

CALIFORNIA LEGISLATURE

SENATE SELECT COMMITTEE ON AUTISM & RELATED DISORDERS

Senator Darrell Steinberg, Chair

INFORMATIONAL HEARING ON SB 946 (STEINBERG):

*An Overview on the Implementation of
California's Autism Insurance
Mandate Coverage Legislation*



March 4, 2014 • State Capitol, Sacramento

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INFORMATIONAL HEARING on SB 946 (STEINBERG):
*An Overview on the Implementation of California's Autism
Insurance Mandate Coverage Legislation*

March 4, 2014 at 1:30 PM
The State Capitol – Room 4203

Agenda

- 1) Welcoming Comments – Sen. Steinberg & Committee Members: **(1:30-1:35 PM)**
- 2) An Overview of SB 946 **(1:35-1:45 PM)**
 - a. Department of Managed Health Care (DMHC): Ms. Shelley Rouillard
 - b. California Department of Insurance (CDI): Mr. Robert Herrell
 - i. Explanation of the legislation
 - ii. Actions taken in the implementation of SB 946
 - iii. Establishing a network of providers for SB 946
 - iv. Overview of the DMHC Taskforce findings/recommendations
 - v. Monitoring & oversight
 - vi. Grievances and appeals

3) The Impact of SB 946 on the Regional Center System (1:45-2:00 PM)

- a. Data & Information Overview: Legislative Analyst's Office:
Ms. Rashi Kesarwani & Mr. Shawn Martin
 - i. Methods used by the California Health Benefits Review Program to arrive at SB 946 estimates
 - ii. SB 946 data currently tracked by the Department of Developmental Services
 - iii. Additional data collection that could assist with future SB 946 impact analysis
- b. DDS representative: Ms. Nancy Bargmann & Mr. Jim Knight
 - i. Role of DDS in the implementation of SB 946
 - ii. Copayment and Coinsurance
 - iii. Accessing federal funding for payment of copayments and coinsurance
- c. Regional Center representative: Mr. Rick Rollens – Association of Regional Center Agencies
 - i. The role of the regional centers in accessing SB 946 funding.
 - ii. Operational challenges and opportunities in the implementation of SB 946
 - iii. Update on the co-pays, co-insurance, and deductibles related to SB 946
 - iv. The impact of the emergency regulations issued by the DMHC & CDI

4) The Impact of SB 946 on Consumers & Their Families (2:00-2:20 PM)

- a. Representative of Regional Center Consumers: Ms. Marcia Eichelberger–
President of the Autism Society of California
- b. Representative of Non-Regional Center Consumers:
Ms. Kristin Jacobson – Alliance of California Autism Organizations

- i. Overview of the Autism Society survey findings and results
 - ii. Consumers' knowledge & information
 - iii. Benefits and savings related to SB 946
 - iv. Accessing appropriate services in a timely manner
 - v. Issues related to provider networks
- c. Technical Assistance on the Consumer Survey:
Ms. Beth Burt – President, Autism Society of the Inland Empire

5) SB 946 Implementation: Providing Services and Interventions (2:20-2:40 PM)

- a. Provider Representative: Dr. Doreen Granpeesheh – Center for Autism & Related Disorders
 - i. Data & information on “contracting issues”
 - ii. Information on network of providers
 - iii. Other issues, findings, and recommendations
- b. Health Plan Representative: Mr. Charles Bacchi – California Association of Health Plans
 - i. Overview of the implementation of SB 946
 - ii. Data and monitoring of SB 946
 - iii. Coordination & communication with regional centers

6) Public Testimony (2:40-3:00 PM)

7) Adjournment (3:00 PM)

Welcome – Sen. Steinberg & Committee Members

AGENDA ITEM # 1

- Overview of the Hearing: Goals, Objectives, and Format
- Issues & Factors that Prompted SB 946 (Steinberg)
- The Legislative History of SB 946
- Actions and Requirements of the Autism Insurance Mandate Legislation

INFORMATIONAL HEARING on SB 946 (STEINBERG):
*An Overview on the Implementation of California's Autism
Insurance Mandate Coverage Legislation*

March 4, 2014 at 1:30 PM
The State Capitol in Room 4203

Goals & Objectives:

The Senate Select Committee on Autism & Related Disorders (Committee) will hold an informational hearing on SB 946 (autism mandate), which was signed into law in 2011 and took effect on July 1, 2012. SB 126 (Steinberg), which was enacted during 2013, extends the provisions of the autism mandate until January 1, 2017.

Senator Darrell Steinberg, as the Chairperson of the Committee has requested an informational hearing on the accomplishments, functions, applications and performances of the autism mandate. The overarching goals and objectives of this hearing will include the following:

- 1) Access to care: Are consumers and families obtaining appropriate services and interventions in a timely and effective manner?
- 2) Assessment and treatment: Are consumers and families obtaining services and interventions from appropriate and qualified network of providers?
- 3) Fiscal implications: What are the financial issues (savings and expenses) that that have ensued from the autism mandate and how are they affecting

consumers/families, regional centers, providers, health plans and other stakeholders?

- 4) Benefits & Challenges: Are there other issues, perspectives, and topics that merit consideration in the implementation of the autism mandate?

Hearing Format:

The hearing is committed to present an objective and balanced view of the issues, advantages, and challenges during the first 18 months' implementation of autism mandate. The agenda for this hearing will focus on obtaining as much data and objective information as possible. Therefore, participants will be requested to identify salient issues and, to the greatest extent possible, to support their findings and recommendations with as many facts, statistics, and documentation as possible. In view of the compelling power of personal testimony and anecdotal information, written testimony will also be accepted and the agenda will also include time for public comments.

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California State Senate

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DARRELL STEINBERG
PRESIDENT PRO TEMPORE
SIXTH SENATE DISTRICT

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Medical Insurance Coverage for ASD ~ *Factors That Prompted the Introduction of SB 946 (Steinberg)*

- Coverage of health care, behavioral, and psychotherapeutic services is limited, inconsistent or excluded altogether
- The roles and responsibilities of health plans and insurers for ASD services are not well defined
- Frequently there is lack of consensus about the “medical necessity”
- When health plans and insurers contract (“carve out”) behavioral health services, there is often fragmentation and/or denial of services
- Health plans and insurers frequently lack access to professionals with adequate training and expertise in ASD



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SB 946 (Steinberg): The Bill's Legislative History

- **March 3 SB 946 was unrelated to autism (HIPPA compliance)**
- **Sept. 2 "Gut & Amend" in Assembly (Re-Referred to Committees)**
- **Sept. 7 Approved by Assembly Health Committee (13 to 5 vote)**
- **Sept. 8 Approved by Assembly Appropriations (12 to 5 vote)**
- **Sept. 9 Passed out of the Assembly by (52 to 21 vote)**
- **Sept. 9 In Senate (Re-Referred to Committees)**
- **Sept. 9 Passed out of Senate Appropriations Committee (6 to 1 vote)**
- **Sept. 9 Passed out of Senate (25 to 4 vote)**
- **Sept. 16 Enrolled and presented to the Governor**
- **Oct. 9 Approved by the Governor.**
- **Oct. 9 Chaptered by Secretary of State. Chapter 650, (2011)**



SB 946 (Steinberg): Actions & Requirements of the Autism Insurance Mandate

Every health care service plan contract that provides hospital, medical, or surgical coverage shall also provide **coverage for behavioral health treatment** for pervasive developmental disorder or autism no later than July 1, 2012.

Does not require any benefits to be provided that exceed the essential health benefits required the **federal Patient Protection and Affordable Care Act of 2010**.

This section shall not affect or reduce any obligation of any **IEP or IPP**.

Every health care service plan subject to this section shall maintain an **adequate network** that includes qualified autism service providers.

“Behavioral health treatment” (BHT) means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

1. The treatment is prescribed by a **licensed physician or psychologist**
2. The treatment is provided under a **treatment plan** prescribed by a qualified autism service provider and is administered by one of the following:
 - A **qualified autism service provider** (licensed or certified)
 - A **qualified autism service professional** (provides BHT & RC vendorized) supervised and employed by the qualified autism service provider
 - A **qualified autism service paraprofessional** (unlicensed/non-certified) supervised and employed by a qualified autism service provider

The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated.

The **treatment plan** shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent of the following:

1. Describes the patient's behavioral health impairments to be treated.
2. Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
3. Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
4. Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

The DMHC shall convene an **Autism Advisory Task Force**:

1. Scientifically validated Interventions that have demonstrated clinical efficacy and measurable treatment outcomes.
2. Patient selection, monitoring and duration of therapy.
3. Qualifications, training and supervision of providers.
4. Adequate networks of providers.
5. Requirements that unlicensed providers must meet in order to obtain licensure from the state.

~~The DMHC shall submit a **report** of the Autism Advisory Task Force to the Governor and the Legislature by December 31, 2012, on which date the task force shall cease to exist.~~

SB 126 (Steinberg) chaptered in 2013 extends the "sunset" of SB 946 until January 1, 2017.

SB 946 does not alter California's Mental Health Parity Law

An Overview of SB 946

AGENDA ITEM # 2

(a) Department of Managed Health Care (DMHC):

- Biography of Ms. Shelley Rouillard
- DMHC Enforcement Actions

(b) California Department of Insurance (CDI)

- Biography of Mr. Robert Herrell

(c) Background information on SB 946 (Steinberg)

- SB 946: Fact Sheet
- SB 946: Press Release
- SB 946: Chapter 650 (October 11, 2011)



Shelley Rouillard is the Director of the California Department of Managed Health Care, the state entity that oversees health plans that provide health care services to more than 21 million Californians. As Director, Rouillard is responsible for ensuring that health plan enrollees receive high quality health care services in accordance with federal and state rules. Prior to her appointment as director, Rouillard served as DMHC Chief Deputy Director for two years, overseeing the day-to-day operations of the department.

Rouillard came to the DMHC with more than 20 years of experience as a health care consumer advocate. She has an extensive background in government and health care including, health care policy, provider contracting, network development, health care quality and health plan performance. Prior to joining the DMHC, she served as the Deputy Director for Benefits and Quality Monitoring at the California Managed Risk Medical Insurance Board, where she oversaw the contractual and clinical quality performance of 33 health, dental, and vision plans serving children in the Healthy Families Program. While at MRMIB, Rouillard also directed the development of the benefits and plan operations of the Pre-Existing Condition Insurance Plan (PCIP), the first expansion of health care coverage under the Affordable Care Act for people with pre-existing conditions.

She previously was a founder and director of the Health Rights Hotline, the first-of-its-kind independent consumer advocacy program designed to assist consumers who have problems with the health care system. Through data collected from consumers, the Hotline identified and addressed system problems in order to improve the health care system. The Hotline, established in 1997, became the model for the DMHC Help Center and Rouillard advised the DMHC on its data collection and consumer assistance policies and practices.

She has also served as chief of health policy at the California Public Employees Retirement System, director of network development for a national preferred provider organization, and legislative advocate working on health and long term care issues affecting low income seniors and persons with disabilities.

Rouillard received the Patient Advocacy Achievement Award from the Office of the Patient Advocate and in 2005 and in 1990 she received the Client Advocacy Award from the California Foundation for Independent Living Centers.

She is the author of numerous publications focusing on the health care delivery system including *Sacramento Geographic Managed Care: Eight Years Later* and *The Impact of the Health Rights Hotline – Making a Difference for Health Care Consumers through Direct Service, Advocacy and Systemic Change*.

During her career, Rouillard has served on the Boards of Directors of various non-profit organizations including the Integrated Health Care Association, Center for Health Care Decisions, the California Law Center on Long Term Care and the Legal Center for the Elderly and Disabled.

Rouillard holds a bachelor of arts degree in social work from Rutgers University and is Fellow of the University of Southern California/Sierra Health Foundation Leadership Program.

Senate Office of Research: DMHC Enforcement Actions

9-3-13

Responses from Office of Enforcement

The Department of Managed Health Care (“DMHC”) is dedicated solely to regulating health care service plans (“plans” or “health plans”) and assisting consumers to resolve disputes with health plans. The DMHC’s main priorities are to protect the rights of approximately 20 million consumers enrolled in health plans, educate consumers about their rights and responsibilities, ensure the financial stability of the managed health care system, and assist Californians in navigating the changing health care landscape.

The DMHC’s oversight activities begin with the Office of Plan Licensing. This division is responsible for issuing new licenses to plans and reviewing changes to existing plan operations. The Office of Financial Review regularly reviews financial statements submitted by plans and their contracted Risk Bearing Organizations (“RBO”),¹ conducts financial examinations of plans and RBOs, and monitors them to ensure that they meet the Knox-Keene Act’s solvency requirements and their financial obligations to consumers and providers. The Help Center assists consumers with resolving issues with their health plans via the complaint and Independent Medical Review processes. The Help Center’s Division of Plan Surveys conducts medical surveys of plans to ensure that they are able to meet Knox-Keene Act’s requirements pertaining to quality management, grievances and appeals (enrollee complaints), access to and availability of services, utilization management (referrals and authorizations), and overall plan performance in meeting enrollees’ health care needs. Most of the DMHC’s regulatory oversight activities take place as part of the above divisions’ normal processes and enforcement actions occur when health plans have failed to comply with these regulatory processes.

The charge of the DMHC is to ensure that health plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees. The DMHC’s Office of Enforcement (“OE”) supports this mission through investigation and prosecution of health plans and their medical groups, as well as non-licensed entities/individuals who may be in violation of the Knox-Keene Act. The overarching goal of the DMHC in pursuing enforcement action is to protect the public, change health plan behavior, and deter future violations.

The determination of which enforcement action to pursue and the remedies to be sought are analyzed on a case-by case basis, with the goal being to ensure compliance with the Knox-Keene Act, address the harm that may have been caused, prevent further harm, and to make the aggrieved parties whole (e.g. past, current and/or future enrollees and providers of the health plan). The

¹ A RBO is a medical group which contracts with a health plan to arrange for or provide health care services to the plan’s enrollees. The RBO also pays provider for services rendered to the health plan’s enrollees, and takes on risk for the financial costs of providing those services.

DMHC utilizes a number of mechanisms to accomplish these goals, based on the Knox-Keene Act and its corresponding regulations, as well as other statutory and case law, to undertake enforcement action against health plans and others who violate the law. These enforcement actions include:

- assessing monetary penalties
- issuing cease and desist orders
- requiring corrective action
- filing civil actions, for example against providers to prevent them from balance billing enrollees
- installing conservators or monitors at financially insolvent plans to ensure that enrollees continue to be able to access health care services and that providers and vendors are properly paid
- installing a monitor for quality of care review.

The DMHC also has negotiated various types of settlement agreements² that resulted in substantial payments to enrollees or providers, a change in health plan behavior, or investment in community healthcare needs, but may not have included fines paid to the DMHC. For example:

- In 2011, the DMHC reached settlement agreements with two large plans (Blue Cross of California and Blue Shield) that resulted in thousands of children receiving behavioral health treatment for autism and pervasive developmental disorders and, in some cases, reimbursement to families who paid out-of-pocket for such treatment that had been denied by their health plans³.
- In 2012, the DMHC reached a settlement agreement with Kaiser following issuance of a Cease and Desist Order which resulted in the health plan modifying its policies to comply with California law and ensured that thousands of its enrollees would no longer be denied access to speech, occupational and physical therapy services to which they were entitled under the law. In addition, Kaiser reimbursed families who incurred out-of-pocket costs for having to obtain such services. A similar agreement was reached with United Healthcare and US Behavioral Healthcare in August, 2013. The DMHC continues to review the business practices of other plans to determine whether they may have been similarly noncompliant.
- In 2013, in a settlement agreement with Blue Cross of California, the plan paid providers millions of dollars owed them as a result of underpayment of claims. This agreement also resulted in the plan changing its claims

² The most common type of settlement agreement is a Letter of Agreement.

³ While these actions are reflected in the Enforcement Action Database ("EAD") as only a handful of cases, the resolution affected thousands of enrollees.

payment and provider dispute processes, including training and auditing policies and procedures to ensure appropriate payment of claims.

- Further, in some settlement agreements, the DMHC negotiated with plans or medical groups to provide substantial community investment payments, often to underserved communities.

Questions

1. Could you provide an overview of the enforcement action process (i.e. how violations are uncovered, investigated, and resolved)?

- **How do you learn about violations? Is it through consumer complaints, surveys, etc.?**

The OE obtains information about potential violations of the Knox-Keene Act in a number of ways. The OE receives referrals from programs within the DMHC (i.e., Division of Financial Oversight, Division of Plan Surveys, Office of Plan Licensing, Division of Provider Solvency and Support, the Executive Office and, most often, from the Help Center). It also receives information on potential violations from public sources, such as court filings, consumer groups, media articles, and the general public.

The OE investigates each referral, although the depth and length of the investigation may vary depending upon the facts and potential violations involved. Investigative tools utilized by the OE include, but are not limited to, depositions, witness statements, document requests, written interrogatories, review of filings with the DMHC, subpoena of documents from other entities, asset review and expert consultation and retention, as well as any other investigative tools under the DMHC's authority. The aim is to determine the severity of the issue/violation and utilize the evidence as an aid in determining what the DMHC wants to achieve as a resolution.

In determining whether to take enforcement action, the type of penalty to pursue, and the scope of that penalty, the OE applies, among other things, the factors in California Code of Regulations, title 28, §1300.86 ("§ 1300.86"). Some of these factors include, but are not limited to:

- The nature, scope and gravity of the violation;
- The good or bad faith of the plan;
- The plan's history of violations;
- The willfulness of the violation;
- Whether the violation is an isolated incident; and

- The amount of the penalty necessary to deter similar violations in the future.⁴

To determine the penalty to be assessed in a particular case, the DMHC analyzes the facts and circumstances against the penalty justification factors. While each factor is important, it is the factual issues involved in each individual case that forms the basis for analyzing the factors.

The health plan or other violator is generally given notice of the anticipated penalty and, depending on the facts, is provided an opportunity to submit any mitigating or exculpatory evidence to seek a reduction or discharge of the penalty. If the case is resolved via agreement, the agreement is posted to the DMHC's Enforcement Action Database (EAD).

Additional and alternate remedies of a non-financial nature are available to the OE. For example, cease and desist orders, a freeze on health plan or medical group enrollment, health plan seizure, financial oversight, and plan oversight of RBOs.

If no agreement is reached, the DMHC will proceed to accusation or other more formal action, such as a cease and desist order, or an action in Superior Court. The violator is afforded its due process rights under the law throughout the administrative hearing forum or civil court process.

2. ***What are DMHC's timeline parameters for enforcement actions, and specifically for collecting fines and penalties? For example, I see letters of agreement (with the date the letter was sent by mail, the date signed/accepted by the health plan, and the date returned/filed by DMHC as the action date) and stipulation agreements (one example gave the plan 15 days to respond) but it's still not entirely clear how or if deadlines are imposed for payment of penalties and if so, how many days after receiving a letter or stipulation agreement does a health plan have to pay the penalty? If you could give us an indication of how DMHC ensures a timely response, that would be helpful.***

There is no statutory timeframe by which actions must be prosecuted. However, if the DMHC elects to pursue civil penalties for a violation (as opposed to administrative penalties which are sought under the Administrative Procedure Act), the DMHC must bring a civil action in the name of the people of the State of California in an applicable court of law, and must do so within four years of the violation. Therefore the time for review and issuance of a penalty or other action varies greatly.

⁴ This is a partial list of factors. The full list is found at §1300.86.

When the DMHC negotiates an agreement with another party, the terms of that agreement will specify the timeframe for payment of a monetary penalty. Those timeframes are tracked by the OE, and where payment has not been received by the due date, the OE will follow-up with the other party to demand and ensure payment.

The timing for payment of a penalty in disputed matters that are not resolved via a negotiated agreement will be dependent upon the outcome of administrative hearings or trials and associated orders.

3. *Can you give us an indication of the timeline between DMHC being notified of a violation and when a penalty is levied?*

This is highly fact-dependent. For example, a program will often work extensively with a health plan on corrective action before referring the matter to the OE, assuming there is no likelihood of imminent harm to enrollees or providers while that collaboration is underway. Once a matter is referred, cases that generally involve straightforward factual and/or legal issues may be pursued more quickly than others. For example, a grievance violation⁵ may result in the assessment of a penalty without the need for extensive investigation. This can usually be accomplished in a relatively short period of time.

In regard to cases where the likelihood of imminent harm to enrollees and/or providers is great, prompt enforcement action is imperative. Options might include a cease and desist order to prohibit non-compliant conduct which is effective the date of the order, requires the violator to immediately discontinue the non-compliant conduct, and if the violator disputes the order, it still remains in effect throughout the administrative hearing process and until a final decision is issued in the matter. Other actions include issuing a freeze order prohibiting health plans that contract with RBOs and other medical groups from assigning new enrollees to those organizations until the organizations become compliant with applicable requirements in the Act, or even seizing a health plan, which means that the DMHC takes control of a plan because of financial or other wrongdoing. Examples of some of these actions are as follows:

- The DMHC issued a cease and desist order prohibiting a plan from sending letters to providers requesting reimbursement for alleged overpayments that did not comply with the Act. The plan contested the order and the matter proceeded to hearing in the administrative forum. However, as noted above, the order became effective upon issuance, which meant that the plan was required to immediately discontinue the non-compliant behavior. That order remains in effect throughout the

⁵ A grievance violation is found when a health plan fails to comply with the statutory requirements for review and resolution of its grievances. The process itself is violated, while the underlying decision may or may not be questioned.

administrative hearing process, and until a final decision is issued in the matter. A final decision has not yet been issued.

- In another matter, several remedies were employed to curtail non-compliant conduct. A cease and desist order was issued against an on-call plastic surgeon who was not in the plan's network of providers and who was illegally balance billing plan enrollees for emergency services, even going so far as reporting them to credit agencies and suing them to collect the balances. When the DMHC became aware that the provider violated the order, the DMHC filed a civil action and obtained a preliminary injunction requiring the provider to comply with the order. The case recently proceeded to trial, but a decision has not yet been issued by the trial court.
- Following a whistleblower complaint regarding a plan's administrative and accessibility capacity of its kidney transplant program, the DMHC issued an order and entered into a settlement agreement within two months of the whistleblower's complaint to ensure that consumers would be able to get kidney transplant services. The corrective action plan included resolution of the immediate accessibility concerns and proscribed a long term solution and review of the actions taken by the plan. OE monitored the case for 5 years to ensure full compliance with the settlement terms.

Other, more complex and significant cases, can take a substantial period of time, often more than a year, to conduct an investigation and analysis of the available prosecutory actions. Further, either during or after investigation, there are occasions when the DMHC will monitor plan or violator conduct and the corrective actions taken over an extended period of time.

4. Are the amount of the penalties final or are they negotiable? Have any penalties ever been reduced or dismissed entirely? Are those cases noted on the enforcement webpage?

For the most part, monetary penalties, once assessed against a health plan, are final, unless a negotiated agreement is reached reducing or modifying the penalties and/or the health plan disputes the monetary penalties and a hearing is held before the Office of Administrative Hearings.

Examples of negotiated agreements reducing penalty amounts include actions involving financial audits or plan claims payment practices. In such agreements, the total amount of the monetary penalties is contingent on the health plan correcting the behavior that triggered the violation. In those situations, the health plans were assessed a penalty, paid a certain amount of that penalty upfront, and the remainder of the penalty amount was suspended, pending results of a follow up audit. In instances where the DMHC's follow-up audit found either no violative claims payment practices or significant improvement in those practices, the DMHC either waived or reduced the amount due from the

remaining portion of the suspended penalty. Additionally, there are occasions when the DMHC has worked out payment arrangements for the payment of a penalty.

With regard to non-monetary penalties, the DMHC may take follow up action, such as lifting an order, once the violator's conduct has been cured. Both the original action and the lift order will be reflected on the DMHC's website.

5. How does the DMHC determine the amount of the penalty?

The factors in §1300.86 are used in determining the nature of the penalty to be imposed, and the penalty amount.⁶ The factors apply equally to both monetary and non-monetary penalties. For example, where the financial viability of a health plan is questionable, seizure of the health plan may be recommended. If the offending entity is a RBO, an order issued to that RBO's contracted health plans to freeze assigning additional enrollment to the RBO, may be appropriate. These penalties are designed to correct the noncompliance by the health plan and are based on the specific facts of the case. In some instances, a significant penalty is warranted; such as when the violation is found on a repeated basis, is egregious in nature, or involves a significant number of enrollees. Additionally, the DMHC often utilizes a combination of penalties, for example, an accusation levying a monetary penalty combined with a cease and desist order.

The OE is governed by statutes, regulations and other applicable laws when determining the penalty to be assessed for a health plan's violative conduct. Most of the statutes are found in the Knox-Keene Act, which lays out a statutory scheme that effectuates the DMHC's enforcement of the law. Thus, the DMHC construes the facts on a case-by-case basis in determining the scope and nature of a penalty to be assessed, using legally-imposed guidelines.

6. Of the listed enforcement actions in the database, are there any that were never collected? If so, how many? Under what circumstances would a penalty not be collected by DMHC?

