

ACD Round Table #7

10/19/16

1000-1200 PST

Operator: Welcome and thank you all for standing by. At this time, all participants are in listen only mode. After the presentation, we will conduct a question and answer session. To ask a question, please press the star one and please record your name. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would like to introduce your host for today's conference, [Speaker 1]. You may begin.

[Speaker 1]: Alright, thank you very much for that, and welcome everyone. It's great to be here for the eighth meeting for autism care providers and we're looking forward to this. Our first one in San Diego of course, so to those of you from San Diego, thank you for coming. And for those of you who come from somewhere else, again thank you. I very much appreciate everyone being here. I'm [Speaker 1]. I will be the facilitator today. I am actually the Deputy Director for the TRICARE Health Plan. And obviously very actively engaged with the very smart folks sitting to my left here who I'll introduce in a minute who do all the hard work on the autism care program. Before we get too much farther along, I did want to thank our San Diego team, [Speaker 2], who is the medical director, sitting over there in the corner, [Speaker 3] and [Speaker 4], who really did a great job helping us put all of this together, we would not be here, we would not be in this room talking to all of you today without their great work and of course on a day to day basis they make sure our children here in the West Region get the care they need. So very much appreciate all of your work and thank you for making this possible. Alright, I want to thank not only the folks here in the room, but I know we have some 60 folks on the phone; thank you for taking time to join us today. I want to start out by just giving a short status of where we are with the Autism Care Demonstration project. As you know, this is a demonstration project that runs through the end of 2018. So I want to give you an update with that before I turn things over. So right now, I think it's fair to say the Autism Care Demonstration is probably stronger than it's ever been. We now have over 28,000 ABA providers who accept TRICARE. And over 13,100 patients who are receiving ABA services through the demonstration project. Those numbers are both all-time highs. We are very pleased with that. We certainly want to make sure every child, and every adult for that matter, in the military system who has autism spectrum disorder gets all the care they need and they can reach their full potential. And I think this program is an important part of that. In the past three months alone, we had 1700 new patients referred to the program, which I think is good news. I think what that means is that more and more children who need help are starting to get the help and are being recognized or being found earlier. And as we all know, getting help sooner leads to better outcomes. So I think that's a good news story. We've also added over 1400 new ABA providers. Obviously we have over 1700 new patients;

somebody's got to take care of them. And so we very much appreciate the new providers who have joined us as well. So and certainly, obviously a very important concern to all of us I think is access to care. So, I wanted to give you an update on that as well. Right now, as you can probably figure from those numbers, we have a ratio of about two providers per child. Higher in some areas, lower in others. In some areas are doing great on access, actually in most areas. There are some areas where we have some challenges. I think the good news is that pretty much everywhere where we have lots of military folks; we are doing well with access right now. I'm very pleased with that. So, you know, in CA, CO, FL, GA, NC, TX, VA, some places we've had challenges in the past, right now, we are meeting the access standards consistently. We're very happy about that. We do still have some challenges in AZ where we do have a fair number of people; especially in the Yuma area we have some challenges. MA and CT where we don't have as many people, but we do have a significant naval station in CT, and then HI, NM, and we're right on the border in WA about meeting access. Washington state that is, not Washington, D.C. What we have found, what we have drilled down with that is our managed care support contractor colleagues have helped us a lot with that. What we often find is that in many of these areas, that the real challenge we have is that there are simply not enough providers out there. So as we'll talk a little bit later on, one of our big focus is trying to get more providers, just create more ABA providers in total. And then hoping that they'll go to the places we need them. But for example, I can tell you in one state where we were having some [access] challenges, [but] we are now good, 97% of all the ABA providers, certified ABA providers in that state are TRICARE providers. Now, we are very pleased with that. On the other hand, it would be better if there were even more providers there. So that's an important issue for us. We are certainly working very closely to ensure beneficiaries know how to access care. I can tell you that I engaged with some folks in GA a while back who, when I talked to some of the beneficiaries, actually I was working through the Army on this; one of the things that came out was that they weren't talking to the contractors. Instead, they were getting a [provider] list from somewhere that was very outdated with providers' [names]. They would call these providers and of course they didn't work anymore because providers have changed their numbers, they moved, so one of the things we are trying to do is get the word out there for how people should access care. And we, they're here, but I'll say this anyway, we pay the managed care support contractors a lot of money to make sure people get care. That's their job. And they do a good job of it too and I very much appreciate their work. But they can only do their job if they know about the issue. So that's why we really want people to call them; utilize them. And then if they are not getting what they need from them, obviously tell us. So, very important. The other thing that we are working very closely hard on is we have a new effort coming out to encourage military spouses to become ABA providers. We've been working with the military family association and several other advocacy groups to put the word out about that. Really excited about that. I think that this is really a career that works well if you're a military spouse. They move a lot, but this is certainly the kind of position that you can move with and take with you and find new employment somewhere else. Military spouses are obviously going to understand military issues, hopefully.

And while we do have a rule that says you can't provide care for your own children and [have it] be paid for by TRICARE, I think there's good ethical reasons for that, but you certainly can take care of everybody else's children. And so we are working hard to encourage folks to do that, and hoping that you'll start seeing more and more people coming to you who are military spouses saying, hey I've got my BT certification. I'd like to go to work. So we're really encouraging them to do that. So I really think that can be a win-win for everybody; good for the military spouse, good for the providers, good for our patients. So let me move on then, and say none of this is possible without the great work all of you do. We could not do what we do without the providers that provide the care. And we certainly very much respect that you [our providers] work very hard. You take great care of our children, and we appreciate that. And certainly we would not want to let that go unnoticed. Day in and day out, we get together about once a quarter, but we know day in and day out, you all are doing the hard work and making sure these children progress and so thank you for that. We've also, one of the things I think why we do these provider meetings is that we very much value your feedback. You've given us a lot of good feedback over the last couple of years. We certainly hope that continues. I encourage you to give us feedback today. You'll see on the agenda that we've intentionally put a lot of time there for Q&A because we do need to hear from you. And that's not just today. We want to hear from you on an ongoing basis. And I can tell you there are already some things that you are probably aware of that we made based on the great feedback we've gotten is eliminating minimum age, eliminating discharge criteria, we [have made the demonstration as similar as possible] the main TRICARE program, so the cost shares and the catastrophic cap applies to protect our beneficiaries. And the other thing that we've got and I know this was a little controversial, and certainly many of you have told us that you like us requiring the BTs to be certified. But that helps ensure quality. And if you look at the military health system in general, not just the Autism Care Demonstration, but everything we do, we follow something called the Quadruple Aim. And basically there are four components to that and it certainly applies to [this] program as well, and that's making sure that we have the highest possible quality of care; that our patients get the best care available anywhere. That's really number one for us. Number two is that they have a great experience. We want our beneficiaries to be very happy with that care and to have ease and access to have the care when and where they need it. Third, we do want to be efficient. We only have so many dollars in the pot, so we do have to spend our money wisely and we do have to try to be careful with the tax payer's money. That's very important. And finally, all that really feeds into, our overall focus, which is readiness. And sometimes people just think that readiness as the Service member or somebody in uniform, like myself or [Speaker 2], or the junior sailor, who many of you probably work with, being able to go out to sea, being able to out with their unit on a deployment. And that is very important, but we also know that they can't do that if their families aren't ready. I know when I was deployed, I'm actually a psychiatrist for those of you who don't know that, I would see Service members when I was deployed, and they were sometimes very concerned about their family members back home and the care they were getting. So we know this is a crucial part of that. So I really do think this program contributes to

all four, so if anyone ever tells you hey this doesn't really do anything for readiness, tell them they are wrong because it does, and you're a key part of that. Ok, so the other thing we are going to do is get more input on how we should shape this program is that we are going to be going out with a beneficiary survey shortly. We are going to be going to a survey for parents who have children with autism and that will be really our goal is to understand their experiences with this program; what's working well; what's not working well, what do we need to improve; and that will be coming soon. [Speaker 5], I think will talk a little bit more about that. But, certainly if your parents get that survey, please encourage them to fill it out and send it back. We very much need their feedback and want to hear from them. And we will absolutely use that information to make this a better program, cause as I said, even though I think we have a great program, we constantly want to make it better. And that is clearly something we are committed to doing on an ongoing basis. Ok, now I did want, before I turn things over, because I know I've used my time here, [Speaker 5] is next, he's looking at me, but I did want to note a couple of changes to TRICARE to make you aware of. First is, you may know for a long time, some of you know [name removed] was the director for the TRICARE Health Plan for the last four or five years. We have recently reorganized the Defense Health Agency under [name removed], the overall director of Defense Health Agency's leadership. As part of that, the TRICARE Health Plan which used to be part of something called Health Care Operations, has now been elevated to being its own directorate. So now we report directly to [name removed] instead of going through another director. As part of that, they also reassigned all of the directors. So [name removed] is still with the Defense Health Agency, now our administrative director and runs all of the administrative functions, and we now have the pleasure of having [name removed] as our director. He actually ran TRICARE in the past. He has now come back to join us as the director for the TRICARE Health Plan. We are very pleased. He has a wealth of knowledge. He is very interested in the Autism Care Demonstration. He certainly sends his good wishes and his welcome to all of you. And we're looking forward to working with him. I can tell you on a day to day basis, I don't think that's going to have any significant impact on the program. He's as committed to it as [name removed] was. We certainly miss her leadership, but I think he is going to fit right in. Now that does mean that we are not quite as closely aligned [administratively] with our Clinical Support Division colleagues represented here by [Speaker 6] and [Speaker 7]. But we're still working just as closely with them; there are no barriers there. So again, I don't think you'll see any significant change. The other issue is that right now, you know we have three regions. We have a North, a South, and a West Region. Many of you work with those regions. You may know that under the upcoming TRICARE 2017 contracts, we're going to be narrowing that down to two regions. We're going to have an East and a West, and basically what's going to happen is that North and South are merging to become one Region, and the West Region is going to stay the same as it is now. As part of that process, we may end up with new TRICARE contractors. We don't know who that will be yet. As you probably know, there was an announcement. That announcement has been protested by one of the unsuccessful bidders, and it's their right to do that. So we are waiting to hear the outcome of that. The current status of that

protest is it's with the GAO, the General Accountability Office. They review these protests. And we are anticipating a decision on that within a month. So hopefully some time in November we'll be able to let you know. Now there are potentially further appeals beyond that, but certainly we will keep you updated. What is definitely determined is that whenever this becomes implemented, and it takes anywhere from nine to twelve months after we have a final decision about who's going to be awarded the contracts to actually implement. But probably sometime late 2017, maybe early 2018, we will be going to the two region model. Again for those of you in the West, that might mean a new contractor. For those of you who are anywhere East of the Mississippi river, which there is a little bit of difference, it's not quite always on the Mississippi river, but if you look at the map, if you are currently in the North or South Region, you will soon be in the East Region. Now again, that will not change the Autism Care Demonstration program. That's a program that's administered at a higher level. But it will change who you work with day to day. It may work, or for some of you, obviously if you are north and south, one of you is going to get a new contractor. In the west, you may or may not. We don't know yet. So, with that, let me turn things over. One of the great things I get to do in this job is, you know I get to sit up here and talk, but what you don't see, or maybe you do, probably you do, is that really, I'm talking here because of the great work done by the people who are on the team. And they're the ones doing the hard work making sure everything is taken care of day to day. So I'd like to go ahead and introduce them, and I'll start off with [Speaker 5]. You want to introduce yourself?

