COLORADO
Department of Health Care Policy & Financing

Published: 9/25/2018

Benefits Collaborative Questions & Answers: Pediatric Behavioral Therapy

This document summarizes:

- Unanswered stakeholder questions received during the Benefits Collaborative Process regarding the Colorado Department of Health Care Policy & Financing's (Department) efforts to refine Pediatric Behavioral Therapy (PBT) service provision and policy, as offered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policy; and
- Suggestions made during the Benefits Collaborative process to improve upon PBT service provision and policy.

Below each item, the Department has provided an *interim* response.

Important Note: There are several stages of the Benefits Collaborative process through which proposed policy changes must still pass. Any responses in this document represent a snap-shot of the Department's position as of 9/25/2018 and should not be read as a final policy determination.

General Questions & Comments

Item 1

Where can I find the specific service delivery and policy changes proposed in the first Pediatric Behavioral Therapy Benefits Collaborative meeting, held on 5/23/2018?

- The 5/23/2018 meeting presentation is posted on the Benefits Collaborative webpage; slides 20-27 contain proposed changes.

- The meeting recording can be accessed at this link: https://cohcpf.adobeconnect.com/r1q91if511qc/

COLORADO
Department of Health Care Policy & Financing

Published: 9/25/2018

Item 2

Several stakeholders thanked the Department for considering creation of a new mid-level provider type (Board Certified Assistant Behavior Analyst or BCaBA) that may render and bill for services, and shared that they believe it will encourage individuals to become BCaBA certified, and that the pool of BCaBA Medicaid providers should increase over time. These stakeholders asked questions about what this might mean in practice and offered additional suggestions to consider, including:

The Department should clearly specify the duties and functions of what would be, with the inclusion of the BCaBA mid-level provider type, a three-tier rendering provider model.

Practice guidelines on the Behavior Analyst Certification Board website require Board Certified Behavioral Analysts (BCBAs) to supervise BCaBAs 5% of their practice time; will BCBAs be allowed to bill for that supervision.?

Supervision of BCaBAs, as well as effective treatment planning, are essential to ensuring quality service. New Mexico Medicaid's supervision and treatment planning requirements can help the Department understand how other states have addressed both the need for supervision (of Registered Behavioral Technicians or RBTs) and patient-not-present treatment planning.

- Under the proposed rendering provider model, and per Behavior Analyst Certification Board (BACB) criteria:
  - Registered Behavior Technicians (RBTs) and other first-tier paraprofessionals/technicians do not design intervention or assessment plans. It is the responsibility of the technician supervisor to determine which tasks a technician may perform as a function of his or her training, experience, and competence. And the supervising professional is responsible for the work performed by the technician. Technicians must meet *all* the following requirements:
    1. Be at least 18 years of age
    2. Have graduated from high school or earned a high school equivalency degree.
    3. Have or acquire 20 hours or more of direct supervised experience billable under the direction of a Lead or a Senior Therapist, in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

4. Demonstrate understanding of the services and outcomes for children with autism as attested to by the Lead Therapist or Senior Therapist.
5. Have cleared the provider's background check at the time he/she is hired.
6. All information related to these requirements shall be kept by the provider for auditing purposes.

- BCaBAs would be added to the list of eligible rendering providers as a second (or mid-level) provider type, reimbursed at a higher rate than RBTs and other technicians and eligible to supervise RBTs and other technicians who implement behavioral services. BCaBA professionals hold an undergraduate-level certification in behavior analysis, have completed the BCaBA Exam, and practice with periodic monthly BCBA supervision and in accordance with Behavior Analyst Certification Board experience standards.

- The third-tier of the rendering provider model consists of Lead/Senior Therapist professionals, including but not limited to BCBAs, currently eligible to provide the full range of behavior analysis and therapy services independently. These professionals are reimbursed at the highest provider reimbursement rate. Lead/Senior Therapists must meet *one* of the following requirements:
  1. Have a doctoral degree with a specialty in psychiatry, medicine or clinical psychology and be actively licensed by the state board of examiners. Have completed 400 hours of training and/or have direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.
  2. Have doctoral degree in one of the behavioral or health sciences and have completed 800 hours of specific training and/or experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.
  3. Have a Master's degree, or higher, in behavioral sciences and be nationally certified as a "Board Certified Behavior Analyst" or certified Relationship Development Intervention (RDI) consultant or certified by a similar nationally recognized organization.
  4. Have a Master's degree or higher in one of the behavior or health sciences and certification as a School Psychologist; or licensed teacher with an endorsement of special education or early childhood special education; or licensed psychotherapy provider; or credentialed as a related services provider (Physical Therapist, Occupational Therapist, or Speech Therapist) and have completed 1,000 hours of direct supervised training or experience in behavioral therapies that are consistent

with best practice and research on effectiveness for people with autism or other developmental disabilities.

