California Board of
PSYCHOLOGY

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MEMORANDUM

DATE	August 3, 2016
TO	Board of Psychology
FROM	Jason Glasspiegel Central Services Coordinator
SUBJECT	Agenda Item #20(j) – 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, which may include clinical management and case supervision under the direction and supervision of a qualified autism service provider. The bill would require that, unless a treatment plan is modified by a qualified autism service provider, utilization review be conducted no more than once every 6 months. The bill would also provide that coverage for behavioral health treatment for pervasive developmental disorder or autism would be dependent on medical necessity, subject to utilization review, and required to be in compliance with federal mental health parity requirements. 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.

On July 28, 2016, the Board sent an "Oppose" letter to the Senate Appropriations Committee, as well as the author's office. The oppose letter expressed the Board's concern with the lack of consumer protection due to no requirement for licensure of providers.

Location: Assembly Appropriations Committee

Status: 08/03/2016 in Assembly Appropriations Committee: To Suspense File.

Action Requested:
There is no further action required for this bill.

Attachment A is the Analysis for SB 1034 (Mitchell)
Attachment B is the language of SB 1034 (Mitchell)
Attachment C is the Assembly Appropriations Committee Analysis of SB 1034 (Mitchell)
Attachment D is the Oppose letter submitted to the Senate Appropriations Committee as well as the author's office.

CALIFORNIA STATE BOARD OF PSYCHOLOGY

BILL ANALYSIS

BILL NUMBER: SB 1034 **VERSION: AMENDED: 08/01/2016**

AUTHOR: MITCHELL **SPONSOR:**

- **AUTISM DESERVES EQUAL COVERAGE FOUNDATION**
- **AUTISM SPEAKS**
- **CENTER FOR AUTISM AND RELATED DISORDERS**
- **SPECIAL NEEDS NETWORK**

BOARD POSITION: OPPOSE

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, which may include clinical management and case supervision under the direction and supervision of a qualified autism service provider. The bill would require that, unless a treatment plan is modified by a qualified autism service provider, utilization review be conducted no more than once every 6 months. The bill would also provide that coverage for behavioral health treatment for pervasive developmental disorder or autism would be dependent on medical necessity, subject to utilization review, and required to be in compliance with federal mental health parity requirements. 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.

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:

This bill extends and broadens an existing mandate that requires health plans and insurers to cover medically necessary behavioral health treatment services, including applied behavioral analysis (ABA) for Pervasive Developmental Disorder (PDD) or Autism Spectrum Disorder (Autism). Specifically, this bill:

1) Revises the definition of Behavioral Health Treatment (BHT) to require coverage of other evidence-based behavior intervention programs and programs that maintain the functioning of an individual with autism, as specified.

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

3) Prohibits lack of parent or caregiver participation from being used to deny or reduce medically necessary BHT.

4) Prohibits health plans or health insurers from denying medically necessary BHT on the basis of setting, location, or time of treatment.

5) Provides that notwithstanding (3) and (4), all services shall remain covered only to the extent that the services are medical necessary and are subject to utilization review, as described.

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

7) Extends the sunset on the mandate to January 1, 2022.

8) Prohibits construing this bill from requiring coverage for services that are included in a patient's individualized education program (IEP; a plan that describes a child's special education needs and services) or delivered by school personnel.

9) Continues the exemption of Medi-Cal from the mandate requirements.

Comments:

Author's Intent

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 extending the sunset on the BHT mandate and increasing access by changing provisions that describe the terms of coverage.

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

08/03/16 August 3 set for first hearing. Placed on APPR. suspense file.
08/01/16 From committee with author's amendments. Read second time and amended. Re-referred to Com. on APPR.
06/30/16 Read second time and amended. Re-referred to Com. on APPR.
06/29/16 From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 13. Noes 1.) (June 28).
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.

(5) This section shall not be construed to require a health care service plan to provide reimbursement for services delivered by school personnel pursuant to an enrollee's individualized educational program unless otherwise required by law.

