



# **Autism Advisory Task Force**

**Report to the Governor of California and the  
California State Legislature**

**February 21, 2013**

**Submitted by the California Department of Managed Health Care in  
Fulfillment of the Requirements of  
Senate Bill 946 (Chapter 650, Statutes 2011), Health and Safety Code  
section 1374.74(c)**

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STATE OF CALIFORNIA  
DEPARTMENT OF MANAGED HEALTH CARE

February 21, 2013

The Honorable Edmund G. Brown, Jr.  
Governor  
Office of the Governor  
c/o State Capitol, Suite 1173  
Sacramento, CA 95814

The Honorable Darrell Steinberg  
President pro Tempore  
California State Senate  
State Capitol, Room 205  
Sacramento, CA 95814

The Honorable John Perez  
Speaker of the Assembly  
California State Assembly  
State Capitol, Room 219  
Sacramento, CA 95814

The Honorable Ed Hernandez, D.O.  
Chair, Health Committee  
California State Senate  
State Capitol, Room 2191  
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The Honorable Bill Monning  
Chair, Health Committee  
California State Assembly  
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The Honorable Tony Strickland  
Vice Chair, Health Committee  
California State Senate  
State Capitol, Room 4062  
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The Honorable Dan Logue  
Vice Chair, Health Committee  
California State Assembly  
State Capitol, Room 4158  
Sacramento, CA 95814

RE: Report of the Autism Advisory Task Force

Dear Sirs:

The Department of Managed Health Care (DMHC) is pleased to present this Report of the Autism Advisory Task Force which was created from legislation authored by Senator Darrell Steinberg, SB 946 (Chapter 650, Statutes of 2011). The bill directed the Task Force to develop recommendations concerning medically necessary behavioral health treatment for individuals with autism, provider qualifications and training, and requirements that unlicensed individuals providing behavioral health treatment should meet in order to obtain licensure from the State. The report, which contains the recommendations that were created and approved by members of the Task Force, is the work product of the Task Force.

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In selecting individuals to serve on the Task Force, the DMHC sought a broad cross-section of experts and people of sound judgment that included researchers, providers, health plan medical directors, and advocates for individuals with autism, as well as individuals with expertise and experience in fields unrelated to autism. From an initial pool of more than 100 individuals, the DMHC selected 18 to participate. Task Force members were asked to look beyond the immediate implementation of SB 946 to provide a longer view about how best to create a sustainable system in California that considered the needs of consumers, families, providers, insurers and health plans.

The DMHC retained Leading Resources, Inc. (LRI) to facilitate the Task Force's discussions and development of these recommendations. LRI conducted ten all day, in-person meetings in Sacramento throughout 2012 and 38 work group meetings by phone.

Task Force members gave freely of their time, in most cases travelling long distances to participate in person at Task Force meetings. Between meetings, Task Force members spent significant time and effort addressing intensely thorny and intellectually-challenging issues. By design, the members came to the Task Force from significantly different perspectives. However, through the many hours of working together, they recognized their mutual commitment to addressing the serious needs of individuals with autism, and came together to develop very thoughtful recommendations contained in this report. Task Force members achieved consensus on 54 out of 55 recommendations. Only one recommendation required approval by majority vote.

The recommendations address the specific issues mandated by SB 946, plus care coordination, parent participation, health plan policies, consumer safety and practice guidelines.

Throughout the year I was repeatedly impressed with the members' dedicated service and their determination to produce thoughtful recommendations on how to improve services to individuals with autism. I also want to thank the facilitator, LRI, an invaluable partner, for their outstanding contribution to the process of conducting Task Force meetings and workgroups, successfully engaging us in meeting the intellectual challenges and continuously refining these recommendations

Sincerely,



Brent A. Barnhart, Director  
Department of Managed Health Care

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## EXECUTIVE SUMMARY

Senate Bill 946 (SB 946) (Chapter 650, Statutes 2011), was signed into law by Governor Edmund G. Brown, Jr. on October 9, 2011. SB 946 imposes a temporary set of rules regarding behavioral health treatment (BHT) that health plans<sup>1</sup> and health insurers<sup>2</sup> in California must cover for individuals with autism and pervasive developmental disorder (PDD) between July 1, 2012 and July 1, 2014. The bill also identifies the required qualifications of individuals who provide BHT, and permits individuals who are not licensed by the state to provide BHT, as long as the detailed criteria set forth in the bill are met. SB 946 becomes inoperative on July 1, 2014, and will be repealed as of January 1, 2015, unless extended by another statute.

SB 946 also required the California Department of Managed Health Care (DMHC) to convene an Autism Advisory Task Force<sup>3</sup> (Task Force) by February 1, 2012, to develop recommendations regarding medically necessary BHT for individuals with autism or PDD, as well as the appropriate qualifications, training and supervision for providers of such treatment. The bill also required the Task Force to develop recommendations regarding the education, training, and experience requirements that unlicensed individuals providing BHT must meet in order to obtain licensure from the state.