- While provider reimbursement is beyond the scope of the Benefits Collaborative Process, we have provided the following information on behalf of staff within the Department who set appropriate reimbursement rates. The Department does not, and did not previously under the Children's Extensive Support (CES) Waiver, reimburse separately for either employment or clinical supervision and does not plan to reimburse BCBAs separately for such supervision of BCaBAs.
  - Employment supervision, in which the supervisor assures job duties are completed and HR issues and paperwork, such as leave requests and employment forms, are resolved, is part of the cost of doing business and is built into the administrative component of the rate.
  - Clinical supervision, in which a behavioral professional with more experience supervises staff with less experience to assist with professional development, to ensure services to members are safe, ethical and competent, and to ensure compliance with professional and organizational treatment standards and practices, is also part of the cost of doing business and built into the administrative component of the rate.

- Under the CES Waiver, the Department did previously reimburse for clinical *consultation*, in which the degreed behavioral professional observes the strategies of lesser degreed professionals and technicians to assess the effectiveness of the intervention. This would constitute assessment and professional consultation, not supervision. The Department is open to discussing how separate reimbursement for clinical consultation might work. Coverage of this service would first require further funding approved by the Legislature.

- The Department reached out to staff in New Mexico regarding the specifics of their supervision and treatment planning policies. The two benefits are not comparable in that New Mexico's benefit is offered through their capitated managed care program (as is California's). Capitated managed care programs provide for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and third party managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services, rather than reimbursement for each service provided. These MCOs, in turn, create their own financial arrangements with providers, who often provide services at a contracted reduced rate. New Mexico staff stated that, were the benefit reimbursed fee-for-service, as it is in

Colorado, the state would be unable to cover the cost. The New Mexico benefit is also limited to children with a diagnosis of Autism; Colorado's benefit is more expansive.

Item 3

Stakeholders shared varied opinions on whether additional types of providers should be included in a new mid-level provider type.

One consumer advocate pointed to the descriptions that accompany the procedure codes used when a BCaBA or RBT bills for pediatric behavioral therapy and noted that the descriptions read "BCaBA or equivalent" and "tech" (rather than RBT). She urged the Department to focus on creating a new mid-level provider type that includes other equivalent provider types (besides BCaBA) with different specialized training (for example, to conduct play date therapy).

The same stakeholder noted that, while we often focus on Applied Behavioral Analysis (ABA) and the treatment of autism when we discuss pediatric behavioral therapy, there are children with other diagnoses (such as Post Traumatic Stress Disorder, Oppositional Defiant Disorder, and Radical Attachment Disorder) and there are other types of specialists (besides BCBA, BCaBA, and RBT) who may best be able to treat those diagnoses. The pediatric behavioral therapy benefit should be flexible to meet the various needs of children.

The same stakeholder also encouraged the Department to look at the outcome of a recent California ruling that required California Medicaid to expand its eligible provider types beyond BCBA, BCaBA and RBT. This stakeholder referred the Department to the Autistic Self Advocacy Network website for more information.

Several providers agreed that there are pediatric behavioral therapy needs beyond ABA and that not all children respond to ABA. These stakeholders stated that any type of pediatric behavioral therapy should only be provided by practitioners with an established code of ethics and specific credentialing. Other therapies include but are not limited to: Relationship Development Intervention (RDI) and Cognitive Behavioral Therapy (CBT)

Several ABA providers stated that ABA should only be performed by a BCBA credentialed professional.

One stakeholder stated that there are fraud investigations in two Florida counties as a result of Florida Medicaid allowing non-credentialed providers to bill for services, and referred the Department to the National Standards Project and the Association for Science In Autism Treatment for further insight into various evidence-based treatments and associated appropriate credentialing.

- Provision of pediatric behavioral therapy services is not limited to RBTs and BCBAs, nor is the Department suggesting that, with the addition of BCaBAs as a mid-level provider type, provision of pediatric behavioral therapy services be limited to RBTs, BCaBAs, and BCBAs.

  - On the Department Pediatric Behavioral Therapy webpage, HCPCs procedure code H0046 is indicated as the appropriate reimbursement code to be used when billing for "technician" services; this includes RBTs and other technicians as outlined in the first bullet under Item 2 above.

  - The Department is open to exploring other provider types (beyond BCaBA; e.g. other professionals with an undergraduate degree and specific training and certification in a type of behavioral therapy) for possible inclusion as mid-level behavioral therapy providers, and welcomes specific suggestions.

- The Department is currently researching whether to include play therapy under the pediatric behavioral therapy benefit. Note: were the Department to include play therapy under this benefit, it would likely require that a Registered Play Therapist (RPT) provide such services, as certified by the national Association for Play Therapy. All such professionals possess a master's or higher mental health degree with demonstrated coursework in play therapy. These providers would be affiliated with Medicaid under provider type 38, mental health professional, and would be able to provide these types of services outside of the pediatric behavioral therapy benefit or under the benefit if they chose to affiliate with Medicaid as a pediatric behavioral therapy provider type 24 or 84.

- The pediatric behavioral therapy benefit covers diagnoses other than autism and therapies other than ABA.
  - A 2018 report to the Colorado legislature, performed by an independent auditor, included the following breakdown of children served.

