Testimony before the Human Services Committee
Roderick L. Bremby, Commissioner
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Good morning Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick L. Bremby, and I am the Commissioner of the Department of Social Services.

I am pleased to appear before you to offer remarks on several of the bills on today's agenda.

SB 836 - AN ACT HOLDING HARMLESS MEDICAID CLIENTS AND PROVIDERS AFFECTED BY AGENCY COMPUTER ERRORS

Section 1 of this bill permits a provider, that is subject to audit by the Department, to provide documentation that errors concerning payment and billing resulted from "the implementation of any new computer system by the Department of Social Services." The Department respectfully submits that this new language is overly broad. It is not clear what is meant by "any new computer system." The Department is open to discussion with the proponents of this bill to better understand the specific issue that this bill is attempting to resolve.

Section 2 of the bill requires the commissioner to grant or continue benefits "when there is credible evidence that the implementation of a new computer system at the Department of Social Services caused delays or errors that prevented an individual from providing timely, accurate information necessary to determine eligibility for assistance." The Department opposes section 2 of this bill as it contradicts federal and state laws that require the verification of eligibility prior to granting or issuing benefits. Failure to comply with requirements regarding the issuance of benefits can result in penalties in the millions of dollars.

While the Department is aware that some client cases were affected during the early stages of the recent implementation of ImpaCT, the new eligibility management system, the number of issues affecting client benefits has significantly declined since 2016. Furthermore, there is already a process in place to address client concerns. Applicants and recipients of benefits may appeal any department decision that aggrieves them, including the termination or denial of benefits. When appropriate, the Department issues underpayments or provides retroactive medical coverage in the event that a hearing officer determines that the Department made an error that resulted in incorrect termination or issuance of benefits.

In light of these reasons, the Department must oppose this bill.

SB 837 - AN ACT CONCERNING MEDICAID PAYMENT RATES FOR NURSE-MIDWIVES

The Department of Social Services appreciates the intent of this legislation, however we believe any fee increase should be tied to improvements in clinical outcomes. The care provided to pregnant women in Connecticut must be better.

Currently, the Department pays for over 16,000 deliveries annually or 47% of all births in Connecticut. The Department's policy of paying nurse midwives, nurse practitioners and physician assistants at 90% of the physician's fee schedule dates back for as long as we have records of our fee schedules.

We suspect that the original reason for this policy was to recognize the more extensive training that physicians receive in comparison to nurse practitioners, nurse midwives and physician assistants. In addition to 4 years of medical school, physicians undergo a minimum of 3 years of residency training, often supplemented by fellowship specialty training. Further, physician's training is standardized nationally, as are the national medical board exams and the specialty exams for board certification.

In contrast, nurse midwives undergo 2-4 years of midwifery training before being eligible to take the national certification exam. Nurse practitioners generally have a 2-year training Masters level program, possibly followed by doctoral training or specialty training; physician assistants similarly complete a 2-3 year Masters level program possibly followed by supplemental training. Nationally, training standards and curricula for these providers are more variable as compared to physicians' training.

Further, the average debt carried by a medical school graduate in 2016 was $190,000 with 25% of graduates having debt in excess of $200,000. In contrast, the American Association of Colleges of Nursing estimates that the typical graduate level nurse incurs between $40,000 and $55,000 in debt for their training.

Despite the differences in training, experience and debt between physicians and nurse midwives, the Department also recognizes the difference in the comparison of clinical outcomes between nurse midwives and obstetrician gynecologists. Numerous studies show that, when compared head to head, the outcomes of women and infants served by a nurse midwife are as good as if not superior to those served by an obstetrician. The most comprehensive independent review, by the Cochrane Foundation, found nurse midwives' outcomes were significantly superior. More recent studies comparing states where midwives are a more routine and accepted part of obstetric care are shown to have better maternal and infant outcomes than states where physicians and hospitals dominate care.

The Department of Social Services believes that equalizing fees paid to midwives and obstetricians is an idea whose time, clinically, has come. The financial impact of this legislation, however, would be substantial, not only due to the extra payments to nurse midwives, but because nurse practitioners and physician assistants will expect their fees to be increased, as well. Because of these increased expenditures, the Department cannot support this bill.

