California Board of
PSYCHOLOGY

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MEMORANDUM

DATE	July 7, 2016
TO	Board of Psychology
FROM	Jason Glasspiegel Central Services Coordinator
SUBJECT	Agenda Item #4(k) – SB 1034 (Mitchell) Health care coverage: Autism

Background:

This bill would, among other things, modify requirements to be a qualified autism service professional to include providing behavioral health treatment, such as clinical management and case supervision. The bill would require that a treatment plan be reviewed no more than once every 6 months, unless a shorter period is recommended by the qualified autism service provider. The bill would extend the operation of these provisions to January 1, 2022. The bill would require behavioral health treatment for purposes of the Medi-Cal program to expressly comply with the approved Medicaid state plan.

Location: Assembly Appropriations Committee

Status: In Assembly. Read second time and amended. Re-referred to Committee on Appropriations.

Action Requested:
Staff recommends an "Oppose" position on SB 1034 (Mitchell).

Attachment A is the Analysis for SB 1034 (Mitchell)
Attachment B is the language of SB 1034 (Mitchell)
Attachment C is the Assembly Health Committee Analysis of SB 1034 (Mitchell)

CALIFORNIA STATE BOARD OF PSYCHOLOGY

BILL ANALYSIS

BILL NUMBER: SB 1034 **VERSION:** **AMENDED:** 05/31/2016

AUTHOR: MITCHELL **SPONSOR:** AUTISM DESERVES EQUAL COVERAGE FOUNDATION
AUTISM SPEAKS
CENTER FOR AUTISM AND RELATED DISORDERS
SPECIAL NEEDS NETWORK

BOARD POSITION: NONE

SUBJECT: HEALTH CARE COVERAGE: AUTISM

Overview:

This bill would, among other things, modify requirements to be a qualified autism service professional to include providing behavioral health treatment, such as clinical management and case supervision. The bill would require that a treatment plan be reviewed no more than once every 6 months, unless a shorter period is recommended by the qualified autism service provider. The bill would extend the operation of these provisions indefinitely. The bill would make conforming changes.

Existing Law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Services Plan Act of 1975 in the Health and Safety Code; the California Department of Insurance (CDI) to regulate health insurers under the Insurance Code; and, the California Health Benefit Exchange (Exchange) to compare and make available through selective contracting health insurance for individual and small business purchasers as authorized under the federal Patient Protection and Affordable Care Act (ACA).

2) Establishes as California's essential health benefits (EHBs) benchmark the Kaiser Small Group Health Maintenance Organization plan, existing California mandates, and the 10 ACA mandated benefits.

3) Requires every health plan contract that provides hospital, medical, or surgical coverage and health insurance policy to also provide coverage for behavioral health treatment for pervasive developmental disorder or autism. Requires the coverage to be provided in the same manner and to be subject to the same requirements as provided in California's mental health parity law.

4) Sunsets the provisions described in 3) on January 1, 2017.

This Bill:

1) Revises the definition of "behavioral health treatment" to include other evidence-based behavior intervention programs that keep the functioning of an individual with pervasive developmental disorder.

2) Deletes requirements in law that qualified autism service professionals and paraprofessionals are employed by qualified autism service providers.

3) Requires treatment plans to be reviewed no more (rather than no less) than once every six months by the autism service provider, unless a shorter period is recommended by the qualified autism provider.

4) Specifies that parent or caregiver participation in the treatment plan is recommended by the qualified autism service provider, and prohibits lack of parent or caregiver participation from being used to deny or reduce medically necessary behavioral health treatment.

5) Permits intensive behavioral intervention services to be discontinued when the treatment goals and objectives are achieved, or when treatment is no longer appropriate and continued therapy is not necessary to keep function or prevent deterioration.

6) Prohibits the setting, location or time of the treatment from being used as a reason to deny medically necessary behavioral health treatment. Prohibits this provision from being construed to require coverage for services that are included in a patient's individualized education program.

7) Revises the definition of "qualified autism service professional" to include someone who provides clinical management and care supervision, deletes a requirement that he or she is approved as a vendor by a California regional center, and instead, requires him or her to meet the education and experience qualifications defined in section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant or Behavior Management Program.

8) Revises the definition of "qualified autism service paraprofessional" to indicate that the paraprofessional provides treatment and implements services pursuant to a plan developed and approved by a qualified autism service professional.

9) Deletes exemptions from the law for plans that participate in Healthy Families (which no longer exists) and CalPERS.

10) Deletes the sunset date in existing law.

Comments:

Author's Intent

According to the author, this bill ensures that children diagnosed with autism continue to have access to medically necessary treatments to increase their quality of life and functional independence by removing the 2017 sunset on the requirement for health plans and insurers to provide behavioral health treatments to children with autism.

