

## ACD Round Table #6 Meeting Minutes

4/22/16

1205-1330

Operator – Welcome and thank you all for standing by. At this time, all participants are in a listen only mode. During the question and answer session, if you would like to ask a question, please press star one. Please unmute your phone and record your name clearly when prompted. Your name is required to introduce your question. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I will now turn the meeting over to [REDACTED]. Thank you, sir. You may begin.

[REDACTED] – Alright. Thank you and good afternoon everyone. I apologize that we had a couple of technical challenges. We're starting a couple minutes late, but we will make sure we get everything in. First of all, we'd like to welcome everyone. I know we have, I understand that we have more than 140 people dialed in, well at least 140 phone lines, which I'm sure that means more than that number of people. We have a number of providers who have told us they are going to dial in. I know we have some advocacy groups on the phone, some congressional offices, and some pediatricians as well. So welcome to all. Let me just start out by saying, introducing myself here, and in a minute, I'm going to introduce the team. I am [REDACTED]. I am the deputy director for the TRICARE Health Plan; directly involved with the Autism Care Demonstration. And we have a number of experts here on the demonstration who will be speaking to you this afternoon. And then we are also definitely going to allow time for some questions at the end because we want to hear from you. A number of people have already submitted questions by email to [REDACTED] and we appreciate that. And we are going to do our best to get all of those answered and you can continue to submit questions to her during and after this session. And we will certainly get you answers to those. Now let me just start out with speaking on behalf of the TRICARE Health Plan. We recognize that for some of our provider partners that the past few months have been difficult; have been challenging. We know that the rate changes have created some challenges and that you've had to make some decisions about how to move forward. We are very grateful that over 99% of our providers are continuing to see our military children with autism. And we greatly appreciate your continued dedication to taking care of our children and continuing to provide the great service you do to ensure that our children with autism spectrum disorder reach their maximum potential. We very much look forward to continuing to work with you to improve the autism care demonstration and make it even better for the people that we serve and continuing to improve the care we are providing to our patients. A couple of other things I want to let you know, as you know, we are doing this one as a phone only conference a) to make sure that everyone has an equal chance to participate, but also because it was somewhat short notice. But our next one will be in person and we are going to be doing our next round table on the West Coast because we've certainly heard that we have done all of these on the East Coast so far and it's been somewhat of a problem for our West Coast

providers to get here and participate. So our next round table will be on the West Coast sometime later this summer. We will get you out exact dates and location shortly. We are looking at either Seattle or San Diego. So for those of our providers on the West Coast, we hope to see you there. And certainly the East Coast providers are welcomed to fly out and join us too. Now, with that, let me go around and ask our team to introduce themselves, and I will start with [REDACTED]

[REDACTED] – Hello, this is [REDACTED] [REDACTED] clinical psychologist, I'm the chief of Condition Based Specialty Care here in the Defense Health Agency.

[REDACTED] – This is [REDACTED] [REDACTED] with the Defense Health Agency Office of General Council.

[REDACTED] – [REDACTED] [REDACTED] with the TRICARE policy and benefits.

[REDACTED] – [REDACTED] [REDACTED] I'm a psychiatric nurse practitioner working for Condition Based Specialty Care under Dr. Davison.

[REDACTED] – [REDACTED] [REDACTED] with the TRICARE Health Plan policy and benefits.

[REDACTED] – And, [REDACTED] [REDACTED] I am the email contact on the invite and I am a clinical psychologist and I work for [REDACTED] [REDACTED] for Condition Based Specialty Care and I've (gap in sound) for many years providing ABA services.

[REDACTED] – Ok, so I know we've got quite an agenda here. So we want to jump right in. Just a couple of things, as I said, we are going to try during the presentations to answer as many of the questions that have been submitted as possible. And then we will also go over some of the questions that have been submitted at the end. And then we will also open the lines up for some questions. We are going to ask that when we open the lines up, because we have so many providers on the phone, and we are really designing these round tables primarily for our provider partners, that only the providers actually ask questions on the live line. And we've asked the operator to try to monitor that. But certainly anyone can submit the email questions, and we will certainly answer questions by email too. And we will also post all of the email questions on our website after this event. So you can go back and see the answers. Alright, so with that, it is my pleasure to turn things over to our outstanding autism program manager, [REDACTED] [REDACTED] who is going to talk to you a little bit about manual changes and some of our quality initiatives related to BLS certification and Behavioral Technician certification.

[REDACTED] – Hi everybody. [REDACTED]. First on the agenda we had the TRICARE manual changes. I just wanted to go over real quick to let everybody know that today, we do not have a manual change out in coordination, although we got a few things still to make to clarify some language in there. So in the next coming months, we'll do our next change to the manuals. And I'll thank everybody out there who has submitted things to me to consider, and we've been keeping notes for the last 3 or 4 months. First thing we wanted to talk about was our BT certification. Just to remind everybody that for the legacy BTs, those hired prior to January, have

until December 31<sup>st</sup> of this year. We consider this one of the quality and safety issues. And I would like to point out, we still have few who've have obtained their certification, so we would ask that you please go ahead and try to get that done this year so that we can avoid the back log we had in December of last year. New hires, hired after January, we've had in the policy now where they have to have their RBT before they can come on and be credentialed and we've got several inputs in on grace period, provisional credentialing, etc. and we are going to keep that as an open item right now. We've got that here for the leadership committee to talk about. So we will get out more information about that going forward in the next few weeks. Next is on BLS and CPR equivalent certification and just a reminder again, it is in the manual that we require live training; no web-based programs. We want hands on training. And again, we view this as like in most health care clinics, as a major safety issue. So we would ask that everybody please pursue that and get your certification as soon as possible. We are tracking compliance and we certainly expect everybody to be in compliance by say September 30<sup>th</sup> of this year with their BLS or CPR certification training. Ok, [REDACTED].

[REDACTED] – OK, thank you very much [REDACTED] Next, a little bit about (gap in sound) and for that we have [REDACTED].

[REDACTED] – Good afternoon everyone, I want to briefly discuss the fact that in the autism care demonstration policy, there is a provision for quality oversight monitoring through the TRICARE Quality Monitoring Contract, and we have arranged for our first audit to be conducted. The time period is from March 1, 2016. The final report will be completed by 30 September 2016. And the first quality monitoring audit will review the ABA assessments, the initial treatment plan, and the every sixth month reassessment and treatment plan update on a statistically significant random sample. And we will share the results that are relevant with the ABA providers because the goal is to use this information to improve the ACD. In 2017, the TQMC audit will be repeated for a longer period of time and some of the elements that will be audited will be reviewed for expansion. And basically that is all. We're very excited that we were able to arrange this and that we will have the first report by September 30<sup>th</sup>. Thank you.

[REDACTED] – Thank you [REDACTED] appreciate that. So now it's back to [REDACTED] again to talk a little bit about rates.

