

ASD Advisory Committee Meeting

Session 4

9/9/2014

Notes

Review of Group Norms, Charge and Intentions- Refer to PPT Presentation

- Overview (see slides)
- Recommendations by December
- Process: Each workgroup has a template. Focus on 7 questions (see slides)
- Workgroups/Areas of Focus (see slides). Note, areas of overlap b/t workgroups. There is a website and Drop Box for materials.
 - o Early ID and Referrals
 - o Reducing System Complexity
 - o Evidence Based Treatment
 - o Building Network Capacity
 - o Adults w/ ASD
- Q and As:
 - o Q: Understand that this is an AHCCCS Committee but where is integration of services that DES can provide? For example, there is a change of how employment services are offered.
 - o A: The focus is on AHCCCS members, but understand is that health is beyond physical. Will circle back.

Emerging Themes: (see slides, organized topically)

- Integration and Choice
 - o With changes coming, i.e., HCBS rules, the choice piece is an area of concern b/c instead of having more choices there are fewer choices. It's important to discuss that since there is no one size fits all, just b/c there are changes in employment, we will still be able to have services b/c everyone is different. Don't forget the choice piece.
 - o "Choice" for my workgroup was more about carve-out. AHCCCS members should have choice while being less fragmented. Decrease carve out in different systems and how they're fragmented
 - o Important to have distinction that 1 system opens up ability to create a network if a few are responsible. Interesting to hear how 1 system can limit choice.
 - o What are the changes coming down the pipe?
 - Services w/in the system. Talking apples and oranges. Instead of 27 different, then have 5.
 - Talking about systems like CMDP, CRS, AHCCCS, DDD
 - We're also talking about choices from a plan, and service choices w/in different organizations.
 - Want 1 single plan and have all services covered under that 1 plan.
 - Move from multiple agencies to a single one. Important to recognize can't choose just one therapy, but that there's a range of services and choice of providers

- In evidence-based standards should have enough choices and not get too narrow for what's appropriate. Giving families more choice than not. Especially w/ sheltered employment.
 - From consumer standpoint, like the fact there are lots of choices especially at health plans. Don't have for BH but do have for acute. Don't like the navigation among plans and the management and coordination of care. There's got to be some way w/ the technology we have to come up w/ care coordination to coordinate services and leaves with choice
- Short Term and Long Term (see slides)
 - Thought of consolidating...all kids and their families need help in all areas. It would be easier to navigate if there was just one system and wouldn't need a crosswalk. Plus consider that it's always changing. As a provider, make sure to keep up to date, but still get it wrong. So for a family it would be impossible.
 - As a health plan director, spend lots of time doing the work, but important to recognize making it consolidated should still offer choice. Hard to keep track of all things going on at all the different areas/systems.
 - Do have an agency for children w/ DD. Doesn't serve all children. The problem is that the way their authority is configured they don't have a super Ombudsman. They're fragmented and don't have authority to navigate all networks on time. Doesn't mean that with some tweaks that it can't happen. There's a new DD director here and a new DES Director talking about connecting silos and work w/ agencies so families get seamless coordination of services (on YouTube).
- Care Coordination
 - Should also talk about who is paying. There are internal problems as well and someone should be paying. Medicaid should be payer of last resort and coordinate w/ other insurance
 - Care Coordinator to help family coordinate individual child services. CC shouldn't be the solution to navigating 6 different systems.
 - Need 1 system and within that system need CC
 - Some CCs are better than others. So much variation. And then CCs come and go. Should move beyond DDD if there is more of an integrated system. For example, x agency takes DDD but not ALTCS, or private insurance and not DDD, etc. They are also providers not talking to one another. CCs need to be folks that can problem solve. Some are great and others not as great.
 - Who is responsible for what when? School? Like the shell game...school day w/ early release so Wed. is one day and Thurs another. Schools have signed forms that say Medicaid will pay. True CC is from cradle to grave, from the morning to night. Not just pediatrician, or just therapy. Never turn it off.

