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December 28, 2012

By Facsimile & Overnight Delivery

Presiding Justice Joan Dempsey Klein and Associate Justices H. Walter Croskey,
Patti S. Kitching, and Richard D. Aldrich
California Court of Appeal
Second Appellate District, Division Three
Ronald Reagan State Office Building
300 So. Spring Street, 2nd Floor
Los Angeles, CA 90013

Re: *Consumer Watchdog et al. v. California Department of Managed Health Care et al.*
2d Civ. No. B232338 (LASC Case No. BS121397)

Dear Presiding Justice Klein and Associate Justices:

By letter of December 12, 2012, the Court requested additional briefing from the parties on the issues of whether (1) the appeal should be dismissed as moot; and (2) the cross-appeal should be dismissed as moot and untimely. The Court's letter notes that Senate Bill No. 946, which was enacted while this appeal was pending, requires that health plans must provide coverage no later than July 1, 2012, for "behavioral health treatment" for autism, specifically including Applied Behavioral Analysis (ABA), and that SB 946 further provides that the treatment may be provided by a person certified by the Behavioral Analyst Certification Board (BACB) or an uncertified individual supervised by someone so certified. (Health & Saf. Code, § 1374.73.) The Court's letter therefore suggests that "to the extent appellants sought a writ of mandate directing the Department [of Managed Health Care] to order coverage for the provision of ABA treatment by (or supervised by) BACB certified analysts *in future grievances*, it is clear that Senate Bill No. 946 resolves the issue." (Emphasis in original.) Moreover, with respect to individuals who were denied coverage for such treatment prior to the effective date of Senate Bill No. 946, the Court's letter suggests that "it does not appear that appellants sought relief regarding already-resolved grievances, and it further does not appear that appellants would have had standing to do so."

As is set forth in greater detail below, the instant appeal is not moot. Regrettably, Senate Bill No. 946 did not fully resolve the dispute between the parties *even as to future grievances*, because the bill explicitly does not apply to the *more than a million* health care service plan contracts issued by Medi-Cal, the Healthy Families Program, and CalPERS. (See Health & Saf. Code, § 1374.73, subd. (d).) DMHC conservatively estimates that more than 13,500 children enrolled in managed care

plans under the Healthy Families Program and through CalPERS have autism, and the Department has taken the position that even after the implementation of Senate Bill No. 946, "health plans continue[] to be required to cover medically necessary services for PPD or autism to Healthy Families and CalPERS enrollees *by licensed health care providers* as originally contemplated by Health and Safety Code Section 1374.72." (DMHC Notice of Rulemaking Action: Pervasive Developmental Disorder and Autism Coverage (Sept. 25, 2012), p. 9 [emphasis added].) Thus, an actual, live controversy very much still exists with respect to the legal dispute that lies at the heart of this appeal — whether Business and Professions Code section 2052 or any other provision of law requires that behavior analysts who administer medically necessary ABA therapy as a treatment for autistic children must be licensed by the state.

For similar reasons, Appellants do not believe that Respondent DMHC's cross-appeal is moot; DMHC apparently intends to continue to use the standards and procedures set forth in its March 9, 2009, memorandum for resolving complaints filed by any of the thousands of autistic enrollees who are not expressly covered by Senate Bill No. 946. *Appellants do believe, however, that Respondents' cross-appeal is untimely.* As the Court's December 12, 2012, letter indicates, the deadline for filing the notice of cross-appeal under rule 8.108(g) was May 5, 2011, but the notice was not filed until May 11, 2001. "If a notice of appeal is filed late, the reviewing court must dismiss the appeal." (Cal. Rules of Court, rule 8.104(b).)

I. The Instant Appeal Is Not Moot Because There Is Still "An Actual Present Controversy" Between the Parties Regarding the Critical Legal Issue in this Case: Whether Health Plans Are Required to Provide Coverage for Medically Necessary ABA Treatment When Provided or Supervised by a Non-Licensed, But BACB-Certified, Behavior Analyst

The Court's December 12, 2012, letter essentially questions whether the enactment of Senate Bill No. 946 has mooted the instant appeal. It has not, neither for all future enrollee grievances nor for those enrollee complaints that were wrongly denied by Respondent DMHC on licensure grounds prior to the enactment of Senate Bill No. 946 during the pendency of this litigation.

A. Respondent DMHC Continues to Impose Its Unlawful Licensure Requirement for the Coverage of Medically Necessary ABA Treatments Under Health Plan Contracts Issued by Medi-Cal, the Healthy Families Program, and CalPERS

As noted above, the Court's letter suggests that "to the extent appellants sought a writ of mandate directing the Department [of Managed Health Care] to order coverage for the provision of ABA treatment by (or supervised by) BACB certified analysts *in future grievances*, it is clear that Senate Bill No. 946 resolves the issue." (Emphasis in original.) Unfortunately, that is not the case, because Senate Bill No. 946 by its terms does not apply to all health care service plans under the jurisdiction of DMHC, and the Department has refused to extend the legislation's logic to apply it

to any future grievances that may be filed by the more than 13,500 autistic enrollees who are not explicitly covered by the bill.

The Court's letter rightly notes that Senate Bill No. 946 requires full-service health plans to provide coverage for "behavioral health treatment" for pervasive development disorder or autism no later than July 1, 2012 (Health & Saf. Code, § 1374.73(a)(1)), and that the bill specifically defines "behavioral health treatment" to include ABA treatment that is administered or supervised by *non-licensed*, but BACB-certified, professionals and paraprofessionals (*id.*, § 1374.73(c)). Senate Bill No. 946, however, does not apply to *all* health care service plans under DMHC's jurisdiction. Health plan contracts issued under Medi-Cal, the Healthy Families Program, and by CalPERS are all expressly exempt from Senate Bill No. 946, but remain subject to the requirements of the Mental Health Parity Act ("MHPA"), Health and Safety Code section 1374.72. Subdivisions (d) and (e) of Senate Bill No. 946 declare:

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

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

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

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

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

(e) Nothing in this section shall be construed to limit the obligation to provide services under Section 1374.72." (Health & Saf. Code, § 1374.73, subds. (d) & (e).)[1]

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[1]The legislative history of Senate Bill No. 946 does not indicate why the Legislature excluded Medi-Cal, Healthy Families Program, and CalPERS health care service plan contracts from the bill's coverage, but it appears that these contracts — all of which are funded in whole or in part by the State — were exempted in order that no argument could be made that the legislation would impact the state budget, which could have delayed or even thwarted the bill's passage in the last days of the legislative session.

On October 5, 2012, after Appellants had filed their final brief in this appeal, DMHC issued a Notice of Rulemaking proposing to adopt a regulation entitled "Pervasive Developmental Disorder and Autism Coverage."[2] One of the stated purposes of the regulation is to clarify the health plans' statutory obligation after July 1, 2012, to provide autism-related behavioral health treatments, including ABA, to Healthy Families enrollees and CalPERS members. (See Notice of Rulemaking Action, p. 11.) As set forth by DMHC in the "Informative Digest/Policy Statement Overview," the Healthy Families program is California's low-cost insurance program that provides health, dental and vision coverage to children who do not have insurance and do not qualify for no-cost Medi-Cal; as of April 2012, the Healthy Families program had over 870,000 enrolled children, with approximately 420,000 children enrolled in the three largest health plans regulated by DMHC — Kaiser Foundation Health Plan, Inc. ("Kaiser"), Blue Shield of California ("BSC"), and Anthem Blue Cross ("ABC"). (Notice of Rulemaking Action, p. 5.) CalPERS is the largest purchaser of health benefits in California, providing comprehensive health benefits to more than 1.3 million California state employees, retirees and their families, and local government agency and school employees; Kaiser and BSC alone have approximately 930,000 CalPERS enrollees. DMHC conservatively estimates that there are over 13,500 children with autism who are covered by managed health care plans that contract with the Healthy Families Program and CalPERS. (*Ibid.*)

DMHC's Notice of Rulemaking goes on to explain that following the enactment of Senate Bill No. 946, Kaiser, BSC, and ABC (as well as many other health plans) took the position that as of July 1, 2012, they had no legal obligation to provide behavioral health treatment or ABA services to CalPERS members and Healthy Families Program enrollees, and they informed the Department that they would cease providing ABA therapy to these enrollees pursuant to the terms of their respective settlement agreements with DMHC. (*Id.*, pp. 9-10.) Following further discussions with the health plans and receipt of a petition from Kaiser requesting the initiation of a formal rulemaking to clarify whether health plans' contracts with CalPERS and the Healthy Families Program must include coverage of ABA and other behavioral health treatments (BHT) — and, if so, what "the licensure and certification requirements [are] for individuals who provide BHT" (*id.*, p. 10 & Attachment 3) — DMHC issued the Notice of Rulemaking Action proposing the adoption of Section 1300.74.73 in Title 28, California Code of Regulations, entitled "Pervasive Developmental Disorder and Autism Coverage."[3]

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[2]A true and correct copy of the Notice of Rulemaking, together with the Initial Statement of Reasons, the Text of Proposed Regulation, and the Economic and Fiscal Impact Statement, are attached hereto as Exhibit 1. These documents were obtained from the DMHC's website, at the URL: <http://wpso.dmhc.ca.gov/regulations/regs/?key=28>, last visited December 27, 2012. Appellants request that the Court take judicial notice of these documents pursuant to Evidence Code section 452, subdivision (c).

[3]An identical regulation was adopted by DMHC on an emergency basis on August 28, 2012, and approved by the Office of Administrative Law on September 6, 2012, to expire on March 6,

Most of the text of proposed Regulation 1300.74.73 fleshes out the details of a requirement that each plan must submit a report to DMHC no later than December 31, 2012, demonstrating that the plan maintains an adequate network of qualified autism providers, as mandated by Health and Safety Code section 1374.73, subdivision (b). (See Text of Proposed Regulation 1300.74.73, subd. (a)(3).) The proposed regulation also includes one subsection, however, that addresses the continuing obligation of health plans to provide medically necessary behavioral health treatments to CalPERS and Healthy Families Program enrollees following the enactment of Senate Bill No. 946. Subdivision (a)(1) of the proposed regulation provides:

> "(1) For health plans that provide hospital, medical or surgical coverage under contract with the Healthy Families Program or the Board of Administration of the California Public Employees' Retirement System, *section 1374.73 of the Act does not affect, reduce or limit the obligation to provide coverage* for the diagnosis and medically necessary treatment of pervasive development disorder (PDD) and autism, including medically necessary behavioral health treatment, pursuant to Health and Safety Code section 1374.72." (Text of Proposed Regulation 1300.74.73, subd. (a)(1) [emphasis added].)

Although the text of the proposed regulation does not elaborate any further on exactly what obligation is imposed on health plans to provide coverage for medically necessary behavioral health treatment "pursuant to Health and Safety Code section 1374.72 [the MHPA]," the Notice of Rulemaking Action leaves no doubt that DMHC continues to believe — and will continue to take the position in resolving enrollee grievances from CalPERS and Healthy Families Program enrollees — that health plans are required to provide coverage for such treatment *only* when it is administered by a *state-licensed* professional. Thus, the Notice of Rulemaking explains:

> "Health and Safety Code Section 1374.73(d) expressly excludes Healthy Families enrollees and CalPERS members from the relaxed provider licensure requirements that apply to health plans under the Knox-Keene Act and the Business and Professions Code. . . . Health and Safety Code Section 1374.73(d) must be read in conjunction with subsection (e), which emphasizes that '[n]othing in this section shall be construed to limit a health plan's obligation to provide services under Section 1374.72.' As previously discussed, Section 1374.72 of the Knox-Keene Act is the existing mental health parity law, which requires health plans to cover medically necessary treatment for PDD and autism, including BHT and ABA therapies, *as long as the service is provided by a licensed professional.* After the July 1, 2012, implementation date of SB 946, health plans continued to be required to cover medically necessary services for PPD or autism to Healthy Families and

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2013. (See <http://wpso.dmhc.ca.gov/regulations/docs/regs/27/1346972976124.pdf>, last visited December 27, 2012.)

> CalPERS enrollees *by licensed health care providers* as originally contemplated by Health and Safety Code Section 1374.72." (DMHC Notice of Rulemaking, p. 9 [emphasis added].)[4]

In sum, although Senate Bill No. 946 does (or at least should) resolve the instant dispute with respect to future grievances filed by enrollees who are in health care plans subject to the bill's requirements, there are more than a million Californians who are enrolled in managed care plans within DMHC's jurisdiction *that are not covered by Senate Bill No. 946*. And as to these enrollees, DMHC continues to take the position, notwithstanding the enactment of Senate Bill No. 946, that health plans cannot be ordered to provide coverage for medically necessary ABA therapy that is administered or supervised by a BACB-certified, but not state-licensed, behavior analyst. An "actual present controversy" continues to exist between the parties with respect to this particular issue, and the instant appeal therefore is not moot. More generally, as is reflected in the Notice of Rulemaking and in the attached correspondence from the three largest health care service plans regulated by DMHC, there is a continuing dispute in desperate need of resolution regarding the obligation of health plans under contracts with Medi-Cal, the Healthy Families Program, and CalPERS to provide coverage for behavioral health treatments for autism following the enactment of Senate Bill No. 946. As Kaiser's Senior Vice President succinctly stated in its petition requesting the initiation of formal rulemaking, a resolution of this issue "will eliminate the uncertainty and confusion that does not serve anyone." (Notice of Rulemaking, Attachment 3, p. 3.)[5]

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[4]The Notice of Rulemaking contains many other, similar statements expressly articulating DMHC's continuing position — consistent with the briefing that it has filed in the instant appeal — that *only ABA treatments administered by state-licensed therapists* are required to be covered by health plans under the MHPA. (See, e.g., *id.*, p. 3 ["Health and Safety Code Section 1345 requires health care services to be furnished by professionals . . . licensed by the State to deliver or furnish health care services."], p. 6 ["In the vast majority of cases that come to the Department, the Department finds that the requested ABA is a covered health care service that must be provided by a licensed provider."], p. 7 ["Business and Professions Code Section 2052 states that only licensed individuals can diagnose or treat a person for any physical or mental condition unless the Legislature provides an exception to the prohibition."].)

