

**Autism Care Demonstration
Provider Information Meeting
April 26, 2018
10:30 am ET**

Coordinator: Welcome and thank you for standing by. All participants will be able to listen only. Today's conference is being recorded. If you have any objections, please disconnect at this time.

I would like to turn the conference over the (Speaker One). Sir, you may begin.

Speaker One: Great. Thank you very much. I appreciate that and good morning and welcome everyone. I am (Speaker One), Chief Clinical Officer for TRICARE. Thank you for joining us today and participating in today's Autism Care Demonstration Provider Information Meeting.

It's great to talk with everyone again and we're looking forward to a productive meeting. As we celebrate Autism Awareness Month, TRICARE continues to be committed to providing quality care to all of our beneficiaries including those diagnosed with Autism Spectrum Disorder (ASD).

Just to give you a little bit of background information: as of December 31st, we had over 28,000 Applied Behavior Analysis providers in the TRICARE network and we are serving about 14,500 military beneficiaries with Autism Spectrum Disorder and their families. As you're probably aware, we recently got approval to extend the Autism Care Demonstration beyond the initial expiration date, which would have been December 31st, 2018. We got an additional five years, so the Autism Demonstration is now going to expire on December 31st, 2023. That's good news for us, certainly, as that will give us more time to develop our plan, which we will be talking about here in the next few minutes. At this point, I'd like to take this opportunity to introduce the rest of the TRICARE autism team that's here with me.

Speaker Three: Good morning. My name is (Speaker Three). I'm the Program Manager for the Autism Care Demonstration.

Contract Support: Hi. My name is (Contract Support) and I'm contractor support.

Speaker Two: Hi. It's (Speaker Two). I'm a clinical psychologist with Medical Affairs here at the Defense Health Agency and I'm the Clinical Lead for the program.

Speaker One: Okay. And not here with us today, but the other four members of our ACD team, are our Behavioral Health lead in San Antonio, our Behavioral Health Lead in San Diego, the Behavioral Health Lead in Falls Church, and the

individual who does our Special Needs work in San Diego. And they are also very valuable members of our team.

We're fortunate to have (Speaker One) and (Speaker Two) here with us today and they will be doing much of the brief. But let me give you a little bit of an introduction first. First, let's talk a little bit about the transition from the prior TRICARE contracts, which we knew as T3, to the current T17 contracts, which has Humana in the East and Health Net in the West. Unfortunately, as you probably know, we had a number of problems with that transition, especially related to autism care. Those had a significant impact on both our beneficiaries and our providers, and we certainly apologize for those difficulties. And I want to let you know that we have been working very closely with both contractors to ensure that all those challenges are resolved and we get back to full normal functioning. I think we're getting very close. I think we have taken care of most of the problems. We know there are still a few issues out there for some providers and I can assure you that we are not going to rest until we have each one of those problems resolved and everyone taken care of. We appreciate all of the providers, families, and advocates who brought those concerns to our attention so we can get them resolved. If you are still having challenges, please let the contractors know. And if that doesn't solve the issue, contact us and we will take it up with them as well.

Just as a note: due to privacy concerns during this call, we cannot discuss individual beneficiary issues. All individual beneficiary and provider issues should be addressed directly with the contractor. But we do appreciate all the questions that were submitted in advanced. We are going to respond to as many of those policy questions as we can, if time allows. And all questions, including those submitted questions that we're not able to get to, or questions that are received after the submission deadline -- including those that you might think of during the meeting, please send to us. We will include those in our Question and Answer document that will be posted on our website at www.health.mil/autism following the meeting. Now, I will tell you that it does take us a little time to get that document put together. So, I'll ask for your patience with that, but we'll get it out there as soon as we can.

Over the course of the demonstration, the DHA has engaged with various stakeholders regarding TRICARE's coverage of Applied Behavior Analysis for the diagnosis of Autism Spectrum Disorder. Included in those groups have been participants from various organizations, families of children diagnosed with Autism Spectrum Disorder, military providers who diagnose and treat autism, and autism advocacy groups.

This past summer, we sent out a formal request for information and hosted an Industry Day to explore ways where we can improve the autism care benefit. We had many organizations participate and received significant

feedback and some great information and ideas as a result of both the request for information and the Industry Day. We have also been meeting with experts in the field, including researchers from the National Institute of Health, leaders of some innovative programs at military treatment facilities, and others. And we greatly appreciate everyone who has generously shared their time and work with us with the goal of improving the care and services we provide to military beneficiary with autism and their family.