Previous Legislation

AB 2041 (Jones of 2014), would have required that a regional center classify a vendor as a behavior management consultant or behavior management assistant if the vendor designs or implements evidence-based behavioral health treatment, has a specified amount of experience in designing or implementing that treatment, and meets other licensure and education requirements. AB 2041 would have required the Department of Developmental Services to amend its regulations as necessary to implement the provisions of the bill. AB 2041 died in the Senate Appropriations Committee.

SB 126 (Steinberg, Chapter 680, Statutes of 2013), extends, until January 1, 2017, the sunset date of an existing state health benefit mandate that requires health plans and health insurance policies to cover behavioral health treatment for pervasive developmental disorder or autism and requires plans and insurers to maintain adequate networks of these service providers.

SB 946 (Steinberg, Chapter 650, Statutes of 2011), requires health plans and health insurance policies to cover behavioral health treatment for pervasive developmental disorder or autism, requires health plans and insurers to maintain adequate networks of autism service providers, establishes a task force in DMHC, sunsets the autism mandate provisions on July 1, 2014, and makes other technical changes to existing law regarding HIV reporting and mental health services payments.

AB 1453 (Monning, Chapter 854, Statutes of 2012), and SB 951 (Ed Hernandez, Chapter 866, Statutes of 2012), established California's essential health benefits.

SB 770 (Steinberg of 2010) would have required health plans and insurance policies to provide coverage for BHT. SB 770 was held in the Assembly Appropriations Committee.

SB 166 (Steinberg of 2011) would have required health care service plans licensed by DMHC and health insurers licensed by CDI to provide coverage for behavioral health treatment for autism. SB 166 was held in the Senate Health Committee.

AB 1205 (Bill Berryhill of 2011) would have required the Board of Behavioral Sciences to license behavioral analysts and assistant behavioral analysts, on and after January 1, 2015, and included standards for licensure such as specified higher education and training, fieldwork, passage of relevant examinations, and national board accreditation. AB 1205 was held in the Assembly Appropriations Committee on the suspense file.

Support

Autism Deserves Equal Coverage Foundation (co-source)
Autism Speaks (co-source)
Center for Autism and Related Disorders (co-source)
Special Needs Network (co-source)
A Change in Trajectory, ACT
Autism Behavior Services Inc.
Autism Business Association
Autism Learning Partners
Autism Spectrum Interventions
Bloom Behavioral Health
California Psychcare
California School Employees Association, AFL-CIO
Disability Rights California
Hope Autism Therapies
Inizio Interventions Inc.
National Association of Social Workers- California Chapter
Star of California Behavioral and Psychological Services

Opposition

California Association of Health Plans
California Chamber of Commerce

History

06/09/16 Referred to Com. on HEALTH.

06/02/16 In Assembly. Read first time. Held at Desk.

06/01/16 Read third time. Passed. (Ayes 25. Noes 12. Page 4102.) Ordered to the Assembly.

05/31/16 Read second time and amended. Ordered to third reading.

05/27/16 From committee: Do pass as amended. (Ayes 5. Noes 2. Page 4002.) (May 27).

05/20/16 Set for hearing May 27.

05/09/16 May 9 hearing: Placed on APPR. suspense file.

04/29/16 Set for hearing May 9.

04/26/16 Read second time and amended. Re-referred to Com. on APPR.

04/25/16 From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 6. Noes 0. Page 3645.) (April 20).

04/07/16 Set for hearing April 20.

02/25/16 Referred to Com. on HEALTH.

02/16/16 From printer. May be acted upon on or after March 17.

02/12/16 Introduced. Read first time. To Com. on RLS. for assignment. To print.

California LEGISLATIVE INFORMATION

SB-1034 Health care coverage: autism. (2015-2016)

SECTION 1. Section 1374.73 of the Health and Safety Code is amended 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 individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal 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 *other* evidence-based behavior intervention programs, that ~~develop~~ *develop, keep,* 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~~ *more* than once every six months by the qualified autism service ~~provider~~ *provider, unless a shorter period is recommended 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 or developmental challenges that are to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent ~~participation needed~~ *or caregiver participation recommended by the qualified autism service provider* to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported. *Lack of parent or caregiver participation shall not be used to deny or reduce medically necessary behavioral health treatment.*

(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.~~ *appropriate, and continued therapy is not necessary to maintain function or prevent deterioration.*

(D) *(i)* The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or ~~educational~~ *academic* 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.~~

(ii) The setting, location, or time of treatment shall not be used as a reason to deny medically necessary behavioral health treatment.