[5]Appellants apologize for not focusing the Court's attention on Senate Bill No. 946's express exclusion of Medi-Cal, Healthy Families Program, and CalPERS enrollees in any of our prior briefing. As is set forth in Appellants' Opening and Reply Briefs, Appellants believe that the Legislature's enactment of Senate Bill No. 946 — which explicitly defines "behavioral health treatments" for autism to include ABA services that are administered or supervised by non-licensed, but BACB-certified, professionals and paraprofessionals (see Health & Saf. Code, § 1374.73, subd. (c)) — *conclusively refuted* DMHC's contention that Business and Professions Code section 2052 prohibits unlicensed ABA therapists from providing any "medically necessary treatment" for autism pursuant to Health and Safety Code section 1374.72. Appellants could not

B. The Proper Resolution of Enrollee Complaints That Were Denied by DMHC Before the Effective Date of Senate Bill No. 946 Also Presents a Continuing Controversy That is Within the Scope of the Petition for Writ of Mandate

In addition to there being a continuing controversy regarding the proper handling and disposition by DMHC of *future grievances* submitted by any of the more than a million Medi-Cal, Healthy Families Program, and CalPERS health plan enrollees whose contracts are not covered by Senate Bill No. 946, an actual controversy also continues to exist stemming from DMHC's unlawful handling of consumer complaints in accordance with the standards and procedures memorialized in its March 9, 2009, memorandum regarding ABA services requested or provided to autistic enrollees *prior to* the effective date of Senate Bill No. 946. (See generally Appellants' Opening Brief, pp. 49-51.) During this time period, which spanned the entirety of this litigation in the trial court, DMHC applied its bogus "licensure" requirement to deny consumer appeals seeking coverage from health plans for medically necessary ABA services that were administered or supervised by non-licensed, but BACB-certified, therapists. (See, e.g., Appellants' Request for Judicial Notice, Exh. 6.) As recently as December 7, 2011, even after the enactment of Senate Bill No. 946, DMHC rejected an appeal by the parent of an autistic child seeking reimbursement for ABA treatment provided in 2009 because "[a]t the time of this complaint, applicable law required ABA to be delivered directly by a California licensed clinician." (*Ibid.*) DMHC's rejection of that consumer complaint demonstrates that the legal question presented in this appeal — whether state licensure is a prerequisite for health care service plans to provide coverage for medically necessary ABA therapy for autistic children — remains a relevant and disputed question whose resolution by this Court will very much affect families around the state who have advanced substantial sums of money for ABA services that should have been provided and paid for by their health plans.

This Court's December 12, 2012, letter acknowledges the existence of these claims, but suggests that the resolution of such claims is not within the scope of the Petition for Writ of Mandate. This is an overly narrow construction of the proper breadth of the Petition in this case. The First Amended Petition for Writ of Mandate sought writ, injunctive, and declaratory relief, alleging as follows:

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have imagined that DMHC would hold to that position, even for health plan contracts that were not specifically covered by Senate Bill No. 946's requirements, after the enactment and effective date of that legislation. It was not until DMHC issued its emergency regulation and Notice of Rulemaking — *after* Appellants had filed their final brief in this appeal — that Appellants became aware that DMHC would take the absurd position that enrollees in health care plans under contract with Medi-Cal, the Healthy Families Program, and CalPERS would have their grievances reviewed under a different legal standard than all other health care plan enrollees following the enactment of Senate Bill No. 946.

> "Specifically, and as alleged above, under the Mental Health Parity Act and the Knox-Keene Act, in all cases in which an enrollee of a DMHC-regulated full-service health plan has filed an appeal that is treated by the DMHC as a grievance pursuant to Health and Safety Code section 1368, Respondents and Defendants have a clear, present, and ministerial duty to 'order' any plan that has denied coverage for ABA to an autistic enrollee — where ABA was both medically necessary and was to have been provided or supervised by a licensed or certified professional — to *either* 'promptly offer and provide' ABA to the enrollee, or *to 'promptly reimburse' the enrollee* for 'any reasonable costs' associated with obtaining ABA, whichever is applicable." (First Amended Verified Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief, ¶ 48 [emphasis added], found at JA 2:377); accord, *id.*, ¶ 55 [injunctive relief cause of action], found at JA 2:378-379.)[6]

The First Amended Petition thus was not limited, as the Court's December 12, 2012, letter suggests, merely to requesting issuance of "a writ (and/or injunction and/or declaratory relief) directing the Department to order the provision of challenged ABA services in response to enrollee grievances." Rather, Appellants sought a writ that would require the Department to properly apply the law in reviewing and resolving all ABA-related consumer grievances, including by ordering health plans *to reimburse* enrollees for any costs they had incurred in obtaining ABA services in those instances in which a health plan had denied coverage and the Department had improperly upheld the plan's decision on the ground that the therapist administering the ABA was not licensed by the state.[7] The First Amended Petition expressly alleges that DMHC has a duty not only to ensure that ABA services *are provided in the future* in response to enrollees' complaints, but also to make enrollees whole by ordering plans *to reimburse them* for any funds they were forced to expend themselves in order to obtain medically necessary ABA services that should have been, but were not, paid for by their health care plans. Contrary to the implication in the Court's December 12, 2012, letter, Appellants need not have sought a writ in the trial court directing the Department "to reopen old grievances" in order to obtain such reimbursement relief at this point in time. Rather, all that is required is for this Court to reverse the judgment below and to direct the trial court instead to grant

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[6]The Petition's Prayer for Relief likewise seeks relief for "*any* enrollee complaint or grievance regarding a health plan's decision to deny ABA treatment to an autistic enrollee on the ground that it is not a covered benefit," specifically requesting issuance of a writ of mandate or injunction commanding DMHC to order the health plans "to either 'promptly offer and provide' ABA to the enrollee or *to 'promptly reimburse' the enrollee for 'any reasonable costs' associated with obtaining ABA,* whichever is applicable. (*Id.*, Prayer for Relief, ¶¶ 1.a & 2.a [emphasis added], found at JA 2:388-389)."

[7]The Knox-Keene Act specifically authorizes DMHC, in response to an enrollee grievance, to order a health plan to reimburse the enrollee for expenses incurred as a result of the plan's wrongful denial of coverage. (See Health & Saf. Code, § 1368, subd. (b)(6)).

the relief that was actually sought in the Petition, applying that relief to all grievances that were filed by enrollees and were improperly decided by the Department *while the instant litigation was pending*.

Issuance of a writ of mandate directing DMHC to order reimbursement for ABA services rendered in the past in response to enrollee complaints that were unlawfully denied is perfectly consistent with the approach taken by other courts reviewing the validity of agency actions requiring various forms of reimbursement. In *California Assn. for Health Services at Home v. Department of Health Services* (2007) 148 Cal.App.4th 696, for example, the court of appeal considered an appeal from the trial court's partial denial of a petition for writ of mandate seeking to have the Department of Health Services review and raise its Medi-Cal reimbursement rates. The trial court had issued a writ commanding the agency to review its rates only for the current year, and not for any prior years. (*Id.* at p. 703.) Although at the time of the appeal, the Legislature had repealed the statute that required annual rate review, the court of appeal rejected the Department's contention that the repeal of the statute had mooted the case, noting that "because the repealed provision had no effect on the earlier years, the appeal of the order denying rate increases for prior years is not moot." (*Ibid.*) The court then reversed the trial court's ruling denying rate increases for prior years, concluding that the agency had a mandatory duty to review rates and that there was no legal authority that prevented the state from retroactively addressing any deficiencies in reimbursement that might be revealed as a result of the rate review. (*Id.* at p. 709.) Notably, the appellate court's ruling was not limited to any sort of class represented by the petitioners, but rather benefitted all interested parties.

Similarly, in *California Association of Nursing Homes, Sanitariums, Rest Homes and Homes for the Aged v. Williams* (1970) 4 Cal.App.3d 800, in a challenge to a regulation of the state agency responsible for administering the Medi-Cal program, the court of appeal invalidated a regulation based upon the agency's failure to adhere to procedural requirements in its promulgation. (*Id.* at p. 810.) The court ordered the agency to prepare a valid regulation, and noted that the agency would have authority to correct its previously invalid regulations in a retroactive manner. (*Id.* at p. 818.) Once again, nothing in the court's opinion limited the scope of relief to the specific parties before the court in that particular appeal.

Consistent with these authorities, the trial court in the present case may still issue a writ of mandate commanding Respondents to apply the proper legal standard in all enrollee grievances regarding a health plan's denial of coverage for ABA therapy administered by non-licensed, but BACB-certified, behavior analysts, including ordering the plans to reimburse the enrollees for any reasonable costs they incurred in obtaining ABA treatment that the plans had refused to pay for, as there is no statute of limitations or other legal impediment to the granting of such relief. Because

effective relief can still be granted, the instant appeal is not moot.[8]

The Court's December 12, 2012, letter also suggests that Appellants might not have had standing to seek relief regarding "already-resolved grievances." Appellants do not understand why this would be the case. Appellant Consumer Watchdog alleged that it had a "beneficial interest," apart from that of the public at large, in the issuance of a writ directing DMHC to comply with its legal obligations in the processing of enrollee grievances owing to the nonprofit organization's specific activities advocating before the Department and elsewhere on behalf of health care consumers. (First Amended Petition, ¶ 51, found at JA 2:377.) Respondents never refuted that allegation or challenged Appellant's standing below. Additionally, this writ action falls squarely within the doctrine providing for "citizen standing" in suits enforcing public rights, such that the requirement of "beneficial interest" does not apply. As the Supreme Court has explained:

> "It is true that ordinarily the writ of mandate will be issued only to persons who are 'beneficially interested.' Yet . . . this court recognized an exception to the general rule 'where the question is one of public right and the object of the mandamus is to procure the enforcement of a public duty, the relator need not show that he had any legal or special interest in the result, since it is sufficient that he is interested as a citizen in having the laws executed and the duty in question enforced.' The exception promotes the policy of guaranteeing citizens the opportunity to ensure that no governmental body impairs or defeats the purpose of legislation establishing a public right. It has often been invoked by California courts." (*Green v. Obledo* (1981) 29 Cal.3d 126, 144, *quoting Board of Soc. Welfare v. County of Los Angeles*

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[8]Appellants' Petition for Writ of Mandate, it should be noted, also included a cause of action for declaratory relief regarding Respondents' legal duty under the MHPA and the Knox-Keene Act to require health plans to provide coverage for medically necessary ABA treatments administered or supervised by either licensed *or* BACB-certified professionals. (See Petition for Writ of Mandate, ¶ 59, found at JA 2:380; *id.*, Prayer for Relief, ¶ 3.a, found at JA 2:389.) An action for declaratory relief continues to lie when the parties are in fundamental disagreement over the construction of particular legislation, or when they dispute whether a public entity has engaged in conduct or has established policies in violation of applicable law. (*Alameda County Land Use Assn. v. Hayward* (1995) 38 Cal.App.4th 1716, 1723.) Here, notwithstanding the enactment of Senate Bill No. 946, a fundamental disagreement continues to exist between the parties — indeed, among the parties, the health plans, and the California Department of Insurance, as well — over the proper interpretation of the MHPA and the Knox-Keene Act. A key purpose of declaratory relief is to "liquidate doubts" regarding legal controversies that might result in future litigation. (*Baxter Healthcare Corp. v. Denton* (2004) 120 Cal.App.4th 333, 360.) The legal controversy underlying the dispute in this case therefore is, and continues to be, a proper subject for declaratory relief.

(1945) 27 Cal.2d 98, 100-101[citations omitted].)[9]

Under the "citizen suit" exception for lawsuits brought to enforce a public right, Appellants thus have standing to file a writ of mandate action to compel DMHC to resolve consumer complaints in accordance with the laws enacted by the Legislature, and as part of such an action to seek relief directing the Department to order health plans that have wrongly denied coverage for autism-related ABA treatments to reimburse enrollees for the expenses they incurred in obtaining such treatment themselves. The operative complaint in this case seeks precisely such relief. Because DMHC's actions and the trial court's decision have resulted in the denial of such reimbursement for many enrollees whose complaints to the Department were improperly rejected while this action has been pending, a live controversy continues to exist on appeal for this Court's review and adjudication.[10]

II. The Appeal and Cross-Appeal Regarding the Legality of DMHC's March 9, 2009, Memorandum Are Not Moot, But Respondent's Cross-Appeal is Untimely and Must Be Dismissed

For reasons similar to those discussed above, the parties' appeals regarding the trial court's

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[9]The Supreme Court recently reaffirmed the validity of citizen standing to seek a writ of mandate enforcing a public right, and the Court confirmed that such standing applies equally to corporate or nonprofit petitioners. (*Save the Plastic Bag Coalition v. City of Manhattan Beach* (2011) 52 Cal.4th 155, 168.)