[Speaker 5] – Thank you, sir. I'm [Speaker 5]. I'm a senior health policy analyst with the TRICARE Health Plans, and I'm the program manager for the Autism Care Demonstration.

[Speaker 1] – Ok, thank you. [Speaker 6]?

[Speaker 6] – Hi, I'm [Speaker 6]. I'm a clinical psychologist and I am a contractor who supports the Clinical Support Division at DHA.

[Speaker 1] – And she's also an ABA provider, by the way. You didn't say it, but I'll say that.

[Speaker 7] – And I am [Speaker 7], and I am a psychiatric nurse practitioner by training. And I am in the Clinical Support Division supporting the Autism Care Demonstration.

[Speaker 1] – Thank you, [Speaker 4]?

[Speaker 4] – Hi everyone, [Speaker 4], I'm the nurse consultant for case management here at TRO West which includes autism, the autism program which I actually co-manage with [Speaker 3].

[Speaker 1] – Ok, [Speaker 8]?

[Speaker 8] – Hi, I'm [Speaker 8]. I'm actually from TRO South. I'm the behavioral health nurse consultant there.

[Speaker 3] – I'm [Speaker 3], I'm the behavioral health specialist here at TRO West.

[Speaker 1] – Ok, and [Speaker 2]?

[Speaker 2] – I'm [Speaker 2]. I'm the medical director here at TRO West. I'm a family physician and I'm very happy to have the team here. Thank you for coming.

[Speaker 1] – Thank you. Can I ask the United folks to introduce themselves?

[MCSC 1] – Hi I'm [MCSC 1] from United Health Care.

[MCSC 2] – [MCSC 2] from United Health Care, VP of behavioral health, clinical psychologist, and six sigma black belt.

[Speaker 1] – Great, thank you for coming. Wow, and [MCSC 3]?

[MCSC 3] – [MCSC 3] from Health Net Federal Services.

[Speaker 1] – Thank you. And I don't think we have anyone here from Humana. But obviously Humana is from our South Region, current South Region contractor. Ok, so with that, I'm going to turn things over to [Speaker 5]. And he's going to talk, start by talking about reimbursement rates.

[Speaker 5] – Ok, thank you sir. We know and we understand that reimbursement rates are a sensitive issue and generate a lot of interest from the provider community obviously. So we wanted to tell you what we know at this point about reimbursement rates. We are relooking at all of the rates right now through a third party independent contractor that will look at all of the Medicaid rates that are being paid now and what commercial rates are available and that will tell us. And we will go through the same process that we did last year with conforming to what Medicare would pay if they were paying reimbursement for ABA. And so we'll post those results and I can't speak to those results because we don't know what that will produce. But we'll post that as soon as we know. And then once we have the national rate, of course we'll apply the geographic indexes to those rates so that rates will go by region. Now having said all that, we are aware that the FY17 NDAA may have some language or provisions specifically for ABA reimbursement. And of course, whatever is in that language as it will be law, we will comply and make the necessary adjustments. That's basically what I have on reimbursement rates at this point.

[Speaker 1] – Does everybody know what the NDAA is? I'm sorry.

[Speaker 5] – National Defense Authorization Act.

[Speaker 1] – That's basically the law that tells us what to do. That is the law that gives the military direction for the next year and more importantly, and very importantly is money. So if they tell us to do things, and there are always things in there telling us what to do medically,

whether it's autism or something else. The challenge we have this year of course is that we don't know when it might be passed. There are some things holding it up. It's our understanding, it might be, it certainly won't happen until after the election because Congress is not back in session until after the election. It may not be until there is a new president. So we're going to continue on the current path until we are told to do otherwise. And then obviously as [Speaker 5] said, once that law is in place, whatever it says, we will do what it says.

[Speaker 5] – Exactly.

[Speaker 1] – Ok, great. [Speaker 5], I guess next up is BLS and BT certification.

[Speaker 5] – So a lot of feedback about BT certification. We are requiring, and it's been in policy for a while now, BT certification through one of the three certifying bodies. We are going to enforce the December 31, 2016 deadline to have that done. So after that, if your BT is not certified, and you submit a claim, it will be kicked back. And that's per direction of senior TRICARE leadership. Taking that into consideration, however, they also approved a provisional status that [Speaker 7] will talk about in a little bit. And that will allow the period of time from when your BT is certified, but you are still going through the credentialing process, and getting all of the paperwork aligned, you can start billing. [Speaker 7] will go over that in a little bit. We're also going to take the education requirements out of the policy, the 40 hours, all that stuff. You're either certified or not. That covers all the training requirements. So with an upcoming policy, you'll see all that will go away. And that was based on a lot of feedback that we have received from the provider community on BT qualifications. CPR, again as we previously announced we expect all BCBA's, assistants, and BTs to complete Basic Life Support or CPR equivalent certification. And again, December 31st is the drop dead date. If you're not certified through BLS or CPR, and you submit a claim, it's going to be kicked back. So, that's basically in a nutshell the BLS and CPR certification requirement. Again, it's a safety issue and it's for the well-being of the children. That's our primary focus, and it's the bottom line, so.

[Speaker 1] – Ok, great. Thank you. And what I am going to do is ask you to hold questions. And we'll take questions at the end. That's we have that big block of time then. But, for those of you on the phone, I guess you could do it in the room too to ask your questions, but for those of you on the phone, please submit your questions to [Speaker 6]. We have to do it the same way we did last year and we'll take those questions, we take as many questions as we possibly can today. But what we will tell you is that if there are duplicates, we'll just answer them once, but we will answer all questions online, and we will post those Q&A after the session like we did the last time. So let me ask [Speaker 6], would you mind giving us your so they can send you the questions?

[Speaker 6] – Sure, it's long, so I'll go slow: [email removed]. It's in the invite too, so if you have that in front of you.

[Speaker 1] – So, certainly like I said, please send your questions in. We're also going to take a look at those and like we did last time, we are also going to post a transcript of the session, so you'll have that available to you online. I will tell you that [Speaker 6] graciously types that for us, because it really helps to have somebody who knows this well to type the transcript. That does that a little time, so give us a couple of weeks to post that. I very much appreciate her doing that, and we will have that out there for you. Ok, so, with that, let's move on to some behavioral technician updates. And [Speaker 7].

[Speaker 7] – So, everything I'm going to say, and actually this is true for all of the policy revisions that we're discussing here, will be effective the date that the policy manual update is published. So please know that we go with the currently published edition of the policy always. We're hoping that we will have it published early

[Speaker 5] – We've asked for an expedited

[Speaker 7] – Time frame.

[Speaker 5] – Hopefully by December.

[Speaker 7] – December/January. But we will let everyone know. Ok, so I just want to be clear about that because we are about to segue into the revisions that we have put into coordination. You know, we're a large organization. Every time we revise a policy, we have several levels of approval that are required. So that's why everything, all the changes as you know, there's always been a lag between making a decision, revising the policy and the final approval and publication. Ok, so that said, I'm going to talk a bit about supervision here. I'm segueing here into behavior technician supervision. And I just want to provide some background history. This may be redundant for people who have been with us since the beginning. But as you know, under the ACD, and I think most people do know this, that we, when the AMA CPT Category III codes came into effect, we incorporated those codes for covered services that are coverable under TRICARE. So that's in our coding section. That's how you all file your claims. Under the AMA CPT guidance, there are not separate codes for supervision, because supervision is incorporated; it's a treatment component. There's a pre-treatment component that's incorporated; there's an actual delivery of services to each beneficiary; and then there's a post component embedded in each AMA CPT code, and supervision is already embedded. Because this is a demonstration project, and because we agree with you about the quality oversight, we modified the CPT code 0360T/0361T. These things are paired together for the first thirty minutes and the following thirty minutes under the [Category] IIIs. One day hopefully we'll have [Category] Is. But now this is how it is, to allow that code to be used for supervised fieldwork. We did this because we value quality oversight and safety of the beneficiaries. Also, when we started this program, we did not have the certification for behavior technicians and as everyone knows, we've pushed back that deadline a little bit, and we've aligned the hard stop certification of behavior technicians to December 31 along with the CPR and/or BLS certification to be at the same date.

We also have aligned our self with trying to follow the BACB guidelines, so we have a requirement in the policy for 5% overall supervision. And one of the things that we've heard a lot feedback is regarding the challenges of providing supervision in the clinical setting because of the amount of time it takes. And this is because we have always, going way back before the ACD, we had legacy programs. We had an Extended Care Health Option ECHO Autism Demo for Active Duty going back to 2008. So way back to 2008, we've always had a supervision requirement. It's always been per individual beneficiary. So feedback from you all pointed out the logistical challenges that you all experience related to providing that one-on-one direct supervision; and direct is all that we cover. So our, after looking at our requirements for what we are able to provide within the boundaries of our statutory and regulatory requirements, we are revising the policy to allow, it will still be per one beneficiary, with the one ABA supervisor, but we will allow it in the group format so that you could take all the BTs involved in your team and provide the supervision in a group format at once and that we hope will help you decrease the number of hours that you are taking away from other care activities. And that's what we can do. We can't cover indirect [services]; you know we don't cover indirect, which is when the beneficiary is not there. It involves more of the administrative, what we would consider administrative aspects of the treatment plan, but we can cover direct, and we can allow you to have all of the BTs on one case at one time. And it is one to one, at least one of the supervision sessions, you know in a month, has to be face to face, in person. Did you want your paper back?

[Speaker 4] – Well, we were going to do questions at the end.

[Speaker 7] – We're going to do questions at the end.

[Speaker 4] – So you want to write down your questions so you don't forget.

[Speaker 7] – Yeah, write down your question.

[Speaker 1] – I'll make sure I come to you first.