Numerous overarching themes and elements of interest have emerged from these events and those are going to help us as we shape the autism care benefit going forward. As you may know, we are in the process of revising the demonstration, making very significant changes. Probably the biggest changes since we've started the benefit almost five years ago. And we're going to be incorporating the themes and information that we've learned to significantly improve the benefit. (Speaker Two) will touch on those initiatives in a few minutes, but first, I'd like to introduce (Speaker Three), who is going to provide an update on reimbursement rates and the recent Department of Defense Officer of the Inspector General Audits of the Autism Care Demonstration.

Speaker Three: Thank you, sir. Good morning everyone. First, an update on the reimbursement rates. We have calculated the 2018 National ABA reimbursement rates for each geographic locality and the appropriate overseas locations. And, as I'm sure you are aware, under Section 716 of the 2017 NDAA, we need to insure that the reimbursement are not less than those that were in effect on March 31st, 2016. So, we have done that. Therefore, the 2018 rates will be the higher of the calculated rate or the rate that was in effect on March 31st, 2016.

Network discounts are not applied to these rates and these rates will be effective May 1st, 2018. We will get those published on the health.mil website shortly. We did run into a bit of a snag. That's why we're a bit late in getting those posted. When the budget deal was agreed to and signed by President Trump on April 23rd, about 52 locations had a change in their geographic adjustment factor. Which in turn affected the ABA rates. So, we had to go back and recalculate. That's been done, so we're getting the updated rates up to our contractors. And again, we should have that posted within the next few days. Just bear with us on that.

The next issue is just to talk a little bit about the recent DoD IG audits of the former TRICARE North Region. This is an audit that our director for the TRICARE Health Plan requested based on the audit from the South Region. March 14th of this past year, the IG release the report stating that TRICARE improperly paid about \$80 million of \$120 million billed to healthcare providers in the former TRICARE North Region in 2015 and 2016. In the prior audit in the South Region, the IG also identified improper payments for ABA services. And in that region, the IG projected that we improperly

paid about 2 million of 3.1 million billed. So, as you can imagine, that got our attention. That's about 2/3 of all ABA payments reviewed by the IG were improper. This is primarily due to medical records either lacking the documentation to support the claim or having insufficient documentation. One of the reasons why we didn't detect this is because we didn't have, in our policy, a requirement for our contractors to do a comprehensive review of claims and records documentation. We've corrected that. We put in our policy this past December and our contractors will start doing those audits or reviews to make sure that we are properly paying on the ABA claims.

We felt this was a very worthwhile initiative. And again, we've used feedback from the IG to revise our policies. And that's found in the TRICARE Operations Manual (TOM), Chapter 18, Section 4, Paragraph 17.4, which is publically available on the web.

It's important to note that the lack of adequate documentation is concerning to us not only because of the inability to justify the payments, but because it's impossible to demine the quality of care provided when the documentation is lacking. So, again, we're going to use the results to further improve our quality monitoring and oversight of the ABA program or the ACD to ensure that we are properly paying for the services that are being provided to our beneficiaries.

So, we are looking at further policy revisions in the future to detect potential fraud waste and abuse and improve the effectiveness in our program. With that, I'll turn it over to (Speaker Two).

Speaker Two:

All right. I will start with rounding out with what (Speaker Three) just talked about with the IG report and then I will go into some manual reminders, the TOM manual reminders, that we published last December that are currently effective, and then I will talk a little bit about the plan going forward and kind of give you a preview of the concepts that we are considering.

To circle back to the end of (Speaker Three)'s piece about the IG reports, some of you may or may not know we presented last week at the annual Association of Professional Behavior Analysts (APBA) annual convention. And we did a presentation on medical records documentation and we're finishing up those slides and we will post them on the web as well. We believe we got some good feedback and I got the impression that there was a lot of dialogue afterwards and people kept asking questions for clarifications. I think this is a good opportunity to provide what would be expected in a medical record.

Just to give the highlights of what you guys will see on a slide deck that we will publish is in each CPT code - what are we looking for when it comes to a progress note or a treatment plan: the name of the beneficiary, name and signature of the rendering provider, date of the session, time of the session,

and then the contents of the notes should reflect, obviously, the purpose of the session. Who was there? What was done? What were strengths and weaknesses? Anything notable? All of this will be available in the slide deck. I just wanted to recap some of the highlights.