- The way system works now, no one asks the parents how the CC is doing. Not using input from the user. Parents have the right to give feedback that doesn't involve hearings so less likely to have really great vs. crappy people.
 - Support vs. Care Coordination. Those are 2 different things happening. Make sure we are not talking about one vs. the other. What do support coordinators do? What do CCs do?
 - Re consumer feedback. Afraid to complain b/c threatens services that are already short. Impacts quality of services received. It is a reality. There are threats that have been made that shouldn't have been. Services are limited b/c we need to expand capacity. When advise families to file grievance they're scared b/c where do they take kids. Needs to be a way to give feedback to the system re quality w/o repercussions (have examples)
 - Who's coordinating the CCs? There was an article and it's a good point. For a long time CC is a key component in pediatric medical home. Research has been to have CCs in PCP office. Not necessarily at Health Plan or in system.
 - Pay with grant \$ to fund CCs in office. Insurance companies don't pay for CCs. Need AHCCCS and Plans to pay for those codes.
 - There are health plans that pay PMPM for CC. Instead of opening code they're paying as an administrative service and work out a performance. AZ trying to support and sponsor through VBP. Also includes other supportive wrap around services to keep members out of hospital and higher cost settings.
 - But kids w/ autism, doesn't necessarily keep out of hospital or crashing from diabetes...hard to show on kids with autism. This is more part of the HCBS setting. Requiring ALTCS plans to do these arrangements. If on ALTCS the goal is to keep out of institutional setting. If doing this as a provider, contributing to overall goal.
 - DDD does not have the majority of members w/ ASD in DDD ALTCS. So what are we doing with kids who are DD targeted but aren't in ALTCS and considered an acute member. This is an issue that continues to come up. (In AHCCCS but not DD, failed the PAS)
 - Skill set for CCs are social workers. Experience, training and education is on cross-over systems. So when looking at skill set, those are the types of folks should be looking for. Universities are always hungry and look for internships for master's program. Could serve as a resource to build workforce capacity.
- ASD Diagnosis (confirm who can provide diagnosis for autism for DDD- is this a rule vs. statute)
- Lots of models where trained developmental pediatric practitioner to see patients.

- Add 26 psychologists included as part of capacity. Right now if you don't work for an agency w/ a contract w/ a RBHA, those psychologists can't fill or have access to diagnosis.
- Leave statute/rule open ended and let DDD put in policy.
- Re who can diagnose - DDD vs. ALTCS. The PAS tool is a roadblock to getting diagnosis. If family goes through interview and not found eligible, can appeal decision or request another interview. Appeal process is semi-judicial and decisions are individually made. Don't appeal; instead request another interview and the result may be different. The child has not changed but just the interviewer so it is a flawed process. Results in different determinations. Inter-reliability concerns.
- Is CMS giving out funding to apply to build core of medical professionals to serve the ASD population? In 2009 lots of funding was lost to train physicians in AZ...is there some specialized \$ that we could use to tailor recommendations to go after funding source?
- Patient goes to DDD using rule of who can diagnose, to get actual services, need to be eligible for ALTCS. Perhaps got into DDD, and need to be assessed for ALTCS. Issue of #s who are DDD targeted. It's not that ALTCS accepts diagnosis of autism, it's if their symptoms are bad enough.
 - Technically, shouldn't matter if get into ALTCS, currently covered services through the HPs and RBHAs.
- Look at PAS tool and minor changes. There is a flaw in the tool b/c it doesn't screen for autism. Ridiculous that some people get the diagnosis. Total inconsistencies. Families who get it have done 3x and get it b/c they've learned the tool. And that's the reason why more kids w/ autism aren't in the system.
- 50% of parents that come to her are b/c they don't make it thru the PAS tool. Got parents to try to get services through Plans and RBHA and not happening in Maricopa. Tried to set up as a provider and RBHA said it doesn't exist. Families tried for a month and a half and have been told that ABA doesn't exist. And for diagnosis, will take 6 months b/c there are 5 things to do.
- Notion that RBHAs can diagnose. Doesn't work properly. BH piece needs to be on there.
- Providers don't know how to use codes.
 - Don't need waiver/SPA to make changes. Need to update policy and coding systems to make it clear to Plans and RBHAs...register BCBAs so they can bill. Could be in AMPM, covered BH services guide. Moving forward at the same time.