Distribution of Diagnoses	Number of Children/Youth	Percent of Eligible Children/Youth
Number of Diagnoses		
Single Diagnosis	1,380	60%
Multiple Diagnoses	918	40%
Diagnoses of Eligible Children and Youth *Total exceeds number of children eligible because of multiple diagnoses per child.* *Percentages total to more than 100% because some children were counted multiple times.*		
Autism Spectrum Disorders (incl. Asperger's syndrome)	1,285	56%
Intellectual/Developmental Disabilities	293	13%
Congenital or Neuro-Developmental Disorders	171	7%
Other Behavior Health Diagnoses	280	12%
Other Physical Health Diagnoses	269	12%

  - Behavioral therapy criteria, including diagnosis and treatment criteria, can be found on the Department Pediatric Behavioral Therapy webpage.

- Most behavioral professionals with a master's degree or higher and who are trained to treat the types of conditions listed in the table above are presently eligible to render such

services under the Lead or a Senior Therapist (BCBA or equivalent) provider type using HCPCs procedure code H0046 with Modifier TJ. See also response in first bullet under Item 2 above.

- The Department agrees that pediatric behavioral therapy services should only be provided by practitioners with an established code of ethics and specific credentialing. See also response in first bullet under Item 2 above.

- The Department agrees that ABA therapy should only be performed by a BACB credentialed professional.

- Further Department response forthcoming.

Item 4

Several providers participating via webinar did not agree that the addition of BCaBAs as eligible providers would improve member access to services over time.

A provider participating via webinar stated that the addition of a mid-level provider type is not going to increase his company's ability to serve Medicaid members, given the BCBA supervision requirement.

This same stakeholder stated there is little difference between an RBT and a BCaBA and that commercial insurers usually reimburse them the same.

Several stakeholders participating via webinar suggested recent regulations issued by BACB might impact the number of bachelor level staff that seek to become BCaBAs.

These same stakeholders suggested that greater focus should be placed on how to recruit additional BCBAs to serve Medicaid members.

- Department response forthcoming.

Published: 9/25/2018

Item 5

The Department seeks to create greater consistency of access to quality services for children across the state and is trying to understand why there may be differences in the amount of hours providers are spending with different children who have similar needs. Stakeholders suggested that differences may be attributable to multiple factors and offered several suggestions, including:

Differences in the duration of services provided may be related to each child's availability, the availability of the qualified provider, and the general guidelines under which the provider operates.

Clinicians may recommend a certain number of hours based on actual clinical need, but certain providers may choose to write a plan of care that requires fewer hours of service based on the amount of time the family reports they are available.

Motivational variables for stakeholders constantly shift (e.g. family schedules and dynamics, treatment response rates), so it is unclear that any comparative analysis between hours requested and delivered would be informative.

Applied Behavioral Therapy (ABA) progress monitoring is ongoing (daily, weekly, monthly) and treatment can change based on how the member is presenting and responding to current ABA treatment.

The Behavioral Analyst Certification Board practice guidelines for Autism treatment, found at the BACB website, can assist the Department to assess whether hours spent delivering recommended treatment are appropriate.

- The Department thanks stakeholders for this important context and looks forward to the further findings of the behavioral professional we plan to hire to: evaluate past prior authorization requests, plans of care, and treatment goals and outcomes; and identify similar such observations that may arise from that analysis. These observations should help us identify ways to improve the quality, effectiveness, and consistency of services members receive across all providers.

- With respect to the observation that providers may choose to write a plan of care that requests fewer hours than medically necessary due to family availability or other constraints, the Department would like to clarify that the plan of care should always request what is medically necessary, and then should specify that the parents are requesting a lower number of hours based on their needs.

- After professional review of past prior authorizations and their associated plans of care is complete, the Department plans to work with our Utilization Management vendor to author additional guidance to providers regarding appropriate variables to include in prior authorization request and plan of care documentation.

Item 6

Several stakeholders stated the Department should explore how to foster better treatment coordination and family/parent education, where possible.

Many stakeholders in the 5/23/2018 meeting indicated support for the concepts below, as outlined by one consumer advocate:

> Coordination of school-based interventions and home-based interventions is critical and must improve. For children with, for example, Post Traumatic Stress Disorder or Reactive Attachment Disorder, who may be receiving both behavioral health therapies provided under EPSDT policy and mental health treatment provided under the capitated mental health benefit, coordination must also improve.
>
> Parents need to be educated on what good intervention looks like so that they may actively participate, advocate for their child, and be responsible consumers of services. For example, they should know how to track their child's progress.

- The Department allows for collaboration with the schools and encourages parents to share treatment plans with other providers if they choose. The Department does not separately reimburse for this activity. See Item 7 response below.

- On July 1, 2018, new Regional Accountable Entities (RAEs) began serving as the single entity responsible for coordinating both physical and behavioral health for Health First Colorado (Colorado's Medicaid Program) members. Part of the objective behind joining

physical and behavioral health under one accountable entity was to strengthen coordination of services by advancing team-based care and health neighborhoods. Parents and providers in need of support with care coordination should first contact their RAE.

- As a result of this feedback, Department staff have begun to arrange training for the RAEs regarding EPSDT benefits. RAEs will be audited on the program in early 2019.

