

State of Connecticut

Draft Proposed Plan to Cover Autism Services for Children and Youth under Connecticut's Medicaid Program Submitted by DSS and DDS to the Autism Advisory Council

October 22, 2014

Glossary of Frequently Used Terms Frequently Asked Questions

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Administrative Services Organization (ASO) – *the company under contract to the state that is responsible for beneficiary and provider support, referrals to providers, utilization management (e.g., prior authorization of services when required), grievances and appeals.*

Autism Spectrum Disorder (ASD) – *a neurodevelopmental condition marked by challenges with social functioning, communication, restricted interests and repetitive behaviors, and sensory processing. Autism impacts individuals across the lifespan and is considered a “spectrum” disorder, as the intensity of the disability and the level of functioning varies widely. The causes of autism are not yet well understood. It is a neurological condition with some genetic factors contributing to its occurrence. The incidence of autism has grown precipitously over the last 20 years with the most recent CDC estimates indicating that autism affects one in 68 individuals nationally.*

Applied Behavior Analysis (ABA) – *A behavioral treatment model that focuses on the careful assessment of behaviors and their underlying functions, examination of how the environment triggers and maintains behaviors, and structured teaching of skills and positive behaviors. It is an empirical model that requires collecting and analyzing data to understand behaviors and chart progress. ABA includes a variety of individual interventions that can be selected and tailored as appropriate to each individual's needs.*

Centers for Medicare and Medicaid Services (CMS) – *the division of the U.S. Department of Health and Human Services that oversees state Medicaid programs.*

Department of Developmental Services (DDS) – *the state agency responsible for the coordination of autism services.*

Department of Social Services (DSS) – *the state agency responsible for the administration of the Medicaid program.*

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – *a federally mandated Medicaid benefit that requires states to provide comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.*

Medicaid – *a state-administered health care program jointly funded by the state and federal government that assists low-income individuals and families, including individuals who are aged, blind or disabled. The Medicaid program is a partnership between the state Medicaid agency (DSS) and the federal Centers for Medicare and Medicaid Services (CMS). All medical services covered by the Medicaid program for which federal reimbursement is sought must be articulated in the Medicaid state plan and approved by CMS. Medicaid programs have different names in different states. In Connecticut, the Medicaid coverage groups serving children and their parents or a relative caregiver is called HUSKY A; the coverage groups serving aged, blind and disabled individuals is called HUSKY C; and the coverage groups serving low-income adults without dependent children is called HUSKY D.*

Medicaid State Plan – *the document submitted by a state and approved by CMS that describes the state's Medicaid program and has all of the conditions for the state to receive federal matching reimbursement from CMS for its Medicaid program. It includes a description of each service including what is covered and by whom and the*

methodology for payment. Whenever a state wants to add a new service it must submit a state plan amendment (SPA) and obtain CMS' approval.

Medically Necessary – the criteria for approving covered Medicaid services. Those criteria are specifically defined in state statute as “those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning, provided such services are:

(1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on:

- (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community,
- (B) recommendations of a physician-specialty society,
- (C) the views of physicians practicing in relevant clinical areas, and
- (D) any other relevant factors;

(2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease;

(3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers;

(4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and

(5) based on an assessment of the individual and his or her medical condition.” (Section 17b-259b(a) of the Connecticut General Statutes)

State Plan Amendment (SPA) – the method for a state Medicaid agency to request changes to the Medicaid State Plan (defined above), which must be approved by CMS.

Licensed Practitioners – health care providers that are licensed by the State of Connecticut Department of Public Health (DPH) and subject to DPH requirements. Licensed practitioners include a variety of professionals, including physicians (e.g., psychiatrists, pediatricians, neurologists, and other applicable specialties), licensed psychologists, licensed clinical social workers, licensed professional counselors, and licensed marital and family therapists.

Qualified Autism Providers - health care providers that, because of documented training and experience in autism, are approved by the Department of Developmental Services as qualified to provide specified services to individuals with autism.