(iii) 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.~~ *treatment, including clinical management and case supervision.*

(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~~ *who meets the education and experience qualifications defined in Section 54342 of Title 17 of the California Code of Regulations for* 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.~~ *Program.*

(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.~~ *provider or qualified autism service professional.*

(C) Meets the ~~criteria set forth~~ *education and training qualifications defined* 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). *The provision of behavioral health treatment in the Medi-Cal program, including any associated obligation of a health care service plan in the Medi-Cal program, is governed by Section 14132.56 of the Welfare and Institutions Code, the approved Medi-Cal state plan and waivers, and applicable federal Medicaid law.*

~~(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~~ *This section does not* limit the obligation to provide services ~~under~~ *pursuant to* 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 not be construed to require coverage for services that are included in a patient's individualized education program.

~~(g)~~ *(h)* This section shall remain in effect only until January 1, ~~2017,~~ *2022,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2017,~~ *2022,* deletes or extends that date.

SEC. 2. Section 10144.51 of the Insurance Code is amended 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 individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal 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) 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 *other* evidence-based behavior intervention programs, that ~~develop~~ *develop, keep,* 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~~ *more* than once every six months by the qualified autism service ~~provider~~ *provider, unless a shorter period is recommended 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 or developmental challenges that are to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent ~~participation needed~~ *or caregiver participation recommended by a qualified autism service provider* to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported. *Lack of parent or caregiver participation shall not be used to deny or reduce medically necessary behavioral health treatment.*

(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.~~ *appropriate, and continued therapy is not necessary to maintain function or prevent deterioration.*

(D) *(i)* The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or ~~educational~~ *academic* 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.~~

(ii) The setting, location, or time of treatment shall not be used as a reason to deny medically necessary behavioral health treatment.

(iii) 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.~~ *treatment, including clinical management and case supervision.*

(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~~ *who meets the education and experience qualifications defined in Section 54342 of Title 17 of the California Code of Regulations for* 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.~~ *Program.*

(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.~~ *provider or qualified autism service professional.*

(C) Meets the ~~criteria set forth~~ *education and training qualifications defined* 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). *The provision of behavioral health treatment in the Medi-Cal program, including any associated obligation of a health insurance policy in the Medi-Cal program, is governed by Section 14132.56 of the Welfare and Institutions Code, the approved Medi-Cal state plan and waivers, and applicable federal Medicaid law.*

~~(3) A health insurance policy in the Healthy Families Program (Part 6.2 (commencing with Section 12693)).~~

~~(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)~~ *(e)* 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.

(f) This section shall not be construed to require coverage for services that are included in a patient's individualized education program.

(g) This section shall remain in effect only until January 1, ~~2017,~~ *2022,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2017,~~ *2022,* deletes or extends that date.

SEC. 3. Section 10144.52 of the Insurance Code is amended 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 remain in effect only until January 1, ~~2017,~~ *2022,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2017,~~ *2022,* deletes or extends that date.

SEC. 4. *Section 14132.56 of the Welfare and Institutions Code is amended to read:*

14132.56. (a) (1) Only to the extent required by the federal government and effective no sooner than required by the federal government, behavioral health treatment ~~(BHT), as defined by Section 1374.73 of the Health and Safety Code,~~ *(BHT)* shall be a covered Medi-Cal service for individuals under 21 years of age.

(2) It is the intent of the Legislature that, to the extent the federal government requires BHT to be a covered Medi-Cal service, the department shall seek statutory authority to implement this new benefit in Medi-Cal.

(3) For purposes of this section, "behavioral health treatment" or "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 are administered as described in the approved state plan.

(b) The department shall implement, or continue to implement, this section only after all of the following occurs or has occurred:

(1) The department receives all necessary federal approvals to obtain federal funds for the service.

(2) The department seeks an appropriation that would provide the necessary state funding estimated to be required for the applicable fiscal year.

(3) The department consults with stakeholders.

(c) The department shall develop and define eligibility criteria, provider participation criteria, utilization controls, and delivery system structure for services under this section, subject to limitations allowable under federal law, in consultation with stakeholders.

~~(d) (1) The department, commencing on the effective date of the act that added this subdivision until March 31, 2017, inclusive, may make available to individuals described in paragraph (2) contracted services to assist those individuals with health insurance enrollment, without regard to whether federal funds are available for the contracted services.~~

~~(2) The contracted services described in paragraph (1) may be provided only to an individual under 21 years of age whom the department identifies as no longer eligible for Medi-Cal solely due to the transition of BHT coverage from the waiver program under Section 1915(c) of the federal Social Security Act to the Medi-Cal state plan in accordance with this section and who meets all of the following criteria:~~

~~(A) He or she was enrolled in the home and community-based services waiver for persons with developmental disabilities under Section 1915(c) of the Social Security Act as of January 31, 2016.~~

~~(B) He or she was deemed to be institutionalized in order to establish eligibility under the terms of the waiver.~~

~~(C) He or she has not been found eligible under any other federally funded Medi-Cal criteria without a share of cost.~~