But really, this is coming from the findings of the IG report, where, like (Speaker Three) mentioned, its lack of documentation. But there are other kinds of several glaring things too that I'll just, I guess, recap for everyone. Lack of documentation was obviously one critical component. No note means we can't prove that there was a rendered session. That's one element. There were also services that are not TRICARE covered benefits that were documented. Which, obviously, we cannot reimburse. There are unreliable documentations. And what I mean by that is cutting and pasting from session-to-session-to-session. Not that the goals necessarily, these may not change from session to session, but the rest of the contents of the note should reflect what happened in that session, so should be different for each session. So, if I see a holiday-related activity noted when there's another time of year, that's concerning to us that the note was perhaps cut and pasted.

I think the last point I want to make about the IG reports is the concept of improper payments. That's a consciously chosen word. The idea is that there are a lot of criteria that one has to meet to create a fraudulent claim. And so, we want to make the distinction that not everybody will have criminal activity that comes following a claim, but there will definitely be some sort of follow up. Whether it's in the form of an audit, whether it's in some sort of communication of documentation improvement, but I want to make sure that everybody hears the distinguishing terms between improper payments and then fraudulent. Keep that in mind.

Now I'm going to cover to what's currently in the TOM, the highlights that I hope everybody's tracking that are the changes, and really recapping what (Speaker Three) said: regarding paragraph 17.4. That is the requirements of the contractors to review the statistically representative a sample audit on all of the notes and claims. That's one of the big ones. The other big one is that the Social Responsiveness Scale was added. That is the other every two-year outcome measure that will be required.

The other big one is the addition of the T1023 code, which is the code that we had to make up for this demonstration for the authorized ABA supervisor, generally the Board Certified Behavior Analysts (BCBAs) or BCBA-Ds, because there was the comparable CPT code under the category I codes, the psychometric code, because this code wouldn't be applicable to this provider category. T1023 is the code that BCBAs get to use. One unit for each authorization period for the Pervasive Developmental Disorders Inventory (PDDBI) and then one more unit each when a specialized diagnosing provider is unable to meet the requirement of the every two-year

outcome measures. That's for the Vineland and the Social Responsiveness Scale (SRS). The specialized ASD diagnosing provider will submit a referral to the contractors for them to issue an authorization to a specific BCBA, who can in fact complete those two measures.

I haven't really run this part by the team, but I think it would be a really good idea. If you are a BCBA who has experience, who wants to, who is available to, who has the materials already ready, contact your regional contractor and let them know and, should the referral come through, you could be on that list of somebody who's already ready to assist and then the contractor, hopefully, will issue the authorization. And one unit per measure to complete that.

A reminder that the SRS requirement became effective January 29, 2018. Those [beneficiaries] coming up on their two-year cycle will be required to complete those measures. The other highlight is we received a lot of questions regarding the CPT code 0368 and 69 and that's the Adaptive Behavior Treatment Protocol Modification code. We made some revisions to that [code], which has shed some light on the confusion that we created, so I want to take a minute to review and go back through what are the acceptable scenarios. There are four that are described in this December '17 publication. The first three are where the beneficiary is required to be present. The BCBA works directly one on one with the beneficiary and that's where they're doing treatment modifications right on the spot. The next one, again, the beneficiary is required to be present is when the BCBA is demonstrating the new or modified treatment plan to maybe the Behavior Technician (BT) and/or maybe the parents or maybe anybody else on the treatment team that would benefit from the demonstration. The next scenario, again, beneficiary present, is when the BCBA is working to create a transition plan or a discharge plan. That would be another opportunity. And on the last example or option where the beneficiary is not required to be present, although we encourage it, is that the BCBA would lead a treatment team meeting. And this is where the entire team is getting together, talking about what's working, what's not working, where modifications have happened. That was the newest addition because there was a request about who's managing the child or who's delivering care; who's doing what with the child when the team is focused on the treatment plan. That's the other big category to highlight in the most recent manual change.