[10]Finally, an appellate court always retains the discretion to hear and resolve an appeal on the merits, even if the case might otherwise be considered to be moot, "if there may be a recurrence of the controversy between the parties or the case presents an issue of broad public interest that is likely to recur." (See *Vernon v. State of California* (2004) 116 Cal.App.4th 114, 121.) The present case falls squarely within this well-established exception that authorizes courts to adjudicate the merits of moot appeals involving questions of broad public interest that are likely to recur between the parties. (See, e.g., *State Bd. of Education v. Honig* (1993) 13 Cal.App.4th 720, 742.) Senate Bill No. 946 becomes inoperative in less than 18 months, on July 1, 2014. (Health & Saf. Code, § 1374.73, subd. (g).) If the bill is not extended or new legislation is not enacted by that date, coverage for behavioral health treatments for autism under *all* health care service plan contracts — not just those for Medi-Cal, Healthy Families Program, and CalPERS enrollees — will revert to being governed by DMHC's erroneous interpretation of the plans' obligations under the MHPA and the Knox-Keene Act. With one out of every 88 children estimated to have autism, and with hundreds of millions of dollars at stake, there is an enormous public interest in resolving the instant dispute once and for all. As the court emphasized in *City of Hollister v. Monterey Ins. Co.* (2008) 165 Cal.App.4th 455, 481: "We are loath to dismiss an appeal where the likely result would only be a further expenditure of judicial and litigant resources — including, in this case, taxpayer-funded resources — and further delay in achieving a final resolution of the underlying dispute."

rulings with respect to the legality of DMHC's March 9, 2009, Memorandum are likewise not moot. The Memorandum set forth both the policies and the procedures that DMHC would apply in processing and resolving autism-related consumer complaints. Respondent has indicated in the Notice of Rulemaking that — at least for those Healthy Families Program and CalPERS enrollees whose health care service plan contracts are not covered by Senate Bill No. 946 — it will continue to implement the substantive policies and procedures set forth in the Memorandum, including denying claims for coverage unless "the treating provider determines that the requested ABA therapy requires the skill and expertise of a licensed health care provider" and the treatment itself is actually administered by a state-licensed provider. (See Notice of Rulemaking, pp. 6-7.)

Appellants agree, however, with the suggestion in the Court's December 12, 2012, letter that Respondents' cross-appeal is untimely. The notice of cross-appeal undeniably was not filed until May 11, 2011 (JA 11:2980) — more than 20 days after the clerk served notification of the appeal filed by Appellant (see Notice to Attorney in Re Notice of Appeal, dated Apr. 15, 2011).[11] Pursuant to rule 8.104, subdivision (b), of the California Rules of Court, "no court may extend the time to file a notice of appeal. If a notice of appeal is filed late, the reviewing court must dismiss the appeal." (Cf. Cal. Rules of Court, rule 8.100, subd. (f) ["As used in this rule, 'notice of appeal' includes a notice of cross-appeal . . . ."].) It has long been held that "the reviewing court lacks jurisdiction to excuse a late-filed notice of appeal." (Advisory Committee Comment to Cal. Rules of Court, rule 8.104; see, e.g., *Planning and Conservation League v. Department of Water Resources* (1998) 17 Cal.4th 264, 274 ["[A]n appellant's good intentions cannot excuse noncompliance with the time limits for appeal, which are jurisdictional."]; *Laraway v. Pasadena Unified School Dist.* (2002) 98 Cal.App.4th 579, 582 ["Compliance with the time for filing a notice of appeal is mandatory and jurisdictional. If a notice of appeal is not timely, the appellate court must dismiss the appeal."] [citations omitted]; *Nu-Way Associates, Inc. v. Keefe* (1971) 15 Cal.App.3d 926 [notice of appeal allegedly mailed prior to deadline but not filed until one day after deadline was untimely, and appellate court was without jurisdiction to consider late appeal].)

Sincerely,

Fredric D. Woocher

Counsel for Appellants and Cross-Respondents Consumer Watchdog and Anshu Batra

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[11] A true and correct copy of the Superior Court's Notice to Attorney in Re Notice of Appeal, filed and served on the parties on April 15, 2011, is attached hereto as Exhibit 2. Appellants request that the Court take judicial notice of this court record pursuant to Evidence Code section 452, subdivision (d).

DEPARTMENT OF
Managed Health Care

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
Department of Managed Health Care
Office of Legal Services
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ACTION: Notice of Rulemaking Action
Title 28, California Code of Regulations

SUBJECT: Pervasive Developmental Disorder and Autism Coverage; Adopting section 1300.74.73 in Title 28, California Code of Regulations; Control No. 2012 - 3681

PUBLIC PROCEEDINGS:

Notice is hereby given that the Director of the Department of Managed Health Care ("Department") proposes to adopt a regulation under the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act"), section 1300.74.73, "Pervasive Developmental Disorder and Autism Coverage,"

This rulemaking action proposes to adopt section 1300.74.73, in Title 28, California Code of Regulations. Before undertaking this action, the Director of the Department ("Director") will conduct written public proceedings, during which time any interested person, or such person's duly authorized representative, may present statements, arguments, or contentions relevant to the action described in this notice.

PUBLIC HEARING:

No public hearing is scheduled. Any interested person, or his or her duly authorized representative, may submit a written request for a public hearing pursuant to Section 11346.8(a) of the Government Code. The written request for hearing must be received by the Department's contact person, designated below, no later than 15 days before the close of the written comment period.

WRITTEN COMMENT PERIOD:

Any interested person, or his or her authorized representative, may submit written statements, arguments or contentions (hereafter referred to as comments) relating to the proposed regulatory action by the Department. Comments must be received by the Department, Office of Legal Services, **by 5 p.m. on November 19, 2012,** which is hereby designated as the close of the written comment period.

Please address all comments to the Department of Managed Health Care, Office of Legal Services, Attention: Jennifer Willis, Senior Counsel. Comments may be transmitted by regular mail, fax, email or via the Department's website:

Website:	http://dmhc.ca.gov/regulations/
Email:	regulations@dmhc.ca.gov
Mail:	Department of Managed Health Care Office of Legal Services Attn: Jennifer Willis, Senior Counsel 980 9th Street, Suite 500 Sacramento, CA 95814
Fax:	(916) 322-3968

Please note: if comments are sent via the website, email or fax, there is no need to send the same comments by mail delivery. All comments, including via the website, email, fax or mail, should include the author's name and a U.S. Postal Service mailing address so the Department may provide commenters with notice of any additional proposed changes to the regulation text.

Please identify the action by using the Department's rulemaking title and control number, **Pervasive Developmental Disorder and Autism Coverage, Control No. 2012 - 3681** in any of the above inquiries.

CONTACTS: Inquiries concerning the proposed adoption of these regulations may be directed to:

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AVAILABILITY OF DOCUMENTS:

The Department has prepared and has available for public review the Initial Statement of Reasons, text of the proposed regulation and all information upon which the proposed regulation is based ("rulemaking file"). This information is available by request to the Department of Managed Health Care, Office of Legal Services, 980 9th Street, Sacramento, CA 95814, Attention: Regulations Coordinator.

The Notice of Proposed Rulemaking Action, the proposed text of the regulation, and the Initial Statement of Reasons are also available on the Department's website at the "Open Pending Regulations" section of http://wpso.dmhc.ca.gov/regulations/.

You may obtain a copy of the final statement of reasons once it has been prepared by making a written request to the Regulation Coordinator named above.

AVAILABILITY OF MODIFIED TEXT:

The full text of any modified regulation, unless the modification is only non-substantial or solely grammatical in nature, will be made available to the public at least 15 days before the date the Department adopts the regulation. A request for a copy of any modified regulation(s) should be addressed to the Regulations Coordinator. The Director will accept comments via the Department's website, mail, fax or email on the modified regulation(s) for 15 days after the date on which the modified text is made available. The Director may thereafter adopt, amend or repeal the foregoing proposal substantially as set forth without further notice.

AUTHORITY AND REFERENCE:

California Health and Safety Code Section 1344 authorizes the Director to adopt, amend and rescind regulations as necessary to carry out the provisions of the Knox-Keene Act, including rules governing applications and reports, and defining any terms, whether or not used in the Knox-Keene Act, insofar as the definitions are not inconsistent with the provisions of the Knox-Keene Act. Furthermore, the Director may waive any requirement of any rule or form in situations where in the Director's discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to the Knox-Keene Act.

Health and Safety Code Section 1345 requires health care services to be furnished by professionals, organizations, health facilities, or other persons or institutions licensed by the State to deliver or furnish health care services.

Health and Safety Code Section 1367 lays out the general requirements that must be met by health plans under the Knox-Keene Act, including the requirement that a health plan provide enrollees with medically necessary basic health care services and access to an adequate provider network.

Health and Safety Code Section 1374.72 requires health plans to provide coverage for diagnosis and medically necessary treatment of specified mental health conditions, including PDD and autism, under the same terms and conditions that are applied to physical health conditions. Health and Safety Code Section 1374.72 requires all full-service[1] health plan contracts to "provide coverage for the diagnosis and medically necessary treatment of severe mental illness [SMI] of a person of any age, and of serious emotional disturbances of a child." SMI is specifically defined to include PDD and autism.

[1] A full-service health plan is a health plan that offers all basic health care services as required by the Knox-Keene Act.

Health and Safety Code Section 1374.73 allows health plans to provide medically necessary BHT, including ABA, to individuals with autism and PDD, beginning July 1, 2012, by non-licensed professionals in compliance with detailed criteria set forth in the statute. Health and Safety Code Section 1374.73 states that its provisions do not apply to Healthy Families enrollees and the California Public Employees Retirement System ("CalPERS") members, it also specifically states that it does not affect, reduce, or limit the health plans' obligations to cover medically necessary treatment, including BHT, under existing mental health parity law, Health and Safety Code Section 1374.72.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW:

General Background

Autism spectrum disorders ("ASD"), including PDD, are developmental disabilities that can cause significant social, communication, and behavioral challenges over the span of a person's entire life. These conditions are typically diagnosed in early childhood and are characterized by social and communication impairments, focused interests, and repetitive behaviors. Many children diagnosed with autism are also intellectually disabled.[2] The per-capita lifetime costs of autism are estimated at $3.2 million, including lost productivity and the need for adult care.[3] A recent study by the Centers for Disease Control and Prevention estimates the prevalence of ASD at 1 in 88 children, an increase of 23 percent over two years.[4] The same report noted that the prevalence of ASD in boys is 1 in 54 and the prevalence in girls is 1 in 252.[5] Given the increase in ASD diagnoses and the significant medical and financial implications for this growing population, uninterrupted behavioral health interventions, such as BHT, including ABA therapy, can substantially improve outcomes for children diagnosed with these conditions. These interventions are critical and should be administered at the earliest possible time.

Research has shown that early and immediate intervention is vital to effective treatment of PDD or autism.[6] If ASD symptoms are apparent before the age of 3 years, treatment for the condition should begin immediately upon diagnosis. However, disputes over whether certain types of treatments are medically necessary or a covered health care service often delay necessary

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[2] Geraldine Dawson et al, Randomized, Controlled Trial of an Intervention for Toddlers with Autism: The Early Start Denver Model, *Pediatrics*, Vol. 125, No. 1 (Nov. 30, 2009), p. e18; http://pediatrics.aappublications.org/content/125/1/e17.full.html.

[3] *Ibid.*

[4] Centers for Disease Control and Prevention, Prevalence of Autism Spectrum Disorders — Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2008; Morbidity and Mortality Weekly Report (Mar. 30, 2012); http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6103a1.htm?s_cid=ss6103a1_w.

[5] *Ibid.*

[6] A 2009 study compared young children (18-30 months) who received comprehensive early intervention, including applied behavior analysis, for 25 hours per week to children who received intervention from commonly available community providers. Those who received comprehensive early intervention demonstrated improved outcomes, including significant improvements in IQ, adaptive behavior, and diagnostic status compared to the group who only received community interventions. Geraldine Dawson et al, "Randomized, Controlled Trial of an Intervention for Toddlers with Autism: The Early Start Denver Model," *Pediatrics,* Vol. 125, No. 1 (Nov. 30, 2009), p. e22.

treatment for children with autism.[7] This delay can result in stifled improvement, severe impairment, and permanent developmental damage that may not be regained through later treatment. [8] In addition, when health plans deny or delay coverage for PDD and autism, including ABA therapy, families with children diagnosed with PDD or autism must either pay thousands of dollars out-of-pocket for critical treatment or forgo altogether beneficial and necessary BHT for their children.

The Healthy Families program is California's low-cost insurance program that provides health, dental and vision coverage to children who do not have insurance and do not qualify for no-cost Medi-Cal. As of April, 2012, the Healthy Families program had over 870,000 enrolled children.[9] The Managed Risk Medical Insurance Board administers the Healthy Families program and contracts with health plans to arrange and cover health care services.