- The Department also encourages parents in need of support with care coordination to contact a Family Health Coordinator through our Health Communities program, who can assist in linking members to Health First Colorado providers and provide members with information and referrals to other community programs and resources.

Item 7

Several providers participating in the 5/23/2018 meeting via webinar elaborated on the need for parental education, stating:

> There should be a separate, reimbursable service for parental training, which should be recurring.
>
> Often quality parent training needs to occur without the child present. At times, it's not appropriate to talk about the child in front of them, and at other times parent training in the presence of the child can present antecedents to challenging behavior. This can result in parent training being exclusively related to de-escalation or problem behavior response rather than teaching essential proactive strategies.

- The Department does not separately reimburse for parental education, or training in general, within the State Plan, nor does it do so within majority of its waivers. This is, in part, because part of therapeutic intervention includes teaching the individual and those supporting the individual proper interventions. Were the Department to pursue reimbursing parent education as a separate task for this purpose it would need to do so across multiple therapeutic services and would need to seek federal authority and additional funding from the Legislature.

- Several providers have stated, outside of this Benefits Collaborative process, that the Department used to reimburse for parental education, clinical supervision, treatment

planning, and IEP (Individualized Education Plan) or IFSP (Individualized Family Service Plan) meetings, under the CWA waiver. The Department would like to clarify that, to the extent that certain CCBs or behavioral therapy providers provided and billed for such services as clinical consultation in the past, this was an erroneous practice..

Item 8

Several stakeholders stated that treatment planning is lacking at present and that limited treatment planning negatively impacts effective treatment and case management.

A provider participating via webinar suggested the Department look at what other states are doing to address indirect treatment planning and supervision.

Another provider participating via webinar stated the Department might be able to attract more BCBAs to serve Medicaid members, and thereby increase member access to Applied Behavioral Therapy, by opening a Current Procedural Terminology (CPT) code that would allow BCBAs to bill for treatment planning and supervision.

A consumer advocate stated that reimbursing for as little as two team meetings a year, so that parents and various providers can plan and coordinate treatment, would be helpful to get everyone on the same page.

One provider stated that submitted care plans have less detail than before because indirect treatment planning is not a separately reimbursable task.

- At the direction of stakeholders, the Department investigated policies in California and New Mexico and found the two benefits are not comparable in that they are capitated managed care programs. Refer to the last bullet in the response to Item 2 above for further explanation.

- The Department is unaware of other states that provide separate reimbursement for treatment planning, team meetings, and clinical supervision. If stakeholders are familiar with other state policies that differ from, or are more expansive than, Colorado policy regarding separate reimbursement for treatment planning and supervision, we invite you to provide that information for consideration by the appropriate Department staff.

- Note: were the Department to open a Current Procedural Terminology (CPT) code that would allow behavioral therapy providers to bill separately for treatment planning and supervision, it would need to seek federal authority and additional funding from the Legislature.

- It should not be the case that treatment plans have less detail than they did under the CWA waiver due to reimbursement. Indirect treatment planning has never been a separately reimbursable task; it is accounted for in the administrative component of the rate. See also second bullet under Item 7.

- It is the provider's professional responsibility to write a comprehensive treatment plan that clearly outlines all the following:
  - specific and measurable goals of the treatment plan;
  - how the direct treatment hours and supervision hours will be delivered at a sufficient intensity to achieve treatment plan goals;
  - the level of primary caregiver/responsible adult training and support and how this support is going to be delivered in a manner individualized to the child and family, to ensure skills transfer to the parent/caregiver; and a
  - plan of evaluation for measurable impact on the member's behavior or skills.

Item 9

The Department should consider reimbursing for co-treatment to foster better integration of services.

One provider stated the Department should allow for co-treatment by a Speech Language Pathologist (SLP) and BCBA, the way SLPs and occupational therapists are currently allowed to co-treat at Children's Hospital.

Another provider stated the Department should allow for co-treatment during times of crisis intervention; New Mexico Medicaid policy allows for this.

- With respect to the Children's Hospital example above, the delivery and reimbursement of health care services that occur in a member's home are individually reimbursed and cannot be compared to those occurring in a hospital setting. Services provided in a hospital are paid using a bundled payment which means we pay for an episode of care, or the entire set of services, supplies, and procedures provided to a member, rather than

paying for each individual piece of that episode.

- Further Department response forthcoming.

Item 10

Several stakeholders shared feedback on questions that were added to the Prior Authorization Request (PAR) process on 4/1/2018, the responses to which the Department plans to use to identify practice trends and service gaps over time (not to deny services presently). Feedback included:

It is unclear what value can be gained by asking providers "has the child been diagnosed with a condition for which behavioral therapy services are recognized as therapeutically appropriate?" It is also overly vague. For example, "recognized" by who?

The question "is the primary caregiver willing and able to support the child's therapy?" is also overly vague and potentially subjective. For example, what does "support" mean?

The question "what percentage of progress overall has the child made towards achieving previous goals" is problematic because responses will be subjective and it is not possible to answer the question if the PAR is an initial request.