~~(D) He or she had received a BHT service from a regional center for persons with developmental disabilities as provided in Chapter 5 (commencing with Section 4620) of Division 4.5.~~

~~(e)~~ *(d)* Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, the department shall provide semiannual status reports to the Legislature, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

~~(f)~~ *(e)* For the purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance. Contracts may be statewide or on a more limited geographic basis. Contracts entered into or amended under this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract ~~Code, Section 19130 of the Government Code,~~ *Code* and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

~~(g)~~ *(f)* The department may seek approval of any necessary state plan amendments or waivers to implement

this section. The department shall make any state plan amendments or waiver requests public at least 30 days prior to submitting to the federal Centers for Medicare and Medicaid Services, and the department shall work with stakeholders to address the public comments in the state plan amendment or waiver request.

~~(h)~~ *(g)* This section shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 5. *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.*

Date of Hearing: June 28, 2016

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 1034 (Mitchell) – As Amended May 31, 2016

SENATE VOTE: 25-12

SUBJECT: Health care coverage: autism.

SUMMARY: Eliminates the sunset date on the health insurance mandate to cover behavioral health treatment (BHT) for pervasive developmental disorder (PDD) or autism, and prohibits health care service plans (health plan) or health insurers from excluding medically necessary BHT on the basis of setting, location, time of treatment, or lack of parent or caregiver participation. Specifically, **this bill**:

1) Revises the BHT definition to include other evidence-based behavior intervention programs that maintain the functioning of an individual with PDD, as specified.

2) Deletes requirements that qualified autism service (QAS) professionals and paraprofessionals be employed by QAS providers.

3) Requires treatment plans to be reviewed no more than once every six months by a QAS provider, unless a shorter period is recommended by the QAS provider. Revises previous requirements that the treatment plan be reviewed no less than once every six months.

4) Specifies that an intervention plan include parent or caregiver participation as recommended by a QAS provider and prohibits lack of parent or caregiver participation from being used to deny or reduce medically necessary BHT.

5) Allows intensive behavioral intervention services to be discontinued when continued therapy is not necessary to maintain function or prevent deterioration.

6) Revises the prohibition that the treatment plan not be used for the purposes of providing or for the reimbursement of academic services. Prohibits health plans or health insurers from excluding medically necessary BHT on the basis of setting, location, or time of treatment.

7) Revises the definition of a QAS professional to include an individual providing BHT, including clinical management and case supervision; deletes the requirement that the individual be employed by a QAS provider; and, deletes the requirement that the individual be a behavioral service provider approved as a vendor by a California regional center and instead requires the behavioral service provider meet the education and experience qualified in existing regulations, as defined.

8) Revises the definition of QAS paraprofessional to delete the requirement that the individual be employed by a QAS provider and to include language indicating that the treatment plan be developed and approved by a QAS professional.

9) Deletes exemptions from the law for health plans that participate in the Healthy Families Program (which no longer exists) and California Public Employees' Retirement System (CalPERS).

10) Deletes the sunset in existing law.

11) Prohibits construing this bill from requiring coverage for services that are included in a patient's individualized education program (IEP).

12) Makes other conforming and technical changes.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans; the California Department of Insurance (CDI) to regulate health insurers; and, the California Health Benefit Exchange (the Exchange or Covered California) to compare and make available through selective contracting health insurance for individual and small business purchasers as authorized under the federal Patient Protection and Affordable Care Act (ACA).

2) Requires health plans and insurers providing health coverage in the individual and small group markets to cover, at a minimum, essential health benefits (EHBs), including the 10 EHB benefit categories in the ACA, and consistent with California's EHB benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan (Kaiser benchmark), as specified in state law.

3) Requires issuers of individual and small group coverage to, at a minimum, cover EHBs in the following 10 categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including BHT, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

4) Requires every health plan contract that provides hospital, medical, or surgical coverage and health insurance policy to also provide coverage for BHT for PDD or autism no later than July 1, 2012. Requires the coverage to be provided in the same manner and to be subject to the same requirements as provided in California's mental health parity law.

5) Defines BHT to mean specified services provided by, among others, a QAS professional supervised and employed by a qualified autism service provider. Defines a QAS professional to mean a person who, among other requirements, is a behavior 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 pursuant to specified regulations adopted under the Lanterman Developmental Disabilities Services Act.

6) Requires DMHC, in consultation with CDI, to convene a task force by February 1, 2012, to develop recommendations regarding BHT that are medically necessary for the treatment of individuals with PDD or autism, as specified. Requires DMHC to submit a report of the task force to the Governor, President pro Tem 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 ceases to exist.

7) Exempts from 4) above a specialized health plan or health insurance policy that does not deliver mental health or behavioral health services to enrollees, or an accident only, specified disease, hospital indemnity, or Medicare supplement policy, a health plan contract or health insurance policy under Medi-Cal or Healthy Families Program, and a health care benefit plan or contract with CalPERS.