Workgroup Findings:

- Early Screening and Diagnosis
 - Regional assessment teams successful in Ohio. Most helpful with regional assessment teams is putting together the pediatrician, early intervention, and school so that child has evaluation by appropriate

person and entry into services by a team that knows each other. All comes down to communicating. Hoping to have a rep from RSK on each time to have a parent on each team. State has broken things in so many pieces. Goals should be to bring people back together to support families so that PCPs don't have to be in that "I don't know where to refer" position.

- AzEIP system has a high bar for children to be eligible. Many young children eligible for AHCCCS b/c of income and aren't getting services b/c getting referred to AzEIP and don't qualify. PCPs need tools so kids get services.
 - AzEIP trying to close loop and refer them back to HP and CC, are hooking up with doctors. Doctors can ask for authorization and not go through AzEIP.
 - But if they do pass, they get referred directly to DDD.
- Roadmap example: Yuma County Roadmap. (see slide)
- Key Issues for Adults w/ASD (see slide)
 - Is there support from DES w/ discussion guide and data collection?
 - Not sure specifically. Work group members taking lead but not sure. Will follow up.
 - Concern is that there are already folks who can assist.
 - The work group wants to take a totality, not just DES related topics, but more broadly ALL things for an adult
 - There is a piece of DES, but a broader conversation
 - Transportation is a limiting factor depending on the program/service, etc.
 - Was transportation added to employment issues? Yes

Models under discussion

- CMS Health Homes, TriCare, Other States (Missouri, NJ, etc.)
 - Can Health Homes be a wrap around that utilizes the existing care delivery systems of DDD, RBHAs and Acute care plans w/out creating a separate entity except for care management?
 - Contemplated: If in ALTCS, your plan would have a structured set of benefits and provider network to treat whole spectrum. If in Acute, the idea is that bring BH benefit into Acute plan and that HP would have a full array of services re ASD for members.
 - So would be changing the service delivery system?
 - Yes to eliminate steps. DDD would create a health home specific to ASD. If acute, wouldn't have to interface with other systems...the acute plan would coordinate. The providers would contract w/ Plans. All Plans would be required to create a health home.
 - Currently has this through DDD. DDD is contracting w/ plans and has distinct network. Could still offer array that offering now with this home health model w/ additional services.

- Is there coordination w/ private health insurance?
 - Could be. Would need to be discussed.
- Does this eliminate the need to contract w/ several entities? Does it eliminate the different reimbursement rates of several entities and solve the system complexity issue?
 - If in acute plan w/ ASD, need to go through the RBHA etc. The requirement would be that the acute plan would manage full array of services. If ABA provider, would need to contract w/ different acute plans.
- What about management of reimbursement rates?
 - Providers negotiate directly w/ plans.
- Talking apples to oranges. Multiple systems and pulling together is a nice idea, but the only plans that have a set rate are the public. Will still be contracted rates and not negotiated. The whole transparency issue is being driven down from CMS. These are privately held contracts. And level of services are different. Not just a BCBA...front line therapist for CIGNA might need to be an RBT.
 - Implement uniform coding system across the board and include DDD.
- If rates are so low, won't contract = network capacity issues. Need to be consistent across payer systems.
- Rates are very different and adds to issue of capacity. Providers will trend. Also happening in private insurance and ask self: are we being reimbursed enough to cover all costs?
- If we had the codes correct (Medicaid payer of last resort) maybe Medicaid could afford to pay for services.
- Learned as a mom from a son who is a hab provider, depends what agency the family goes to, the training is significantly different than someone from another agency. This is concerning.
- This is a problem across the entire health care social service delivery system. Same problem w/ OT, PT, speech, doctors, etc. That's what happens when you have a gov't system that contracts w/ a private entity. DDD pays every agency the same rate and it's up to that agency to decide how they train their folks depending on what their contract says and how DDD enforces them to comply. Every care provider has that same exact issue.
- Need capacity to provide training.
- Points being raised b/c of Health Homes: it's not necessarily decreasing fragmentation will be the cure to all...all the rest of these other things (codes, payment, enforcement, flexibility) still needs to happen.