[Speaker 7] – We want your questions; we just want to take them in the end. And that is what we can do within the boundaries of TRICARE. And I think that group format, with all of the BTs on one case with the supervisor and the [beneficiary], right because you got to have the one to one, face to face, should help you with your time. Ok, so we really spent a lot of time trying to figure out how we could best meet that need. But I think that was a big change. Alright, and then the other thing that we did, is of course the BT certification is December 31 and we have pushed that back and we are accepting the three certification bodies, and because of that, once everyone, 100% of BTs are certified, that removes what we felt was the necessity of having all of those other educational requirements. We wanted to ensure a minimal level of competency and those requirements actually, just by way of history, were originated in the original ECHO Autism Demo for Active Duty family members before there was certification. So if you all can just help us to make sure everybody is certified, we really won't need those other requirements because the floor, a minimal level of competency, will be assured by BT certification by one of the three

certification bodies and also the safety component the BLS or CPR. And now I'm going to segue to provisional status was is the next big category. We had heard over the last year from, actually everyone at the round table pretty much in 2015-16, that it is somewhat of a hardship for the ABA practices to train up the behavior techs before you can actually submit billable services to TRICARE while you're waiting for them to become TRICARE authorized providers. And now with the certification requirements, that they have to have that in order to become a TRICARE authorized behavior technician. So we have received requests from several sources, different ABA providers, to grant a grace period, which some providers have defined as any time period from the date of hire until the person becomes a TRICARE authorized behavior technician, which also requires the TRICARE receives a certificate, right? So we have ABA providers asked us to provide this grace period to include 40 hours of online training, the company training, the supervised field training as required by the certifying bodies in preparation for the exam. We looked at what we are able to do, and what we have come up with is that we are, we have come up with a definition for BT provisional status. It will, it should assist you some, not maybe 100%, but some. And I think a lot actually. And we are defining as the time period from the time the person passes the BT exam until you become a TRICARE authorized provider. And the certification exam can be passed by any of the three qualifying bodies, BACB, QABA, and BICC, right? And this provisional status will be in the new revised policy and we of course have to have the condition that if there was a case where the BT didn't get their certification for some reason, that we would have the ability for seeking recoupment of payment if the application is denied. I would think that would be so rare that that would be an outlier. And this change will ensure that every BT has completed all of the training and supervision requirement by the certifying bodies, that they've passed the exam, and therefore, you will experience some relief by being able to bill for their services from the time they pass the test until you get that TRICARE authorized status from TRICARE. We haven't worked out the whole exact processes. I think that will require close communication between the ABA supervisor or corporate service provider and the contractor to make sure that the packages are complete because the ability to provide that reimbursement will be contingent upon receiving that complete application with the, whatever, the email, I think you get an email verification of each certificant's exam score and the fact that they passed, right? The process will have to be worked out contractors and the provider groups to make sure that the contractors have everything. And when that's verified, I'm just saying, everybody will have to talk to everybody, and once that's verified, yes we have everything, then once you have that, I would ask for that in email writing, some sort of documentation both sides so everybody knows that everybody has everything, and then that time between passing the exam and getting the TRICARE authorized status once TRICARE receives the certificate can help you because you'll be able to bill for claims. So those are the updates, and I think they really should help you in a sweeping way. I now am segueing to [Speaker 5] for other policy updates. This is the physician.

[Speaker 5] – Additional feedback we received involved the new, for the requirement for a new referral every six months from the PCM. Due to the logistics in setting the child up with the

PCM, the availability, and so on, so we relooked at that and we are going to delete that requirement. We're not deleting the requirement. We are changing the time frame. So it's not going to be every six months; it will be every two years. And that will be in conjunction with the two year review, the clinical review. To ensure continuity of care, the contractors have issued interim authorization via what we refer to as a common letter. So that should be in place right now. And then we are allowing the reassessment code 0359T in circumstances where the PCM has failed to submit a timely referral. So we're working with that now. And we will address that in the upcoming policy update. We received a lot of feedback about that, and we got it. And we're going to make some changes on that. Oh, I'm sorry. Thank you for that reminder, [Speaker 6]. The BCBA still needs to submit a request for referral, I mean a request for continued ABA every six months.

[Speaker 7] – So instead of it coming from the PCM, you will submit your treatment plan updates every six months, and that will be the request for the next six months' worth of treatment. And the PCM will just put in a referral at the every two, every two year with the review. And that should streamline the process for you all, I think.

[Speaker 5] – Break down that barrier.

[Speaker 1] – That's very similar with what we do in other mental health.

[Speaker 7] – So it will be based on your treatment plan and the identified needs. You'll still get a new [authorization] every six months.

[Speaker 5] – DNPs, [Speaker 7]?

[Speaker 7] – I'm up? DNPs. Alright, so you know, access, we care, there are a few big rocks that we care about, right? Access to care is one of them. Quality of care is another. And we're committed to streamlining the process as much as possible over time as we continue to learn lessons, cause are goal is not to make busy work where busy work may not be needed.

[Speaker 1] – You know I co-chair the streamlining committee.

[Speaker 7] – Streamlining is like a new thing. So on this access to care, this is an access to care rock, there are nurses who are doctors of nursing practice. And we have received, actually multiple requests, this is just another feedback thing that has come to us, that certain of these nurses who are nurse practitioner, but they are doctors of nursing practice who are also certified as nurse practitioners, who meet certain very specific requirements, have requested that they be recognized as specialized ASD diagnosing providers, which may help a lot, actually in certain locations, in terms of getting the initial diagnosis, diagnostic evaluations, and that specialized evaluation if you get diagnosed by a PCM initially. So there are two categories of these doctors of nursing practice for which we worked with them, their groups, and came up with criteria for them to be specialized ASD diagnosing providers. And one are the DNPs as providers of

developmental pediatric services; and the other group is actually for people like me if I went back for my DNP who are providers of psychiatric services. So currently, the developmental pediatric services and psychiatric services are offered at our large military health system medical centers. And want to optimize the time of providers because they really are extremely busy. And we want to do this through leveraging the skills of these highly qualified doctors of nursing practice who are trained in these two sub-specialties of developmental [pediatrics] or psychiatry/psychiatric services so that we can increase access to care at the entry point level for diagnosis and for that specialized ASD evaluation which is required within one year if you get diagnosed by a PCM. So, we also have learned from our network partners that in large medical centers, folks work in teams, so we're going to have these people on psychiatric teams and developmental [pediatric] teams, so it's the same, it's like the medical home model like but for specialty care, people work in teams today, and we want to keep up with the times while ensuring quality. So we have worked out the criteria, and we have included in this next policy update a section that specifies the criteria for the two areas and we have added the DNPs meeting those criteria to the group of specialty providers who are considered specialized ASD diagnosing providers. Now we go to you [Speaker 5]. And if you have questions, write them down.

[Speaker 1] – Can I just make a point here? Just to make absolutely sure whoever you are working with is in fact qualified, it's probably a good idea to check with the managed care support contractors, is this person good to go. Cause that is a little confusing, I wasn't entirely sure who is not either.

[Speaker 7] – And it is. Please do not take away that all nurse practitioners fall into this category, cause this is not true. Pediatric nurse practitioners in the pediatric clinics and primary care clinics, they are not in this category. This is specifically people with the DNP, who are nurse practitioners, who meet certain criteria for developmental pediatrics only, and also under psychiatric services who also meet those criteria.

[Speaker 1] – And you'll figure out, hopefully in a short period of time, who in your area meets that criteria. Ok, good. [Speaker 5]?

[Speaker 5] – OK, the next issue that we received a lot of feedback on concerns the Individualized Education Plan, IEPs. We've received feedback from ABA providers that TRICARE requesting the IEPs violates the Family Education Right and Privacy Act. And we dispute that a bit, but nevertheless, parents are refusing or have

[Speaker 1] – Concerns

[Speaker 5] – Concerns about meeting that requirement. So we've had a lot of discussion about it and we are going to remove that requirement from the policy. However, doing that makes it impossible for us to verify whether any ABA that is being done in the school setting and any ABA we authorized it not going to be duplicate. Schools are required to provide ABA in the school. I mean, the school system, and pay for it. So we are not going to authorize ABA in a

public school setting with the policy update. We do understand that there are autism schools, or “autism centers,” “private settings.” We will have to work through that a bit. But we are not going to authorize any educational or academic goals for treatment plans in conjunction with ABA. So [Speaker 7] do you have anything to add to that?

[Speaker 7] – Yea, just that we really can’t. That we learned that, and I will defer to our, to [Speaker 6], who may have more to say since I’m not an ABA provider, but we did learn along the way, and I wasn’t aware of this, since 2012. I actually learned that because of the different, the nature of the ABA interventions, the different techniques, that it is possible and sometimes can happen where the treatment plan in the school will specify techniques that may be in conflict with the ABA interventions specified in the treatment plan on the medical side provided under the ACD. And if we do away with that requirement, there’s just no way for us to separate out, for our people going into a school setting. You know, what at all would be educational from medical. We can’t do it. So, we hear you. We heard that people did not want to, there was resistance to getting us the IEP, a copy of the IEP from the parents. We never asked for it from the schools. In my opinion, and the opinion of many others, in no way violated the fair education act, Privacy Act because we were never asking for it from the school. But we can’t determine what is being delivered. So, we understand that it was a burden and therefore we are doing away with it. That should simplify the task of trying to get it and fighting an unnecessary battle. But the downside is that without it, we can no longer cover school related targets.

[Speaker 1] – I would say to, we are trying to make this similar to all other medical benefits we cover. In general, other things that are provided via school, we don’t pay for because it is the public school’s responsibility to provide by law to pay for those. And there’s no reason to pay for those twice. So I think we are really bringing this into line with everything else that’s provided in the school setting.

[Speaker 7] – So I hope that the easy part of not trying to get the IEPs and worrying if you can’t or getting an outdated one or all of that, that should simplify that process for you. I would think that, we’re moving, we’re evolving. We started coverage under the ACD on July 25, 2014, so we’re heading into our third year and we’re streamlining it and finding out what is working and what isn’t working and what’s causing an undue administrative burden as we go, but sometimes you have to give up something if you’re going to get rid of a requirement. So we can’t, we just can’t cover the school and educational targets.

[Speaker 1] – [Speaker 5] makes a good point about the private autism schools and their treatment programs not really educational settings, you’re not getting a high school diploma from the place. So I think we’re going to have to look at that and probably ask you all to look at that too and see are these things really named properly. Because words do matter, and if something is being called a school and it’s really not, that could be a problem. So I would ask you to think about that and we’ll be taking a look at some of those individual situations as well.

[Speaker 7] – Yea, because we don't know enough from this end. I imagine there are centers that have a school program and an ABA, autism center clinical program. I think clearly defining your different programs, if you have more than one, would be a very good thing to think about.