I would like to state, however, that the Department firmly believes that any increase should be held to a value-based system that rewards and incents improved outcomes- and that obstetricians should be held to the same standard. Connecticut has the dubious distinction of having some of the poorest maternal outcomes and highest maternal death rates among adjoining states. The March of Dimes Preterm Birth Report Card gives each of our neighboring states a B grade, whereas Connecticut merits only a C. We can do better, but only by measuring and paying for better care. The Department's Obstetrics Pay-for-Performance program is a start down this road, paying participating obstetrics providers for earlier and better pre- and post-natal care, use of medications to prevent preterm births, and for a full term, spontaneous, vaginal delivery. A continuation of that practice will continue to better the outcomes of our mothers and newborns.

SB 898 - AN ACT ESTABLISHING THE HISPANIC AND FELLOW COMMUNITIES OF COLOR NONPROFIT STABILIZATION AND GROWTH FUND

The Department's mission reads as follows, "We, along with our partners, provide person-centered programs and services to enhance the well-being of individuals, families and communities." In accordance with that mission the Department delivers and funds a wide range of programs and services as Connecticut's multi-faceted health and human services agency. We serve approximately one million residents of all ages in all 169 Connecticut cities and towns and support the basic needs of children, families, older and other adults, including persons with disabilities. Services are delivered through 12 field offices, central administration, and online and phone access options as well as through our various partners across the state to ensure access across the state.

The outcome of this bill does not align with the Department's mission. The bill as written will direct the funding from the Human Resource Development - Hispanic Programs account that has traditionally been used to provide direct services to our most vulnerable populations to a fund that would be used to build the service capacity of certain nonprofit organizations that meet the proposed definition of "eligible community based organization".

The Human Resource Development - Hispanic Programs funds have been used to support services such as classes for English as a second language, employment services, certified nurse's aide program, client advocacy, literacy training, and service plan development to achieve goals such as permanent housing and treatment for substance use disorder. These are direct programs and services that assist clients in achieving self-sufficiency in the community. This bill would

redirect those funds from the support of direct client programs and services to instead be used to improve operational efficiencies and adopt strategies for long-term fiscal sustainability of "eligible community based organizations".

The Department supports and understands the value and importance of a strong and viable network of non-profit providers. Without our nonprofit partners we would not be able to support the various service needs of our communities. We do not, however, agree that the funds in the Human Resource Development – Hispanic Programs account should be diverted from direct client services to support the economic development of a nonprofit provider. There are more appropriate resources within the state for the development and support of our non-profit providers. Specifically, Governor Lamont's budget for fiscal year 2021 includes an allocation of $25 million dollars for the nonprofit grant program administered through the Office of Policy and Management. This program, established in 2013, awards grants-in-aid to selected private, nonprofit health and human service organizations to improve the efficiency, effectiveness, safety and accessibility of the delivery of health and human services. Further, the Department of Economic and Community Development is the state's lead agency for economic development and would be a more appropriate agency to assist with support for our nonprofit partners.

Finally, as the Governor's budget does not include funding for this bill, we must oppose SB 898.

SB 899 - AN ACT CONCERNING CHILDREN WHO TRANSFER FROM HUSKY A TO HUSKY B HEALTH CARE COVERAGE

This legislation seeks to establish a system to 1) standardize documentation for prior authorization and reauthorization of HUSKY B services, 2) set a timeline for these authorizations and reauthorizations to be completed, 3) immediately notify providers when a child's coverage changes from HUSKY A to HUSKY B, 4) retroactively pay for authorized services provided in good faith after a child moves from HUSKY A to HUSKY B, and 5) ensure that these services are paid for in a timely fashion.

The Department opposes this legislation. While children do move between HUSKY A and HUSKY B, the numbers are minimal. During a six month period last year, only 1% of children newly enrolled in HUSKY A moved to HUSKY B. Among those who transitioned, few children experienced difficulty in receiving services and only a small number of providers experienced issues with receiving payment for services. This is due, in part, to the providers having the capability to follow the eligibility changes through the Automated Eligibility Verification System (AEVS). This system allows providers to obtain on-line, real time access to the eligibility information sought by this bill.