- TRICARE example
 - PCP diagnosing - do they assume screening and evaluation.
 - Sounds like what states were looking at. States trying to get diagnosis and comprehensive, it took time. This way, they do a basic diagnosis and within 1 year get comprehensive evaluation and doesn't delay getting ABA services.
 - Does it get other services faster?
 - Yes, need to have evaluations.
 - TriCARE requires providers to report back to PCP. All treatment plans need to be sent back to PCPs. VERY critical part of CC.
 - Already have that within EPSDT- anyone who is a Medicaid provider providing services on script written by PCP should be sending reports.
 - Work with families on TriCare plan. Works better than what doing here. Tell families to just stay on TriCare and don't even apply for DDD.
 - It is easier to know how to provide service, what to expect and report. Could be tricky in changing frequency. How they expect service to be provided is very clear cut and easy to follow.
 - Challenge - unless PCP offices are set up for this, they are not prepared to do this.
 - Is it individual evaluations or is there a team process? When getting comprehensive assessment - sounds sensible if it were a team vs. individual. Have coordinated plan. Perfect example is that assessment = early intervention. Still think if the system is disconnected isn't helpful.
 - Agree, but attempted team assessments in Down Syndrome clinic, and get denied repeatedly the OT, PT, speech evaluations b/c they say DDD should be doing that.
 - Get reimbursed ¼ of what it costs to use team approach.
 - Part of what needs to be in revamp is that the systems/AHCCCS Plans need to recognize that coordinated teams are helpful and can be \$ saving.
 - Sometimes don't like teams. But should give families choice.
 - Remember to look at whole person and bring silos together.
 - Autism care demo is where ABA is housed. If a family gets assigned a CC/RN who is coordinating stuff, just call RN to see speech. Just call one person and they will do all the work. All components are worked into it.
 - Also an advantage by having a single payor can't point fingers. Also, there's a gray area as to if something is developmental vs. behavioral, etc. Advantage of integration at the payor level so no pointing of fingers.
 - Feeds into VBP idea. Not paying for widgets, but paying for outcomes. Do things better. As an example, it's better to have all the PT, OT and speech from 0-5 years old. Too overwhelming to look at each from a medical director. Just cover it for all.

- Performance based accountability. They don't get paid unless they meet all requirements.

Next steps before 10/28 (see slides)

ASD Advisory Committee Meeting

Session 4

September 9, 2015



Agenda

- Review of group norms, charge, and intentions
- Work Groups: Areas of Focus
- Emerging Themes
- Next steps before Oct. 28 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 Work Groups.
- 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.



Line of Sight



Process

1. What are the areas of focus of this work group?
2. What do we collectively know about each area of focus?
3. What data do we have?
4. What data do we need to obtain?
5. What insights do we have that flow our collective knowledge and the data?
6. What draft recommendations related to our areas of focus do we want to bring to the full Committee?
7. What outcomes measures do we suggest for each recommendation?



Work Group Areas of



Early Identification & Referrals

- Screening and assessment.
- Referrals to providers who can diagnose ASD.
- Communication and coordination between PCPs and intervention providers.
- Removing barriers to children getting care.



Reducing System Complexity

- Immediate need for parents and providers: clarity about eligibility, entry into the system, roles of different types of providers, and who provides and pays for what.
- Need for an integrated care model with strong care coordination.



Evidence-Based Treatment

- Evidence-based practice and emerging science.
- Family- and member-centered care.
- Integrated physical and behavioral health care models.
- Establishing a committee that reviews annually evidence-based treatment.



Building Network Capacity

- Better understand:
 - What services are covered
 - Who can provide services
 - Who is providing services and where (urban, suburban, rural areas)
- Expand the types of specially trained providers from whom DDD will accept an ASD diagnosis.
- Increase the number and competency of providers for both diagnosis and treatment.
- Expand use of technology to support diagnosis and treatment.
- Address the reimbursement barriers that keep qualified providers from participating in the network.

Adults with ASD

- Comprehensive data on AHCCCS members (children and adults) with ASD and where they are (or are not) receiving services within the system.
- Integration of medical care, behavioral health, and support services.
- Effective models of support for adults with ASD—outcomes measures and impact studies to identify best practices.
- Effective training and education for community members who interact with adults with ASD (e.g., judicial system, emergency personnel, employers, neighbors, etc.)



