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MEMORANDUM

To: Individuals Who Commented on Regulation 14-07
Requirements for Payment of Autism Spectrum Disorder (ASD) Services

From: Roderick L. Bremby, Commissioner
Department of Social Services

Date: May 19, 2015

Re: Response to Comments on Regulation 14-07 – ASD Services

The Department of Social Services (DSS) responds to public comments received concerning the proposed regulation referenced above. The Notice of Intent for this regulation was published on the Secretary of State's website on December 29, 2014. A copy of the regulation with revisions based on public comments and DSS's other revisions is attached.

GENERAL COMMENTS

1. Comments Regarding Medicaid State Plan Amendment

Comment: In addition to sending comments on this proposed regulation, several commenters also sent comments on the related Medicaid State Plan Amendment (SPA) 15-004.

Response: Because the substance of the comments on the regulation and the SPA overlap substantially, all of the comments and responses to the SPA and the regulation are, in effect, included in this document.

2. Section 17b-262-1052 (Definition of Applied Behavior Analysis)

Comment: Add a definition of applied behavior analysis (ABA).

Response: A definition of ABA is already included in the regulation.

3. Section 17b-262-1052 (Definition of ASD Treatment Services)

Comment: One commenter requested to remove the phrase "such as evidence-based ABA interventions that meet the criteria in one or more of such subparagraphs" from the definition of ASD treatment services and that commenter also requested to avoid any text that ABA therapists are the only profession that is able to assess individuals with ASD.

Response: DSS declines to make the requested revision because that language is listed as one example of a variety of ASD treatment services and for illustration purposes. ABA is specifically listed as an example because it is a very common treatment modality for ASD. The same general evidence-based criteria apply to all services, including ABA.

4. Comment Regarding Work Group

Comment: Applied Behavior Analyst (ABA) providers should have been invited to work group meetings.

Response: DSS met extensively with an inter-agency work group of clinical and policy staff from the Department of Developmental Services (DDS) and other state agencies. This group included state agency employees, a state agency consultant, and a state agency contractor, and among whom were clinicians with expertise in ASD services, including ABA, and a Board Certified Behavior Analyst (BCBA). One provider was included, but in his capacity as a DDS consultant, not in his capacity as a provider. This approach ensured that a variety of expertise and perspectives were included in discussions without favoring one specific provider or group.

In addition, DSS and DDS presented an initial plan for ASD coverage, which is the subject of this regulation, to the Autism Spectrum Disorders Advisory Council on October 22, 2014. Additionally, DSS and DDS discussed various details of the proposal in depth at multiple subsequent meetings of the ASD Advisory Council later in 2014. The ASD Advisory Council includes providers (and providers of in-home ASD services). DSS and DDS, along with the various other state agency partners, carefully considered the feedback from the advisory council in developing these regulations and incorporated many of their comments and concerns in the revised regulations.

Finally, pursuant to the Connecticut Uniform Administrative Procedure Act, DSS accepted public comments during a thirty-day written public comment period and at a public hearing on the proposed regulation that was held on February 10, 2015.

5. Comments Regarding Overall Requirements

Comment: Do not impose requirements more stringent than the requirements imposed by other payers for the same or similar services (such as commercial insurance, Birth to Three, DDS autism waiver, and other states' Medicaid programs).

Response: DSS declines to make specific revisions based on this comment because the requirements in this proposed regulation are appropriate for the Medicaid program. There are a variety of differences between Medicaid and other programs, which means that the specifics of each program should also differ. For example, commercial insurance has a variety of different types of cost-sharing, different overall benefit packages of covered services, different network

rules, and different overall volume. In addition, the overall Medicaid children's behavioral benefit under the Medicaid State Plan is quite different from commercial insurance, Medicaid waivers, and Birth to Three. There are also substantial differences between Connecticut's Medicaid program and other states' Medicaid programs. Accordingly, while DSS welcomes specific comments and best practices (many of which are discussed below), DSS declines to make specific revisions based solely on a general comparison to other programs. Specific revisions that have been made to the regulations are described below.

PROVIDERS

6. Sections 17b-262-1052 and 17b-262-1058(d) (Add BCaBAs)

Comment: Add Board Certified Assistant Behavior Analysts (BCaBAs) to the list of providers who may perform ASD treatment services.

Response: Under the supervision of a BCBA, a BCaBA is authorized to perform ASD treatment services. Accordingly, BCaBAs are added to the regulation as a category of professional who may perform ASD treatment services under the supervision of a BCBA, provided that the BCaBA must have at least one year of full-time equivalent experience providing ASD treatment services, which experience may occur at any time, either before, during or after the BCaBA receives the bachelor's degree that is required for the BCaBA credential. The BCBA who supervises the BCaBA will need to enroll as a Medicaid provider and can bill for services provided by the BCaBA under the BCBA's supervision. BCaBAs will not enroll separately as Medicaid providers.

7. Sections 17b-262-1052 and 17b-262-1057(d) (Add Speech and Language Pathologists)

Comment: Add speech and language pathologists as one of the types of clinicians that may perform assessments, participate in developing the behavioral plan of care, and provide ASD treatment services, especially in the context of ensuring that an assessment of communications skills and addressing communication break-downs are coordinated with overall ASD treatments and services and other providers.