[Speaker 1] – That would help us certainly.

[Speaker 7] – Yea, that would help us. And I think what we consider education as anything that has oversight by the Department of Education. If the regulations require complying with Department of Education requirements for educational facilities, that's an educational facility. But that doesn't mean that one center can't have two distinct programs. I think those things exist. They just have to be very clearly defined.

[Speaker 1] – Thank you [Speaker 5]. Anything else on the IEPs?

[Speaker 5] – No, sir.

[Speaker 1] – Alright, good. Now we're going to move onto [Speaker 7]'s talk about outcome measures. But let me give a little introduction first.

[Speaker 7] – Will you? That will be good.

[Speaker 7] – I know this is going to be a little bit of a controversial topic, so let me say that up front. It is also one that I think is very important. And I will tell you think is not something we are only doing with Autism Care Demonstration, although we are going to be doing it here. We are starting to look at outcomes in everything we do. I can tell you that we actually have a purchased care dashboard that measures all sorts of different types of care we provide. You can actually go to the TRICARE website now and look up outcomes for many different medical things that we do within the direct care system. You can look up the Naval Medical Center in San Diego, since we happen to be here, and you will see what their outcomes are for the different types of treatment, different types of patients. And that's not only true for military, although we certainly do try to lead the way in terms of quality, but a lot of civilian systems do this now too. I can tell you, the Cleveland Clinic is one that most people are familiar with, I'm not here advertising them necessarily, but I get a book from them every year that's 150 pages that shows me all different outcomes that they get for their mental health clinic. It's quite impressive and it tells you this is where we do really well, and where we need improving, and here's what we need to do to make them better. So outcomes measurement is becoming a key in medicine in general. We have a number of programs that we're developing where we're actually rewarding providers for better outcomes and to encourage them. So that is coming. Medicare is doing that in many different areas, if you read the newspaper or go look at their website. So this is definitely an area that I think is coming to all of medicine, autism care included, but certainly not limited to autism care. So let me say that I want you to, I don't want you to feel that autism is being singled out for this, or this is in any way a comment on the great quality of care that our kids are getting already.

But this is a reflection of where medicine is going, of all medicine is going, in the United States, and probably overseas too. So with that, [Speaker 7].

[Speaker 7] – I just want to say one more thing about health systems in the United States. Hospital Compare is a great example if you want to look up one site because Hospital Compare, and we participate in this, and of course it doesn't apply to the ACD. The ACD needs its own outcome measures, but on Hospital Compare, military health systems participates and those are measures listed, and they evolve and change over time, that all of the big civilian medical centers, including the military health system participates in to compare how different systems perform on specific metrics. So this is completely, I thank you for that, here to stay that it's important to understand the context in which we live. So that said, on May 18, 2016, the Senate Arms Services Committee, which we adoringly refer to as the SASC, directed us to report on health related outcomes for beneficiaries under the Autism Care Demonstration. So, I think we knew things were going in this direction because I certainly recall [Speaker 1], our facilitator and leader, bringing up the topic way back in September 2015 when we had an information session and then in the round tables in December of 15 and April of 16. We've been talking about this for quite some time. In fact, I recall [Speaker 1] asking folks to provide some input on outcomes measures and what you all use in your different centers and practices. And I know that we received very detailed information, yea, from [Provider 1], and others, there were a few others. And other people did not send us anything. But what we did get was certainly very useful and I thank you for that. Ok, so we are required, under this directive from the SASC, to require health related outcomes for beneficiaries under the program. It's element 6. I'm not going to read it, but you know there's other things they want us to report on. That is the last one, and they definitely wanted, and in fact, we already have to answer that, so we're in a process of evolving. So in order to report on outcomes to the SASC, we actually have to have norm-referenced, valid, and reliable metrics. And we did select some which I'm going to review now. And we've tried to insert them into the normal process of care delivery under the ACD in a way that shouldn't be overly burdensome in being mindful of streamlining, but also of the fact that we have to answer this. Ok, so after reviewing at the ABA provider level for BCBAs, we have, the current state is that we have allowed each provider, individual or center provider, to use individual targets for the treatment plans and to just map out your findings for each individual beneficiary. And we understand that. We understand that this is highly individualized care. But after looking at, we now have had a little bit of time, we've had an opportunity to see what kind of information that yields as a program level, that is not going to answer these outcomes for Congress cause they're too individualized. So, at the ABA provider level, we have to standardize it, but we want to standardize the metrics in accordance with your usual practice and the tools that they ABA providers use. So every six months with the treatment plan update, we want the VB-MAPP to be included, because that's a tool that people are trained in more the most part.

[Provider 1] – No. I don't use it at all.

[Speaker 7] – Well, one reason that the VB-MAPP is easy on our end, as compared to the ABLLS-R, which we also looked at,

(Indecipherable comment)

[Speaker 7] – And you don't use that? A lot of other people do. You know, I mean those are the ones that we've received information and feedback that people use it all of the time, please hold your questions till the end, is that one advantages for the people who review on our end, is that the VB-MAPP provides a score. So it gives you an overall percentage score and it is easy for the reviewer, who are BCBA's on our end, to be able to, it's not me, but we have BCBA's who work on the ACD program for us, that was an important thing to us to have people from your profession who actually understand what you do, and the VB-MAPP provides a numerical score that makes it easier for them to figure out where an individual beneficiary is on their progress. Now all of this said, we've said this before, we're not using one measure or anything to discharge patients. This is to meet these requirements; we have to have a standardized measure. So that would be, and before, people who have followed us from the very beginning, when we had a one year ABA pilot for non-Active Duty Service members, and remember in that, we received pushback because we had included the ADOS at baseline and then the Vineland, we had put the Vineland in there for global assessment of functioning, and people felt that was not specific enough because it wasn't a tool used for specifically this population, and the feedback was that we were requiring it at too frequent an interval. That if you're going to use the Vineland, it's good like annually or biannually because it gives you more of a global assessment of functioning. So we were sensitive to that and we selected a tool that BCBA's are trained in and it's not something that's outside the scope of practice. So that's where we came to that. Now, the true, so that would be progress. That would be standardizing, along with everything else, how progress is reported by the BCBA's. And then every two years, this will not be done by the BCBA's, with the every two year review, we are going to require, whichever is the appropriate Wechsler intelligence test, and this will assess intellectual functioning, and that's because the majority of the research is used IQ functioning as an indicator of success of ABA services. It's in all of the literature, and I think you all know that. The Vineland is now in its third edition, and we will require that just every two years as a global assessment of functioning. And this won't be done by the BCBA's either. And then also the ADOS-2 at baseline and then every two years. And we're doing it to align with the every two year review to make it not overly cumbersome and to conform with a realistic interval measure this kind of outcome progress. And so the only change for you all is the VB-MAPP. And I know this standardizes what you do, but we really have no choice in light of, we're providing all of the resources to support the program. We have to report the outcomes for the program. And we didn't make this decision lightly, just know that. And really I cannot stress this enough, that no single element will be used to discharge kids. We've been supporting our beneficiaries to get the services they need, the medically necessary services they need. And we will continue to support them to continue to receive the medically necessary services they require. But, there's no way, when you look at, say you take 400 individualized

treatment plans on 400 patients, say you did that for a representative sample, you cannot draw conclusions about outcomes from those treatment plans. We need some middle ground. I think the every other year is a reasonable period. And just in terms of phase-ins, because this question has come up, ok, so we haven't published the policy revisions yet, correct? The ACD started July 25, 2014, so the first, everyone who enrolled two years ago, when we started the ACD, just now have come up for their every two year review. I think the regional contractors, I think those are underway, and if not already completed, so say we don't, we get this published December/January, it would be like the new cases, I'm talking about like for the baseline ADOS and that, right? The new cases would have those measures. Everyone else will have those every two year measures, that you all wouldn't be doing, the specialized ASD diagnosing providers would, mostly the psychologist, when the child comes up on their next every two year review. It will be phased in. We're not going to take like the 13,000 kids and say, alright this is the policy, you all have to run and get this today in order to continue services. We're going to have it when each child's every two year, because you have to have phased in implementation to make it realistic. And I know that will take it past 2018; we'll have to see where we are in 2018, but you know we have to work towards outcomes and we have to phase it in in a way that conforms to reasonable workload, right? You want to, is there anything you want to add?

[Speaker 1] – Maybe a couple of things. Thank you for that great summary [Speaker 7]. I'm sure one of the questions that you are thinking, some of you may be thinking. I shouldn't say all of you are, is how are we going to use these measures. Obviously one is we are going to report them to Congress. When Congress passes a law and the president signs it, we do it. And so we are absolutely going to report to Congress. But we want to get some value out of this besides just reporting to Congress. So I think we are going to use these in a couple of ways, really to focus on process improvement and improving the program as a whole and the quality of care we give to each child. Certainly if we see a child, and the outcomes suggest that the child is not getting any better, we may ask you to take a look at the treatment plan if there are things that could be tweaked here to help that child start moving forward. So we will I think be using them that way as part of the treatment plan review to say, is this child making progress? If not, we're not going to discharge the child based on that, but we're going to say are there some things maybe we should change in the treatment plan to help them start moving forward. So I think we will use it to try to improve the treatment our kids are getting. I think the other way we may use them, is certainly we may look at them and say, what is working well for particular groups of kids. Maybe we'll see based on the outcomes that hey, children under the age of 10 who are getting this number of hours or this combination of services are doing really well. Cause that research really isn't out there right now. This is not primarily a research tool, but we'll use it to try to improve our processes for our population, yes, absolutely. And I think that's an appropriate use, that's not the primary use. The primary use is for the individual child to get better. And use this as one tool that will help us get there. So I think that's how we're going to use it. We will report to Congress, but I can tell you Congress is going to ask, and we would do it whether they would asked or not, that we want to make sure our children are getting better, as I said reaching their

full potential. And that we are also identifying those things that work with you so that more people can adopt. So I think we'll use them in all those ways. Really with the goal of making sure our children are getting the very best care possible, and that the ACD is the best autism treatment system in the country. That's really our goal. So I think that's where we are going with this. I really see this as a win for our kids. Like I said, we're doing this in lots of other medical care now too. The upcoming TRICARE contracts required a lot of what we call HEDIS metrics to be reported, which is looking at how our people are doing on a whole bunch of different quality measures ranging from are they getting the right diabetes care to, are we managing their lower back pain properly. It's all part of that. So this is just another piece of that, and again really with the goal of making sure that we're taking care of, doing the right thing for the children who are getting care. I want to assure you that's our focus here. Not looking to get anyone in trouble. Not looking to discharge anybody, but we are looking to make sure the kids get better. So, anything you wanted to add?