Although HUSKY A and HUSKY B are similar in most respects (shared physician, inpatient and outpatient hospital, and behavioral health coverage and network), they differ in a few respects;

HUSKY B covers different medications (due to different rebate arrangements), fewer home nursing benefits, and only a defined length of physical, occupational and speech therapy sessions per diagnosis.

The first provision of this bill would require standardized documentation for authorization requests. This is in direct conflict with Connecticut General Statutes § 17b-259b which defines medical necessity and requires all authorization decisions to be "based on an assessment of the individual and his or her medical condition."

Regarding the second provision, our administrative services organizations (ASOs) are contractually obligated to meet timeliness standards for the review of all requests for authorization and reauthorizations. In the case of OT and PT, initial requests have a 2 business day turn-around time and re-authorizations have a 14 calendar day turn-around time. If the ASO requires additional information to complete their review, the review must be completed within 20 business days.

The last three provisions in the legislation would require the Department to notify providers of a child's change in coverage, to retroactively pay for services provided in good faith that should not have been provided because of a change in coverage, and to ensure that payments are made in a timely fashion. While the Department does not have the capability of notifying a provider that a child has transitioned from HUSKY A to HUSKY B, each provider has the capability through the Automated Eligibility Verification System to validate a child's eligibility, real-time. Providers should be checking member eligibility for every date of service and when submitting any necessary authorization requests, as validating a patient's eligibility before a service is provided would ensure that the service was covered. In addition. covered services that are properly billed in accordance with the provider agreements for all of our participating Medicaid providers ensure prompt payment. The Connecticut Medical Assistance Program pays clean claims, in full, every two weeks. In contrast, most payors make monthly payments to providers.

For all of these reasons, the Department must oppose this legislation.

HB 7121 - AN ACT CONCERNING SEMI-MONTHLY TRANSFERS OF SUPPLEMENTAL NUTRITION BENEFITS.

This bill requires the distribution of Supplemental Nutrition Assistance Program (SNAP) benefits twice per month. As a threshold matter, the Department notes that federal law (Food, Conservation, and Energy Act of 2008) prohibits agencies from issuing SNAP benefits more than once per month absent special circumstances.

In addition to the legal limitations, the Department believes that providing the full monthly benefit allotment at one time allows households to maximize flexibility when managing food budgets within the time, transportation and other constraints that low-income households often

face. Split issuances would likely require some families to make unwanted additional trips to the grocery store each month, thereby reducing the amount of time they can spend working, attending school or job-training programs, or being with their family. Other households, such as households with elderly members, households with individuals with disabilities, and households receiving small benefit amounts can also benefit from being able to minimize the frequency of shopping trips. In addition, split issuances limit households' ability to take advantage of the cost discounts that can be realized by buying in larger volumes.

The Department would also incur costs to implement this proposed change, including, but not limited to, costs for: modifying our computer system, changing the phone and messaging systems, rewriting client notices, informing and educating clients of the issuance schedule change, and changing file transfer processes with our EBT card vendor.

The Department notes that states have flexibility in managing the distribution of SNAP benefits by "staggering" distribution of monthly benefits among households over more days of the month, rather than issuing all monthly benefits to all SNAP households on the same day. Connecticut currently issues benefits on the first, second and third day of each month. Nationally, the issuance schedule varies widely between states. Ten states or territories disburse all SNAP benefits on one day, including many of our New England counterparts (Rhode Island, Vermont, New Hampshire). 22 states have a disbursal range of less than 10 days, including Connecticut, and 8 have a disbursal range of 18 to 22 days. Of note, however, is that no other state or territory offers a split issuance. When the State of Michigan attempted to do so in 2008, a survey of SNAP recipients found that 59 percent preferred continuing to receive their benefits once per month with only 35 percent favoring a twice-a-month system.

For these reasons, the Department must oppose this bill.