Response: DSS declines to make this revision. If the evaluation or assessment shows that other services are necessary for the member's needs, such as services from a speech and language pathologist, the provider should refer the member for such other services and coordinate ASD services with those other services. The regulation has been revised to require appropriate referrals and coordination of care, which are already the standard of care for providers. Speech and language pathologist services are already separately covered by Medicaid under the independent therapy benefit category. The requirements for those services are separately described in the DSS regulation regarding independent therapists set forth in sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies. Some of the ASD services included in this regulation may be outside the scope of practice of speech and

language pathologists. Therefore, in order to reduce potential conflicts, DSS is open to consider revising the independent therapy regulation and/or fee schedule if appropriate but declines to add speech and language pathologists to this regulation.

8. Sections 17b-262-1052 and 17b-262-1057(d) (Add Occupational Therapists and Occupational Therapy Assistants)

Comment: Add occupational therapists and occupational therapy assistants as types of clinicians that may perform assessments, participate in developing the behavioral plan of care, and provide ASD treatment services, especially in the context of a holistic approach to take into account the whole person and context.

Response: DSS declines to make this revision. If the evaluation or assessments shows that other services are necessary for the member's needs, such as services from an occupational therapist, the provider should refer the member for such other services and coordinate ASD services with those other services. The regulation has been revised to require appropriate referrals and coordination of care, which are already the standard of care for providers. Occupational therapist services are already separately covered by Medicaid under the independent therapy benefit category, where the occupational therapist enrolls as a Medicaid provider (and may also bill for services provided by an occupational therapy assistant working under the occupational therapist, since occupational therapy assistants do not separately enroll as Medicaid providers). The requirements for those services are separately described in the DSS regulation regarding independent therapists set forth in sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies. Some of the ASD services included in this regulation may be outside the scope of practice of occupational therapists. Therefore, in order to reduce potential conflicts, DSS is open to consider revising the independent therapy regulation and/or fee schedule if appropriate but declines to add occupational therapists to this regulation.

9. Section 17b-262-1052 (Augmentative and Alternative Communication Systems)

Comment: Include augmentative and alternative communication systems as part of the behavioral plan of care and as ASD treatment services.

Response: DSS declines to make this revision. Various augmentative and alternative communication systems are already separately covered by Medicaid under the durable medical equipment benefit category. It is inappropriate to include them as part of this program because the systems are for general use whenever they are medically necessary, not solely in connection with treating ASD. Moreover, the requirements for those services are separately described in the DSS regulation regarding durable medical equipment set forth in sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies. Accordingly, there is no need to add those items to this regulation.

PROVIDER QUALIFICATIONS

10. Section 17b-262-1056(c)(3) (Comprehensive Diagnostic Evaluation Provider Qualifications)

Comment: Remove existing language on providers who may perform comprehensive diagnostic evaluations and remove any experience and educational qualifications. Instead say that any provider may perform a comprehensive diagnostic evaluation if it is within the provider's scope of practice. Alternatively, add additional types of practitioners as appropriate (such as licensed professional counselors or licensed marital and family therapists) to the list of providers who may perform comprehensive diagnostic evaluations.

Response: This regulation has been revised to enable any type of licensed practitioner to perform a comprehensive diagnostic evaluation if it is within the practitioner's scope of practice and the practitioner otherwise meets the general qualifications to perform those evaluations, with an illustrative list of practitioners whose scope of practice includes diagnosing ASD. Licensed professional counselors have been added to that list because their scope of practice statute includes diagnosis, but not licensed marital and family therapists because diagnosis is not listed in their scope of practice statute.

In order to add flexibility, the requirements for these providers have been revised to broadly require that the provider must work within his or her scope of practice to diagnose ASD; must have training, experience or expertise in ASD; and must be qualified and experienced in diagnosing ASD. The regulation has also been revised to remove any requirement for DDS to credential providers of comprehensive diagnostic evaluations.

In the future, DSS may consider adoption of a model for comprehensive diagnostic evaluations based on centers of excellence, where specific clinical centers would be certified as experts in the evaluation and assessment of ASD. These centers would provide standardized diagnostic testing, comprehensive evaluation and multi-disciplinary treatment planning.

11. Sections 17b-262-1056(c)(3)(C) and 17b-262-1057(d)(5) (DDS ASD Credential)

Comment: Remove requirement for providers to receive the DDS ASD credential before performing ASD services. Alternatively, make DDS ASD credentialing criteria clearer and more consistent.

Response: As described in response to Comment 10 above, this regulation has been revised to remove the requirement in former section 17b-262-1056(c)(3)(C) for providers to receive a DDS ASD credential in order to be reimbursed for comprehensive diagnostic evaluations, although providers are still required to meet general requirements for expertise in diagnosing ASD. However, the regulation continues to require all performing providers to receive a DDS credential in order to be reimbursed for providing behavior assessments, developing behavioral plans of care, and providing ASD treatment services. The DDS ASD credential is necessary to

ensure that providers have sufficient expertise and skills to provide high quality ASD services because neither the BCBA credential nor any of the license requirements for the other relevant categories of clinicians ensures that the providers have specific training, expertise, or skills in providing ASD services. The DDS ASD credentialing process is an established method to validate that providers have the necessary expertise and skills to provide high quality ASD services. It is particularly important to ensure that providers are qualified to provide ASD services specifically because ASD treatment services are designed as a home-based model provided by practitioners in independent practice, the large majority of which are intended to be provided by unlicensed and uncertified technicians, with much less opportunity for structured supervision than in an office or institutional setting. Highly qualified providers are also essential because ASD services are very individualized and complex and treatment models continue to evolve based on ongoing research and clinical practice. DSS and DDS are committed to making the credentialing process clearer and more consistent.