The Task Force consisted of 18 members. In order to ensure a broad base of special knowledge, expertise, and balance of perspectives among Task Force members, members included research experts, treating providers, health plan representatives, consumer advocates, and members-at-large, many of who were also the parents of individuals with autism or PDD.<sup>4</sup> It was recognized from the start that the work of the Task Force would not be an easy undertaking. However, the DMHC and its facilitator, Leading Resources, Inc., approached the Task Force with the goal of achieving consensus wherever possible. Drawing upon Task Force members' considerable knowledge, skills, and experience, as well as their common desire to ensure appropriate treatment, provided by qualified providers, for individuals with autism and PDD, the Task Force reached consensus on 54 of 55 recommendations and approved one recommendation by a vote of the majority.<sup>5</sup>

It should be noted that while the Task Force was chaired by the Director of the DMHC, the Chair was, by design, not a voting member nor did he try to influence the specific recommendations of the Task Force. Rather, the Chair's role was to ensure the integrity of the process and to serve as a sounding board for the facilitators.

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<sup>1</sup> The California Department of Managed Health Care (DMHC) is the state organization responsible for regulating health care service plans, which offer a wide variety of health care products, including full-service managed care, and other types of products.

<sup>2</sup> The California Department of Insurance (CDI) is the state organization responsible for regulating the business of insurance companies, agents, and brokers in California.

<sup>3</sup> Section 1374.74, which was added to the California Health and Safety Code by SB 946, requires the DMHC to convene the Autism Advisory Task Force in consultation with the CDI, and in collaboration with other agencies, departments, advocates, autism experts, health plan and health insurer representatives, and other entities and stakeholders that it deems appropriate.

<sup>4</sup> "Members-at-large" are individuals who have expertise and experience in non-healthcare related fields and who bring an "outside" (or unaligned) perspective to the discussion and development of recommendations.

<sup>5</sup> One recommendation was approved by a vote of the majority. See Guideline 11 discussed in Part II, Section III of this report.

This report, which contains the recommendations that were created and approved by the Task Force, is the work product of the Task Force. These recommendations are intended to inform state policymakers and guide future state legislation.

## **Recommendations**

SB 946 stated that the Task Force should address the following:

1. Interventions that have been scientifically validated and have demonstrated clinical efficacy.
2. Interventions that have measureable treatment outcomes.
3. Patient selection, monitoring and duration of therapy.
4. Qualifications, training, and supervision of providers.
5. Adequate networks of providers.
6. The education, training, and experience requirements that unlicensed individuals providing autism services shall meet in order to secure a license from the state.

Part II of this report contains the Task Force's recommendations.

**Part II, Section II** contains recommended guidelines with regard to BHT that is medically necessary for the treatment of individuals with autism. The guidelines address scientific evidence, validation and expert opinion; patient screening and diagnosis; treatment authorization, prescription, planning and monitoring; care coordination; family education; and monitoring and duration.

A guiding principle of the Task Force was that every individual with autism or PDD is unique. Individuals have different combinations of characteristics, different needs for assistance, and respond differently to treatment. Therefore, behavioral health interventions need to be highly individualized. Since treatment selection should be made by a team of individuals who can consider the unique needs and history of the individual with autism or PDD, the Task Force determined that it would not be informative to state policy makers to merely develop a list of BHTs that are determined to be effective, based solely on current scientific literature. Since scientific research and findings naturally advance, the Task Force determined that the choice of BHTs should be grounded in scientific evidence, clinical practice guidelines, and/or evidence-based practice.

**Part II, Section III** contains the Task Force's recommended guidelines for the qualifications, training, education, and supervision of providers who treat individuals with autism, including diagnosticians, prescribers, treatment plan developers, and front-line providers whether or not they are licensed or certified.

In developing these recommendations, the Task Force focused on the critical role BHT providers play in the selection of treatments and in ensuring that appropriate treatment plans are developed and implemented correctly, are effective, and do no harm to the individual with autism or PDD. Consequently, the Task Force defined the functions of each provider involved in the continuum of care, from initial screening through treatment provision, and identified the qualifications of the persons performing those functions.

**Part II, Section IV** contains the Task Force's recommendations regarding the education, training, and experience requirements that unlicensed individuals providing autism services shall

meet in order to secure a license from the state. This section also addresses adequate networks of providers.

In developing these recommendations the Task Force balanced the need for ensuring consumer safety while not impeding access to providers of BHT. The Task Force concluded that all top level providers should be licensed by the state, and set forth a process for establishing a new professional license titled “Licensed Behavioral Health Practitioner.” Since the process for establishing a new professional license by a licensing board can take time, the Task Force recommended that the license requirement not take effect until 3 years after the new professional license is established and that an interim commission be formed to implement the new license until the relevant licensing board is able to do so. This new license is intended to expand, not supplant, the existing professional licenses discussed in the report. Furthermore, the Task Force recommends that all providers of autism services be registered with the state’s Trust Line Registry<sup>6</sup> or comparable system as conditions of employment by service organizations and contracting with health plans and health insurers.

In addition to addressing the specific requirements of SB 946, the Task Force made recommendations regarding care coordination, parent participation, health plan policies, consumer safety, and practice guidelines. These recommendations are found in **Part II, Section V** of the report.

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<sup>6</sup> This process involves being screened via a Live Scan fingerprint-based criminal background check against three databases (FBI, California Department of Justice, and the Child Abuse Index), as well as being subject by the California Department of Social Services to disciplinary action, including suspension and de-registration, for certain subsequent criminal convictions.



# **PART I: INTRODUCTION**

## **Overview, Task Force Goals, Task Force Composition, and Task Force Process**

## OVERVIEW

This report of the Autism Advisory Task Force is organized into four parts.

**Part I:** Introduction. This section includes:

1. This overview
2. The goals of the Task Force;
3. The composition of the Task Force;
4. The process used to reach Task Force decisions, including the Task Force operating principles and meeting schedule.