Frequently Asked Questions

1. What did the Centers for Medicare and Medicaid Services (CMS) Informational Bulletin say?

In July 2014, CMS issued an informational bulletin (posted at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf>) clarifying that state Medicaid programs must cover medically necessary services for Medicaid members under 21 with autism spectrum disorder (ASD) through Medicaid under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid benefit, including certain types of services provided by unlicensed individuals in independent practice. Previously, CMS had informed states that such services provided by unlicensed individuals in independent practice settings could generally not be covered in the Medicaid State Plan. Specifically, prior to 2014, the option for covering services provided by unlicensed individuals in independent practice was the rehabilitative services benefit category,

which CMS has continued to clarify requires the services in that benefit category to be designed to restore functioning that previously existed and not be habilitative services meant to acquire skills.

2. What happened after the CMS informational bulletin was released?

In order to ensure that Connecticut implemented CMS' guidance in a timely manner, the Governor directed an inter-agency work group consisting of the Departments of Social Services, Developmental Services, Children and Families, Education, Mental Health and Addiction Services and the Office of Policy and Management to develop a plan to implement this guidance. The group has developed a draft proposed plan that is being submitted to the Autism Spectrum Disorders Advisory Council to detail how such services would be provided, target populations, recommendations for who can render the services, authorization standards and the medical necessity review process.

Governor Malloy invited the members of the Autism Spectrum Disorders Advisory Council to provide input to the draft proposed plan ( Gov letter to Autism Council.pdf). The initial opportunity for input is today's meeting on October 22, 2014.

3. Who will qualify for services? How? For what?

To qualify for services, a child must:

- Be a Connecticut Medicaid beneficiary
- Be younger than 21
- Have a diagnosis of autism spectrum disorder from a provider licensed to diagnose autism. This includes DSM IV diagnoses of Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, and a DSM V diagnosis of Autism Spectrum Disorder.

Children and youth who qualify will receive medically necessary services that are coverable under the Medicaid State Plan.

4. What is an "evidence-based" practice, treatment, or intervention?

To determine whether an intervention is "evidence-based," experts in the field review all the published studies of the intervention and see if the results support its effectiveness. As of October 2014, there have been three such nationally recognized reviews of research regarding treatments for autism. These three reviews have been conducted and/or supported by the Agency for Healthcare Research and quality (AHRQ), the National Autism Center's National Standards Project (NSP) report, and the National Professional Development Center on ASD (NPDC). The NPDC review is the most inclusive in supporting specific treatments. The Departments will continue to monitor updates to nationally recognized research.

5. What practices, treatments or interventions are currently considered evidence-based by the NPDC research review that was updated in 2014?

At this time, the NPDC research review, which was updated in 2014, which currently has the most inclusive list among the three reviews referenced in response to Question 4 above, identifies the following practices as evidence-based:

- Antecedent-based intervention (ABI)
- Differential reinforcement of alternative, incompatible or other behavior (DRA/I/O)
- Discrete trial teaching (DTT)
- Extinction (EXT)
- Functional behavior assessment (FBA)
- Functional communication training (FCT)
- Modeling (MD)
- Naturalistic intervention (NI)
- Parent-implemented intervention (PII)

- Peer-mediated instruction and intervention (PMII)
- Picture exchange communication system (PECS)
- Pivotal response training (PRT)
- Prompting (PP)
- Reinforcement (R+)
- Response interruption/ redirection (RIR)
- Scripting (SC)
- Self-management (SM)
- Social narratives (SN)
- Social skills training (SST)
- Structured play group (SPG)
- Task analysis (TA)
- Technology-aided instruction and intervention (TAII)
- Time delay (TD)
- Video modeling (VM)
- Visual support (VS)

For additional information on these practices, please see the separate document summarizing the NPDC’s list of Evidence-Based Practices with Definitions (based on NPDC 2014).

6. Why would a seemingly promising intervention not be considered evidence-based by a nationally recognized research review?