CalPERS provides comprehensive health benefits to more than 1.3 million California state employees, retirees and their families, and government agency and school employees. CalPERS is the largest purchaser of health benefits in California and the second largest in the country after the federal government. CalPERS offers a choice of coverage between HMO coverage and self-insured products. Two major health plans that contract with CalPERS are regulated under the Knox-Keene Act: Kaiser Foundation Health Plan, Inc. ("Kaiser") and Blue Shield of California ("BSC").

It is estimated that 1 out of every 88 children has ASD. [10] This means that it can be estimated that at least 9,886 children in the Healthy Families program have ASD. Using a conservative estimate that 25% of CalPERS members are children under the age of 18, it can be estimated that 3,693 CalPERS members have ASD. With a per-capita lifetime cost for autism of $3.2 million for the estimated 13,579 Healthy Families enrollees and CalPERS members, this equals approximately $43,452,800 in lifetime autism care, including health care costs, if services are interrupted.

The three largest health plans with Healthy Families enrollees and CalPERS members are: 1) Kaiser; 2) BSC; and 3) Anthem Blue Cross ("ABC"). Kaiser has approximately 190,000 Healthy Families enrollees and 530,000 CalPERS members. BSC has approximately 33,000 Healthy Families enrollees[11] and 400,000 CalPERS members. ABC has approximately 197,000 Healthy Families enrollees and no CalPERS members.

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[7] Since 2010, the Department's Help Center has received 228 grievances involving health plan denials of ABA therapy. In those cases where the ABA issue was resolved exclusively using the Department's standard complaint process, 185, or approximately 81%, of the complaints were resolved in favor of the enrollee. In those cases that involved an IMR, 86% of the IMRs were resolved in favor of the enrollee.

[8] http://www.cdc.gov/ncbddd/autism/facts.html#3

[9] http://www.mrmib.ca.gov/mrmib/HFP/Apr_12/HFPRptSum.pdf

[10] Centers for Disease Control and Prevention, Prevalence of Autism Spectrum Disorders — Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2008; Morbidity and Mortality Weekly Report (Mar. 30, 2012); http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6103a1.htm?s_cid=ss6103a1_w.

[11] BSC will be exiting the Healthy Families program on October 31, 2012.

California has a mental health parity law contained in Section 1374.72 of the Knox-Keene Act. This law was enacted in 1999. The mental health parity statute does not list the specific services that health plans must cover. Rather, it identifies specific mental health conditions (such as PDD and autism) that are subject to the statute's requirements. The mental health parity statute requires that health plans provide medically necessary treatment for those conditions. As such, BHT is used to treat individuals with both physical and mental health issues and conditions.[12] ABA therapy is a type of BHT.[13] ABA therapy is a recognized treatment used to treat children with PDD or autism.[14] ABA uses modern behavioral learning theory to modify behaviors by focusing on the observable relationship of behavior to the environment. Because ABA comprises many assessment and behavioral changing procedures, ABA can be a medical or non-medical service depending on its application. Since the implementation of mental health parity in 2000, health plans have been required to cover medically necessary treatments for autism, including ABA services, when provided by a licensed individual.[15] SB 946, which relaxed the licensure requirements for administering ABA therapy, did not affect this coverage requirement for Healthy Families and CalPERS enrollees.

Historically, health plans denied claims for BHT, and more particularly, ABA, for children diagnosed with PDD and autism on the grounds that the services were either not medically necessary or were experimental/investigational. Those decisions by the health plans were generally overturned by the Department's external review process known as Independent Medical Review (IMR). However, a few years ago health plans began denying coverage for those services altogether, arguing they have no legal obligation to cover ABA because the services are: (1) not health care services and health plans are only obligated under the Knox-Keene Act to cover health care services; (2) excluded under the terms and conditions of the health plan contract; or (3) educational services. Another frequent health plan argument was that since ABA services could be administered by non-licensed individuals, they could not, as a matter of law, be health care services. This argument, however, ignored the fact that licensed health care providers were authorized to provide BHT, including ABA therapy, as an integral part of a patient's treatment plan.

In the vast majority of cases that come to the Department, the Department finds that the requested ABA is a covered health care service that must be provided by a licensed provider. The determination whether ABA therapy is a covered benefit requires a case-by-case analysis and depends primarily on the licensed treating provider's assessment and evaluation. If the treating provider determines that the requested ABA therapy requires the skill and expertise of a licensed health care provider, then the services are likely to be considered health care services and, consequently, a covered benefit, subject to exclusions and limitations in the health plan

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[12] For example, *see* http://www.healthline.com/galecontent/behavioral-therapy.
[13] See the National Autism Center's National Standards Project, "Findings and Conclusions," (2009). http://www.nationalautismcenter.org/pdf/NAC%20Findings%20&%20Conclusions.pdf
[14] Geraldine Dawson et al, Randomized, Controlled Trial of an Intervention for Toddlers with Autism: The Early Start Denver Model, *Pediatrics*, Vol. 125, No. 1 (Nov. 30, 2009), pgs. e21-22; http://pediatrics.aappublications.org/content/125/1/e17.full.html.
[15] Health and Safety Code Section 1374.72(a).

contract. If the individual's condition does not require the skill and expertise of a licensed health care provider, prior to July 1, 2012, the services were not found to be a covered benefit.

While health plan BHT denials have been frequently overturned by the Department's Complaint and Independent Review Processes,[16] health plans have resisted developing adequate networks of licensed providers with the skill and expertise to deliver medically necessary BHT therapy, and particularly ABA. Health plans generally have two reasons for failing to develop adequate networks: 1) a shortage of appropriately licensed providers willing to provide ABA, and 2) their claim that ABA is not a health care service. Currently, when ABA services are deemed medically necessary, many health plans enter into arrangements with a licensed provider with BHT or ABA experience on an individual patient basis. But that provider remains unavailable to other health plan members seeking similar services.

In July 2011, to improve access to ABA therapy, the Department undertook enforcement actions against two of California's largest health plans: ABC and BSC for their systemic denial of ABA authorizations for individuals with autism, in violation of Health and Safety Code Section 1374.72, the mental health parity statute. To avoid the prospect of litigation, these two major health plans entered into settlement agreements with the Department to provide coverage for medically necessary ABA services without waiving their coverage and provider licensure defenses. Time restraints impeded the Department's ability to secure similar settlement agreements with the other full-service health plans[17] that are subject to the mental health parity statute.

Knox-Keene Act and Other Statutory Provisions

Under the Knox-Keene Act, a health plan may be obligated to cover a service because it is: (1) a basic health care service as defined in Health and Safety Code Section 1345(b); (2) a specific service mandated by the Legislature; or (3) a service the health plan contractually agreed to provide.

Health and Safety Code Section 1345(b) of the Knox-Keene Act defines the broad categories of basic health care services that health plans must offer, which include physician services, both consultation and referral; hospital inpatient services and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventative health services; emergency health care services, ambulance transport services; and hospice care.[18] Health and Safety Code Section 1345 requires health care services to be furnished by professionals, organizations, health facilities, or other persons or institutions licensed by the State to deliver or furnish health care services. Business and Professions Code Section 2052 states that only licensed individuals can diagnose or treat a person for any physical or mental condition unless the Legislature provides an exception to the prohibition.

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[16] Health and Safety Code Sections 1368 (b), 1370.4, and 1374.30 (d)(3).
[17] A full-service health plan is a health plan that offers all basic health care services as required by the Knox-Keene Act.
[18] Health and Safety Code Section 1345(b).

Health and Safety Code Section 1367 sets forth the general requirements that health plans must meet under the Knox-Keene Act, including the requirement that a health plan provide enrollees with medically necessary basic health care services and access to an adequate network.[19] The Knox-Keene Act, with the exception of specific health benefit mandates, does not attempt to enumerate the specific health care services and treatments that are included in the concept of "basic health care services" under Health and Safety Code Section 1367(i).[20] As indicated above, in addition to basic health care services, the Legislature enacts specific health benefit mandates that require health plans to include specific services in their health insurance products (plans and policies).[21]

In 1999, AB 88 (Thompson), Chapter 534, Statutes of 1999, California enacted a mental health parity law, Health and Safety Code Section 1374.72 of the Knox-Keene Act, which requires health plans to provide coverage for diagnosis and medically necessary treatment of specified mental health conditions, including PDD and autism, under the same terms and conditions that are applied to physical health conditions.[22] Health and Safety Code Section 1374.72 requires all full-service health plan contracts to "provide coverage for the diagnosis and medically necessary treatment of severe mental illness [SMI] of a person of any age, and of serious emotional disturbances of a child." SMI is specifically defined to include PDD and autism.

SB 946 adds Section 1374.73 to the Knox-Keene Act. The statute provides:

> 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.
> (Section 1374.73(a)(1), emphasis added.)

Health and Safety Code Section 1374.73 defines BHT to mean professional services and treatment programs, including ABA and evidence-based behavior intervention programs, needed to develop or restore functioning in an individual with PDD or autism, and meets criteria requirements such as a treatment plan with measurable goals.[23]

Health and Safety Code Section 1374.73(b) authorizes health plans to use non-licensed professionals and paraprofessionals to deliver BHT: "[e]very 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 and qualified autism service

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[19] Health and Safety Code Section 1367(i).
[20] For examples of required statutory benefit mandates see the California Health Benefits Review Program, "Appendix 20: Existing Mandates in California Law," (2009) at http://www.chbrp.org/documents/sb1704/ap_20.pdf
[21] *Ibid.*, at p. 6.
[22] Health and Safety Code Section 1374.72(a).
[23] Health and Safety Code Section 1374.73(c)(1).

paraprofessionals . . ." (Emphasis added.) Once SB 946 created an exception to the licensed provider requirement, the Legislature simply required health plans to maintain an adequate network of qualified autism service providers, professionals or paraprofessionals who provide and administer BHT, including ABA therapy.[24]

Health and Safety Code Section 1374.73(d) expressly excludes Healthy Families enrollees and CalPERS members from the relaxed provider licensure requirements that apply to health plans under the Knox-Keene Act and the Business and Professions Code. Specifically, Health and Safety Code Section 1374.73(d) provides that the SB 946 requirements do not apply to health plan contracts for: (1) specialized health plans that do not provide mental or behavioral health services, (2) Medi-Cal Managed Care, (3) the Healthy Families Program, and (4) CalPERS.[25]

Health and Safety Code Section 1374.73(d) must be read in conjunction with subsection (e), which emphasizes that, "[n]othing in this section shall be construed to limit a health plan's obligation to provide services under Section 1374.72." As previously discussed, Section 1374.72 of the Knox-Keene Act is the existing mental health parity law, which requires health plans to cover medically necessary treatment for PDD and autism, including BHT and ABA therapies, so long as the service is provided by a licensed professional. After the July 1, 2012, implementation date of SB 946, health plans continued to be required to cover medically necessary services for PDD or autism to Healthy Families and CalPERS enrollees by licensed health care providers as originally contemplated by Health and Safety Code Section 1374.72.

Health Plan Confusion Regarding Coverage Requirements under the Knox-Keene Act

On December 11, 2011 and April 26, 2012, BSC and ABC notified the Department that effective June 30, 2012, they would cease providing ABA therapy pursuant to the terms of their respective settlement agreements.[26] BSC further informed the Department the health plan believes that as a result of the enactment of SB 946, health plans have no legal requirement to provide BHT or ABA services to CalPERS members and Healthy Families enrollees as of July 1, 2012, even under existing mental health parity law.[27] ABC verbally communicated the same to the Department. The Department understands that this position is shared by many of the other full-service health plans that provide services to Healthy Families enrollees and CalPERS members. BSC sent a second letter to the Department on February 27, 2012, reiterating its decision to cease providing ABA services under the terms of the health plan's settlement agreement with the

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[24] Health and Safety Code Section 1374.73(b).
[25] Health and Safety Code Section 1374.73(d).
[26] *See* Attachment 1, December 7, 2011, Letter from Marcy C. St. John, Associate General Counsel, Blue Shield of California, to Brent Barnhart, Director of the Department of Managed Health Care: "Re: Enforcement Matters 10-560, 10-561, 11-022, 11-038, 11-039, 11-262, Settlement Agreement of July 1, 2011." *See also* April 26, 2012, Letter from Andrew Russell, Associate General Counsel, Anthem Blue Cross, to Brent Barnhart, Director of the Department of Managed Health Care, "Re: Notice Pursuant to Settlement Agreement."
[27] *See* Attachment 1, December 7, 2011, Letter from Marcy C. St. John, Associate General Counsel, Blue Shield of California, to Brent Barnhart, Director of the Department of Managed Health Care: "Re: Enforcement Matters 10-560, 10-561, 11-022, 11-038, 11-039, 11-262, Settlement Agreement of July 1, 2011."

Department.[28] The Department is also currently reviewing health plan filings that contain information regarding each health plans implementation of SB 946. All health plans that have Healthy Families enrollees and CalPERS members have provided a written affirmation in their SB 946 filings that state it is their understanding that Healthy Families and CalPERS coverage is exempt from the requirements of SB 946. The revised Evidence of Coverage ("EOC") for most of the health plans with CalPERS members or Healthy Families enrollees does not contain information regarding BHT, unlike other EOCs for different types of coverage.