Now, I'm going to talk a little bit about what's happening, what's in the works. We have some ideas -- from the Request for Information in the Industry Day. Probably for the last -- definitely for the last four years, but over the course of the last several months in particular, we have received lots of feedback about ways to enhance, ways to shape, [and] ways to revise various elements. And I want to highlight the ones that we can broadly talk about because I think that everybody is consistently in agreement. Going

forward, we really want to have a bigger parental piece. How that is going to look exactly, we're not sure as none of this information is approved yet. But how to get parents more involved in, not only the delivery of care, but the understanding of ABA and maybe their own mental health.

I recently heard a quote by an active duty sponsor where his child was receiving services and he said, and it really has stuck with me, he said that everybody needs to be taking care of themselves; parents need to be taking care of themselves as. If you're burning out, if you're struggling, you're going to have a hard time supporting the rest of your family. And he used the analogy, this is what sticks out, that if you're on a plane, before you take off, the flight attendant gives the safety briefing in the beginning and she/he says, if the masks come out from the roof the airplane and you're supposed to put your safety mask on first before helping other people. And so, that really has stood out to me as something that this demonstration really has not highlighted or not encouraged, really not focused on. Going forward, there will be a huge parental piece. Again, getting parents to feel better for themselves, be stronger, be more confident, and feel competent, not just confident. That's a big component going forward.

Along with that, there are a whole host of other services that TRICARE offers. Both as the medical benefit, but through some of the other supplemental options and we're going to try and figure out how to tie in some of those services. Not just for the child with the diagnosis, but the siblings and the caregivers and the parents and maybe other prominent figures that are within the home of the beneficiary, for the care giving role of this beneficiary population. Some of that, too, will be trying to connect more folks to specialty services, maybe cover more conditions that are really outside of the scope of the Primary Care or the Speech and OT or even outside the scope of ABA. Those are some of the big notable enhancements.

The other is to improve quality monitoring and oversight. Obviously, the IG reports have told us we need to do a better job, so we are going to do that. And I think that's all I have.

Speaker One: Sure. Thank you, (Speaker Two). I appreciate that.

As she said, a lot of big changes coming. I think that didn't even scratch the surface. And we look forward to talking with you more about those [changes]. At this point, we'd like to go into answering your questions that you've submitted. And again, very much appreciate all the great questions that we got. And looking at the time, I think we should be able to get through most, if not all, of them.

I'll go ahead and take the first one, and then we'll kind of go around. The first question was on the topic of Case Managers and the question was: "Providers have not been informed of the organizational system used for Case Managers and how they are assigned clients and their authorizations.

Can you please let us know who our Case Managers are” -- I’m assuming you mean the Case Managers for the children you’re taking care of -- “so that we can know who’s handling each case?” At this point, we are still working on that as part of the transition. The process of identifying and assigning Case Managers for these children is currently in development. I can’t give you an absolute definite answer at this time because it’s still being worked. But we will definitely send you an update. We’ll post it on the website. We’ll post it with the Q&As as soon as this process is in place and final. Keep an eye out and we hope to have that for you very soon. And I’m going to then turn things over to (Speaker Two).

Speaker Two: Sure. The next topic -- the next two questions fall under the same topic of claims filing. I’ll take the first question and then I’ll punt the other one to (Speaker Three). I’ll read the question. It is: “Does each individual provider need their own initial code or should only one initial code be billed for each service per day per group?” Currently, my understanding is that the contractors have their system set up that in the paired codes that you bill the initial code once per day and that every other rendering provider bills the second code. I recognize that’s confusing. We’ll have to get back with the contractors about if that’s even a process we can modify or change. But that is something we’re definitely tracking and recognized that that needs some additional work. (Speaker Three)?

Speaker Three: Thank you. The next question also has to do with claims filing. The question was, “What is the expected timeframe for a corrected claim? I get a different answer with every representative.” First, I would encourage you to continue to work with your respective contractor representatives and what we will do is we’ll go back to the contractors and find out how quickly they are reprocessing corrected claims and we will put that answer when we post the Q&As.

The next question has to do with co-pays. “We would like to know if clients are supposed to have multiple co-pays per day. For instance, if they see two Registered Behavior Technicians (RBTs) in one day, would they have separate co-payments for each?” In answer to that question, there should be only one co-pay per day for the same service. For example, if ABA services are being delivered in multiple sessions per day (and we do know this was an issue and that beneficiaries were being billed for multiple co-pays) [that there should be just one copay]. We’re working with our contractors currently to resolve this and we hope to have an update and a final resolution when we post the Q&As in the next week or two.

(Speaker Two), I believe the next one is yours.