There is no known cure for autism and not every treatment works equally well for all individuals on the autism spectrum. Many treatments have been proposed, but most have been ineffective and some have even been found to be harmful to certain individuals with autism. In offering services through Medicaid, it is essential to focus on treatments that nationally recognized research has indicated will be high quality and beneficial in reducing the challenges of autism and facilitating development. Accordingly, this plan needs to ensure that individuals and their families are not exposed to unhelpful and potentially harmful practices. Likewise, under federal and state requirements, the Medicaid program must carefully monitor and foster quality of care and responsible stewardship of Medicaid resources. See 42 U.S.C. §§ 1396a(a)(19), (22)(D), and (30)(A); 42 C.F.R. § 440.260. In addition, the statutory definition of medical necessity (quoted in the glossary above) includes a criterion that the services are “Consistent with generally-accepted standards of medical practice that are defined as standards that are based on: (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community....” Connecticut General Statutes § 17b-259b(a)(1). As the course of research moves forward, such as with further updates to nationally recognized research reviews, the set of interventions considered to be evidence based by such research reviews may be expanded and/or modified. A review board consisting of members of the public and the Autism Spectrum Disorder Advisory Council will be responsible for reviewing new interventions and their level of research support.

7. Is ABA – Applied Behavior Analysis – considered an evidence-based package of services by nationally recognized research reviews?

Applied Behavior Analysis is a behavioral treatment model including a package of individual interventions that can be selected, many of which are identified as evidence-based services by the nationally recognized research reviews identified in response to Question 4 above, including the NPDC research review. ABA focuses on the careful assessment of behaviors and their underlying functions, examination of how the environment triggers and maintains behaviors, and structured teaching of skills and positive behaviors. It is an empirical model that requires collecting and analyzing data to understand behaviors and chart progress. ABA treatment is usually carried out by a bachelor’s level technician supervised by a master’s level Board Certified Behavior Analyst (BCBA).

More generally, the efficacy of ABA services for certain groups of individuals with ASD has been supported by a growing body of empirical research. Not all ABA interventions are considered to be evidence based by nationally recognized research reviews. Separately, there are also interventions with empirical support outside of the ABA model that are considered to be evidence based by the NPDC research review.

8. What is the process for getting services?

There are three steps to getting services (see the plan for additional details):

1. An up-to-date medical evaluation by the primary care practitioner, including a physical exam and referrals for any specialized medical treatment – *to rule out medical factors that might explain the presenting problems and to ensure the individual receives needed medical treatment and that medical care is coordinated with behavioral health and autism-specific services.*
2. A comprehensive diagnostic evaluation from a licensed provider qualified to evaluate and diagnose children with autism (e.g. psychiatrist, psychologist, neurologist, developmental/behavioral pediatrician) – *to establish the presence of an autism spectrum disorder.*
3. An in-home behavior assessment with a qualified provider – *to establish the treatment plan and begin collecting baseline data.*

9. Why is so much documentation required before services can be accessed?

Services being provided in the plan are designed for children with ASD. Consequently, careful diagnostic evaluation is paramount. Establishing a diagnosis of ASD is a complex process requiring consideration of medical factors, developmental history, and current functioning (including social skills, communication, behavior, cognition, academic performance, and adaptive competencies). It requires a range of techniques such as medical evaluation, standardized testing, interviewing the family, observational ratings, and direct interaction with the child. Furthermore, not all children with ASD have the same needs for services. The goal is to identify every child who has ASD and specify which interventions are likely to benefit each child, while referring others without autism to more appropriate services. This requires the three step process presented above to rule out medical problems, establish a clear diagnosis, and create an appropriate individualized treatment plan.

10. What are the required provider qualifications and enrollment procedures?

To ensure high quality and effective assessment and treatment of ASD, providers must apply to the Department of Developmental Services and present documentation establishing that they have appropriate training and experience providing services to children with autism (see the plan for additional details on the key required qualifications). For the initial stages of implementation in 2015, in order to ensure prompt access to services, when necessary to ensure access and as instructed by DSS and DDS, certain providers who already meet these qualifications with necessary expertise in assessment and treatment of autism may be able to provide specified services pending the formal credentialing process through DDS. DSS and DDS will issue additional guidance to providers as soon as these processes (both interim and long-term) have been finalized.

