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By E-mail

Ginny Mahoney (ginny.mahoney@ct.gov)
Connecticut Department of Social Services
Medical Policy Unit
55 Farmington Avenue
Hartford, CT 06106

**Re: Connecticut Advocates' Comments to DSS's Proposed Medicaid State Plan
Amendments Regarding Services to Treat Autism Spectrum Disorders
(SPAs 15-004, 15-005, 15-010)**

Dear Ms. Mahoney:

These comments are submitted by Connecticut Medicaid, disability and child advocates to the department's proposed Medicaid state plan amendments (SPA) and proposed amendment to the alternative benefit plan (for HUSKY D enrollees) regarding services to treat Autism Spectrum Disorders (ASD). Several of the provisions set forth in SPA will unnecessarily and illegally restrict access to ASD services which CMS has mandated be provided under the EPSDT provisions of federal Medicaid law. These provisions are particularly problematic in the context of other aspects of the department's planned implementation of this mandate not fully specified in the proposed SPA, but included in DSS's proposed regulations in this area. We discuss some of these concerns as well.

Failure to Mention Applied Behavioral Analysis Services

The proposed SPA does not make any mention of applied behavioral analysis services (ABA), even though DSS recognized, in its original plan for implementing the July 7, 2014 CMS guidance, that, while "[t]here is no one single treatment or intervention that works best for all individuals with ASD," "the ABA intervention package has the most evidence and research." Since ABA is the most clearly effective treatment, the one most requested and the treatment which primarily motivated the July 7th guidance, it is surprising that the SPA does not once mention it. This may confuse stakeholders, particularly parents and caregivers who need to understand that ABA is now a covered service for children with autism for whom it is medically necessary. Our specific recommendation is to add the following sentence:

"The covered services for children include, but are not limited to, Applied Behavioral Analysis or ABA and other behavioral interventions."

By using “including but not limited to” language, the plan will make clear that ABA is only one of several different treatment options available for children with autism, while appropriately and explicitly identifying the most commonly needed service and the one which has been routinely denied to needy children for some time.

Overall Burden of the SPA’s Requirements for Accessing Treatment

The large number of unnecessary requirements in the proposed SPA and the proposed regulations would effectively bar, or severely delay or limit, access to ASD services for most children with a medical need for such services in violation of CMS’s July 7th guidance and the EPSDT mandates on which it is based. Given the critical importance of providing ASD treatment early, these multiple hoops will cause irreparable harm for many children whose families and providers are unable to timely navigate them.

Under the SPA, a child’s providers will need to complete **four** steps before the child can receive any services for ASD: a screening, a comprehensive diagnostic evaluation, a behavioral assessment and development of a treatment plan. EPSDT requires provision of services when a need for treatment to correct or ameliorate a child’s illness or condition is identified in a screening. This multi-step process will serve as a barrier to services, or at least slow provision of needed services. At the very least, the SPA should include a short time frame for conducting the additional assessments once a probable diagnosis is identified, with provisions to ensure timely access to treatment if those timelines cannot be complied with.

1. Need for ASD Services to be Timely Provided

The SPA requires that a comprehensive diagnostic evaluation (CDE) be completed before the child can move on to the other steps to receiving ASD treatment services. However, it says nothing about the timeliness of the CDE or behavioral assessment being performed. We certainly understand that it would be preferable to have a definitive diagnosis of ASD before beginning services for ASD. Unfortunately, in other states, children are seeing substantial delays in receiving CDEs, during which time critical therapy services are going un-provided. This will likely happen in Connecticut, once families understand the availability of these services under Medicaid. In addition, the American Academy of Pediatrics recommends that providers ensure “entry into intervention as soon as an ASD diagnosis is *seriously considered*, rather than deferring until a definitive diagnosis is made.” Identification and Evaluation of Children with Autism Spectrum Disorders *Pediatrics*, (Nov. 2007; 120(5))(emphasis added), *reaffirmed*, *Pediatrics*, 2014; 134:5 e1520 (published ahead of print October 27, 2014). Accordingly, CDEs should be performed expeditiously following a screening indicating a probable ASD diagnosis, and behavioral assessments also should be timely provided once a CDE confirms a diagnosis of ASD.

Because we do not expect that there will be sufficient providers to timely conduct all the needed CDEs, we urge that the SPA be amended to provide that, if, on average, CDEs cannot be scheduled within a reasonable period of time (we suggest 30 days) following the date the screening identifies a probable diagnosis of ASD, the screening should be sufficient for the child

to proceed to a behavioral assessment and plan of care, and for treatment services to commence, pending the completion of the CDE. We understand that the California Medicaid agency has already agreed to this precisely because of the serious delays in having CDEs completed. If the CDE does not ultimately confirm the ASD diagnosis, payment for treatment services should be terminated at that point, with proper written termination notice.