The penalties assessed are generally paid to the DMHC. There have been occasions where, rather than payment to the Managed Care Fund, the penalties have been redirected to investment in measures designed to correct violations, such as enhancement of the plan's provider network. Penalties have also been partially suspended contingent on some action by the health plan to remedy the violative conduct. And, where the health plan fails to meet the requirements of

⁶ The factors identified in § 1300.86 are used to determine the amount of an administrative penalty. Administrative penalties are pursued under the rules of the Administrative Procedure Act and, if disputed, are challenged at a hearing before the Office of Administrative Hearings. If a civil penalty is pursued, the Knox-Keene Act limits those penalties to \$2,500 per violation. If the violation is ongoing and continuous, the penalty is \$2,500 for each day that the violation continues. (Health & Saf. Code § 1387; Cal. Code Regs., tit. 28, § 1300.87.)

the contingency, the suspended portion of the penalty has been reinstated and immediately collected. For example, as a result of financial audits of several health plans, a combined \$4 million in penalties was levied against several health plans. However, a portion of that monetary penalty was suspended contingent upon the plans' compliance with specific provisions of the Knox-Keene Act which were verified at the next financial exam conducted by the DMHC. In one follow up exam, the plan's compliance was confirmed and the suspended penalty was waived. In another, the plan's substantial compliance resulted in a reduction of the outstanding penalty, which was paid by the plan. Follow up audits for several plans are not yet complete.

Penalties have at times not been collected. For example, upon surrender of a license, the penalty has on occasion been waived because the money would be better used to make the plan's providers and enrollees whole, and there is no need to correct future plan behavior.

7. What is the appeals process for a health plan if they dispute a reported violation or penalties assessed? What's the timeline for appeals?

When formal disciplinary action such as a cease and desist order or an accusation is contested, the hearing and appeals process is governed by the Administrative Procedure Act and the Office of Administrative Hearings process. If the OE files a civil complaint in Superior Court, the rules and procedures governing civil actions apply.

During the investigation of the violation, the OE may informally advise the health plan that a violation has occurred warranting disciplinary action. The OE will generally provide the health plan the opportunity to produce any exculpatory or mitigating evidence. Should the health plan provide such evidence, the penalty may be negotiated or discharged.

8. *Of the enforcement actions listed in your database, how many penalties are for behavioral/mental health parity related violations? Would you be able to provide a list of those with details such as which health plan, amount of penalty, action date, etc.?*

There are 20 matters⁷, in total, on the EAD related to California's Mental Health Parity Act, codified at Health & Safety Code §1374.72 and its corresponding

⁷ A "matter" is an enforcement action that is listed in the EAD under a single "matter number." This matter, however, may contain more than one complaint and/or more than one type of enforcement action imposed. For example, a cease and desist order may be issued and an accusation filed - - resulting in two enforcement actions.

regulation, California Code of Regulations, title 28, §1300.74.72. The monetary penalties for these matters total \$4,200,000.00⁸.

In addition, non-monetary settlements have been reached in several matters. For example, health plans have been required to reimburse enrollees for their out-of-pocket costs in obtaining services that the plan should have covered, and change their policies to ensure that enrollees obtain the services they are entitled to under the law. See the attached summary chart for information on these matters.

⁸ The \$4,000,000 penalty recently assessed against Kaiser has yet to be collected as the plan is contesting this penalty assessment. A hearing will be held before the Office of Administrative Hearings.

BIOGRAPHY – ROBERT HERRELL

Robert Herrell serves as the Deputy Insurance Commissioner and Legislative Director for the California Department of Insurance under Insurance Commissioner Dave Jones. He has served in that role since April 2013.

Mr. Herrell has a wide range of experience in the public, private and non-profit sectors. He served as Staff Director for then-State Senator Jackie Speier and was the lead staff person on consumer financial privacy legislation and dietary supplement reform. He also served as both Chief Consultant and Senior Consultant to the Assembly Consumer Protection, Governmental Efficiency and Economic Development Committee under then-State Assembly member Susan Davis, where he worked on a myriad of consumer protection and economic development issues and analyzed hundreds of legislative proposals.

Mr. Herrell's legislative experience also includes working as the Legislative Director in 2007-08 for Commissioner Jones when he served in the California State Assembly. Early in his career Mr. Herrell was a consultant on budget, appropriations, consumer protection and economic development issues at the Assembly Ways and Means Committee under Chairman John Vasconcellos (ret.).

Mr. Herrell has worked extensively on a wide range of public policy areas, including consumer protection, financial and consumer privacy, health care, immigration, economic development, capital access, transportation, energy, environmental protection and budgetary policy.

Mr. Herrell returned to California in Spring 2013 following more than four years in Chicago, IL, where he served as the Vice President of an internet start-up company focused on the Latino community. He also spent two-and-a-half years living throughout Latin America and served as a community volunteer for local non-governmental organizations in Guatemala, Peru, and Argentina.

Mr. Herrell is a California native and has a BA and MBA from the University of California, Irvine.

FACT SHEET

SB 946 (Steinberg)

Autism & Behavioral Health Treatment

Purpose of the Bill

SB 946, authored by Senator Steinberg— President Pro Tempore, requires that private health plans and insurance companies must provide coverage of behavioral health treatment (BHT) for individuals with autism or pervasive developmental disorders. BHT is now recognized as the single most effective form of healthcare therapy for these disorders. The intent of this legislation is to ensure access to quality behavioral health treatment for individuals with autism and pervasive developmental disorders.

The Problem & Need for the Bill

Autism Spectrum Disorder (ASD) is the fastest-growing serious developmental disability in the U.S. ASD is now more common than childhood cancer, juvenile diabetes and pediatric AIDS combined. Although there is no cure for ASD, behavioral health treatment (BHT) is now widely accepted as an effective medical treatment for this disorder (i.e. American Academy of Pediatrics; National Institutes of Mental Health; U.S. Surgeon General; medical/scientific literature). Nevertheless, many private health plans and health insurance companies deny BHT under the pretext that it is an educational service and therefore not a covered benefit. This administrative decision by the health plans precludes any review by physicians or other medical providers; thereby potentially withholding crucial medical services.

What Will This Bill Do?

SB 946 establishes a definition and criteria for BHT that are consistent with established medical treatment standards. This bill simply requires coverage for BHT services that meet these standards. This legislation also establishes appropriate guidelines and standards for individuals, groups, and entities that will be designated as appropriate providers for these services. In addition, the Department of Managed Health Care will convene an Autism Advisory Task Force that will provide technical assistance on specified issues related to BHT for autism and pervasive developmental disorders. This legislation does not alter the current grievance or appeals process nor does it affect case management or utilization review. Furthermore, questions of medical necessity, experimental interventions, and other treatment issues will be resolved by the existing “Independent Medical Review” process that is regulated by the Dept. of Managed Health Care or the California Dept. of Insurance. SB 946 is a step in the right direction to ensure that the health plans are doing their fair share in the treatment of this disorder

Sponsors: Alliance of California Autism Organizations; Autism Speaks; Special Needs Network; The Help Group

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SENATOR
DARRELL STEINBERG
PRESIDENT PRO TEMPORE
SIXTH SENATE DISTRICT



FOR IMMEDIATE RELEASE
September 9, 2011

Contact: Alicia Trost
916-651-4006

Steinberg Bill to Mandate Autism Treatment Coverage Sent to the Governor

(Sacramento)-- Senate President pro Tem Darrell Steinberg's (D-Sacramento) measure to ensure people with autism have access to the medical treatments and therapies they need has been passed by the California Legislature and sent to the Governor for his consideration.

SB 946 mandates health insurance coverage of behavioral health treatment, such as Applied Behavioral Analysis (ABA) and other prescribed intensive early intervention therapy, for those with autism. The bill also defines the scope of these treatments and eliminates unwarranted restrictions on those who are qualified to provide the treatment.

"Despite promises from health care plans, coverage of ABA services is still being denied," Steinberg said. "While there are many challenges that still need to be overcome, this bill is a huge step in the right direction in giving families a ray of hope that brings light at the end of the tunnel."

The bill follows through on work the pro Tem has done as Chair of the Senate Select Committee on Autism and Related Disorders and as Chair of the Legislative Blue Ribbon Commission on Autism. In both forums Steinberg heard compelling stories from families and advocates about their plight in battling health plans and insurance companies in obtaining medically necessary treatment for these devastating disorders.

"Many other states have passed varying autism mandates but this bill is unique because there are no caps or limits on the age of recipients or the types of services that will be mandated," Steinberg said.

The bill is supported by Autism Speaks, Alliance of California Autism Organizations, Special Needs Network, and The Help Group.

Alicia Trost
Press Secretary; Senate President Pro Tempore Darrell Steinberg
916-651-4006 (work) 916-207-8245 (cell)

Senate Bill No. 946

CHAPTER 650

An act to amend Section 121022 of, to add Section 1374.74 to, and to add and repeal Section 1374.73 of, the Health and Safety Code, to add and repeal Sections 10144.51 and 10144.52 of the Insurance Code, and to amend Sections 5705, 5708, 5710, 5716, 5724, and 5750.1 of the Welfare and Institutions Code, relating to health.

[Approved by Governor October 9, 2011. Filed with
Secretary of State October 9, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

SB 946, Steinberg. Health care coverage: mental illness: pervasive developmental disorder or autism: public health.

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of these provisions is a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to provide benefits for specified conditions, including certain mental health conditions.

This bill, effective July 1, 2012, would require those health care service plan contracts and health insurance policies, except as specified, to provide coverage for behavioral health treatment, as defined, for pervasive developmental disorder or autism. The bill would provide, however, that no benefits are required to be provided that exceed the essential health benefits that will be required under specified federal law. Because a violation of these provisions with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

These provisions would be inoperative July 1, 2014, and repealed on January 1, 2015.

The bill would require the Department of Managed Health Care, in conjunction with the Department of Insurance, to convene an Autism Advisory Task Force by February 1, 2012, to provide assistance to the department on topics related to behavioral health treatment and to develop recommendations relating to the education, training, and experience requirements to secure licensure from the state. The bill would require the department to submit a report of the Task Force to the Governor and specified members of the Legislature by December 31, 2012.

Existing law establishes various communicable disease prevention and control programs. Existing law requires the State Department of Public Health to establish a list of reportable diseases and conditions and requires health care providers and laboratories to report cases of HIV infection to the local health officer using patient names and sets guidelines regarding

these reports. Existing law requires the local health officers to report unduplicated HIV cases by name to the department.

This bill would authorize the department to revise the HIV reporting form without the adoption of a regulation, as specified.

Under the Bronzan-McCorquodale Act, the State Department of Mental Health administers the provision of funds to counties for community mental health services programs. Existing law also permits counties to receive, under certain circumstances, Medi-Cal reimbursement for mental health services. Under existing law, negotiated net amounts or rates are used as the cost of services in contracts between the state and the county and between the county and a subprovider of services. Existing law establishes the method for computing negotiated rates. Existing law prohibits the charges for the care and treatment of each patient receiving service from a county mental health program from exceeding the actual or negotiated cost of the services.

This bill would only allow the use of negotiated net amounts as the cost of services in a contract between the state and a county and the county and a subprovider of services, and would eliminate the use of negotiated rates. The bill would also specify that the charges for the care and treatment of each patient receiving a service from a county mental health program shall not exceed the actual cost of the service.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Under existing law, the State Department of Health Care Services promulgates regulations for determining reimbursement of Short-Doyle mental health services allowable under the Medi-Cal program. Existing law requires the State Department of Mental Health and the State Department of Health Care Services to jointly develop a ratesetting methodology for use in the Short-Doyle Medi-Cal system that maximizes federal funding and utilizes, as much as practicable, federal Medicare reimbursement principles. Existing law requires that this ratesetting methodology contain incentives relating to economy and efficiency.

The bill would delete the requirement that the ratesetting methodology in the Short-Doyle Medi-Cal system include incentives relating to economy and efficiency.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1374.73 is added to the Health and Safety Code, to read:

1374.73. (a) (1) Every health care service plan contract that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 1374.72.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health plans will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individualized service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400, et seq.) and its implementing regulations.

(b) Every health care service plan subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. Nothing shall prevent a health care service plan from selectively contracting with providers within these requirements.

(c) For the purposes of this section, the following definitions shall apply:

(1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

- (i) A qualified autism service provider.
- (ii) A qualified autism service professional supervised and employed by the qualified autism service provider.
- (iii) A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

- (i) Describes the patient's behavioral health impairments to be treated.
- (ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
- (iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
- (iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 1374.72.

(3) "Qualified autism service provider" means either of the following:

(A) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

(4) "Qualified autism service professional" means an individual who meets all of the following criteria:

- (A) Provides behavioral health treatment.
- (B) Is employed and supervised by a qualified autism service provider.
- (C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
- (D) Is a behavioral service provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst,

Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.

(E) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(5) "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

(A) Is employed and supervised by a qualified autism service provider.

(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

(C) Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.

(D) Has adequate education, training, and experience, as certified by a qualified autism service provider.

(d) This section shall not apply to the following:

(1) A specialized health care service plan that does not deliver mental health or behavioral health services to enrollees.

(2) A health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(3) A health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code).

(4) A health care benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code).

(e) Nothing in this section shall be construed to limit the obligation to provide services under Section 1374.72.

(f) As provided in Section 1374.72 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

(g) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 1374.74 is added to the Health and Safety Code, to read:

1374.74. (a) The department, in consultation with the Department of Insurance, shall convene an Autism Advisory Task Force by February 1, 2012, in collaboration with other agencies, departments, advocates, autism experts, health plan and health insurer representatives, and other entities and stakeholders that it deems appropriate. The Autism Advisory Task Force shall develop recommendations regarding behavioral health treatment that is medically necessary for the treatment of individuals with autism or

pervasive developmental disorder. The Autism Advisory Task Force shall address at the following:

(1) Interventions that have been scientifically validated and have demonstrated clinical efficacy.

(2) Interventions that have measurable treatment outcomes.

(3) Patient selection, monitoring, and duration of therapy.

(4) Qualifications, training, and supervision of providers.

(5) Adequate networks of providers.

(b) The Autism Advisory Task Force shall also develop recommendations regarding the education, training, and experience requirements that unlicensed individuals providing autism services shall meet in order to secure a license from the state.

(c) The department shall submit a report of the Autism Advisory Task Force to the Governor, the President pro Tempore of the Senate, the Speaker of the Assembly, and the Senate and Assembly Committees on Health by December 31, 2012, on which date the task force shall cease to exist.

SEC. 3. Section 121022 of the Health and Safety Code is amended to read:

121022. (a) To ensure knowledge of current trends in the HIV epidemic and to ensure that California remains competitive for federal HIV and AIDS funding, health care providers and laboratories shall report cases of HIV infection to the local health officer using patient names on a form developed by the department. Local health officers shall report unduplicated HIV cases by name to the department on a form developed by the department.

(b) (1) Health care providers and local health officers shall submit cases of HIV infection pursuant to subdivision (a) by courier service, United States Postal Service express mail or registered mail, other traceable mail, person-to-person transfer, facsimile, or electronically by a secure and confidential electronic reporting system established by the department.

(2) This subdivision shall be implemented using the existing resources of the department.

(c) The department and local health officers shall ensure continued reasonable access to anonymous HIV testing through alternative testing sites, as established by Section 120890, and in consultation with HIV planning groups and affected stakeholders, including representatives of persons living with HIV and health officers.

(d) The department shall promulgate emergency regulations to conform the relevant provisions of Article 3.5 (commencing with Section 2641.5) of Chapter 4 of Division 1 of Title 17 of the California Code of Regulations, consistent with this chapter, by April 17, 2007. Notwithstanding the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), if the department revises the form used for reporting pursuant to subdivision (a) after consideration of the reporting guidelines published by the federal Centers for Disease Control and Prevention, the revised form shall be implemented without being adopted as a regulation, and shall be filed with

the Secretary of State and printed in Title 17 of the California Code of Regulations.

(e) Pursuant to Section 121025, reported cases of HIV infection shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

(f) State and local health department employees and contractors shall be required to sign confidentiality agreements developed by the department that include information related to the penalties for a breach of confidentiality and the procedures for reporting a breach of confidentiality, prior to accessing confidential HIV-related public health records. Those agreements shall be reviewed annually by either the department or the appropriate local health department.

(g) No person shall disclose identifying information reported pursuant to subdivision (a) to the federal government, including, but not limited to, any agency, employee, agent, contractor, or anyone else acting on behalf of the federal government, except as permitted under subdivision (b) of Section 121025.

(h) (1) Any potential or actual breach of confidentiality of HIV-related public health records shall be investigated by the local health officer, in coordination with the department, when appropriate. The local health officer shall immediately report any evidence of an actual breach of confidentiality of HIV-related public health records at a city or county level to the department and the appropriate law enforcement agency.

(2) The department shall investigate any potential or actual breach of confidentiality of HIV-related public health records at the state level, and shall report any evidence of such a breach of confidentiality to an appropriate law enforcement agency.

(i) Any willful, negligent, or malicious disclosure of cases of HIV infection reported pursuant to subdivision (a) shall be subject to the penalties prescribed in Section 121025.

(j) Nothing in this section shall be construed to limit other remedies and protections available under state or federal law.

SEC. 4. Section 10144.51 is added to the Insurance Code, to read:

10144.51. (a) (1) Every health insurance policy shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 10144.5.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare

and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individualized service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400, et seq.) and its implementing regulations.

(b) Pursuant to Article 6 (commencing with Section 2240.1) of Title 10 of the California Code of Regulations, every health insurer subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. Nothing shall prevent a health insurer from selectively contracting with providers within these requirements.

(c) For the purposes of this section, the following definitions shall apply:

(1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

- (i) A qualified autism service provider.
- (ii) A qualified autism service professional supervised and employed by the qualified autism service provider.
- (iii) A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

- (i) Describes the patient's behavioral health impairments to be treated.
- (ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
- (iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the insurer upon request.

(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 10144.5.

(3) "Qualified autism service provider" means either of the following:

(A) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

(4) "Qualified autism service professional" means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment.

(B) Is employed and supervised by a qualified autism service provider.

(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.

(D) Is a behavioral service provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.

(E) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(5) "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

(A) Is employed and supervised by a qualified autism service provider.

(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

(C) Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.

(D) Has adequate education, training, and experience, as certified by a qualified autism service provider.

(d) This section shall not apply to the following:

(1) A specialized health insurance policy that does not cover mental health or behavioral health services or an accident only, specified disease, hospital indemnity, or Medicare supplement policy.

(2) A health insurance policy in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(3) A health insurance policy in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code).

(4) A health care benefit plan or policy entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code).

(e) Nothing in this section shall be construed to limit the obligation to provide services under Section 10144.5.

(f) As provided in Section 10144.5 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

(g) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 5. Section 10144.52 is added to the Insurance Code, to read:

10144.52. (a) For purposes of this part, the terms "provider," "professional provider," "network provider," "mental health provider," and "mental health professional" shall include the term "qualified autism service provider," as defined in subdivision (c) of Section 10144.51.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 6. Section 5705 of the Welfare and Institutions Code is amended to read:

5705. (a) It is the intent of the Legislature that the use of negotiated net amounts, as provided in this section, be given preference in contracts for services under this division.

(b) Negotiated net amounts may be used as the cost of services in contracts between the state and the county or contracts between the county and a subprovider of services, or both. A negotiated net amount shall be determined by calculating the total budget for services for a program or a component of a program, less the amount of projected revenue. All participating government funding sources, except for the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9), shall be bound to that amount as the cost of providing all or part of the total county mental health program as described in the county performance contract for each fiscal year, to the extent that the governmental funding source

participates in funding the county mental health programs. Where the State Department of Health Care Services promulgates regulations for determining reimbursement of Short-Doyle mental health services allowable under the Medi-Cal program, those regulations shall be controlling as to the rates for reimbursement of Short-Doyle mental health services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries. Providers under this subdivision shall report to the State Department of Mental Health and local mental health programs any information required by the State Department of Mental Health in accordance with procedures established by the Director of Mental Health.

(c) Notwithstanding any other provision of this division or Division 9 (commencing with Section 10000), absent a finding of fraud, abuse, or failure to achieve contract objectives, no restrictions, other than any contained in the contract, shall be placed upon a provider's expenditure pursuant to this section.

SEC. 7. Section 5708 of the Welfare and Institutions Code is amended to read:

5708. To maintain stability during the transition, counties that contracted with the department during the 1990-91 fiscal year on a negotiated net amount basis may continue to use the same funding mechanism.

SEC. 8. Section 5710 of the Welfare and Institutions Code is amended to read:

5710. (a) Charges for the care and treatment of each patient receiving service from a county mental health program shall not exceed the actual cost thereof as determined or approved by the Director of Mental Health in accordance with standard accounting practices. The director may include the amount of expenditures for capital outlay or the interest thereon, or both, in his or her determination of actual cost. The responsibility of a patient, his or her estate, or his or her responsible relatives to pay the charges and the powers of the director with respect thereto shall be determined in accordance with Article 4 (commencing with Section 7275) of Chapter 3 of Division 7.

(b) The Director of Mental Health may delegate to each county all or part of the responsibility for determining the financial liability of patients to whom services are rendered by a county mental health program and all or part of the responsibility for determining the ability of the responsible parties to pay for services to minor children who are referred by a county for treatment in a state hospital. Liability shall extend to the estates of patients and to responsible relatives, including the spouse of an adult patient and the parents of minor children. The Director of Mental Health may also delegate all or part of the responsibility for collecting the charges for patient fees. Counties may decline this responsibility as it pertains to state hospitals, at their discretion. If this responsibility is delegated by the director, the director shall establish and maintain the policies and procedures for making the determinations and collections. Each county to which the responsibility is delegated shall comply with the policy and procedures.

(c) The director shall prepare and adopt a uniform sliding scale patient fee schedule to be used in all mental health agencies for services rendered to each patient. In preparing the uniform patient fee schedule, the director shall take into account the existing charges for state hospital services and those for community mental health program services. If the director determines that it is not practicable to devise a single uniform patient fee schedule applicable to both state hospital services and services of other mental health agencies, the director may adopt a separate fee schedule for the state hospital services which differs from the uniform patient fee schedule applicable to other mental health agencies.

SEC. 9. Section 5716 of the Welfare and Institutions Code is amended to read:

5716. Counties may contract with providers on a negotiated net amount basis in the same manner as set forth in Section 5705.

SEC. 10. Section 5724 of the Welfare and Institutions Code is amended to read:

5724. (a) The department and the State Department of Health Care Services shall jointly develop a new ratesetting methodology for use in the Short-Doyle Medi-Cal system that maximizes federal funding and utilizes, as much as practicable, federal medicare reimbursement principles. The departments shall work with the counties and the federal Health Care Financing Administration in the development of the methodology required by this section.

(b) Rates developed through the methodology required by this section shall apply only to reimbursement for direct client services.

(c) Administrative costs shall be claimed separately and shall be limited to 15 percent of the total cost of direct client services.

(d) The cost of performing utilization reviews shall be claimed separately and shall not be included in administrative cost.

(e) The rates established for direct client services pursuant to this section shall be based on increments of time for all noninpatient services.

(f) The ratesetting methodology shall not be implemented until it has received any necessary federal approvals.

SEC. 11. Section 5750.1 of the Welfare and Institutions Code is amended to read:

5750.1. Notwithstanding Section 5750, a standard, rule, or policy, not directly the result of a statutory or administrative law change, adopted by the department or county during the term of an existing county performance contract shall not apply to the negotiated net amount terms of that contract under Sections 5705 and 5716, but shall only apply to contracts established after adoption of the standard, rule, or policy.

SEC. 12. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime

within the meaning of Section 6 of Article XIII B of the California Constitution.

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The Impact of SB 946 on the Regional Center System

AGENDA ITEM # 3

(a) Data & Information Overview: Legislative Analyst's Office

- Biographies of Mr. Shawn Martin & Ms. Rashi Kesarwani
- Data & Information Overview for Autism Insurance Mandate

(b) Department of Developmental Services

- Biographies of Ms. Nancy Bargmann & Mr. Jim Knight

(c) Regional Center representative

- Biography of Mr. Rick Rollens – Association of Regional Center Agencies (ARCA)
- Testimony from Ms. Eileen Richey – Executive Director of ARCA
- FAQs Regarding Insurance Funding for Behavioral Health Treatment for Autism & PDD

Shawn Martin,

Shawn Martin, Managing Principal Analyst, Legislative Analyst's Office

Shawn Martin is the Managing Principal Analyst for Health and Human Services at the Legislative Analyst's Office, where he provides nonpartisan fiscal and policy advice to the California Legislature. Prior to joining the Legislative Analyst's Office, Mr. Martin was a Finance Budget Analyst at the California Department of Finance. Mr. Martin served as a Peace Corps. Volunteer in Honduras for two years before he earned a graduate degree from the American Graduate School of International Management (MIM). Mr. Martin earned his undergraduate degree from the University of California at Santa Barbara (BA).