**Part II:** This section contains the recommendations of the Task Force.

**Part III:** This section contains an explanation of Task Force decisions regarding the recommendations.

**Part IV:** This section contains the Appendices and the following documents:

1. The Framework of recommendations adopted by the Task Force;
2. Task Force member biographies;
3. Minutes of Task Force meetings;
4. Presentations to the Task Force;
5. Written public comment received by the Task Force.

## TASK FORCE GOALS

(SB) 946 required the DMHC to establish an Autism Advisory Task Force. The bill stated:

“An Autism Advisory Task Force shall develop recommendations regarding behavioral health treatment that is medically necessary for the treatment of individuals with autism or pervasive developmental disorder, as well as the appropriate qualifications, training and education that providers who administer behavioral health treatment must have.”

SB 946 stated that the Autism Advisory Task Force should address the following:

1. Interventions that have been scientifically validated and have demonstrated clinical efficacy.
2. Interventions that have measurable treatment outcomes.
3. Patient selection, monitoring and duration of therapy.
4. Qualifications, training, and supervision of providers.
5. Adequate networks of providers.
6. Recommendations regarding the education, training and experience requirements that unlicensed individuals providing autism services shall meet in order to secure a license from the state.

The bill required the DMHC to submit a report of the Task Force to the Governor, the President pro Tempore of the Senate, the Speaker of the Assembly, and the Senate and Assembly Committees on Health by December 31, 2012, at which time the Task Force would cease to exist.

# TASK FORCE COMPOSITION

## Task Force Selection Process

Given the broad goals of the Task Force established by SB 946, it was imperative that the Task Force be comprised of a cross-section of stakeholders, including researchers, providers, advocates, and parents of individuals with autism, as well as experts and other individuals with special skills, knowledge or expertise in areas germane to the work of the Task Force.

In consultation with the California Health and Human Services Agency, the Department of Developmental Services, and the California Department of Insurance, the DMHC established parameters for Task Force representation to ensure such a broad base of special knowledge, expertise, and balance of perspectives. Categories of member representation included the following:

- **Research Experts** (three seats) – Individuals currently engaged in cutting-edge autism research.
- **Treating Providers** (three seats) – Private or public sector providers of behavioral interventions (including applied behavior analysis), pediatricians, and/or ancillary health care providers, such as occupational or speech therapists.
- **Health Plan Representatives** (three seats) – Representatives with medical backgrounds from full-service health plans and behavioral health plans.
- **Consumer Advocates and Parents of Individuals with Autism** (four seats) – Individuals who have a broad range of experience and familiarity with consumer concerns related to access to services to treat autism and activity across California, in other states, and on a federal level.
- **Members-at-Large** (four seats) – Individuals who have expertise and experience in non-health care related fields and who bring an “outside” (or unaligned) perspective.

The DMHC established the following primary selection criteria for membership on the Task Force:

- Demonstration of breadth and depth of expert knowledge and expertise related to behavioral health interventions for individuals with autism or pervasive developmental disorder. Priority was given to those whose experience reaches across the state and impacts a wide range of California’s stakeholders.
- Primary special knowledge and expertise as a researcher, treatment provider, health plan representative, consumer advocate/parent, or other non-health care perspective as it relates to the deliverables mandated by SB 946.
- Demonstration of intellectual curiosity, open-mindedness, and an ability to participate in collaborative decision-making.
- Agreement to comply with established operating principles and ground rules of the Task Force.

The DMHC sent letters of inquiry to over 100 stakeholders exploring their interest in participating on the Task Force. These stakeholders were asked to send the DMHC a copy of their resume or Curriculum Vitae. They were also asked to complete a Statement of Interest Form, describing why they were interested in participating on the Task Force, and the skills, knowledge, or expertise they had that would benefit the work of the Task Force.

The DMHC reviewed the written submissions received from interested applicants. Applicants' written submissions, the selection criteria, and the designated categories of member representation were considered in the selection of members to the Task Force. To ensure focus, promote meaningful dialogue, and reach consensus, the DMHC limited the size of the Task Force to 18 individuals. Consequently, many well-qualified individuals, dedicated to the issues before the Task Force, were not selected.

However, to ensure that the Task Force process was one of inclusion rather than exclusion, the DMHC made all Task Force meetings open to the public. This guaranteed that any interested person, group or organization had a chance to speak and be heard. All Task Force meeting information, including agendas, schedules, and informational materials were made available on the DMHC's website. Members of the public were able to attend the Task Force meetings in person or participate via phone by calling a toll-free phone number, and time was set aside during each meeting for public comment.

### **Task Force Members**

The Task Force consisted of the following 18 members, including the Director of the DMHC, who served as chair.<sup>7</sup> (See Appendix I for biographical descriptions of each member.)