2. Improper and Excessive Prior Authorization Requirements for Diagnostic Services

If the department intends to keep all four of the above requirements for obtaining ASD treatment services, it is clearly inappropriate to impose multiple prior authorization requirements on top of the multi-step substantive requirements. Although not spelled out precisely in the SPA, the alternative benefit package proposed amendment declares that prior authorization is “required for all services.” The proposed ASD regulations prepared by the department make this explicit, requiring a child with autism in need of services or his/her provider to go through **three** rounds of prior authorization review to receive even one hour of treatment services: after an initial screen using an autism screening tool, prior authorization is required to have a comprehensive diagnostic evaluation performed, to have a behavioral assessment and plan of care developed, and, finally, to obtain payment for any treatment services provided based on those two assessments. Since obtaining a timely CDE will already be a major challenge in Connecticut, the last thing that DSS should do is impose **another** obstacle to obtaining one: the need to go through an unnecessary prior authorization process for this diagnostic service. Under these burdens, it will be difficult, if not impossible, for many children to receive, in a timely manner, services required to be provided under EPSDT.

The prior authorization requirements for the CDE and the behavioral assessment also are illegal on their face under EPSDT. Although most of the discussion around the provision of ASD services has focused around treatment, there of course also are critically important diagnostic services: The EPSDT statute mandates “other necessary health care, *diagnostic services*, treatment, and other measures ... **to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.**” (emphasis added). Under this provision, once a “screening” determines a probable diagnosis of, and need for treatment for, ASD, further diagnostic assessments must be covered by Medicaid. DSS has no discretion to **refuse** coverage for these diagnostic services and thus no authority to require prior authorization for such services.

A prior authorization requirement for the CDEs and behavioral assessment is also unnecessary as a means to ensure that ASD treatment services are only provided to individuals for whom they are needed and appropriate. DSS, or Value Options acting on its behalf, will have the ability to review all of the previous assessments, along with the proposed plan of care, and then determine the validity of all of the diagnoses, assessments and proposed treatments. This is the **only** place where prior authorization is both permissible and warranted. Accordingly, all prior authorization requirements except for those applicable to the actual provision of ASD treatment should be removed.

Qualifications for Providers Performing Evaluations and Providing Services

The requirement of two years of additional experience after earning one's degree or obtaining certification, to make an individual eligible to be a qualified provider, will significantly impede access to care for children with ASD by unnecessarily reducing the already limited pool of available providers. Connecticut has an urgent need to produce and attract more qualified providers in order to serve the needs of its ASD Medicaid population. Imposing unnecessary requirements will only impede and delay this process. No other state imposes such limitations on EPSDT services or insurance reimbursed care by Board Certified Behavior Analysts (BCBAs).

BCBAs certified by the national Behavior Analyst Certification Board are subject to rigorous training, examination, and practice requirements including continuing education obligations, adherence to the BACB code of ethics and disciplinary oversight by the BACB. BCBAs have extensive supervised experience in ABA services as a prerequisite to BACB certification including supervised fieldwork of at least 1500 hours or at least 1,000 hours in an approved university practicum. The BCBA credential is the key credential for licensure in the 18 states that license behavior analysts and all other states where insurance coverage of ABA treatment for ASD is mandated but no license for behavior analysts has yet been adopted. There are currently 38 states mandating this coverage.

Accordingly, the SPA should not impose what amounts to a two-year delay in a BCBA's eligibility to become a qualified provider.

The requirement that all BCBAs performing behavioral assessments or developing plans of care, have "at least one year of supervised experience under a licensed practitioner or a BCBA who is also a licensed practitioner..." will also effectively disqualify many fully trained and competent BCBAs from being able to provide urgently needed ASD services. In Connecticut, BCBAs who provide ABA services are not eligible to be licensed as such, and so the supervised experience for a year or more will most likely **not** be "under a licensed practitioner." Rather, such experience will likely be provided under the supervision of an unlicensed, but board-certified, behavioral analyst. This is reflected in the state's statutory mandate for commercial insurance coverage of ABA services, C.G.S. § 38a-514b(a)(4)(B)(i)(requiring that services be provided, among other professionals, by "a behavior analyst who is certified by the Behavior Analyst Certification Board," without further qualification).