[REDACTED] – Ok everybody. Hi again, [REDACTED] [REDACTED] The 2016 ABA rates, they all went into effect April 1<sup>st</sup>. Let me clarify all being the original 89 localities, so they started April 1<sup>st</sup>. For the new localities out there, there were 14 that we found during the resurvey after we posted the December rates; they go into effect on May 1<sup>st</sup>. I apologize for the delay. Bust because they are new localities, we don't have them built into the claims system today. So PGBA, our contractor, has promised to get those up and running, and they will start paying those new rates for those 14 new localities on May 1<sup>st</sup>. Again, I apologize, but they have to map the zip codes and map all of the rates to the correct place to make sure the claims are paid properly, so it took just a little bit of an extra time there. I would like to point out, I've had a couple of emails that the rate sheet

posted in December is not the rate sheet that went into effect. When we did the resurvey, which we will do every year going forward, we found 11 states that had made changes; we found the new Medicare locality factors. So to be fair to everybody, we incorporated those. And I reposted the rates on March 23<sup>rd</sup>. If you haven't found the rate sheet, it's on [health.mil/autism](http://health.mil/autism) and that will show you the rates that actually started on April 1<sup>st</sup> and will start on May 1<sup>st</sup>. The rate process, I was asked a couple of questions, what happens going forward? Well, we're going to resurvey going forward just like we do for all the TRICARE rates. We'll take all the 50 states, we'll contact them, again come this fall. We chose the formula that's hopefully the best predictor of what Medicare would be allowing today. I've had several questions out there on the Kennell and Rand reports. But again, we tried to be the best we could at predicting where the Medicare rates would be set once they set rates for the CPT codes. Again, this fall, we will resurvey all the states. The states that have made changes actually impact everybody because the national rate is calculated based on all the Medicaid rates across the country. One thing good about the process is going forward, you're rates will not be frozen again for another seven or eight year period. What this will result in, as evidenced by what we just did, as we find changes, every fall we publish the new rates. We will stay on schedule to where we publish the rates when we publish all the CMAC, the other CHAMPUS Maximum Allowable rates in March and April every year. Remember now as we transition, if Medicare establishes rates, by law, we pick up those rates. so, it will be a gradual process going forward and again as we audit every fall once Medicare does something, we transition over to the Medicare rates, by law. While I have the floor, I was going to go ahead and answer a couple of questions that I've received personally before we hit the Q&As at the end of the meeting. One of the questions I had was: why didn't you use the 80<sup>th</sup> percentile method to calculate the rates? Which certainly was an option. It's an option assuming you have data. And that was the problem with this one as most all of you on the phone, all of the providers have been billing the \$125, \$75, \$50. So we really don't have the usual and customary charges in our database. So it's pretty difficult to do the 80<sup>th</sup> percentile model. So, what we tried to do is come up with another model, that again, would best predict what Medicare would be allowing if they covered the CPT codes today. I will point out that remember the commercial rates that you negotiate with your carriers, obviously those are proprietary. We can't be told those. You can't share them with us. And certainly your payers out there, the commercial carriers are certainly not going to share them with us. So again, we tried to focus on what best way could we use to predict where Medicare is going to set the rates. Another question I received was why did we change rates now and not wait until the demo ended? And certainly that is a good question. But we have to remember the \$125 was set back when this first started as an educational benefit and it was for Active Duty Families only. So what we have to do is come up with a way that the rate is not set arbitrarily. We have to have data to support that, the rate process, that is supportable by law. So today, as we sit here, the new rate process that we are using today again, will result in an annual review, that is fair to you across the network, as we are with all of the other providers. When we tried this, remember, three years ago, we were going to set the rate, but we put it in abeyance and held it pending the results of the RAND and the

Kennell work. We'll tell you that RAND and Kennell is great stuff. They worked together. RAND helping and sharing their data with Kennell. And again, we tried to pick out the best process to be fair to all 50 states going across the nation. Let me point out it is a three-step process, to where we take the Medicaid rates, we use that to set what's called a national rate, similar to other TRICARE, and we adjust that based on locality factors which supposedly take into account that cost of living differences between the more rural markets and the major cities. And then we look at the statewide Medicaid rate to see where we are, and for that particular state compared to the statewide Medicaid rate that they have published. Ok, [REDACTED] [REDACTED]

[REDACTED] – Ok, very good. Thank you, [REDACTED] Alright, well. Let me just note that for about the last six months or so, [REDACTED] has been the acting program manager and has done a superb job during that time to say the least. I know many of you on the provider side have talked with him. He's also talked with many of our parents whose children use the autism care demonstration. And he has been filling that role, filling in for [REDACTED] [REDACTED] [REDACTED], who's been away on a special assignment, a very important special assignment. But I'm pleased to say that [REDACTED] is now back. He is back here with us in Falls Church. We are thrilled to have him back. And that means we are going to be turning things back over from [REDACTED] to [REDACTED]. That won't happen overnight. There will be, you know, they're talking. They'll make sure that anything that has been brought to [REDACTED] attention, [REDACTED] is aware of. So nothing will fall through the cracks. But very happy to welcome [REDACTED] back to the team. Those of you who have been with us for more than six months probably remember him. He's been at several of our round tables in the past. And he will be the program manager from here on out, indefinitely, we certainly hope. So, [REDACTED], let me just turn things over to you. Do you have anything that you wanted to say?

[REDACTED] – No Sir. Just pleased to be back and I look forward to working with everybody to make this program the best that we can. And feel free to contact me, and I will transition with [REDACTED] over the next week or two. And as [REDACTED] said, we will make sure that nothing falls through the cracks.

[REDACTED] – And [REDACTED] can you give your email address?

[REDACTED] – Sure it's um, I don't remember though, [REDACTED].

[REDACTED] – The middle initial

[REDACTED] – [REDACTED] [REDACTED]

[REDACTED] – Can I give it, I have it...ok. It's [REDACTED]

[REDACTED] – Thank you [REDACTED]

[REDACTED] – And we will send that to everyone who is on our email group for this conference as well. And certainly that's actually a good point too, if anybody is not on our email group, and