(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 *herein* 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 than once every six months by the qualified autism service ~~provider~~ *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~~ *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.~~ *objectives.*

(iii) ~~Provides intervention plans that utilize~~ *Utilizes* 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.*

(v) Makes the treatment plan available to the health care service plan upon request.

(D) 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.~~

(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, which may include clinical management and case supervision under the direction and supervision of a qualified autism service provider.*

(B) Is ~~employed and~~ supervised by a *person, entity, or group that is 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 *person, entity, or group that is a* qualified autism service ~~provider.~~ *provider or qualified autism service professional.*

(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 in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.~~ *education and training qualifications defined in Section 54342 of Article 3 of Subchapter 2 of Chapter 3 of Division 2 of Title 17 of the California Code of Regulations.*

(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.

(1) Unless a treatment plan is modified by a qualified autism service provider, utilization review shall be conducted no more often than every six months and shall be conducted in accordance with good professional practice and consistent with the requirements of Section 1363.5.

(2) The setting, location, or time of treatment recommended by the qualified autism service provider shall not be used as a reason to deny or reduce coverage for medically necessary services.

(3) Lack of parent or caregiver participation shall not be used as the sole basis for denying or reducing coverage of medically necessary services.

(4) Notwithstanding paragraphs (2) and (3), all services shall remain covered only to the extent that the services are medically necessary and subject to utilization review as described in this subdivision.

(5) Provision of services under this section, including any limits on the scope or duration of these services, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(g) This section shall not be construed to require coverage for services that are included in an enrollee'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.

(5) This section shall not be construed to require a health insurer to provide reimbursement for services delivered by school personnel pursuant to an insured's individualized educational program unless otherwise required by law.

(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 *herein* 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 than once every six months by the qualified autism service ~~provider~~ *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~~ *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.~~ *objectives.*

(iii) ~~Provides intervention plans that utilize~~ *Utilizes* 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.*

(v) Makes the treatment plan available to the health insurer upon request.

(D) 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.~~

(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, which may include clinical management and case supervision under the direction and supervision of a qualified autism service provider.*

(B) Is employed and supervised by a *person, entity, or group that is 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 *person, entity, or group that is a* qualified autism service ~~provider.~~ *provider or qualified autism service professional.*

(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 in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.~~ *education and training qualifications defined in Section 54342 of Article 3 of Subchapter 2 of Chapter 3 of Division 2 of Title 17 of the California Code of Regulations.*

(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.

(1) Unless a treatment plan is modified by a qualified autism service provider, utilization review shall be conducted no more often than every six months and shall be conducted in accordance with good professional practice and consistent with the requirements of subdivision (f) of Section 10123.135.
(2) The setting, location, or time of treatment recommended by the qualified autism service provider shall not be used as a reason to deny or reduce coverage for medically necessary services.

(3) Lack of parent or caregiver participation shall not be used as the sole basis for denying or reducing coverage of medically necessary services.

(4) Notwithstanding paragraphs (2) and (3), all services shall remain covered only to the extent that the services are medically necessary and subject to utilization review as described in this subdivision.

(5) Provision of services under this section, including any limits on the scope or duration of these services, shall be in compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(f) This section shall not be construed to require coverage for services that are included in an insured'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) 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) 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, 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) 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) 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: August 3, 2016

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Lorena Gonzalez, Chair
SB 1034 (Mitchell) – As Amended August 1, 2016

Policy Committee: Health Vote: 13 - 1

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill extends and broadens an existing mandate that requires health plans and insurers to cover medically necessary behavioral health treatment services, including applied behavioral analysis (ABA) for pervasive developmental disorder or autism (autism). Specifically, this bill:

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

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

3) Prohibits lack of parent or caregiver participation from being used to deny or reduce medically necessary BHT.

4) Prohibits health plans or health insurers from denying medically necessary BHT on the basis of setting, location, or time of treatment.

5) Provides that notwithstanding (3) and (4), all services shall remain covered only to the extent that the services are medical necessary and are subject to utilization review, as described.

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

7) Extends the sunset on the mandate to January 1, 2022.

8) Prohibits construing this bill from requiring coverage for services that are included in a patient's individualized education program (IEP; a plan that describes a child's special education needs and services) or delivered by school personnel.