[Speaker 5] – No, sir.

[Speaker 1] – Alright, we've covered a fair amount here. So it's time to move on to the Q&A, it's the most important part because we learn from you. So we have some questions submitted in advance. We are going to take those first. We very much appreciate the people who did that. And then what we'll do is kind of what we did before. We'll take questions from the room, starting with you, and then we'll also take some that are coming in online, and we'll just go back and forth. We've got almost an hour, so we've got plenty of time. So we are very pleased with that. So I'll turn things over to [Speaker 5] to take the advanced questions.

[Speaker 5] – Ok. First question we got regards progress notes.

[Speaker 6] – Let's punt that to [Speaker 7].

[Speaker 7] – Alright, I'll answer progress notes since it's sort of more of a nursely sort of topic. And this was a question that we received and the question is, it reads a little long; the main point is that the background and training of ABA providers, in the view of the person who asked the question, does not include content relevant to the ACD's requirement for documentation, specifically the content of the session, narratives of interventions and responses, and progress summaries are not addressed in training requirements by the BACB or other credentialing agencies and training programs. I don't know that that's entirely correct, but at any rate, the point was that ABA providers document using graphic formats to measure time and frequency of events, which is certainly something you all provide to use, and we appreciate that. Thus is it common for an ABA provider to submit progress notes in a manner consistent with their training which is at odds with our requirement. Is there any plan to revise the TOM requirements? Bottom line, we thank the questioner for bringing this up this issue

[Speaker 4] – Just for clarification purposes, that's from a managed care support contractor, in case you didn't quite get that.

[Speaker 7] – Yea, I didn't know if I could say that. At any rate, the design of the Autism Care Demo is to administer this demonstration as a medical benefit as much as possible. That because we're a TRICARE program, we're a health benefit program, and entitlement program governed by statute and regulation which makes it unique from, we're not a health insurance program, but we have to administer this benefit, even though it's under a demonstration authority, as in alignment with medical benefits as possible, as much as possible. So we really try to do that. And as part of the health care industry, documentation of session encounters is one element that composes all medical records. And at minimum, we have a policy, the contractors use our policy manuals as their policy guidance in administering the benefits. So that may be slightly different than the ABA providers because the, our regional contractors go to our policy manuals and that's their instructions for administering the benefit. And we have a TRICARE policy manual section, Chapter 1, Section 5.1 and it is on medical record documentation, the basic minimum requirements. And therefore, there is a requirement for documentation of a progress note that has basic requirements like why the patient came in that day, how they were doing that day, if they were able to, an assessment if they were able to engage in the treatment plan, and then the plan of care. I'm simplifying it but that's basically what's in there. And since TRICARE reimbursement rates for ABA services provided by TRICARE, the requirements of medical record documentation under the TRICARE Basic program apply. So we can't get rid of progress notes because they show you that, whoever, the technician met with the beneficiary that day, the beneficiary was able to participate versus if they slept all day, or you know what I mean? So you need a little bit of narrative, but I don't think it needs to be overly burdensome. It meets those critical elements because your graphic representation for that day is going to provide the rest of what the patient was able to do vis a vis the treatment targets, right, and the interventions. But you do have to say, October 19, 2016 met with [Speaker 7], or whatever, [Speaker 7] at 10am. She was alert, oriented, participating; worked on these areas. You have to be able to have some basics. And you can refer back to the treatment plan to keep it as succinct as you can. So that was one. Any other questions that are related to that?

[Speaker 6] – Not at the moment.

[Speaker 7] – Alright, and then ok, then we received this one. And this was from a provider in the West who wanted clarification CPT code 0368T and I know these codes are confusing. The person wants to know whether or not a parent or client needs to be present. Is it clinically necessary to have these meetings to ensure that the RBT on the same page in between supervision so that everybody is implementing the procedures the same way, oh, It is clinically necessary, that's what they're saying, and that they understand any amendments to the behavior plan program to ensure fidelity of implementation. And the codes require beneficiaries to be present, yea they do. So the one code, 0370T for parental guidance, having the actual beneficiary present is optional. Right? But that's the code, the one code, where that is an optional choice based on the needs of that particular session, right? So, direct service demonstration means demonstrating the service on the beneficiary, with the beneficiary, the beneficiary has to be

there. And if they were not, then that falls into the bucket of indirect services, right, where you're discussing patients but the patients aren't there, parents aren't there. The codes don't apply or it's an embedded element. Alright, and then this is from the north, and actually, I can say this right? This question is from you [Provider 1], providers are inquiring about how they would bill for indirect services or those that don't include the [beneficiary], and again this is 0368T/0369T, which can only be billed with the [beneficiary] present, right? The other discussion is that the code does not include all the other tasks required to maintain a program. And that's the indirect services. We don't cover the indirect services. The best that we could do is modifying, and it's a direct service, we did modify the direct supervision code to allow the 0360T/0361T to allow direct supervision. Nothing we can do about indirect. And that is not just us. We actually have a policy in TRICARE, there's a policy in TRICARE in the manual that very specifically says we cannot cover, any coverage, for any condition, any service, elements that are considered administrative functions, and they are defined this way. So it's a prohibition within the TRICARE manuals themselves. I can't site the policy of it, but I have it saved.

[Speaker 1] – Remember that many of our policies, by law, are based off of Medicare. That is one of them. In general, if it's a Medicare policy unless there is a very strong reason, with a few exceptions, that we are required to follow them. And what about the last one, then?

[Speaker 6] – We can save that.

[Speaker 1] – Ok, very well. That's fine. Whatever you want to do. And I think that finishes the pre-submitted questions portion.

[Speaker 7] – I found that actually in our response, I do have the TRICARE, it's in the TRICARE Reimbursement Manual Chapter 1, Section 19 that says we can't do it, and that's based on the 32 Code of Federal Regulations 199.4(c)(1) if anyone needs the reference. (Indiscernible talking). I'm trying not to read, and I then realized.

[Speaker 1] – You're doing very well. Ok, so I think I promised first to come to you for a question. What I will ask though is before you ask your question, use the microphone that's close to you

[Speaker 7] – When it's green, the microphone is one.

[Provider 2] – I just wanted some clarification on the supervision requirement.

[Speaker 6] – Can you please introduce yourself?

[Provider 2] – Yes, I'm so sorry. I'm [Provider 2], I'm the director of the [ABA Practice] in the [location removed] area. Supervision is definitely an area where we've been struggling with in our center based program and was wondering if you could give us a little bit more clarification. Is the requirement still 5% of the hours that a child receives per bene, for each child, per therapist who works with this child?

[Speaker 7] – Yes.

[Provider 2] – So each therapist must still be supervised for 5% of their time, per child.

[Speaker 7] – Yes.

[Provider 2] – Can it, I wasn't sure if I understood this, this could all be group supervision, is there a still one on one supervision requirement?

[Speaker 7] – The change that we are able to make, within our requirements, because we've come to understand that most children have a group of, a team of BTs. You can get all the BTs in the team, try to say that three times, with one child, with the child present, and provide that supervision with the ABA supervisor for that supervision.

[Speaker 1] – So it could all be group supervision then?

[Speaker 7] – Yea. Do you want to speak to the 50%? Yea, but, I thought we were looking at that.

[Speaker 6] – We can hold it for later.

[Provider 1] – I think you guys wanted the 50% to be face to face perhaps.

[Speaker 7] – Yea, well it has to be face to face with the child there, everybody there, just we're letting you do it in a group format.

[Provider 1] – Which I think is a fabulous solution. That's one of the best solutions, because that's going to

[Speaker 7] – Because it goes with your workflow.

[Provider 1] – That's how we do it. Perfect.

[Speaker 5] – Great!

[Provider 1] – That's how we've done it for 30 years.

[Speaker 5] – That's awesome.

[Speaker 7] – Right, just so the child is there, and

[Provider 1] – This child is there, the parents are there, the whole team is there.

[Speaker 7] – The parents are there, and that each of the BTs on the team, you know actually watching them deliver

[Provider 1] – That's exactly what we do.

[Speaker 7] – But it should decrease the number of hours

[Provider 1] – Significantly.

[Speaker 7] – That you're spending on each child in the one to one with each BT, if they can all meet together, right?

[Provider 1] – Right, and that's a significant removal of burden on the provider because when you had to do it one to one per beneficiary, one to one therapist and supervisor, BT and supervisor, that was just, it was a burden on everyone. Getting the child in there for even that length, let's assume you have six BTs. It was really amazing.

[Speaker 7] – Right, so of course it's going to be one longer session.

[Provider 1] – Correct, and then

[Speaker 7] – Everyone can be taking turns while you're watching.

[Provider 1] – Perfect.

[Speaker 1] – And that's really our goal, I think, to make sure their getting quality care, but also to make this as streamlined, if I may use that word, and it's easy on all of you, and the parents too for that matter, as possible.

[Speaker 7] – We think with scheduling, would that help with that?

[Provider 3] – It's impossible not to do it this way.

[Provider 1] – It will make a huge difference now. It will help a lot.

[Speaker 5] – Just a reminder when you speak to just identify yourself so we can capture everything.

[Provider 1] – Sure. And I do have some questions.

[Speaker 1] – Ok, let me take her first.

[Provider 2] – Yes, that answers my question. Thank you.

[Speaker 7] – Now that is not in effect now. That's clear, right? We have to wait for the manuals to be published.

[Speaker 5] – We will get it published as quickly as possible.

[Speaker 1] – We'll post it as soon as we do, and we'll also put it out in email to this group. We won't

[Speaker 7] – Yea, I mean we'll let you know. We're trying where we can. It just has to be within the requirements, because we need the assurances each child is directly observed and supervised, the BTs are directly supervised.

[Speaker 1] – Right here.

[Provider 4] – Just a related question. My name is [Provider 4]. I'm from [ABA Practice]. So the challenge right now that I find with the 5% and the 20% is sometimes logistically I'm planning to go out next week and then the child cancels for the month because he's sick and now I didn't provide the 5%. And we try our best to document some of that or the bigger situation where we ran into recently, we had an audit that we did not pass because we try very hard to make sure there is consistency and we will provide a sub if possible. So I had internally made a rule that if someone goes out one or two times, if it's a sub, please let's make sure the child has services, try to do supervision if you can, but logistically sometimes we can't schedule that nor do we have that authorization to have that many codes. And we actually got dinged because we too many basically had sub coverages we provided that didn't have supervision, which to me, clinically was in the best interest of the beneficiary. And we always made the rule that if you've gone three times, this BT needs supervision; they've been out there enough. Similarly we have the reverse sometimes, where maybe I went out in the beginning of the month, had sessions happened the way they were supposed to, I would be in the 10% or 5%, but now I did 50% of supervision because it turns out that sessions got cancelled. So for me it's a challenge. I want to stick with the policy, but life and home and session doesn't work out that beautifully. So I guess I pose to the team, is that rule staying strict, if so, as the provider, how do we best practice but then cover ourselves logically with what the intent of the policy is?