would like to be, please let us know that. Perhaps you got forwarded this invite. We'd be happy to add you. Ok, so, moving forward, before we get into the Q&A session, I just wanted to make a couple of comments about kind of the autism care demonstration and where we're moving forward and our plans to move forward with this. One of the things, obviously, that the autism care demonstration is designed to do is really to determine the best way we can meet the needs of every child with autism who is a military beneficiary and how we can help every child with autism reach their full potential. And that may be a little bit different for each child. But clearly our goal is to provide the very best care we can so that those children can have the very best chance for success. So one of the things as we've talked about before in our last round table in December, is that are actively looking at ways to measure outcomes, because, you know if we can measure outcomes, we can better determine what things are doing the most good for the children we serve. We've certainly asked you for input. We've gotten some input from people but we certainly would like more. So if you have ideas on how we should measure outcomes most effectively, we would love to hear from you. So please send us that. Because we do need to make some decisions fairly soon on how we're going to measure outcomes. And we anticipate that we will be announcing some initiative in terms of measuring outcomes and how we're going to use that information over the next few months. Because again, we really want to make sure we are meeting the needs of our beneficiaries with autism spectrum disorder. Are we tailoring the right treatment to the right patient, that we're giving the right dose, all the things that we usually do in terms of providing medical care. Do we ensure the right patient is getting the right treatment at the right time. So that they can have again the very best outcome and reach their full potential. And that really, you'll hear that from us several times, because that is very much our goal with this. I think we are on a sustainable path with the rates, so at this point now we are really focused on let's make the care the very best it can be. And we've always been focused on that. It's going to be something that we are re-doubling on and we really see outcomes measures as a key part of that. So with that statement, let's go onto the question and answer period. And we have a number of questions. I'm going to take the first one. All the rest of our team are going to be answer questions as well. So, the first question we have is that people have heard from families that, and this particular question related to families in South Carolina, and very similar questions from North Carolina and some other areas, that they're having some difficulty with access to ABA therapy. And there was also a recent survey, which some of you may have read that found that for TRICARE families, 66% are waiting for services or not receiving the recommended level of care. And the question is: Where are there access issues, and how is DHA addressing the problem? I can tell you that in the vast majority of our areas, we have providers available to see patients today and we can place a patient with a network provider almost everywhere. We do have roughly 90 patients nationwide on a wait list. Most of those we are able to place in a fairly short period of time. We are also working on a couple of areas. We are working on bringing some new providers in. So for example in the Ft. Leonard Wood, MO area, we know we have a shortage of providers. We are working with our managed care support contractor partner, we have identified three new providers for that area who are currently in

credentialing and will be seeing patient very soon. Which we think will then eliminate any wait list issue or access issues we have there. So we, in those areas where we know we have problems, we work those very aggressively. Our contractors are very good. We've been able to bring providers into several areas including Seattle, Yuma, AZ, MO as I mentioned, and some others. The other thing that I would ask folks too is that, you know, sometimes you get referred a patient and maybe you don't have space right now or maybe that patient needs a time when you just don't have a provider available. No problem with that, but we would ask please never put a patient on a wait list. Our contractors are responsible for finding providers, but they can't do that if they don't know there's a need. So if you get a referral and you cannot see that patient within the access standard, which is 28 days, simply let the contractor know that and we'll place that patient with another provider. That's no problem. That's certainly no negative against you. It will not prevent you from getting future referrals, I want to emphasize that. That if you're a network provider and you call and say hey I got this referral and I can't see this patient within the time frame, that doesn't mean that we're going to turn you off. You'll still get other referrals, but we'll make sure that particular patient gets care in a timely fashion with a qualified provider. The other thing I would note is that if you do have patients currently on a wait list, let us know that. We work with those wait lists. Sometimes we find that those patients have already found care elsewhere, perhaps have moved and didn't let you know that. But if you have anyone on a wait list, let us know that. You can send it to [REDACTED] or [REDACTED]. Make sure the managed care support contractor for your region knows that. Because this is a team effort. We are all working together to make the patients get what they need and get the very best care possible. Then we need your participation in that too so that if you're not able to see someone, we're getting them placed with someone who can. Alright, so I think that's the answer, excuse me, to that one. Next up goes to [REDACTED].

[REDACTED] – Sure. So this question came in: Is there a way to make the progress report/reauthorization process less confusing for pediatricians? We're actually thankful that you brought this to our attention, and we will follow up with the pediatricians, but right now we're not sure what this means, so again we'll take this for action to clarify and then follow up with what's actually happening.

[REDACTED] – Thanks [REDACTED]. And I'll also tell you that we had a few questions submitted that were very specific to one provider or a specific issue that they wanted us to address. We've taken all of those for action. We're not going to necessarily answer all of them here in the interest of time. But we have all of those. We will definitely follow up with each person that sent those questions to us. And in many cases, we are engaging with you and the TRICARE regional office or the managed care support contractor or both to make sure we get you to the right answer. So we are working all of those very specific individual questions and we'll have those for you. And with your permission, be posting those on the website as well. So then we have some questions on diagnosis and CPT coding and I'm going to ask [REDACTED] if she would take those.

█ – Thank you. The first question had to do with the CPT category III codes for ABA. And the question is: whether given the fact that there are recognized problems with the CPT category III adaptive behavior codes for ABA, is TRICARE considering going back to using the non-standard usage H-codes that are used by certain other plans most commonly by certain Medicaid plans under the home and community based waiver ABA services. And actually, we used a combination of non-standard usage codes including F codes and then G sub-codes, along with a few other codes. But the answer is no. That when there are official AMA CPT codes, even category III codes, TRICARE uses the official codes. We do not use non-standard usage codes when official AMA CPT codes exist even if they are category III, which refers to codes, temporary codes for new and promising or emerging treatment. We carefully are monitoring the developments by the AMA CPT ABA committee and we will implement category I codes if and when they are developed and approved. And no we will not go back to non-standard usage codes. Thank you. The next question has to do with how often new diagnostic evaluations are required. Is the initial diagnosing provider required to complete any additional diagnoses in order for treatment to continue? A diagnostic evaluation for the diagnosis of ASD is required only at the outset of treatment. ABA treatment plan and reassessments are required every six months along with the treatment plan update. That would be a result of those reassessments. The referring and diagnosing provider should be reviewing the treatment progress every six months to evaluate the symptom presentation and ABA is authorized in six month intervals. So a new referral and auth is required every six months, which is how this all gets tied together. But once the initial ASD diagnosis is made, and submitted with the initial referral, we do not ask for that again unless the provisional diagnosis was made by a primary care physician in which case, within one year we ask that a specialized ASD diagnosing provider evaluate the beneficiary. Ok, and then the next question has to do with why we are requiring symptom severity. In the policy, in the ACD policy, require that the specialized ASD diagnosing provider include symptom severity in the diagnosis when they do their evaluation. And this is made in accordance with the DSM 5 diagnostic criteria. There is a symptom severity matrix in the DSM 5 that very clearly delineates severity according to level of supports needed. I'm very happy to send a copy of that matrix to anyone who would be needing it. But the level of supports is actually an important piece of information in knowing the needs that they patient may be requiring. So yes, that is required. And is there anything else? I'm looking through the ones for me. Mental Health Parity: alright, there's a question about parent training and the question is: isn't parent training component a violation of Mental Health Parity and Addiction Equity Act since it isn't required for any other services? And no, this is not correct. Mental Health Parity actually does not apply to the TRICARE plan, but the TRICARE plan is deeply committed to meeting the spirit of mental health parity and mental health parity basically requires that medical services and behavioral health services are provided with the same requirements and without restriction basically as to quantity of treatments. But there are many services that we provide in the medical arena for pediatric patients and other treatments, other populations where training of the caregiver is required. And an example would be like in the rehabilitation arena, there are certain

lift devices for a person who is paraplegic or quadriplegic and the caregivers are required to learn how to safely administer the use of these services. There are many, many examples of this. And also I think it is important to point out that the Behavior Analyst Certification Board and the AMA CPT codes identify parental involvement as a critical element of any treatment plan. And the research literature supports that parental involvement is a very important component to the effectiveness of ABA for beneficiaries and for patients in general. And do you see any others for me right now?