If, in the future, these questions became exclusionary, several would first need to be re-worked so that they are less subjective and allow for meaningful conclusions. For example, in response to the question immediately above, a provider could report that a child has made 0-10% progress, but limited progress may have nothing to do with the effectiveness of the provider or the care plan. Instead, it may be due to a seizure disorder or an extinction burst (in which a behavior is eliminated by not reinforcing it). Inquiring about the reason behind the numbers will be important before making any decisions about continued treatment and will prevent providers from falsifying numbers.

Questions about self-harm should not be used to limit service.

- Pediatric behavioral therapy is an evolving field. Newer therapies sometimes lack an evidence-base that speaks to their effectiveness. As such, several providers have answered "no" to the question "has the child been diagnosed with a condition for which behavioral therapy services are recognized as therapeutically appropriate." Understanding when and why behavioral therapy services are requested for conditions that perhaps have not traditionally received them will help the Department to craft appropriate eligibility policy over time. This question will be modified to read as follows:
  - *Has the child been diagnosed with a condition for which evidence-based best practice indicates behavioral therapy is therapeutically appropriate?*

- Several of the questions asked when a provider submits a pediatric behavioral therapy PAR seek the provider's professional opinion based on the assessment conducted. Therapeutic assessment is somewhat subjective and, for that reason, a certain level of subjectivity in the wording of questions is unavoidable. However, the Department is exploring the following changes based on feedback received, which should help bring clarity to the questions asked and help standardize responses.

- The question "Is the primary caregiver willing and able to support the child's therapy?" is intended to help the reviewer identify those children and families that may need additional support and resources for therapy to be successful. The Department is exploring two possible changes:
  - Rewording the question as follows "*Do you as the provider believe the primary caregiver is able and willing to support the plan of care and care goals to the extent needed by the child. If no, please explain why."*

  - Rewording the question as follows "*On a scale of 1-4, where 1 is totally unable, 2 is somewhat unable, 3 is able, and 4 is totally able, to what extent do you as the provider believe the primary caregiver is able to support the plan of care and care goals to the extent that is needed by the child*? *If scored a 1 or a 2, please explain why.*"

- The Department is exploring the following possible changes to the question "What percentage of progress overall has the child made towards achieving previous goals?"
  - Splitting the question into three parts and modifying to read as follows.
    - "*If this request is for reauthorization of behavioral therapy services, what percentage of progress overall has the child made towards achieving previous goals?*
    - *Do you believe lack of progress is attributable to the original care plan design? Yes/No.*

- *Do you believe lack of progress is attributable to a change in life circumstances? Yes/No.*"
  - Standardizing responses to the first question using a drop-down menu with limited choices.
- Questions about self-harm are not, and will not be, used to limit service. They are intended to help the reviewer identify those children and families that may need additional support and resources for therapy to be successful.

Item 11

Can the Department provide the full list of questions asked as part of the PAR process?

- The full list of questions can be accessed on the Department website.

Item 12

Time ran short in the 5/23/2018 meeting and the Department committed to convening a webinar to discuss the Department's plan to hire a degreed professional to assess previously approved PARs for quality of: care plan; goals w/in the plan and any previous plans; and the degree to which goals were met.

One provider proactively shared that the proposal seems reasonable and all other payers engage in similar practices.

- The Department thanks stakeholders for this important context and looks forward to the further findings of the behavioral professional we plan to hire to: evaluate past prior authorization requests, plans of care, and treatment goals and outcomes; and identify similar such observations that may arise from that analysis. These observations should help us identify ways to improve the quality, effectiveness, and consistency of services members receive across all providers.

Published: 9/25/2018

Item 13

After the 5/23/2018 meeting, David B. Hatfield, Clinical Psychologist and BCBA-D, sent the Department the following list of questions and recommendation:

What would the proposed credentials be for the professional reviewer of PARS?

Would you consider adding a comments box for PARs questions; specifically, for "What percentage of progress overall has the child made towards achieving previous goals?" I would find it useful to have a space to detail why progress of less than 50%; it might help with the review of PARs.

Would the new (mid-level) provider tier for BCaBAs be for those fully credentialed as BCaBAs or would it allow those enrolled in coursework towards that goal and under BCBA supervision as well (like we had in the waivers)?

Are indirect services like program writing, IEP attendance/other treatment planning team meetings, supervision time, and parent training being considered for inclusion? The latter would help with dosage and consistency.

What was the answer on the ability of a BCBA to co-treat with any other professional?

Is there a website where we can review all EPSDT regulations?

When you consider dosage, the US Surgeon General Report, the American Academy of Pediatrics recommendations, and McKesson (now InterQual) criteria, may be of use. The latter serves as a consulting agency for commercial insurance.

- The Department is actively soliciting feedback on what the proposed credentials should be for the professional the Department hires to review past PARs. The Department presently envisions that this professional would have, at minimum, a bachelor's degree in behavioral therapy or a closely related field.

- The Department will explore the addition of a comment box for providers to provide additional context regarding certain PAR responses.

- The new mid-level provider tier would be for fully credentialed BCaBAs.

- IEPs and IFSPs are educational documents and therefore cannot be charged to Medicaid; nor can Medicaid require that IEPs be provided.