The alternative educational requirement also is not an appropriate standard because these educational criteria are inferior to supervised experience under the supervision of a BCBA as a means to insure quality and competence; the specified coursework is not linked to BACB credentials. It also is very likely that individuals who hold BACB certificates and who are currently delivering reimbursed services in Connecticut will not have had the majority of these courses, rendering it an ineffective criteria. If this requirement is not amended to allow supervised experience under either a licensed *or* board certified professional to constitute adequate supervised experience, children in Connecticut in need of these services will likely go without simply because of this unduly strict, and inappropriate to our state, qualification requirement.

Another inappropriate qualification in the SPA is the requirement that “the provider who develops the behavioral plan of care should be the same provider who performed the behavioral assessment.” However desirable, such a requirement is unduly restrictive. It disregards the way that professional responsibilities are divided up in practice. Some professionals only perform behavioral assessments. We would not want to restrict the ability of these qualified professionals to perform the assessments or tell a child’s family that the child cannot receive ASD treatment simply because their perfectly appropriate plan of care was prepared by a different qualified professional than the one who performed an appropriate behavioral assessment. The allowance for separate individuals in “extenuating circumstances” puts an additional hurdle in the way of access to treatment, as special dispensation will be necessary to avoid this inappropriate requirement. Accordingly, the plan should be revised to make clear that these two activities may, but are not required to be, performed by the same professional.

Obligation of family members/guardians to be present for and participate in provision of services

The SPA includes a requirement that a parent or caregiver participate in the provision of services for “at least fifty percent (50%) of all treatment sessions” and “must be present and/or available in the setting where services are being provided at all times (even when not directly participating in the services) in order to care for individuals under the age of eighteen.” There are no such requirements in the state insurance mandate governing commercial coverage for ASD services. We are not aware of any other kind of treatment where DSS has imposed such onerous and arbitrary requirements on family members as a condition on a Medicaid enrollee receiving services conceded to be medically necessary.

Although parental involvement should be encouraged, 50% involvement is unrealistic, particularly for busy parents working jobs with inflexible schedules, and with other children to care for, while some parents may not have the capacity to participate at all. The level of the parent’s/guardian’s involvement should be determined by the supervising professional for each individual child, on a case by case basis, as part of their treatment plan, without mandating a specific percentage across the board (the exception for “unique circumstances” will rightly be perceived as no exception at all). Indeed, the department effectively recognizes the importance of this individualized professional judgment, noting that participation should be “[b]ased on the practitioner’s clinical judgment as specified in the behavioral plan of care,” but then undermines this with the imposition of an arbitrary 50% participation requirement. In the absence of such professional judgment, it is fundamentally unfair to apply this 50% rule to families whose personal, social or economic limitations or situations may render them unable to comply, denying access to medically necessary treatment to their children as a result.

As to the second requirement, that a parent/caretaker be present at the treatment setting at all times, this also is unnecessary, at least for some older children, and could serve as an unnecessary restriction on access to services. In clinic or community settings, it is unreasonable to expect parents or guardians to be present at all times, and it is unreasonable to require this at all times for older teens. This requirement is particularly onerous for families with working parents, single parents or parents with disabilities, let alone families with multiple young children. Once again, the requirement would serve the function of inappropriately denying

access to needed treatment for needy children whose families are unable to satisfy an arbitrary rule not required by EPSDT.

Both of these rules should be eliminated in favor of an encouragement for caregivers to participate, but with the amount of participation and the degree of presence of non-participating caregivers to be left to the sound judgment of the treating providers.

Limit of 25 Hours per Week of Treatment Services

The SPA also has an inappropriate arbitrary maximum of 25 hours per week for ASD treatment services. Although it provides that this “may be exceeded based on medical necessity,” this is a meaningless statement which will have a chilling effect in cases where more than 25 hours are viewed by the evaluators as appropriate, since **all** requests for ASD must go through a prior authorization process where the medical need for treatment must be justified. The existence of such an arbitrary limit will send the inappropriate message that more than this will be difficult to obtain approval for, even though BACB guidelines specify 30 to 40 hours per week of treatment as typically appropriate. . Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2nd ed.), p. 14. The 25 hour maximum should be deleted, in favor of the general requirement that all requests for ASD treatment must be justified in amount and duration under EPSDT and the state statutory medical necessity definition.

All of these extra requirements and restrictions will have the effect of frustrating the goals of EPSDT and the July 2014 CMS directive, by rendering very few professionals capable of making the necessary diagnoses and evaluations and, for those children who make it through these hoops, very few providers able to be reimbursed for providing ASD services. The inappropriate 25 hour maximum and caregiver presence/participation requirements will likely restrict access to treatment for still more children. Revision is essential to ensure that these needed services are timely provided, and permanent harm avoided.

Thank you for your attention to our concerns with the proposed SPA.

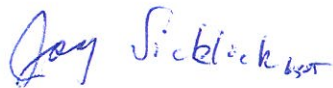
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