██████: Hi it's █████ █████ █████, and I'll follow up with a related question about Mental Health Parity that came in. The question was: isn't requiring the IEP, in order to have services, a violation of the Mental Health Parity and Addiction Equity Act? And as █████ just explained, first of all TRICARE is not technically subject to the Mental Health Parity act, but we've actually, for those of you who are following this, in February, the DoD published a proposed rule regarding our entire mental health and substance use disorder treatment benefit and one of the major changes in that proposed rule is changing our regulations to reflect the principles of Mental Health Parity and especially in terms of quantitative limitations and things like that. But to follow up on the specific question on the IEP, that is our policy to align the goals of our benefit with what's in the proposed rule, but incorporation of the IEP is really no different than any other pre-authorization requirement to obtain a specific benefit. And that goes for medical, surgical, as well as behavioral health care. So an IEP, in this case, is incorporated to avoid any duplicative or contraindicated services. So let's see, an analogy might be to be no different than any other benefit that requests supplemental or supportive information, such as if someone is getting a bariatric surgery procedure there might be collateral documentation required for pre-authorization documentation required, etc. Should we move on to my next one or go to █████? Ok, I'll just hit all mine at once. Another question, we're going to switch back to the topic of RBT certification, again that █████ mentioned earlier. So a question came in, what is the justification for accepting the non-accredited credentials issued by the Qualified Applied Behavior Analysis Board, or QABA, as evidence of qualification to practice ABA? So, just a note about, and this was mentioned before, the main purpose of the demo is to pilot how we would be delivering this benefit consistent with the way we deliver other mental health other, and medical benefits under TRICARE. So according to our regulations, if you want to look it up specifically, 32 CFR 199.4 under c(ii), TRICARE authorization of individual providers, and that's really what we are talking about, if we consider technicians to be individual providers, authorization primarily relies on state licensure or state certification where that exists. Now, in many, many states, we do not have that, therefore, where there is no licensure of a specific category for an individual professional, the certification by a qualified accreditation organization is required. Our regulation actually defined what a qualified accreditation organization is in section 199.2. So, as of now, we are certainly surveying the market and the field here, currently the Behavioral Intervention Certification Counsel or BICC is the only certification that is accredited and it has that accreditation by the National Commission for Certifying Agencies. I think that was announced in November 2015. Both the BACB and QABA are in the process of

getting accreditation, and so, I think it's important to note as well that our regulation also authorizes the Assistant Secretary of Defense for Health Affairs to determine what credentials are appropriate and this again is just speaking specifically about behavior tech certification. So moving onto the next question. This is about reimbursement rates, I believe. Do you want me to talk about the, I've just got one more and then you won't have to hear from me anymore. So the question, again switching topics, is back to reimbursement rates. A specific question came in: why after 8 years of no fee increases would TRICARE reduce the rates for providers in high-cost metropolitan areas such as San Diego. And this is a two part question really, does TRICARE understand that this will severely limit access to services for families as many providers will not be able to accept new TRICARE patients with these rates? So, certainly as Doug explained earlier, adjusting the rates takes into account the locality factors in each of the 89 localities that the factors apply. So this should account for the prevailing rates in both urban and rural markets. So, by contrast to what we've been doing with ABA reimbursement for the last 8 years, reimbursement rates for other CPT codes, both medical and behavioral health, there have been rate changes both an increase and a decrease depending on the market. ABA codes have been frozen for almost 8 years. So, access is monitored regularly, and will continue to be monitored. And, yes we are always concerned about the potential impacts on access and we're monitoring that. This actually relates to the next question, I don't know if you want to pick it up [REDACTED] [REDACTED] about the concerns in changes to reimbursement rates causing folks to leave the network.

[REDACTED] – I'm sorry. I'm moving the mic closer. So the question is: are you at all concerned that changes in reimbursement rates will cause providers to leave the network thereby adversely impacting access to care? So, the answer is yes. We are, we are very concerned about making sure we have an adequate network; that we have enough high quality providers to take care of all of our children with autism. So naturally, providers leaving that network would be a concern. Having said that, at this point, as I have mentioned before, I think, we very much appreciate that so many providers are staying with us, continuing to see our patients. We are tracking the size of the network very carefully. But in order to make this benefit look more like a medical benefit, one of the goals of the ACD is to make this as much a part of regular TRICARE as we can. So that, it's very important that we shape this much like regular TRICARE which means rates that are defined by regions that are adjusted every year and they are based as much as they can be on Medicare rates. The other thing is that, just like all other parts of TRICARE Prime, we always use network providers first. When there's a network provider available, those network providers will preferentially get referrals and we will certainly move folks to network providers as much as we can. Ok, so I think next up we have some questions about RBTs and I'm going to ask [REDACTED] [REDACTED] to answer those.

[REDACTED] – Hi everybody. [REDACTED] again. The question was: TRICARE requires additional educational requirements above and beyond what's required for the RBT certificate. So I won't read the entire question, but certainly would let everybody know we are going to

revisit the whole requirement for the RBTs being certified. So, these requirements were historically in place because there was no certification established back when, but now that we have those, again as I stated earlier on our next manual change, we're looking at the whole RBT issue. We'll take that one as an open item and revisit it later. The next question we have was: could you review the most efficient way or quickest way to credential out RBTs through TRICARE? So to first off, glad to say thanks to our contractors; they are moving these quite rapidly, so the good news on that hat as an old administrator is that they are doing it pretty rapidly. Once the RBTs obtain their certification through one of the three certifying bodies, they should submit a complete packet, and that is really the key is the complete packet. We meet with our contractors every two weeks and if the packet is complete, heck I've had some tell me 15 days, but it kind of runs 15 to 45 days. So if we're missing something though, that's where we have a hiccup. So we would ask if you've got a question, hey check with your network managers to make sure we have everything correct. The standard out there, at least in my career, has typically been around 90-120 days. So here I think the good news is, we've got some at 15 up to 45 days and I think they are rolling quite well. Next question we have is: why is TRICARE proposing to reimburse providers at rates that are lower than the MediCal rates?, which is really a California issue and another couple of other states I know. The states where they farm out a region into one of the for profit entities, that is a complication in our process, because we are not allowed to know what those rates are. You may, I've never done it in my career because we never had those, but if you are negotiating those rates with them, that's a proprietary rate that's set between you and your negotiations with your contractor. We have out three-tier process that we do: we survey all of the Medicaid rates, the statewide Medicaid rates; we establish what's called the national rate; we adjust them through the localities using the Medicare factors like we do all other rates; then we bounce it back up against the statewide rates to see where we are. But there are areas of the country where there is no statewide Medicaid rate to bounce it up against because they are again with for profit, private entities that we can't look at those rates. OK

██████ – Next up we have| ██████

██████ – Hello. Ok. (gap in sound)

Operator –Excuse me, this is the operator. Would you like me to instruct parties on how to ask questions over the phone? We are unable to hear you.

██████ – There's no light. (gap in sound)

Operator – Your line is breaking up. We heard you for a second. We are now unable to hear you. (gap in sound)

(Indiscernible talking)

Operator – You're speakers have now rejoined the conference.