Speaker Two: Yes. Actually, the next handful are mine. I hope you can bear with me. The next couple [of questions] are about CPT codes. I will read the question and then, obviously, share the answer. The first one is, “What is the

reimbursement rate for T1023 and what date did that go into effect? In the manual, I can get the reference in a second here - but in the manual for the reimbursement for T1023, the reference is paragraph 13.6. That code shall mirror the geographically adjusted reimbursement rate for the CPT code 96102. That's the psychometric code for -- there are three in that series: 96101, 102, and 103. We have selected the 96102 because that most closely mirrors the provider level and ask of the task. You can find that rate at, it's a long website address, but if you Google "CMAC rates", and the first item that comes up is the link to the TRICARE CHAMPUS [Maximum Allowable Charge].

Speaker One: Yes. Costs.

Speaker Two: That's the first one that comes up and you will be able to click a couple of links, you have to accept going in. You have to click procedure pricing, and then it will bring you to a page where you can put in your state, your zip code, your city, your address, essentially kind of how to narrow down to your area, and then it will ask you to enter the CPT code that you're looking for. And so you would put 96102 and then click submit and then it will bring up a table. It's, I believe the last four, possibly five years, but you're obviously looking for the one for this current year. And it has four columns. There's Facility/Physician, Facility/Non-physician, Non-physician/Non-facility, and Non-Facility/Non-physician. Essentially, forget the facility ones. None of that applies to essentially anybody on this call. You're looking at the right two columns for reimbursement and the top line, you'll be able to see your reimbursement rate.

To answer the second part of the question: "What date did this go into effect?" The manual was published December '17 and its "effective" date was January 29 of this year. Any time you're using the T1023 for the PDDBI, you can go to the CMAC Rates website and you can see what you expect to get reimbursed.

Again, a reminder that you only get one authorization, one automatic unit authorization per six-month authorization period. And that's for the PDDBI except for the first one. You will need to submit the parent form and the teacher form to get reimbursed for that code. The regional contractors may issue a second or possibly a third unit if you are assigned to do the Vineland or authorized to do the Vineland and the SRS. Please, please, please do not bill more than one T1023 without an authorization as those units will be denied.

All right. Next question: "We frequently need to make changes to the treatment plan multiple times between the six month assessment and treatment plan updates. What codes can we use and how often can we use that? We consider this a requirement for quality of our programs." Modification to the treatment plan should be occurring throughout the six

month period and changes to that treatment plan, like I gave the four scenarios, should be demonstrated pretty regularly to the team members, which includes the tech and the assistant and the parents or other caregivers. This code is that 0368T and 69T. Again, this is essentially like the quality of the program. Every authorization should really be requesting these codes. We have seen some authorizations come in where no units are being requested and I would highly encourage everybody to request as many as you want. Because this a good one to use. This is something that allows you the in between the 0359Ts, those six month assessments, to really make changes and get reimbursed for them.

In regards to how often can you use them; I guess it really depends on the beneficiary. You might have a child who is moving so quickly that they need to be seen twice a week. That might not be unreasonable, but maybe once a week or multiple times a month. Or you might have a child who is actually really struggling with progress and you might need to be meeting frequently to adjust the treatment plan or revise the goal or the targets that you are working on. I don't know that I have the answer of how often can you use it. I think it really needs to match what you're doing with the program and then where the child is. I really want to reiterate using this code. It's a good one. There are lots of ways to use it.

I will say, the one place we've recently got questions is about developing of materials. This is not a code, none of these codes are about material development. This is about the program and about the changes to the program. Material development is an administrative task that is not a reimbursable activity.

Moving on to the next question: "Do the regional contractors follow the daily unit restrictions for all of the CPT codes? The 60, 61, 64, 65, 68, 69, and 70?" Yes. Those daily units are called "medically unlikely edits" set by CMS, not by us. The contractors are supposed to follow those units. I think everybody is familiar with the 64, 65, those together are allowed for up to eight hours per day. And I think the other ones have something like several units per day. Yes, they should be following them, but they are pretty liberal in the allotment.

Next question is about documentation. "We keep graphs in our internal electronic health record, but are they required on the document submitted for treatment plan reviews?" I would say that really any documentation that you have to support your treatment plan is good to submit. Especially if you're highlighting it in your treatment plan as a critical variable. Session-to-session like data and charts like that, I would only submit those if you're being requested for the audit of your session notes. I don't think we need those day-to-day data sheets or maybe not long-term tracking graphs.

