ASD Advisory Committee
Full Committee Meeting
December 16, 2015
AHCCCS Office, 701 E Jefferson, Phoenix AZ; Gold Room

Note-takers: Monica Coury and Theresa Gonzales

- Facilitator reviewed group norms and beginning/intro slides
- Lauren Prole from AHCCCS reviewed the data
    - This is a summary and not done by health plan
    - 70% of 10,000 were serviced through DDD
    - 57% of the 10,000 received a service through a RBHA
    - 48% through school based claims
    - Some numbers were too small by health plan so the AHCCCS privacy officer did not allow release/disclosure
    - Review by provider type
    - These are not all encompassing
    - 33,000 are at risk; review showed most receiving services through health plan
    - Q: Does the 1.4% # include individuals who are DD/ALTCS? A: Yes
    - Review of recommendations Services post 6 months after evaluation - Q: Top 10 providers: hab and others not listed? A: There, just not in top 10%

- Review of Executive Summary section:
    - Page 4, line 3. Question about wording. Facilitator explained this is how the work group decided to word this. OK. No other comments.
- Process of Process section – no comments
- Review of Systems-Level Recommendations
  AHCCCS Integrated Care
    - Page 6, line 11. Developing infrastructure…"multiple" contracts. One commenter says seems too easy the way it's explained. When special populations are woven into HPs, must make sure the infrastructure accounts for that. Facilitator said work group said choice is important but commenter said limited number of providers is difficult, so not sure about value of having 4 or 5 health plans having contracts with the same provider. Facilitator asked for suggestion about changing the word "multiple" and asked if "more than one" works. Most people agreed. One person brought up one contract covering the provider for all health plans, which is a new concept not previously discussed. After discussion, no proposal to add that. Agreement to say "more than one at the discretion of AHCCCS." AHCCCS is the agency that decides how many contracts it awards.
    - Page 6, lines 18-19: Issue re individual's medical home would be primary care provider. For a person with special need, a PCP may not be appropriate. A specialist may be more appropriate, like SMI clinic. Facilitator explained that work group recommended PCP because a person with ASD is at higher risk for co-morbidities. Commenter said but this assumes PCP knows ASD issues and they don't. Facilitator said other places in report

address PCP education. Another commenter said maybe we don't want to tie our hands but the health plan could use other models for medical home. Facilitator asked if everyone understood this? One member said she thought we wanted broader language so we don't tie plans' hands. Another commenter also supports broader language. "In general, the PCP is considered the medical home but plans can implement other models."

- Typo on line 29 – should be Applied Behavior Analysis
- Lines 37-39 (page 6) Do we mean ASD members only or DDD? Facilitator said just ASD. How would you suggest changing language to clarify? Say "individuals with ASD diagnosis" because DDD is much broader. Also – line 38 – covered by the AHCCCS acute health plan.
- Page 7, line 9 and 10. Revise wording to say AHCCCS is in process of adopting person-centered planning. Remove second part of sentence.
- Page 7, lines 11-13. Point about commercial payors not using same codes that AHCCCS uses. One suggestion was to adopt the codes whenever possible or once "universally accepted" codes are available.

Care Coordination

- One concern re health plans not paid for care coordination. Do we want to note that? Do we want to rely on value based purchasing? There are not going to be open codes. Someone said plans can pay on a PMPM to a provider and use value based. One suggestion was for page 7, line 22, plans can "explore models to encourage" instead of saying incentives.
- Page 7, line 24. Care coordinators have medical training line. Commenter said a lot of good care coordinators do not have medical training and some of our best are assistants, etc. Care coordinator should have "relevant experience and training"…
- Throughout the document: Page 8, line 5. It says for ALTCS members. My notion of ALTCS member is different from a DDD member and DDD targeted. Unclear if ALTCS means DDD or ALTCS means EPD and DDD. Group thinks this should specify that this is DES DD ALTCS and DD targeted members.
- Page 8, line 18 regarding habilitation and adding it. Facilitator explained this was not added because recommendation was integrating BH and PH into acute health plan contracted with DDD, which includes EPSDT and medically necessary services. One suggestion is changing wording to say, DDD will continue to cover HCBS services, which is a term of art and EPSDT goes to acute plan. Consensus on that suggestion.
- Line 28: specify AHCCCS acute health plan, clarify that HP needs to be able to track TCS (spell out, explain this means targeted).
- Line 34: add that AHCCCS acute health plans need to notify and coordinate with DDD when members transition between acute health plans.
- Line 35. Rationale was to keep continuity of provider. DDD comment about need to clarify the recommendation. Acute health plans = DDD contracted acute plans or all AHCCCS? Are providers willing? Can we add "whenever possible"? Consensus reached but one person said not sure if clarifies DDD contracted acute plans. Clarification

provided that this means both DDD contracted acute plans and all AHCCCS contracted acute plans