Rashi Kesarwani

Rashi Kesarwani, Fiscal and Policy Analyst, Legislative Analyst's Office:

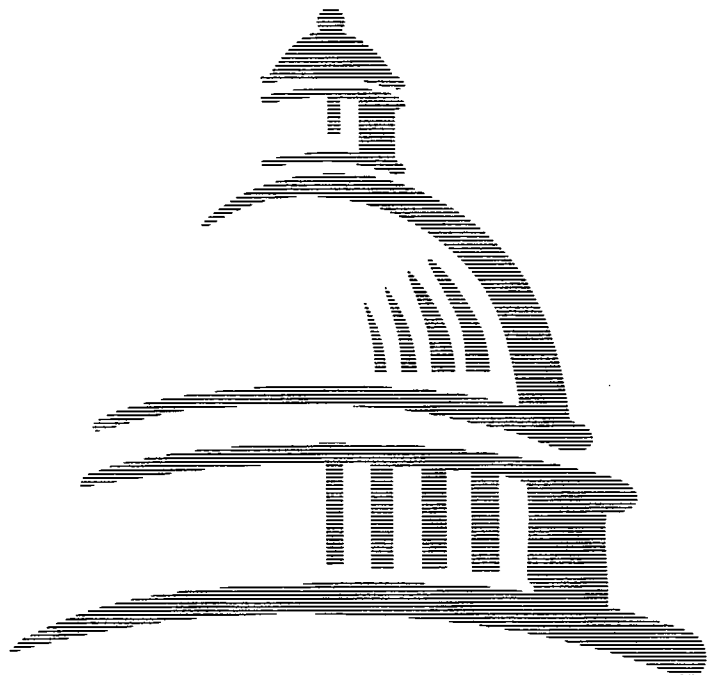
Rashi Kesarwani is a Fiscal and Policy Analyst at the Legislative Analyst's Office, where she provides nonpartisan fiscal and policy advice to the California Legislature related to Developmental Services and the In-Home Supportive Services program. Ms. Kesarwani worked as a journalist before earning a graduate degree from the University of California at Berkeley (MPP). Ms. Kesarwani earned her undergraduate degree from Brown University (BA).

March 4, 2014

Data and Information Overview For Autism Insurance Mandate

LEGISLATIVE ANALYST'S OFFICE

Presented to:
Senate Select Committee on Autism and Related Disorders
Hon. Darrell Steinberg, Chair





The CHBRP's Estimate of Annual Cost of BHT Provided by Private Health Insurance Plans

The California Health Benefits Review Program (CHBRP) Conducts Analyses of Health Insurance Benefit Mandates.

The CHBRP responds to requests from the Legislature to provide independent analyses of the medical, financial, and public health impacts of proposed health insurance benefit mandates and proposed repeals of health insurance benefit mandates.

In 2013, the CHBRP Analyzed the Impact of Legislation Extending the Autism Insurance Mandate—Chapter 650, Statutes of 2011 (SB 946, Steinberg)—Requiring Private Health Insurance Plans to Provide Behavioral Health Treatment (BHT) to Enrollees With Autism.

- ***Average Annual Hours of BHT Used for CHBRP Study.*** In 2013, CHBRP estimated that consumers with private health insurance plans receive BHT—on average—for a total of 600 hours annually. This estimate is based on academic literature, expert opinion, and a 2007 study of 383 families with a child age 11 or younger with autism.
- ***Average Per-Hour Cost of BHT Used for CHBRP Study.*** In 2013, CHBRP estimated that BHT cost—on average—\$90 per hour. This estimate is based on health insurance plan data from 2008 provided by an actuarial firm.
- ***Average Annual Cost of BHT.*** Taken together, CHBRP estimated the average annual cost of BHT provided through private health insurance plans to be \$54,000 per child in 2013.



SB 946—Relevant Data Currently Tracked by DDS



After a Period of Caseload Growth, the Number of Consumers With Autism Receiving BHT Purchased by Regional Centers (RCs) Falls. After growing by 94 consumers in 2009-10, by 278 consumers in 2010-11, and by 89 consumers in 2011-12, the number of consumers with autism receiving BHT purchased by RCs fell by 684 consumers in 2012-13—when the mandate for private health insurance plans to provide BHT went into effect. This reflects a roughly 10 percent reduction in RC caseload (not on Medi-Cal) receiving BHT.

Number of Regional Center (RC) Consumers With Autism Receiving Behavioral Health Treatment Purchased by RCs ^a				
2008-09	2009-10	2010-11	2011-12	2012-13
6,251	6,345	6,623	6,712	6,028

^a Does not include consumers on Medi-Cal.



SB 946 Impact May Be Understated. We note that several factors cause consumers who may be receiving BHT from a private health insurance plan to remain in the Department of Developmental Services (DDS) count as receiving BHT from RCs; these factors include cases in which a consumer receives another behavioral service (not covered by the insurance plan) from the RC or if a consumer's BHT was slow to transition from RC-purchased services to insurance coverage in 2012-13.



The DDS Tracks RC Expenditures to Assist Consumers With Out-of-Pocket Costs for BHT Through Private Health Insurance Plans. The DDS tracks the estimated RC expenditures for assisting consumers with out-of-pocket costs, such as copays and coinsurance, to receive BHT through their private health insurance plans. We note there are some limitations associated with this estimate of RC expenditures. (We are awaiting the data from DDS.)



Additional Data Collection That Could Assist With Future SB 946 Impact Analysis

- The CHBRP Reports That More Data Will Become Available the Longer the Mandate Is in Effect.*** Data from private health insurance plans becomes available through actuarial firms on a time lag of roughly 18 months. In the future, once more recent data is fully available through an actuarial firm, CHBRP could conduct estimates of the utilization of BHT provided by health insurance plans and the average annual cost of this benefit. Unlike prior estimates that relied on academic literature and expert opinion, future estimates could be based on plans' actual experience with the mandate.

- A New CHBRP Study Could Be Informative for the Legislature.*** A new CHBRP study could help the Legislature evaluate the impact of SB 946.

Nancy Bargmann, Department of Developmental Services (DDS).

Ms. Bargmann is the Deputy Director of the Community Services Division at DDS. Prior to coming to DDS in 2012, Ms. Bargmann was the executive director for a non-profit affordable housing foundation. Additionally, Ms. Bargmann worked for a national service provider in multiple executive positions from 1998 to 2009, including vice president of operations, and also served in a number of roles at the Inland Regional Center from 1985 to 1998, including community services director. Ms. Bargmann holds a Masters in Social Work and a Masters in Business Management Administration

Jim Knight, Department of Developmental Services (DDS).

Mr. Knight is an Assistant Deputy Director in the Community Services Division at DDS where he has held a number of positions since 2000. Prior to coming to DDS, Mr. Knight was the assistant director for a non-profit agency that provides community services for people with developmental disabilities. Further, Mr. Knight worked for multiple other community service providers, in a number of roles, from 1982-1995. Mr. Knight holds a Bachelor of Arts Degree in Social Sciences

RICK ROLLENS

Rick Rollens, 62, resides with his wife of 37 years, Janna, and their two sons Matthew, 28, and Russell, 23, in Granite Bay, California. Rick is President of Rollens Consulting, a government relations and lobbying company in Sacramento representing clients from the brain injury, autism and developmental disabilities community. Rick has been the Legislative Advisor to Association of Regional Center Agencies (ARCA) for over 18 years.

Twenty one years ago when his son Russell was diagnosed with autism, Rick began an unprecedented father's battle to find a cure for his son's disability. Shortly after Russell was diagnosed, Rick became a co-founder of Families for Early Autism Treatment (FEAT). Rick established an annual "Autism Awareness Week" that is proclaimed by the Governor and Legislature each year and is celebrated throughout the world. FEAT established the "Rick Rollens Research Award," which is presented each year to an outstanding person in the field of autism and autism research. Rick is also a co-founder of Alliance of California Autism Organizations (ACAO).

Rick is the former Secretary of the California State Senate, a position he held for many of his 24 years of distinguished service to the California State Senate. Prior to his career with the California Senate, Rick served on the staff of Congressman Jerome Waldie in Washington, D.C. With his numerous government and private contacts at the state and federal level, Rick was successful in securing legislation in California to produce the 1999 "California Report," the first state or federal report documenting the alarming increase in autism in the U.S. in recent decades. This ground breaking report, which has had annual updates since 1999, led to funding for the recently released Byrd study examining factors that have been linked to California's autism epidemic.

Rick was one of the parent co-founders of the U.C. Davis M.I.N.D. Institute, having secured, in 1998, the passage of state legislation creating what has become one of the world's largest private or public entities dedicated to research and treatment of neurodevelopmental disorders in children. Rick is directly responsible for raising millions of dollars for ongoing funding, from state and private sources, for M.I.N.D., and for autism research. Rick has testified before Congress and the California legislature on autism as well as vaccine safety and proposed new vaccine mandates. He has participated in NIH Committees setting autism research agendas and spoken at many meetings around the world, including an invitation from the government of Ireland to address the European Union (EU) in 2007 on the U.S. autism epidemic. His son, Russell, was featured on the cover the July 31, 2000 issue of *Newsweek*, which became the all-time best selling issue of the magazine. Rick has contributed to or been featured in hundreds of media reports, including *60 Minutes*, *Reader's Digest*, *Washington Post*, *New York Times*, and *BBC* and was featured in the best selling book *Evidence of Harm*.

Rick is on the board of the M.I.N.D. Institute, Autism Education Network, Autism Coalition for Research and Education, and Unlocking Autism and is a former board member of Cure Autism Now (CAN) and Autism Society of America. He was appointed in 2006 by the California Speaker of the State Assembly to serve on the Blue Ribbon Commission on Autism and recently was appointed by California's Superintendent of Public Instruction to the State Department of Education's Autism Advisory Committee. Rick also served on the California Department of Managed Health Care's Autism Task Force.



ASSOCIATION OF REGIONAL CENTER AGENCIES

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February 24, 2014

Senator Darrell Steinberg, Chairman
Senate Subcommittee on Autism and Related Disorders
State Capitol, Room 250
Sacramento, CA 95814 - 4900

RE: March 4, 2014 Informational Hearing on SB 946

Honorable Senator Steinberg:

The Association of Regional Center Agencies (ARCA) represents the network of twenty-one regional centers that advocate on behalf of and coordinate services for over 260,000 Californians with developmental disabilities, including more than 65,000 individuals with Autism Spectrum Disorder (ASD).

The role of the regional centers in accessing SB 946 funding

- The Lanterman Act requires regional centers to fund only services that are not the responsibility of another public or private entity.
- Regional centers, through their association, worked with the Department of Managed Health Care and the California Association of Health Plans to streamline the insurance referral process and to identify single points of contact within each regional center and health plan.
- Regional centers worked to learn the most efficient ways to access insurance funding for services in order to simplify the process for families.
- Regional centers trained staff to access insurance funding and to respond appropriately to unfavorable funding decisions, including the complaint and independent medical review processes through the Department of Managed Health Care and the Department of Insurance.
- Regional centers worked to transition individuals from regional center funding to insurance funding and tried to ensure a continuity of services.
- When denials were received from insurers, regional centers aided many in challenging those decisions or exploring the reason for the denial (i.e., self-insured plans).

Operational challenges and opportunities in the implementation of SB 946

- The biggest challenge was with families happy with their current service provider that was not in their insurer's network.

- As behavioral health treatment for ASD was not something most insurers were providing before July 2012, it took some time for them to develop internal processes and to panel enough providers.
- Individuals seeking initial regional center funding for ABA after July 2012 could be connected with a provider in their insurer's network to begin receiving services.
- Many regional centers are now more comfortable accessing insurance-funded services and appealing when services are denied.

Update on the co-pays, co-insurance, and deductibles related to SB 946

- Requiring many families to pay copayments or coinsurance for needed ABA services is an obstacle to services that should be eliminated, particularly because these services were once paid for in full by regional centers without cost to families. Even if regional centers paid all associated copayments and coinsurance costs, the state would still realize significant cost savings from the implementation of SB 946.
- The prohibition on funding deductibles has posed a significant barrier to a handful of families; in one case the regional center was ordered at hearing to fund the full service rather than the deductible at a greater cost to the state. It is the only funding limitation in the Lanterman Act that has no exception clause.
- Requesting and tracking financial information for more families has been an administrative burden. With other programs dependent on family income (Annual Family Program Fee and Parental Copayment), financial information is not collected if the child has Medi-Cal.

The impact of the emergency regulations issued by the DMHC & CDI

- Emergency regulations by DMHC and California Department of Insurance helped to increase access to needed funding by clarifying the responsibilities of insurers .
- The emergency regulations by DMHC made it clear that Healthy Families plans and some CalPERS plans were responsible for funding needed behavioral health treatment, which helped more people to access insurance funding and saved money for the regional centers.
- Emergency regulations put into place by the Department of Insurance clarified that services that must be provided also include necessary speech and occupational therapy and also limited funding delays and denials based on three number of factors, including:
 - The need for IQ testing
 - A belief that behavioral health treatment is experimental
 - A preference for behavioral health treatment supervised by a licensed medical professional rather than a certified behaviorist
- The California Department of Insurance has recently proposed permanent regulations that clarify that regional center service funding does not change the responsibility of the insurer to fund services.

ARCA would like to thank the Senate Select Committee on Autism and Related Disorders for convening a hearing on the implementation of California's autism insurance mandate and appreciates the opportunity to provide input to committee members.

Sincerely,

/s/

Eileen Richey

Executive Director



FAQs Regarding Insurance Funding for Behavioral Health Treatment for Autism and PDD February 3, 2014

1. Which insurance plans are required to provide funding for behavioral health treatments for autism and PDD?

Every privately-funded health insurance plan that provides hospital, medical or surgical coverage in addition to behavioral and health services is impacted with the exception of employer self-funded plans is responsible for coverage of these services as of July 1, 2012 as a result of Senate Bill 946. Additionally, the Department of Managed Health Care has indicated that as of this same date this responsibility also applies to certain plans funded by CalPERS under Assembly Bill 88 (Mental Health Parity). TRICARE funds ABA services for active duty family members through its ECHO program, but all members can now access BCBA only programs with no tutor hours through the basic benefits package and can apply for additional services through an ABA pilot program.

2. Which CalPERS plans are required to fund behavioral health treatments for individuals with autism or PDD?

The three CalPERS HMO plans (Blue Shield of California Net Value, Blue Shield Access+ and Kaiser Permanente) are required to fund these services. CalPERS PPO plans (PERS Select, PERS Choice and PERSCare) are self-funded and are not required to offer these services.

3. Do different standards apply to plans funded by CalPERS?

Yes. As of September 6, 2012 there was an emergency regulation put in place that applies to plans funded by CalPERS, which became permanent on April 8, 2013. Essentially, the regulation establishes that CalPERS plans noted above in question 2 must provide "medically necessary" treatment for Autism and PDD under existing mental health parity law. This means that services provided under those plans must be provided by licensed mental health professionals rather than by unlicensed BCBAs and paraprofessionals. CalPERS funded Blue Shield plans have been permitted to utilize the services of unlicensed professionals under a settlement agreement with DMHC.

4. Are any self-funded plans providing coverage for behavioral health treatments for individuals with autism or PDD?

Self-funded plans are not required to provide funding for these services under California law. Some are, however, opting to provide this as a benefit to their members. At least one regional center is requiring that families in self-funded plans provide evidence that their plan is self-funded as well as an indication from their insurers whether this is a covered benefit.

5. When do the funding requirements go into effect?

Most insurance carriers were required to comply no later than July 1, 2012. TRICARE was already providing services as were some insurance companies that were part of a settlement agreement on this issue in 2011.

6. What is the process for requesting funding for behavioral health treatments for individuals with health care service plans based in other states?

Thirty states have mandates of one kind or another that require health insurers to fund behavioral health treatment for individuals with autism. For a list of those states, please visit <http://www.autismspeaks.org/advocacy/states>. If the state has a mandate, the referral process would be initiated by contacting the insurer. If problems arise in with these referrals, the regulatory agency overseeing health insurers in that state can be contacted for assistance (http://www.naic.org/documents/members_membershiplist.pdf).

7. What should regional centers do with children who are receiving behavioral health treatment services and are institutionally deemed?

As with other clients, check to ascertain whether they have private health insurance in addition to Medi-Cal and pursue funding for behavioral health treatment through that insurance provider.

8. Will insurance companies implement these requirements consistently from one provider to the next?

No. Insurance companies have broad latitude in the implementation of the requirements. Insurance plans can choose what providers to contract with and what rates to pay. They will also individually determine what copayments will be charged for the services provided.

9. Will authorizations for these services be handled similarly to those for medical services that insurance companies authorize?

There are a couple of important distinctions to be aware of. First, some insurance plans contract out their behavioral health services to other providers such as Magellan or Optum Behavioral Health, so individuals may be redirected to call a different phone number once it is apparent that the request is for behavioral health treatment. Some insurance cards have a distinct phone number on the back for the behavioral health provider, but this is not necessarily the case. Second, some insurers that are anticipating a high volume of referrals for these services have established special units to address concerns related to these specific services. For information regarding how to best access these services from many health providers, please see the document titled "Behavioral Health Treatment Insurance Referral Processes" that ARCA has developed.

10. What types of treatments are required to be covered?

The statute states that funding will be provided for ABA services in addition to "evidence-based behavior intervention programs". There is a lot of ongoing discussion about what other therapies would be considered "evidence-based" and those that would not.

11. What efforts are in place to try to increase consistency?

Senate Bill 946 also required the creation of an Autism Advisory Task Force overseen by the Department of Managed Health Care that is exploring best practices related to evidence-based treatment options, duration of therapy as well as the qualifications of providers among other topics. The group finished its work and submitted a report to the Legislature in early 2013 with recommendations on implementation practices.

12. How will this change impact service provision for regional center clients in need of behavioral health treatment?

Under Welfare and Institutions Code Section 4659 (a)(2) regional centers are required to access funding from "private entities to the maximum extent they are liable for the cost of services, aid, insurance, or medical assistance to the consumer." As such, individuals and family members need to access available funding from insurance companies for behavioral health treatment associated with autism and pervasive developmental disorder before the regional center can offer funding for these services.

13. How can regional centers facilitate a referral for behavioral health treatment to an individual's health insurer?

The procedure for each plan differs a bit. The larger plans have developed a distinct referral process for those individuals that transitioned from regional center funding. In general, the plans are requesting that either the current behavioral provider or regional center contact the plan and be able to provide at a minimum:

- Individual's date of birth
- Individual's health member identification number
- Diagnostic assessment confirming the diagnosis of autism or PDD
- Current behavioral treatment plan that includes:
 - Measurable goals
 - Current symptomatology
 - Background of the individual
 - Number of hours of service requested delineated by service level (i.e., BCBA and paraprofessional)

ARCA has developed detailed procedures for specific health plans on their preferred referral processes. As noted in the following question, it is important to realize that different timelines for approval or denial of funding requests apply depending upon who initiates contact with the health plan.

14. Once a health plan receives a request for services, how long does the plan have to determine if funding for the service will be granted?

This depends upon whether the request for services is initiated by a provider or another entity. If a provider (in-network or not) requests authorization to provide a service, the plan has five business days to determine whether to fund it, deny the request or request additional information necessary to make a decision. If a family requests the service, there are no firm timelines, but a health plan must initiate its internal grievance procedure if an enrollee or representative expresses dissatisfaction with the actions of the plan. The internal grievance procedure can take no longer than thirty calendar days. If either the five day or thirty day timelines pose an "imminent and serious threat to the health of the enrollee", plans must issue an expedited decision within three calendar days.

15. Should regional centers refer only those clients with a firm diagnosis of autism or PDD to health plans, or should others be referred as well?

The statute stemming from Senate Bill 946 refers back to the statute that established mental health parity in the state of California. Per regulation, mental health parity requires services be provided to those with a "preliminary or initial diagnosis" until a final diagnosis can be made. If a health plan questions the validity or strength of the diagnosis of autism or PDD, it would then be incumbent upon the plan to seek further diagnostic clarity at its expense while providing medically necessary services to treat the condition. Most health plans follow the American Academy of Pediatrics screening guidelines

for Autism and PDD and complete screening of toddlers at ages 18 and 24 months and full diagnostic assessments if indicated at that time.

16. Once a health plan has approved funding for behavioral health treatments, how long may an individual wait before services begin?

The health plan is responsible to offer an appointment to begin services within a specified period of time depending on the services being offered. This offer of an appointment may not work with the individual's schedule and services may be delayed for that reason. Non-physician mental health provider appointments must be offered within 10 business days. An appointment must be offered for an occupational therapist, speech therapist or specialty physician (i.e., a psychiatrist) within 15 business days. Generally, these requirements are considered for the plan as a whole rather than in individual cases as it is a measurement of overall network adequacy.

17. If a regional center is currently funding a behavioral health treatment for a client, how can it discontinue funding for that service as a result of availability of funding for similar services through the individual's health insurance?

As with other changes to the Individual Program Plan, this change requires the consent of the planning team. If agreement cannot be reached, the regional center will need to issue a notice of proposed action at least thirty days prior to discontinuing funding. Many regional centers have found that having personal conversations with impacted clients and families prior to sending written notification of the change is an important first step to take. Clients and their families will have an opportunity to appeal that decision.

18. How do regional centers and the people they serve know which providers have contracted with which insurance companies?

Families and regional centers should access the health plan's on-line provider list. Since the providers change frequently, a printed listing would be quickly out of date. One regional center has indicated they have asked behavioral treatment vendors to provide this information so that they can match families with insurance to vendors that are contracted with their health plans. Lastly, regional centers and health plans have been asked to provide liaison contact information to troubleshoot issues such as this as they arise. ARCA has provided regional centers with the insurance liaison contact information that has been received. If contact information for a specific plan is needed, please let Amy Westling in the ARCA office know so that efforts can be made to get that information for you.

19. Are all regional center vendors being accepted by health insurers into their network?

No. As long as an insurer can show that it has an adequate network of providers to serve various geographic areas as well as the volume of those needing services, it can contract with as few providers or as many as it would like. Some insurers have indicated a plan only to contract with providers associated with licensed professionals (i.e., psychologists or LMFTs) rather than those overseen by BCBAAs. This is permissible, but under recent Department of Insurance regulations only as long as it does not delay the services. Many providers have associated themselves with licensed professionals that more insurance companies are willing to contract with.

20. What are the options if an individual or family is currently receiving services from a provider that is not contracted with their health provider and would like to continue with that same provider?

This depends a bit upon the type of health plan involved. If the coverage is provided through an HMO, the provider can request a "single case agreement" or to be paid as an out-of-network provider if there is a strong justification to not change providers. HMOs have wide discretion on whether to approve such requests or not. In a PPO plan, contracted providers are in the network and those meeting necessary qualifications that have not contracted with the PPO are not. Coinsurance rates for non-network providers are higher than those for in-network providers. As regional centers are the payers of last resort, ongoing funding of alternative providers at family request may not be permissible.

21. What should a regional center do with new requests for behavioral health treatment for this population?

As health insurance funding for these services began on July 1, 2012, regional centers should assist families to pursue funding for these services through their private insurance before making funding commitments. This will ensure the smoothest access to services for individuals and their families.

22. How do health care service plans determine the amount of service they will fund?

In most cases, the plan determines the number of service hours that it believes is medically necessary. A few health plans (Blue Shield and Blue Cross included) entered into settlement agreements in 2011 that resulted in the granting of hours without considering medical necessity. In some areas of the state, it has been reported that the number of hours that a health care services plan has granted exceeds the service level that the regional center would have authorized, which may be related to the settlement agreements.

23. What if insurance companies deny funding for these services?

Most impacted health plans are licensed by the Department of Managed Health Care. That department provided a webinar training about the internal grievance procedures for plans as well as further appeal processes to regional center staff on June 14, 2012. This was intended to enable regional center staff to assist individuals and their families with walking through the insurance appeal process. DMHC archived this webinar for future regional center training use. It is available for viewing at <https://dmhc.webex.com/dmhc/ldr.php?AT=pb&SP=MC&rID=66226517&rKey=db1a63e163e38fdd> or for download at <https://dmhc.webex.com/dmhc/lsr.php?AT=dw&SP=MC&rID=66226517&rKey=2f9baf31be70da14>.

The Department of Managed Health Care (DMHC) needs specific information about problems that have arisen to be reported to their Help Center at 1-888-466-2219. Complaint forms may also be completed online by visiting http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_forms.aspx. This will allow them to intervene in specific cases as well as provide them with insight about the nature of any systematic problems. DMHC has four complaint processes, including:

- Quick Resolution – Routine matters that can be resolved within a couple of days via telephone with the health plan.
- Urgent Complaints – Issues that cannot wait thirty days for resolution such as prescriptions and delays in obtaining appointments.
- Standard Complaint Resolution – Coverage disputes and concerns about the quality of care (i.e., a plan indicates it does not cover ABA).
- Independent Medical Review – Medical necessity for a covered benefit (i.e., a plan covers ABA but indicates a belief that the client does not need it).