██████ – Ok. Can you hear me now ma'am?

Operator – Yes we can hear you now.

██████ – Ok. This is ██████ I'm going to rephrase the question and the response, ok? So I need this, ok. This question has to do with treatment plans and parent goals, objectives and goals, and the question is: if parents are not interested or able to complete the goals, how should this be documented? Again I think this is a very good question. I want to, for a moment, just discuss that in the Behavior Analyst Certification Board guidelines, parental involvement is deemed to be a very important element, and it is expected that the ABA supervisor would continue to engage the parents because their involvement in implementing the ABA treatment interventions is very important for generalization of the mastered skills. And generally speaking, it's not possible to provide the best quality of care if parents are not involved. That said, we do recognize that there are certain circumstances during which a parent would not be able to participate in the execution of the treatment plan and these examples would include situations where the parent or caregiver is an AD/SM that is deployed, or in certain situations where a parent or caregiver is ill with a major illness such as cancer or has a psychiatric condition that would prevent them from being able to participate in the treatment plan. And if this were to be the situation, then what we ask is for the ABA supervisor to document the reason that the parent or caregiver is unable to participate in the treatment plan. And in this situation, TRICARE, please be assured that TRICARE would not deny services to the child, but we value and find parental involvement very important as a key ingredient. Therefore, please document the involvement and the ability to carry out what is taught, the guidance provided, or the reason that the parent or caregiver is unable to participate. Thank you. I think there was one more. Was there one more related?

██████ – We already got to it.

██████ – I'll take the next one. This is ██████ ██████ again. Let me just apologize for our technical difficulties. Our mic died on us there for a minute, but I think we got it fixed. Thank you for bearing with us. The next question, I'm going to paraphrase just slightly to shorten a little bit: but basically, prior to the recent changes in the rates, North Carolina already had a problem with wait lists and access to ABA services for military families as there are not enough BCBA's in the state for the entire state's population. The concern is that this rate may become worse with the changes in the rates. And the question is then, what is being done to address access to care issue for military families in North Carolina especially in light of the recent announcement that coverage will be added for Federal insurance plans and Medicaid in North Carolina? I think our answer to that is as follows, right now, as I mentioned earlier, we track access very carefully, and obviously in the south region we work with Value Options who is the mental health subcontractor in the south region. At this point, we do not have problems with access in North Carolina. We have enough providers that every patient is getting seen within 28 days assuming they are willing to go with a network provider. So at this point, we are tracking it very carefully. We are very pleased that we have enough providers there at this time. We also

work very carefully with the Exceptional Family Member Program offices, and that if they see a problem they certainly tell us that. If they have many concerns, but at this point, I think we are doing well in North Carolina. We're very fortunate that we do have enough network providers there. We are tracking that, as I said though, carefully. If we do start to see access issues, we'll certainly address those. We are always recruiting new providers to our network. As I think I mentioned at the outset, we've actually been pretty successful with that here over the past 5 months getting new providers in, including North Carolina. So at this point, I think we are going to be fine, but we are going to watch it very carefully to make sure. Do we have others?

██████ – We do. There are

██████ – Ok, so back to ██████.

██████ – I am coming to the mic and I am not touching it. Ok, this question is: is it true that beneficiaries will lose their services if they aren't meeting the goals of their treatment plan? Is it appropriate that these decisions are being made by individuals from contractors who have never met the child and don't know the entire situation? And actually, to that piece of it, I want to stress that this is where your documentation, as the ABA supervisor, is critically important. We rely on your documentation during the ABA reassessment and treatment plan update to provide us the whole picture, to include, you know, extenuating circumstances that may have triggered the regression and progress or being stuck and not making any progress. So you know the goal, and I know this is also the goal for the ABA provider, I know that the goal is to assist the beneficiaries to improve and to make progress on the treatment targets. I know you are all deeply committed to that goal, as are we. However, you know, there is an overall hope and view that ABA should result in some progress on the treatment targets and that treatment protocols are revised as needed to address times when progress isn't being made. So, the contractors and they get the every six month reassessment and treatment plan update over time, over successive reauthorization periods, cause each authorization period is every six months, do look at overall progress and do expect that there will be some sort of transition to another type of care or provider or level of treatment in situations where after successive reassessment and treatment plan update periods there are no progress. Ultimately this is a clinical decision and the contractors work with the ABA supervisors and the parent and family to provide the best way to meet the needs of the child so that they can reach their optimal level of functioning. Thank you. Alright, is it true, this is a subsequent question: is it true that beneficiaries will lose services if they aren't meeting the goals of their treatment plans and parents aren't participating or meeting the goals of parent training? And you know, really this dove-tails on what I just said which was that we really are all, we know all of you, as well as us here, are committed to assisting the child to reach their maximum potential and we do believe that parent involvement is crucial. And the research does show that parent involvement is very, a very important variable in the success of ABA as an effective treatment. And as I brought up previously, we know there are extenuating circumstances that may prevent parent/caregiver treatment engagement in the treatment plan, and

we rely on the ABA supervisor to document these reasons and these reasons should be addressed in the treatment plan. Thank you.

██████ – Thank you ██████ So, next question is, I'll take the next question, this is ██████ again, and the question is: What is, you know, that there is perception that TRICARE has ignored providers, beneficiaries, and even Senators' concerns about how the rate cuts will adversely affect access to ABA therapy. Well, I want to assure you that we certainly have not ignored those concerns at all. We have very regular meetings with our managed care support contractors, with our Exceptional Family Member Program coordinators, and others including this meeting of course, but many other meetings; and I know that Doug has been working very closely and that Rick will be, with all of the providers that have contacted him and the beneficiaries that have contacted him. So we take all of the concerns that you express very seriously, We certainly are, as I mentioned, very concerned about access, and we are tracking it very closely. At this point, as I have said, we are very pleased that access remains very strong in our network. The few areas that we are close to being a little bit short, we are actively working to recruit new providers. So I want to assure you we have not ignored those concerns at all. We are going to continue to address them. We'll certainly address them at our next round table as well. But at this point, you know, I think we have considered all that, and that's one of the reason we did, for example, put the 15% cap on the decrease in rates because we did want to make sure that we limited the impact. And I think so far, have been relatively successful in that. I do appreciate the question, and certainly want you to let you know that we are going to continue monitoring that closely. So I think ██████ is up next with our next set of answers.