8) Sunsets the provisions described in 4) through 7) above on January 1, 2017.

9) Establishes the independent medical review (IMR) process as part of the DMHC or CDI appeal process. Makes IMR available to the enrollee or insured after participation in a health plan or health insurer's grievance process.

FISCAL EFFECT: According to the Senate Appropriations Committee:

1) One-time costs of about $50,000 and ongoing costs of $15,000 per year to review health plan filings for compliance with the requirements of this bill and to undertake any necessary enforcement actions by the DMHC (Managed Care Fund).

2) Likely costs of less than $100,000 per year for review of health insurance plan filings and enforcement actions by the CDI (Insurance Fund).

3) No state costs are anticipated due to the elimination of the existing sunset on the benefit mandate or the extension of the existing benefit mandate to CalPERS coverage. While existing law specifically mandates coverage for BHT, separate federal and state mental health parity requirements and requirements for the provision of EHBs implicitly require coverage for BHT for autism and related disorders. Therefore, elimination of the statutory sunset and extension of the mandate to CalPERS health coverage will not increase state costs, because CalPERS plans would have to provide coverage for these services even without a specific benefit mandate. Nor will eliminating the sunset require the state to pay for the costs to subsidize coverage for BHT coverage for subsidized Covered California plans.

4) Ongoing costs of about $300,000 per year due to a minor increase in health care premiums to CalPERS due to the expansion of the existing benefit mandate to require coverage to "keep" the functioning of eligible individuals (General Fund, special funds, and local funds). About half of the above costs would accrue to the state and half to local governments. See below.

5) Uncertain impact on CalPERS health care costs from other changes to the existing benefit mandate in the bill (General Fund, special funds, and local funds). According to the California Health Benefits Review Program (CHBRP), there are several changes to the existing benefit mandate that could increase utilization of services, but that CHBRP was unable to quantify. To the extent that those factors do increase utilization, premium costs to CalPERS would increase.

6) No increased costs for the Medi-Cal program are anticipated due to this bill. Current law exempts Medi-Cal managed care plans from the existing benefit mandate. (However, federal guidance requires coverage for BHT for Medi-Cal enrollees with autism or related disorders. The state has just begun providing this benefit in Medi-Cal and is in the process of

transitioning Medi-Cal enrollee previously served by regional centers to having coverage provided by Medi-Cal.) This bill does not eliminate the existing Medi-Cal exemption.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill would ensure that children diagnosed with autism continue to have access to medically necessary treatments to increase their quality of life and functional independence by removing the 2017 sunset on the requirement for health plans and health insurers to provide BHT to children with autism.

   According to one of this bill's cosponsors, Autism Speaks, since the passage of SB 946 (Steinberg), Chapter 650, Statutes of 2011, countless children have received treatment through their health plans. Prior to the passage of SB 946, families (with health insurance) often paid upwards of $50,000 per year. In the process, many risked their homes and the educations of their unaffected children – essentially mortgaging their entire futures. Alternately, services were provided by regional and developmental centers at a high cost to the state. Removing the sunset will allow children with autism to continue to receive medically necessary BHT from QAS providers.

   According to the Centers for Disease Control and Prevention, autism spectrum disorder (ASD) is a developmental disability that can cause significant social, communication, and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, PDD not otherwise specified, and Asperger syndrome. These conditions are now all called ASD. About one in 68 or 1.5% of children were identified with ASD based on tracking in 11 communities across the United States in 2012.

2) **BACKGROUND.**

   a) **CHBRP analysis.** AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP states in its analysis of this bill, as introduced on February 12, 2016, the following:

      i) **Enrollees covered.** In 2017, 18.3 million of 25.2 million Californians would have state-regulated health insurance that would be subject to this bill. Of the varied requirements, this bill would place on DMHC-regulated plans and CDI-regulated insurers, CHBRP can only quantify the impacts of coverage for BHT for ASD for maintenance. Currently 6% of enrollees with health insurance that would be subject to this bill have such coverage; postmandate 100% would. This bill's other coverage requirements might have an impact on enrollees' health insurance, but CHBRP is unable to quantify such effects.

      ii) **Impact on expenditures.** Total premiums and cost sharing would increase by $8.3 million (0.006%). Post mandate, as a result of the coverage change for BHT for

ASD for maintenance, assuming that maintenance BHT would occur for persons with ASD who use a moderate amount of BHT (defined as $10,000–$30,000 per year), CHBRP would expect an initial year increase in utilization from approximately 44 to 47 annual hours per 1,000 enrollees with health insurance subject to this bill.