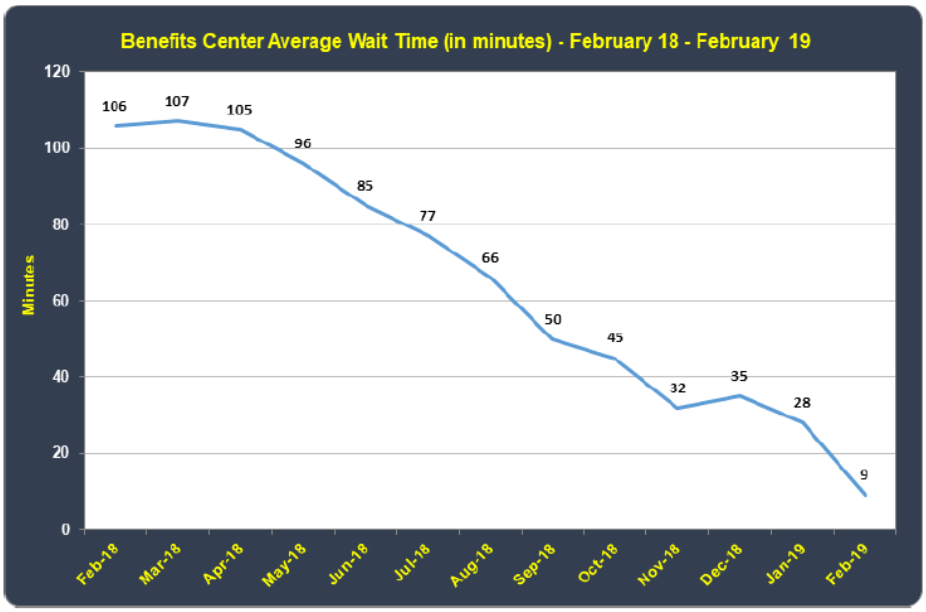
HB 7123 - AN ACT CONCERNING TELEPHONE WAIT TIMES FOR PERSONS CONTACTING THE DEPARTMENT OF SOCIAL SERVICES

This bill requires the Department of Social Services to increase staffing, resources, and telecommunications technology in an effort to ensure that wait times for calls to the Department's Benefits Centers do not exceed 60 minutes.

The Department has several concerns with this bill. Foremost, there is no need for the bill given the Department's recent performance. The Department also has concerns about provisions in the bill that conflict with federal law, as well as the potential for increased costs to the state budget.

Over the last year, the Benefits Centers have experienced a steady decrease in wait times. In January 2018, the average wait time was 100 minutes while the average wait time in January 2019, was 28 minutes. The current average wait time for February 2019 is approximately 10 minutes. Below is a graphical depiction of the improvement.

DSS Benefits Center Data as of 2/28/19



It is also worth noting that applicants and beneficiaries are not required to call the Department when applying for or renewing benefits. In addition to the Benefits Centers, beneficiaries have the option to seek assistance in person at any one of our 12 field offices, as well as the ability to access services online or via mail.

The Department does not currently have the technology to link attempted phone calls with client eligibility data. Integrating systems to realize this concept would have a significant cost and would raise federal data security concerns. This does not mean that the Department is not pursuing technology enhancements. As the next phase of our modernization efforts, the Department is actively working on a large-scale infrastructure and software upgrade to our Benefits Center technology. The Department anticipates a final proposal from vendors by the second quarter of 2019.

The bill also seeks to prevent any beneficiary of the Department's assistance programs from having their benefits reduced or terminated if that person placed a call to the Department but was unable to speak to staff within 60 minutes of placing the call. This aspect of the bill conflicts with federal laws that require eligibility to be established and verified prior to the issuance of benefits, including the fully federally funded Supplemental Nutrition Assistance Program. Failure to comply with federal laws that require verification of eligibility prior to the issuance of benefits could result in sanctions and financial penalties to the State of Connecticut.

Last, but not least, this bill will require State expenditures to ensure compliance with the bill as currently written. There would be costs for systems upgrades, additional technology features and ongoing maintenance of those additions. There could also potentially be expenses in the form of added eligibility staff, additional office space and the operational and administrative costs needed to support that staff.

The Department understands that nobody wants to wait in line, and we are committed to continuous improvement in our client experience. Given our demonstrated commitment to reducing call wait times, the conflict with federal law, and the potential costs to the State, the Department cannot support this bill.