Regional centers or providers can act as an authorized representative for the individual and family in the complaint and Independent Medical Review process through completion and submission of forms available on the DMHC website.

The California Department of Insurance regulates other health plans. It has similar processes for dispute resolution. Information concerning its complaint and independent medical review procedures can be found at <http://www.insurance.ca.gov/0100-consumers/0020-health-related/0010-consumer-provider-complaints/index.cfm> and <http://www.insurance.ca.gov/0100-consumers/0020-health-related/0020-imr/> respectively.

24. There have been reports that some families are seeking a denial from their health plan rather than funding for services in order to approach regional centers for continued funding. Is it permissible for an insurance company to deny services at the request of the family?

No. A health plan must evaluate a request for services on the merits of the claim. The plan must first determine whether the requested treatment is a covered benefit under the plan. If it is, the plan must determine medical necessity for the service and issue the correct decision related to funding based on

the facts of the individual case. Health plans may only issue denials if the requested service is either not a covered benefit or if it is found not to be medically necessary for the individual.

25. Do insurance companies provide aid paid pending during the appeal process if they decide not to support ongoing authorization for services?

No. Services are authorized for a specified period of time. Before the authorization ends, the insurer makes a decision as to whether to authorize additional service hours for another period of time. If the decision is not to authorize additional services that are being requested, the individual or family of a minor child is notified in writing and given the opportunity to appeal.

26. Is the expectation that regional centers will fund ongoing services while a funding decision is being appealed through the insurance carrier?

It is incumbent upon the regional center to make an independent decision about whether to support funding of a service that an insurance company denies. Part of making this decision would likely mean requesting records about interventions that the individual has received via health insurance funding. Once regional centers begin providing funding, they are likely responsible for aid paid pending should an appeal stem from a decision to discontinue it at a later date.

27. How is information exchanged between regional centers and health care service plans related to an individual's diagnosis, treatment and progress?

Both health care service plans and regional centers are subject to the requirements of HIPAA. Regional centers have additional requirements related to their practice outlined in Welfare and Institutions Code Section 4514. Section 4514 (c) allows for an exception to normal confidentiality of regional center records "to the extent necessary for a claim, or for a claim or application to be made on behalf of a person with a developmental disability for aid, insurance, government benefit, or medical assistance to which he or she may be entitled." Some regional centers have indicated a plan to obtain signed releases from families before disclosing specific information to health insurers.

28. Is there a means for regional centers to recover funds from health care service plans for services funded during periods that individuals or their families are appealing a decision by a health care service plan?

The Department of Managed Health Care cannot require insurers to reimburse regional centers or any third parties that provide funding even when the funding decision by the health care service plan is

overturned on appeal. There is a provision in Welfare and Institutions Code Section 4659.11 that appears to allow for regional centers to submit claims to health care service plan in this instance.

29. What are regional centers doing relative to requests for assistance with funding of the copayments, coinsurance, and deductibles associated with behavioral health treatments funded by health care service plans?

Trailer bill language in 2013 clarified that regional centers may fund copayments and coinsurance for children whose family income is equal to or less than 400% of the Federal Poverty Level (FPL) or adults whose personal income is equal to or less than 400% of FPL. Exceptions may be made for families or individuals whose incomes exceeds 400% of FPL in cases of an extraordinary event, catastrophic loss, or significant unreimbursed medical expenses for the individual or another child who is also served by a regional center. The Department of Developmental Services provided regional centers with accounting subcodes for payment of copayments and coinsurance assistance to allow the funds expended in these areas to be more easily tracked. Regional centers are not permitted to fund deductibles.

30. Are providers permitted to accept third-party (i.e. , regional center) payments for copayments?

Yes. Providers can accept third-party payments for copayments if they choose to.

31. How do families know when they've reached their annual copayment maximum?

Some health insurers are less consistent at tracking copayments for behavioral health than for medical services. Families should be encouraged to keep track of copayment amounts paid in order to avoid an overpayment of copayments. Some insurers provide information about copayment expenditures on their websites to make this simpler to follow.

32. Is it permissible for a BHT provider to accept a contracted rate from a health care plan and subsequently bill the regional center or family for the difference between the provider's typical rate and the contracted rate?

No. This is known as "balance billing" and is not allowed. Providers are expected to charge copayments and coinsurance consistent with the terms of the health plan, but an in-network provider in an HMO plan should not be engaging in this practice.

The Impact of SB 946 on Consumers & Their Families

AGENDA ITEM # 4

(a) Perspective of Regional Center Consumers:

- Biography of Ms. Marcia Eichelberger— President of the Autism Society of California

(b) Perspective of Non-Regional Center Consumers:

- Biography of Ms. Kristin Jacobson – Alliance of California Autism Organizations

(c) Technical Assistance & Background Information

- Biography of Ms. Beth Burt – President, Autism Society of the Inland Empire
- Autism Society of California’s Online Survey: Executive Summary
- Office of Administrative Hearings Related to Regional Center Funding of Co-Pays & Deductibles
- Example of “Explanation of Benefits”

Marcia Eichelberger

President, Autism Society of California

Marcia is the mother of a twenty one year old son with autism and a daughter with specific learning disabilities. Both students are served by the Santa Barbara Unified School District. She has been married to her husband Derrik, a partner at Arcadia Studio Landscape Architecture firm, for 26 years.

Marcia has been a tireless advocate in the field of developmental disabilities since 1995 when her son was diagnosed with autism. In addition to her work with the Autism Society of California, Marcia currently serves as the President of the Autism Society of Santa Barbara, is a Founding Member and the Coordinator of the Alliance of California Autism Organizations (ACAO), and is Chair of the Santa Barbara Unified School District Special Education Parent Advisory Council (SSEPAC). She is also an active member of the National Autism Society's Affiliate Leadership Committee. Marcia is a highly sought-after conference speaker and has presented on a variety of topics regarding autism and related disorders at the local, state and national levels.

From 1997-2007, Marcia was a supervisory appointee and served as the Chair of Area Board IX for Developmental Disabilities for the tri-counties area, and in 2002, as Chair of the Organization of Area Boards at the state level. In 2008 Marcia was appointed as a parent representative to the California Department of Developmental Services Advisory Committee for ASD: Best Practice Guidelines for Treatment and Interventions as a document commentator for the National Autism Center's National Standards Project.

Marcia is the former Chair of the Santa Barbara Tri-Counties Inter-Agency Autism Task Force. She represented Santa Barbara School District as a parent representative on the Santa Barbara County SELPA CAC from 2009-2011. In 2003, she was honored with the "Child Friendly Award" by the County of Santa Barbara Board of Supervisors and Kids Network in recognition of outstanding service to children of Santa Barbara County. She has also served as a member of the Santa Barbara Parks and Recreation Adaptive Recreation Advisory Council and is a graduate of the Leadership Santa Barbara program.

Kristin Jacobson

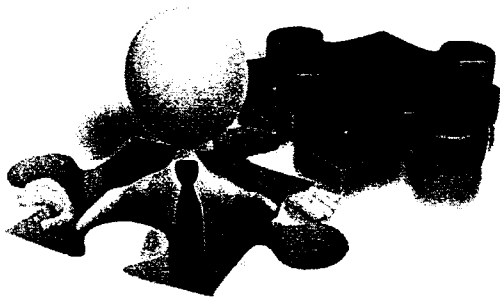
Kristin Jacobson is the Co- Founder and President, Autism Deserves Equal Coverage; Founding Member and Steering Committee Member, Alliance of California Autism Organizations; State Policy Chair, Autism Speaks California; and served as a member of the Autism Advisory Task Force to the DMHC established by SB 946 and as Chair of the Bay Area Autism Regional Task Force (BAART) through the Senate Select Committee for Autism and Related Disorders.

As part of a more than 20 year career in healthcare marketing and reimbursement, Kristin has advocated for autism related causes for over 9 years, playing a leading role in the statewide effort to pass autism insurance reform in California. In 2009, Kristin co-founded Autism Deserves Equal Coverage to help families and providers access health care treatment through private insurance. She also co-founded the ASD Insurance Help Yahoo group to assist parents secure insurance coverage for autism. Through message boards and individual case advocacy, Kristin has helped hundreds of families successfully appeal insurance denials. More than 15 of her cases have resulted in enforcement actions taken by the Department of Managed Health Care and California Department of Insurance to require compliance by health insurers doing business in California.

She has extensive experience in reviewing, researching and drafting complex language for both regulations and legislation. As a lead member of the advocates working on SB 946, the insurance mandate law, Kristin worked with state legislators, regulators, nonprofit organization leaders, legislative staff and attorneys, lobbyists and consultants to help develop language for the Autism Insurance bill (SB 946 – Steinberg) that ultimately was signed into law by Gov. Brown in October of 2011.

Beth Burt

Beth Burt is the President of the Autism Society Inland Empire and First Vice-President of the Autism Society of California. She is the mother of a 21 year old with Autism and a 17 year old with Dyslexia and ADD. As a volunteer parent advocate she has helped numerous families in the last 10 years secure services for their children. She has served on numerous local and regional committees, including acting as co-chair for the Inland Empire Autism Regional Task Force on Housing, and founder and co-chair of the Inland Empire Autism Transition Collaborative. She was recognized as the 2011 Molina Community Champion Award for Advocacy in the Inland Empire. She has co-authored two books on inclusion and is dedicated to helping all children reach their maximum potential.



Autism Society of California

Executive Summary

Impact of California's Autism Insurance Mandate Coverage Legislation

Autism is a complex developmental disability that typically appears during the first three years of life and among other symptoms, affects a person's ability to communicate and interact with others. Autism is defined by a certain set of behaviors and is a "spectrum disorder" that affects individuals differently and to varying degrees. Autism affects all races, ethnic and socioeconomic backgrounds. The Autism Society of California estimates there are over 85,000 individuals living in California with autism.

On July 1, 2012, the Autism Health Insurance Mandate, SB 946, (Steinberg) went into effect. This law states that California state regulated health care plans fall under the guidance of the new Autism Health Mandate. Those plans that provide hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism. Behavioral health treatment (BHT) includes applied behavior analysis (ABA) and other evidence-based behavior intervention programs. This law does not apply to health care plans that do not deliver mental health or behavioral health services to enrollees, to participants in the Medi-Cal program, the Public Employees Retirement System (CalPERS),

California's former Children's Health Insurance Program (CHIP), or Healthy Families.

This law is groundbreaking in that there are no limits regarding the age of the child, limits or caps on the number hours of Behavior Health Therapy (BHT), or caps on dollar amount for coverage. Eligibility for BHT should be determined individually by medical necessity.

This mandate opened the door for services to thousands of families with individuals with autism who were not able to access these services before – both Regional and non-Regional Center clients.

In an effort to capture the issues surrounding the autism community, including the impact and issues related to the Autism Health Insurance Mandate, the Autism Society of California designed an online survey and distributed it through its affiliates and over 50 collaborating California autism organizations. A total of 1,615 individuals responded to the survey - both Regional Center and non-Regional Center families of all ages, all abilities, and from each of the 21 Regional Centers, and 44 of the 59 counties in California (76%).

However, we realize that there are some limitations to this data including the number of respondents; that this survey was only available online and not available in other languages; and though a total of 1,615 responses were gathered, we realize that this represents only 1.9% of the projected autism population in California. Respondents to this survey tend to be of higher socioeconomic status, lower portion of non-English speakers, and higher proportion of Regional Center clients than is representative in California.

Summary of Findings:

1. Increased Access to BHT.

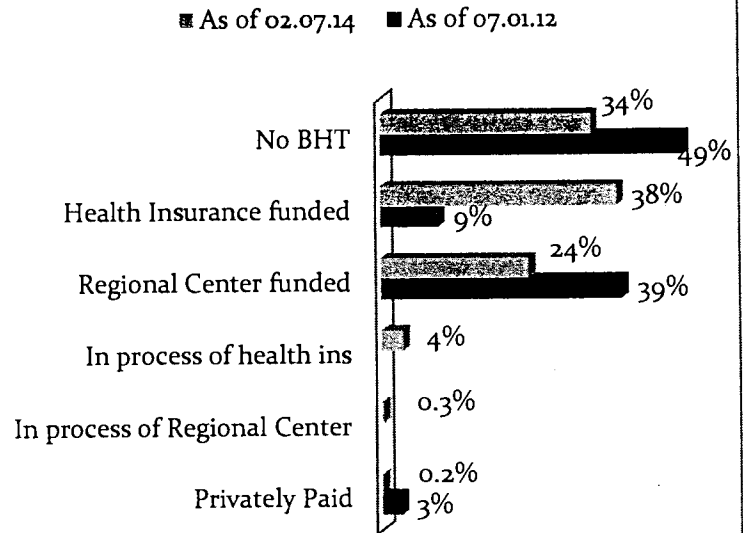
a. **Regional Center Families:** The number of Regional Center families accessing BHT increased from 51% as of 07/01/12 to more than 62% with another 4% in the process of applying for BHT. The survey also showed that previously less than half the Regional Center families in the critical age group of 0-5 years were accessing BHT; that has since increased to 88% in this age group.

b. **Non-Regional Center Families:** The number of non-Regional Center families accessing BHT prior to the Autism Insurance Mandate was reported at 22%. That has actually decreased to 19% with another 4% in the process of applying for BHT through their health insurance. The lack of change in access to BHT could indicate that Regional Centers played a critical role in helping families to access BHT through insurance. It would be worth exploring how to provide some support for awareness and assistance to access BHT through insurance to non-Regional Center consumers as well.

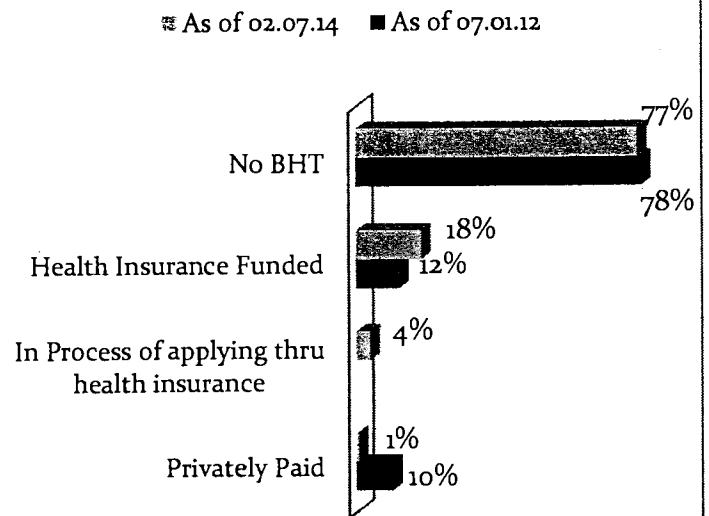
2. Shift in Funding.

a. **Regional Center Families:** The largest shift in funding for Regional Center families was a shift from Regional Center funded BHT to insurance funded BHT. Insurance funding of BHT has increased from 9% as of July 2012 to 38% as of February 2014. Conversely, Regional Center funding of BHT has fallen from 39% to 24% over the same time period.

Regional Center Families - BHT Status, Before and After Insurance Mandate



Non-Regional Center Families- BHT Status, Before and After Autism Insurance Mandate



b. **Non-Regional Center Families:** The largest shift in funding for non-Regional Center families was a reduction in private payment for BHT. Insurance funding of BHT has increased from 12% as of July 2012 to 18% as of February 2014. Conversely, private funding

of BHT has fallen from 10% to 1% over the same time period.

- c. **Comparison:** There is only a 50% increase in insurance funded BHT for non-Regional Center families compared to a 400% increase for Regional Center families. Less than half as many non-Regional Center families have insurance funded BHT (18% vs 38%). There clearly needs to be some education and assistance provided for non-Regional Center families to access health insurance in the same way Regional Center clients have.

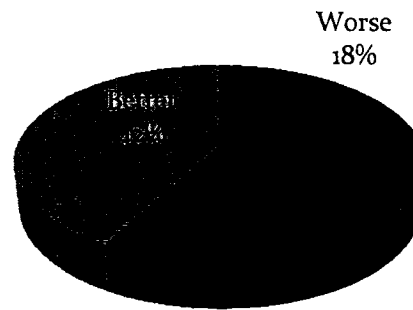
3. **Overall Higher Quality of Life.**

Overall, the autism community reports a having a better quality of life since the start of the Autism Insurance Mandate; 42% of Regional Center families and 41% of the non-Regional Center families report that their life has improved.

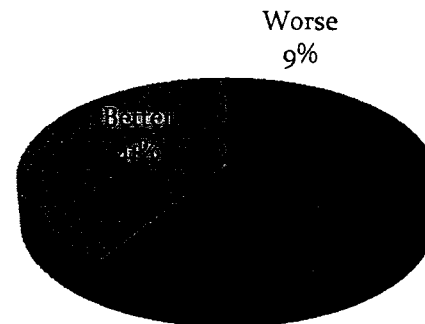
While in both groups more families are better off than worse off, twice as many Regional Center families are worse off than non-Regional Center families (18% vs 9%), primarily due to issues with co-pays and deductibles (see financial barriers.)

- 4. **Financial Barriers.** The Welfare and Institutions Code 4659.1 Section 7 enacted July 1, 2013, states that Regional Centers may no longer pay for a family's deductible, with no exceptions, and may pay co-pay/co-insurance for services only if the family's annual gross income does not exceed 400% of federal poverty level, with limited exceptions for extreme hardship. While the survey showed that this did not impact a large portion of the Regional Center families in 2013 (11% received financial assistance with their deductible in 2013 and 35% received assistance with co-pays), of all Regional

Regional Center Families - How Has Quality of Life Changed Since 07/01/2012?



Non-Regional Center Families - How Has Quality of Life Changed Since 07/01/12?



Center families, 66% expected or have experienced significant negative impacts to BHT such as having to reduce therapy or supervision hours, having to discontinue BHT completely, or having to reduce other services to keep BHT.

Instead of shifting 90% of the costs from Regional Centers to private insurance, which was the intent of the SB 946, the co-pay and deductible changes in the Budget Act change the impact of the Autism Insurance Mandate and result in shifting the cost of BHT from Regional Centers to shifting to insurance companies AND families. This reduces the benefit of the Autism Insurance Mandate to families and reduces the potential savings to the state by disincentivising Regional Center families from pursuing

insurance as aggressively as they otherwise would and, in some cases, shifting the entire burden of BHT back to the Regional Centers.

- 5. Denial Reasons Still Not Appropriate.** Focusing on the CA regulated plans that should be covering BHT, 14% were still denied BHT. Of those denials, 44% were due to advanced age, despite the law having no age caps; 33% of denials were due to low cognitive function, and 22% due to high cognitive function, despite no basis under the law for such limitations; 22% of denials cited location of service, which also is not an appropriate denial reason as SB 946 requires coverage of all medically necessary BHT. Most alarming, 39% of denials still claimed BHT as experimental and 11% as not a covered benefit despite SB 946 clearly establishing it as a required benefit when medically necessary.

- 6. Timely Access.** California law requires health plans to provide timely access to care. The Timely Access Regulations state that requests for treatment be processed within 5 days, and Rule 1300.67.2.2 requires that services should be available to start within 10 days.

The 2014 ASC Survey showed that only 15% of California families received authorization within the required 5-day time frame; 58% of California families had a delay greater than 14 days; 34% indicated that services took more than 31 days.

- 7. Excessive Requirements for Approval.** Families indicate that insurance companies are requesting significant documentation before authorizing BHT, including IEPs, speech and occupational therapy reports, psychological and medical reports, IQ testing, full diagnostic reports, and new assessments to confirm diagnosis. These are all above

and beyond the requirements in the Autism Insurance Law, which are diagnosis, prescription and treatment plan with measurable objectives. These excessive requirements are irrelevant to determinations of medical necessity, add to the time required to authorize treatment, and are burdensome for families and providers. California Department of Insurance has addressed some of these issues, such as the requirement for IQ testing, in regulations passed in early 2013, but this data suggests many of the problems persist.

- 8. Need for Awareness.** Overall, 82% of Regional Center families were aware of the Autism Insurance Mandate vs. only 71% of non-Regional Center families. ASC suggests a requirement for California regulated insurance companies to contact policy holders and advise them that this benefit is now available by law. Education and assistance provided to non-Regional Center families will allow them to access health insurance in the same way Regional Center clients have.
- 9. Improve Awareness.** Because of the small sample size we collected, we would call for Regional Center to collect this data and publish it on a larger scale to verify if access, quality and the financial issues are being impacted as predicted by this report.



For more information on autism spectrum disorders in California, visit the Autism Society of California website at www.autismsocietyca.org
1-800-869-7069



**Office of Administrative Hearings Related to
Regional Center Funding of Co-pays and Deductibles**

The following case summaries and detailed descriptions are respectfully submitted by Autism Deserves Equal Coverage (ADEC) to the March 4, 2014 Hearing of the Senate Select Committee on Autism and Related Disorders regarding the implementation of the Autism Insurance law SB 946/SB 126 (Steinberg). ADEC believes these cases argue strongly for the repeal of the 2013 Budget Act trailer bill limiting the ability of regional centers to pay for co-pays and prohibiting them for deductibles. That language should be replaced with an affirmative requirement for regional centers to reimburse co-pays and deductibles for IPP services without income restrictions, as long as the reimbursed expenses can be affirmatively linked to an IPP service for a regional center client (e.g., through an Explanation of Benefits). In addition insurance companies should be required to track co-payment and coinsurance maximums and stop charging enrollees (and therefore regional centers) once maximums have been reached. Together these changes in the law will result in significant savings to the state and restore the intent of the Autism Insurance Law to what it was prior to the 2013 Budget Act changes. According to the Autism Society of California Survey being presented at the Hearing, the Budget Act changes have caused hardship to regional center families and significantly undermined the benefits of the Autism Insurance Law.

SUMMARY

p. 1-3

CASE 1: ARC vs DDS

P. 4-5

California Supreme Court 38 Cal. 3d 384 [211 Cal. Rptr. 758, 696 P.2d 150]

“The Court provided the authority for the proposition that services under the Lanterman Developmental Disabilities Services Act were an entitlement without regard to need or financial status” (from ARCA legal brief). “While it is true, as the Attorney General has observed, that the regional centers have “wide discretion” in determining how to implement the IPP (62 Ops.Cal.Atty.Gen., supra, 229, 230; see § 4648), they have no discretion at all in determining whether to implement it: they must do so (§ 4648).” (from Decision.)

CASE 1: TRENTON N., CLAIMANT, VS. HARBOR REGIONAL CENTER

P. 5-7

OAH No. 2013040148, August 1, 2013 (Post 2013 Budget Act Changes)

Post 2013 Budget Act changes, the Lanterman Act obligations now result in the requirement for the Regional Center to pay the entire cost of BHT services in the IPP if the regional center client cannot afford the deductible and therefore cannot access the BHT through his or her health insurance. Requiring the regional center to fund the entire cost of BHT until the family can afford the deductible “more readily reconciles with the statutory purposes, mandates and requirements expressed in the Lanterman Act, and does not conflict with the evident legislative intent behind sections 4659, subdivision (e), and 4659.1.”

If there were no prohibition in the Budget Act for regional centers funding deductibles, Harbor Regional Center would only be required to fund the portion of the deductible related to BHT instead of the entire cost of the BHT as they are in this case. This is a bad fiscal outcome for the State from a trailer bill intended to save money. In fact, the state would save significantly money if it required regional centers to pay for co-pays/coinsurance and deductibles specifically related to services in an IPP. The cost obligation for the regional center would be only 10-20% of the cost of BHT (co-pay/coinsurance + deductible) compared to 100% of the cost of BHT with the deductible prohibition. Further, if the use of insurance were cost neutral to consumers instead of financially harmful, families of consumers would have more incentive to pursue insurance funding of BHT. At a minimum, the incentive to pursue insurance would no longer be negative, resulting in additional cost saving opportunities for the state by shifting more funding of BHT from regional centers to insurance.

CASE 3: SHAZEB M VS. REGIONAL CENTER OF EAST BAY
OAH No. 2012090527, Nov 27, 2012 (Pre 2013 Budget Act Changes)

P. 7-9

The regional center was required to pay the deductible in cases where the family cannot afford the deductible as therefore the generic resource of insurance is not available. While post 2013 Budget Act changes, these obligations no longer result in the regional center being required to fund the deductibles (as it is now prohibited), these obligations result in the requirement for the Regional Center to pay the entire cost of BHT services in the IPP if the family cannot afford the deductibles and therefore could not access his or her health insurance nor the services (see Trenton above).

CASE 4: M. S., CLAIMANT, vs. CENTRAL VALLEY REGIONAL CENTER
OAH No. 2012120844, August 19, 2013 (Post 2013 Budget Act Changes)

P. 9-11

Even Post 2013 Budget Act, “requiring consumers to pay copayments after the implementation of SB 946 for IPP services previously fully-funded by CVRC undercuts the IPP process and imposes an additional liability on the parents of those consumers in violation of section 4659, subdivision (e).” Similarly, “regional centers cannot ‘impose any additional liability on the parents of children with developmental disabilities, or to restrict eligibility for, or deny services to, any individual who qualifies for regional center services but is unable to pay.’ (§ 4659, subs. (a) and (e).)”