- Refer to Items 2, 7 and 8 responses above for the Department's position on supervision time, parental education, and treatment planning, respectively.

- Refer to Item 9 response above for the Department's position on co-treatment.

- EPSDT regulations can be found on the Department website.

- The Department will review the dosage resources suggested above. Presently, the Department's utilization management vendor, currently eQHealth Solutions, uses InterQual criteria, along with Department criteria created in consultation with stakeholders, to determine medical necessity.

Published: 9/25/2018

Item 14

After the 5/23/2018 meeting, Jennifer Tilley, Clinical Director, Autism Behavioral and Educational Consulting, sent the Department the following list of questions and recommendation:

> I think the addition of the BCaBA provider type will be great. Because other funding sources do not recognize it, there's not a lot of incentive for folks in Colorado to get it, but I currently have three people that would be eligible to take the exam today if there was a need.
>
> I agree with the idea of an experienced/credentialed person reviewing PARs. It seems to be the industry standard from all other funding sources.
>
> What is the turnaround time on a PAR once we submit a plan, and is the authorization back dated to the date of submission if the time is more than 3-5 business days?
>
> There was a lot of talk about an indirect code and supervision code. Some commercial funders, such as United Behavioral Health and Cigna, have these and some do not. Generally, the funders that do have them have some caps on them (for example, one hour of indirect supervision for every ten hours of direct service provided). The funders that don't have indirect codes typically have higher rates for both the tech and BCBA code.
>
> I'm so glad there were some parents in the room. While I 100% support the requirement of specific credentials (for providers billing certain codes) and evidence based practices, I also understand the parent perspective that something "different" may work for families. There is an extensive amount of research to support the effectiveness of ABA to treat a variety of disabilities. There are also many different approaches under the umbrella of ABA that might feel better to specific families. I've received a few referrals from families that didn't have good experiences with other agencies and had given up behavioral intervention for a time. I'm wondering how we can help families find a good match.

- The time between PAR submission and approval is no more than four business days. The authorization is back-dated to the date of submission.

- Further Department response forthcoming.

Item 15

After the 5/23/2018 meeting, Kate Veeder, LSW at Kalis & Associates, sent the Department the following list of questions and recommendation:

I recommend adding language to include other licensed professionals (besides BCBA, BCaBA and RBT). It limits choice from the end user by restricting them to ABA. As was mentioned, for individuals with trauma history or attachment disorder, strict ABA may not be the appropriate method. There are LCSWs and even PhDs that aren't able to provide behavioral therapy in this new model. What we know is that individuals need consistent care and interventions. When we aren't allowed to collaborate with the schools, we don't know if the interventions we are recommending, implementing, and training parents to implement contradict what the school is doing. Consistent care increases the ability for skills to transfer to different environments.

- Refer to the response in Item 2 above, which explains the types of providers and therapies allowable under the pediatric behavioral therapy benefit. LCSWs (provider type 38) are eligible to provide pediatric behavioral therapy services, as are most PhDs. If stakeholders are aware of specific Medicaid enrolled providers who believe they meet provider eligibility criteria for provision of pediatric behavioral therapy services, as outlined in Item 2 above, and find themselves ineligible to provide pediatric behavioral therapy services, or who have unsuccessfully billed for prior-authorized services, the Department encourages stakeholders to share that information with us, so that we may investigate.

- The Department allows for collaboration with the schools and encourages parents to share treatment plans with other providers if they choose. The Department does not separately reimburse for this activity.

Published: 9/25/2018

Item 16

After the 5/23/2018 meeting, Travis Blevins, Executive Director of Behavior Services of the Rockies provided a list of suggested changes to pediatric behavioral therapy service delivery, policy, and funding, after conferring internally with each of their regional coordinators. Suggestions included:

Create a tier system/severity scale that ascribes a certain number of units of service to certain service delivery aspects, such as patient severity and the recommended frequency and duration of service. It should also measure the disruption that behaviors are having on child's current placement (e.g. in school, at home, etc.). There are many of these assessments already in use and at no cost.

- Included in this scale should be evaluation of skills deficits that are interfering with socialization and independence.
- Require measurable goals for reducing the number of units/tier level, including required criteria for ending treatment (e.g. discharging the patient) upon intake.
- Allow providers to request additional funds beyond tier limits in emergent and dire situations.

To reduce fraud, use visit verification to ensure in-home service providers are where they say they are when providing direct services.

Provide telehealth options for rural enrollees; several health insurers do this, and several Medicaid states, including New Mexico.

Reduce the rate for the RBT (high school prepared) service, and use those funds to increase the BCBA oversight rate; lead clinicians determine the scope of services, conduct the assessment, and alter ongoing treatment protocols. To offset costs, allow BCaBAs (rather than BCBAs) to provide supervision to the RBT (per the Behavior Analyst Certification Board guidelines).