HB 7165 - AN ACT CONCERNING MEDICAID COVERAGE FOR DONOR BREAST MILK

The Department of Social Services wishes to offer our strongest endorsement of breast feeding for all newborns. After loving parents, breast feeding is one of the best ways to start a newborn on their life's journey.

Through the Connecticut Medical Assistance Program, we provide medical assistance and medically necessary services to 23% of the state's citizens including our most vulnerable citizens. Among these services are many nutritional supplements and artificial nutritional products to treat or help treat many medical conditions.

Breast milk is neither a nutritional supplement nor an artificial nutritional product to treat a medical condition; breast milk is food. Were Medicaid to cover this food, we would need to cover all other foods. In addition, federal law does not allow us to cover breast milk or any other type of food, because food does not fall within the federal definition of medical assistance that may be covered under Medicaid. See 42 U.S.C. § 1396d(a).

Second, this legislation would mandate that breast milk be a covered benefit for newborns "on an inpatient basis in a hospital." Medicaid pays for hospital inpatient services using an all-inclusive Diagnosis-Related Group (DRG) methodology which pays the hospital a fixed fee according to the patient's diagnosis(es). Different DRGs are priced differently depending upon the average cost to care for each diagnosis. For example, care for a community-acquired pneumonia in the absence of other complications would pay less than care for a heart attack that required treatment with an invasive procedure. DSS would therefore not pay the hospital more were we to cover donated breast milk or any other new service. The payment levels are all-inclusive and adjusted based upon national cost estimates.

The Department of Social Services supports breast feeding, but must oppose this legislation.

HB 7166 - AN ACT CONCERNING NONEMERGENCY MEDICAL TRANSPORTATION FOR MEDICAID BENEFICIARIES

The Department of Social Services thanks the members of the Committee for your interest in and continued support for our Medicaid members. However, we believe that HB 7166 is not necessary as the proposed requirements are already incorporated in the Department's Non-Emergency Medical Transportation (NEMT) contract with the current provider, Veyo.

As the single state agency in Connecticut designated to administer the Medicaid program, DSS oversees the NEMT program. NEMT is an important benefit for Medicaid members who lack the appropriate means of transportation to get to and from Medicaid-covered medical services.

The ultimate goal of NEMT in Connecticut is person-centered, medically necessary, timely, and high quality access to medical services provided by a reliable, flexible, and innovative NEMT system. A person-centered health care delivery system only succeeds when a Medicaid member can effectively schedule and access Medicaid medical, behavioral health, and dental services. NEMT services provide a necessary bridge to ensure Medicaid members can manage their health conditions, live independently, and achieve their own health goals.

The Department entered into an NEMT contract with Veyo, a Total Transit Company ("Veyo"), on January 1, 2018. The contract restructured the NEMT program to provide Veyo with greater flexibility and capacity to engage a range of transportation providers throughout the state in order to best serve Medicaid members. A copy of the NEMT contract is available at www.ct.gov/dss/nemt under Documents/Forms.

As drafted, HB 7166 requires the Department to "ensure that the state's medical assistance program shall provide coverage for non-emergency medical transportation to each eligible member." Section II beginning on page 16 of the contract requires the NEMT vendor to provide this service.

The Department has reviewed each requirement proposed within this legislation and we are confident that they are addressed and monitored within the current contract. A section by section breakdown follows:

Section 1 (a) proposes that the Department:

(1) Shall not fail or refuse to provide nonemergency transportation to eligible Medicaid beneficiaries

Federal law imposes this requirement on the Department and we have made assurances to CMS in the State Plan provisions governing NEMT. In addition, the NEMT contract requires that the contractor shall be responsible for receiving and processing all requests for non-emergency medical transportation. The contract also requires that, "the contractor shall respond to non-emergent transportation inquiries and requests made by the Department's members, parent/guardian, or member representative including healthcare providers."

Section 1(a) (2) proposes:

(2) Unless there is a documented weather or traffic emergency that impedes access to a Medicaid beneficiary, exceed a (A) fifteen-minute waiting time for a scheduled pickup of a beneficiary en route to an appointment, or (B) thirty-minute waiting time for a beneficiary's scheduled return trip.