CASE 5: CLAIMANT vs. SAN GABRIEL/POMONA REGIONAL CENTER
OAH No. 2013081025, October 22, 2013 (Post 2013 Budget Act Changes)

P. 11-13

Post 2013 Budget Act regional center was required to reimburse co-payments for an IPP service in a situation where the family earns more than the 400% of Federal Poverty Level cut off. “Father’s gross income is above the threshold set by the legislature for a family of four. However, Claimant’s care and needs require substantial expenditures above Claimant’s care and needs require substantial expenditures above and beyond what insurance pays for such care. Finally, in trying to provide relief to Claimant, his family incurred substantial debt . . . Even

considering his father's income, the totality of Claimant's unreimbursed medical expenses and costs associated with Claimant's needs and care are significant"

CASE 6: CLAIMANT vs. KERN REGIONAL CENTER

P. 13-14

OAH Nos. 2013071245, October 14, 2013 (Post 2013 Budget Act Changes)

This decision follows the Budget ACT limiting payment of co-pays and deductibles, which was effective July 1, 2013, and requires reimbursement of co-payments and other related expenses for emergency mental health care obtained for a regional center client outside of the IPP process. The Judge determined that it is appropriate for the regional center to reimburse for the co-pay and other expenses related to the emergency mental health service and so ordered.

CASE 7: ELLIOT E., CLAIMANT, vs. SAN ANDREAS REGIONAL CENTER

P. 14

OAH Nos. 2012080352, October 5, 2012 (Pre 2013 Budget Act Changes)

Regional Center was required to cover co-pays for BHT, speech and occupational therapy services even if they were not on the IPP since it was determined services had been improperly denied and should have been on IPP. However regional center is only required to reimburse co-payments for services not available through generic resources. For example 25 hours per week of behavior therapy was established as needed, but a generic resource was available to provide three hours per week, therefore the regional center was requires to reimburse co-payments for 22 hours per week of behavioral therapy.

CASE 1: ASSOCIATION FOR RETARDED CITIZENS vs. DDS

California Supreme Court 38 Cal. 3d 384 [211 Cal. Rptr. 758, 696 P.2d 150]

Commentary: “The Court provided the authority for the proposition that services under the Lanterman Developmental Disabilities Services Act were an entitlement without regard to need or financial status” (from ARCA legal brief). From Decision, “While it is true, as the Attorney General has observed, that the regional centers have “wide discretion” in determining how to implement the IPP (62 Ops.Cal.Atty.Gen., supra, 229, 230; see § 4648), they have no discretion at all in determining whether to implement it: they must do so (§ 4648).

Excerpts from Decision

“The Legislature has enacted a comprehensive statutory scheme known as the Lanterman Developmental Disabilities Services Act (hereinafter the Lanterman Act or the Act) (Welf. & Inst. Code, §§ 4500-4846) fn. 2 to provide a “pattern of facilities and services ... sufficiently complete to meet the needs of each person with developmental disabilities, regardless of age or degree of handicap, and at each stage of life.” (§ 4501.) Such services include locating persons with developmental disabilities (§ 4641); assessing their needs (§§ 4642-4643); and, on an individual basis, selecting and providing services to meet such needs (§§ 4646-4647). The purpose of the statutory scheme is twofold: to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community (§§ 4501, 4509, 4685), and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community (§§ 4501, 4750-4751). [38 Cal. 3d 389]

In the Lanterman Act “[t]he State of California accepts a responsibility for its developmentally disabled citizens and an obligation to them which it must discharge.” (§ 4501.) In so doing, the Legislature has not only recognized that “[p]ersons with developmental disabilities have the same legal rights and responsibilities [as those] guaranteed all other individuals by the Federal Constitution and laws and the Constitution and laws of the State of California” (§ 4502), but has also granted them certain statutory rights, including the right to treatment and habilitation services at state expense. (See §§ 4502, 4620, 4646-4648.) . . .

While it is true, as the Attorney General has observed, that the regional centers have “wide discretion” in determining how to implement the IPP (62 Ops.Cal.Atty.Gen., supra, 229, 230; see § 4648), they have no discretion at all in determining whether to implement it: they must do so (§ 4648). . . .

[6] From our review of the provisions of the Act, we reach the following two conclusions. First, the regional centers and DDS have distinct responsibilities in the statutory scheme: that of the regional centers is to provide each developmentally disabled person with the services to which he is entitled under the Act; that of DDS is to promote the cost-effectiveness of the operations of the regional centers, but not to control the manner in which they provide services. Second, the Act defines a basic right and a corresponding basic obligation: the right which it grants to the developmentally disabled person is to be provided with services that enable him to live a more

independent and productive life in the community; the obligation which it imposes on the state is to provide such services.”

CASE 2: TRENTON N., CLAIMANT, vs. HARBOR REGIONAL CENTER
OAH No. 2013040148, August 1, 2013 (Post 2013 Budget Act Changes)

Commentary: Trenton N vs Harbor Regional Center specifically addresses the impact of the Budget Act prohibition of regional centers paying deductibles on regional center obligations to pay either the deductible or the entire cost of services. While the Lanterman Act obligations discussed in Shazehb vs RCEB no longer result in the regional center being required to fund the deductibles (as it is now prohibited by the Budget Act), the Lanterman Act obligations cited in that case now result in the requirement for the Regional Center to pay the entire cost of BHT services in the IPP if the regional center client cannot afford the deductible and therefore cannot access the BHT through his or her health insurance. Requiring the regional center to fund the entire cost of BHT until the family can afford the deductible “more readily reconciles with the statutory purposes, mandates and requirements expressed in the Lanterman Act, and does not conflict with the evident legislative intent behind sections 4659, subdivision (e), and 4659.1.”

If there were no prohibition in the Budget Act for regional centers funding deductibles, Harbor Regional Center would only be required to fund the portion of the deductible related to BHT instead of the entire cost of the BHT as they are in this case. This is a bad fiscal outcome for the State from a trailer bill intended to save money. In fact, the state would save significantly money if it required regional centers to pay for co-pays/coinsurance and deductibles specifically related to services in an IPP. The cost obligation for the regional center would be only 10-20% of the cost of BHT (co-pay/coinsurance + deductible) compared to 100% of the cost of BHT with the deductible prohibition. Further, if the use of insurance were cost neutral to consumers instead of financially harmful, families of consumers would have more incentive to pursue insurance funding of BHT. At a minimum, the incentive to pursue insurance would no longer be negative, resulting in additional cost saving opportunities for the state by shifting more funding of BHT from regional centers to insurance.

Finally, the judge surmised that “The legislature likely concluded that, since a deductible can be satisfied through payments for general medical visits as well as the provision of services for a developmental disability, regional centers would be responsible for funding medical services outside of their statutory authorization. . . . [whereas] a regional center would know whether a copayment or coinsurance is for non-specialized services, and would thereby be able to refuse payment.” The judge then concluded that the concern about paying for services outside the statutory authority was not a valid concern because the “service program is specifically geared to Claimant’s condition, and has been proven to be an effective service for him.”

Insurance claims processing is consistent with the Judge’s conclusion. Medical expenses put toward deductibles are allocated to a specific service for a specific enrollee on a specific date just as co-pays and coinsurance are, whether there is an individual or family deductible. In every case, regional centers can identify if deductible expenses are not for a specialized IPP service or not for the individual with the IPP and refuse payment in the same way they can for co-pays and coinsurance. Every insurance company provides information about co-pays, coinsurance and deductibles on the same single piece of paper for every service for each enrollee on a specific date. The document is the Explanation of Benefits (EOB) and includes the enrollee’s name, the date of service, a description of the service, the charge, the applicable co-pay/coinsurance, the applicable allocation to the deductible, applicable reductions in charges by the insurance company, and the amount paid by the insurance company. Examples of EOBs for BHT for every major insurance company are attached. (Attachment A)

Excerpts of Legal Conclusions from the decision (emphasis added):**“LEGAL CONCLUSIONS**

13. Health and Safety Code section 1374.73, subdivision (a)(1), requiring private health insurers to fund necessary ABA programs, has greatly expanded the available funding for ABA services. The legislation was sought to provide autistic individuals with highly-effective and well-proven approaches for controlling maladaptive behaviors. But in a largely unintended and unanticipated way, insurance policies, with their high deductibles, copayments, and coinsurance, now effectively prevent many consumers from accessing coverage for ABA programs which were funded by regional centers in the past.

14. As demonstrated by this case, the laudatory goal of Health and Safety Code section 1374.73 has, in some instances, worked to the disadvantage of these consumers. Instead of facilitating the consumer’s ability to obtain ABA services, many, like Claimant’s family here, stand to lose these services previously funded by regional centers because they are now expected to pay deductibles on existing policies originally purchased only for catastrophic events.

15. There is an obvious conflict. **On the one hand**, the Lanterman Act requires regional centers to identify a necessary service or program in an IPP and then do everything they can to promote cost-effectiveness by directing, when necessary, the consumer to access his or her parent’s insurance coverage. Further, in recognition that a necessary service or program should be provided even when a consumer’s parents lack the financial means to themselves fund a service, section 4659, subdivision (e), excuses those who are unable to pay. **On the other hand**, under section 4659.1, subdivision (g), a regional center may not pay for the deductible in a health insurance plan. Here, Anthem Blue Cross will accept only bills paid by Claimant’s family as a reduction of the deductible, and will not pay STAR for its services until the deductible has been satisfied. As Dr. Carter stated, STAR cannot work for free. In effect, the new statute prevents Claimant from receiving services which have otherwise been identified in his IPP as integral for his development.

16. The legislative histories of sections 4743 (e) (inability to pay) and 4659.1, subdivision (g) (prohibition on regional centers paying for a consumer’s insurance health care plan deductible) shed no light on resolving this issue. The deductible prohibition is unambiguous. Yet, under section 4659.1, a regional center may apply a means test to provide financial assistance to a consumer to meet the other two cost components of insurance coverage—copayments and coinsurance. Thus, the legislature has evinced an intent to help consumers in paying for copayments and coinsurance, but prohibits a regional center from providing any assistance as to deductibles.

17. **In determining legislative intent courts have applied several approaches.** One is to construe the words of the statute—in context, keeping in mind the statutory purpose, and statutes or statutory sections relating to the same subject must be harmonized, both internally and with each other, to the extent possible. *Katz v. Los Gatos-Saratoga Joint Union High School Dist.* (2004) 117 Cal.App.4th 47, 54. A review of the Lanterman Act’s provisions strongly suggests **two possible goals of the Act** which are furthered by a prohibition of payment for a deductible by a regional center. **The first** is preserving the funds of the regional center system through requiring generic sources, including a family’s private insurance or health care service plan, to pay for necessary services. **Secondly**, section 4512, subdivision (b), when read in conjunction with section 4501, requires a regional center to provide only those specialized services and supports that are directed towards the alleviation of a developmental disability or are otherwise involved with a developmental disability, and not those conditions which are shared by all persons. The legislature likely concluded that, since a deductible can be satisfied through payments for general medical visits as well as the provision of services for a developmental disability, regional centers

would be responsible for funding medical services outside of their statutory authorization. By contrast, a regional center would know whether a copayment or coinsurance is for non-specialized services, and would thereby be able to refuse payment, which is discretionary in the first place and payable only when there is some extraordinary event, catastrophic loss, or significant unreimbursed medical costs associated with the care of the consumer.

18. As applied to the facts presented here, the first goal—obtaining funding from other generic sources—is not furthered because the family is financially-strapped at this time, and cannot pay down the deductible. HRC determined that Claimant’s family did meet the legal requirements set forth in section 4659.1. The second goal also does not come into play since the STAR service program is specifically geared to Claimant’s condition, and has been proven to be an effective service for him.

19. ~~There are two options in resolving this issue. The first is to decide that Claimant cannot receive a necessary service identified in his IPP because his parents are unable to pay for an insurance deductible that the regional center is now prohibited from covering. Significantly, in enacting the statutory prohibition on a regional center paying for the deductible, the legislature left intact the provision in section 4659, subdivision (e), which prohibits regional center coverage of services that are available through private insurance or a health care service plan, but otherwise exempts parents who are unable to pay. The second option is a decision that HRC continues its funding of the STAR program services until such time as it determines that the family has the financial ability to pay for the deductible. In the context of this case, the latter option more readily reconciles with the statutory purposes, mandates and requirements expressed in the Lanterman Act and does not conflict with the evident legislative intent behind sections 4659, subdivision (e), and 4659.1.~~

ORDER

The appeal of Claimant’s parents from a decision of HRC to decline funding of the deductible in their policy with Anthem Blue Cross is denied. Their appeal to require HRC to continue funding for four – six hours per week of ABA services through STAR is granted.”

CASE 3: SHAZHEB M VS. REGIONAL CENTER OF EAST BAY OAH No. 2012090527, Nov 27, 2012 (Pre 2013 Budget Act Changes)

Commentary: The Judge concluded that the regional center was required to pay the deductible in cases where the family cannot afford the deductible as therefore the generic resource of insurance is not available. The Judge reasoned that “Regional centers are required to carry out the state’s responsibility to the developmentally disabled. (§ 4501.) . . . Regional centers have no discretion in determining whether to implement an IPP: they must do so . . . Subdivision (e) states that section 4659 ‘shall not be construed to impose any additional liability on the parents of children with developmental disabilities, ... or deny services to, any individual who qualifies for regional center services but is unable to pay’ . . . There is no issue of whether claimant has ‘chosen’ not to pursue coverage under his health insurance policy: he cannot access that coverage until he has met the deductible.. . . under section 4648, subdivision (a)(1), it is the regional center’s obligation to pay for the ABA services called for in the IPP Addendum. Under section 4659, that obligation ends only when the service is available from claimant’s private insurer. . . . Subdivision (e) of section 4659 prohibits the regional center from denying Services to claimant that he is qualified to receive, but unable to pay for. For these reasons, RCEB may not discontinue funding of claimant’s ABA services at this time based upon his health insurance coverage.”

While this decision pre-dates the Budget ACT limiting payment of co-pays and deductibles, which was effective July 1, 2013, the requirements of the Lanterman ACT cited in this decision were not changed by

the Budget Act and still apply. While those obligations no longer result in the regional center being required to fund the deductibles (as it is now prohibited), those obligations would result in the requirement for the Regional Center to pay the entire cost of BHT services in the IPP if the regional center client could not afford the co-payments or deductibles and therefore could not access his or her health insurance and therefore not access the services. OAH agreed with this analysis – see Trenton N vs Harbor Regional Center above. The Lawyers for the Association of Regional Center Agencies also agree – see attached analysis (Attachment B)

Legal Conclusions from the decision: (emphasis added)

“LEGAL CONCLUSIONS

1. Under the Lanterman Developmental Disabilities Services Act (Welf. & Inst. Code, § 4500 et seq.), the State of California accepts responsibility for persons with developmental disabilities.¹ The Lanterman Act provides that an "array of services and supports should be established; ... to meet the needs and choices of each person with developmental disabilities ... and to support their integration into the mainstream life of the community." (§ 4501.) Regional centers are required to carry out the state's responsibility to the developmentally disabled. (§ 4501.)

2. The services and supports to be provided to a consumer are set forth in the consumer's IPP. (§4646.5, subd. (a)(4).) A regional center must secure services and supports that meet the needs of the consumer "as determined in the consumer's [IPP]." (§ 4648, subd. (a)(1).) Regional centers have no discretion in determining whether to implement an IPP: they must do so. (*Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 C-1.3d 384, 390.)

3 In its Notice of Proposed Action, RCEB states that it proposes to discontinue funding of ABA services for claimant. RCEB relies on section 4659. to support its proposed action. Subdivision (a) of that section directs regional centers to "identify and pursue all possible sources of funding for consumers receiving regional center services," including private insurance. Subdivision(c) states:

Effective July 1, 2009; notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from . . . private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. . . .

Subdivision (e) states that section 4659 "shall not be construed to impose any additional liability on the parents of children with developmental disabilities, ... or deny services to, any individual who qualifies for regional center services but is unable to pay."

4. It follows from the legal principles set forth above that; unless section 4659 relieves RCEB of its obligation, the regional center must continue ABA services for claimant to the extent set forth in his IPP Addendum. The parties' characterization of the issue presented - whether RCEB is required to pay all or part of claimant's deductible for ABA services - is not correct. The issue is whether, given the facts of this case and RCEB's Notice of Proposed Action, the regional center can discontinue its funding of ABA service based upon claimant's health insurance coverage.

5. Section 4659 does not justify RCEB's decision to discontinue funding of ABA services for claimant. ABA services are not available from claimant's health insurer because claimant has not met the policy's deductible. There is no issue of whether claimant has "chosen" not to pursue coverage under his health insurance policy; he cannot access that coverage until he has met the deductible.

¹ All statutory citations are to the Welfare and Institutions Code.

It is recognized that RCEB is willing to reimburse claimant, at the end of 2013, for the cost of his ABA services up to the point that his deductible is satisfied. But, under section 4648, subdivision (a)(1), it is the regional center's obligation to pay for the ABA services called for in the IPP Addendum. Under section 4659, that obligation ends only when the service is available from claimant's private insurer. Moreover, under subdivision (e) of section 4659, RCEB may not impose on claimant the obligation to advance, on RCEB's account, the costs of his ABA services. That is an additional liability not imposed on other parents of autistic consumers who are provided with ABA services. Finally, the evidence establishes that claimant cannot afford to pay for his ABA services. Subdivision (e) of section 4659 prohibits the regional center from denying services to claimant that he is qualified to receive, but unable to pay for. For these reasons, RCEB may not discontinue funding of claimant's ABA services at this time based upon his health insurance coverage. . . .

ORDER

The appeal of claimant Shahzeb M, is granted, At this time, RCEB may not discontinue funding of claimant's ABA services based upon his health insurance coverage.”

CASE 4: M. S., CLAIMANT, vs. CENTRAL VALLEY REGIONAL CENTER
OAH No. 2012120844, August 19, 2013 (Post 2013 Budget Act Changes)

Commentary: This decision follows the Budget ACT limiting payment of co-pays and deductibles, which was effective July 1, 2013, and addresses reimbursement of co-payments and other related expenses for BHT for a regional center client. The Judge determined that requesting payment of co-pays for an IPP service is not a new request but is part and parcel of the related IPP service. Decisions about reimbursement of co-payments cannot be decided outside the IPP process. The Judge further finds that SB 946 requires coverage of BHT be provided in the same manner as in the Mental Health Parity Act, specifically that the terms and conditions may include co-payments. She finds that SB 946 also holds that its coverage requirement “shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500 of the Welfare and Institutions Code...” The Judge finally concludes that “Requiring consumers to pay copayments after the implementation of SB 946 for IPP services previously fully-funded by CVRC undercuts the IPP process and imposes an additional liability on the parents of those consumers in violation of section 4659, subdivision (e).” and he concludes that similarly “regional centers cannot ‘impose any additional liability on the parents of children with developmental disabilities, or to restrict eligibility for, or deny services to, any individual who qualifies for regional center services but is unable to pay.’ (§ 4659, subs. (a) and (e).)”

Importantly, the Judge also determined that “CVRC’s responsiveness to the wishes of claimant’s family has been more than consistent with the Lanterman Act. Based on the record as a whole, however, CVRC inappropriately denied claimant’s request to fund co-payments assessed for her ABA therapy services which are part of the services and supports outlined in her current IPP.” The Judge then orders the regional center to reimburse and pay prospectively for copayments for the BHT as long as it is in the client’s IPP.

Excerpts From the decision:

“FACTUAL FINDINGS . . .

28. Following the transfer mandated by SB 946, CVRC’s policy of reviewing the appropriateness of an existing IPP service outside the IPP process to determine whether to fund a co-payment for that service is not consistent with the Lanterman Act. As previously discussed, CVRC and claimant’s parents have had very different opinions over the years about the efficacy of intensive ABA services. Despite those differences, intensive ABA services are included in claimant’s IPP and are characterized as being

necessary for her success in remaining placed in her home. It is well-established that services in an IPP are an entitlement and that a regional center may not impose a parental co-payment in the absence of express statutory authorization. (*Clemente v. Amundson* (1998) 60 Cal.App. 4th 1094, 1097.) As noted by the Third District Court of Appeal in that case, "remedial statutes such as the Lanterman Act must be liberally construed to effectuate the purposes for which they were enacted." (*Id.*, at 1102.)

29. When it enacted SB 946, the Legislature was aware that consumers who have insurance coverage would be subject to co-payments. Health and Safety Code section 1374.73, subdivision (a), expressly states that the insurance "coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 1374.72 [the mental health parity law]." (Health & Saf. Code, § 1374.73, subd. a.) That statute provides that the terms and conditions applied to the required benefits "shall include, but not be limited to . . . Copayments. . ." (Health & Saf. Code, § 1374.72, subd. (c)(2).) SB 946 expressly states that its requirement "shall not affect services for which an individual is eligible pursuant to Division 4.5 commencing with Section 4500 of the Welfare and Institutions Code..." (Health & Saf. Code, § 1374.73, subds. (a)(3).) This reference clearly encompasses services and supports outlined in an IPP. **Requiring consumers to pay copayments after the implementation of SB 946 for IPP services previously fully funded by CVRC undercuts the IPP process and imposes an additional liability on the parents of those consumers in violation of section 4659, subdivision (c).**

30. Effective June 27, 2013, section 4659.1 of the Lanterman Act gives regional centers discretion to pay co-payments associated with a service or support provided pursuant to a minor consumer's IPP that are paid for, in whole or in part, by the consumer's parents' health insurance plan or policy, when such payment is "necessary to ensure that the consumer receives the service or support." (§ 4659.1, subd. (a).) Certain conditions must be met before the regional center can exercise this discretion: i.e., the consumer must be covered by her parent's health plan; the family's annual gross income must not exceed 400 percent of the federal poverty level; and there must be no other third party with liability for the costs of such services or supports. (§ 4659.1, subd. (a).) Under certain circumstances, the regional center may pay the copayment where the income of the consumer's family exceeds 400 percent of the federal poverty level. (§ 4659.1, subd. (c).)³

² Similarly, despite the requirement to "identify and pursue all possible sources of funding" for consumers receiving services, **regional centers cannot impose any additional liability on the parents of children with developmental disabilities, for or restrict eligibility for, or deny services to, any individual who qualifies for regional center services but is unable to pay.**" (§ 4659, subds. (a) and (e).)

³ Section 4659.1 was enacted as an urgent measure effective June 27, 2013, as part of AB 89 (Stats. 2013, c. 25, section 7). In pertinent part, that statute provides:

(a) If a service or support provided pursuant to a consumer's individual program plan under this division. . . is paid for, in whole or in part, by the health care service plan or health insurance policy of the consumer's parent, guardian, or caregiver, the regional center may, when necessary to ensure that the consumer receives the service or support, pay any applicable copayment or coinsurance associated with the service or support for which the parent, guardian, or caregiver is responsible if all of the following conditions are met:

- (1) The consumer is covered by his or her parent's, guardian's, or caregiver's health care service plan or health insurance policy.
- (2) The family has an annual gross income that does not exceed 400 percent of the federal poverty level.

31. Even assuming that CVRC has discretion to determine the appropriateness of a particular IPP service as a precondition of funding co-payments, the evidence in this case does not indicate that it properly exercised that discretion. . . .

32. CVRC has worked with claimant's family for many years and has acceded to their desires for intensive ABA therapy, even though those desires have been at odds with the clinical judgment of its professional staff. In this respect, CVRC's responsiveness to the wishes of claimant's family has been more than consistent with the Lanterman Act. ~~Based on the record as a whole, however, CVRC inappropriately denied claimant's request to fund co-payments assessed for her ABA therapy services which are part of the services and supports outlined in her current IPP.~~

LEGAL CONCLUSIONS

1. *Burden of Proof* As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly, in Factual Finding 27, CVRC has the burden of establishing, by a preponderance of evidence, that its denial of claimant's request to fund co-payments for the ABA services in her IPP was appropriate and consistent with the Lanterman Act. (Evid. Code, §§ 115, 500.)

2. As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly, in Factual Findings 28 through 33, CVRC did not meet its burden of proof, and is required to fund co-payments for ABA services contained in claimant's IPP.

ORDER

1. Claimant's appeal is GRANTED.

2. Within ten (10) business days of the date of this Decision, CVRC shall pay claimant's outstanding co-payments for ABA therapy services provided through Kaiser and CARD. In the alternative, within ten (10) business days of the date of this Decision and upon proof of payment, CVRC shall reimburse claimant's mother for any such co-payments she has made.

3. CVRC shall continue to pay co-payments for claimant's ABA therapy services as long as such services are included in the services and supports in her IPP.

4. For co-payments incurred after June 27, 2013, CVRC may require proof of the annual gross income of claimant's family as authorized by Welfare and Institutions Code section 4659.1.