[Speaker 1] – Good question. Thank you.

[Speaker 7] – I don't really have an answer, do you have any thoughts on that [Speaker 6] because I think that's something that each practice. My initial thought is that you all are the experts when it comes to implementing your program. I had actually, until this point, and I assure you that this is a collaborative interaction, I hadn't even thought about or realized that, I mean I knew about with vacation coverage that you might have to have teams, people who might not be usual BTs, but I hadn't thought about it in the framework of substitutes.

[Speaker 1] – How about if we take it off line?

[Speaker 7] – Yes.

[Speaker 1] – And let's get back to you on that. And we'll get you an answer.

[Speaker 7] – Or maybe we'll even talk to you to get more information, but I, this is the kind of thing that I think I for one would appreciate like how other practices have come up with creative solutions for that circumstance. And I don't know that you have, but I think within a lot of

professions, I know you do it all of the time, sharing best practices, for how to keep in line with the, certainly TRICARE in this requirement can't be the only one, I mean the BACB requires 5% supervision. You know, so it's required for

[Provider 5] – per therapist.

[Speaker 7] – Per therapist, right not per [beneficiary]. And I know we require per [beneficiary].

[Speaker 1] – Right, we understand that. We will definitely get back to you on that. Let's talk about that and we'll regroup and let you know. So thank you. It's a good question. I guess, [Speaker 6], Do you want to go to an online question?

[Speaker 6] – Sure. There are a couple that came in, and I'm just going to summarize because some are saying the same thing, so instead of going through, I'll address those now. There have been several questions about the VB-MAPP being an appropriate for all children. I think our response to that at this time is we're going to take that back. What has been posed are different elements for why it may or may not be appropriate. So know that this is now taken for discussion. Ok, the other issue is

[Speaker 1] – Can I say one thing?

[Speaker 6] – Sure.

[Speaker 1] – We do need a standardized tool, so certainly we'll take a look at that, but it will probably stand.

[Speaker 7] – Well, unless you all as a group, and I would leave this for you all to send us, chose one spokesperson, but if you all, all the ABA providers, BCBAs/BCBA-Ds sent us an alternative, that one that you could all agree on, that you are all trained in,

[Speaker 1] - We would consider it.

[Speaker 7] – We would consider it. But you know, we have to meet this. We can't, we did take a look at a representative sample of what we've been getting in treatment plans. It's not going to answer standardized progress measurements. So a tool you all use, that you all agree upon,

[Speaker 1] – Could all use.

[Speaker 7] – Could all use, that you all agree upon, because I'm not an ABA provider, but we had been told, oh VB-MAPP yes, or ABLLS, we were told those two, many times by different people, so.

[Speaker 5] – We'll just say the manual change process, it takes a while to get something implemented and we send out the proposed language changes to all our stakeholders and we get feedback. So right now, as of this very moment, I'm sitting here and nothing is final. We have

gotten a lot of feedback from the Services, Navy, Army, Air Force, and other stakeholders, and we're soliciting feedback from you all now, so keep the recommendations coming.

[Provider 3] – Well, the VB-MAPP has milestones up to 48 months.

[Speaker 6] – Right, and I think those are some of the things we are going to take back.

[Provider 3] – Is it possible to have that and then an additional like a social skills curriculum or social skills assessment, so maybe not for some of those older kids. So, I understand the need for standardized measures, however, we have a handful of kids that are above 48 months of typical developmental milestones. However they still have a significant amount of deficits that we still need to treat, so how would we document that if they are off the VB-MAPP. They no longer fit themselves?

[Speaker 1] – Those are good questions.

[Provider 3] – We have an alternative for those types of

[Speaker 7] – I think that would be wonderful if your field could come up with the alternatives and give it to us, quite frankly because then we could have the VB-MAPP for this situation and then for the people like this subgroup, I don't think we have any objection to adding another tool that would better meet the needs of that subgroup. But I think your profession, it would be best if you all would agree on one and send it forward to us.

[Speaker 1] – Thank you.

[Speaker 6] – I have more, but if this is about the VB-MAPP, can, we'll take

[Stakeholder 1] – It's about this whole area. I'm [Stakeholder 1] with the Association of Professional Behavior Analysts. I'm a long time researcher in a previous life and to a certain extent know, so I am completely on board with the need for clear, reliable, valid measurement of outcomes. So I just wanted to make a couple of comments. My organization is developing, will be developing evidence-based guidelines for assessing individuals with autism throughout the lifespan for treatment planning and progress reporting. We are following a protocol that we've adapted from the Institute of Medicine about how to develop evidence-based practice guidelines. We're just starting this process. We will put together a group of experts on various aspects of assessment, both behavior analytic measurements and more typical psychometric types of measures. The VB-MAPP is not standardized. It's not norm-referenced. It's not valid. It's not reliable. It's not comprehensive. I'm sorry. I know it's really popular.

[Provider 1] – I want to hug you right now.

[Speaker 7] – We agree with you, but we, that shows actually to the extent that we are trying to meet you have way. Because we are trying to reach out, that's why we only went with the valid

and reliables every two years. We're trying to reach out and offer you a tool that you said is popular in your field. You can

[Stakeholder 1] – Yes, but there is popular and there's good.

[Speaker 7] – Exactly.

[Speaker 5] – What is your timeline?

[Stakeholder 1] – Well, that's hard to say. We have to get this done within a year, and we are just to the point of beginning to identify the people who will be the guidelines development group, so the experts, so it will unfold in the next few months. I can't you exactly when we'll have a document ready. I'm sorry. I do appreciate all of the efforts to reach out. I understand that again this is a popular instrument and it is easy. But again, that's not the same as being an accurate, valid, and reliable measure of behavior. My sense from being a researcher, reviewing a lot research, we've just had to update, we're working a proposal to modify the CPT codes. We've had to update the literature review section. I've been working on that. I don't think there is going to be a single measure. If you look at best practices. If you look across the board at the research, it again varies with each individual child on a developmental level. What's medically necessary for them, if you look at the BACB's autism treatment guidelines you'll see that is says for the initial assessment, the behavior analyst is to use a variety of sources and information. That includes the results of well validated, reliable, and assessment instruments with good psychometric properties and direct observation and measurement. If you look at the research on studies for early intensive ABA, including ones that I've coauthored, we use a battery of assessments. So again, valid and reliable measures of yes cognitive developmental functioning overall, but for little kids, and for the intensive comprehensive ABA, you won't see that kind of measure for focused ABA treatments for older people with autism. IQ isn't going to be sensitive and not a valid measure of clinically important outcomes in those cases. But if you look at the comprehensive intensive ABA, its measures of language skills, measures of adaptive skills across the board, social skills, I mean all of the domains. So the core symptoms for all the domains that are effected. There's no single instrument that I'm aware of that will detect that. There is one instrument, and I've put this in previous written comments to you guys, that I think would be beneficial in a lot of ways and it's the PDD Behavior Inventory. It is well researched.

[Provider 1] – I agree,

[Stakeholder 1] – It is norm-referenced. It's valid and reliable. It gives an index of autism severity, of maladaptive behavior, and of adaptive skills. It's currently standardized, it is standardized in terms of its assessment, in administration and scoring, which the VB-MAPP is not. But only for ages 2-12. But still that's going to cover, right, a lot of beneficiaries. I would encourage you to take a look at that. Dr. Ira Cohen

[Provider 1] – I sent it to you guys, (indiscernible talking)

[Stakeholder 1] – New York institute of measures, and some others developed it. It's meant to specifically assess response to intervention, all kinds of intervention, all kinds of intervention, in people in the Pervasive Developmental Disorders category. So it's used in drug studies, behavioral interventions, and other interventions. So I just wanted to throw that out there.

[Provider 1] – Thank you.

[Speaker 1] – Thank you. We appreciate that.

[Speaker 5] – Is that a common measure?

[Speaker 7] – Does anybody know how to do it?

[Stakeholder 1] – Well, BCBA's are not necessarily all trained on it, but the PDDBI is not very complicated. It doesn't require extensive training to administer. It's to be done by direct observation by a caregiver, it could be a parent, or it could be done by a therapist or a BCBA. The scoring is pretty straight forward. It helps if you have some experience with administering standardized tests. Frankly a lot of behavior analysts don't have training. I do because I, my Master's in school psych and my doctorate, but many BCBA's won't have that.

[Speaker 7] – To that end, because what we tend to do then is then we go back and research what does the training entail, is it just a couple of days of a workshop, what would it take for people not trained on, to get trained on it.

[Stakeholder 1] – Not much.

(Indiscernible talking)

[Stakeholder 1] – I can send you a link to, Dr. Cohen has a website where he kind of summarizes the development and research of the PDDBI and what it takes to administer and score it.

(Indiscernible talking)

[Stakeholder 1] – It's sensitive enough that it could be administered at 6 months, 12 months intervals. It depends on the intervention and on the treatment targets and so on. But it's a much more sensitive change then.

[Speaker 7] – So it would be in line with the 6 month progress update.

[Provider 1] – Totally. Completely. It's a much better choice.

[Speaker 5] – I think at this point, in this forum, we can and take a look at it.

[Speaker 1] – So we'll take it back and consider it.

[Stakeholder 1] – I think it would be easy for people to incorporate into their clinical practices especially if it's only at every 6 months.

[Speaker 1] – We would like to have that if we can.

[Speaker 7] – This is what we need if possible. And something that people either know how to do or can learn how to do it easily, that is within the scope of their practice as a BCBA.

[Speaker 1] – And lets us track the child's progress over time. That's what we would want.

[Speaker 7] – That's what we need.

[Stakeholder 1] – The Vineland, I think, even that has limitations with one every year

[Speaker 1] – Two years.

[Stakeholder 1] – Got you. I think that's great.

[Speaker 7] – Don't you think that's a good alignment.

[Stakeholder 1] – The Vineland is a third party report, but it's valid and reliable with this population. It is comprehensive.

[Speaker 7] – And it's only every other year, so we're not loading. We've learned enough about cycle of treatments.

[Stakeholder 1] – Yea. I think that's fine.

[Speaker 7] – I'm glad that that, we really worked hard on that.

[Speaker 1] – It is a good discussion. I very much appreciate this.