11. Why do credentials need to be higher than in some other programs?

The routine training of many BCBA's and licensed practitioners does not include extensive exposure to the specialized needs of individuals with autism spectrum disorder. Consequently, if they have not otherwise had such training, many BCBA's and licensed practitioners would not be prepared to work with them. In recent years, research has identified better assessment and intervention techniques, and specialization in working with individuals with autism has developed. Observation of the child in the home and in social interactions is a critical component of identifying the child's service needs. Ensuring that providers are qualified is particularly important for this service because it is designed as a home-based model provided by practitioners in independent practice, with less opportunity for structured supervision than in an office or institutional setting.

12. How can I navigate the system? Can I get help?

Families and other stakeholders have said that navigating the system is often the most difficult part of securing services for an individual with ASD. As a way to help, **Care Coordination** services will be provided at no cost to participants. Care coordination will be provided by someone, such as a parent of an individual with ASD, who is trained in understanding the needs of families of individuals with ASD. Care coordination will help families and individuals navigate the system by giving them timely information that they need as well as home visits or phone contact to help families and individuals access resources. Care coordination is an integral part of the plan to make sure that families can access the services they need.

13. Will training be provided? Who will receive training? On what topics?

One of the goals of implementing CMS' guidance will be to build on the existing infrastructure to create a statewide system of care for individuals with ASD and their families. Training for all stakeholders is an important part of the creation and success of the system. The Autism Spectrum Disorder Advisory Council has a subcommittee dedicated to developing and providing training for various audiences. Training may be designed for the following groups: individuals with ASD, families, direct support professionals, clinicians/physicians and school district staff. Training topics may include areas such as: educating children with ASD, self-advocacy, navigating the service system, evidence-based practices, best practices in diagnosis, and other appropriate topics.

14. Who can provide services under this plan? And what is the credentialing process?

See also response to Question 10 above. In addition, based on ongoing input from clinicians, stakeholders, and others, including from the ASD Advisory Council's credentialing subcommittee, DDS has developed provider qualification requirements and credentialing procedures. Interested providers would apply to DDS with documentation of the required minimum training, experience, supervision, and other requirements.

15. What is the timing of Implementation?

Medical assessments and comprehensive behavioral evaluations can begin immediately if performed by Medicaid enrolled providers who have already been credentialed by DDS, such as DDS waiver providers who have already been credentialed as meeting those requirements. In the meantime, efforts will be expedited to expand the provider pool for all levels of providers but especially for BCBA's and practitioners that will be performing the hands-on services because they are currently not Medicaid providers.

Implementation will begin effective for dates of service starting in January 2015 with various elements of the program being implemented as soon as they ready throughout the first few months of 2015, as described in more detail in the plan.

16. Why will implementation take so long? What needs to be done?

Before the plan can be fully implemented, there are a number of processes that need to be completed, including the following:

- Credentialing and enrolling providers
- Rate setting
- Medicaid Management Information System (MMIS) changes to be able to enroll and reimburse providers through the Medicaid program
- Coordinating with other benefits
- SPA approval – will require negotiations with CMS, as well as a fiscal analysis
- State regulations – will require a fiscal analysis
- Staffing up of the ASO for:
 - Care Coordination / Family Navigators
 - Utilization management functions
 - Quality monitoring.

17. What will happen to the existing waivers?

Work is still being done to understand how to coordinate existing services with new services and to assure services and efforts are not duplicated, while also promoting continuity of care for existing participants.

18. Does this plan change the Birth to Three program?

If a child receiving services under the Birth to Three program is on Medicaid, that individual will continue to be eligible to receive the Birth to Three services as provided through the Individualized Family Service Plan in accordance with federal and state requirements. In addition, the child may be eligible to receive additional ASD services, if medically necessary and properly documented, beyond what could otherwise be provided through Birth to Three. Work is still being done to understand how to coordinate existing services with new services and to assure services and efforts are not duplicated.