Following the receipt of the health plan communications regarding cessation of ABA services, the Department immediately commenced discussions with the health plans. In June 2012, the Department entered into limited informal interim agreements with BSC, ABC and Kaiser in which these three major health plans agree to continue covering BHT, including ABA, for Healthy Families enrollees and CalPERS members after the July 1, 2012 implementation date of SB 946. BSC agreed to cover ABA through September 30, 2012 for Healthy Families enrollees and CalPERS members and will cover and authorize ABA services on or after June 15, 2012, for a period of three months. ABC agreed to follow the terms of the previous executed settlement agreement and issue 6 month authorizations for Healthy Families enrollees, and more recently, the parties have agreed to extend ABC's interim agreement to December 31, 2012. These agreements are temporary in nature and are not a permanent fix to the coverage disputes amongst the parties. In addition, these settlements do not bind the 25 other health plans that provide services to Healthy Families enrollees. Kaiser agreed to cover medically necessary BHT for both Healthy Families enrollees and CalPERS members diagnosed with PDD or autism for no specific duration.

On June 27, 2012, Kaiser sent the Department a "Petition Requesting Initiation of Formal Rulemaking and Promulgating of Regulations" ("Petition") requesting that the Department adopt a regulation under Government Code section 11340.6.[29] The terms of the requested regulation would clarify:

- Whether contracts between health care service plans and the Board of Administration of the California Public Employees Retirement System (CalPERS) and the Healthy Families Program (Healthy Families) administered by the California Managed Risk Medical Insurance Board (collectively referred to herein as the "Public Purchasers") must include coverage of Behavioral Health Treatment (BHT), including applied behavior analysis (ABA) defined in Health & Safety Code § 1374.73 (S.B. 946);

- If DMHC requires coverage of BHT in health care service plan contracts with Public Purchasers, the licensure and certification requirements for individuals who provide BHT;

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[28] *See* Attachment 2, February 27, 2012, Letter from Marcy C. St. John, Associate General Counsel, Blue Shield of California, to Brent Barnhart, Director of the Department of Managed Health Care: "Re: Enforcement Matters 10-560, 10-561, 11-022, 11-038, 11-039, 11-262, Settlement Agreement of July 1, 2011."

[29] *See* Attachment 3, June 27, 2012, Letter from Jerry Fleming, Senior Vice President, Kaiser Permanente, to Brent Barnhart, Director of the Department of Managed Health Care: "Re: Petition Requesting Initiation of Formal Rulemaking and Promulgating of Regulation."

- The ongoing statutory obligations of the Regional Centers to provide BHT to enrollees of the Public Purchasers pursuant to the Regional Centers' contracts with the State of California for services governed by the Lanterman Act (Cal. Welf. & Instit. Code § 4500 et seq.) and the Intervention Services Act (Cal. Gov't Code § 95000 et seq.) in light of the statutory exemption contained in S.B. 946 for health care service contracts with the Public Purchasers.

The Department responded to the Kaiser Petition on August 27, 2012.[30]

Purpose of the Regulation

The health plans' stated confusion and misinterpretation regarding whether there is a statutory obligation after July 1, 2012 to provide medically necessary services will lead to denials or delays in authorizing BHT, including ABA, to Healthy Families enrollees and CalPERS members. These denials and delays could cause stifled improvement, severe impairment and permanent developmental damage to impacted enrollees that may not be regained through later treatment as well as substantial financial harm.

This confusion could also lead to negotiation problems with the Managed Risk Medical Insurance Board ("MRMIB") and CalPERS as they attempt to negotiate premium rates with health plans based on the scope of covered services for enrollees, and whether BHT, including ABA, is included.

The regulation proposed in this rulemaking action clarifies and makes specific the requirements within State law. The regulation proposed in this rulemaking action is neither inconsistent nor incompatible with existing state regulations.

This regulation was initially adopted by the Department as an emergency regulation that was approved by the Office of Administrative Law on September 6, 2012.

Broad Objectives and Benefits of Regulation

Pursuant to Government Code Section 11346.5(a)(3)(C), the broad objectives and benefits of this proposed regulation, subdivision (a)(1), is that it will clarify that SB 946 did not reduce, limit, or exclude coverage for medically necessary mental health services, including BHT and ABA, provided by licensed providers for Healthy Families enrollees and CalPERS members after the July 1, 2012 implementation date of the legislation. The public health will be protected because the regulation will ensure that Healthy Families enrollees and CalPERS members access to medically necessary BHT, including applied behavior analysis, is not interrupted or delayed. It is generally recognized that significant interruptions or delays in securing medically necessary BHT, including ABA therapy, can result in stunted and permanent impaired developmental outcomes and can cause irreparable disability to children with PDD and autism.

[30] The Department and Kaiser entered into an agreement on July 24, 2012, extending the date that the Department could respond to the Petition until July 27, 2012.

Pursuant to Government Code Section 11346.5(a)(3)(C), the broad objectives and benefits of this proposed regulation, subdivision (a)(2) is that health plans cover health care services that are medically necessary and health plans may perform utilization review of requested health care services to ensure that the services are medically necessary.

Pursuant to Government Code Section 11346.5(a)(3)(C), the broad objectives and benefits of this proposed regulation, subdivisions (a)(3)(A)-(a)(3)(D), is that the Department must be able to verify the adequacy of each health plan's BHT network to protect the public health. This reporting requirement will help ensure that children with autism will not be subject to potential delays and/or interruptions in accessing BHT, including ABA services, which can result in stifled improvement, severe impairment and permanent developmental damage that may not be regained through later treatment. The network reporting information will allow the Department to determine service areas where provider shortages exist and to identify strategies, in collaboration with the health plans, to make certain that children with autism who live in underserved or other challenged geographic areas receive timely access to medically necessary BHT services and are not subject to potential delays or interruptions in care because of an inadequate network.

Comparison to Existing Regulations

Pursuant to Government Code Section 11346.5(a)(3)(D) the proposed regulation was evaluated and was not found to be inconsistent or incompatible with existing state regulations. The Department compared the following related existing regulations located in the California Code of Regulations, title 28: 1300.74.72, 1300.67.2, 1300.67.2.1, 1300.67.2.2, 1300.45, and 1300.74.30.

ALTERNATIVES CONSIDERED:

Pursuant to Government Code Section 11346.5(a)(13), the Department must determine that no reasonable alternative considered by the Department or has otherwise been identified or brought to the attention of the Department would be more effective in carrying out the purpose for which the above action is proposed or would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provisions of law.

The Department invites interested persons to present statements or arguments with respect to alternatives to the requirements of the proposed regulations during the written comment period.

SUMMARY OF FISCAL IMPACT:

- Mandate on local agencies and school districts: None
- Cost or Savings to any State Agency: Yes (see below)
- Direct or Indirect Costs or Savings in Federal Funding to the State: None

- Cost to Local Agencies and School Districts Required to be Reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None
- Costs to private persons or businesses directly affected: The Department is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.
- Effect on Housing Costs: None
- Other non-discretionary cost or savings imposed upon local agencies: None

COSTS OR SAVING TO STATE AGENCY

The Department of Developmental Services ("DDS") states in the May 2012 Revised Budget that there will be an anticipated savings of $69.4 million to the General Fund resulting from the implementation of SB 946, because health plans are now authorized as a result of this bill to provide medically necessary behavioral health treatments, including applied behavior analysis, through non-licensed professionals and paraprofessionals that meet certain specified criteria. These savings stem from a DDS assumption that certain medically necessary behavioral services that health plans previously refused to cover and pay for because they were provided by non-licensed individuals will now be available (reimbursable) through private health insurance coverage.

DETERMINATIONS:

The Department has made the following initial determinations:

The Department has determined the regulation will not impose a mandate on local agencies or school districts, nor are there any costs requiring reimbursement by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.

The Department has determined the regulation will have no significant effect on housing costs.

The Department has determined the regulation does not affect small businesses. Health care service plans are not considered a small business under Government Code Section 11342.610(b) and (c).

The Department has determined the regulation will not have a significant statewide adverse economic impact directly affecting businesses, including the ability of California businesses to compete with businesses in other states.

The Department has determined that this regulation will have no cost or savings in federal funding to the state.

RESULTS OF THE ECONOMIC IMPACT ANALYSIS (Government Code § 11346.3(b)

Creation or Elimination of Jobs Within the State of California

This regulation is intended to clarify and make specific the existing State law for health plans under the Knox-Keene Act. This regulation is designed to clarify and make specific that health plans are required to provide medically necessary BHT, including ABA, for CalPERS members and Healthy Families enrollees under existing law. The health plans continue to be able to conduct utilization review to determine the medical necessity of these requested services. Health plans subject to the requirements of SB 946 must also demonstrate that they have an adequate network of providers to treat enrollees as required by this legislation. Therefore, the Department has determined the regulation will not significantly affect the creation or elimination of jobs within the State of California.

Creation of New or Elimination of Jobs Within the State of California

This regulation is intended to clarify and make specific the existing State law for health plans under the Knox-Keene Act. This regulation is designed to clarify and make specific that health plans are required to provide medically necessary BHT, including ABA, for CalPERS members and Healthy Families enrollees under existing law. The health plans continue to be able to conduct utilization review to determine the medical necessity of these requested services. Health plans subject to the requirements of SB 946 must also demonstrate that they have an adequate network of providers to treat enrollees as required by this legislation. The Department has determined the regulation will not significantly affect the creation of new businesses or the elimination of existing businesses within the State of California.

Expansion of Businesses or Elimination of Existing Businesses Within the State of California

This regulation is intended to clarify and make specific the existing State law for health plans under the Knox-Keene Act. This regulation is designed to clarify and make specific that health plans are required to provide medically necessary BHT, including ABA, for CalPERS members and Healthy Families enrollees under existing law. The health plans continue to be able to conduct utilization review to determine the medical necessity of these requested services. Health plans subject to the requirements of SB 946 must also demonstrate that they have an adequate network of providers to treat enrollees as required by this legislation. The Department has determined the regulation will not significantly affect the expansion of businesses currently doing business within the State of California.

BENEFITS OF THE REGULATION

This regulation will clarify that SB 946 did not reduce, limit, or exclude coverage for medically necessary mental health services, including BHT and ABA, provided by licensed providers for

Healthy Families enrollees and CalPERS members after the July 1, 2012 implementation date of the legislation. This regulation benefits the public by making specific that health plans continue to be obligated to provide medically necessary BHT, including ABA, to CalPERS members and Healthy Families enrollees. The public health will be protected because the regulation will ensure that Healthy Families enrollees and CalPERS members access to medically necessary BHT, including applied behavior analysis, is not interrupted or delayed. It is generally recognized that significant interruptions or delays in securing medically necessary BHT, including ABA therapy, can result in stunted and permanent impaired developmental outcomes and can cause irreparable disability to children with PDD and autism. The regulation also clarifies that health plans continue to be permitted to perform utilization review of requested health care services to ensure that the prescribed services are medically necessary.

This regulation is necessary so that the Department is able to verify the adequacy of each health plan's BHT network to protect the public health. The benefits of this reporting requirement is that it will help ensure that children with autism will not be subject to potential delays and/or interruptions in accessing BHT, including ABA services, which can result in stifled improvement, severe impairment and permanent developmental damage that may not be regained through later treatment. The network reporting information will allow the Department to determine service areas where provider shortages exist and to identify strategies, in collaboration with the health plans, to make certain that children with autism who live in underserved or other challenged geographic areas receive timely access to medically necessary BHT services and are not subject to potential delays or interruptions in care because of an inadequate network.

ATTACHMENT 1

blue of california

Mary C. St. John
Associate General Counsel

December 7, 2011

Brent Barnhart, Director
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814

Re: Enforcement Matters 10-560, 10-561, 11-022, 11-038, 11-039, 11-262
Settlement Agreement of July 11, 2011

Dear Mr. Barnhart:

This letter serves to notify the Department of Managed Health Care (the "Department") that the California Legislature has taken action that impacts the Settlement Agreement between the Department and Blue Shield of California (the "Plan") dated July 11, 2011 (the "Agreement"). While the Plan could cease performance under the Agreement, the Plan intends to continue covering ABA services to provide its members continuity. However, in order to transition members to the coverage contemplated by the Legislature, the Plan is proposing to amend the Agreement, as described below.

Pursuant to Paragraph J of Section II of the Agreement, the Plan has the right to cease performance upon 60 days notice to the Department that an act by the California Legislature supports the Plan's contention that ABA is not required to be covered under the Knox-Keene Act. On October 9, 2011, SB 946 (Steinberg, Chapter 650) was enacted into California law. This bill requires health care service plans to provide coverage of behavioral treatment, including Applied Behavior Analysis ("ABA") services, beginning July 1, 2012. The benefit mandate imposed by SB 946 does not apply to CalPERS or Healthy Families members. Additionally, the mandate to provide the coverage is inoperative as of July 1, 2014 and does not require coverage beyond that which is required as an essential benefit under federal regulations (currently undefined).