1. Brent A. Barnhart, Director of the Department of Managed Health Care (Chair)
2. Rhonda Robinson Beale, M.D., Chief Medical Officer, United Behavioral Health
3. Gerald Caplan, former dean, University of Pacific, McGeorge School of Law
4. Florence Clark, Ph.D., Associate Dean, Division of Occupational Science and Occupational Therapy, Ostrow School of Dentistry, University of Southern California
5. Tim Gage, former Director, California Department of Finance
6. Martin E. Glasser, M.D., Chief Medical Officer, Human Affairs International/Blue Shield of California
7. Beth Gould, former Assistant Secretary, Health and Human Services Agency, State of California
8. Robert Hendren, D.O., Director of Child and Adolescent Psychiatry at the University of California, San Francisco (UCSF), Director of the Autism and Neurodevelopment Program, UCSF
9. Kristin Jacobson, Co-Founder and President, Autism Deserves Equal Coverage; Founding Member and Steering Committee Member, Alliance of California Autism Organizations; and State Policy Chair, Autism Speaks California
10. Areva D. Martin, Managing Partner of Martin & Martin, LLP
11. James McCracken, M.D., Director of the Division of Child and Adolescent Psychiatry at the UCLA NPI-Semel Institute (formerly the Neuropsychiatric Institute)
12. John Moulds, former Chief Magistrate Judge, Eastern District of California
13. Sheldon Orloff, M.D., Co-Director Early Disabilities Screening Program and Director Regional Center Review Committee, Kaiser Permanente Northern California
14. Rick Rollens, former Secretary of the California State Senate; Legislative Advisor to the Association of Regional Center Agencies
15. Bryna Siegel, Ph.D., Director of Autism Clinic, Langlely Porter Psychiatric Institute
16. Lorri Unumb, Director of State Government Affairs, Autism Speaks
17. Renee C. Wachtel, M.D., Medical Director, Medical Management and Rehabilitation Services, Inc.; Chairperson, Committee on Developmental and Behavioral Pediatrics, Northern California Chapter, American Academy of Pediatricians

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<sup>7</sup> The chair was a non-voting member.

18. John Youngbauer, Ph.D., Behavioral Services Supervisor at the North Los Angeles County Regional Center

## TASK FORCE PROCESS

The process of facilitating the Task Force was managed by Leading Resources Inc. (LRI), a California consulting firm.<sup>8</sup> The work of the Task Force was iterative in nature. The Task Force was asked to envision an effective system for treating individuals with autism – and to use that vision as the basis for its recommendations. It was asked to look beyond the immediate implementation of SB 946 to provide a longer view about how best to create a sustainable system in California that considered the needs of consumers, families, providers, insurers and health plans.

The initial in-person meetings consisted of presentations of data, small group exercises, and lively, full group discussions of issues. After each in-person meeting, work groups – composed of Task Force members and facilitated by LRI – convened telephonically and drafted language. That language was vetted and refined via group discussions and surveys of Task Force members.

Using data from the surveys, Task Force members identified areas of consensus, and debated and discussed topics where members were not yet in full consensus. Using this process iteratively, over the course of ten in-person meetings, 38 work group meetings, five surveys, and more than 20 different draft sets of recommendations, the Task Force succeeded in reaching full consensus on 54 out of 55 recommendations. One recommendation was approved by a vote of the majority.

It should be noted that while the Task Force was chaired by the Director of the DMHC, the Chair was, by design, not a voting member nor did he try to influence the specific recommendations. Rather, the chair's role was to ensure the integrity of the process and to serve as a sounding board for the facilitators.

A consistent decision-making process was used to adopt recommendations by the Task Force:

1. A quorum of the Task Force had to be present (either in person or by phone) in order to make decisions. A quorum equaled a majority of Task Force members (9 voting members).
2. The Task Force first heard the relevant data and information on a given topic.
3. The Task Force then generated relevant questions, issues, and perspectives on that topic.
4. Based on the discussions of the Task Force, work groups drafted proposals for the Task Force to consider relevant to that topic.
5. The Task Force heard and discussed the draft proposals in the order presented to them by the chair or facilitator.
6. The facilitator worked first with the Task Force to see whether consensus could be achieved for a given proposal. (Consensus meant that the recommendation was approved unanimously by all Task Force members present.) If consensus could not be achieved, then the Task Force voted on proposals, with the majority prevailing.

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<sup>8</sup> For more information, see [www.leadingresources.com](http://www.leadingresources.com)