[Stakeholder 1] – Part of what we are going to be doing is looking at well researched instruments as we develop our assessment guidelines.

[Speaker 1] – I appreciate that.

[Speaker 7] – I'm so glad you came today. This is good.

[Speaker 5] – Please keep up apprised of the progress.

[Stakeholder 1] – That's my plan to do that. I wish I had more to report, but lots of things going on.

[MCSC 2] – I'm [MCSC 2] from United. First of all I want to applaud changing the PCM requirement every 6 months. I think that removes a substantial bottleneck, and because streamlining is so important. My question, I have two questions, it's kind of a two part question,

one is, so we've moved that bottleneck to every two years, we haven't eliminated the bottleneck, and then we've added as I understand it, another potential bottleneck by adding a series of standardized and reliable and valid tests that can be administered by a psychologist, which may not be available in certain white spaces. So at that every two year review, running into these two bottlenecks potentially colliding, what is our potential fall back plan?

[Speaker 7] – Well, number one, it won't be, that's why I did talk about the fact that we are not going to have 13,000

[MCSC 2] – Right, exactly.

[Speaker 7] – It will be phased in people's normal two year review. We just have, just about, right? Those who completed the two year review on our, really our first cohort for those who started July 25, 2014. So I think that that will help. In terms of who can do what,

[Speaker 6] – Well it's all of the specialized ASD diagnosing providers that are eligible. Now most of them may not be able to do all, but there is enough of a variety that when you're planning for the two year mark, these beneficiaries should not be waiting until the last month.

[MCSC 2] – I think you are absolutely right. We just completed all of our two year reviews. We've been on target. If the PCM were in that process, that would've again, posed a substantial challenge and then on top of that, finding a psychologist who is qualified to administer these tools might make that a double-fold challenge even though it's staggered and spread out on a case-by-case basis, there are potential challenges, and I'm just wondering what we would do if we run into that.

[Speaker 7] – I think encouraging families to start in on the process early, one thing, I'm sorry for interrupting, I recall when we were under the ABA pilot for Non-Active Duty, we had the requirement for the ADOS and for the Vineland, right? And that was going to be for baseline and once a year. And it was my experience during that, at least for the MTFs, the developmental pediatricians all learned how to do the ADOS, right? We also had in there, and we will have in there in this revision, that we will accept whatever testing was done by the school systems that was done with the year. It doesn't have to be, you know what I mean, like if a child was tested, and then they came in the program, we will recognize that results for either the baseline or for the every two year review, depending if it's within one year of when it's required. But I believe, based on my experience from when we had the ABA pilot, that at least for the Vineland, and for the ADOS, that a variety of those ASD diagnosing providers will be trained to administer those two. I think the Wechsler tests are going to go to psychologists. And I understand that. Do you have anything?

[Speaker 6] – Just one more thing about IQ testing, for the kids that are non-verbal, there is the non-verbal alternative in the manual, so it's not going to be just a WPPSI or a WISC for those kids. There are options, but we had to narrow it so that we could have something standardized.

That's really the point, and I get the VB-MAPP and it's applicability across the ages, but again, this is the effort to produce something consistent through everybody's treatment plan. That's been a huge observation, I guess nationwide, of the lack of consistency and generalizing of what's going on period, never mind just scores, but what's happening out there.

[Provider 3] – Who's going to be responsible for educating beneficiaries and parents and providers and PCMs?

[Speaker 6] – The contractors.

[Speaker 7] – That's a good question. The contractors do a good deal of education on an on, right, but you do phenomenal education. In terms of educating beneficiaries and providers, I've looked at numerous power point presentations on the ACD benefit provided by the different regional contractors and they've been very good. This is stuff that I don't think anyone else would know, but on our internal end at DHA, we, [Speaker 5] and I, do presentations for providers, for EFMP, for different groups that work with all of our families on the ACD. I do an annual TRICARE mental health benefit presentation. I do it every year. I've done it for the last 6 years. And I have a subsection on the ACD, and I go through all of the mental health benefits, and there are usually 100-200 people that dial into that webinar. And then it's posted. I've done it through Military One Source and through our TRICARE communication's office. Now that we actually have some many revisions to so many sweeping changes, these things become more and more important to stick to a regular schedule. [Speaker 5] and I are doing our next one in December. We do this frequently.

[MCSC 1] – If I could make a comment on that. Hi, it's [MCSC 1] from United Health Care. About educating beneficiaries and families in particular, I totally agree with you that it starts with us, and initially getting the word out aligning it to the government messages and how we collaborate. I would challenge all of us those, and I think it's all the way through the process, and the minute you start working with the child, as a provider, and the family it becomes continuing to reinforce that education and the messages. So I think we will, in working with providers, need to be sure that there are tools in hand, FAQs, and different things folks can have so that, there's that thread that pulls all the way through. I think we all have that responsibility and accountability. And we sometimes do get that feedback from families that they heard from United or they read the website in the beginning and they really haven't heard anything since. So I think we're going to do, and continue to strive to do a much better job of working hand in glove across the board. I think we're all challenged to do that because the message has to be clear, consistent, and persistent, I think, especially for families who are stressed, who may have more than one autistic child, to deal with that situation. And these benefits and all of the administrative components they have to put together are really hard for them. So I think we all have to help in multiple ways.

[Speaker 7] – To that end, can I add one other request for help, because this has come up in other areas, and this is where there is such utility to our meetings like this, but I think one area, and this speaks to your question previously, I think every two years requiring the outcome measures is the only way to make it reasonable and sync up and have it staggered. That's the only thing that we can do in that regard. I think the measures we selected are valid and reliable and that's all good. But one thing that we've always had a challenge with is what happens, understanding parents understanding the referral and authorization process, and starting the process early. And we are trying to address that through some of our educational offerings, but I would reach out to, and I remember I even wrote a one pager on this for just referring to you all, like how to make sure the referrals and [authorizations] get to the ABA provider practices the way they should without confusion because there's been so much confusion. So I would like to ask everyone to help us out as the every two year requirement comes in to encourage, the techs and when you work with the families, to encourage them to start that process many months before they are coming up on their two year. That would be a help. If we all worked together, I think we can help decrease the bottlenecks. But this is where it really will take a village, because people do things not realizing that they need the referral. So they'll just call and get on a wait list, and it's not helping if we don't know about them to help them, the regional contractors. So this is where I'm sending a general plea, please keep the communication coming like you all do now. And let's just help each other and we'll try to send out some clear guidance like when it comes to the every two year. We'll have FAQs and things to go out that are posted to families.

[Speaker 6] – In the interest of time,

[Speaker 7] – Go ahead

[Speaker 1] – [Speaker 6], can you give us another question?

[Speaker 6] – I'm going to give three statements because these are general questions that are coming in. So, a lot of questions about the IEP, and clarifying, once effective, the new manual, that's when the IEP requirement will stop, but it's still required until that date. So that was, a couple came in about that. There was a request for reiterating about goals: education and academic goals will not be reimbursed in any setting. Ok, and then the issue of supervision, a question came in about reimbursement for supervision, it's only the BCBA who is going to be reimbursed for that time. Nobody else will be reimbursed separately.

[Speaker 7] – That's under Medicare rules. It's prohibited. It's double billing for the same services.

(Indiscernible talking)

[Speaker 1] – Whoever is the direct supervisor.

[Speaker 7] – But we're hoping the group format will help.

[Speaker 6] – The other thing that questions came in was for billing for other services on that same day. I'm not sure what, I understand the question, and I don't know how it's being applied by the contractors. So like if I have my BT session, and then I come in later for supervision hours after that, and maybe a couple hours after that, I'm seeing the parents

[Provider 5] – That's fine.

[Speaker 6] – Right, that's fine. I'm not sure where that's not going right, so I will just make sure, and I will touch back with the contractor for that region where that came from and clarify.

[Speaker 1] - We'll come back with an answer for that online.

[Speaker 6] – Those were the big themed ones. Private schools was another question, but as we stated earlier, we're going to take any private school related questions for later because it's becoming a bigger complicated answer.

[Speaker 1] – Ok, [Provider 1]?

[Provider 1] – I'm [Provider 1] from [ABA Practice]. My question is that, first of all, now that I have a minute, I just wanted to say thank you because a couple of things that have changed are fantastic: group supervision I think is awesome. It would be easier on us all if it wasn't per beneficiary, but nevertheless, I understand your system requires that and it helps tremendously to have group. That's going to be a huge thing. The other thing is thank you very much for not requiring the IEPs. That's going to be very helpful as well. The question I have with regards to that, and I also want to thank you about the [education] requirements removal, once the BT, which is a quick question on that, does that mean that you don't care about the 500 hours of experience as long as they are a BT, certified BT.

[Speaker 6] – So that was another question that came in, the entire section on 6.3.2 that the BTs, TOM Chapter 18, Section 18, Paragraph 6.3.2, that whole thing about the high school graduate, having the 40 hours

[Provider 1] – 40 hours

[Speaker 6] – or the 500 hours, that will all be deleted once you all have 100% BT certification.

[Provider 1] – Got it.

[Speaker 1] - So once we get to January 1st.

[Provider 1] – Totally got it.

[Speaker 7] – We encourage every ABA provider to embrace the certification because that enables us to get rid of the

[Provider 1] – Absolutely. Fantastic.

[Speaker 1] – And if you're folks get it in now, they still get it done by December 31st.

[Provider 1] – Oh yeah, for sure. Quick question

[Speaker 7] – We're making progress.

[Provider 1] – Definitely. And you've delayed it already a year, so I'm all for moving forward on this. So the issue with the schools situation, I'm not even talking about private schools, I'm just saying that a lot of kids don't have ABA programs going on in schools, and perhaps the ABA provider needs to go to the school for generalization or to see what's going on in school, that sort of thing. Are saying that anything that occurs in a setting on school grounds will no longer be funded, paid for?

[Speaker 7] – Yep.

[Provider 1] – Ok. So if that child, all of their tantrums are restricted to just school, what happens then?

[Speaker 1] – I think, no please, you go ahead.

[Speaker 6] – I think the issue is that not knowing what is happening in the school or what the school should in fact be responsible for, puts us as a medical benefit kind of in jeopardy of what's going on. We would have no visibility. We have no understanding, there is no way to engage with that. Unfortunately it's just a clear line that we had to draw. And I understand that some of these behaviors, treatment goal behaviors, happen in other settings outside of the ABA session, or outside of the home, or outside of

[Provider 1] – In life.

[Speaker 6] – Right. I think it's about that overlapping of what we have visibility on. And I think unfortunately there has got to be a clear line. And we've heard from everybody. Make it clear, clear, clear. Make it understandable. Make it so everybody, so there's not room for weird interpretations, right? So that's the motivation.