The Plan contends that SB 946 provides legislative confirmation that health care service plans are under no obligation to cover ABA services prior to July 1, 2012. However, the

Blue Shield of California
50 Beale Street, San Francisco, CA 94105
P 415 229-5921 F 415 227-8543

Plan will continue covering ABA while it implements the requirements of SB 946. In order to facilitate a smooth transition from the Settlement Agreement to SB 946, and in recognition of the new law, the Plan proposes amending the Agreement as follows:

1) The Agreement will automatically terminate at midnight June 30, 2012.

2) Authorizations for services made pursuant to the Agreement will be phased out to end July 1, 2012.

3) From January 1, 2012 to March 31, 2012 Blue Shield will cover ABA services for an initial 3 month period and will not dispute the medical necessity of the services or the frequency of which the services are prescribed.

4) Authorizations made pursuant to the Agreement from April 1, 2012 to June 30 will end July 1, 2012. After April 1 and after the plan's SB 946 implementation filing is submitted, the Plan will have the option to cover ABA services pursuant to its SB 946 filing.

5) Healthy Families and CalPERS members will continue to receive coverage until July 1, 2012.

6) Beginning January 1, 2012, once the enrollee has received services for the initial six- or three-month period, ongoing authorizations will be subject to medical necessity review.

7) Amendments to the Agreement will not impact authorizations currently in effect.

Thank you for your prompt attention to this matter. Please feel free to contact me with any questions.

Very truly yours,

Mary C. St. John, Esq.
Associate General Counsel

Anthem Blue Cross

Andrew G. Russell
Associate General Counsel
Legal Department

April 26, 2012

VIA EMAIL AND CERTIFIED MAIL

Mr. Brent Barnhart
Director
Ms. Maureen McKennan
Deputy Director of Plan and Provider Relations
California Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814

RE: Notice Pursuant to Settlement Agreement

Dear Mr. Barnhart and Ms. McKennan:

This letter serves as notice to the Department of Managed Health Care (the "Department") that as of July 1, 2012, the effective date of the ABA coverage mandate in California SB 946, Blue Cross of California dba Anthem Blue Cross ("Anthem Blue Cross") will cease to perform its obligations under the Settlement Agreement that the Department and Anthem Blue Cross entered into on July 15, 2011 (the "Settlement Agreement"), as provided for in the Settlement Agreement.

Paragraph C of the Settlement Agreement states that "BLUE CROSS agrees to arrange for the provision of all medically necessary ABA services for the treatment of PDD or ASD for all current and future Enrollees and the Subject Enrollees, in accordance with the terms of this Agreement, subject to any development or change in law or regulation, as set forth in paragraph I, that clarifies BLUE CROSS' legal obligations with respect to ABA services."

SB 946 is a change in law that clarifies Anthem Blue Cross' legal obligations with respect to ABA services by requiring every health care service plan that provides hospital, surgical or medical coverage to also provide coverage for behavioral health treatment (including ABA services) for pervasive developmental disorder and autism as of July 1, 2012.

Pursuant to paragraphs C and I of the Settlement Agreement, the enactment of SB 946 relieves Anthem Blue Cross of its responsibility to perform in accordance with any provision of the Settlement Agreement as of July 1, 2012. Consequently, Anthem will change its practices as of that date to comply with SB 946 and cease to perform under the Settlement Agreement as of that date.

21555 Oxnard Street, CAAC01-01B, Woodland Hills, CA 91367 • Telephone: 818.234.2217 • Fax: 818.234.2344

Anthem Blue Cross

Anthem Blue Cross is willing to work with the Department on a transition plan for enrollees who are receiving coverage for ABA services pursuant to the Settlement Agreement as of July 1, 2012.

Please feel free to call me at (818) 234-2217 if you have any questions about this letter.

Sincerely yours,

Andrew Russell
Associate General Counsel

cc: Tony Manzanetti, Deputy Director, DMHC Office of Enforcement

21555 Oxnard Street, CAAC01-01B, Woodland Hills, CA 91367 • Telephone: 818.234.2217 • Fax: 818.234.2344

ATTACHMENT 2

blue of california

Mary C. St. John
Associate General Counsel

February 27, 2012

Brent Barnhart, Director
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, California 95814

Re: Enforcement Matters 10-560, 10-561, 11-022, 11-039, 11-262
Notice of Termination of the Settlement Agreement of July 11, 2011 re ABA Services

Dear Mr. Barnhart:

On December 7, 2011, Blue Shield of California (the "Plan") gave notice pursuant to Paragraph J of Section II of the Settlement Agreement of July 11, 2011 (the "Agreement") between the Plan and the Department of Managed Health Care (the "Department") that actions of the California Legislature supported the Plan's position that ABA is not required to be covered under the Knox-Keene Act. Thereafter, the Plan and the Department entered into good faith negotiations to amend the Agreement consistent with the enactment of SB 946 and in anticipation of the July 1, 2012 effective date of Health & Safety Code § 1374.73.

Regrettably, those negotiations have not resulted in an agreement to amend the Agreement. Pursuant to Paragraph J, the Plan hereby gives notice that it considers the Agreement to have terminated, effective February 5, 2012, and will cease performance under the Agreement. To avoid disruption to Plan enrollees, the Plan will continue to authorize ABA services consistent with the Agreement Section II.A. However, all authorizations under the Agreement will end no later than June 30, 2012.

If Department has further questions or believes that additional information is required, please do not hesitate to contact the undersigned.

Blue Shield of California
50 Beale Street, San Francisco, CA 94105
p 415 229.5021 f 415 229.5343

Sincerely,

Mary C. St. John, Esq.
Associate General Counsel

cc: Maureen McKennan, Deputy Director, Plan and Provider Relations
Anthony Manzanetti, Deputy Director, Office of Enforcement
Holly Pearson, Deputy Director and General Counsel
Gretchen M. Lachance, Esq.
Kathleen Lynaugh, Esq.

ATTACHMENT 3

KAISER PERMANENTE®

Jerry Fleming
Senior Vice President
Health Reform Implementation & Policy
300 Lakeside Dr.
Oakland, CA 94612

June 27, 2012

Brent Barnhart
Director
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Re: **Petition Requesting Initiation of Formal Rulemaking and Promulgating of Regulations**

Dear Director Barnhart:

Pursuant to California Government Code Section 11340.6, Kaiser Foundation Health Plan, Inc. ("Petitioner") petitions the Department of Managed Health Care ("DMHC") to initiate formal rulemaking and to promulgate regulations to clarify:

(1) Whether contracts between health care service plans and the Board of Administration of the California Public Employees Retirement System ("CalPERS") and the Healthy Families Program ("Healthy Families") administered by the California Managed Risk Medical Insurance Board (collectively referred to herein as the "Public Purchasers") must include coverage of Behavioral Health Treatment ("BHT") including Applied Behavioral Analysis ("ABA") defined in Health & Safety Code Section 1374.73 ("S.B. 946");
(2) If DMHC requires coverage of BHT in health care service plan contracts with Public Purchasers, the licensure and certification requirements for individuals who provide BHT;
(3) The ongoing statutory obligations of the Regional Centers to provide BHT to enrollees of the Public Purchasers pursuant to the Regional Centers' contracts with the State of California for services governed by the Lanterman Act (Cal. Welfare & Institutions Code § 4500 et seq.) and the Intervention Services Act (Cal. Government Code § 95000 et seq.) in light of the statutory exemption contained in S.B. 946 for health care service contracts with the Public Purchasers.

S.B. 946 mandates that certain Knox-Keene health care service plans "provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012." Cal. Health & Safety Code § 1374.73 (a)(1). However, S.B. 946 contains a provision exempting certain types of plans from its mandates (in relevant part):

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

...

(2) A health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).
(3) A health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code).
(4) A health care benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code).

Id., § 1374.73 (d)(1)-(4).

The plain statutory language, legislative history, and various legislative analyses of S.B. 946 appear to demonstrate the California Legislature's explicit and purposeful exclusion of health care service plan contracts with Medi-Cal, Healthy Families and CalPERS from S.B. 946's coverage mandates. Initial drafts of S.B. 946 required all health care service plan contracts, except for contracts with the Medi-Cal program, to provide coverage for BHT.[1] A report analyzing the initial draft of S.B. 946 determined that the coverage mandates would cost the State more than $50 million annually for Healthy Families and CalPERS enrollees alone.[2] Subsequent drafts of S.B. 946 excluded contracts with Healthy Families and CalPERS from its coverage mandates.[3] A Senate Appropriations Committee analysis found that because S.B. 946 "would exempt health plans and insurers that contract with Medi-Cal, Healthy Families, and CalPERS, there would be minimal costs to the state to pay for these mandated services."[4] The Assembly Appropriations Committee Bill analysis similarly noted that S.B. 946 would create "[m]inor, if any, state health care costs. This bill exempts health plans provided through Medi-Cal, Healthy Families program, and CalPERS from the coverage mandate."[5]

In November 2011, the DMHC informed some health care service plans that despite Section 1374.73(d), it believed that, pursuant to Health and Safety Code Section 1374.72, health care service plans should cover BHT for autism and pervasive developmental disorder for the Public Purchaser enrollees, though not Medi-Cal enrollees. Moreover, in or around March 2012, the DMHC confirmed with the California Association of Health Plans that it had begun an emergency rulemaking process to address its interpretation of S.B. 946 and Section 1374.72. Health care service plans have been awaiting the issuance of these emergency regulations.

It is our further understanding that Public Purchasers interpret Section 1374(d) differently than the DMHC's apparent interpretation. Health care service plans and Public Purchasers negotiate premium rates based on the totality of covered services. Therefore, inclusion or exclusion of a particular set of services will necessarily, and possibly materially, impact the premium. Accordingly, it is essential for health care service plans and Public Purchasers to have a meeting of the minds regarding the scope of contractually covered services. However, the current uncertainty and confusion precludes a

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[1] California State Senate Appropriations Committee Fiscal Summary, September 9, 2011, at p. 2.
[2] California Health Benefit Review Program, Analysis of Senate Bill TBD 1: Health Care Coverage: Autism, at 16, Table 1 (March 20, 2011).
[3] Fiscal Summary, *supra* note 1 ("... in addition to plans and insurers contracting with Medi-Cal, [S.B. 946] would exempt plans and insurers contracting with Healthy Families and CalPERS.").
[4] *Id.* at p. 3.
[5] California State Assembly Appropriations Committee Bill Analysis, September 8, 2011, at p. 2.

meeting of the minds about a sufficient and sustainable premium.

It is our further understanding that several Regional Centers assume that effective July 1, 2012, they will discontinue providing BHT to health care service plan enrollees and refer their clients, including Public Purchaser enrollees, to the health care service plan or insurer with whom a client is enrolled. The Regional Centers' anticipated plans exacerbate the current regulatory and contract uncertainty with respect to Public Purchasers and their enrollees and underscore the urgent need for clarifying regulations.

Based on the forgoing, Petitioner requests that DMHC complete its emergency rulemaking as soon as possible in light of the July 1, 2012 effective date of S.B. 946.

Promulgation of regulations will clarify Public Purchaser enrollees' expectations about their benefits and enable Public Purchaser enrollees to make informed plans and decisions about the needs of their children.

It will establish clear and fair guidance for all health care service plans as they complete their implementation in preparation for the July 1, 2012 effective date of S.B. 946.

It will enable health care service plans and Public Purchasers to agree on the scope of contractual coverage and enable negotiation of premiums appropriately reflecting the scope of coverage.

It will eliminate the uncertainty and confusion that does not serve anyone.

We respectfully await the DMHC's response.

Sincerely,

Jerry Fleming
Senior Vice President
Kaiser Foundation Health Plan, Inc.

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

TITLE 28, CALIFORNIA CODE OF REGULATIONS
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE
CHAPTER 2. HEALTH CARE SERVICE PLANS
ARTICLE 5.6. POINT OF SERVICE HEALTH CARE SERVICE PLANS

SECTION 1300.74.73 PERVASIVE DEVELOPMENTAL DISORDER AND AUTISM COVERAGE

INITIAL STATEMENT OF REASONS

Department Control No. 2012-3681

As required by Section 11346.2 of the Government Code, the Director of the Department of Managed Health Care ("Department") sets forth below the reasons for the proposed adoption of section 1300.74.73 to Title 28 of the California Code of Regulations.

AUTHORITY:

California Health and Safety Code Section 1344 authorizes the Director to adopt, amend and rescind regulations as necessary to carry out the provisions of the Knox-Keene Act, including rules governing applications and reports, and defining any terms, whether or not used in the Knox-Keene Act, insofar as the definitions are not inconsistent with the provisions of the Knox-Keene Act. Furthermore, the Director may waive any requirement of any rule or form in situations where in the Director's discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to the Knox-Keene Act.

Health and Safety Code Section 1345 requires health care services to be furnished by professionals, organizations, health facilities, or other persons or institutions licensed by the State to deliver or furnish health care services.

Health and Safety Code Section 1367 lays out the general requirements that must be met by health plans under the Knox-Keene Act, including the requirement that a health plan provide enrollees with medically necessary basic health care services and access to an adequate provider network.

Health and Safety Code Section 1374.72 requires health plans to provide coverage for diagnosis and medically necessary treatment of specified mental health conditions, including PDD and autism, under the same terms and conditions that are applied to physical health conditions. Health and Safety Code Section 1374.72 requires all full-

service[1] health plan contracts to "provide coverage for the diagnosis and medically necessary treatment of severe mental illness [SMI] of a person of any age, and of serious emotional disturbances of a child." SMI is specifically defined to include PDD and autism.