9) Continues the exemption of Medi-Cal from the mandate requirements.

FISCAL EFFECT:

1) According to the California Health Benefits Review Program (CHBRP):

   a) Annual premium costs to CalPERS of about $290,000 per year (GF/ special/ federal/ local). Cost savings are split approximately 50-50 between state and local government.

b) Annual employer-funded premium costs in the private insurance market of approximately $4 million.

c) Increased premium expenditures by employees and individuals purchasing insurance of $3.4 million, and increased total out-of-pocket expenses of $0.5 million.

2) CHBRP notes several other provisions may increase utilization of services and commensurate costs, including the prohibition against denials of parent/caregiver involvement, the elimination of restrictions on settings (as public schools could now be covered settings), and utilization of maintenance behavioral health treatment among older individuals who are not currently receiving BHT services. However, CHBRP was unable to quantify these increases.

Given CHBRP identified only 6,000 individuals who are receiving BHT services, out of a total of 36,000 diagnosed with autism with coverage that is affected by this mandate, utilization of coverage for maintenance therapy among individuals who may have had some prior treatment but are currently not using services could be quite significant (i.e., a portion of those 30,000 people may begin to use coverage). In addition, if schools are now covered settings whereas school-based services were previously being denied due to setting or timing of services during the school day, it stands to reason a larger number of hours may be paid for by plans, because there are simply a limited number of hours available outside of school. Rejection of treatment during the school day or in a school setting may constrain utilization, and this would no longer be the case.

Any significant increased costs associated with these "unquantifiable" provisions would affect CalPERS premiums and the state as a payer, as well commercial plans.

3) 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, and this bill continues to exempt Medi-Cal. (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.)

4) Minor costs, under $50,000, to the California Department of Insurance (Insurance Fund) and minor and absorbable costs to the Department of Managed Health Care (Managed Care Fund) to verify plans and insurers comply with this requirement.

5) Since the bill does not require plans to pay for services that are included in an IEP, it is unclear whether this bill will lead to plan-covered services displacing services that would otherwise be funded by the public school system. To the extent this occurs, however, there could be reduced Proposition 98/GF cost pressure for special education services.

COMMENTS:

1) **Purpose**. 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 extending the sunset on the BHT mandate and increasing access by changing provisions that describe the terms of coverage.

2) **Background.** The state's BHT mandate (SB 946 (Steinberg), Chapter 650, Statutes of 2011), imposes a set of rules regarding BHT that health plans and health insurers in California must cover for individuals with autism. 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. Before and since the time SB 946 was signed, BHT has also found to be required under different provisions of law, namely under regulatory interpretation of federal mental health parity laws for commercial plans, and under federal Centers for Medicare and Medicaid Services (CMS) guidance for Medi-Cal.

3) **IEPs.** Pursuant to the federal Individuals with Disabilities Education Act (IDEA), children with disabilities are guaranteed the right to a free, appropriate public education (FAPE), including necessary services for a child to benefit from his or her education. 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, and behavioral health services.

   Pursuant to federal regulation (34 CFR §300.154), schools are allowed to seek insurance coverage for services required for a child to benefit from a FAPE, as long as they have parent consent. Schools must still provide special education services regardless of parental consent to use their private insurance. Schools can also use special education funds to pay copayments for health insurance.

4) **Support.** Advocates for children and autistic children, autism providers, the National Health Law Program, and the California School Employees Association, AFL-CIO support this bill, stating it will ensure children are not denied medically necessary services.