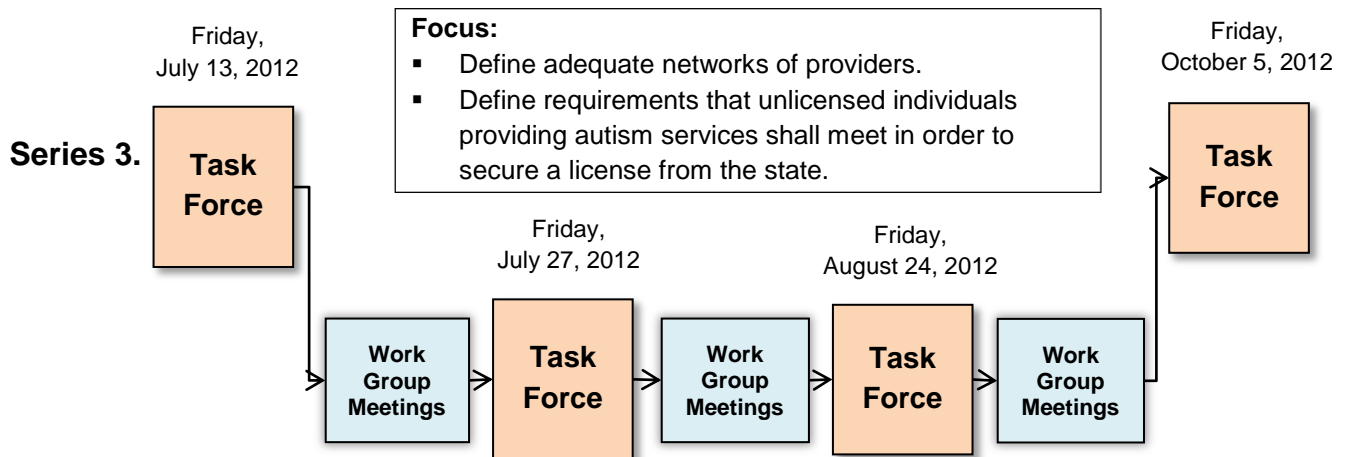
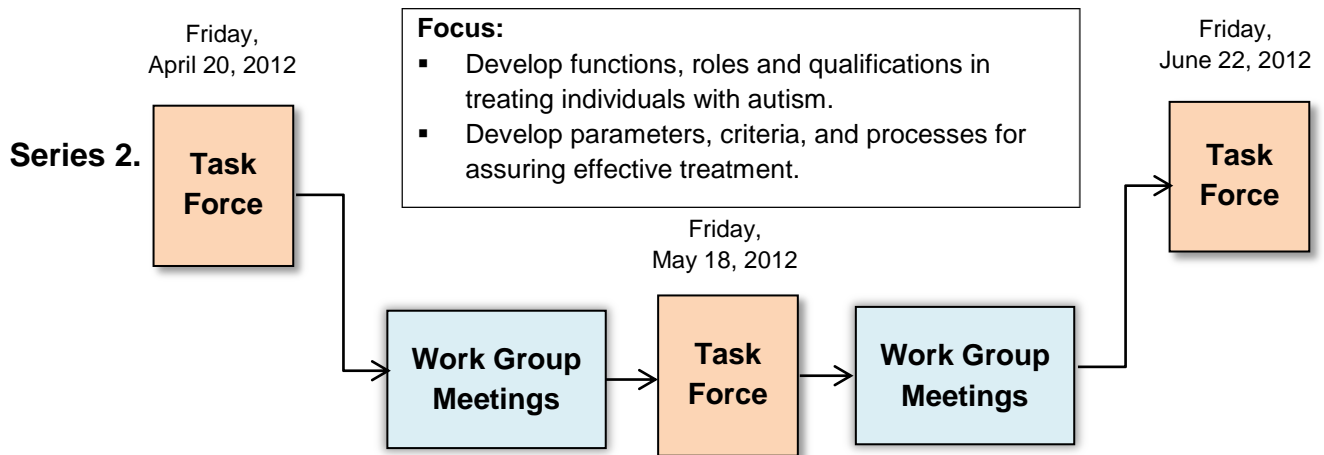
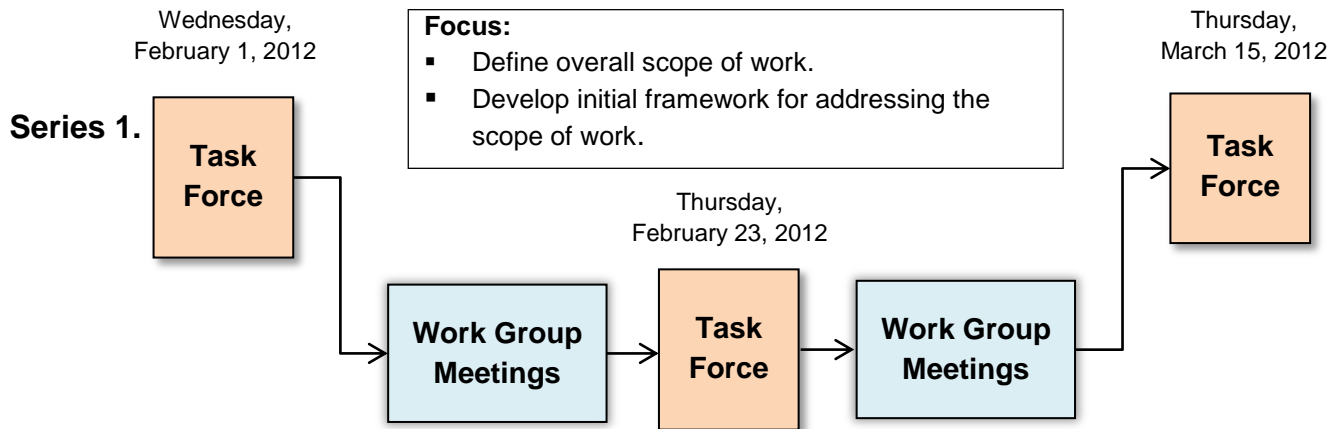
7. Once the Task Force approved a recommendation on a given issue, no subsequent action could be taken by the Task Force or a Task Force member to reopen that issue or overturn that recommendation, unless permitted by the chair.

In addition:

- All in-person meetings of the Task Force were open to the public.
- All agendas, meeting minutes, and meeting materials for in-person meetings were sent to Task Force members in advance (to the extent possible) and posted on a website accessible to the public ([www.dmh.ca.gov](http://www.dmh.ca.gov)).
- Meeting minutes were kept and approved by the Task Force.

The following page presents a flow diagram of the Task Force's meeting schedule and topics considered in each series of Task Force meetings.

## Autism Advisory Task Force Process and Meeting Schedule



## **PART II: TASK FORCE RECOMMENDATIONS**



## INTRODUCTION

SB 946 states that the Task Force shall develop recommendations regarding behavioral health treatment that is medically necessary for the treatment of individuals with autism or pervasive developmental disorder (PDD) and shall address the following:

1. Interventions that have been scientifically validated and have demonstrated clinical efficacy.
2. Interventions that have measureable treatment outcomes.
3. Patient selection, monitoring and duration of therapy.
4. Qualifications, training, and supervision of providers.
5. Adequate networks of providers.
6. The education, training, and experience requirements that unlicensed individuals providing autism services shall meet in order to secure a license from the state.