██████ – K, question we received was: can someone clarify if we are to use the new rates beginning April 1 or May 1. The answer there is you should be billing your billed rate. So we have our allowed rates out there, that's what's on the spread sheet. You would follow what your normal clinic process is for billing for your contracts based on whatever contracts that you have. The next one is: I understand using Medicaid as a baseline, however, Medicaid allows us to bill for outside work. The new rates do not accommodate this. So how are these new rates really representative of what Medicaid rates are? There's a difference in the plans there. We have TRICARE, and we follow the rules of TRICARE where we follow the CPT codes that are set. So, you may have others out there, other commercial carriers that do the same. They may allow you to bill for things that aren't covered through all of your commercial carriers or through even the TRICARE Medicaid program. But ours is very consistent. We follow the CPT codes that are set out by the AMA, as we do with all of the TRICARE medical plans. The next one we have for us is: who do we contact is we can't serve a beneficiary? I'm relatively new to the process. We would ask that you as a provider should get a letter, and also the beneficiary gets a letter, and the letter should say they have an appointment within 28 days. And if you can't book them, or they have a preference and they want to stay, that's fine, but the patient should always be referred back to the contractor if you can't book them at the time or at the time that you meet them. So you should call back the contractor and then turn that patient back. The patient may do that

because they get the same letter you do. But if you could help us out, please don't hold them on a wait list. Let the parent know that if they call back the contractor, we'll try our very best to place them with another provider. Ok, the contractors, by the three regions, if I read the rest of the question, for the west you could contact UnitedHealthcare/Optum, and for the south it should be Humana Military/Value Options, and for the north it would be Health Net Federal Services. I think the 800 numbers are on the letters that we send out, so for the parent, they should have that. If you could also do us a favor please, and make sure the parent reads through the letter and if they are looking for specific hours or a specific provider, that's great, but if they needs some help, if they call back we'd be glad to assist them and try to get them placed with a provider.

██████ – And ██████ let me jump in there. A lot of this information is also available at [www.health.mil/autism](http://www.health.mil/autism). You'll find a lot of information there. The patient version of that website is [www.tricare.mil/autism](http://www.tricare.mil/autism). Lots of good information out there including a list of all of the contractors and their information and point of contact information. So please use those. But also, as we've said, you are also welcome to email us and we'll get you the information too.

██████ – The next question concerns remittances: they said, prior to April 1, remittances and payments were being processed very quickly. I will tell you there was a slight delay. The contractors are still within the contract standards, but they are making the changes to get the rates loaded and then to go back and verify that they got all of the zip codes mapped to the correct rates. I had an email yesterday, so I think you should have them going out today or soon. One of the providers emailed me back that she already went back online and all of hers had cleared. So if you'll go online, if you know how to use the PGBA website, you can check your claims and you should be able to confirm that they are now starting to be released. Again for the California localities, please remember on those, they will not start with the new rates till May 1 cause we have to map out the zip codes and the rates. The PGBA website, in case you don't know, is the website for the payer that has the contract for our three regions. Ok, the next question involves: why did the rates in the DC area get cut from the proposed \$60 to \$48 at the last change. And I will have to admit that there, we had a mathematical error that was sent to us by the DC district so if whoever asked the question will email me, I can go back and confirm we have it right this time, but that was a mistake that we found when we did the resurvey. When the district sent us over their new rates, they had actually made a typo and for the BCaBA and the BT rate, it was wrong in their initial December spread sheet. So our apologies for that.

██████ – Ok, next question is directed to me so I will answer it. It says, ██████ ██████ indicated that providers should notify the contractor if they cannot accept the referral, but the contractors have communicated something different. Can you have ██████ ██████ let the contractors know that they need to receive the referral and send a new referral out to the patient. Yes, we meet with them on a very regular basis, and I can assure you that I will raise it at our next meeting. I'll also actually raise it before that because we need to make sure that's being done properly. And if it's not, I will make that it gets taken care of. So thank you for telling us that. That's the kind of feedback we absolutely need. If you are having a challenge with one of

our contractors, you need to tell us that, and we will address it. So thank you. So the next question is: how do the contractors track the large number of children not receiving the recommended level of care? Well, we don't know if you don't tell us. So I think that's the short answer. The contractors don't know if you don't tell us. So if you have a child that's not receiving the recommended level of care for whatever reason, you need to tell us that please. Let the managed care support contractor know that and the reasons they are not receiving the recommended level of care. If it's an access issue, then we will work, put that child with a provider who can provide the recommended level of care. So absolutely we will address that. We will work those very carefully and make sure people are getting the right level of care. So again, if it's either you have people on a wait list or you are not able, maybe you can see them but not give them as much care as they need because you simply don't have the capacity, then let the managed care support contractor know that and they will make sure that patients gets moved to someone who can. So thank you for that question.

██████████ –The next one is: it is extremely unlikely that there will be a standard Medicaid, I think you meant Medicare, reimbursement rates for ABA services by the fall or even by the end of the year. So if that indeed happens and Medicare does not establish a rate in the next year, come next fall, we'll follow the exact same process we did this year. We will resurvey all 50 states, get their statewide Medicaid rate, recalculate the national rate, we'll verify the Medicare locality factors because they sometimes adjust based on the cost of living in any area. You'll notice this year for this example, they year they set up 14 new localities out in the state of California, so we go back with Medicare, we go back with the states to confirm the Medicaid rates, and we do exactly what we just did in December of 2015 and then just recently on March 23<sup>rd</sup>, when we posted the rate. Again, the formula we picked, we're pretty confident it's going to be pretty close to what Medicare will eventually establish. But until Medicare does that, we'll just repeat this process by resurveying all 50 states and the Medicare locality factors each year going forward.

██████████ – So, you know to clarify, as soon as there are Medicare rates, we are required by law to use them and we will. However, until then, we're going to continue to use this current process which we think gets us to as close to what the Medicare rates are likely to be with any process we've been able to determine.

██████████ – Ok, the next question was: North Carolina is in the south region,

██████████ – It's not in the

██████████ – That's right, it's not in the south region, so if we said that, our apologies.

██████████ – I said it was in the south, I misspoke, it's in the north.

██████████ – For some reason we split the Carolinas. It goes on to say that there is a huge access problem, Camp Lejeune has halted orders. That is certainly a true statement. We have other areas

in the country, it doesn't really matter if your commercial insurance, or TRICARE or Medicaid. There's a shortage of providers. Yes, the Services have that option to, with their EFMP officers at each of the base levels and up here at the headquarters level, to look and see what the access is in any one area. We would ask, please provide us with feedback for the North Carolina providers and any other providers again, please work with the contractors to help us manage the wait lists and see if we have other providers out there who are available. We have providers joining all of the time, I have 1036 I think is the number just since last December, so we're hopeful that across the nation as you are profession is growing here, we have providers we can place all of the children.

██████ – I think the next question reads: Can someone please follow up with Health Net to create a better process for returning authorizations when we cannot serve. And the answer is absolutely yes. We have been talking with all three contractors about this process and obviously based on the input today, we are going to continue to do so. And what I will tell you is that we will work with the contractors on that. Keep an eye out on the website. We will probably post a revised answer to this question within a few weeks after we've had a chance to work with our managed care support contractors and get you, really make sure we've got this process down really well. And again, if you are having problems with that as you're trying to send them back, let us know that. Drop an email to ██████ or one of us. We need to know when you're having problems. I assure you I will be meeting with the managed care support contractors, along with our team, and this will be a topic of, lead off topic on our agenda at our next meeting.