Value-Based Purchasing

- Page 9, line 3. Discussion about including quality measures to qualify a provider for incentives. Clarify quality-based incentives. One person said but why limit to quality because the improvement could be around quantity or timeliness. Also depends on volume of the practice. Lines 40, 41, 42 on page 8 address this. Consensus – on and page 9 leave in 1 and 2, eliminate 3, and leave in 4. Facilitator said recollection that this came in early in the process and value-based purchasing developed after. One person said they want to show incentives for ASD. Lines 4-9 on page 9 already cover it but others are saying not sure. One suggestion was to combine line 3 and 4. Heads nodding yes. Agree that better to leave "incentives" flexible. "Outcomes measures and provider incentives for caring for individuals with ASD in a VBP model…"
- Line 13 – change "more numerous and" to "have more complex needs."
- Add another bullet after line 14: "Prioritize increasing providers in underserved areas."

Tracking ASD Utilization

- Q: Should it be tracking ASD utilization and outcomes?
  - This grew out of data requests. Talking about utilization. Outcomes were addressed when discussing VBP.
  - Meant to ensure timely evaluation and subsequent services to receive treatment. Outcomes are discussed in evidence-based treatment section and other places in the report.
  - Consensus -rename subhead "Timely Access to Care"
  - Change to "Measurements should include" vs. recommend

Understanding the Current System

- Page 10, line 3 - key areas of confusion include…first two bullets reflect that but following bullets suggest more solutions than confusion. Just say "Key areas include:"
- Page 10, lines 22-23 - Entire crosswalk will appear in appendix but activities put in crosswalk as listed in slide. You will have chance to review crosswalk with Draft 4.
  - One suggestion to expand to understand there are CRS members with ASD that are fully integrated. Recommendation to expand chart to include CRS and ALTCS EPD. One recommendation to have Dr. Paulus review crosswalk. Also seek review from behavioral health.
- Page 10, line 26: Another change recommended via e-mail to note DSM 5 uses the number and not Roman numeral V.
- Question re the chart regarding what services are covered? Mercy Maricopa has changes and this is complicated. Facilitator said we will discuss after this meeting.
- Note that not all of the groups completed work for the appendices. The full committee will have opportunity to look at next draft before it gets finalized.

Accessing the Current System.

- Page 10, Line 35-36. What does that mean? Facilitator said the idea is often people do not know what is available and who does it. Similar to chart Aaron and subgroup is

working on. Idea is that this could be put in database. Committee indicated that AHCCCS should be the state agency responsible for updates.

- Page 11, line 19. ALTCS EPD add w/ or w/out CRS. But rules changed. Add bullet for CRS that can include fully integrated or partially integrated w/ CMDP. Send e-mail to facilitator with clarification.
- Page 11, footnote: Don Fowls will send information about transition.
- Page 12, line 8 re telemedicine. Speech is frequently missing for ASD in rural areas and current rules restrict. Recommendation is to include speech that can be provided via telemedicine. Others said the language in this area is broad enough to include speech. Suggestion to include speech in text as one example; there are other examples, too. A suggestion via e-mail: telemedicine should include training.
- Page 12, lines 13-14 – remove "set up a committee of professionals"
- Page 12, line 30 - RBHA codes defined. Add a disclaimer that additional codes may be added.
- Page 12, line 30 - Change "supervision" to "clinical direction" and remove travel
- Page 13, lines 1-6 - this service is broader than just for people with autism. DDD suggested deleting the last sentence in paragraph.
    - Q: Can health plans still offer case management to DDD TCS? Yes.
    - Q: Habilitation, consulting and training service – consensus was that committee wanted DDD to move forward with this. Beyond that, not in the scope. Can we just leave it at the first sentence? Consensus yes.

Information about Resources

- Page 13, lines 8-10. Simplify to say, improve access to web based resources. Concern re create and secure funding….so take that out.

Provider Education

- Page 13, line 25-27. Add Arizona Chapter of American Academy of Child and Adolescent Psychiatry. Commenter would e-mail to Facilitator more recent recommendations. Consensus to include all so this is more comprehensive.
- Page 13, lines 25-27. Is there a reason only medical associations listed? No. If anyone wants to add other professional associations, send e-mail to Facilitator.
- Page 14, lines 13-14. Do we want to call out specific hospitals? Consensus to change to "providers" so as not to limit to hospitals or any specific hospitals.
- Developmental pediatricians for children…we need an equivalent for adults. AHCCCS should designate a subset of PCPs for adults who are specialized in ASD similar to developmental pediatricians for children.