This section contains the recommendations of the Task Force. The Task Force reached consensus on 54 of 55 recommendations and approved one recommendation by a vote of the majority.<sup>9</sup> These recommendations are intended to inform state policymakers and guide future state legislation.

## SECTION I: DEFINITIONS

The Task Force intends the following recommendations to pertain to the treatment of individuals with “pervasive developmental disorder or autism,” which includes:

- Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS)
- Autistic disorder
- Asperger syndrome
- Rett’s syndrome
- Childhood disintegrative disorder

For purposes of consistency, this document uses the term “autism” to mean all of the above.

## SECTION II: BEHAVIORAL HEALTH TREATMENT

This section contains the Task Force’s recommended guidelines with regard to behavioral health treatment that is medically necessary for the treatment of individuals with autism. The guidelines address:

- Interventions that have been scientifically validated and have demonstrated clinical efficacy
- Interventions that have measurable treatment outcomes
- Patient selection, monitoring and duration of therapy

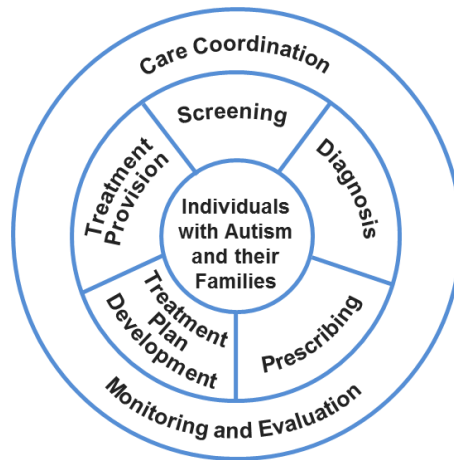
A guiding principle of the Task Force was that every individual with autism or PDD is unique. Individuals have different combinations of characteristics, different needs for assistance, and respond differently to treatment. Therefore, behavioral health interventions need to be highly individualized. Since treatment selection should be made by a team of individuals who can consider the unique needs and history of the individual with autism or PDD, the Task Force determined that it would not be informative to state policy makers to merely develop a list of

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<sup>9</sup> Guideline 11 in Section III was approved by a majority vote.

BHTs that are determined to be effective, based solely on current scientific literature. Since scientific research and findings naturally advance, the Task Force determined that the choice of BHTs should be grounded in scientific evidence, clinical practice guidelines, and/or evidence-based practice.

Guideline 1:<sup>10</sup> There are multiple functions involved in providing care to individuals with autism, including screening, diagnosis, prescribing, treatment plan development, treatment provision, care coordination, and monitoring and evaluation (see diagram). The qualifications, training, education, and supervision of the people serving in these functions are critical.



### **Scientific Validity, Clinical Efficacy, and Measurable Outcomes**

Guideline 2: Many scientific studies have addressed the efficacy of behavioral health treatments for autism. The choice of behavioral health treatments for autism should be grounded in scientific evidence, clinical practice guidelines, or evidence-based practice. Evidence-based practice means a decision-making process that integrates the best available scientifically rigorous research, clinical expertise, and the individual's strengths and needs. Evidence-based practice is an approach to treatment rather than a specific treatment. Evidence-based practice promotes the collection, interpretation, integration, and continuous evaluation of valid, important, and applicable individual- or family-reported, clinically-observed, and research-supported evidence. The best available evidence, matched to the individual's circumstances and preferences, is applied to ensure the quality of clinical judgments.

Guideline 3: There are different types of scientific evidence, including but not limited to randomized clinical trials, meta-analyses, experimental studies, observational studies, replicated single subject design studies, and national consensus statements or recommendations.

Guideline 4: In addition to this (or in the absence of specific scientific studies, reviews or consensus reports), expert opinion which relies on scientific evidence as defined in Guideline 3 can then lend perspective on interpreting likely treatment outcomes for newly emerging treatments, and for applicability of any treatment with weaker evidence to an individual case.

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<sup>10</sup> Guideline numbers refer to the specific numbering system used by the Task Force to organize its findings.

## **Patient Selection**

Guideline 5: All children should receive screening for autism based on the screening guidelines issued by the American Academy of Pediatrics.

Guideline 6: All other individuals should receive screening for autism if they show signs or symptoms that may be caused by autism.

Guideline 7: Those who are identified as potentially having autism in the screening process should be referred for diagnosis by a qualified practitioner.

Guideline 8: The diagnosis should be made based on professionally recognized diagnostic criteria. The diagnosis should consider coexisting and/or comorbid conditions.

Guideline 9: Treatment should be authorized for individuals who receive a diagnosis of autism.

Guideline 10: Treatment should also be authorized for individuals who receive a preliminary or provisional diagnosis of autism until a definitive diagnosis replaces the preliminary or provisional diagnosis. This preliminary or provisional diagnosis can be made by a primary care physician, mental health provider or pediatrician acting within the scope of his or her license and competence.

Guideline 11: The treatment should be prescribed by practitioners with the appropriate qualifications.

Guideline 12: The treatment should be planned and provided by practitioners with the appropriate qualifications.

Guideline 13: There should be a reasonable expectation that the particular treatment will be effective for the individual with autism.

## **Monitoring and Duration of Therapy**

Guideline 14: The course of treatment should be individualized and linked to clear, quantitative, developmentally appropriate goals and objectives, with targeted timelines for achieving them.