Before these regulations were proposed, DDS was already credentialing BCBAs and therefore the requirement for BCBAs to be credentialed by DDS in order to be reimbursed for providing behavior assessments, developing plans of care, and providing ASD treatment services went into effect January 1, 2015. However, because DDS did not previously credential the other categories of performing providers (physicians, advanced practice registered nurses, physician assistants, psychologists, licensed clinical social workers, licensed professional counselors, and licensed marital and family therapists), and in order to promote access to services by enabling DDS to increase its capacity to credential providers efficiently, the requirement for a DDS credential for those remaining categories of performing providers starts January 1, 2016.

12. Section 17b-262-1057(d) (Provider Qualifications for Behavior Assessments, Development of Behavioral Plans of Care, and ASD Treatment Services)

Comment: Remove all BCBA education, supervision, and experience qualification requirements and simply state that BCBAs may provide any services within their scope of practice.

Response: Provider qualifications for BCBAs and all other categories of performing providers who provide ASD services are necessary to ensure that each practitioner is qualified to perform high quality services. The routine training of many BCBAs and other practitioners does not necessarily include extensive exposure to the unique needs of individuals with ASD. In recent years, research has identified better assessment and intervention techniques, and more specialization in working with individuals with autism has evolved. It is particularly important to ensure that providers are qualified for this service specifically because it is designed as a home-based model provided by practitioners in independent practice, the large majority of which is intended to be provided by unlicensed and uncertified technicians, with much less opportunity for structured supervision than in an office or institutional setting.

In response to public comments and other feedback from stakeholders, as well as based upon further internal review and consultation with state agency partners, the regulation has been revised to make the provider qualifications more streamlined and focused. In particular, the

regulation has been revised in multiple ways. First, the continuing education requirement is more flexible and now simply requires continuing education in ASD to be part of a practitioner's certification or license maintenance (compared to the previous version, which required a specified number of hours). Second, the timing has been adjusted, so that the regulation now clarifies that one of the two years of professional experience may occur before graduation from the applicable degree. Finally, the scope and timing of supervised professional experience have been clarified to conform to best practice regarding professional supervision.

13. Section 17b-262-1057(d) (BCBA Qualifications)

Comment: Remove any requirement that treats BCBAs different from the various other categories of performing providers.

Response: The regulation has been revised so that all provider qualification requirements apply uniformly to BCBAs and all other categories of performing providers, with the limited exception of the delayed requirement of the DDS credential to the other categories of performing providers, as described in response to Comment 11 above.

14. Section 17b-262-1057(d)(2) (Professional Experience)

Comment: Remove the BCBA two-year ASD experience requirement. Do not require any experience beyond that required for the BCBA credential by the Behavior Analyst Certification Board (BACB).

Response: Two years of professional experience for all performing providers is necessary to ensure that the practitioner has sufficient expertise to perform high quality, economic, and efficient assessments, plans of care, and supervision of ASD treatment services. In order to increase flexibility and access to services, this provision has been revised to require that only one year of the experience must occur after the individual graduated with the appropriate education. The other year could overlap with pre-graduation experience, including experience required for the performing provider's license or certification. These experience requirements apply uniformly to all providers of ASD assessment and treatment services.

This requirement is also appropriate because it is consistent with the separate general requirements for certain behavioral health clinicians to obtain a license from the Department of Public Health. As an illustration of these separate licensing requirements, licensed marital and family therapists (LMFTs) must complete at least twelve months of post-graduate experience in order to obtain a license (Conn. Gen. Stat. § 20-195c(a)(3)); licensed clinical social workers (LCSWs) must complete at least three thousand hours of post-graduate experience in order to obtain a license (Conn. Gen. Stat. § 20-195n(c)(2)); and licensed professional counselors must complete at least three thousand hours of post-graduate professional experience in order to obtain a license (Conn. Gen. Stat. § 20-195dd(a)(3)).

Those examples of general licensing requirements described above show that the professional experience requirement in this regulation for performing providers of ASD assessment and treatment services is appropriate.

15. Section 17b-262-1057(d)(3)(A) (BCBA Education)

Comment: Remove BCBA educational requirements or modify them to be within the scope of practice for BCBAs. Do not require any education beyond that required for the BCBA credential by the BACB.

Response: The regulation has been revised to remove any specific educational requirements beyond those already required for the provider's applicable license or certification.

16. Section 17b-262-1057(d)(3)(B) (Professional Supervision)

Comment: Remove professional supervision requirement for BCBAs, especially remove any provision that requires BCBAs to be supervised by another type of practitioner. Do not require any professional supervision beyond that required for the BCBA credential by the BACB.

Response: The regulation has been revised to clarify that professional supervision of BCBAs may be provided by another BCBA who already has the required experience. Professional supervision is necessary to ensure that providers are qualified to perform and supervise ASD services, especially because these are designed to be home-based services predominantly provided by technicians. One year of professional supervision ensures that the BCBA or other practitioner has been reviewed and mentored in providing ASD services before being responsible for supervising treatment services and coordinating the implementation of the plan of care.