CASE 5: CLAIMANT vs. SAN GABRIEL/POMONA REGIONAL CENTER
OAH No. 2013081025, October 22, 2013 (Post 2013 Budget Act Changes)

Commentary: This decision follows the Budget ACT limiting payment of co-pays and deductibles, which was effective July 1, 2013, and requires reimbursement of co-payments for an IPP service in a situation where the family earns more than the 400% of Federal Poverty Level cut off. The Judge determined that "Claimant meets the requirements for an exemption from the prohibition on regional center payment of copayments for behavioral services" based on the following facts. "Father's gross income is above the threshold set by the legislature for a family of four. However, Claimant's care and needs require substantial expenditures above Claimant's care and needs require substantial expenditures above and beyond what insurance pays for such care. Finally, in trying to provide relief to Claimant, his family incurred substantial debt . . . Even considering his father's income, the totality of Claimant's

(3) There is no other third party having liability for the cost of the service or support. . .

unreimbursed medical expenses and costs associated with Claimant's needs and care are significant." The decision required the regional center to reimburse the co-pays related to the BHT in the IPP.

Legal Conclusions from the decision (emphasis added):

"LEGAL CONCLUSIONS AND DISCUSSION

1. The Lanterman Development Disabilities Services Act (Lanterman Act) sets forth a regional center's obligations and responsibilities to provide services to individuals with developmental disabilities. As the California Supreme Court explained in *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 388, the purpose of the Lanterman Act is twofold: to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community.

2. In enacting the Lanterman Act, the Legislature accepted responsibility to provide for the needs of developmentally disabled individuals, and recognized that services and supports should be established to meet the needs and choices of each person with developmental disabilities. (Welf. & Inst. Code, § 4501.)

3. "Services and Supports for persons with disabilities" means:

Specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. (Welf. & Inst. Code, § 4512, subd. (b).)

4. Appropriate services and supports include diagnosis, evaluation, treatment, mental health services, protective services, emergency and crisis intervention. The determination of which services and supports are necessary for each consumer shall be made through the IPP process. (Welf. & Inst. Code, § 4512, subd. (b)).

5. The Lanterman Act gives regional centers, such as SGPRC, a critical role in the coordination and delivery of services and supports for persons with disabilities. (Welf. & Inst. Code, § 4620 et. seq.) It is the intent of the Legislature to ensure that the individual program plan and provision of services and supports by the regional center system is centered on the individual and the family of the individual with developmental disabilities and takes into account the needs and preferences of the individual and the family, where appropriate, as well as promoting community integration, independent, productive and normal lives, and stable and healthy environments. It is the further intent of the Legislature to ensure that the provision of services to consumers and their families be effective in meeting the goals stated in the IPP, reflect the preferences and choices of the consumer, and reflect the cost-effective use of public resources. (Welf. & Inst. Code, §4646.) . . .

9. In relevant part, Welfare and Institutions Code section 4659. 1, provides that effective July 1, 2013, regional centers may only fund co-payments or co-insurance when: (1) the service or support is paid for, in whole or in part, by the health care service plan or health insurance policy of the consumer's parent; (2) the consumer is covered by his her parent's health plan or health insurance; (3) the family has an annual gross income that is less than 400% of the federal poverty level; and (4) there is no third party with liability for cost of the service or support.

11. Welfare and Institutions Code section 4659.1, subdivision (c) contains an exception to the prohibition when the service or support is necessary to successfully maintain the consumer at home in the least restrictive setting and the parents or consumer demonstrates one or more of the following:

- (1) The existence of an extraordinary event that impacts the ability of the parent, guardian, or caregiver to meet the care and supervision needs of the child or impacts the ability of the parent, guardian, or caregiver, or adult consumer with a health care service plan or health insurance policy, to pay the copayment or co-insurance.
- (2) The existence of a catastrophic loss that temporarily limits the ability to pay of the parent, guardian, or caregiver, or adult consumer with a health care service plan or health insurance policy and creates a direct economic impact on the family or adult consumer. For purposes of this paragraph, catastrophic loss may include, but is not limited to, natural disasters and accidents involving major injuries to an immediate family member.
- (c) Significant unreimbursed medical costs associated with the care of the consumer or another child who is also a regional center consumer.

Here, Claimant's severe behaviors have a tremendous impact on his family and prevent his mother from returning to full-time employment or from leaving home most days. His behaviors have caused serious injury. His IPP provides for behavioral services and the services are helping him to make slow improvement and are necessary for him to be maintained in the family home.

Claimant has health insurance paid for by his father through his employment with the federal government, but the insurance has a co-payment which amounts to a sizable monthly payment for the services.

Father's gross income is above the threshold set by the legislature for a family of four. However, Claimant's care and needs require substantial expenditures above and beyond what insurance pays for such care. Finally, in trying to provide relief to Claimant, his family incurred substantial debt to install a pool on their property. While the pool may be considered a luxury, the fact is that it was installed for Claimant, at great expense, before Claimant's family was aware that they would be required to pay several hundred dollars more per month for Claimant's behavioral services and without giving them any opportunity to adjust the family budget to accommodate the new expenses. Even considering his father's income, the totality of Claimant's unreimbursed medical expenses and costs associated with Claimant's needs and care are significant. Based on factual findings 1 to 8, Claimant meets the requirements for an exemption from the prohibition on regional center payment of copayments for behavioral services.

CASE 6: CLAIMANT vs. KERN REGIONAL CENTER

OAH Nos. 2013071245, October 14, 2013 (Post 2013 Budget Act Changes)

Commentary: This decision follows the Budget ACT limiting payment of co-pays and deductibles, which was effective July 1, 2013, and requires reimbursement of co-payments and other related expenses for emergency mental health care obtained for a regional center client outside of the IPP process. The Judge determined that it is appropriate for the regional center to reimburse for the co-pay and other expenses related to the emergency mental health service and so ordered.

Legal Conclusions from the decision (emphasis added):

“LEGAL CONCLUSIONS . . .

11. “Here, Claimant's depression is a result of her developmental disability and related seizures. Despite psychiatric treatment and medication, Claimant's depression became life-threatening, and her family acted quickly to care for her, and obtain follow-up treatment that was recommended by KRC vendor

psychiatrist Cameron Johnson. The treatment that Claimant required was not available in her community and she was required to travel to obtain the care. The acute care hospitalization and the subsequent outpatient treatment were necessary for Respondent to remain living in the family home. Although Claimant has medical insurance, the sizable co-payments coupled with necessary transportation and lodging costs are significant. Under these circumstances, it is appropriate for KRC to reimburse Claimant for the co-payments, hotel lodging, parking and mileage at the Internal Revenue rate for mileage to and from her treatment and hospitalization at UCLA.

ORDER

1. Claimant's appeal is granted.
2. KRC shall reimburse Claimant for co-payments made to the UCLA Neuropsychiatric Hospital, hotel lodging, mileage and parking expenses incurred for to her depression."

CASE 7: ELLIOT E, CLAIMANT, vs. SAN ANDREAS REGIONAL CENTER
OAH Nos. 2012080352, October 5, 2012 (Post 2013 Budget Act Changes)

Commentary: Regional Center was required to cover co-pays for BHT, speech and occupational therapy services even if they were not on the IPP since it was determined services had been improperly denied and should have been on IPP.

The primary issues of fact and law in the case were whether the services were required to be provided on the IPP.

Legal Conclusions from the decision (emphasis added):

"LEGAL CONCLUSIONS . . .

5. SARC Argues that the prohibition against supplanting generic resources precludes it from funding co-payments for Claimant's occupational and speech therapies because they are otherwise available from the school district. The analysis, however, does not stop here. The question in the instant case is whether the services offered by the District are sufficient to meet the claimant's needs. If they are SARC is under no obligation to fund copayments for such services. If they are not, SARC must fund the copayments for the services he requires in addition to those available from the school district.

6. [Claimant established need for occupational therapy (OT) services above those provided by the school district. SARC is required to fund the co-pays of only those OT services in excess of those provided by the generic resource, the school district, and not the co-pays for all the OT services.] . . . SARC shall therefore pay the copayment for one hour of occupational therapy per week.

7. [Claimant established need for speech therapy (ST) services above those provided by the school district. SARC is required to fund the co-pays of only those ST services in excess of those provided by the generic resource, the school district, and not the co-pays for all the ST services.] . . . SARC shall therefore pay the copayment for one and one-half hours of speech therapy per week.

8. With respect to behavioral services, as set forth in Factual Findings 28-31 claimant established that he requires 25 hours per week of behavioral services. . . . In so far as there is a generic resource available to provide three hours per week of behavioral services, however, SARC need only fund copayments for 22 hours per week behavioral services.

Deductibles are as easy to identify on EOBs as co-pays. Every health insurer provides EOBs for each date of service to both the subscriber and the provider. ADEC can provide samples from every major insurance company. Contact 650-759-5737

EXPLANATION OF BENEFITS
This is NOT a Bill

Retain for your records along with any provider bills.

This Explanation of Benefits (EOB) is to notify you that we have processed your claim. It clarifies your payment responsibility or reimbursement.

Your claim information is also available in the My Health Plan section of www.blueshieldca.com. If you have any questions about this document or your benefits, please call us at (800) 200-3242

Patient can be identified as RC client or non-RC client

Provider can be identified as IPP. Provider of, in this example, NOT

CONSUMER AGREE

Patient Name: [REDACTED]	Subscriber ID: [REDACTED]	Claim Number: [REDACTED]
Patient responsibility: \$258.70 <small>(Amount you paid or owe to provider.)</small>	Your claim was received 01/18/13 and processed in 4 day(s).	
Amount we paid: \$78.30	We paid MILLS PENINSULA EMERGENCY.	
Amount billed by Provider: \$517.00	Deductible Status:	
	As of 01/22/13, [REDACTED] has met \$250.00 of the \$2500.00 annual deductible for 2013.	

Date of service

DETAIL Provider: MILLS PENINSULA EMERGENCY

Service Date	Type of Service and Procedure Number	Amount Billed <small>For or billed for services</small>	Amount Allowed <small>Under contract benefits</small>	Amount We Paid	Patient Responsibility			Notes
					Non Covered	Deductible <small>You pay or do before we begin paying</small>	Copayment/ Coinsurance	
01/06/13	OFFICE MEDICAL 99284	517.00	337.00	78.30	0.00	250.00	8.70	1
	Chiropractic	517.00	337.00	78.30	0.00	250.00	8.70	

Notes
 1 The allowed amount is the amount determined by Blue Shield to be the reasonable and customary value for the services reported. The subscriber is only responsible for deductible, copayment and non-covered amounts, if any, noted on this Explanation of Benefits. Please contact us, by calling or writing to the phone number/address indicated on page two of this Explanation of Benefits, if you are billed by the provider for more than the patient responsibility amount indicated on this form.

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 Get paperless delivery of this document! It's fast, easy and convenient! View, print or download this document anytime at blueshieldca.com. Sign up today at blueshieldca.com/gopaperless
 Diagnosis and treatment codes billed on this claim, and their meanings, can be requested by contacting Customer Service.

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Co-pay/coinsurance for this service only

Type of service can be identified as IPP service or, in this example, NOT

Deductible portion for this service only

SB 946 Implementation: Providing Services and Interventions

AGENDA ITEM # 5

(a) The Providers' Perspective

- Biography of Dr. Doreen Granpeesheh – Center for Autism & Related Disorders
- Overview of Issues Arising from Autism Insurance Mandate
- Ensuring an Adequate Network of Providers
- Behavioral Health Treatment: Authorized Insurance Hours
- Unfulfilled Treatment Hours

(b) The Health Plans' Perspective

- Biography of Mr. Charles Bacchi – California Association of Health Plans

Dr. Doreen Granpeesheh Biography

Dr. Doreen Granpeesheh (www.doreengranpeesheh.com) has dedicated over thirty years to helping individuals with autism lead healthy, productive lives. She is licensed as a psychologist in California, Texas, Virginia, and Arizona and holds a Certificate of Professional Qualification in Psychology from the Association of State and Provincial Psychology Boards. She is a Board Certified Behavior Analyst – Doctoral and is licensed as a behavior analyst in Arizona and Virginia.

Dr. Granpeesheh began her studies in autism as an undergraduate at UCLA and earned a Master's degree in psychology from UCLA in 1987, followed by a Ph.D. in psychology from UCLA in 1990. While completing her degrees, Dr. Granpeesheh worked with Dr. Ivar Lovaas on the groundbreaking outcome study published in 1987 which showed a recovery rate of close to 50% among the study's research participants. Dr. Granpeesheh built on Dr. Lovaas's work, developing the CARD Model, which is a comprehensive, evidence-based approach to treating autism. In August, 2009, CARD researchers published "Retrospective Analysis of Clinical Records in 38 Cases of Recovery from Autism" in the *Annals of Clinical Psychiatry*, showing that recovery from autism is possible with early, intensive intervention using ABA. This study echoed the results of Dr. Lovaas's earlier study and garnered Dr. Granpeesheh the prestigious George Winokur Research Award.

In 1990, Dr. Granpeesheh founded the Center for Autism and Related Disorders, also known as CARD (www.centerforautism.com). Under Dr. Granpeesheh's leadership, CARD has become one of the world's largest providers of ABA-based treatment for individuals diagnosed with autism spectrum disorder. Today, CARD has nearly 30 locations throughout the United States and internationally, employs nearly 1,500 highly-skilled employees, and is a leading employer of Board Certified Behavior Analysts (BCBAs).

CARD's highly-regarded behavior management and skill acquisition programs are the culmination of decades of research in the field of autism treatment. As part of the nation's third largest non-governmental organization contributing to autism research, CARD scientists have published groundbreaking studies that have contributed significantly to the field of autism treatment research. In 2011, Dr. Granpeesheh founded **Autism Research Group** (www.AutismResearchGroup.org), a nonprofit organization whose mission is to identify and conduct treatment research that will improve the quality of life for individuals with autism spectrum disorder.

Dr. Granpeesheh's unwavering commitment to provide evidence-based treatment is reflected in CARD's comprehensive treatment curriculum which produces successful outcomes for every child CARD treats. To increase access to evidence-based treatment, CARD launched **Skills™** (www.SkillsforAutism.com), an innovative web-based toolkit that optimizes treatment programs for individuals with autism spectrum disorder by providing comprehensive assessment and curriculum, positive support planning for challenging behavior, progress tracking, and treatment evaluation. Skills™ enables healthcare professionals, teachers, parents, and/or caregivers to design and manage a comprehensive, individualized treatment program for children and adolescents with autism spectrum disorder.

Dr. Granpeesheh has developed extensive state-of-the-art training programs for CARD's clinical employees, parents and caregivers, and school personnel which are conducted both in person and via the Internet. As demand for CARD training programs increased, Dr. Granpeesheh established the Institute for Behavioral Training (www.iBehavioralTraining.com) to develop web-based training programs and make them more broadly available, targeting the specific training needs of school districts, parents and caregivers, physicians, and autism treatment providers.

Dr. Granpeesheh has participated in numerous government taskforces and currently co-chairs the Early Intervention sub-committee of the North Los Angeles County Taskforce of the Senate Select Committee on Autism and Related Disorders. She is a member of several scientific and advisory boards and an active member of the Autism Human Rights and Discrimination Initiative Steering Committee. Dr. Granpeesheh was also a member of the Practice Board of the Association for Behavior Analysis International and the Oversight Committee of the Department of Developmental Disabilities for the State of Arizona. In addition, Dr. Granpeesheh is the founding member and president of Autism Care and Treatment Today (ACT Today!), a nonprofit organization that helps families access effective treatment (www.act-today.org).

Issues Arising from Autism Mandate	Potential Solution(s)	Support
<p>Consumer Cost-Sharing</p> <p>Consumers are responsible for as many as six or seven co-pays per week, as well as co-insurance and deductibles. Many clients decrease treatment hours to limit co-pays which, in turn, decreases the effectiveness of the ABA-based treatment by reducing the “intensive” aspect that is so critical to the effectiveness of autism treatment.</p> <p>AB 89 prohibits regional centers from paying any portion of a consumer’s insurance deductible, which often effectively makes the cost of insurance-funded treatment unaffordable.</p> <p>Some regional centers limit the number of co-pays that they will authorize, precluding consumers (who qualify financially for co-pay support from regional centers) from accessing medically necessary treatment because they cannot afford to pay the co-pays themselves.</p>	<p>Pass AB 2299 (Nazarian - Pending legislation to address AB 89)</p> <p>Amend Section 4659.1(a) to require regional centers to fund all cost-sharing when appropriate, including deductibles, co-insurance, and co-pays.</p> <p>Amend Section 4659.1(a) of the Welfare & Institutions Code to require regional centers to pay co-insurance and/or co-pays by changing language from “may” to “shall.”</p>	<p>Autism Speaks CARD</p> <p>CARD CPC ARCA Autism Health Ins. Project</p> <p>CARD CPC Autism Speaks ARCA Autism Health Ins. Project</p>
<p>Medi-Cal Enrollees Have No Autism Treatment Services</p> <p>While some Medi-Cal enrollees qualify for services through their local regional center, many do not meet regional center criteria but do require medically necessary treatment that Medi-Cal does not cover.</p>	<p>Add autism treatment as a covered service to Medi-Cal.</p>	<p>CARD Autism Speaks Autism Health Ins. Project Alliance of CA Autism Orgs. CPC</p>

<p>Insurance Authorization Issues</p> <p>Many carriers do not authorize components of treatment that comprise best practices, such as:</p> <ul style="list-style-type: none"> • Indirect supervision • Clinic team meetings • Three-tiered model of treatment delineated by BACB that expands provider's capacity to provide treatment 	<p>Ask CDI and DMHC to issue clarifying regulations.</p>	<p>CalABA CPC CARD</p>
<p>Cognitive Testing</p> <p>Some plans illegally require costly and time-consuming cognitive testing before authorizing services.</p>	<p>Enforce CDI emergency regulations [CCR Section 2562.4(c)(1)] that prohibit plans from denying services because a child has an intellectual disability and urge DMHC to issue and adopt the same emergency regulations:</p> <p>(c) In cases where behavioral health treatment is medically necessary, an insurer shall not deny or unreasonably delay coverage:</p> <p>(1) Based on an asserted need for cognitive or intelligence quotient (IQ) testing....</p>	<p>CalABA Autism Health Ins. Project</p>
<p>Developmental Testing</p> <p>Some plans require treatment plans to include developmental testing with standardized scores and are denying treatment when certain undefined measures have not been reached.</p>	<p>Do not allow plans to deny medically necessary treatment on the basis of developmental test results.</p> <p>Do not allow health plans to delay authorization pending results of developmental tests.</p>	<p>Autism Health Ins. Project</p>
<p>Partial Authorization/Capping of Medically Necessary Services</p> <p>Some plans rarely authorize the full amount of treatment hours that the provider has determined are medically necessary.</p> <p>Some plans arbitrarily implement visit caps. Some plans wrongly cap hours at 20 hours per week and require an appeal for client to secure additional hours.</p>	<p>Enforce existing law.</p> <p>To ensure that outcomes of Independent Medical Reviews (the consumer external appeals process when they disagree with their health plans) reflect California law, add BCBA's to Independent Medical Review panels, so IMRs are conducted by individuals whose expertise meets or exceeds federal legal standards.</p>	<p>CARD CalABA CPC</p>
<p>Plans Don't Track Out-of-Pocket Maximum Cost</p> <p>Insurance carriers do not inform consumers when they have reached their out-of-pocket maximum and, typically, continue to bill</p>	<p>Introduce legislation to require plans to track co-pays and co-insurance and to inform consumers when out-of-pocket maximums are reached.</p>	<p>CARD Autism Health Ins. Project</p>

<p>consumers for cost-sharing that is no longer the responsibility of the insured because the out-of-pocket maximum has been reached. If families have dual coverage that includes Medi-Cal, Medi-Cal is wrongly billed the balance.</p>		
<p>Medically Necessary School-Based Services</p> <p>Many plans are confused by the characterization of school-based services as medically necessary, rather than educational. School-based services are the responsibility of the insurance carrier when the child's delays prevent him from accessing education and when his deficits can only be managed by a qualified autism service paraprofessional and not a teacher's aide.</p>	<p>Clarify with legislation that tasks in a school setting that require a qualified autism service paraprofessional are the responsibility of the health plan, not the school.</p> <p>Give autism-specific paraprofessional training to teacher's aides.</p>	<p>CARD</p>
<p>Regional Center Vendor Rate Reduced When Providers Open New Offices to Accommodate Private Insurance Clients</p>	<p>Eliminate requirement for existing vendors to "negotiate" new (and lower) rates when they expand their businesses to meet demand. [Each location must be separately licensed and vendored and a new rate must be established for the new/additional location(s). (Title 17, Sections 54340 (a)(1)(A), 54302, 54306, 54308, 54310, 54312, 54314, 54316, 54318, 54319, 54320, 54322, 54324, 54326, 54327, 54327.1, 54327.2, 54330, 54332)]</p> <p>Increase mean rates to reflect actual provider rates.</p>	<p>CARD</p>
<p>Use of Third-Party Administrators Limits Consumer Access to Treatment and Reduces Quality of Treatment</p> <p>Health Net only uses providers in ASG's network, and Kaiser only uses Easter Seals providers, both of which clearly do not comprise "adequate networks" as required by SB 946 and the Affordable Care Act. Moreover, quality of treatment is typically lower in these networks.</p>	<p>Enforce existing law regarding network adequacy.</p> <p>Enable consumers to go to "out-of-network" providers without incurring additional cost-sharing.</p>	<p>CalABA CARD</p>
<p>Licensing Issues</p> <p>Some plans try to require a licensed individual to supervise autism treatment.</p>	<p>Issue clarifying regulations to ensure that health plans authorize medically necessary services when services are supervised by a Board Certified Behavior Analyst.</p>	<p>CalABA</p>
<p>Independent Medical Reviews</p>	<p>Ask DMHC and CDI to amend their contracts with IMROs, requiring the</p>	<p>CARD</p>

<p>Consumers request Independent Medical Reviews (IMRs) when they disagree with a health plan decision. The state regulatory authorities contract with IMR Organizations (IMROs) and send medical records and other documents to IMROs for review when an IMR is requested. While federal and state law require that the professional conducting the review have specific experience and expertise regarding the specific medical condition, IMROs do not use reviewers who meet this criteria. As such, many final decisions issued by DMHC or CDI as the result of IMR findings do not reflect accurate clinical conclusions, depriving consumers of medically necessary treatment.</p>	<p>IMROs to add BCBA's to their clinical review boards and to assign IMR regarding autism treatment to BCBA's or other licensed professional who meets the criteria established by current state and federal law.</p>	
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The Issue of Network Adequacy as It Relates to Individuals with Autism Spectrum Disorder

Network adequacy is a critical element of autism treatment delivery for a variety of reasons:

- The prevalence of autism spectrum disorder (ASD) (1 of every 88 children)¹;
- The substantial number of hours required to treat it (30-40 hours per week)²;
- The nature of evidence-based treatment (1:1 ratio of therapist to patient)³; and
- The fact that insufficient treatment hours and/or delayed access to qualified providers can result in permanent developmental deficiencies and enormous economic costs to the state⁴.

Adequate Network of Providers – Background

The Patient Protection and Affordable Care Act (ACA) requires that the Secretary of Health and Human Services (HHS) establish criteria for network adequacy,⁵ including network adequacy of mental health providers.⁶ The ACA delegates the regulatory oversight of network adequacy to the states.⁷ California has quantified network adequacy for health care providers, delineating a minimum enrollee/provider ratio (1 physician per 1,200 enrollees), a maximum geographic distance (30 miles), and a maximum wait time (48-96 hours for urgent care; 10-15 days for non-urgent care).⁸ These guidelines have very little application in the provision of behavioral health treatment for autism or for other specialty health providers because treatment is typically not intermittent. That is, no single specialty health provider could adequately treat 1,200 enrollees if they needed treatment on a daily basis, as is the case in autism treatment. Insurance carriers that offer health plans through the state exchange (known as Qualified Health Plans) are required to ensure a “sufficient”⁹ choice and number of providers, including providers who specialize in mental health. The insurance carrier has the burden of demonstrating network adequacy, but how does a state determine whether the insurance carrier has met that burden for its enrollees who are diagnosed with ASD?

National Association of Insurance Commissioners - Network Adequacy Determination

Insurance carriers should have a system in place to assess network adequacy, including whether their network of specialists, such as Board Certified Behavior Analysts (BCBAs), is adequate based on enrollee needs. According to a

¹ "Prevalence of Autism Spectrum Disorders — Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2008." Department of Health and Human Services, Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report*, 30 March 2012.

² Granpeesheh, Tarbox, & Dixon (2009). Applied behavior analytic interventions for children with autism: A description and review of treatment research. *Annals of Clinical Psychiatry*, 21(3): 162-173.

³ McEachin, J. J., Smith, T., & Lovaas, O. I. (1993). Long-term outcome for children with autism who received early intensive behavioral treatment. *American Journal on Mental Retardation*, 97, 359-372.

⁴ Ganz (2007). The Lifetime Distribution of the Incremental Societal Costs of Autism. *Pediatrics & Adolescent Medicine*, 161(4):343-349. doi:10.1001/archpedi.161.4.343.