Guideline 15: There should be appropriate care coordination as defined in Section V.

Guideline 16: Family members should be educated about the importance of the family's role and trained in supporting the behavioral health treatments provided.

Guideline 17: If a health plan has a periodic review process in its terms and conditions, then the treatment plan should be submitted to the health plan for periodic review no more frequently than every six months, or at a frequency agreed on by the health plan and the provider on an individual patient basis. The health plan should be timely in its decisions and approval process.

Guideline 18: The treatment plan's goals, objectives, and targeted timelines should be monitored by the treatment plan developer and treatment provider(s) on an ongoing basis and refined as needed.

Guideline 19: The treatment plan's goals, objectives and targeted timelines should be reviewed on a periodic basis (no less than every 6 months or as clinically indicated) by the treatment team, including as appropriate the prescriber, the treatment plan developer, the treatment provider(s), and the family.

Guideline 20: The determination of continued treatment under a given treatment plan should consider the individual's needs, response to treatment, maintenance of skills, and progress toward meeting the treatment plan's goals and objectives over time. Lack of progress does not substantiate a lack of medical necessity but may indicate a need to change the treatment plan's goals, methods, and/or the provider. Knowing that disruption of an individual's care can cause significant setbacks, the health plan should ensure continuity of care by continuing the existing treatment, existing provider, and treatment plan during any authorization or review period until the review process and resolution is complete.

### **SECTION III: QUALIFICATIONS, TRAINING, EDUCATION, AND SUPERVISION OF PROVIDERS**

This section contains the Task Force's recommended guidelines for qualifications, training, education and supervision of individuals who treat individuals with autism.

In developing these recommendations, the Task Force focused on the critical role BHT providers play in the selection of treatments and in ensuring that appropriate treatment plans are developed and implemented correctly, are effective, and do no harm to the individual with autism. Consequently, the Task Force defined the functions of each provider involved in the continuum of care, from initial screening through treatment provision, and identified the qualifications of the persons performing those functions.

#### **Preamble**

Definitions: In the following recommendations, any reference to a "licensed" individual applies to someone with the following qualifications: licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech language pathologist, or audiologist, who designs, supervises, or provides treatment for autism, provided the services are within the experience and competence of the licensee.

Any reference to a certified individual applies to someone with the following qualifications: certified in behavioral health treatment by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies who designs, supervises, or provides behavioral health treatment for autism, provided the services are within the experience and competence of the person who is nationally certified.

#### **Qualifications of Providers**

##### **Diagnosis**

Guideline 1: The function of diagnosis includes:

- Making a diagnosis of autism based on professionally recognized diagnostic criteria
- Considering coexisting and/or comorbid conditions
- Informing and coordinating with the primary care physician or medical home

Guideline 2: Qualifications of diagnosticians: Should be a physician, psychologist or other licensed health professional who is acting within his or her scope of license and competence.

## **Prescribing**

Guideline 3: The function of prescribing includes:

- Making referrals for further assessment
- Prescribing types of treatment and treatment parameters (e.g. frequency, intensity, duration)
- Making referrals for treatment
- Overseeing and reviewing treatment plans
- Informing and coordinating with the primary care physician or medical home

Guideline 4: Qualifications of prescribers: Should be a physician, psychologist or other licensed health professional who is competent in the function of prescribing as defined in Guideline 3.

## **Treatment Plan Development**

Guideline 5: The function of treatment plan development includes:

- Conducting a comprehensive assessment (identify strengths, deficits, family support)
- Specifying goals of treatment
- Specifying type of treatment(s)
- Specifying parameters of treatment (e.g. frequency, intensity, duration)
- Determining data required and data collection methods for tracking progress of treatment
- Identifying criteria for mastery
- Adjusting treatment plan as needed to ensure progress toward short-term objectives and long-term goals
- Assuring that family members are educated about the importance of the family's role and trained in supporting the behavioral health treatments provided
- Tracking progress and outcomes
- Identifying and implement modifications to treatment approaches as needed based on data collected
- Summarizing overall case status
- Making recommendations regarding continued medical necessity, continued need for current level of intensity, and treatment completion parameters

Guideline 6: Qualifications of treatment plan developers: Those who conduct treatment plan development should be licensed or certified as defined in the preamble to Section III. If not licensed or certified, they should at a minimum be competent in the functions of treatment plan development defined in Guideline 5, should have direct and documented experience working with individuals with autism, and should, at minimum, hold a Master's degree or be a Master's candidate in behavior analysis or related field, or a field related to the behavioral health treatment provided.

Guideline 7: Training and education of treatment plan developers: Treatment plan developers who are licensed or certified as defined in the Section III preamble should receive ongoing education and training in autism in accordance with the specifications of licensure or certification. Unlicensed or uncertified treatment plan developers should receive ongoing training in the planning and delivery of behavioral health treatments for autism.

Guideline 8: Supervision of treatment plan developers: Treatment plan developers who are neither licensed nor certified as defined in the in the preamble to Section III should be supervised by individuals possessing those qualifications and competent in the functions of treatment plan development as defined in Guideline 5.