This requirement is also appropriate because it is consistent with the separate general requirements for certain behavioral health clinicians simply in order to obtain a license from the Department of Public Health. As an illustration of these separate licensing requirements, post-graduate professional supervision is required for LMFTs (Conn. Gen. Stat. § 20-195c(a)(3)), LCSWs (Conn. Gen. Stat. § 20-195n(c)(2)), and licensed professional counselors (Conn. Gen. Stat. § 20-195dd(a)(3)).

Those examples of general licensing requirements described above show that the professional supervision requirement in this regulation for performing providers of ASD assessment and treatment services is appropriate.

17. Section 17b-262-1058(f) (Technician Qualifications)

Comment: Use the credential or some of the requirements of the Registered Behavior Technician credential. Alternatively, make the technician requirements more flexible and workable.

Response: In response to public comments and other feedback from stakeholders, internal review, and consultation with state agency partners, the regulation has been revised to make the technician requirements more flexible. First, the required experience has been reduced to one year (previously two years) for technicians with a bachelor's degree and the experience may occur at any time, including before, during or after graduation. Second, an option has been added for a technician with an associate's degree or equivalent plus two years of experience, which may also occur at any time, including before, during or after graduation. Finally, the continuing education requirement has been made more flexible (especially to accommodate potentially large turnover) to require a smaller number of hours per year rather than a larger number every three years and explicitly includes in-house training.

18. Section 17b-262-1058(f)(1) (Technician Experience)

Comment: Remove ASD experience requirement for technicians. Instead, potentially add a requirement for each provider to maintain professional development training records and descriptions of training protocols, document in-field supervision of technicians, and ongoing professional development.

Response: Experience is necessary for technicians to ensure that they have appropriate expertise to provide high quality, economic, and efficient ASD treatment services, especially because the technicians will typically be providing one-on-one services in the home, only a relatively small portion of which will be observed or supervised by a BCBA or another masters or doctoral level practitioner. As described immediately above, the overall experience requirements have been made more flexible. Finally, as suggested by the commenter, a requirement has been added for the provider to have a professional development plan for each technician.

SERVICE REQUIREMENTS AND LIMITS

19. Section 17b-262-1055(b)(3) (25-Hour Weekly Limit)

Comment: Remove the twenty-five hour per week limit on ASD treatment services, which under existing language could be exceeded by prior authorization based on medical necessity.

Response: The regulation has been revised to remove this language.

20. Sections 17b-262-1056(b)(3) and 17b-262-1060(d)(3) (Medical Evaluation)

Comment: Do not require the medical evaluation (formerly described as a "medical/physical evaluation") before ASD treatment services may be delivered. Leave that decision up to the relevant providers. Alternatively, potentially require simply a physician sign-off on the diagnosis.

Response: DSS declines to make the requested revision. Requiring a medical evaluation before ASD services are provided is necessary to ensure that each member's care is appropriately coordinated and appropriately tailored to each individual by taking into account the individual's overall health and conditions, including those other than ASD. This overall medical evaluation is particularly important because there are medical and genetic conditions that can contribute to and/or cause behavior that resembles autism (*e.g.*, fragile X syndrome, hearing loss). The July 2014 Informational Bulletin regarding ASD services in Medicaid from the U.S. Centers for Medicare & Medicaid Services (CMS) also indicates that "Good clinical practice requires ruling out any additional medical issues and not assuming that a behavioral manifestation is always attributable to the ASD." *See* CMS, Centers for Medicaid & CHIP Services (CMCS) Informational Bulletin, Clarification of Medicaid Coverage of Services to Children with Autism, July 7, 2014, p. 4, available at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf. Finally, standard early and periodic screening, diagnostic and treatment (EPSDT) guidelines provide for routine medical evaluations. These evaluations are provided on a regular basis to many Medicaid members. For technical clarity, the term medical/physical evaluation was revised to medical evaluation.

21. Sections 17b-262-1056(b)(3), 17b-262-1057(b)(4), and 17b-262-1060(d)(3) (Steps Required Before Treatment)

Comment: Do not require multiple steps (medical evaluation with screening, comprehensive diagnostic evaluation, behavior assessment, and development of the behavioral plan of care) before treatment may be provided.

Response: Multiple steps are required (although with additional flexibility as described below) before ASD treatment services can be provided in order to ensure that treatment services are appropriately tailored for each member's unique needs, which is critical because of the complexity of ASD and the substantial variability in appropriate treatments for each child. Collectively, all of the required steps before treatment (medical evaluation, comprehensive diagnostic evaluation, behavior assessment, and behavioral plan of care) coordinate ASD services with the member's overall health, rule out other conditions, establish an accurate and precise diagnosis, assess the member's needs, and develop a clear plan for treatment that is individually tailored to each member's unique needs.

Medical Evaluation: A medical evaluation before treatment (and also before the comprehensive diagnostic evaluation and behavior assessment) is essential for the reasons described in response to Comment 20 immediately above.