Next question is about hours per week. “How should the units be approved for authorizations? Is it a total number that can be used over the entire date range?” I’m assuming the question is about the six-month authorization period. “Or biweekly or bimonthly units approved with no carryover?” At this time, the contractors each have their own way of managing that. We haven’t dictated any of that in the TOM. But remember, conceptually, you are recommending hours per week. You really should be sticking to that. If a child needs 20 hours per week, they should be getting 20 hours per week. If they can’t make the 20 hours and, let’s say, do 10 or 15. That’s, obviously not what is recommended. But then making that up, on the flip side of it, that’s also not recommended. However you receive them, whether it’s by week, by month, or by the six-month authorization, you have documented a request for X number of hours per week. That’s what they should be adhering to. I think that answers that.

The next question: “Are IEPs required?” For those of you who have been with us long enough, you have known that there has been much discussion over Individualized Education Programs (IEPs) and the current language in the TOM is that they’re required only if the treatment is requesting TRICARE-reimbursed ABA services in the school setting. And remember, the language in the TOM is that the parents need to voluntarily submit that. Without the IEP, if you’re requesting in-school hours and there is no IEP, they will not be approved. I think we’ve talked at previous provider meetings that there really is a multi-purpose for that request to ensure we’re not duplicating services, to ensure that we’re not conflicting with services, to ensure that they’re actually medically necessary services. There’s good justification and rationale for that requirement.

The next couple [of questions are] on outcome measures. “How old can outcome testing evaluations be for it to be valid? For example, within the two-year period.” The Vineland and the SRS are required at baseline and then every two years thereafter. Essentially, we’re hoping to get it as close to starting services as possible. And then some time within that next two-year period. But you really want to do it so there’s actual demonstration of progress. Or at least with the hope. So, doing it within six month -- while some of these measures can be repeated within six months, it really isn’t in the best interest of demonstrating the objective of the outcome inclusion. I would say that you should shoot for the two-year period. Obviously, if you are trying to get before the next authorization, you want to do it before two years are up. But really, that window is to -- the intent is to allow for the entire window to get that appointment, to see the provider, to get all that required documentation, report outcomes to the provider. So that the provider can submit into the regional contractor.

Okay. The next outcome measures question is, “Why do some clients require the Teacher PDDBI and some do not?” I’m not really sure the origin of this question because it’s required of everybody except at initiation of

services. Essentially, everybody, unless you're brand new to the ACD, everybody is completing both the parent and the teacher form and submitting both every authorization period. And we've allowed for the BCBA, if the teacher doesn't or isn't able, can complete that form and get reimbursed for it.

Next outcome measures question: "Is the Vineland required at the start of services or just after the first two years?" The answer to that is yes. It's required at baseline and every two years thereafter.

Last outcome measures question, I promise. "Does the physician need to submit a referral for the assessment authorization?" So, if I can draw everyone's attention to paragraph 8.1.1.2, the specialized ASD diagnosing providers are the ones who are supposed to be completing the outcome measures. And, if they cannot do that in a timely fashion, and that is at baseline or within that first year -- then they are to submit a referral to the regional contractor to issue an authorization for an outcome measure to be completed by another appropriately trained provider within their scope of practice for that provider. That will probably be those folks on the phone right now. BCBA says it is a -- both of those measure are chosen because of the qualification level that most BCBAs meet. That's why we chose some of those measures. And I think I've said it a couple times now, please do not complete either the Vineland or the SRS without an authorization or you will not get reimbursed.

Okay. I will stop talking for just a few questions and pass it back to (Speaker Three).

Speaker Three: Thank you, (Speaker Two). All right. The next question has to do with points of contact at WPS, the claims processor for Humana. And the question states, "Is there another way to contact WPS? Their voicemail says to call the basic Humana Customer Service line, but the reps can't answer my questions about if the paperwork sent to WPS for RBTs to get into the billing system has been processed." First, all inquiries should be directed to your regional contractors and they should be able to answer your question or direct you to the proper person who can answer your question. We know this was an issue during the transition and we really are hoping that this has been resolved. We've had lots of discussions with Humana about such issues. I would say if you're still having problems with customer service, not just WPS, but any type of customer service and you can't get it resolved directly with the contractor, then you most certainly can contact the ACD team through the ACD mailbox.