Health and Safety Code Section 1374.73 (Senate Bill 946 (Steinberg), Chapter 650, Statutes of 2011) ("SB 946") allows health plans to provide medically necessary BHT, including ABA, to individuals with autism and PDD, beginning July 1, 2012, by non-licensed professionals in compliance with detailed criteria set forth in the statute. Health and Safety Code Section 1374.73 states that its provisions do not apply to Healthy Families enrollees and the California Public Employees Retirement System ("CalPERS") members, it also specifically states that it does not affect, reduce, or limit the health plans' obligations to cover medically necessary treatment, including BHT, under existing mental health parity law, Health and Safety Code Section 1374.72.

NECESSITY

The Department has determined the adoption of this regulation is necessary in order to clarify and make specific the uniform and timely application of the laws related to health plan coverage of medically necessary PDD and autism related services, and to implement, interpret and make specific certain provisions of SB 946 and existing law under the Knox-Keene Act.

SPECIFIC PURPOSE AND NECESSITY OF THE REGULATION

Subsection (a)(1) of proposed section 1300.74.73 is necessary to clarify that health plans continue to be required to provide coverage for the diagnosis and medically necessary treatment of PDD and autism, including BHT, for Healthy Families enrollees and CalPERS members after July 1, 2012. This proposed subsection is necessary to prevent Healthy Families enrollees and CalPERS members from experiencing disruptions and/or delays in accessing medically necessary mental health services, including ABA therapy, due to health plans' misinterpretation that after July 1, 2012 they were no longer required to provide BHT services to Healthy Families enrollees and CalPERS members under the existing mental health parity law.

Subsection (a)(2) is necessary to clarify that health plans cover health care services, including BHT and ABA, that are medically necessary and health plans may perform utilization review of requested health care services to ensure that the services are medically necessary.

Subsection (a)(3) is necessary to implement the requirements of the Knox-Keene Act that health plans subject to the requirements of SB 946 establish and maintain an adequate network of qualified autism service providers, professionals and paraprofessionals that are capable of providing medically necessary BHT, including ABA therapy, to health

[1] A full-service health plan is a health plan that offers all basic health care services as required by the Knox-Keene Act.

plan enrollees. In order for a health plan to demonstrate that it has created an adequate network, a one-time reporting requirement is contained in this subsection. It requires health plans subject to the requirements of SB 946 to compile information about the composition of their network for providing BHT, including ABA services. Subsections (a)(3)(A) and (a)(3)(B) require that health plans subject to the requirements of SB 946 submit information that includes data regarding the number and geographical location of their qualified autism service provider organizations or groups, qualified autism service providers (individual), qualified autism service professionals and qualified autism service paraprofessionals. Subsection (a)(3)(C) requires health plans subject to the requirements of SB 946 to report how they determined the adequacy of their network to ensure that enrollees have geographic accessibility and timely access to medically necessary BHT, including ABA therapy. Subsection (a)(3)(D) requires that health plans subject to the requirements of SB 946 submit additional information requested by the Director of the Department to determine whether health plan enrollees are receiving timely access to medically necessary BHT, including ABA therapy.

DOCUMENTS CONSIDERED

The Department considered the following documents:

1. California Health and Safety Code Sections 1344, 1345, 1351, 1367, 1374.72 and 1374.73;

2. California Code of Regulations, Title 28, sections 1300.74.72, 1300.67.2, 1300.67.2.1, 1300.67.2.2, 1300.45, and 1300.74.30;

3. California Health Benefits Review Program, "Appendix 20: Existing Mandates in California Law," (2009) at: http://www.chbrp.org/documents/sb1704/ap_20.pdf;

4. Healthline, Connect to Better Health, "Behavorial Therapy," Paula Ford-Martin, the Gale Group, Inc., at: http://www.healthline.com/galecontent/behavioral-therapy;

5. The National Autism Center's National Standards Project, "Findings and Conclusions," (2009) at: http://www.nationalautismcenter.org/pdf/NAC%20Findings%20&%20Conclusions.pdf;

6. Official Journal of the American Academy of Pediatrics, Geraldine Dawson et al, "Randomized, Controlled Trial of an Intervention for Toddlers with Autism: The Early Start Denver Model", *Pediatrics*, Vol. 125, No. 1 (Nov. 30, 2009) at: http://pediatrics.aappublications.org/content/125/1/e17.full.html;

7. Pringle BA, Colpe LJ, Blumberg SJ, Avila RM, Kogan MD, "Diagnostic history and treatment of school-aged children with autism spectrum disorder and special

health care needs," NCHS Data Brief, No. 97. Hyattsville, MD: National Center for Health Statistics, 2012;

8. Centers for Disease Control and Prevention, FACTS, "Facts about ASD," Last Updated March 29, 2012, at: http://www.cdc.gov/ncbddd/autism/facts.html#3;

9. Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly*, "Prevalence of Autism Spectrum Disorders – Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2008," (Mar. 30, 2012) at: http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6103a1.htm?s_cid=ss6103a1_w

10. The California Managed Risk Medical Insurance Board, "Healthy Families Program," (April 2012 Summary) at: http://www.mrmib.ca.gov/mrmib/HFP/Apr_12/HFPRptSum.pdf;

11. Disability Rights California, "Rights Under the Lanterman Act: Regional Center Services for People with Developmental Disabilities," Publication #5063.01, Copyright ©1983, Revised Edition 2012;

12. State of California, Department of Developmental Services, "Regional Center 2012 May Revision for Fiscal Years 2011-12 *and* 2012-13," May 14, 2012;

13. State of California, Health and Human Services Agency, Department of Health Care Services, "Transition Plan, Transfer of Medi-Cal Related Specialty Mental Health Services from the Department of Mental Health to the Department of Health Care Services, effective July 1, 2012," Submitted by the Department of Health Care Services in Partial Fulfillment of Requirements of Assembly Bill 102, (Chapter 29, Statutes of 2011), October 1, 2011;

14. The Lanterman Developmental Services Act, California Welfare and Institutions Code Sections 4500 et seq.;

15. Business and Professions Code Section 2052;

16. The California Legislative Blue Ribbon Commission on Autism Report, "An Opportunity to Achieve Real Change for Californians with Autism Spectrum Disorders," September 2007;

17. The California Legislative Blue Ribbon Commission on Autism, "A Comprehensive Service System for Adults with Autism Spectrum Disorders," September 2006;

18. Sen. Bill No. 946 (2011-2012 Reg. Sess.) § 1;

19. Sen. Amend. to Sen. Bill No. 946 (2011-2012 Reg. Sess.), May 10, 2011;

20. Assem. Amend. to Sen. Bill No. 946 (2011-2012 Reg. Sess.), September 2, 2011;

21. Assem. Amend. to Sen. Bill No. 946 (2011-2012 Reg. Sess.), September 6, 2011;

22. Assem. Amend. to Sen. Bill No. 946 (2011-2012 Reg. Sess.), September 9, 2011;

23. Sen. Bill No. 946 (Steinberg), Approved by the Governor Oct. 9, 2011, Chap. 650, Stats. of 2011;

24. Sen. Health Com., Analysis of Sen. Bill No. 946 (2011-2012 Reg. Sess.), as introduced Mar. 31, 2011 (Hearing Date May 4, 2011);

25. Sen. Rules Com., Off. of Senate Floor Analysis, 3d reading analysis of Sen. Bill No. 946, (2011-2012 Reg. Sess.), as Amend. May 10, 2011;

26. Assem. Health Com., Hearing on Sen. Bill 946 (2011-2012 Reg. Sess.), as amend. Sep. 6, 2011 (Hearing Date Sep. 7, 2011);

27. Assem. Com. on Appropriations, Hearing on Sen. Bill No. 946 (2011-2012 Reg. Sess.), as amend. Sep. 6, 2011 (Hearing Date Sep. 8, 2011);

28. Sen. Com. on Appropriations, Hearing on Sen. Bill 946 (2011-2012 Reg. Sess.), as amend. Sep. 9, 2011 (Hearing Date Sep. 9, 2011);

29. Sen. Rules Com., Unfinished Business Sen. Bill No. 946 (2011-2012 Reg. Sess.), as amend. Sep. 8, 2011;

30. California Health Benefits Review Program, "Executive Summary Analysis of Senate Bill TBD 1: Autism," A Report to the California State Legislature, March 20, 2011;

31. California Health Benefits Review Program, "Letter to Assembly Member Monning and Senator Hernandez re: the August 16, 2011 amended version of Senate Bill 770," August 24, 2011;

32. Assem. Amend. to Sen. Bill No. 770 (2011-2012 Reg. Sess.), August 16, 2011;

33. Assem. Amend. to Sen. Bill No. 770 (2011-2012 Reg. Sess.), August 31, 2011;

34. Assem. Com. on Appropriations, Hearing on Sen. Bill No. 770 (2011-2012 Reg. Sess.), as amend. Aug. 16, 2011;

35. Sen. Amend. to Sen. Bill No. 166 (2011-2012 Reg. Sess.), April 4, 2011; and,

36. Sen. Health Com., Analysis of Sen. Bill No. 166 (2011-2012 Reg. Sess.), as amended Apr. 4, 2011 (Hearing Date April 27, 2011).

37. December 7, 2011, Letter from Marcy C. St. John, Associate General Counsel, Blue Shield of California, to Brent Barnhart, Director of the Department of Managed Health Care: "Re: Enforcement Matters 10-560, 10-561, 11-022, 11-038, 11-039, 11-262, Settlement Agreement of July 1, 2011."

38. April 26, 2012, Letter from Andrew Russell, Associate General Counsel, Anthem Blue Cross, to Brent Barnhart, Director of the Department of Managed Health Care, "Re: Notice Pursuant to Settlement Agreement."

39. February 27, 2012, Letter from Marcy C. St. John, Associate General Counsel, Blue Shield of California, to Brent Barnhart, Director of the Department of Managed Health Care: "Re: Enforcement Matters 10-560, 10-561, 11-022, 11-038, 11-039, 11-262, Settlement Agreement of July 1, 2011."

40. June 27, 2012, Letter from Jerry Fleming, Senior Vice President, Kaiser Permanente, to Brent Barnhart, Director of the Department of Managed Health Care: "Re: Petition Requesting Initiation of Formal Rulemaking and Promulgating of Regulation."

ECONOMIC IMPACT

The Department has determined the regulation will not have a significant statewide adverse economic impact directly affecting businesses. Existing State law, Health and Safety Code Section 1374.72, requires that health plans provide medically necessary treatment under mental health parity, including medically necessary treatment for PDD and autism. Further, existing State law, Health and Safety Code Section 1374.73, requires that health plans have an adequate network of autism providers, professionals and paraprofessionals to provide medically necessary BHT and ABA to enrollees with PDD and autism. The clarification of the requirements under existing laws will not create a significant, statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

REASONABLE ALTERNATIVES

The Department will consider all reasonable alternatives submitted by members of the public through the comment period.

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE
TITLE 28, CALIFORNIA CODE OF REGULATIONS
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE
CHAPTER 2. HEALTH CARE SERVICE PLANS
ARTICLE 5.6. POINT OF SERVICE HEALTH CARE SERVICE PLANS

Control Number: 2012-3681

Add new section 1300.74.73 as follows:

Section 1300.74.73. Pervasive Developmental Disorder and Autism Coverage

Health plans subject to Section 1374.73 of the Act shall comply with this section.

(a) Requirements

(1) For health plans that provide hospital, medical or surgical coverage under contract with the Healthy Families Program or the Board of Administration of the California Public Employees' Retirement System, section 1374.73 of the Act does not affect, reduce or limit the obligation to provide coverage for the diagnosis and medically necessary treatment of pervasive developmental disorder (PDD) and autism, including medically necessary behavioral health treatment, pursuant to Health and Safety Code section 1374.72.

(2) Nothing in subdivision (a)(1) of this section shall be construed to mandate coverage of services that are not medically necessary or preclude a plan from performing utilization review in accordance with the Act.

(3) Each health plan that is subject to the requirements of section 1374.73 of the Act shall submit a report to the Department no later than December 31, 2012, demonstrating that the health plan has an adequate network of qualified autism service providers, qualified autism service professionals and/or qualified autism service paraprofessionals. The required report shall include the following information:

(A) The name of each qualified autism service provider entity or organization/group, listed by county and zip code. For each identified qualified autism service provider entity or organization/group, state the following information:

1. The number of individual qualified autism service providers available to the entity or organization/group;

2. The number of qualified autism service professionals available to the entity or organization/group; and,

3. The number of qualified autism service paraprofessionals available to the entity or organization/group.

(B) The number of the health plan's individual qualified autism service providers, listed by county and zip code. For each qualified autism service provider identified, state the following information:

1. The number of qualified autism service professionals available to the qualified autism service provider pursuant to Health and Safety Code section 1374.73(c)(4)(B); and,

2. The number of qualified autism service paraprofessionals available to the qualified autism service provider pursuant to Health and Safety Code section 1374.73(c)(5)(A).