⁵ 42 U.S.C. 18031 § (c)(1)(B)

⁶ 42 U.S.C. 18031 § (j)

⁷ 42 U.S.C. 18031 § (d)(3)(B)

⁸ Cal. Health & Safety Code §§ 1367, 1367.03; Cal. Ins. Code § 10133.5; Cal. Code Regs. tit. 10, § 2240.1; Cal. Code Regs. tit. 28, §§ 1300.51, 1300.67.2, 1300.67.2.1, 1300.67.2.2

⁹ 42 U.S.C. 18031 § (c)(1)(B)

white paper released by the National Association of Insurance Commissioners (NAIC) in 2012,¹⁰ insurance carriers should have procedures in place to ensure an adequate network of providers and to analyze network adequacy. In determining network adequacy, insurance carriers should consider the health needs of enrolled *and* prospective members, including needs related to cultural and linguistic diversity. According to the NAIC, because an insurance carrier's network is always changing, "In order to ensure it meets the minimum standards for network adequacy on a consistent basis, a carrier must **maintain a system for monitoring its network and develop procedures to react to impending and existent changes in its network that impair adequacy**. This would entail a **regulatory review** of the procedures for monitoring as well as what procedures are in place to as to when and how to take corrective action as it applies to its network" (emphasis added).

Determining Whether an Insurance Carrier Has an Adequate Network of Autism Treatment Providers

To determine whether an insurance carrier has sufficient providers to screen, assess, and treat its enrollees who are diagnosed with autism spectrum disorder, the following criteria should be considered:

- **Sufficient Provider Choice:** Are sufficient in-network providers located within 30 miles of enrollees and prospective enrollees, given geographic density, to ensure that enrollees can access providers without unreasonable delay?
 - Enrollees are able to secure autism treatment within a reasonable period of time so as not to subject enrollees to delays that could cause substantial harm and within the time periods mandated by existing law.
 - Provider has sufficient availability to fulfill authorized treatment hours.

- **Coordination and Continuity of Care:** Does the carrier have an adequate system in place to ensure continuity of care for its enrollees without placing undue burdens on providers?
 - Treatment plans are authorized within a reasonable period of time.
 - Interim treatment is authorized during treatment authorization processes so as to ensure continuity of care.
 - Treatment plans are authorized in six-month increments.

- **Provider Capacity:** Are in-network providers able to ensure high quality treatment?
 - Providers supervise a maximum of 20 paraprofessionals (therapists).
 - Paraprofessionals have passed the BACB's Registered Behavior Technician exam or equivalent and have autism-specific training and experience.

California's Qualified Autism Service Providers

In California law, the group of professionals who "design, supervise, and provide"¹¹ autism treatment are called Qualified Autism Service Providers. This group includes BCBAs, licensed physicians, surgeons, physical therapists, occupational therapists, psychologists, marriage and family therapists, educational psychologists, clinical social workers, professional clinical counselors, speech-language pathologists, and audiologists, as long as the services they provide are "within the experience and competence" of their credential. Most often, Board Certified Behavior Analysts are the Master's-level individuals who design, implement, and supervise autism treatment. California leads the nation in Board Certified Behavior Analysts (BCBAs) with nearly 1,900 as of August, 2013, a number that has likely increased in the interim.

¹⁰ NAIC's Plan Management Function: Network Adequacy White Paper, found at http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

¹¹ Cal. Health & Safety Code §1374.73; Cal. Ins. Code § 10144.51; Cal. Welfare & Inst. Code Cal. §5710

Growing Demand for Qualified Autism Service Providers

The number of children and adults receiving state-supported services for autism in California was estimated by the Department of Developmental Services to be just under 60,000 in 2012. The number of children, age 0-17, in California as of 2011 was estimated at just under 9 million. Given a prevalence rate of 1 in 88, the number of children in California likely to have ASD should be just over 100,000. Therefore, the 60,000 number from DDS, although it includes adults who may only receive limited targeted treatment or no treatment at all, represents only a fraction of the total number of children with ASD.

Conclusion and Recommendations

California is in a period of transition as it trains and attracts additional qualified autism service providers to design, implement, and supervise treatment plans for its ASD population. It is critical to expand opportunities and support education tracks that lead to the BCBA certification, as well as those that produce the paraprofessionals. Moreover, it is critical to keep providers in California once they earn their credentials, which are in high demand throughout the nation. Those insurance carriers that require BCBA supervision for behavioral health treatment should honor the BACB guidelines regarding the role of BCBA in autism treatment and should never require BCBA to provide the 1:1 therapy.

To facilitate and expand high-quality, evidence-based autism treatment in California, some potential steps include:

- Streamline health plan policies that enable providers to become “in-network.”
- Minimize and/or eliminate health plan policies that create barriers to treatment for enrollees, such as geographical restrictions that put service providers out of reach of their enrollees.
- Minimize delays between diagnosis and authorization of treatment.
- Ensure that health plans authorize adequate supervision hours to ensure that providers can spend sufficient time designing, implementing, and supervising treatment.
- Eliminate higher enrollee cost-sharing when enrollees use out-of-network providers in instances when network providers are not located within a reasonable geographic distance, do not offer top-quality, evidence-based treatment, and/or are not able to offer care within a reasonable period of time.
- Authorize innovative service delivery options, such as the use of telehealth and center-based models.
- Create a tax credit for employers who fund their employees’ BCBA educational programs in order to increase and retain autism treatment providers in California. The amount of the tax credit could be scaled to reflect the percentage of cost that the employer contributes, i.e., if an employer pays 100% of the cost of a BCBA program, the tax credit would be twice the amount of the tax credit for an employer funding 50% of the cost.
- Incentivize community and state colleges to create career pathways in the field of autism treatment for target populations, such as veterans and chronically unemployed and underemployed.

Number of BCBA's by State¹²

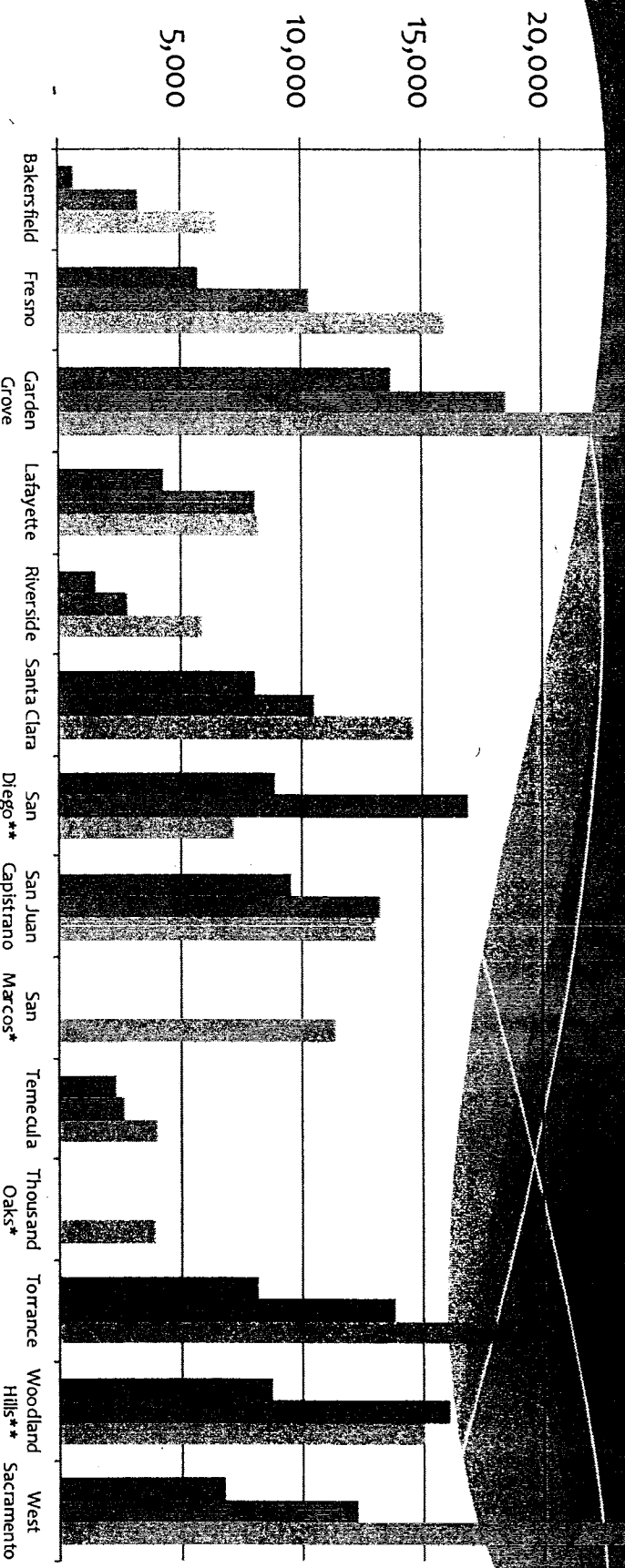
STATE	BCBA's
Alabama	124
Alaska	20
Arizona	92
Arkansas	22
California	1858
Colorado	165
Connecticut	283
Delaware	17
DC	23
Florida	1130
Georgia	168
Hawaii	63
Idaho	10
Illinois	320
Indiana	151
Iowa	38
Kansas	74
Kentucky	102
Louisiana	68
Maine	64
Maryland	172
Massachusetts	1030
Michigan	162
Minnesota	80
Mississippi	19
Missouri	176
Montana	16
Nebraska	55
Nevada	65
New Hampshire	95
New Jersey	622
New Mexico	22
New York	783
North Carolina	129
North Dakota	5
Ohio	143
Oklahoma	33
Oregon	24
Pennsylvania	728
Rhode Island	71
South Carolina	89
South Dakota	6
Tennessee	259
Texas	555
Utah	51
Vermont	40
Virginia	344
Washington	195
West Virginia	46
Wisconsin	60
Wyoming	4

¹² According to the Behavior Analyst Certification Board as of August, 2013

25,000

Authorized Insurance Hours July 2012 – Dec 2013 (in 6-month periods)

Authorized Insurance Hours



CARD California Locations

- 2012 July - December
- 2013 January - June
- 2013 July - December
- 2012 July - December

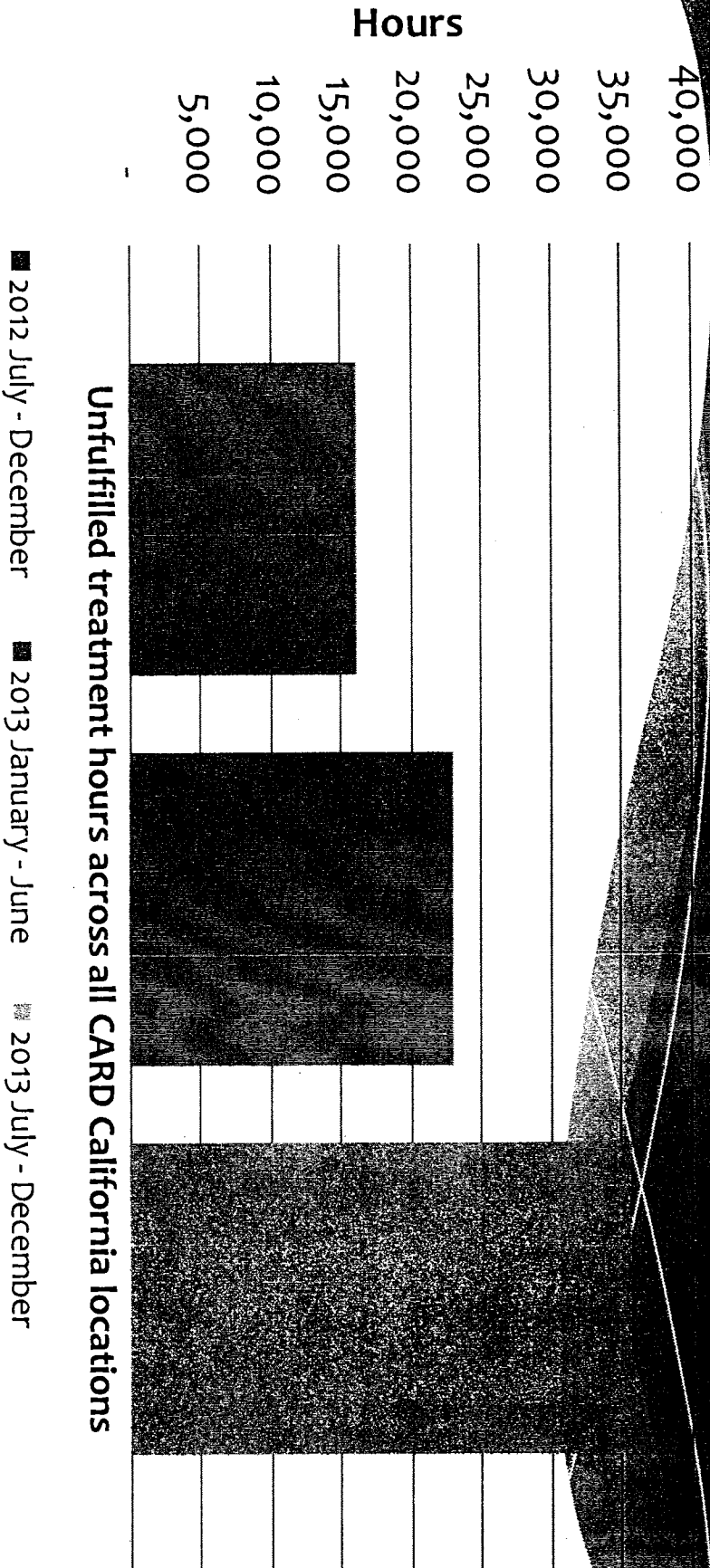
This graph illustrates the steady increase in the number of hours authorized by insurance carriers for autism treatment since California's autism mandate took effect, likely indicating a substantial increase in access to treatment for Californians as a result of SB 946.

*New CARD locations
 **Decline in hours in July, 2013, indicates temporary impact of new CARD locations.



Unfulfilled Treatment Hours

July 2012 – Dec 2013 (in 6-month periods)



This data indicate the increase in treatment hours that were authorized by health plans but not used. Although treatment hours may be unused due to illnesses and scheduling conflicts, families increasingly cancel therapy sessions because they cannot afford the cost-sharing (i.e., co-pays, co-insurance, and deductible that are responsibility of insured).





Charles Bacchi
California Association of Health Plans
Executive Vice President

Charles Bacchi is the Executive Vice President for the California Association of Health Plans and coordinates advocacy activities before the California Legislature, the California Health Benefit Exchange, and the Department of Managed Health Care on behalf of CAHP's 40 health plan members that provide health coverage to 21 million Californians.

Mr. Bacchi has 19 years of experience in the California legislative and advocacy arena. Mr. Bacchi recently led health plan efforts to establish new geographic rating regions in California, led efforts to defeat proposals to require prior approval of health plan premiums, and helped secure funding to save California's Healthy Families Program (CHIP).

In previous roles with the California Chamber of Commerce and the Legislature, Mr. Bacchi was instrumental in developing and negotiating the bi-partisan 2004 California workers compensation reform package and the bi-partisan 1998 school bond effort that reformed funding for school construction and limited fees on new homebuyers.

Mr. Bacchi graduated from the University of California at Santa Barbara with a degree in English Literature.

Public Comments & Testimony Submitted to the Committee

(Received by February 25th)

AGENDA ITEM # 6

- Mr. Keith Calrdwell
- Ms. Dena Dersh
- Mr. Rich Esposto
- Ms. Karen Fessel
- Ms. Margret Jerram
- Ms. Sue Kim
- Ms. Wendy Liu
- Ms. Sonja Luchini
- Ms. Melissa Roth
- Ms. Erin Schmidt
- Southern California Consortium of Behavior Analysts

Dr. Vismara

We met last year in your office at the annual SELPA Legislative Day and I spoke to you then about these points and will present them again in hopes that you and Senator Steinberg will hear them now.

Access to care for my son has definitely diminished since the SB 946 was enacted.

Absent this law, my son would still be receiving excellent care from qualified service providers instead of getting dropped by these providers because our insurance would not pay a rate high enough for these service providers to actually pay their highly trained staff. So, my son was dropped by them and we had to go in search of a new provider(s) that was qualified AND would be willing to accept the pittance the insurance company was willing to pay.

It's sad to say, that it is actually better if my autistic son were dropped from his insurance in order to regain access to the more qualified network of care providers available to us BEFORE SB 946 was signed by the Governor.

From my view, all this bill has done is made it harder for some to get qualified services from care providers and shifted the majority of the financial burden away from the State of California and onto the insurance carriers AND the back of parents through co-pays and deductibles that never had to pay prior to this bill.

I am writing this letter to you as a parent of a child with special needs and not in my official capacity as the Chair of the Placer County SELPA Community Advisory Community.

Keith Caldwell

Hello Louis,

Unfortunately our insurance is unaffected by this very important piece of legislation and I wish I could figure out how to change it. My husband works for Dell Computer and they are a self-funded plan out of Texas. They have elected to NOT cover autism. My husband, myself, and our two kids (my daughter has Autism as her primary diagnosis & my son has PDD as his primary diagnosis) live in CA. My husband is a remote worker. I do not understand why they are allowed to not to cover these two conditions. That should be illegal. In order for our insurance to pay 50% of the out-of-network psychiatry for both kids we have to use their secondary conditions as their primary conditions. So that means for my daughter we use her anxiety/depression and for my son we use his GAD (general anxiety disorder). I am angry at this situation as it means we basically have to lie on all the forms. The doctors are fine doing it as they understand the unfairness of the situation and have a duty to treat our kids. I would love to sue Dell Computer, but I am just one person. Any ideas?

Thank you,

Dena Dersh

Richard and Katherine Esposto
146-46th Street
Sacramento, CA 95819-2211

Senator Darrell Steinberg,
Chair, Senate Select Committee on Autism and Related Disorders
March 4 Hearing

Senator Steinberg;

Our almost 6 year old grandson is on the Spectrum. He is with us more than half time and since we retired he has been our primary focus.

Last September he began applied behavioral therapy under the auspices of Kaiser, your legislation and Capitol Autism Services. He was objectively evaluated last August and again last month. Using the same criteria, his reassessment showed that his overall maturity level increased by over 1 year in 6 months of therapy. He continues to get stronger and more independent daily and our subjective assessment of his progress is more positive than the hard data. Our experience on the receiving end of the Kaiser program is decidedly positive. It is data driven and run efficiently.

I would welcome the opportunity to testify publicly as well as participate in any study to show the long term cost benefits of early and intense intervention to those on the autism spectrum. Our story would be a very different one today, had it not been for the intervention we received through your legislation and implemented by Kaiser. Based on our experience it provides much better service delivery than the regional center model.

'Best

Rich Esposto
Retired Bureaucrat



Autism Health Insurance Project

February 25, 2014

Submitted to the Senate Select Committee on Autism
In preparation for the March 4, 2014 Senate Hearing

I am writing in on behalf of the Autism Health Insurance Project, in response to the requests for written statements on the implementation of SB 946. The Autism Health Insurance Project is a 501 (c3) non-profit public charity dedicated to helping families with children on the autism spectrum obtain health insurance coverage for autism related interventions including speech, occupational, and physical therapies, and intensive behavioral therapy (aka ABA). We also co-moderate several yahoo users groups where parents frequently write in about challenges that they encounter. In these capacities, we are in a unique position to monitor the implementation of the SB 946/126, the state mandate which addresses intensive behavioral treatment for ASDs.

By and large, with some initial bumps and starts, our sense is that the majority of children with ASDs who have state-regulated private health plans have been helped enormously by this legislation, allowing them access to comprehensive behavioral programs that result in reduction of many adverse behavioral symptoms associated with ASDs. Many have been able to access a greater number of hours of services than what they were previously able to get through programs funded by regional centers.

Recent spike in Medical Necessity denials

We have, however, worked with many who have experienced challenges. Recently, probably due the fact that we have approached 18 months since the passage of bill, we are seeing an increased number of children who have experienced medical necessity denials. Many of these denials are in fact frivolous:

"Your behaviors do not appear to be significantly interfering with your home or community activities. You do not present as a health or safety risk to self or other. In school support by school staff has not been attempted in order to maintain appropriate in school behaviors. Your specific goals, including a well delineated treatment plan has not been provided. Treatment plan objectives should be measurable. Parent support and training does not appear to be incorporated into the treatment plan. No new problems or symptoms that met admission criteria have appeared. You are not expected to benefit from the continuation of ABA services in the school setting. Your treatment plan has not been updated. Your progress should continue even

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with withdrawal of services. Medical necessity criteria appear to be met for ABA services at the above rate, transition to mostly in home or community based ABA services, which is available to you. Your social skills and behaviors will continue to be evaluated and should continue to improve with in home or community based ABA services."

The insurer was saying that the child no longer needed services in the pre-school setting, though he was continuing to elope from the classroom, touch other students inappropriately, had had aggressive incidents, and could not interact with peers at all without adult facilitation. Updated treatment plans with measurable goals, including parent training, had been submitted to the insurer. There was no medical reason to believe that progress would continue without ABA services, when many of the goals had not been achieved.

For "lower functioning children," we are seeing requests for cognitive testing, even though CDI has indicated that they will not allow cognitive tests to be used to deny or delay providing treatment. Once they receive such tests, denials typically indicate that the child is failing to make progress, when in fact they are. More recently, we are seeing requests for "developmental assessments," and/or the IEP, though what measures they are requesting, and whether they will pay the costs for these assessments if they are unavailable from other sources, is unclear. Whether this should be allowed needs to be examined, as it seems that these assessments are being used prejudicially against "low functioning" children to deny treatment. At the very least, it would be useful to have conformity from the two regulatory agencies so that the regulations developed by one agency will be honored by the other.

Requiring Standardized Assessments

We have heard reports from several providers that certain health plans are requiring standardized developmental assessments. They want these developmental assessments to be used to measure progress, even though most of these assessments have not been developed for this purpose. One company named the Vineland as an example. This instrument merely assesses the parent's perception of the child's ability, it does not directly measure performance. The people that work at the insurance companies are not experts in this area and it is not appropriate for them to be dictating how progress should be reported. Many children make remarkable progress but it is often not reflected directly in standardized assessments.

Abrupt Terminations, Need for Expedited Review or Aid Paid Pending

We are also seeing abrupt terminations in care. Parents either scramble to fund such terminations out of pocket, or the child must forego services at the risk of severe

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regression, disruption of routine, disruption in pre-school placements, and disruption of the ABA team. Typically, there is not even sufficient time for the family to line up services from their regional centers (and if they the child is fortunate enough to qualify for RC services, often it will be for significantly fewer hours). A potential solution is to allow these cases access to expedited IMR. When the IMR process is working at its best, it typically takes three months, which includes submitting an appeal to the insurer, waiting 30 days, submitting to the regulator for IMR, being prepared for IMR at the regulator (2-4 weeks), and then being adjudicated by IMR (up to 30 days). In that time, if the parent cannot afford to pay out of pocket, the child must forego services. Another potential solution is to allow "aid paid pending," or stay put, as we see in school situations and with Medi-Cal enrollees, where the insurer must continue to pay for the services until the dispute resolution process has been resolved.

Kaiser's Network of One Provider

In many parts of the state, Kaiser has contracted with one provider, Easter Seals, to handle all of its ABA issues. We have had many complaints from many Kaiser families who have had horrible experiences with delays in accessing care, and also quality of care issues. In some parts of the state, Easter Seals has established a list of preferred providers that they sub-contract services out to. In other parts of the state (Southern CA) there are only a few providers, and it is not clear who gets a choice and who does not. There have been reports that Easter Seals controls the recommendations, and that sub-contracted providers do not feel free to make recommendations, as it will interfere with their ability to get sub-contracts. Many families have expressed privacy concerns with having Easter Seals as a "middle-man." That ABA information is sensitive mental health information, and should be protected between the provider and the insurance company.

Out of Pocket Payments Incurred by Families

Families continue to have huge frustrations with out of pocket payments. Many in high deductible plans cannot afford their deductibles. When this happens, there is a direct barrier to accessing medically necessary services.

We have heard of several problems where regional centers dispute the amount of hours that a child gets from insurance. Many will only pay co-pays on the number of hours that they think the child should get. This needs to be formally addressed. In one case (M.S. vs CVRC) the ALJ found: "Section 4659.1 does not grant CVRC discretion to determine which IPP services are "appropriate" before it assists consumers whose parents come within the poverty guidelines." It would be useful if this ruling could be

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standardized into law, as many regional centers have different policies on how much behavioral services they will fund, and when this happens, there are inconsistencies based on where one lives (lack of "statewideness.")

