ongoing evaluation of effectiveness of services
  - Medical and behavioral health services, with attention to high risk for comorbid conditions (acute care plans and RBHAs)
  - Coordination with schools/Dept. of Education
  - Consistent policies across agencies
  - Long-term care services for eligible individuals

Coordination Questions

continued

- For AHCCCS members who are DDD eligible, how does *care coordination* differ from *support coordination*?
- How would coordination with CRS and the Foster Care acute plan be handled?
- What would be the qualifications, continued training, and accountability of care coordinators?
- What incentives might be put in place to ensure all entities work with the care coordinator to deliver timely, high quality, coordinated care, with consistent communication across all agencies and health plans?

Value-Based Purchasing (VBP)

- Linking provider payments to improved performance by providers holds providers accountable for both the cost and quality of care they provide.
- Potential to reduce inappropriate care and to identify and reward the best-performing providers.
- Could address concerns about DDD’s low reimbursement rates compared to commercial plans and RBHAs. Low rates are a disincentive for qualified providers to contract with DDD.

Early Screening & Diagnosis

- Major “breaks” in the system between screening and referral:
    - PCPs may not know best practices regarding what to do next when screening indicates a potential problem.
    - PCPs perceive and/or experience barriers when they try to make referrals for diagnosis and services.
    - RBHAs vary in responses when a provider or parent seeks an evaluation for ASD.

DDD Eligibility Clarification

Who can diagnose ASD for the purpose of DDD eligibility?

Licensed psychiatrist, licensed psychologist, or developmental pediatrician.

The authorization for a diagnosis by a licensed psychiatrist or licensed psychologist is defined in DDD rule: Arizona Administrative Code R6-6-302.

The authorization for a diagnosis by a developmental pediatrician is included in DDD's Eligibility Manual, Policy 200-G.

Per Laura L. Love, Ph.D. Assistant Director/CEO, DDD

DDD Eligibility continued

Arizona Administrative Code R6-6-302. Guidelines for Determining Developmental Disabilities

"A. Autism, cerebral palsy, epilepsy, and mental retardation are determined as follows:

1. Autism — by a licensed psychiatrist or psychologist whose expertise in diagnosing autism is determined by the Division."

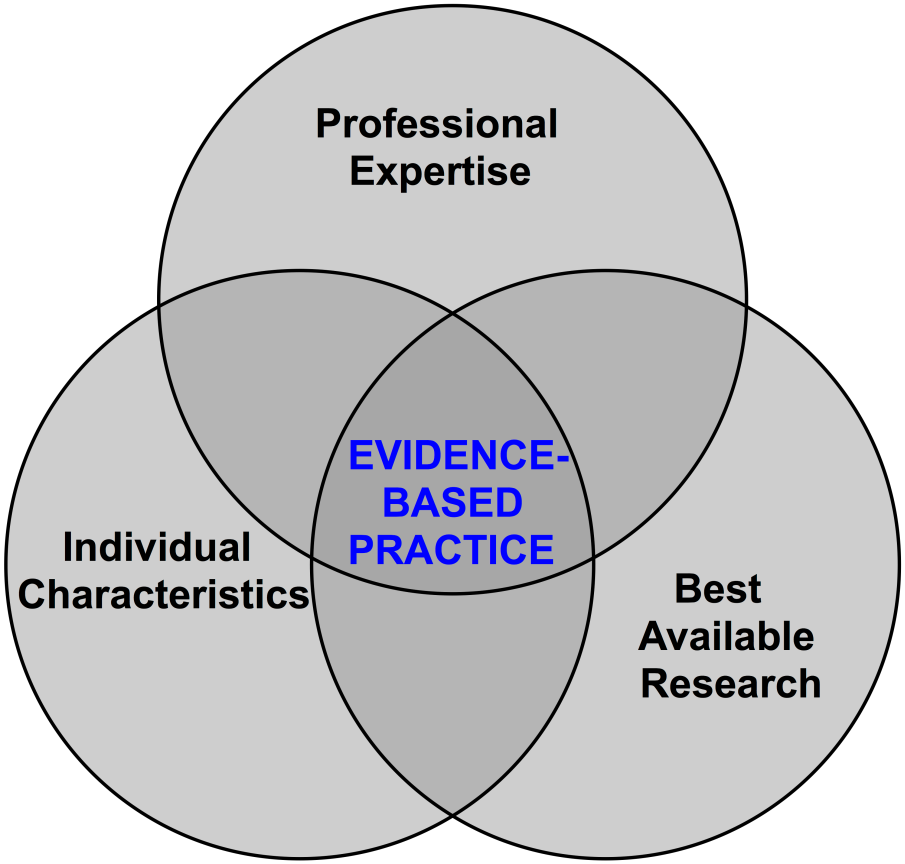
DDD Eligibility Manual, Policy 200-G, Autism (A)

"Acceptable documentation of autism must include a statement by, or evaluation from, a psychiatrist, a licensed psychologist, or developmental pediatrician with experience in the area of autism identifying a diagnosis of Autistic Disorder"

Evidence-Based Practice Definition

Evidence-based practice means a decision making process that integrates the best available scientifically rigorous research, clinical expertise, and the individual's characteristics. Evidence-based practice is an **approach to treatment** rather than a specific treatment. Evidence-based practice promotes the collection, interpretation, integration, and continuous evaluation of valid, important, and applicable individual- or family-reported, clinically-observed, and research-supported evidence. The best available evidence, matched to the individual's circumstances and preferences, is applied to ensure the quality of clinical judgments and facilitate the most cost-effective care. (*Adapted from CA Trailer Bill*)

Evidence-Based Practice



Missouri Autism Guidelines Initiative (2012)
Autism Spectrum Disorders: Guide to Evidence-based Interventions

Evidence-Based Treatment

Ideas under discussion:

- Use matrix of latest studies and classification of treatments (evidence-based/established, emerging/empirical support).
- Create a committee of multidisciplinary licensed professionals and a few family members to update matrix annually.
- Improve communication to families about all services available to them.
- Design and implement a consistent process for ongoing evaluation of whether a treatment results in improvement for the individual.

Technology

Greater use of technology to:

- Train pediatricians, dentists, and other providers about treating individuals with ASD (MMIC is doing online training)
- Support diagnosis and treatment (SAARC is working on this)
- Integrate data for each individual with ASD, leveraging the state’s Health Information System

Key Issues for Adults with ASD

- People are safe, healthy, happy, and living to full potential through:
  - Member-directed services
  - Coordinated, integrated physical & behavioral health care
  - Residence options
  - Employment options
  - Social connections
  - Community awareness
  - Supportive services

Additional Concerns

Need further discussion on:

- Feeding issues
- Oral health issues
- Genetic testing
- Prescribing authority (specifically, Risperdal/ Risperidone)
- PAS (Pre-Admission Screening) tool (a perceived barrier and not believed to be appropriate for individuals with ASD)
- Habilitation/Rehabilitation Distinction
- Others?

Next Steps before Nov. 18

Facilitator will assist each Work Group, through in-person meetings, teleconferences, and e-mails, to move forward in developing specific recommendations.

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