5) **Opposition.** Health plans and insurers are opposed raise a number of concerns, including the following:

   a) Cost-shifting to the plans for services that may have otherwise have been provided by schools. They see the prohibition on denying services based on time, location, or setting as requiring plans to pay for significantly more school-based services, likely as a result of increased utilization as well as cost-shifting.

   b) A lack of geographical boundaries with respect to provisions prohibiting denial based on the setting or location of treatment. Plans see this as an open-ended requirement to cover treatment at any time or location.

   c) Concern that the combination of mandating coverage for therapy that seeks to maintain functioning and the prohibition on denial of services due to lack of parent participation will mean therapists paid for by plans will displace support provided by parents, who are critical partners in ensuring effective treatment according to medical literature.

   d) The exemption of Medi-Cal creates dual standards and may not stand up to legal or public scrutiny.

e) According to federal student privacy law, plans are not legally allowed to access IEPs, so they have no way to verify whether services should be covered or may be denied based upon their inclusion in an IEP or provision by the school district.

f) Provisions requiring coverage for maintenance services and prohibiting denial based on lack of parental participation runs afoul of accepted best practices and is unsupported by medical literature or peer review.

6) **Prior Legislation**. SB 126 (Steinberg), Chapter 680, Statutes of 2013, extends, until January 1, 2017, the sunset date of the BHT mandate.

7) **Related Legislation**. AB 796 (Nazarian) requires the Department of Developmental Services 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 Appropriations Committee.

8) **Staff Comments**. By exempting Medi-Cal, the bill sets up conflicting standards for the provision and denial of care between Medi-Cal and the commercial market, which raises the question of why the bill's protections, which according to proponents are important to ensure those children in commercial plans receive adequate treatment, are not granted to children on Medi-Cal.

   A technical issue that appears unresolved is that the bill exempts plans from covering services that are in an IEP – but how will a plan know whether services are in an IEP for purposes of this bill?

   More broadly, in the case of autism, a brain disorder that impedes social development, there is often no clean line between social and developmental services that may be necessary to benefit from a FAPE, and "medically necessary" behavioral health treatment services. According to health plans, the denial of coverage for health services provided at a school setting during the school day may have maintained a line between school-based special education services and health care services, which this bill seeks to blur or eliminate for purposes of autism treatment. Without comment on the desirability of removing this distinction, it does appear to merit additional discussion of who should be the primary payer for needed services for which there is a dual coverage mandate.

Analysis Prepared by: Lisa Murawski / APPR. / (916) 319-2081

California Board of
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July 28, 2016

The Honorable Lorena S. Gonzalez
California State Assembly
State Capitol, Room 2114
Sacramento CA, 95814

RE: **SB 1034 (Mitchell) – Health Care Coverage: Autism**

Dear Assembly Member Gonzalez:

At its July 27, 2016 meeting, the Board of Psychology (Board) adopted an **Oppose** position on **SB 1034**. This bill would 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 six 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.

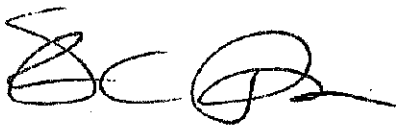
The Board supports access to reimbursable services for those with Pervasive Developmental Disorder (PDD) or Autism Spectrum Disorder (ASD). However, we believe that in order to ensure a basic level of competence for those providing the services, oversight in the form of state licensure is crucial to the safe provision of care. If SB 1034 is passed as written, it will mandate insurance providers and Medi-Cal cover services provided by unlicensed and sometimes unqualified providers without consideration for the protection of consumers or the qualifications or lack of qualifications of the providers.

Insurance reimbursement for these services began with the passage of SB 946 (Steinberg) on October 9, 2011. SB 946 required the Department of Managed Health Care (DMHC) to convene an Autism Advisory Task Force (Task Force) by February 1, 2012. The purpose of the Task Force was to develop recommendations regarding medically necessary BHT for individuals with ASD or PDD, as well as the appropriate qualifications, training and supervision for providers of such treatment. 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." SB 1034 fails to meet the goals of the Task Force.

The Board of Psychology's mission is to· advance quality psychological services for Californians by ensuring ethical and legal practice and supporting the evolution of the profession.

If you have any questions or concerns regarding this position, please feel free to contact the Board's Executive Officer, Antonette Sorrick, at (916) 574-7113. Thank you.

Sincerely,



STEPHEN C. PHILLIPS, JD, PsyD
President, Board of Psychology

cc: Senator Holly Mitchell
Assembly Appropriations Committee
Assembly Appropriations Committee Consultant
Assembly Republican Caucus