iii) **EHBs.** For two reasons, this bill would not trigger financial costs to the state for exceeding EHBs. First, this bill alters the terms and conditions of an existing benefit mandate, but does not require an additional benefit to be covered. Second, the current law that this bill would alter expressly indicates that it ceases to function if it exceeds EHBs and this bill does not eliminate this clause of the current law (so neither the current law nor the version this bill would create function if they are deemed to exceed EHBs).

iv) **Medical effectiveness.** CHBRP found insufficient evidence to determine whether BHT aimed at maintaining function derived from intensive BHT is effective. Studies have not separately examined its effects on improvement of functioning from its effects on maintenance of improvements in functioning. In light of the large body of evidence from studies with moderately strong research designs that BHT improves functioning across multiple domains, it stands to reason that it could also be useful for maintaining functioning. A preponderance of evidence from studies with moderately strong research designs suggests that parent/caregiver involvement in BHT improves outcomes. However, evidence also suggests that BHT is more effective than usual care regardless of the degree of parent/caregiver involvement. There is a preponderance of evidence from studies with moderately strong research designs that BHT can be delivered effectively in multiple settings. There is insufficient evidence to assess the impact of prohibiting health plans from reviewing treatment plans more frequently than every six months. There is a preponderance of evidence from studies with moderately strong research designs that BHT provided by persons who are trained or supervised by experienced BHT providers improves outcomes.

v) **Benefit coverage.** Of the varied requirements this bill would place on DMHC-regulated plans and CDI-regulated insurers, CHBRP can only quantify the impacts of coverage for BHT for ASD for maintenance. Currently 6% of enrollees with health insurance that would be subject to this bill have such coverage; postmandate 100% would. This bill's other coverage requirements might have an impact on enrollees' health insurance, but CHBRP is unable to quantify such effects.

vi) **Utilization.** Post mandate, as a result of the coverage change for BHT for ASD for maintenance, assuming that maintenance BHT would occur for persons with ASD who use a moderate amount of BHT (defined as $10,000–$30,000 per year), CHBRP would expect an initial year increase in utilization from approximately 44 to 47 annual hours per 1,000 enrollees with health insurance subject to this bill.

vii) **Public Health.** CHBRP found wide variance in individual outcomes from BHT for ASD and insufficient literature from longitudinal studies to indicate that ongoing maintenance therapy is effective or necessary to preserve gains conferred by early intensive BHT. Therefore, CHBRP concludes that the overall public health impact

of this bill is unknown. However, to the extent that maintenance therapy is comprised of less intensive applications of medically-effective BHT, such as applied behavioral analysis, it would be reasonable to assume that, for some children and adolescents with a history of BHT for ASD, maintenance therapy would reinforce and possibly enhance gains in intelligence quotient, adaptive social behaviors, and language skills.

viii) **Long-term impacts.** Although CHBRP can make only directional statements, a number of aspects of this bill could lead to greater increases in utilization of BHT in the first year and in years following. This bill's prohibition against denials based on parent/caregiver involvement may increase some enrollees' use of BHT as a covered benefit. In addition, the elimination of restrictions on settings may increase use, particularly as public schools could now be covered settings. It is also possible that utilization of maintenance BHT among the older population with ASD may increase. Although older people may not currently use BHT for skill acquisition purposes, providers may develop an applicable treatment plan for maintenance of gains made through prior courses of BHT among their older patients. Although not quantifiable at this time, expenditure increases would correspond to utilization increases. Although not quantifiable at this time, increases in utilization could also be expected to result in some increase in some desirable health outcomes among some persons with ASD.

b) **SB 946.** SB 946 was signed into law on October 9, 2011. SB 946 imposes a temporary set of rules regarding BHT that health plans and health insurers in California must cover for individuals with autism and PDD. SB 946 also identifies the required qualifications of individuals who provide BHT, and permits individuals who are not licensed by the state to provide BHT, as long as the detailed criteria set forth in the bill are met. SB 946 also required the DMHC to convene an Autism Advisory Task Force (Task Force) by February 1, 2012, to develop recommendations regarding medically necessary BHT for individuals with autism or PDD, as well as the appropriate qualifications, training and supervision for providers of such treatment. SB 946 also required the Task Force to develop recommendations regarding the education, training, and experience requirements that unlicensed individuals providing BHT must meet in order to obtain licensure from the state.

c) **Task Force.** The Chair of the Task Force was the DMHC Director, who was a non-voting member, and 17 other members were appointed by the DMHC. Members of the Task Force include parents of children with autism and individuals with legal, health plan, behavioral health, and medical expertise. The charge of the Task Force was to make recommendations to inform state policymaking and guide future recommendations addressing six subjects and 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. The six subjects are:

i) Interventions that have been scientifically validated and have demonstrated clinical efficacy;

ii) Interventions that have measurable treatment outcomes;

iii) Patient selection, monitoring, and duration of therapy;

iv) Qualifications, training, and supervision of providers;

v) Adequate networks of providers; and,

vi) The education, training, and experience requirements that unlicensed individuals providing autism services shall meet in order to secure a license from the state.