Section VI beginning on page 31 of the contract sets forth expected performance standards. The contract requires that the waiting time for a scheduled pickup going to an appointment should not exceed fifteen (15) minutes before and fifteen (15) minutes after the scheduled pickup time and

that the average waiting time for a scheduled return trip, after an appointment shall not exceed thirty (30) minutes.

Section 1(a) (3) proposes:

> *(3) The contractor shall not provide a mode of transportation other than the mode requested by the Medicaid beneficiary, provided such mode is medically necessary, as set forth in section 17b-259b of the general statutes.*

Section I.7.F. on page 13 of the contract prohibits the contractor "…from authorizing transportation that is not the most appropriate and cost effective means of transportation for the member for the purposes of financial gain, or any other purpose." Mode of transportation is recorded with each trip and is based on medical necessity and availability of the service being requested.

Section 1(a) (4) proposes:

> *(4) The contractor shall not maintain a transportation provider network that is incapable of meeting the nonemergency transportation needs of the state's Medicaid beneficiaries.*

Section I. 5 beginning on page 12 of the contract requires the Contractor to "…develop, implement and maintain a transportation network that has a variety of providers for each mode of transportation. The Contractor shall ensure the ability to provide necessary NEMT services by establishing a network of providers through the use of subcontracts."

It is important to note that in 2018, under the current contractor and model, the transportation provider network has increased by 20% and NEMT utilization has increased by 17% from 2017 under the previous contractor and model.

Many of the problems that may arise in securing NEMT are not attributable to the raw number of transportation providers. Instead, such problems may result from other circumstances. For example, ambulance providers have refused to service certain geographical regions of the state citing regulatory requirements, although it is our position that such limitations do not actually govern the provision of NEMT. Also bariatric support services for transportation (and for a variety of other medical services) are not always readily available because of the lack of inventory. This is a problem that affects bariatric patients regardless of health insurance status.

Section 1 (b) proposes:

> *Medicaid beneficiaries who are denied medically necessary, nonemergency medical transportation required pursuant to this section may seek civil injunctive relief from the Superior Court. The court may order the Department of Social Services to impose penalties on the contracted transportation brokerage vendor as required by the contract between the Department and the vendor.*

This provision is unnecessary and will not provide a timely, effective remedy for members who are denied medical transportation. Under the provisions of state and federal law and the Constitution, the Department is required to issue a notice of action to a member who has been

denied NEMT by the Department or its NEMT broker acting on the Department's behalf. The notice describes the member's right to a contested case hearing before the Department. The hearing decision may be appealed to the Superior Court. To add a right of injunctive relief on top of these existing due process rights could create unnecessary confusion and redundancy. The proposed approach could also tie up court time and resources with matters for which there is already an effective and speedier remedy.

The provision allowing a court to order the Department to impose penalties on the broker is also unnecessary, raises potential Constitutional Contracts Clause issues and interferes with the Department's responsibility as the single state Medicaid agency. Further, the Department's contract includes the assessment of sanctions for failure to meet performance standards. Refer to section XIV of the contract beginning on page 51.

We are also concerned that this bill is seeking to direct the Department to take specific actions relative to one of its contracts. While we defer to the legislature to establish policy and make appropriations, contract negotiation and management is the responsibility of Executive Branch agencies. The Department, however, remains willing to work with the Committee and stakeholders to ensure that specific elements of the program continue to be monitored and standards of service continue to be maintained.

In addition to the testimony regarding the language of the proposed bill, the Department is respectfully providing the following points on the NEMT program, in addition to a performance dashboard:

- On a monthly basis, Veyo brokers, and transportation providers complete between 350,000 and 400,000 trips for Medicaid members.

- DSS receives detailed monthly data reports from Veyo on performance indicators including, but not limited to, the Veyo call center, NEMT trip performance, member complaints, and issuance of Notices of Action (NOA).

    - ✓ Call center performance (call response, wait time, abandonment) is meeting and exceeding contract standards

    - ✓ Pick-up and return wait times are within contract standards for approximately 70% of A-leg trips and 92% of B-leg trips

- The contract allows DSS to impose performance sanctions for failure to meet established standards, including, but not limited to, failure to submit required reports, failure to respond to complaints, failure to schedule transportation, and failure to meet timeliness standards for trips.