Next question has to do with referral and authorization: "Does the physician need to submit a new referral every two years?" The answer is yes. The authorization does not continue after two years of ABA services without a

new referral from the Primary Care Manager (PCM) or the specialized ASD-diagnosing provider.

We have three more questions that I believe are for (Speaker Two).

Speaker Two:

Yes. I want to follow up with your response to the last one. We have heard people say that you can just continue to get ABA every six months, every six months, every six months. That is not true. If you do not go back to your diagnosing and referring provider at the two-year mark, they will stop. And I realize I'm using the wrong pronoun as "you all" on the phone are not the rendering beneficiaries. But please remind your beneficiaries to not wait to the last minute to make that appointment. Most of these providers have appointments open many months in advance and it would behoove them to think about that well ahead of time.

Now I'll answer the last few questions. This question is, "Can a Board Certified assistant Behavior Analyst (BCaBA) be a supervisor on a case?" And the answer is BCaBA cannot supervise a case independently under TRICARE. While that is one of our rules, it's also one of the credentialing bodies' rules that they cannot be practicing independently. Having said that, assistants can actually assist the BCBA, but they can't do it independently. And that responsibility has to be delegated. So, the person who signs off on the assistance, supervision form and I think there's an attestation form. I may be wrong on that. Essentially, there is somebody responsible for every tech and assistant and that's usually the BCBA. So, no, a BCaBA cannot independently do anything for us.

The next question is about BT Supervision. Essentially, "is BT Supervision required?" All BTs, every single one of our BTs, must be supervised at least 5% of their direct service time during a 30-day period for every child or every beneficiary that they see. All treatment plans that have BTs rendering services must meet this minimum 5% requirement. This is a little bit different than the BACB requirements. And I believe the other two accrediting bodies have similar requirements. That is, 5% of their total time. For us, our focus is the beneficiary and we want to ensure that every single tech, that every single supervisor is observing every single tech for each of our kids. We place a lot of value and stake in that. And maybe as we move forward, there will be an opportunity for revision, but at the current time, [supervision for] every tech with every beneficiary, at least 5% over a 30-day period [is required]. And that's clearly spelled out in the TOM as well.

The last question I have is about the treatment plan. "What are the required documents for submitting a treatment plan at the every six month mark?" For continued authorization, the contractor should receive the updated treatment plan and the PDDBI and whatever other graph, charts, information that you are updating. But if you are also completing the Vineland or the SRS, that would be at the two-year interval. I have no idea where people are

and where beneficiaries fall. If you are the BCBA and you have an authorization to complete those two other, the Vineland and the SRS, those should be submitted at that time too. Really, anything that you are highlighting in the treatment plan should be submitted for the next review and authorization.

That's all I have for submitted questions. (Speaker One), back to you.

Speaker One: Thank you, (Speaker Two). Appreciate that. I have a few closing remarks, but before I do that, I wanted to talk just a little bit more about some of the pending changes. And as I mentioned, we've been getting input from a lot of people. But, certainly, we want to encourage everyone on the call, we'd love to hear from you about your ideas about how we can make the ACD better as well.

So, I'm going to talk about just a few more things that we're considering and ask for your input. I'm going to give you the ACD e-mail box before we close - and that's a great way to do that, but certainly any suggestions or ideas, something that you just think, "Gosh. If they would do this with the ACD, we could give better care to the children we take care of," we would love to hear that.

So let me just talk about a couple other things that we're looking at. (Speaker Two) has already mentioned that we were really focused on improving parental support. Less than half of our parents currently are participating in treatment. At least as measured through the 0370T code. We'd really like to see that go up significantly. So, looking at ways that we can encourage parents to participate and become an active partner in their child's treatment. Also looking at ways we can support the parents themselves.

Some other areas that we're looking at is how we can improve utilization management. And what does that term mean? Well, utilization management is basically a process by which we ensure every child and family receives the right services at the right time; to ensure every child can reach their maximum potential and that we also direct our resources where they'll do the most good. So, really, the goal there is to ensure that we're doing the most amount of good that we can for the children with the resources we have. We're looking at ways to make sure we're doing that for every individual child.

Also want to make sure that we have strong provider networks. That we have access to high-quality timely services and looking at are there ways that perhaps we can have preferential networks; so that if there are groups of providers that can provide a lot of care across an area, we'd like to look at maybe having a special contract with those providers to see if we can improve access that way.