There is also variation in policies and practices on out of pocket annual maximums. According to a review of recent Evidence of Coverage Manuals, Blue Shield, Kaiser, United, and HealthNet all put the onus on the consumer to save receipts, submit to the insurance company, and inform them when they have hit their out of pocket maximum. This issue impacts families with chronic and acute conditions, not just autism, and will hopefully be addressed through legislation during the current legislative session. Families dealing expensive medical conditions, possibly in the midst of a life changing health crisis, may be in the worst possible position to be saving, copying and mailing in their medical receipts. Health plans routinely track expenses of their enrollees, (they monitor payment toward the deductible). To require them to track and inform on expenses made towards the out of pocket maximum should not impose a huge administrative burden. It is important to note that many people with autism and other developmental disabilities are often covered by Medi-Cal as secondary. When the plans do not assume responsibility for tracking of co-pays and co-insurance towards the out of pocket maximum, regional centers and Medi-Cal are picking up the difference. This legislation will likely result in cost savings to the state.

Thank you for allowing the Autism Health Insurance Project this opportunity to inform the legislature of some of the common issues and concerns that we are seeing. We are happy to provide additional or more detailed information upon request.

Sincerely,



Karen Fessel, Dr Ph

Executive Director and Founder

Autism Health Insurance Project

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2/23/2014

Margret Jerram
2154 Scenicpark St.
Thousand Oaks, CA 91362

Dear Senator Steinberg,

I'm unable to make it to the hearing but would like to give my input regarding the topics: access to care, assessment and treatment, and fiscal implications that are to be discussed.

Access to care:

Through our insurance company, Anthem Blue Cross, our son currently has access to care that he needs to help him improve his behavior as well as having access to ways to assist with his OCD behaviors. Last year, we had to fight our insurance company to keep our hours that we originally had through Tri-Counties Regional Center. In the beginning, when we were transitioned to our health insurance, Anthem wanted to cut our services in half saying it "wasn't medically necessary." The Medical Review Board heard our case and granted to keep our 10 hours of ABA, however, they reduced our supervision hours from 4 hours per month down to 2 hour per month. I am still hearing stories from other families as they transition, that they too, had to fight their insurance for speech, occupational therapy, or other services needed to sustain their child's mental and physical well being. I am hoping that other families, in the future, don't have to fight their insurance to keep any treatment or services that are "medically necessary."

Our son is also seeing a psychologist to help him to become more aware of his OCD behaviors and how to deal with those behaviors. Although he has improved over the years with ABA Services and recent OCD therapy, he is not yet to the point where he can take complete control of those behaviors on his own. ABA Therapy is a slow steady process and takes several years for it to finally to take effect on the child (It is not a "quick fix").

Assessment and Treatment

We are currently using STAR of Calif., a well-known and qualified provider. They have done an outstanding job and have, in my opinion, highly qualified employees to address any issue that arises. They work with children with high functioning to those with

severe Autism. Having a qualified provider helps to insure a steady increase in the child's behavior over time. As the child becomes a teenager, he or she will eventually have the skills to become aware of their behaviors and how their behaviors affects others around them. These behavior skills are important to the teenager as he or she reaches adulthood and can live on his or her own and have a decent job.

Fiscal Implications

In my opinion, this is the area in most need of improvement. Financially, we fall within the criteria of families that have government assistance for our health care. We are grateful that we can now afford to have access good health care for ourselves. As for our son, Anthem is moving us to the Silver Plan with a high deductible because his plan is not "Grandfathered." Because Regional Center cannot help us with the deductible, we are faced with a bill that we are not sure we can pay. Although we have the option of going through Medical for his ABA, we could face a reduction of hours of services through Regional Center because our son has been with ABA services for 4 years. We would face the possibility to fighting another battle to keep our ABA hours out of fear that our son's improvement can regress at this point. We are moving our son to the Gold Plan, however, we will face an increase of premiums.

I propose that it should be mandatory for all health insurance companies to reduce the deductible on the Silver Plan to a "fair" amount where co-insurance can be accessed more quickly so that parents will not have to endure financial stress of the out-of-pocket max. Secondly, I propose that the Trailer Bill should be changed to state that it is mandatory for Regional Centers to pay for co-insurance to families that fall within the 90,000 and below income criteria.

I hope my input helps with your quest in finding out the results of the new law. I can't speak for everyone at the meeting because my situation might be unique, however, I hope there are others out there with similar concerns and that all of these concerns are "heard" and addressed. Thank you for your time.

Sincerely,

Alan and Margret Jerram

Dear. Senator Steinberg,

My son is almost 18 and his life has many events that most of us would never faced. If he was diagnosed early I am sure his life would been so much better and probably his behavior would been almost normal. He is a high function autism student however, we had to spend savings to pay for private psychology sessions, therapist and tutors. I was so relieved when I heard that now insurance company would help with some of these items. Since last September he has been working with behavior therapist 4 days per week. It is a slow process but I do see improvements in him. He can be one of these children who would go out to the world and have a normal life rather than relying on society to help him with every aspect of his life. All of parents with Autism children wants their children to learn to become an independent young adult. We fear what their lives would be like after we pass away. We cannot afford to pay for these behavior therapies even when our income is solid. The living expenses in California is so high, Without help from insurance companies you will see so much increase of these families giving up on their homes to pay for these therapies and, giving up their employment to take care of these children. There has been so much increase on number of children born with this condition. A survey I have found says that 1 out of 4 children in Silicon Valley children are affected by this condition yet the medical industry is not sure what is causing these increase. The nation needs to address this issue as soon as possible as they are growing up and more children are born with this. If we delay or stop assistant with the insurance companies then it will be an epidemic down the road. These children think differently, act differently, talk differently due to their processing ability yet they have huge hearts for caring. They will be the first one to put their lives on the life for others in needs.

We need to continue to work with these children so that they will become a solid and productive citizens of United States of America.

This is a medical condition just like a diabetic so why not cover medical treatments. Treatments for these children might be different yet absolutely necessary. Please help parents and children so that we can continue to receive support from insurance companies.

Thank you

Sue Kim

2/20/14

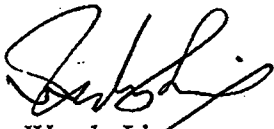
AUTISM INSURANCE MANDATE HEARING

RE: Autism Treatment Insurance Mandate SB 946

Senator Darrell Steinberg and other distinguished committee members, I want to thank you for this opportunity to address SB 946.

I urge you to keep this important legislation. My name is Wendy Liu and I am a mother with a beautiful autistic daughter. Even though she is a severe autistic kid, but we never give up on her. With the insurance help, we can take her to speech therapy and we also have in home ABA program for her to improve her different skills. Now she shows lots of progress on her language and independence skills. Without the insurance, we are not able to pay for all these services, and my daughter will have no future at all. When she grows up, she will become the burden for the society since she may need more care from others. I urge your support SB 946.

Thank you for your attention to this important issue!



Wendy Liu
San Jose, CA

Dear Mr. Vismara,

Thank you so much for replying so quickly on a Sunday evening. Would you mind if I forward your email to my advocacy listserv that included CAC leadership? I don't have all the contact info, but the woman in charge would disseminate it and hopefully you'll hear from those who would appreciate being notified. We've been connecting with each other over the last few years because we seem to have less and less information and support from our SELPA Directors - whether it be due to indifference or being overworked due to budget cuts.

I, too, have a young adult son (turning 22 this year) with autism. I always tell people he's done well in spite of the system (we all have our IEP horror stories). He is taking 2-3 courses a term at West LA Community College and receiving good grades. We've taught him to be an advocate for himself, but he still needs a boost from his circle of support (and probably will for the rest of his life). I see fewer services for younger children in the system as I assist other families with IEPs. What was available to my son in K-12 is not as readily available today and in fact it seems that schools are purposefully making IEP service decisions based on costs, not the needs of the child.

Link to story about my son's participation in a Peer Mentor program (I still cry when I see this):
<http://www.nbclosangeles.com/news/local/What-Happens-When-Autistic-Kids-Grow-Up--168078316.html>
We LOVE Brett and Ben is still working with him on living skills.

I don't know if I will be able to make a public comment submission in time for tomorrow's deadline: meeting a former Autism Society Board member and others concerned about service delivery in LAUSD in the morning. Dr. appt mid day then picking up my son from school to participate with him in the PEERS program at UCLA that evening. It's a full day and I'm just a mom, not a policy expert. I'd like to read up more on the subject so appreciate that there will be future hearings.

Link to UCLA PEERS program:<http://www.semel.ucla.edu/peers>

My son has a friend, a young woman (25 yrs old) with autism attending Pierce College here. We had her over yesterday and she mentioned having difficulty in having broken glasses repaired, plus she's in need of a new prescription. She's a regional center client, has SSI and her apartment, provided through regional center is shared with three other young women. She has very little additional spending money for even small items. Her mother is her only involved parent and works constantly. While I appreciate that this young lady has a roof over her head and supports - there seems to be a disconnect with eye/dental needs and she should have more caregiver support to help her navigate in getting the help she needs. We've seen regional center funding and services drop and my husband and I are fearful that when our son turns 26, he may not have access to the doctors we've had access to all his life. The Psychologist who diagnosed him at 4 yrs is private pay as is his psychiatrist and regular doctor. We'd hate to see him lose his life-long system of support - people who have known him all his life, just because of age requirements in our health insurance. California Care (ACA) would probably not cover such specialists nor would it cover the medications he needs. Those are some brief comments that I could offer tonight and will try to write them up and submit after tomorrow for the binder. I appreciate your true understanding of our issues and would love to share your email with the other groups. They need to hear that we have advocates and supporters in Sacramento for our children who want to help us.

Sincerely,
Sonja Luchini

-----Original Message-----

From: Vismara, Louis <Louis.Vismara@SEN.CA.GOV>

To: sluch20 <sluch20@aol.com>

Cc: Giovati, Bob <Bob.Giovati@sen.ca.gov>

Sent: Sun, Feb 23, 2014 5:41 pm

Subject: RE: AUTISM INSURANCE MANDATE HEARING

Dear Ms. Luchini, Sen. Steinberg and our office are indelibly committed to an inclusive process that is focused on obtaining input and guidance from families who are overcoming the challenges and autism and other developmental disabilities. As a parent of child with full spectrum autism, i can personally attest to the importance of including consumers and their families in every aspect of public policy decisions. Please send me the email contacts of any and all individuals and organizations and we will gladly add them to our distribution list. Please feel free provide any input or recommendations even after tomorrow's deadline for printed information that will be included in the Hearing's binder. This is an ongoing process, the hearing is another step in the journey to improve the lives and future of our vulnerable students. Let me or my colleague (Mr. Giovati) know if we can provide additional information or future assistance. We look forward to working with you and your colleagues. Respectfully yours,

Louis A. Vismara MD

Policy Consultant to Senator Darrell Steinberg

Office of the President Pro Tempore

From: sluch20@aol.com [<mailto:sluch20@aol.com>]

Sent: Sunday, February 23, 2014 5:18 PM

To: Vismara, Louis

Subject: Fwd: AUTISM INSURANCE MANDATE HEARING

Hello, Mr. Vismara

I'm the Chair of the Special Education Community Advisory Committee for Los Angeles Unified School District.

We have found that critical information regarding State and Federal education policy is not getting to our committee or public participants in a timely manner to ensure debate, discussion and provide input for consideration. This email was sent out by you on February 19, and I received it through an advocate friend the next day. While I appreciate getting the information at all, why so little notice to the public regarding this? Are CACs on your distribution list? If not, the 122 CACs active in California could provide a perspective that might not be presented otherwise at hearings such as these. Not all families have the ability to make a trip to Sacramento, but if given better lead time, we could have discussion within our organizations and provide written testimonial. I might also remind you that just because you provide information to a SELPA Director does not mean that it filters down to the committee. The leadership of each CAC should be on contact lists in addition to SELPA Directors. I find that I receive information from my advocacy group contacts well before hearing it from our SELPA Director. We have children with special needs, don't have funds for lobbyists and aren't always able to take the time to keep on top of important issues so it would be helpful if a better communication system were established with CAC leadership specifically.

As things stand with this notice, I'm afraid I will not be able to present it to membership before the

February 24, 2014 deadline for public comment. Our next meeting is March 5th - too late to act. LAUSD's CAC represents approximately 83,000 students with disabilities. We have much to offer and would appreciate your help in being included on mailing lists and in receiving information with time to act as a committee voice.

Thank you for all you and Senator Steinberg do for our students with disabilities.

Sonja Luchini, Chair
Community Advisory Committee for LAUSD

February 20, 2014

Senator Steinberg
Policy Consultant to Senator Darrell Steinberg
Office of the President Pro Tempore
The State Capitol, Rm. 415
Sacramento, CA 95814

RE: California Legislature, Senate Select Committee

Subject: March 4TH: Autism Insurance Mandate Hearing

Dear Senator Steinberg;

As a mother of a 2½ year old autistic son, my experience with the effects of governmental policy in regards to the treatment of autism is very short-lived. In essence, I would say that I was very fortunate that the ground work had been laid, and that I did not have to fight for services as I have read so many before me had. In this way, I am extremely grateful. I can only provide you with my limited experience, but I did meet some frustrating aspects of the system in place. I apologize in advance, as I am not educated in the aspects that are under governmental control, and the ones that are more affiliated with the private sector. As a result, this letter will contain most of the benefits and complaints I encountered through my families' journey of autism so far.

Assessment and Treatment

I was blindsided with my sons' diagnosis. I did not see the symptoms at my child's 18 month appointment. I guess I could say I was fortunate, as even though my son was difficult at times, his difficulties were manageable. Our pediatrician saw the signs, and gave me a questionnaire to fill out. Had it not been for her, my son would not have benefited as much from early intervention. We would have eventually seen the signs, but I imagine we would have lost 6 months of precious intervention time. I feel extremely lucky that my child's doctor saw the signs, and gave me the tools to move forward. I have talked to many other moms' in which case their doctors' were not up to speed on seeing the signs, and as a result they lost valuable time to the "wait & see" approach.

I address my major frustration with the time frame of treatment under the "access to care", but I have to say that once my son began receiving treatment from our ABA Service provider we saw him improve immensely!

My insurance provider really came through with approving the hours recommended by the ABA Servicer, and I am grateful beyond words. In addition, the ABA service provider worked with my insurance company and with the regional center in regards to our copay assistance. This really helped me focus my time on my son rather than on straightening out payments and coverage.

Access to care

When you get the diagnosis, your first instinct is to want to do whatever you can to help your child. The timeline of services can be very daunting and extremely frustrating when everything you read talks about the importance of early intervention. “The earlier the treatment, the better off the child will be in future years”, “the first 3 years are the most important”, are statements that echoed constantly in my head. Yet, access to care was not immediately available.

First, when we turned in the questionnaire we received a call within a couple of days that an evaluation was necessary. Appointments to schedule the evaluation were 30 days out. I was fortunate enough to be added to their cancellation waitlist, and received an evaluation 2 weeks after making the appointment. However, this was only because my employer was very supporting and allowed me to change my schedule on a days’ notice. Most employers are not so understanding, and an hours’ notice to bring your child in to the center would not be doable for most people.

Secondly, when we were told that my son had autism at the actual evaluation, we were told we would have to wait 4 weeks before anything was done. So, now 2 months have passed before my son can get services. AND why did we have to wait 4 weeks? What happened in that 4 weeks, was simply the passing of time. I am not sure if this is normal insurance protocol, but I have to say not given any tools, any guidance, not one thing while you watch your child get worse is every parent’s nightmare. I really would like to know the justification for this waiting period. The evaluators said it was due to another department needing to review their recommendations, but for what? It wasn’t even to figure out how many hours may be necessary for my son, because another evaluation would be needed by the actual service provider before that could be determined.

After waiting 4 weeks (and it was to the day) we received a call with our insurance coordinator to start services. We were given a list of providers, and told to pick one. The availability of services was a complete joke. 3 out of the 4 I contacted had waiting lists. Waiting lists that were a couple of month’s out-- just to sit through another evaluation. Fortunately, one of the places had an opening, but we still had to wait another month to schedule our assessment with the actual ABA. In addressing access to care, I would say a major bottle neck is the availability of service providers. But to have to be put on a waitlist for 2 months, means that 6 months pass by between the time you suspect your child has autism and when something is actually done about it. If the average age of discovering autism is at 18 months, and the first 3 years are where your child is still making those brain connections and can still be re-wired, and you lose 6 months that equals 1/3 of the time you have left to help your child make those connections. And I do not blame the service coordinators, as they are inundated with requests.

After the assessment with the ABA service provider, we were told to wait 2 weeks for our insurance to approve the services. I am not sure if you deem a 4-6 month waiting period between suspecting your child may need help, and actually getting help as a good or bad waiting

period. But I am certain that if this was your child, 4-6 months would feel like an eternity to you.

The ALTA regional center has been extremely helpful in this journey. They sent an evaluator out to my home a week after we began to suspect something was wrong with my son. Services for Speech, Occupational, and Developmental delay therapies began after 2 months. Our Regional coordinator was very helpful, and gave us guidance. They were part of the reason I was able to maintain my sanity while waiting for my insurance coverage to get services started.

Something to consider, is that I am very lucky because I happen to live near the U.C. Davis MIND Institute. The funding for their research, and the proximity of my home to their facility gave my son a huge advantage. They happened to have a study on the Early Start Denver Model, and were accepting participants. In this study, they teach the care givers how to interact with their child in ways to get them interested and out of "their own little world". My son began working with them one month after diagnosis. If this mandate is so new, and you are seeing the autism epidemic spread, having this kind of resource can be a huge help, and possibly save money in the long run to newly diagnosed families. I am not sure if the mandate supports research, but it should.

Fiscal Implications

Savings and Expenses—Can I just say that your mandate on having insurance cover autism therapy literally kept us out of poverty. My family of 4 is still struggling to break even, but without the support we received I have no doubt that my son would be worse off without the help we received. The regional center co-pay assistance was also a huge part of helping us manage, because a 30.00 per day copay for 5 days adds up very quickly.

Expenses that are not covered that would have been a huge help would have been assistance with our high deductible and the costs incurred for my son's original assessment. In addition, we could have benefited from respite help, as a new diagnosis for a struggling family can be very difficult. I am unsure as to why you do not allow respite help until the child is 3.

Finally, the reaching out of the Warmline program is very comforting. I am unsure if this is related to any of the mandates. The problem with their program is that most of their meet ups are during the day when my son is getting services. I was very eager to meet with other parents and share concerns, strategies, successes, but those meet up were also while I was at work, and while my son was getting therapy.

Benefits and Challenges

I would like to thank the State of California for creating this mandate and including autism within its guidelines. Without the support under insurance, and the regional center there would be no way to get my son the help he needs. He has thrived in the past 6 months. I am absolutely grateful for what we currently have, and in addition I am hopeful for my son's future. The ABA consultant works with my son directly, but they also work to educate my husband and me on their strategies.

As mentioned above, a parent's biggest challenge is getting services started in a timely manner, and the availability of service providers. Waitlists to start after waiting to get approved is absolutely ridiculous.

Thank you for taking the time to read my experience. I hope that this is what you were looking for as far as feedback is concerned.

Sincerely,
Melissa Roth

Hayden at 19 Months, July 2013 Mullen Scales

Scale	T score	Age Equivalent	Percentile
Visual Reception	25	13 mos.	1 st
Fine Motor	20	14 mos.	1 st
Receptive Language	20	7 mos.	1 st
Expressive Language	20	5 mos.	1 st
	<u>Standard score</u>		
Early Learning Composite Score	50		1 st

Adaptive Behavior Skills

Scale	Standard score	Percentile
Communication	54	1 st
Daily Living	75	5 th
Socialization	73	4 th
Motor	76	5 th
Adaptive Behavior Composite	66	1 st

Hayden at 28 Months Mullen Scales February 12, 2014

Scale	T score	Age Equivalent	Percentile
Visual Reception	41	24 mos.	18 th
Fine Motor	48	27 mos.	42 nd
Receptive Language	36	22 mos.	8 th
Expressive Language	28	16 mos.	1 st
	<u>Standard score</u>		
Early Learning Composite Score	77		7 th

VABS-II Scale	Standard score	Percentile
Communication	94	34 th
Daily Living	83	13 th
Socialization	80	9 th
Motor	93	32 nd
Adaptive Behavior Composite	85	16 th

Dear Senator Steinberg,

I am a speech-language pathologist and also a mother of a little girl with Autism. I ask that you consider extending more assistance to reach services for speech therapy and occupational therapy for families with children who have Autism. These services are under funded by insurance carriers and can be difficult for families to pay for, including myself. My own health insurance does not cover these services and since my daughter is on Medi-cal and has services through our Regional center, we are very grateful for the help she is receiving.

I also think that more behavioral services other than ABA should be offered, such as DIR/Floortime services to be paid for by health insurance carriers and Regional centers. ABA services are good up to a point, but do not help children with social interaction and social language/engagement with others and this is a huge deficit for children with Autism. It can greatly impact their ability to be self-sufficient later in life, even if they are very smart and high functioning.

Please consider these things carefully when you are reviewing this law. Thank you!!

Erin Schmidt, MS, CCC-SLP;
mother of 6 year old with Autism.



SB946: California's Autism Insurance Mandate Coverage Legislation

Summary: SB 946 (Steinberg) requires most health care service plans to provide coverage for behavior health treatment for pervasive developmental disorder or autism. This mandate allows for increased access to research-based applied behavior analysis (ABA) treatment for individuals with autism spectrum disorder. California's Autism Insurance Mandate (SB 946) was signed into law in 2011 and took effect on July 1, 2012. SB 126 (Steinberg), which was enacted during 2013, extends the provisions of the autism mandate until January 1, 2017.

Position: The Southern California Consortium for Behavior Analysis (SCCBA), an organization of 32 service providers, representing over 7000 clients with autism spectrum disorder or other developmental disabilities, supported SB 946 and SB 126 due to increased access to research-based ABA treatment for individuals with autism spectrum disorder. During implementation of SB 946 there have been benefits and challenges to both clients and service providers.

- 1) **Access to care:** SB 946 has both increased access to care for individuals previously not able to access treatment and limited access to treatment for others.
 - **Limited access:** Some clients previously accessing care through their individual program plan (IPP) with regional centers experienced a lapse in services or barriers to accessing treatment through their health plan. These barriers consisted of responsibility for co-payments and deductibles or denial of treatment by their health plan when treatment was previously provided by their regional center.
 - **Increased access:** Individuals not eligible for treatment through regional center (due to non-eligible diagnoses) are able to access treatment through their health plan when prescribed by their physician.
 - **Timely and Effective Treatment:** Assessment and treatment through health plans are required to be provided by qualified providers with most health plans requiring treatment to be supervised by a Board Certified Behavior Analyst (BCBA). Additionally, clients are able to access assessment and treatment in a timely manner due to health plans responding to service providers within 5 days. Further, health plans typically authorize the recommended service and hours (direct and supervision).
- 2) **Assessment and treatment:**
 - Most health plans have developed an adequate network of providers allowing clients to access treatment from a service provider of their choice.
 - Other health plans have not developed an adequate network of providers leading to increased wait time to begin assessment or intervention and limited choice of service providers.
- 3) **Fiscal implications:** Co-payments and deductibles have limited access to treatment for clients due to the cost incurred by the family.
 - **Co-payments:** Co-payments are determined by an individual's health plan and are incurred daily or per visit and vary in amount. ABA is provided on an ongoing basis with treatment being provided several times per week thus resulting in high co-payment amounts on a weekly basis.
 - **Regional Center co-payment:** Trailer Bill Language limiting regional center's ability to provide co-payment assistance has created a barrier to service for some regional center consumers and added administrative cost for regional center in determining co-payment assistance for families.
 - **Deductibles:** Families accessing ABA treatment through their health plan have incurred cost due to the need to meet their deductible. In some cases, health plans have high deductible amounts creating a barrier to service.
- 4) **Benefits and Challenges:**
 - **Challenges:** SB 946 promotes a 3-tier model of treatment provision, but health plans often do not allow for case supervision by a master's level clinician or BCaBA supervised by a BCBA (2nd tier – Qualified Autism Service Professional).
 - **Access to Treatment for Adults:** Though SB 946 mandates treatment for individuals with pervasive developmental disorder or autism of any age, treatment is routinely denied for adults.
 - **Benefits:** SB 946 has, overall, increased access to research-based ABA services for individuals with pervasive developmental disorder or autism. Health plans require collaboration with schools and other service providers to ensure continuity of care for the individual across settings. Health plans also allow activities restricted by regional centers including provision of treatment in the community, which is critical for generalization of skills across settings. Additionally, health plans authorize 6 months of service with a progress report due at the end of that period allowing for continuity of treatment across that period of time with out lapse in services or unnecessary reporting requirements.

Feedback from SCCBA (Southern California Consortium of Behavior Analysts)

Negatives about 946

- Co-pays and deductibles
 - Regional centers are reluctant to pick up co-pays and they won't pay deductibles
 - Making co-pays and deductibles are hardships for many families
 - Services have had to cease in many cases, if regional centers won't make the co-pays
- 946 promotes a 3-tier model but some insurance companies refuse to accept the 2nd tier
- CPT codes differ from one insurance company to another
- Insurance companies routinely deny services for adults

Positives about 946

- Insurance companies give immediate authorizations for services, while regional centers sometimes take weeks or longer
- Most companies have approved the recommended services and hours
- Most companies allow six months, before a progress report is needed

Ability to provide services in community settings