- To date, DSS has imposed sanctions (most commonly related to late pick-up times, but also reflecting several incidences of multi-loading of members whose health status precludes traveling with other people), totaling $22,000. To the best of DSS' information, Veyo has typically then passed these sanctions on to the involved transportation providers.

HB 7168 - AN ACT CONCERNING AUTISM

DSS is identified in statute as the lead agency for Connecticut for autism spectrum disorder (ASD) services. Further, DSS is responsible for coordinating, where possible, the functions of the several state agencies that are responsible for providing services to persons diagnosed with ASD [CGS Section 17a-215]. On this basis, DSS supports coordination with DDS to ensure that individuals with ASD and developmental disabilities are effectively served.

Section 1 of this bill seeks to implement a coordinated interagency effort to ensure that people with ASD with developmental disabilities receive a full range of available services from the Department of Developmental Services (DDS). The bill would also amend the lifespan autism waiver to provide additional services and the Medicaid State Plan to provide medically necessary services for people with ASD. DSS, through its behavioral health administrative services organization, Beacon Health Options, does have a forum to coordinate care for individuals with ASD and ID. On a weekly basis, Beacon, DDS, and DCF conduct Complex Case Rounds, where members with complex behavioral and/or developmental conditions who are involved in multiple state agencies are discussed. We welcome any suggestions on how to improve that coordination.

The intent of section 2 of this bill is unclear. If the intent is to expand services on the lifetime autism waiver that is administered by the Department, we believe we have the necessary services in place to meet the needs of individuals on the waiver. If the intent is to increase the number of available waiver slots, the Department cannot support that since it was not included in the Governor's budget.

DSS currently operates a lifespan waiver for individuals age 3 and older who have been diagnosed with ASD. Currently, 104 people are covered by the lifespan waiver, and there is a waitlist of 1435 people.

This waiver includes the following services and supports (which are capped at $50,000 annually per participant):

- Clinical Behavioral Supports
- Social Skills Group
- Job Coaching
- Life Community Mentor
- Skills Coach
- Individual Goods and Services
- Personal Emergency Response System
- Respite
- Assistive Technology
- Interpreter
- Non-Medical Transportation
- Specialized Driving Assessment

- Live-in Companion

The Connecticut Medicaid State Plan also provides a range of services for people with ASD who are under the age of 21 and are enrolled in HUSKY A, C or D. Currently, over 2,000 people are receiving State Plan ASD services. The provider network continues to grow in this area, year over year.

In brief, these services include:

- Diagnostic Evaluation, for those members who are not yet diagnosed but suspected to meet criteria for an ASD diagnosis.
- Behavioral Assessment, to determine the specific behavioral needs of the member.
- Treatment Plan Development, including a plan to decrease maladaptive behaviors and increase replacement behaviors with observable and measurable goals and objectives.
- Direct Observation and Direction of a technician providing direct care to a member performed by a licensed practitioner or BCAB
- Treatment services, including: (A) services identified as evidence-based by nationally recognized research reviews, (B) services identified as evidence-based by other nationally recognized substantial scientific and clinical evidence or (C) any other intervention supported by credible scientific or clinical evidence, as appropriate to each individual. ASD treatment services include a variety of behavioral interventions that meet the criteria in one or more of (A), (B) or (C) above, such as evidence-based Applied Behavior Analysis interventions that meet one or more of those criteria.

The Department remains committed to individuals with autism spectrum disorder. In addition to the above referenced Medicaid waiver and the Medicaid state plan services, the Department is supporting several initiatives through the state-funded Autism Feasibility Plan. Additionally, the Department remains receptive to suggestions or innovative solutions on how to improve state agency coordination for individuals with ASD and ID.