A guiding principle of the Task Force was that every individual with autism or PDD is unique. Individuals have different combinations of characteristics, different needs for assistance, and respond differently to treatment. Therefore, behavioral health interventions need to be highly individualized. Since treatment selection should be made by a team of individuals who can consider the unique needs and history of the individual with autism or PDD, the Task Force determined that it would not be informative to state policymakers to merely develop a list of BHTs that are determined to be effective, based solely on current scientific literature. Since scientific research and findings naturally advance, the Task Force determined that the choice of BHTs should be grounded in scientific evidence, clinical practice guidelines, and/or evidence based practice. With regard to PDD or autism, the Task Force considers the following diagnoses to fall under the definition: PDD-not otherwise specified, Autistic Disorder, Asperger Syndrome, Rett's Syndrome, and Childhood Disintegrative Disorder.

The Task Force reached consensus on 54 of 55 recommendations and approved one recommendation by a vote of the majority. The Task Force concluded that all "top level" (undefined) providers should be licensed by the state, and set forth a process for establishing a new professional license for "Licensed Behavioral Health Practitioner." The Task Force recommended that the license requirement not take effect until three years after the license is established, and an interim commission be formed to implement the new license until a board is able to do so. The Task Force also recommended all providers of autism services be registered with the state's TrustLine Registry or comparable system as a condition of employment by service organizations and contracting with health plans and health insurers. TrustLine uses the criminal history background check system to check the fingerprints of applicants, and checks for evidence of additional criminal records.

d) IEPs. Pursuant to the federal Individuals with Disabilities Education Act, children with disabilities are guaranteed the right to a free, appropriate public education, including necessary services for a child to benefit from his or her education. Between 1976 and 1984, to meet this federal mandate, California schools provided mental health services to special education students who needed the services pursuant to an IEP. An IEP is a legally binding document that determines what special education services a child will receive and why. IEPs include a child's classification, placement, specialized services, academic and behavioral goals, a behavior plan if needed, percentage of time in regular education, and progress reports from teachers and therapists. A child may require any related services in order to benefit from special education, including, but not limited to: speech-language pathology and audiology services; early identification and assessment of disabilities in children; medical services; physical and occupational therapy; orientation and mobility services; and, psychological services. According to the California Department of Education, over 700,000 (approximately 11%) California students received special education services in the 2013-14 academic year.

3) **SUPPORT.** Autism Speaks, cosponsors of this bill, states that SB 946 included a sunset to provide an opportunity for the Legislature to revisit issues related to mandated benefits, the ACA and the state's fiscal responsibility and now that some of these issues have been resolved, this bill will allow children with autism to continue to receive medically necessary BHT from QAS professionals. The Center for Autism and Related Disorders, cosponsors of this bill, states that this bill makes changes to existing statute that will ensure timely access and limit delays to treatment. Autism Deserves Equal Coverage Foundation states that this bill cleans up the language to address outstanding confusion and misinterpretation of the statute by health plans and health insurers. The California School Employees Association, AFL-CIO, states this bill is a compassionate bill that recognizes the challenges autistic children face and the need for services that help them and those who care for them.

   Special Needs Network (SNN), cosponsors of this bill, states that this bill clarifies that services cannot be denied solely because they occur on the school-site or because they occur between the hours of nine and three when an individual "should" be in school. Medical necessity needs to determine location and time of day of treatment, not arbitrary limits. This bill also clarifies that services cannot be denied solely due to lack of the ability for parents to participate in the care. SNN contends that some health plans have set 100% participation requirements, which are not appropriate and violate federal mental health parity law. Additionally, SNN states that such requirements have a disproportionate impact limiting access to care for low income families and families of color, who may not be able to take off work to be present for 100% of their child's treatment. According to SNN, this bill clarifies the QAS professional (middle tier) is allowed to supervise and provide case management for health plans, under the supervision of a licensed or certified QAS provider, in the same way they are allowed to do so for regional centers, which was always the intent. Without the clarification, health plans are interpreting the law differently. This clarification could significantly alleviate with capacity issues for plans not using the QAS professional in this capacity.