██████ – K, next question received was for the California localities that are reviewing rates that are lower than Medicare, I assume you meant to say Medicaid, it was indicated that we can negotiate with the contractor. California localities, again, that's one of the states where they carve out parts of the state and they give it to the for-profit entity. Molina Health Care and Beacon, I know them well from my civilian world time. But those rates you negotiate with them. But for TRICARE, we do not negotiate with us. We have our rate. We set them again, if we can, generally to mirror the Medicare rate. Until we do that, we'll use the calculation process that I described going forward, to set our rates. And by the way, we are working with the state of California. We've called them several times to discuss theirs, so changes are made there since they know us fairly well now. We will certainly adjust our rates come this fall when we move forward.

██████ – Alright, now we have a question about CPT codes. I'm going to ask ██████ to take that one.

██████ – Yes, the question is: Is TRICARE aware that there are more CPT codes for ABA? The answer is yes. We carefully assessed the entire spectrum, all of the CPT codes for ABA at the outset of creating the ACD. And the person asking the question would like to know if we are considering adding social skills group, one of the primary skills deficits in autism social skills, as a covered benefit as well as functional analysis of assessment, group parent training, and more

than one technician per client as needed. And the answer is that we carefully assessed those codes when we created the ACD, and we are not adding those codes as covered benefits at this time. And this goes back to the evolution of the coverage of ABA under the TRICARE benefit. ABA has always been covered as an individual intervention for our children, and therefore we have not, and have no plans at this time to cover ABA provided in a group setting. Yes, and group is not one to one. That's basically it. However, we are, we do constantly revisit the codes and if there are situations that arise where coverage of a CPT of an ABA service provided in a group setting is appropriate, we will consider that. So we'll certainly go back and do one more read and we will keep you posted if there are any additional changes to what will be covered going forward. Thank you.

██████ – Thank you ██████ Ok. We had a question that says: does TRICARE realize that to get ABA care in 28 days for a new beneficiary, we'd have to hire another BCBA, that means we'd have to hire 4 more BTs, so I'm assuming this is a practice that uses the tiered model, which means we would need to have approximately 16 new clients in order to fill everyone's schedule full time. It's a long process to staff a client's program in 10 to 30 hours per week. The answer is certainly yes, we do understand that due, if you are currently full, if you currently do not have any capacity, to create new capacity does take time, no question. And that's why we certainly try to develop our network so we have some extra capacity. So we have more network providers than we need to maintain all of the current patients, so that if we get new patients, we have providers we can place them with. That's also why we are actively recruiting new providers to areas where we know that are underserved like Missouri, like Yuma, Arizona, like Seattle for example. And we're trying to bring those new providers in specifically so that we don't have the problem where when we do get a new patient, now we have to wait and get things started up. So yes, we absolutely recognize that it takes time to flex the system and add capacity and again, that's why we really try to make sure that we have a little bit of excess. Ok, so now we are going to switch over to ██████ to answer a question about rates.

██████ – The question is: If we previously entered into an agreement for a reduced rate, however, we can no longer afford this rate reduction, I'm assuming the rate change will nullify the previously negotiated rate reduction. The answer is, it will not. So you do need to call your contractor for whichever region that came from and talk with your contractor. Your contract should be between you and the contractor and you all can negotiate back and forth. We are TRICARE obviously, not the commercial plans, and so we ask our contractors to build the networks and to work with you. So whoever asked the question, again I would recommend calling the network manager, which should be on the documentation you have when you signed the contract originally.

██████ – Ok. Another question that just came in is: is TRICARE still considering dropping all coverage for ABA services if some unspecified new research is not obtained by the end of the autism care demonstration period. Obviously we are not going to drop care and treatment for our children with autism. As I mentioned before, our number one goal is to make sure they receive

the care they need and that it provides the outcome of helping them maximize their potential and become the highest functioning person they possibly can be. That is our goal. So, you know we have several options. We do need to make some decisions before the end of the demonstration. That's why we're doing it. That's why we're working with things like trying to set the rates as close to every other TRICARE rates so that we can move this as close to a regular TRICARE benefit as we can. That is a very important part of the demonstration. We do need, we are hopeful that there will be more clinical evidence, more research evidence regarding ABA because among the things I think we've discussed, is it's not always clear how much treatment for each individual patient, for what patients is ABA appropriate, for what patients should they be receiving some other form of modality. There are certainly other therapies for autism that are being tested as well. And again, our goal is to make sure our children get the treatment they need to get the help to make the absolute maximal gains possible. And what treatment we use to get there is secondary to making sure they are getting better. So that's why we very much want to introduce the outcomes measurements into this program so that we can start making those decisions of what is the right treatment for each individual child. And that is our focus. So, I want to assure you that there is no intention to stop services to our children at the end of the demonstration. We have the option to extend the demonstration if we want. If there is sufficient evidence, we could make this a part of the basic benefit, just like we do every other kind of treatment. So I think there's a number of options. We certainly don't know what the outcome is going to be yet because we still have two and a half years here to go. But clearly our goal is that when we get to 2019, we will have the world's best treatment program for our children with autism. And that's not hyperbole, we truly mean that.

██████████ – The next question we received says: for providers who will not be able to take on new clients due to the rate change, where can we report this information? Again, please call back to the contractor for your particular state. Again, you should have a network manager and I don't know what the phone number is for the network manager off the top of my head, but there should be a network manager who came to your office to sign the original contract or just stop by, like at my clinics, to give you the briefing on what TRICARE plans are available. So for the person who asked the question, again, if you could report that back to your contractor, that was we have a better idea of what's happening in your geographical area and whether or not we need to look at recruitment efforts or work with EFMPs for that particular military location. Ok, someone please address, can someone please address that it takes 90 plus days to credential an in-network BCBA? Without the details, I wouldn't be able to answer that to be honest. Some of them, we track the numbers, and we have very few that actually get up to that number. So whoever asked that question, if you email me directly. This is ██████████. I will get with the contractor and see what the issue is. This generally does not take that long. And the numbers that I've been seeing since I've been here, the average certainly is significantly below that. So if you'll send me the details, I'll certainly be glad to research that one for you.

██████ – So, let's see, the next question, there's a question that says the contractors on contracts received in the north region is the 1-877-healthnet number. There is no direct contact with the network manager. My understanding is that if you call the 1-877-healthnet number, and you tell them you have an autism issue, they will connect you, the main number will connect you with the autism team at Health Net. So you simply need to, if you call the 877 number and say I've got an autism issue I need to ask, they will connect you to the autism team. Ok, so, we've had a couple of more questions about access in North Carolina and again, I think right now, our access in North Carolina is good. You know, we certainly are watching it closely. There's a lot of military families in North Carolina to be sure between Fort Bragg and Camp Lejeune and smaller facilities we have there. But again, at think point, we're doing, again, but if you have patients on a wait list yourself, if you're a provider and you been referred patients you can't see, make sure you're saying no to Health Net because we are not aware of wait list in North Carolina at this time. Our evidence is that we have access to care. We can place the patients who are there. I've talked personally with some of the providers at Naval Hospital Camp Lejeune. They've told me that they think we're doing ok. I've not talked to the providers directly at Fort Bragg, but I will reach out to them and ask. But at this point again, our data shows that we are doing reasonably well in North Carolina. There's certainly not an overabundance of providers there to be sure, but that we are able to place all of our patients with qualified providers right now. And we are tracking that very closely. So I think, is there anything else? So I think that's all of the email questions to this point, but if anymore come in, we will certainly address them, but I'm going to ask the operator to go ahead and open the line. Now what we will do is, you know, to kinds of keep things manageable, and to make sure everybody can be heard, we're going to have one person come on the line at a time and ask a question. I am going to again ask that we limit it only to the providers at least until there are no more provider questions because I want to make sure providers have priority because these round tables are really designed to ensure we are meeting the providers' needs and answering your questions and meeting your needs for information. So with that, if I can ask the operator if you want to start allowing some questions from the providers through, and we would certainly ask, as people are asking questions, if you would please identify yourself.