[Provider 1] – I hear you. Except I think everybody here will agree that it's a whole different story to get those services funded in the schools. That's the issue. So it produces a situation where we can't help the children, and we're not talking about academics at all, we're not talking about academics. We're talking about serious behavioral issues that occur in various group, locations.

[Speaker 1] – If I could ask you to come up and use the mic please.

[Provider 6] – Sure. I'm going to piggy back off of that. I'm [Provider 6] from [ABA Practice]. Just to follow up on that, it's a very few percentages where that situation occurs.

[Speaker 7] – Right, I think that is would be

[Provider 6] – Less than 5%, I would say, and maybe less than that. But in those scenarios, could we still submit the IEP if the parents are ok with it and get that approved.

[Provider 1] – That’s what I was going to say.

[Speaker 1] – We’ll take this back.

[Provider 6] – Ok.

(Indiscernible talking)

[Provider 1] – Is it no program or no

[Speaker 7] – And that’s what I was saying that we need some documentation...

[Provider 3] – That would make sense.

[Speaker 1] – Go ahead, please.

[Provider 3] – I was just going to say, like if there was an instance where the referring provider could provide supplemental language saying that they reviewed the patient’s IEP, and that there’s no duplication of services as well.

[Speaker 5] – We’ll take the whole issue and revisit it.

[Speaker 1] – We’ll take a look at that.

[Speaker 5] – It’s kind of hard to give you an answer right now.

(Indiscernible talking)

[Speaker 5] – It really is a tough issue.

[Provider 7] – What I’ve heard from parents is, I’ll submit the goal section, I’m [Provider 7] from [ABA Practice], I’ll submit the goal section of the IEP. I have heard concerns about

[Speaker 5] – Right, we have too.

[Provider 7] – Right, I’m sure you’ve heard it all. So maybe just a portion of

[Provider 8] – [Provider 8] from [ABA Practice]. Even for continuity of care, like a monthly team meeting or something with the schools, not even to providing services in the school, but to have consistency of services ...

[Speaker 5] – Give us a chance to regroup.

[Provider 1] – Yeah, we’ll send in our email.

[Speaker 5] – We got other emails on this subject that have come in so, in the interest of time, since we don’t have too much left, is there any other question online.

[Speaker 6] – I mean I have a ton, but we’re not going to get to all of them all, but I realize, so do you want one more?

[Speaker 1] – Yea, one more. Yes please.

[Speaker 6] – Some of these are asking for clarification about language and how this stuff will look in the manual. I can’t give that to you now because it’s not final.

[Speaker 1] – It’s not final yet.

[Speaker 6] – There was a question about: is there a way to list ourselves as being open to hiring/working with the military spouses as behavior technicians? That came in around the time you mentioned the efforts to and the movement too. I don’t know. That would probably be negotiated through the contractors, right?

[Speaker 1] – Well, but it could be. The other thing that I would say is if you’re close to a military base, military bases usually have an office, like for the Navy it would be Fleet and Family Services, or spouse support, Army has something similar, that helps spouses with hiring. We do have resources that help spouses find jobs. I would link up with that office. If you call the base, they should be able to point you in the right direction, and they would love to hear about places that want to hire military spouses. So if you’re not near a military base, I realize that it doesn’t work quite so well. But probably most of the military spouses are close to military bases. So if you are close to a military base, I would recommend liaison-ing with the base. They should have an office that assists with spouse employment, and that’s who you want to talk to.

[Provider 3] – Just to piggy back on that, they have, our office is 90% military spouses who live next to a military base and they have an employment office, so we post advertising there. There’s also a program called “MyCAA” and I’m not sure what that means, but it provides funding for military spouses for furthering their education. I used that when I got my BCBA coursework. So reaching out to them and informing the spouses of that program, I think would help also. It provides additional supplemental funding.

[Speaker 1] – Thank you. I appreciate that.

[Speaker 7] – That would be such a win-win. That’s great.

[Provider 3] – Or even having them advertise specifically behavior technicians or BCBA, or BCaBA, I don’t know who would be responsible for that. I had a question unrelated about the credentialing; about the provisional credentialing is a win, a huge win so I want to thank you for that. It will definitely help with access to care tremendously. And I know you haven’t worked out

all of the details, but the RBT number and that process, waiting for the board to post that number, I mean that takes up to six weeks sometimes, so when this comes out, just considering, can we send it out without the RBT number? The board will send you a letter with verifying that you passed the exam.

[Speaker 1] – We want the board letter.

(Indiscernible talking)

[Speaker 1] – Something that shows they passed.

(Indiscernible talking)

[Speaker 6] – Right, but if I were to take the test today, and I call up United, I can't say hey I passed the test, sign me up. That's not going to fly. Something external

[Provider 3] – They send you an email immediately.

[Speaker 1] – And I think that email will do the job.

(Indiscernible talking)

[Speaker 5] – Hang on, we are still working out the language, but we need some kind of validation or verification before the packet gets passed through. That's what we're looking for. And then you can start billing

[Provider 1] – That's fantastic.

[Speaker 5] – Again, we are working out the details.

[Speaker 6] – I think the one thing we can say, and I'll be very clear about this, do not start billing until your contractor has acknowledged whatever we figure out. If I submit today, don't think that you can start billing tomorrow.

[Provider 1] – Sure.

[Provider 9] – It will happen.

(Indiscernible talking)

[Provider 3] – And who's educating the contractors, because I feel like we have a huge

(Indiscernible talking)

[Provider 1] – You know I love United. I do love United. I want them to win again.

(Indiscernible talking)

[Provider 9] – Any interpretation of the policy I think (Indiscernible talking)

[Speaker 1] – Can I address that just a little bit? You know, each contractor does do things sometime a bit differently and they are allowed to do that. And one of the reasons for going from three regions to two is to minimize that actually. So I think that will help some. Having said that, who's responsible for educating the providers, we are. That's my job. That's [Speaker 5]'s job. That's all of our jobs. And if you're not getting what you need from the contractors, tell us. We oversee them. They answer to us. And I know I can tell you that [Speaker 5] gets concerns on a regular basis and he takes care of those.

[Provider 3] – So you would be the one that I would email?

[Speaker 5] – Well, email the contractor first.

[Speaker 1] – Yes, contact the contractor first. (Indiscernible talking) and then

[Provider 3] – Are you the contract person?

[Speaker 5] – I'm the program manager. So last resort, if you don't get anything or a response, let me know.

[Provider 3] – Right.

[Speaker 1] – And we will work on that.

[Speaker 5] – When I contact the contractor, I usually get their response?

[Speaker 1] – Go ahead [Speaker 4].

[Speaker 4] – For those of us that work at the regional offices, myself here and [Speaker 3], [Speaker 8] in the south, is also, we're a great/good points of contact.

[Speaker 1] – Absolutely.

[Speaker 4] – But also I think that it's important for you all to recognize that we see ourselves as a partnership with the managed care support contractors and that we have been meeting every other week, for a while it was weekly, and it felt like every day, so that there is a lot of communication. That was something that actually the TROs really supported, so that the DHA folks who were really at this policy level could understand operationally what they all face to implement this, which translates to you guys communicating to them, these are the challenges we are having. So I would say definitely [Speaker 8] is going to be a great point of contact for you, for the South, to say we're having some difficulties. And then if there are discrepancies in interpretation of how things are being implemented, operationally, implementation-wise, how they expect you to send things is up to them.

[Provider 3] – Right.

[Speaker 4] – But the actual benefit part of it should be consistent.

[Speaker 1] – Yes, exactly.

[Speaker 5] – Thank you [Speaker 4].

[Speaker 1] – [Speaker 6], go ahead.

[Speaker 6] – A brief summary statement, I don't want to get cut off I don't remember how we are coming up to the end. The one thing about, remind about BT certification, everybody hired new, should already have their certification. Everybody else, anybody prior to the January 1st of this year requirement, everybody needs to be certified by the end of this year. Come January 1st, your claims will be denied. The other general question just to remind, is group supervision, only the BCBA will be reimbursed. Nobody else in that setting, any other BTs or assistant, nobody else is going to be able to submit for reimbursement. And the last one if about the 0359T, you still need to request it and you still need to have it for every six months. It's not, but what [Speaker 5] brought up was that, in light of the PCM requirement, right here right now, the contractors have been directed to allow for that next 0359T, you still need to ask for it, it's not going to be doled out.

[Speaker 7] - Yea

(Indiscernible talking)

[Speaker 1] – Ok. So [Speaker 6], thank you. So it is noon. I very much want to thank. Ok, go ahead [Stakeholder 1].

[Stakeholder 1] – I'd like to make a quick announcement because I'm not sure that we, the APBA in conjunction with the BACB, got health care provider taxonomy codes for assistant behavior analysts and behavior technicians approved by the National Uniform Claim Committee. I understand you are requiring everybody to have their own NPI.

[Speaker 7] – Thank you.

[Stakeholder 1] – Their own credentials. We got them to revise/update the ones for assistant behavior analysts and technicians are new. They are now in effect. They went into effect October 1.

[Speaker 7] – And we've implemented that. We implemented that

(Indiscernible talking)

[Speaker 1] – They will be in the manual change.

[Speaker 6] – It's not effective right now, but that's taxonomy will be included in the manual.

[Speaker 7] – That will change the way our claims are done.

[Speaker 1] – So thank you every one.

[Speaker 7] – And congratulations on that. That was a big deal.

[Speaker 1] – So thank you everyone for coming. It is noon, and I want to respect everyone's time. I know we got a lot of online questions that we didn't get to. [Speaker 6] is nodding her head yes there. But we will get you answers to all of those. Like I said, we will post all of those on TRICARE.mil/autism. We will also have a transcript of this proceeding there. So I appreciate everyone's time this morning. I think we had a great discussion. I think we learned a lot as I was hoping. Certainly some things that we're going to take back, work on, and get you some answers to. But again, I think this is invaluable for us. I hope it was helpful for all of you as well. And I can tell you that we will probably do the next one of these after the NDAA has been passed because there may well be some autism things in there and we'll need to talk about. I don't anticipate a lot of changes between now and then except what we've already discussed. We will make sure you know when these things are actually published and in effect. Like I said, we will post these things to TRICARE.mil/autism website, but we will also send an email out to this group, the folks who have registered for this session to let you know that. And with that, certainly please keep sending the questions and recommendations. We very much value those. Thank you to everyone. Thank you again to our TRO West staff who made this possible. And with that, we will wrap it up for today and wish everyone a great afternoon. Thank you!

Operator – Thank you. This completes today's conference. You may disconnect at this time.

[END OF DOCUMENT]