4) **OPPOSITION.** The California Chamber of Commerce contends that this bill will limit the ability of health care issuers to promote and manage the use of applied behavioral analysis for children with autism, and will add to the problem of rising health care costs, making it harder for Californians to access other important care. America's Health Insurance Plans contends that this bill will drive up costs for consumers and stifle the use of innovative, evidence-based medicine. The Association of California Life and Health Insurance Companies (ACLHIC) contends that this bill radically alters the standard of care by requiring coverage "at any location or time" as current law requires health insurers to cover care provided in traditional and widely accepted locations. ACLHIC contends that this bill's expansion could lead to inadequate care being provided in an unsuitable location with little benefit to the patient. ACLHIC also contends that federal law requires schools to facilitate participation in the educational environments and should health insurers be required to cover the cost of treatment in schools, federal funding could be curtailed or eliminated and cause an increase in premiums and decrease in educational assistance by school districts. Finally, ACLHIC states that this bill's provision regarding parental participation runs afoul of accepted best practices and is completely unsupported by medical literature or peer review. The California Association of Health Plans contends that coverage for maintenance services is not supported by medical literature and limitations on parent participation go against clinical best practices.

5) RELATED LEGISLATION.

a) AB 796 (Nazarian) requires the Department of Developmental Services, no later than July 1, 2018, with input from stakeholders, as specified, to develop a methodology for determining what constitutes an evidence-based practice in the field of BHT for autism and pervasive developmental disorder and to update regulations to set forth the minimum standards of education, training, and professional experience for QAS professionals and paraprofessionals, as specified. AB 796 is pending in the Senate Human Services Committee.

b) SB 479 (Bates) would establish the Behavior Analyst Act which requires a person to apply for and obtain a license from the Board of Psychology prior to engaging in the practice of behavior analysis, as defined, either as a behavior analyst or an assistant behavior analyst, and meet certain educational and training requirements. SB 479 is pending in the Assembly Appropriations Committee.

6) PREVIOUS LEGISLATION.

a) AB 2041 (Jones) of 2014, would have required that a regional center classify a vendor as a behavior management consultant or behavior management assistant if the vendor designs or implements evidence-based BHT, has a specified amount of experience in designing or implementing that treatment, and meets other licensure and education requirements. AB 2041 would have required the Department of Developmental Services to amend its regulations as necessary to implement the provisions of the bill. AB 2041 died in the Senate Appropriations Committee.

b) SB 126 (Steinberg), Chapter 680, Statutes of 2013, extends, until January 1, 2017, the sunset date of an existing state health benefit mandate that requires health plans and health insurance policies to cover BHT for PDD or autism and requires plans and insurers to maintain adequate networks of these service providers.

c) SB 946 requires health plans and health insurance policies to cover BHT for PDD or autism, requires health plans and insurers to maintain adequate networks of autism service providers, establishes a task force in DMHC, sunsets the autism mandate provisions on July 1, 2014, and makes other technical changes to existing law regarding HIV reporting and mental health services payments.

d) AB 1453 (Monning), Chapter 854, Statutes of 2012, and SB 951 (Ed Hernandez), Chapter 866, Statutes of 2012, establish California's EHBs.

e) SB 770 (Steinberg) of 2010 would have required health plans and insurance policies to provide coverage for BHT. SB 770 was held in the Assembly Appropriations Committee.

f) SB 166 (Steinberg) of 2011 would have required health care service plans licensed by DMHC and health insurers licensed by CDI to provide coverage for BHT for autism. SB 166 was held in the Senate Health Committee.

g) AB 1205 (Bill Berryhill) of 2011 would have required the Board of Behavioral Sciences to license behavioral analysts and assistant behavioral analysts, on and after January 1,

2015, and included standards for licensure such as specified higher education and training, fieldwork, passage of relevant examinations, and national board accreditation. AB 1205 was held in the Assembly Appropriations Committee on the suspense file.

7) **AMENDMENTS.** To address concerns raised by the Committee, the author has agreed to amend this bill as follows:

   a) To continue evaluating the BHT mandate, extend the sunset to January 1, 2022; and,

   b) Clarify language with respect to the provision of BHT services in the Medi-Cal program.

REGISTERED SUPPORT / OPPOSITION:

Support

Autism Deserves Equal Coverage Foundation (cosponsor)
Autism Speaks (cosponsor)
Center for Autism and Related Disorders (cosponsor)
Special Needs Network (cosponsor)
David Pine, Supervisor, First District, San Mateo County
Alliance of California Autism Organizations
Autism Behavior Services, Inc.
Autism Business Association
Autism Learning Partners
Autism Society California
Autism Society Inland Empire 501©3
Autism Society Santa Barbara 501©3
Autism Spectrum Intervention Parent Network
California Association for Parent-Child Advocacy
California Coverage and Health Initiatives
California Psychological Association
California School Employees Association, AFL-CIO
Center for Autism and Related Disorders
Children Now
Children's Defense Fund
Children's Partnership
Disability Rights California
Families for Early Autism Treatment Sacramento
Families for Effective Autism Treatment Fresno Madera County
Hope Autism Therapies
Inizio Interventions
National Association of Social Workers, California Chapter
National Health Law Program
Orange County United Way
Sacramento Asperger Syndrome Information and Support
Star of CA Behavioral and Psychological Services
United Ways of California

Opposition

America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce

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