Comprehensive Diagnostic Evaluation: Completing a comprehensive diagnostic evaluation before treatment services is essential to confirm that the member actually has ASD, establish a precise diagnosis, and determine overall treatment recommendations, while enabling providers to refer members without autism to more appropriate services. Establishing a diagnosis of ASD is a complex process requiring consideration of medical factors, developmental history, and current

functioning (including social skills, communication, behavior, cognition, academic performance, and adaptive competencies). It requires a range of techniques such as medical evaluation, standardized testing, interviewing the family, observational ratings, and direct interaction with the child. In order to increase flexibility, the comprehensive diagnostic evaluation no longer needs to be performed before the behavior assessment, so long as both of them are performed and documented before DSS receives a prior authorization request for ASD treatment services.

Behavior Assessment and Behavioral Plan of Care: Ensuring that each member has a behavior assessment and behavioral plan of care before receiving treatment services is necessary to tailor treatment services to each child's unique needs. Building upon the comprehensive diagnostic evaluation, the behavior assessment (and, in turn, the behavioral plan of care) determines which interventions are likely to benefit each child. As noted above, in order to increase flexibility, the comprehensive diagnostic evaluation no longer needs to be performed before the behavior assessment, so long as both of them are performed and documented before DSS receives a prior authorization request for ASD treatment services.

In sum, the three-step process presented above is necessary to rule out medical problems, establish a clear diagnosis, and create an appropriate individualized treatment plan that recommends services that are appropriately tailored to each member's unique needs.

22. Sections 17b-262-1056(b)(3) and 17b-262-1060(d)(3) (Comprehensive Diagnostic Evaluation Required Before ASD Treatment Services)

Comment: Remove requirement for the comprehensive diagnostic evaluation to be performed before ASD treatment services are provided.

Response: The comprehensive diagnostic evaluation needs to be performed, updated or confirmed before ASD treatment services are provided in order to ensure the member has an accurate and detailed diagnosis of ASD and ensure that services are appropriately tailored to the member's needs.

In order to increase flexibility, the regulation has been revised in multiple ways. First, the comprehensive diagnostic evaluation must be performed or updated not more than thirty-six months before ASD treatment services are requested (the regulation previously required the evaluation to be performed or updated within twelve months of the request for ASD treatment services). Second, the regulation has been clarified that this requirement applies to the initial request for ASD treatment services, not requests for continued services. Third, the language regarding confirmation of an evaluation that was performed more than thirty-six months before the request has been clarified to avoid potential ambiguity.

See also response to Comment 21 above.

23. Section 17b-262-1056(c)(4) (Comprehensive Diagnostic Evaluation Timing)

Comment: Do not require a new or even confirmation of a comprehensive diagnostic evaluation when one has previously been performed for the same member.

Response: The regulation has been revised to clarify that any comprehensive diagnostic evaluation performed or updated within thirty-six months of the initial request for ASD treatment services is sufficient (the regulation previously required the evaluation to be performed or updated within twelve months of the request for ASD treatment services). For evaluations performed more than thirty-six months before that request, it is necessary to have a formal confirmation or update of the evaluation because clinical situations can change substantially over long periods of time and it is critical that ASD treatment services are based on a diagnosis that is still accurate at the time of treatment. In addition, genetic research is rapidly expanding, which means that updated comprehensive diagnostic evaluations may be medically necessary as genetic causes of ASD are identified.

24. Section 17b-262-1056(c)(4) (Comprehensive Diagnostic Evaluation Timing)

Comment: Do not require repeated comprehensive diagnostic evaluations after the member has already started ASD treatment services under Medicaid.

Response: It was never the intent of the regulation to require repeated comprehensive diagnostic evaluations after the member has already started ASD treatment services. The regulation has been revised to clarify that repeated comprehensive diagnostic evaluations are not required after the member has started ASD treatment services, so long as there is no indication that the diagnosis has changed substantially.

25. Section 17b-262-1057(b)(4) (Behavior Assessment Timing)

Comment: Extend the time period that a behavior assessment is valid for starting ASD treatment services to one year.

Response: An individual's specific behavioral conditions can change substantially, even within six months and is much more likely to change in a short period of time than the diagnosis. Accordingly, the regulation continues to require a behavior assessment to be performed *or updated* not more than six months before submitting the *initial* request for ASD treatment services. In any case, if a member's condition has not changed substantially, then the provider could simply perform a very brief update to confirm that the existing behavior assessment is still appropriate. See response to Comment 26 below regarding behavior assessments after the member has begun ASD treatment services under Medicaid.

26. Section 17b-262-1057(b)(4) (Behavior Assessment Timing)

Comment: Do not require repeated behavior assessments after the member has already started ASD treatment services under Medicaid.

Response: The regulation has been revised to provide that after ASD treatment services have begun, the provider shall review the behavior assessment on an ongoing basis (and at least every six months) and, only *as necessary*, update the assessment. Accordingly, if a member's condition has not changed, then the provider could simply review the assessment to confirm that no updates are needed.

27. Section 17b-262-1057(c)(1) (Provider Performing Behavioral Plan of Care)

Comment: Remove requirement and make optional that the same provider who performed the behavior assessment must also be the provider who prepares the behavioral plan of care.