(C) A description of how the health plan is determining provider network adequacy, including how geographic accessibility and timely access for health plan enrollees to medically necessary PDD and autism health care services is being met. This information should include:

1. Data describing the adequacy of the health plan's provider network for each region or service area, including utilization data and information on the health plan's enrollee population, such as age, gender and other relevant factors used by the health plan; and,

2. A description of the health plan's system for monitoring and evaluating provider network adequacy in each region or service area.

(D) Upon request, the health plan shall submit within 30 calendar days any additional information the Director may request to determine the adequacy of the plan's network to ensure that health plan enrollees are receiving medically necessary PDD and autism health care services, including timely screening, diagnosis, evaluation and treatment.

Note: Authority Cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1367, 1374.72 and 1374.73, Health and Safety Code.

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT

(REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2008)

See SAM Section 6601 - 6616 for Instructions and Code Citations

DEPARTMENT NAME	CONTACT PERSON	TELEPHONE NUMBER
Managed Health Care	Jennifer Willis	916-324-9014
DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400		NOTICE FILE NUMBER
Pervasive Developmental Disorder and Autism Coverage		Z

ECONOMIC IMPACT STATEMENT

A. ESTIMATED PRIVATE SECTOR COST IMPACTS (Include calculations and assumptions in the rulemaking record.)

1. Check the appropriate box(es) below to indicate whether this regulation:

- ☐ a. Impacts businesses and/or employees
- ☐ b. Impacts small businesses
- ☐ c. Impacts jobs or occupations
- ☐ d. Impacts California competitiveness
- ☐ e. Imposes reporting requirements
- ☐ f. Imposes prescriptive instead of performance
- ☐ g. Impacts individuals
- ☑ h. None of the above (Explain below. Complete the Fiscal Impact Statement as appropriate.)

h. (cont.) _____

(If any box in Items 1 a through g is checked, complete this Economic Impact Statement.)

2. Enter the total number of businesses impacted: _____ Describe the types of businesses (Include nonprofits.): _____

Enter the number or percentage of total businesses impacted that are small businesses: _____

3. Enter the number of businesses that will be created: _____ eliminated: _____

Explain: _____

4. Indicate the geographic extent of impacts: ☐ Statewide ☐ Local or regional (List areas.): _____

5. Enter the number of jobs created: _____ or eliminated: _____ Describe the types of jobs or occupations impacted: _____

6. Will the regulation affect the ability of California businesses to compete with other states by making it more costly to produce goods or services here?

☐ Yes ☐ No If yes, explain briefly: _____

B. ESTIMATED COSTS (Include calculations and assumptions in the rulemaking record.)

1. What are the total statewide dollar costs that businesses and individuals may incur to comply with this regulation over its lifetime? $ _____

a. Initial costs for a small business: $ _____ Annual ongoing costs: $ _____ Years: _____

b. Initial costs for a typical business: $ _____ Annual ongoing costs: $ _____ Years: _____

c. Initial costs for an individual: $ _____ Annual ongoing costs: $ _____ Years: _____

d. Describe other economic costs that may occur: _____

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

2. If multiple industries are impacted, enter the share of total costs for each industry: _____

3. If the regulation imposes reporting requirements, enter the annual costs a typical business may incur to comply with these requirements. (Include the dollar costs to do programming, record keeping, reporting, and other paperwork, whether or not the paperwork must be submitted.): $ _____

4. Will this regulation directly impact housing costs? ☐ Yes ☐ No If yes, enter the annual dollar cost per housing unit: _____ and the number of units: _____

5. Are there comparable Federal regulations? ☐ Yes ☐ No Explain the need for State regulation given the existence or absence of Federal regulations: _____

Enter any additional costs to businesses and/or individuals that may be due to State - Federal differences: $ _____

C. ESTIMATED BENEFITS (Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.)

1. Briefly summarize the benefits that may result from this regulation and who will benefit: _____

2. Are the benefits the result of: ☐ specific statutory requirements, or ☐ goals developed by the agency based on broad statutory authority?
Explain: _____

3. What are the total statewide benefits from this regulation over its lifetime? $ _____

D. ALTERNATIVES TO THE REGULATION (Include calculations and assumptions in the rulemaking record. Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.)

1. List alternatives considered and describe them below. If no alternatives were considered, explain why not: There is no reasonable alternative to the proposed emergency regulation.

2. Summarize the total statewide costs and benefits from this regulation and each alternative considered:

Regulation:	Benefit: $_____	Cost: $_____
Alternative 1:	Benefit: $_____	Cost: $_____
Alternative 2:	Benefit: $_____	Cost: $_____

3. Briefly discuss any quantification issues that are relevant to a comparison of estimated costs and benefits for this regulation or alternatives: _____

4. Rulemaking law requires agencies to consider performance standards as an alternative, if a regulation mandates the use of specific technologies or equipment, or prescribes specific actions or procedures. Were performance standards considered to lower compliance costs? ☐ Yes ☐ No
Explain: _____

E. MAJOR REGULATIONS (Include calculations and assumptions in the rulemaking record.) Cal/EPA boards, offices, and departments are subject to the following additional requirements per Health and Safety Code section 57005.

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

1. Will the estimated costs of this regulation to California business enterprises exceed $10 million ? ☐ Yes ☐ No (If No, skip the rest of this section.)

2. Briefly describe each equally as an effective alternative, or combination of alternatives, for which a cost-effectiveness analysis was performed:

   Alternative 1: _____

   Alternative 2: _____

3. For the regulation, and each alternative just described, enter the estimated total cost and overall cost-effectiveness ratio:

   Regulation: $_____ Cost-effectiveness ratio: $ _____

   Alternative 1: $_____ Cost-effectiveness ratio: $ _____

   Alternative 2: $_____ Cost-effectiveness ratio: $ _____

FISCAL IMPACT STATEMENT

A. FISCAL EFFECT ON LOCAL GOVERNMENT (Indicate appropriate boxes1 through 6 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year which are reimbursable by the State pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code. Funding for this reimbursement:

   ☐ a. is provided in _____, Budget Act of _____ or Chapter _____, Statutes of _____

   ☐ b. will be requested in the _____ (FISCAL YEAR) Governor's Budget for appropriation in Budget Act of _____

☐ 2. Additional expenditures of approximately $ _____ in the current State Fiscal Year which are not reimbursable by the State pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code because this regulation:

   ☐ a. implements the Federal mandate contained in _____

   ☐ b. implements the court mandate set forth by the _____

   court in the case of _____ vs. _____

   ☐ c. implements a mandate of the people of this State expressed in their approval of Proposition No. _____ at the _____ (DATE) election;

   ☐ d. is issued only in response to a specific request from the _____

   _____, which is/are the only local entity(s) affected;

   ☐ e. will be fully financed from the _____ (FEES, REVENUE, ETC.) authorized by Section

   _____ of the _____ Code;

   ☐ f. provides for savings to each affected unit of local government which will, at a minimum, offset any additional costs to each such unit;

   ☐ g. creates, eliminates, or changes the penalty for a new crime or infraction contained in _____

☐ 3. Savings of approximately $_____ annually.

☐ 4. No additional costs or savings because this regulation makes only technical, non-substantive or clarifying changes to current law regulations.

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

☑ 5. No fiscal impact exists because this regulation does not affect any local entity or program.

☐ 6. Other.

B. FISCAL EFFECT ON STATE GOVERNMENT (Indicate appropriate boxes 1 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year. It is anticipated that State agencies will:

☐ a. be able to absorb these additional costs within their existing budgets and resources.

☐ b. request an increase in the currently authorized budget level for the _____ fiscal year.

☐ 2. Savings of approximately $ _____ in the current State Fiscal Year.

☐ 3. No fiscal impact exists because this regulation does not affect any State agency or program.

☑ 4. Other. See Attachment

C. FISCAL EFFECT ON FEDERAL FUNDING OF STATE PROGRAMS (Indicate appropriate boxes1 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year.

☐ 2. Savings of of approximately $ _____ in the current State Fiscal Year.

☑ 3. No fiscal impact exists because this regulation does not affect any federally funded State agency or program.

☐ 4. Other.

FISCAL OFFICER SIGNATURE ☒		DATE 7/17/12
AGENCY SECRETARY[1] APPROVAL/CONCURRENCE	☒	DATE 7/17/12
DEPARTMENT OF FINANCE[2] APPROVAL/CONCURRENCE	PROGRAM BUDGET MANAGER ☒	DATE

1. *The signature attests that the agency has completed the STD.399 according to the instructions in SAM sections 6601-6616, and understands the impacts of the proposed rulemaking. State boards, offices, or department not under an Agency Secretary must have the form signed by the highest ranking official in the organization.*

2. *Finance approval and signature is required when SAM sections 6601-6616 require completion of Fiscal Impact Statement in the STD.399.*

ATTACHMENT TO FORM 399 ECONOMIC AND FISCAL IMPACT STATEMENT

DEPARTMENT OF MANAGED HEALTH CARE

Rulemaking Action: Pervasive Development Disorder and Autism Coverage
DMHC Control No. 2012-3681

Form 399, Fiscal Impact Statement, Section B, "Fiscal Effect on State Government," (explanation supporting statement of fiscal savings)

The Department of Developmental Services (DDS) states in the May 2012 Revised Budget that there will be an anticipated savings of $69.4 million to the General Fund resulting from the implementation of SB 946, because health plans are now authorized as a result of this bill to provide medically necessary behavioral health treatments, including applied behavior analysis, through non-licensed professionals and paraprofessionals that meet certain specified criteria. These savings stem from a DDS assumption that certain medically necessary behavioral services that health plans previously refused to cover and pay for because they were provided by non-licensed individuals will now be available through private health insurance coverage.

NAME AND ADRESS OF SENDER

JOHN A. CLARKE
EXECUTIVE OFFICER/CLERK OF THE SUPERIOR COURT
111 NORTH HILL STREET
APPEAL/TRANSCRIPT UNIT, ROOM 111A
LOS ANGELES, CA 90012
Tel. (213) 974 – 5237 Fax (213) 626 - 6651

FILED
LOS ANGELES SUPERIOR COURT
APR 15 2011
JOHN A. CLARKE, CLERK
BY C. KHALIL, DEPUTY

SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES

Consumer Watchdog, et al.,

Plaintiff(s),

vs.

California Dept. Of Managed Health Care, et al.,

Defendant(s).

CASE NUMBER
BS 121397

NOTICE TO ATTORNEY IN RE NOTICE OF APPEAL

Fredric D. Woocher
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Sacramento, CA 95814

In compliance with California Rules of Court 8.100(e), this is to inform you that Notice of ☒ Appeal ☐ Cross-Appeal in the above matter was filed on April 14, 2011 by F. Woocher.

JOHN A. CLARKE, Executive Officer,
Clerk of the Superior Court of California,
County of Los Angeles

DATE: April 15, 2011

BY: _____, Deputy
C. KHALIL

CERTIFICATE OF MAILING

STATE OF CALIFORNIA, County of Los Angeles.

I, JOHN A. CLARKE, Executive Officer of the Superior Court of the State of California for the County of Los Angeles, do hereby certify that true copies of Notice to Attorney in re Notice of Appeal, the original of which appears above, was on this date mailed to the person(s) whose name(s) appear herein above, addressed as therein shown, by depositing same in a sealed envelope with postage thereon fully prepaid, in the United States Post Office mail box at Los Angeles, California.

JOHN A. CLARKE, Executive Officer,
Clerk of the Superior Court of California,
County of Los Angeles

DATE: April 15, 2011

BY: _____, Deputy
C. KHALIL

For information in unlimited civil appeals, go to courtinfo.ca.gov/forms/documents/app001.pdf

PROOF OF SERVICE

STATE OF CALIFORNIA
COUNTY OF LOS ANGELES

Re: *Consumer Watchdog et al. v. California Department of Managed Health Care et al.*, 2nd Civ. No. B232338, (L.A.S.C. Case No. BS121397)

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action. My business address is 10940 Wilshire Boulevard, Suite 2000, Los Angeles, California 90024.

On **December 28, 2012,** I served the foregoing document(s) described as **LETTER BRIEF TO THE COURT OF APPEAL DATED DECEMBER 28, 2012** on all appropriate parties in this action, by the method stated.

Debra L. Denton Drew A. Brereton California Dept. of Managed Health Care 980 Ninth Street, Suite 500 Sacramento, CA 95814 Tel: (916) 323-0435 Fax: (916) 323-0438 E-mail: dbrereton@dmhc.ca.gov *Attorneys for Defendants, Respondents and Cross-Appellants*	Carmen D. Snuggs Janet Burns Deputy Attorneys General Office of the Attorney General 300 S. Spring Street, Suite 1700 Los Angeles, CA 90013 Tel: (213) 897-2450 Fax: (213) 897-2805 *Attorneys for Defendants, Respondents and Cross-Appellants*
Clerk, Department 85 Los Angeles Superior Court 111 N. Hill Street Los Angeles, CA 90012	

☒ If U.S. Mail service is indicated, by placing this date for collection for mailing true copies in sealed envelopes, first-class postage prepaid, addressed to each person as indicated, pursuant to Code of Civil Procedure section 1013a(3). I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice, it would be deposited with the U.S. Postal Service on that same day with postage thereon fully prepaid at Los Angeles, California, in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing contained in the affidavit.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct. Executed on **December 28, 2012,** at Los Angeles, California.

LaKeitha Oliver