Provide funding for:

- Mandatory parent training to access the benefit, as is required in California. In California, parent curriculum must be completed prior to services beginning; the training involves introduction to services, and expectation of parental involvement and role.
- Peer review of programming to ensure best practice and quality control of programming. Many states do this by establishing Behavior Management Committees.
- Indirect service delivery and co-treatment (not to exceed 10% of direct 1:1 services). Audit to ensure providers are maintaining appropriate documentation that demonstrates indirect service time is being used, for example, for parent training, assessment development, treatment plan development, co-treatment, quality assurance, inter observer competency-based quality monitoring, and crisis support.

Provide higher reimbursement in rural areas where there is lower provider capacity or provide per diem reimbursement for underserved areas of the state.

- Department response forthcoming.

Item 17

After the meeting on 5/23/2018, Carol Meredith, Executive Director of the Arc Arapahoe & Douglas, provided the Department with an article that included the following links and encouraged the Department to consult these resources when researching topics.

The National Professional Development Center on Autism Spectrum Disorder (NPDC) 2014 updated review of 29,000 articles on autism and identification of 27 evidence-based practices and online modules for all 27 practices;
The CAPTAIN Project in California, and
The new National Clearinghouse on Autism Research and Practice at the Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill.

- Department response forthcoming.

COLORADO
Department of Health Care Policy & Financing

Published: 9/25/2018

Item 18

After the meeting on 5/23/2018, Maureen Welch notified the Department that it is still very challenging for families to find providers and stated that, to promote person centered choice and ensure early EPSDT services, it is critical that families can find providers easily. She asked the following:

How often and who maintains the list of providers on the Department website? She noted an inaccuracy on the current list.

Can the Department create and maintain a more comprehensive chart for each provider? Parents use the chart frequently. She suggested a chart similar to the one for PASAs and include:

- Whether provider takes private insurance and whether they are in network or out of network for each insurance carrier
- A legend with counties served
- The provider's website, email and phone number
- For each provider, a short statement about agency philosophy and another with information about their offerings. For example, some providers only provide services up to age 6.

- Department response forthcoming.

Published: 9/25/2018

Item 19

The Department held a second Pediatric Behavioral Therapy Benefits Collaborative meeting on 7/17/18 to gather further feedback on the Department's plan to hire a degreed professional to assess previously approved PARs for quality of: care plan; goals within the plan and any previous plans; and the degree to which goals were met. Several stakeholders provided suggestions regarding who should be hired to conduct the assessment, Including the following:

The reviewer should have a degree/licensure in a field that would qualify them to provide behavior therapy.

A degree does not translate to a broad clinical experience of a variety of evidence based behavioral therapy interventions; the reviewer should have training and experience beyond ABA, be objective, neutral and respect many person-centered choice.

The reviewer should have a minimum of 3-5 years of experience developing and implementing treatment plans in the private sector and not within the public-school setting.

BCBAs and BCBA-Ds typically conduct such reviews for private insurance companies and anyone reviewing for approval of ABA should either be a BCBA. Or BCBA-D.

The Department should consider peer review, rather than review by a single professional.

- Department response forthcoming.

Published: 9/25/2018

Item 20

In the 7/17/18 meeting, several stakeholders provided suggestions regarding what the reviewer should be looking for when evaluating the quality of the care plan, or whether the goals were met, including the following:

There will be a difference between the initial treatment plan and the revised plan at six months and the reviewer should treat the two differently. The first plan will involve a lot of those socially significant goals that the family has identified as important to them; subsequent treatment plans should be more robust and demonstrate that assessment is being used to drive intervention.

Care plan goals should flow out of assessment, based on baseline data of strengths and needs as well as the values and goals of client and/or caregiver.

Confirm that stated goals were relevant to the assessment used to justify therapy in the first place, and that providers are breaking down how they plan to utilize therapy hours. For example, 30 minutes for generalization across individuals and settings.

Were parent goals included in the care plan and was progress towards those goals tracked/made? BCBAs should always be planning for the terminal end with the goal of transitioning progress made and direct therapy to parents and direct caregivers.

Look for functionally equivalent interventions for problem behaviors, long term meaningful behavior change, measurable and observable goals, sufficient baseline data prior to intervening, data collection on progress, discharge criteria, and social validity measures (which measure whether services have a meaningful impact to the family). Also assessing generalization of skills to multiple settings, people, etc.

What was the time-lapse between the approval of the PAR and the initiation of services? This is a measure of quality of care. Does the system have a means of tracking that?

What are the barriers to progress towards treatment goals? Does the clinician have access to the resources needed to improve progress? Can another clinician better effect progress?

Identify the original reason for referral and compare it to the targeted behaviors for acquisition/reduction. There should be rationale as to the change or target that might be different.

Time spent training parents.

- The Department thanks stakeholders for their considered suggestions and looks forward to further considering their incorporation within the review plan, once a reviewer(s) is hired.

- Further Department response forthcoming.

Item 21

In the 7/17/18 meeting, several stakeholders also provided suggestions regarding resources the reviewer should consult when evaluating the quality of the care plan, or whether the goals were met, including the following:

The Association for Behavior Analysis International, for how to write good authorizations that document medical necessity.

BACB Practice Guidelines, which summarize the best practices for behavioral therapy based on decades of research, particularly regarding how many hours BCBAs should recommend for a client. Reviewers should use these as a guide when evaluating past PARs.