Response: The behavioral plan of care is the culmination of the behavior assessment, which should generally be prepared as an integral part of the behavior assessment. Accordingly, this provision remains in the regulation because it is best practice for coordination of planning and provision of service that in most cases, the practitioner who performed the assessment should use that experience to develop the behavioral plan of care. In order to add flexibility and accommodate a variety of provider situations and organization, the regulation has been revised to state that the same provider "should" both perform the assessment and prepare the plan of care, but is not required to do so.

28. Section 17b-262-1058 and 17b-262-1060(d)(3) (Timely Access)

Comment: Add a new provision that all necessary evaluations must be scheduled within thirty days of the licensed practitioner's recommendation. If that timeframe is not met, add a provision that ASD treatment services may proceed immediately based on the ASD screen, but that if services are later determined not to be medically necessary based on a later evaluation, the ASD treatment services may be terminated or adjusted as appropriate.

Response: See response to Comment 21 above. In addition, it is essential that each member has an accurate and thorough diagnosis of ASD before ASD treatment services are provided. The comprehensive diagnostic evaluation is critical to ensuring that the services are focused on the member's actual clinical needs. Otherwise, inappropriate, unnecessary, or improperly focused ASD treatment services may be ineffective and potentially harmful.

Requiring a behavior assessment and development of a behavioral plan of care before ASD treatment services are provided are critical to ensuring that the ASD services are provided in a way that is individually tailored to the member's unique needs. A full assessment and plan of care are necessary to make sure this process is done accurately and thoroughly.

Simply starting services based solely on a positive screen for ASD without the comprehensive diagnostic evaluation, behavior assessment, and behavioral plan of care to determine which services are most likely to be effective and appropriate does not tailor services to individuals' needs, nor does it protect members from potentially harmful services.

DSS will continually monitor members' access to all services, including the comprehensive diagnostic evaluation and behavior assessment. DSS is committed to Medicaid members having access to medically necessary services.

29. Section 17b-262-1058(c)(2) (Caregiver Participation)

Comment: Remove minimum requirement for caregivers to participate in at least 50% of treatment sessions, which under existing language could be reduced based on appropriate circumstances. Make this information part of the behavioral plan of care and subject to the provider's judgment.

Response: The regulation has been revised to remove any specific required amount of caregiver participation. This revised language focuses on the provider describing the recommended type and extent of caregiver participation in the behavioral plan of care.

30. Section 17b-262-1058(d) (Caregiver Presence / Availability)

Comment: Remove minimum requirement for caregivers to be present or available when services are being delivered for individuals under age eighteen, especially for older children. Make this decision part of the provider's judgment based on circumstances and to ensure access.

Response: First, the definition of caregiver in the regulation is very broad and includes any individual that is responsible for the care of the member at any given time when ASD treatment services occur, not solely parents or guardians. Second, the presence of a caregiver in or around the home does not mean that the caregiver must participate in the services any more than otherwise required (see response to Comment 29, immediately above). Finally, the regulation has been revised to make this requirement more flexible. Specifically, the regulation now provides that it is up to the provider's clinical judgment to determine if a caregiver must be present for ASD treatment services that are provided outside of the home.

31. Section 17b-262-1059(4) and 17b-262-1063(d)(3)(F) (Relationship to Other Services)

Comment: Clarify this provision to ensure that children who require medically necessary treatment in a school setting have access to such services.

Response: Such a clarification is unnecessary because existing requirements already provide that children receive medically necessary services in appropriate settings, including in the school and as part of a school district's obligations under state and federal law to provide its students with a free and appropriate education.

The referenced provisions in the regulation simply ensure that services provided by Medicaid do not duplicate services actually being received from another source. Overlap in the types of services being received is also permissible, so long as the total amount of services being received in a period of time does not exceed the amount that is medically necessary for each member.

PRIOR AUTHORIZATION REQUIREMENTS

32. Sections 17b-262-1055(b)(1) and 17b-262-1060(a) (Prior Authorization in General)

Comment: Do not require prior authorization for the comprehensive diagnostic evaluation and the behavior assessment after they have been determined to be necessary based on the initial diagnostic services, such as a screen.

Response: The regulation has been revised to provide that in most situations, prior authorization is no longer required for behavior assessments. In general, only registration is required for behavior assessments, which involves submitting information about the service before it is provided, but without the need to receive approval from DSS or its behavioral health administrative services organization. Registration is necessary to enable prompt coordination of care and to enable appropriate utilization management. Neither registration nor prior authorization is required for development of the behavioral plan of care.

Prior authorization remains necessary for the comprehensive diagnostic evaluation because there is a wide range of potential need, intensity, and length of time required for the evaluation. That variation, especially in the length of time that each evaluation may require, makes active utilization management critical for the Medicaid program to understand and briefly review all such requests to ensure these services comply with federal Medicaid requirements for services to be economic, efficient, and of high quality, as well as to ensure ample access to the services. *See* 42 U.S.C. § 1396a(a)(30)(A). DSS works closely with the Medicaid program's behavioral health administrative services organization and other partners to ensure that this is an efficient process that will maintain prompt access to services. As appropriate, DSS may further streamline this authorization process.