19. Will coverage be provided under HUSKY B (also known as the Children’s Health Insurance Program or CHIP)?

Unlike Medicaid, EPSDT does not apply to HUSKY B. Accordingly, coverage of these treatments for ASD is not required under CHIP. Thus, any extension to the state’s HUSKY B program is a new policy that would require legislative action. The Autism Spectrum Disorder Advisory Council could choose to propose to the Departments that the Governor extend coverage to the higher-income households under HUSKY B in his upcoming budget.

20. Will coverage be provided under commercial insurance plans?

The CMS guidance does not apply to commercial insurance plans. Although current state statute (section 38a-514b of the Connecticut General Statutes) requires certain commercial insurance plans to cover ABA services, such coverage is currently not readily available for many individuals. The ASD Advisory Council may also choose to encourage both the Governor and the legislature to take measures to enable coverage for evidence-based ASD treatments under individuals’ commercial insurance plans.

21. Have rates been set for participating providers?

This area is still under review. Additional information will be shared as soon as it is available. The objective is to set the rates at a level that will allow qualified professionals to provide the specialized and time consuming treatments needed by individuals with autism, while also complying with the federal Medicaid requirements that all provider rates must be economic, efficient, and promote comparable access to the services as in the general community. See 42 U.S.C. § 1396a(a)(30)(A).

22. Does this plan provide anything for adults age 21 and over?

Although not required under the federal guidance (because the federal Medicaid EPSDT benefit applies only to individuals under age 21), the plan proposes to extend care coordination and/or family navigator services to adults age 21 and over. At least initially, these services will be developed and available through the behavioral health Administrative Services Organization (ASO) in the draft timeline specified in the draft proposed plan. Specialized care coordination staff at the ASO will have a local presence and will have the ability to do home visits to ensure services are provided in the most effective manner. The staff will be comprised of clinical and non-clinical professionals, including peers and will help:

- Facilitate access to services;
- Ensure coordination between all service providers;
- Provide support to the family or caregiver; and
- Conduct home visits to provide support, evaluate member experience, and determine if the member or the family need assistance with additional health related needs.

23. Does the plan impact what is happening in the schools?

The plan does not change the responsibilities of the school to provide a free and appropriate public education to students with autism spectrum disorders in accordance with applicable federal and state requirements (see

also section 10-76ii of the Connecticut General Statutes). School programming will continue to be dictated by the Individualized Educational Program (IEP) as designed by the Planning and Placement Team. Services covered by this plan cannot duplicate services provided by the school or any other source. In addition, the services covered under this plan are designed to be home and community-based and occur outside of school hours. Additionally, there may be some services provided by the school for which Medicaid-enrolled school districts may be able to bill Medicaid for partial reimbursement as part of the existing Medicaid School-Based Child Health program, in which many school districts already participate. With this in mind, a key focus will be to establish and maintain effective collaboration between school and community-based teams. Care coordinators will work to facilitate this process.

The Departments will work carefully to coordinate this new benefit with services that are already being provided through Special Education programs.

24. What transition services will be available for adolescents?

The Medicaid plan proposes to provide coverage for medically necessary ASD treatments that are coverable under the Medicaid State Plan. Consequently, while there may be some behavioral treatment provided through the plan to build skills needed in adulthood, the bulk of transition programming will remain with the schools. Efforts to build adaptive skills, vocational competencies, functional communication, and social skills toward adult independence will continue to be provided through the school-based Individualized Transition Plan and IEP.

25. How many hours of care will the plan cover?

Authorizations will be based on medical necessity of individualized plans of care and cannot duplicate services already being provided by the schools or by any other source.

26. Does the plan address provider network adequacy?

Currently, there are a limited number of qualified autism specialists working in Connecticut. In part this is because it is a new specialty area and also because most insurance plans have limited coverage and reimbursement for autism specialists. When coverage for services becomes reimbursable under Medicaid it is expected that there will be an increase in the attraction to careers in the field, resulting in an increase in the provider pool over time. Work will need to be done to enable individuals to obtain this coverage through commercial insurance plans. There is no specific license for autism specialists but there is a board certification as a Behavior Analyst or an Assistant Behavior Analyst from the Behavior Analyst Certification Board. In addition, DDS staffing will be increased to expedite their review of the credentials of more individuals seeking to be recognized as qualified autism specialists.