ASD Diagnosis

- Page 14, lines 38-29 - Concern that if you require, how will it not delay? No consensus to change wording.
- Page 15, line 1 correction. American Academy of Child..and Psychiatry ACAP.
- Page 15 line 11-20. Commenter does not understand this section. Dr. Sara Bode came to meeting as a delegate for Dr. Robin Blitz to explain this. Early Access to Care-Arizona program is 6-month fellowship to help pediatricians to make diagnosis and also includes

training re treatment and medical home. Also allows pediatricians to have access to telemedicine consults with specialists. This connects with access to care concerns of work group because initial cohort is in rural areas where there is lack of availability for diagnosis. Question from other member was would commercial insurers cover this diagnosis? Response is yes, that is the purpose and design. Dr. Blitz via e-mail made recommendation to take out word "interim" on line 14. Discussion re degree to which this program is evidence-based. Response from Dr. Bode: Even though it's a pilot in AZ, it's not new. What are the outcomes measures Committee would want? She said this is an established program. A commenter said Medicaid has obligation to provide services that are at the standard of care and one parent said they have a problem using Medicaid children as an experiment until it is an accepted standard of care/practice. Said: One thing about AHCCCS is that we do not have a two-track system – kids on AHCCCS get same quality of care at same community standard and I don't want to create precedent with two different tracks of care. Another commenter is in favor of increasing access to good diagnosis and treatment. Comment: you open to pediatricians and NPs but have others in state that cannot diagnose but have same level of expertise. Another person added re training pediatricians, pilot is also training educators, special educators, others on supporting the treatment plan, multi-systemic, multi-faceted approach, and training on using ADOS [Autism Diagnostic Observation Schedule]. Recommendation to include ADOS as an appropriate assessment tool.

        - Facilitator: Add ADOS as an appropriate tool. Any objection? None expressed.
    - Facilitator: Then the other issue is the PCH Early Access to Care-Arizona pilot. Supporter said that this is part of a team, not only the pediatrician, like licensed person trained in ADOS. One comment from the phone reiterated concern re two-level system for AHCCCS and others. Felt would look bad that general pediatrician can diagnose. Facilitator said I don't think there is a consensus to take out the term "interim." Others want to take the entire paragraph out. Facilitator expressed that this paragraph says "AHCCCS should consider…" once more data available. It is not a mandate. Still concerns. Another commenter said this is just another avenue to get kids into treatment sooner. One commenter said key words are "consider" and "when more data is available." Many agreed. One commenter said lines 18-20 should be taken out then. One commenter said the committee is charged with expanding access to care. One person said can take DDD out but leave AHCCCS in. Facilitator recap: Leave in "interim," leave in paragraph, take out DDD reference. Consensus.
    - Page 15, lines 21-28. NODA. Is everyone ok with this paragraph. One commenter said wording is fine but will send e-mail to group with study information.

Evidence-Based Treatment Modalities

- Commenter expressed concern that focus is on whole person, not just ASD. On page 16, line 22 it says ongoing screening for co-morbidities is essential. If anyone has expansion to that, please send to Facilitator.
- Page 16, line 16. Facilitator explained these are categories that were taken from the literature. Some people want to take out experimental. It should be evidence-based and

emerging evidence-based. This section should match the language used in the appendix. Question about what the absence of an asterisk or bullet indicates. Terry Matteo will send explanation to Facilitator to add to the document.

- Page 16, line 21 – reorder to say Evaluations and treatments – also, should say developmentally related evaluations instead of age and state related.
- Page 16, lines 30-32 - Is that broad enough to include health plans and RBHAs? Monica Coury said yes.

Evidence-Based Practice

- Circles don't match language in text. Others think they do. Entire phrase won't fit in the circle. Change Professional Expertise to Clinical Expertise so circles match text.
- Remove bullet because only one paragraph.

Adults with ASD

- Page 18, lines 12-13 - DDD asked, does this just apply to one population? Answer: This is a recommendation for those with ASD. No changes made.
- Add reference to BCBA services for adults.

Workforce Development

- Overall comment re need to add more developmental pediatricians, etc. Facilitator asked Dr. Rene Bartos and Dr. Sydney Rice to send more information via e-mail. Facilitator said this is not a strong section so anyone wanting to add language, please send. One recommendation to add representatives from community and businesses.

Conclusion. No changes

- Appendices
  - Including a glossary of terms? No one took it on. One person said they have some information and Facilitator asked that the info be e-mailed to her.
  - Appendix E does not address the need. Flow chart for families and members should mention DDD. Maybe also CRS. Still under development.
- Facilitator talked about Janssen Pharmaceuticals settlement in 2012 re alleged improper marketing of Risperdol. AZ AG is issuing an RFP for use of approximately $4M for research or programs benefitting specific groups, including individuals with ASD. They became aware of the work of this Committee and are waiting to issue the RFP until these recommendations are in place so as to potentially utilize funds for some recommendations through settlement dollars.

- Next Steps
  - Facilitator needs subgroups to complete Appendices.
  - Facilitator will send "to dos" reminders to those who took on tasks.
  - Will send Draft 4 for approval to Committee.
  - If there is anything else that needs to be discussed, we will take that up.
  - Some people expressed desire to meet quarterly. Please e-mail interest to the Facilitator.
  - Facilitator thanked the committee members, work group participants, AHCCCS staff, St. Luke's Health Initiatives, which provided support for Facilitator's professional fee.

- Dr. Salek thanked all of the Committee and work group members and provided Facilitator a plaque in recognition of her service!