In one public comment, it was claimed that requiring prior authorization is not permissible for comprehensive diagnostic evaluations or behavior assessments based on the commenters' interpretation of the federal EPSDT statute, which includes, as part of the definition of EPSDT, "Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r)(5). That provision, also known as EPSDT special

services, means that Medicaid programs must cover a variety of medically necessary services for Medicaid members under age twenty-one, including diagnostic services, even if those services would normally be non-covered optional services under the Medicaid State Plan. Nothing in that provision, however, mandates that those services must be covered without prior authorization, especially since prior authorization serves multiple purposes, not solely to validate that a service is covered. Indeed, prior authorization may be necessary to determine if the services are in fact "necessary diagnostic services…to correct or ameliorate defects and…mental illnesses and conditions discovered by the screening services." In any case, federal regulations that apply to all Medicaid services, including EPSDT services, provide that the state Medicaid agency "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 C.F.R. § 440.230(d). Various purposes of prior authorization here, aside from validating that the service is coverable, which DSS agrees would generally not be necessary for comprehensive diagnostic evaluations, include: ensuring that the requested comprehensive diagnostic evaluation (including its scope, length, and other attributes) is medically necessary, coordinating the member's care, confirming that the service is high quality, validating that the provider is qualified to perform the service, preventing against unnecessary utilization, and promoting program integrity.

Therefore, requiring prior authorization is a "utilization control procedure" that is necessary to ensure that a particular requested comprehensive diagnostic evaluation (or, when applicable, a behavior assessment) is medically necessary and for the other reasons described above and is permitted under federal regulations at 42 C.F.R. § 440.230(d). In addition, other federal Medicaid statutes and regulations also require or authorize the state Medicaid agency to employ measures to ensure that services are high quality, economic, efficient, provided in beneficiaries' best interests, and provided by qualified providers. *See* 42 U.S.C. §§ 1396a(a)(19), (a)(23)(A), (a)(22)(D), and (a)(30)(A); 42 C.F.R. § 440.260. In addition to being a utilization control procedure necessary to ensure medical necessity pursuant to 42 C.F.R. § 440.230(d), prior authorization of comprehensive diagnostic evaluations and behavior assessments is also necessary to meet one or more of those provisions, including ensuring that the evaluations or assessments are provided in an economic and efficient manner, that they are high quality, and they are provided by qualified providers.

Requiring prior authorization of the comprehensive diagnostic evaluations (and when applicable, behavior assessments) is therefore appropriate and permissible.

33. Sections 17b-262-1055(b)(1) and 17b-262-1060(a) (Prior Authorization in General)

Comment: Do not require authorization at multiple steps.

Response: See response to Comment 32 above.

34. Sections 17b-262-1055(b)(1) and 17b-262-1060(a) (Prior Authorization for Comprehensive Diagnostic Evaluation)

Comment: Do not require prior authorization for comprehensive diagnostic evaluations.

Response: See response to Comment 33 above. As appropriate, such as for providers who have submitted multiple previous prior authorization requests for comprehensive diagnostic evaluations, DSS may streamline the prior authorization process for future requests.

One commenter stated that the requirement for prior authorization of the comprehensive diagnostic evaluation discriminates on the basis of disability to the extent that children with conditions other than autism do not need prior authorization to be diagnosed. First, relevant federal Medicaid regulations simply provide that the "Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under [federal regulations at 42 C.F.R.] §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c). In this case, the requirement for a medical evaluation is simply to ensure that, as discussed above, co-occurring or other conditions are either ruled out or treated, the ultimate ASD treatment services provided are medically necessary, and care is appropriately coordinated among providers. Accordingly, that requirement is not an arbitrary denial or reduction in a required service based on diagnosis, type of illness, or condition. Likewise, the requirement for prior authorization for comprehensive diagnostic evaluations is necessary to ensure that those very lengthy and involved evaluations are provided only when medically necessary, are high quality, and are performed by qualified providers. Those reasons are not unique to autism and therefore do not discriminate on the basis of autism as a specific diagnosis, condition, or disability.

Separately, the federal Americans with Disabilities Act provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132; *see also* 28 C.F.R. § 35.130. In this case, simply requiring a medical evaluation and requiring prior authorization for a comprehensive diagnostic evaluation do not exclude anyone with autism from participating in Medicaid, nor do they deny the benefits of the Medicaid program or subject anyone to discrimination. Rather, these are basic requirements to ensure that these services are high quality, are provided only when medically necessary, are provided by qualified providers, and are coordinated with other services. These services are different than many other services because they are substantially more time-intensive, complex, and in even greater need of being carefully coordinated than most other Medicaid services. Accordingly, these principles guide DSS's overall approach to imposing requirements for services in the Medicaid program based on the characteristics of those services.

The same commenter also stated that the requirements for a medical evaluation and for prior authorization for comprehensive diagnostic evaluations may violate the federal Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA does not apply to most of the Connecticut Medicaid program for members under age twenty-one because it is delivered using a

fee-for-service delivery model, not through managed care organizations (MCOs). *Cf.* 42 U.S.C. § 1396u-2(b)(8) (applying MHPAEA to MCOs). MHPAEA does apply to Medicaid delivered through alternative benefit plans, which in Connecticut applies to the low-income adult Medicaid expansion population coverage groups, also known as Medicaid Coverage for the Lowest Income Populations or HUSKY D. *See* 42 U.S.C. § 1396u-7(b)(6). There may be HUSKY D Medicaid members age nineteen and twenty who are not classified in another Medicaid coverage group who could qualify for ASD services.