NEMT PERFORMANCE DASHBOARD
2/20/19

	18-Feb	18-Mar	18-Apr	18-May	18-Jun	18-Jul	18-Aug	18-Sep	18-Oct	18-Nov	18-Dec	19-Jan	Total
Completed Trips	271,911	295,179	320,150	364,436	353,356	364,019	377,822	340,123	385,518	358,339	355,682	391,818	4,178,353
Miles traveled	1,905,225	2,034,803	2,174,546	2,490,044	2,443,449	2,449,728	2,600,804	2,340,595	2,635,019	2,427,099	2,431,020	2,658,184	28,590,516
Public Transportation	145,437	158,218	178,985	210,858	206,095	219,987	219,026	197,379	219,952	209,025	207,825	230,177	2,402,964
Livery/Taxi/Car	98,287	105,606	110,073	119,204	113,504	109,757	120,039	107,530	125,101	112,346	111,722	124,061	1,357,230
IDP (subset of above)	2,045	2,153	2,260	2,345	2,291	2,476	2,619	2,759	3,968	3,527	3,927	5,369	35,739
Wheelchair vehicle	22,646	24,145	23,769	25,292	24,540	24,042	26,350	23,427	26,550	23,933	22,870	24,752	292,316
Gas reimbursement	2,216	3,737	3,937	5,554	5,992	7,030	8,917	8,683	10,451	9,816	10,237	10,448	87,018
Ambulance *	3,325	3,473	3,386	3,528	3,225	3,203	3,490	3,104	3,464	3,219	3,028	2,380	38,825
On time percentage						78.61%	79.67%	79.68%	80.47%	77.79%	80.61%	81.27%	
A leg						66.57%	68.14%	68.11%	69.96%	66.60%	69.42%	70.71%	
B leg						90.90%	91.53%	91.52%	91.33%	89.33%	92.12%	92.27%	

* does not include cross over claims

Section VI of the contract

* A leg: wait time should not exceed 15 minutes before or after the scheduled pickup time. Must wait 5 minutes past the pickup time before the provider can leave.
* B leg: average wait time for scheduled return trip, after an appointment, shall not exceed 30 minutes.
  Will call return, when a member does not have a preset pickup time set in advance, will be picked up within 1 hour.
  Hospital discharge: shall be picked up within 3 hours of receipt of request.

* Exceptions: may be made for trips outside of Member's local community, unusual situations such as exceptional distances or other situations beyond the control of the Contractor.

Member no show	18-Feb	18-Mar	18-Apr	18-May	18-Jun	18-Jul	18-Aug	18-Sep	18-Oct	18-Nov	18-Dec	18-Jan
Ambulance - Advanced	0	2	0	0	0	0	0	0	0	1	0	0
Ambulance - Basic	18	6	5	44	23	29	18	22	41	33	13	15
Livery/Taxi/Car	8,928	10,569	10,651	10,566	9,807	12,795	15,847	10,565	11,683	10,938	12,237	13,707
Bariatric Wheelchair	42	33	42	49	38	93	73	45	93	107	88	72
Wheelchair	567	656	721	833	954	811	938	840	966	936	871	1092
Total	9,555	11,266	11,419	11,492	10,822	13,728	16,876	11,472	12,783	12,015	13,209	14,886
Provider no show												
Ambulance - Basic	2	4	10	13	4	2	0	0	0	12	5	0
Livery/Taxi/Car	625	530	386	431	286	236	301	358	390	389	286	235
Bariatric Wheelchair	4	8	2	11	4	4	4	12	4	8	2	2
Wheelchair	93	71	55	112	70	39	43	43	57	52	43	50
Total	724	613	453	567	364	281	348	413	451	461	336	287
Trips not confirmed												
Ambulance - Advanced	6	14	10	11	9	9	2	14	24	13	5	2
Ambulance - Basic	136	162	182	149	185	166	98	168	303	196	158	80
Livery/Taxi/Car	218	193	217	263	255	282	238	505	886	298	256	148
Bariatric Wheelchair	25	25	16	48	65	30	48	64	52	44	37	33
Wheelchair	95	64	79	116	111	110	99	95	130	75	97	52
Other	107	62	42	16	2	0	0	0	0	0	0	0
Total	587	520	546	603	627	597	485	846	1,395	626	553	315

Members can be a no show for a number of reasons besides a missed connection: the member is hospitalized, deceased, canceled the appointment/no longer attends the program, forgot, had another way to get there/back, etc.

Trips not confirmed have been offered to a provider and the provider has not "refused" the trip for assignment to anther provider but has also not closed the trip out as completed in the system.