Operator – If you would like to ask a question over the phone lines, please press star 1 at this time. You'll be prompted to record your first and last name and called on at your turn. Please make sure your phone is unmuted before recording. We do have questions waiting. The first one is from Emily Shuman. You're line is now open ma'am.

██████ – Ok. Go ahead please.

██████ – Hi, my question was answered in an email.

Operator – Ok. Thank you. If that's true with any of the others, you can press star 2 to withdraw from the queue. We'll move on to ██████████ ██████████.

██████ – I don't have a question. I was trying to let you know that we have a deadline for a few minutes, so no question.

Operator – Thank you. ██████ ██████ your line is open.

██████ – Yes, Have you thought about getting some information directly from the beneficiary about wait lists because I don't think your information is close to accurate. And I don't know that you're going to get it if you ask the contractors and the manage support contractors.

██████ – I can tell you that yes we do get information directly from the beneficiaries through several sources. One is that certainly the Exceptional Family Member Program coordinators are talking to the beneficiaries and we hear from them. But also a number of beneficiaries have contacted ██████████ directly and talked with him either by phone or by email. I know he's talked with a significant number of beneficiaries. We are also working on a beneficiary survey that will go out at some point. And we'll obviously be using information from that. We've done those before as well. So we do have a number of different ways. We also talk, I will also note that we do the providers at the military treatment facilities who see many of these and refer many of these beneficiaries for care. And certainly they are talking to the beneficiaries. So I think we do get a lot of beneficiary input and we are working on getting more.

██████ – If I can just share with you, I work with six hundred TRICARE families in the West Region and I can tell you the majority of them, we can't serve when starting out within 28 days and they don't bother going any place else because they wait lists are longer elsewhere. And we tell them that. And we've told the managed care support contractor that. So I don't think your information is accurate for what it's worth.

██████ – Well, ██████ this is ██████████. If you could send me your list. If you could do that, that would be nice, and I would be glad to get with UnitedHealthcare and the Optum team.

██████ – You got it.

██████ – Thank you.

██████ – And I will warn you, we have been told we have to be out of the room in 5 minutes, so we have 5 minutes. But I think we can at least take a couple more questions.

Operator – Thank you. I believe the next name is ██████ ██████

██████ – Ok.

Operator – You have a ██████ ██████ on line.

██████ – Yes please go ahead.

██████ – Yeah, this is ██████████ I'm a provider in North Carolina. And I can tell you there are major access problems in North Carolina. We have wait lists at Camp Lejeune, at Cherry Point, at Ft. Bragg. We give parents when they call us if we can't take them, we tell them how to contact other providers. We let you, TRICARE, know and the EFMP know that we have waiting lists. So they are aware, you know, that we have wait lists. We've had 5 calls in the past week from staff at the EFMP and from TRICARE from ██████████ ██████████ trying to place children. And we have been told that they cannot place them with other providers.

██████ – Hi ██████████ this is ██████████ ██████████

██████ – For example, we have an 11 year old, kicked out of school for problem behaviors, who has been waiting for three months for services.

██████ – Ok. ██████████ this is ██████████ ██████████. If you will, again, send me the list, or if you want to reach out to ██████████ ██████████, we'll be glad to work that issue. We have not heard about that child. I'm trying my best to work each of the emails.

██████ – The child has already contacted EFMP and has contacted TRICARE and has already reached out, and they have been. TRICARE has already been seeking other providers. There is no one here to take this child.

██████ – Well, ██████████ please send me the name so I can go back and see what's happening.

██████ – Ok, will do that. But I want you all to know very clearly that there are not providers here available. You have already been told, told about this child. So I don't want it to get swept away under the rug...knows about them.

██████ – Again, please send the information to ██████████ or call him, either way is fine. And we will certainly look into that, and we will certainly look into that particular case, because again, right now, we have providers where we can place patients with. So send us that patient, and we'll make sure he gets a good provider.

██████ – Fantastic, thank you. They really need that help.

Operator – Thank you. Next is ██████████ ██████████ Your line is open.

██████ – Hi, yes, I'm also in North Carolina with Delta Behavioral Group and I wanted to go back for just a second to the parent training. Exercising that with families is very, very difficult, and we have some that just say that they don't have the time to be involved. So guidance from you all on how we could make that mandatory, I don't like the word mandatory, but that's just what popped into my mind, and also more information to the beneficiaries about why it's important. We obviously educate them on our side from the moment of intake, but they still refuse. And we see that as being a very, very important component as well.

█ – And thank you very much. This is █ I want to thank you for seeing this as such an important component as we do. I, you know, don't have, we don't have any pamphlets to, you know, that stress the importance of parent training. But on the BACB, in their guidelines, which I believe had, they were updated in 2014, I think they may be planning, they plan regular updates, but in those guidelines, they're very, very good, and they stress the importance of parental input as a critical component in ABA. I think that you are doing the best you can, and we applaud you for that and please continue those efforts. So just do the best you can. Thank you.

█ – And thank you. But, that's a good suggestion. I'm going to work with our Strategic Communications team and see if we can develop materials that we can give to parents either electronically or on paper to emphasize how important it is that they stay actively engaged with the treatment planning and with the treatment of their children. So I think that's a great idea, and we will take that for action. So thank you for that comment. We appreciate that. And with that, it is 1:30. I'm sorry, go ahead.

█ – Obviously we would document if there's medical condition or something other. But for documentation, just continuing to put in the progress notes updates that parent training has been attempted but declined is sufficient, for now?

█ – Yes that is sufficient for now and we definitely will, I think you just pointed out a gap, because if we can provide you with some support services to help you actually in the field, we definitely will take that on. We'll follow up with that.

█ – Good, so thank you. So, at this point, it is 1:30, so we are going to have to cut things off. I very much apologize for that. But, you know, please, email the questions to █ █ We will answer every question we receive and we will post answers on the website unless you specifically say you'd rather we not do that with your individual question, we'll certainly respect that if you do not want to post your question and answer. But, whether we post them or not, we will still send you the answer. Again, I just want to close by saying thank you to all of our many, now in excess of 24,000 TRICARE providers. We have one of the largest...

Operator – We seem to have lost audio with the conference leader's line.

Operator – This does conclude today's conference call. Thank you for your participation. All parties may disconnect at this time.