Cigna's process; it includes a phone interview to ascertain why progress isn't being made on goals.

- Department response forthcoming.

Published: 9/25/2018

Item 22

Providers asked several logistical questions, including:

Will providers still be required to use age codes when the new Current Procedural Terminology (CPT) codes come out?

Will providers be required to participate in Electronic Visit Verification (EVV) when administering this benefit?

- Department response forthcoming.

Item 23

A consumer advocate and parent provided input outside of the 7/19/18 meeting and again on 7/17/18 that, as part of this process, the Department needs to do more to engage customers/consumers around their experience and for their input. She recommended a direct email to those families currently approved for behavioral therapy services and/or a meeting specifically for consumers.

- Colorado Senate Bill16-1405 requires the Department to submit a behavioral therapies evaluation report to the state legislature each year, which contains an evaluation of these behavioral therapies as statutorily mandated under Section 25.5-6-806 (2) (c) (I), C.R.S. The statute mandates annual evaluation reporting of the following:
  - The number of eligible children receiving services or who have received services under the EPSDT program;
  - The average and median age of eligible children when they begin receiving services, and the average length of time that children receive services; and
  - The average cost of services provided to an eligible child.

- To inform this report and to support the Department's efforts to improve the benefit over time, the Department has committed to conducting a pediatric behavioral therapy consumer experience survey every year. The first survey, mailed to families in January-March of 2017, netted only 8 responses. To ensure robust and representative feedback, in December 2017 to March 2018, the Department conducted the second annual survey via phone, email and text; the Department received over 100 responses, and conducted 68 subsequent interviews.

- Key themes from survey responses included:
  - Most parents stated that providers are working with a child or youth in the best environment (at home or community, as opposed to the therapist's office) and/or have a generally positive relationship with the child or youth.
  - Most parents spoke of specific positive gains their children had made as a result of services, including increased communication, confidence, and motor skills. Some parents also noted marked decreases in tantrums and violent outbursts, as well as increased functioning at home and in the community.
  - Most frustrations expressed by parents centered around system navigation, including long wait times for referrals and appointments, and/or conflicts with specific therapists.

- In response to the findings above, the Department:
  - now includes questions on the PAR about wait times and provider wait lists, to better manage any noted delays with individual providers;
  - is training the RAEs about the pediatric behavioral therapy benefit; and
  - is exploring ways to streamline the referral process.

- Later this year, once the Department procures a survey vendor, the Department plans to invite stakeholder feedback on questions to modify/include in the next iteration of the survey through the Children's Services Steering Committee and the Children's Disability Advisory Committee. Committee meetings are open to the public and stakeholder feedback is welcome. Meeting agendas can be found on the Department website. To be included on the email list for these two committees, contact Gina.Robinson@state.co.us.

- The Department also plans to send an email to all those families who responded to this year's survey, and for whom the Department has an email address, informing them of the topics under discussion within this Benefits Collaborative, progress to-date, and opportunities for them to get involved, including: how to provide feedback outside of meetings; and how to provide feedback at the Children's Service Steering Committee or during the 30-day public comment period.

Item 24

Where can I find a recording of the 7/17/18 Benefits Collaborative meeting?

- The meeting recording can be accessed at this link: https://cohcpf.adobeconnect.com/py6hi3koh2a5/

Published: 9/25/2018

Item 25

After the meeting on 7/17/18, Shasta Brenske, Clinical Director, Bright Behavior Inc., provided suggestions regarding what the reviewer should be looking for when evaluating the quality of the care plan, or whether the goals were met, including the following:

Goals are written in a measurable format with data collection

Goals are functionally relevant given the child's age and cognitive ability

Progress is measured by improvement on assessments and/or a visual graph

Assessment tools are identified at the onset of treatment, scores on the assessments are available on the first six-month progress update, and the progress update indicates when retesting will occur

Any medical issues that the child may be experiencing that also affect ABA are identified as part of the background summary for the child as well as any other barriers to treatment (i.e. only one parent participates in training, participation limited to lack of transportation, etc.).

The discharge plan is included upon the initial assessment

- Department response forthcoming.

Published: 9/25/2018

Item 26

After the meeting on 7/17/18, Kevin T. McCarthy, President, Spectra Centers Inc., provided to the Department the following additional feedback:

> BCBAs are concerned about a less qualified professional assessing the appropriateness and progression of treatment goals. This is especially the case if this professional would be using the resulting information to inform/train the nurse review team. We as providers have to think this would impact the approval of future PARs.
>
> There are many factors that can impact goal progression (client attendance, changes in medication, parenting dynamics, etc.). As a provider, we would be concerned with a reviewer/panel making determinations about the quality of services without any means of explaining those type of issues. It would be nice to have a way to qualitatively explain these type of factors, and know the reviewing professional will take a look. Perhaps this could be done through the 6-month treatment plan updates?
>
> I would like to see a measure for parent participation/training. We want to train our parents on how to manage maladaptive behaviors in an effort to increase progression and reduce the need for care over time. I know this is massively important to parents, and sometimes providers neglect this piece. It would serve as a very meaningful quality measure.

- Department response forthcoming.