Utilization review requirements such as prior authorization and provider qualification requirements are all classified as "nonquantitative treatment limitations" under MHPAEA by the federal regulations for commercial insurance plans. *See* 45 C.F.R. § 146.136(c)(4). Under those regulations, which do not apply to Medicaid but are relevant for illustration, a health plan "may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder unless, under the terms of the plan….as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification." 45 C.F.R. § 146.136(c)(4)(i). CMS published proposed federal Medicaid MHPAEA regulations in the Federal Register on April 10, 2015. CMS, Mental Health Parity Requirements, Proposed Rule, 80 Fed. Reg. 19418 (Apr. 10, 2015), posted at http://www.gpo.gov/fdsys/pkg/FR-2015-04-10/pdf/2015-08135.pdf. Those proposed regulations include virtually identical language to the regulations for commercial insurance plans regarding nonquantitative treatment limitations: "A state may not impose a nonquantitative treatment limitation for mental health or substance use disorder benefits in any classification unless, under the terms of the ABP as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification." *Id.*, 80 Fed. Reg. 19448 (Proposed 42 C.F.R. § 440.395(b)(4)(i)).

The non-quantitative treatment limitations in this regulation comply with MHPAEA because DSS is using comparable strategies to determine appropriate utilization management procedures and requirements that it would use for any type of service that was also designed to be delivered in the home and was also comparably time-intensive, individualized, flexible, and complex. In particular, the prior authorization and provider qualification requirements for ASD services are necessary to ensure services are provided only to the extent that they are medically necessary as tailored to each individual's unique needs, provided only by qualified providers, high quality and effective for each individual, and appropriately coordinated with any other necessary services. Those are the same types of reasons that would prompt DSS to use comparable strategies or requirements in any context. In addition, as noted above, DSS will continue to monitor access to and the quality of ASD services.

35. Sections 17b-262-1055(b)(1) and 17b-262-1060(a) (Prior Authorization for Behavioral Assessment)

Comment: Remove the prior authorization requirement for behavioral assessment.

Response: See response to Comment 33 above.

36. Section 17b-262-1060(f) (45-Day Initial Authorization)

Comment: Remove shorter initial authorization period. Instead, keep all authorization periods consistent at every six months.

Response: The regulation has been revised to remove the initial 45-day authorization and instead simply require the provider to submit baseline data within 45 days as part of the first six-month prior authorization period.

37. Section 17b-262-1062 (Payment)

Comment: Commenters submitted a variety of comments regarding reimbursement, including: add reimbursement codes for BCaBAs, add a reimbursement code for the BCBA's supervision of the technician, add reimbursement for more hours of treatment planning, increase rates in general in order to cover costs of staff and other expenses, and add more codes.

Response: Specific rates and related details of reimbursement methodology are neither described in, nor governed by the regulations. Accordingly, responding to those aspects of the comments is beyond the scope of this response to comments regarding the regulation. However, some details in these comments are relevant to the regulation. First, a separate reimbursement code for BCaBAs is not necessary because, as described in response to Comment 6, BCaBAs will be reimbursed in the same manner as technicians. Second, as described in item 41 below, separate reimbursement has been added when the performing provider (such as a BCBA) observes and directs the BCaBA or technician, but only when the performing provider is in the presence of both the member and the BCaBA or technician and only when the observation and direction is for the member's benefit (see section 17b-262-1058(g)(3) of the regulation).

ADDITIONAL REVISIONS

In addition to the revisions described above in response to public comments, DSS, in close collaboration with DDS and other state agency partners, made additional revisions to the regulations, some highlights of which are briefly summarized here.

38. Section 17b-262-1052 (Additional Categories of Billing Providers)

In order to expand access to ASD services, medical clinics and rehabilitation clinics are added as categories of billing providers, so long as the services are provided by performing providers who meet the requirements in this regulation. Behavioral health clinics, practitioner groups, and individual practitioners were already included as categories of billing providers.

Clinicians affiliated with a hospital or federally qualified health center (FQHC) provide ASD services through appropriate affiliated practitioner groups separately enrolled with DSS, which does not need to be referenced in the regulation because the requirements are the same as for any other practitioner group. DSS is issuing separate guidance to hospitals and FQHCs regarding the provider enrollment requirements for these services.

39. Section 17b-262-1053(g) (Border Providers)

The regulation has been revised to clarify that border providers (*i.e.*, providers in other states that are located near Connecticut and that typically provide services in Connecticut) may perform ASD services for Connecticut Medicaid members in accordance with this regulation, so long as all services are provided within the provider's scope of practice and within the scope of any applicable license or related requirements in the state where the service is provided.

40. Section 17b-262-1063(f) (Information or Documentation for Rate-Setting Purposes)

A provision has been added to the regulation to enable DSS to require providers to submit cost reports or other information necessary for rate-setting purposes.

41. Section 17b-262-1058(g)(3) (Reimbursement for Performing Provider's Observation and Direction of the BCaBA or Technician)

In response to comments (see response to Comment 37 above), separate reimbursement has been added when the performing provider (such as a BCBA) observes and directs the BCaBA or technician, but only when the performing provider is in the presence of both the member and the BCaBA or technician and only when the observation and direction is for the member's benefit.

42. Technical and Minor Changes

In response to comments and internal review, DSS added and revised definitions as needed and made various other minor and technical changes, including revisions to improve clarity.