Emerging Themes



Integration and Choice

- Work groups are talking about an **integrated** system of physical and behavioral care, where the whole health of the child or adult is considered. There is no “one system” now—services are fragmented.
- At the same time, there is widespread recognition in the work groups that **choice** is essential. A range of services and providers are needed to meet the needs of each individual. Integration does not mean “one size fits all.”



Short-term

- Reducing System Complexity work group is creating a crosswalk of terms used by AHCCCS, DDD, and AzEIP to assist families and providers.
- Create a map of all the “doors” into the agencies for use by PCPs and parents.

Longer-term

- Align language and policies re screening, and assessment across all agencies.
- Ombudsmen at health plans to facilitate navigation and service delivery.
- Potential recommendation: consolidate all services under one agency.



Care Coordination

- Given the complexity of service needs, comorbidities, 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.



ASD Diagnosis

Multiple perspectives—

- Expand the types of providers from whom DDD will accept an ASD diagnosis.
- Consider change so DDD accepts diagnoses made by developmental pediatricians and (perhaps) pediatric neurologists.
- Increase specially trained providers who can diagnose to include pediatricians.
- Monitor the results of the pilot program Dr. Robin Blitz is leading to train pediatricians to diagnose ASD and provide medical homes in rural areas.

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.



Example: Roadmap

Dr. Sydney Rice shared the **Developmental Screening and Surveillance Yuma County Referral Roadmap**

- Four pathways depending on level of concern
- Resources for Yuma County
- Early Intervention, School Services, and Assistance by age range
- Autism
 - School and medical evaluations
 - Resources
- Developmental Promotions, Screens, and Tools
- Providers in various medical specialties and therapies

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



Adults with ASD (continued)

- Denise Resnik's *Viewpoints* article in *Arizona Republic*: "Who will care for autistic adults?" (9/4/15) summarizes extensive research and First Place AZ™, which focuses on community and property development with the mission of empowering people with autism and other special abilities to thrive, through homes, friends, lifelong learning and a supportive community.
- Potential recommendation: "Employment Navigator" role to help adults with autism to navigate job opportunity resources, interviews, and work success.
- Work group is planning to hold on-site conversations with adults with ASD, using a consistent discussion guide, in October to gather input.

Models Under Discussion

- CMS Health Homes
- TRICARE Autism Care Demonstration
- States:
 - Missouri
 - New Jersey
 - Minnesota



Health Homes

- ACA created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with chronic conditions.
- States have latitude in populations served under health homes, who manages health home services, and the rate of reimbursement.
- CMS expects providers to operate under a "whole-person" philosophy.
- Health home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.



More info on Health Homes

- Includes:
 - Comprehensive care management
 - Care coordination
 - Health promotion
 - Comprehensive transitional care/follow-up
 - Patient & family support
 - Referral to community & social support services
- States have flexibility to determine eligible health home providers: designated provider, team of health professionals, health team.
- States have the flexibility in designing their payment methodologies and may propose alternatives.
- Health Home Information Resource Center located on [Medicaid.gov](https://www.Medicaid.gov)

TRICARE Autism Care Demo

- Demonstration July 2014-December 2018.
- Website is good example of clear delivery of information: Three steps and Q&A.
- PCPs (Family Practice, Internal Medicine, Pediatrics) can diagnose, with testing within one year to confirm ASD diagnosis.
- Specialized diagnosing providers are board-certified or board-eligible in Developmental Behavioral Pediatrics, Neurodevelopmental Pediatrics, Pediatric Neurology, Adult or Child Psychiatry, and Licensed Clinical Psychology, doctoral level.
- Provides ABA service.

Next Steps before Oct. 28

Facilitator will assist each Work Group, through in-person meetings, teleconferences, and e-mails, to move forward in answering the questions in the template and addressing other questions and/or issues identified.

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“Line of Sight”

Thinking about “line of sight,” what can the work groups accomplish during the next seven weeks to close in on reaching specific consensus recommendations by December?