Really looking too with care coordination and case management. That was one of the questions, of course, that we talked about. We really want to beef that up, so that every parent, every family, has someone that they can go to ask questions about the program, learn about autism care, and make sure that they have someone that they can trust to go to for questions about everything dealing with autism. That that person is the same person over time.

Also, really want to emphasize the support to the family over the first six months because we know that receiving a diagnosis of autism for your child can be a very devastating thing. I think many times, once parents start to understand more about the diagnosis and there is in fact hope that gets better. But we think that first six months is a really critical time to help the family. So, we're focusing on how we can do that well.

Always looking to improve our outcomes measures. We really want to be able to show that the impact that this program is having and is it helping children and how can we make it help children better. So, looking at the outcomes measures. And I think it was also mentioned, we really want to improve respite care. We think respite care is a very critical part of taking care of the family and the child. They do have access to the ECHO respite care benefit now, which is 16 hours per month, but very few of our families actually use that. And, of course, retiree families are not eligible for that at this time. So, we're looking at making retiree families eligible for respite and, also, looking at how we can make respite a more useful benefit that can help families deal with the stress of being in this situation.

All that we're looking at including, all that possibly under the demonstration, as we rewrite the autism demonstration. Certainly looking at also including things beyond Applied Behavior Analysis. Right now, that's pretty much all the demonstration provides. That's certainly a very important component. We're going to keep that, let me emphasize that. But certainly looking at are there other ways to help families and children with autism spectrum disorder and making sure that we are open to all different types of treatment services that can benefit children with autism.

With that, again, we really encourage you to give us your feedback. Send us e-mails. We definitely read all of the e-mails we get when you send to the ACD mailbox. All of us get that: (Speaker Three), (Speaker Two), and I plus our Behavioral Health Leads at the regional offices. We all see those e-mails. We read them. We discuss them. So, your input is definitely valued and we do use it.

With that, let me move on give you a few closing remarks. First of all, very much thank you again for joining us today. And more importantly, though, for the great work you do for providing services to military children and their families with autism. I've -- if you've heard me before, you know I've

said before that I'm convinced we have the best autism care program anywhere in the country. I certainly still believe that, but we also know that we could not be the best without all the great work you do helping these children and their families. So, thank you for that.

I'd also like to thank our outstanding autism care team. We introduced them a little bit ago, but as I think you can tell from the information they provided and the presentations they gave here, (Speaker Two) and (Speaker Three) are both just outstanding. They are really the architects of the Autism Care Demonstration and they are really key people in helping us revise and rewrite the Autism Care Demonstration and make it even better. So, I certainly want to thank them for all of the outstanding work they do. We would not be here without them. And certainly that also includes, again, our Behavioral Health Leads at the regional offices, who also provide great work to this.

Last week, as I think (Speaker Two) mentioned, we had the privilege of meeting many of you at the APBA annual meeting in St. Louis where we did give a workshop on the ACD. What I want to commit to you is that we are going to continue to be transparent and communicate with you regularly and keep you updated as we move forward on making the changes to the program. We think getting your involvement and keeping you informed is critically important. And so, through presentations like we gave in St. Louis, provider information meetings like this one, our website, and as many other venues as possible, we're committed to ensuring that we are as transparent and are keeping you informed. I will tell you that our goal right now is to have the new manual changes published and the new program implemented by early 2019. And I think we're going to make that. Again, we have very committed folks here who are doing hard work. We have leadership commitment to make this happen. I am absolutely convinced we will make that.

And also, that, of course, means that we'll still have almost five years in the demonstration to work through these new changes and see how they work. Which I think is very important.

We noted that during our workshop last week for us having the best program in the country is not good enough. When we're working with military beneficiaries, we are always trying to get better. That's why we're making these many changes we discussed today. So that we can ensure we do everything we can to help military children and their families with autism and give them the very best care available anywhere.

We again, we appreciate your thoughts and ideas. I'm going to give you the Autism Care mailbox. I'll repeat it twice, so you have a chance to write it down. It is dha.acd@mail.mil. Again, that e-mail is dha.acd@mail.mil. Again, please let us hear from you. We thank you very much for your time

today and for all of your support for the program and our beneficiaries. We hope you have a great day. Thank you.

Coordinator: Thank you for your participation. You may disconnect at this time.

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