## **Treatment Provision**

Guideline 9: The function of treatment provision includes:

- Implementing specific therapies
- Collecting data related to treatment progress
- Tracking progress and outcomes
- Assuring that family members are educated about the importance of the family's role and trained in supporting the behavioral health treatments provided
- Ongoing treatment planning
- Where applicable, case supervision as defined below

Case supervision includes:

- Direct case supervision, e.g.:
  - Observation
  - Instruction
  - Modeling
  - Performance-based feedback to front-line treatment providers and parents on the fidelity of delivery
  - Data collection for the purpose of inter-observer agreement on patients' response to treatment
  - Collecting baseline data with reliability on new targets/objectives as patients master current targets
- Indirect case supervision, e.g.:
  - Development of individualized patient response forms
  - Development of token economy stimuli
  - Development of behavioral contracts or stimulus generalization materials
  - Summarizing, reviewing, and analyzing the data

Note: The above examples of case supervision may not apply to a given behavioral health treatment. The Task Force recognizes that some behavioral health treatments may require other forms of case supervision.

Guideline 10: Qualifications of treatment providers: Front-line providers of treatment should either meet the qualifications required of those who conduct treatment plan development or demonstrate all of the following:

- a. Have adequate training and specific competence in implementing behavioral health treatments for autism, including competence in the scope of treatments outlined in the treatment plan and a minimum of 30 hours<sup>11</sup> of interactive, competency-based autism-specific training, as verified by the treatment plan developer or treatment provider supervisor (see footnote).

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<sup>11</sup> The 30-hour minimum is informed by Section 4686.3 of Welfare and Institutions Code.

- b. Be enrolled in a bachelor's program or possess a bachelor's degree; be enrolled in an associate's degree program or possess an associate's degree; or, at minimum, possess a high school diploma.
- c. Receive adequate supervision, based on both the provider's experience and patient's needs, on a regular weekly schedule consistent with evidence-based practice and sufficient to ensure competence in the delivery of each of the patient's current treatment programs. At least 60 to 75 percent of the supervision should be direct face-to-face supervision and include significant co-therapy with the top or mid-level supervisor.
- d. To be effective the supervision shall cover the functions of ongoing treatment planning and case supervision defined in Section III of this framework.

Parent education and training should only be provided by treatment providers who possess at least one year of supervised behavioral health treatment provision and have sufficient experience as defined by the treatment plan developer or treatment provider supervisor.

### **Training and Education of Providers**

Guideline 11: Specifically with regard to the provision of applied behavior analysis, the BACB practice guidelines should be followed. Supervision by the top supervisor should be 1-2 hours per 10 hours of direct therapy, and mid-level supervision should be adequate to ensure treatment objectives are met.<sup>12</sup>

Guideline 12: Training and education of treatment providers: Licensed or certified front-line providers of treatment should receive ongoing education and training in accordance with the specifications of licensure or certification. Unlicensed or uncertified front-line providers of treatment should receive ongoing training in implementing behavioral health treatments for autism. The training process should include ongoing performance measurement that is aligned with the competencies expected.

### **Supervision of Providers**

Guideline 13: Supervision of treatment providers: Front-line treatment providers who are neither licensed nor certified should be supervised by an individual with any one of the following qualifications:

- a. Licensed as defined in the Section III preamble.
- b. Certified as defined in the Section III preamble, including but not limited to either a Board Certified Behavior Analyst (BCBA) or Certified Assistant Behavior Analyst (BCaBA). A supervisor with the latter qualification should, in turn, be supervised by a licensed or certified individual at the BCBA-level or equivalent.
- c. Has direct and documented experience working with individuals with autism and holds a Master's degree or is a Master's candidate in behavior analysis or another BHT-related field. This supervisor should, in turn, be supervised by a licensed or certified individual competent and experienced in that BHT field.

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<sup>12</sup> This guideline was approved by a majority vote of the Task Force. See "Part III - Explanation of Task Force Decisions" for details.

## SECTION IV: LICENSURE

This section contains the Task Force's recommendations regarding:

- The education, training, and experience requirements that unlicensed individuals providing autism services shall meet in order to secure a license from the state.
- Adequate networks of providers.

In developing these recommendations the Task Force balanced the need for ensuring consumer safety while not impeding access to providers of BHT. The Task Force concluded that all top level providers should be licensed by the state, and set forth a process for establishing a new professional license titled "Licensed Behavioral Health Practitioner." Since the process for establishing a new professional license by a licensing board can take time, the Task Force recommended that the license requirement not take effect until 3 years after the new professional license is established and that an interim commission be formed to implement the new license until the relevant licensing board is able to do so. This new license is intended to expand, not supplant, the existing professional licenses discussed in the report.

Furthermore, the Task Force recommends that all providers of autism services be registered with the state's Trust Line Registry or comparable system as conditions of employment by service organizations and contracting with health plans and health insurers.

### Licensing

Guideline 1: In order to ensure sufficient state oversight of consumers' safety, top level clinicians of autism services should be licensed. For purposes of ensuring adequate networks of providers, the following conditions should be met before this requirement takes effect (see 1.1 through 1.5 below):

Guideline 1.1: A new professional license should be established with a title such as "Licensed Behavioral Health Practitioner." This new license should not supplant but expand the professional licenses applicable for top level clinicians that are cited at the beginning of Section III.

This license is intended to constitute an expedient pathway to licensure for both the existing pool of nationally certified Behavior Analysts and other behavioral health treatment providers, such as developmental psychologists and others.

The Task Force intends for the pathways identified below to be permanent. They are also intended to accommodate the "grandfathering" of those whose work in the field of autism has been long standing and highly reputable.

It is also the expectation of this Task Force that the creation of this new license will facilitate and encourage expansion of nationally accredited certification programs in other behavioral health treatments.

### **New License Qualifications**

Guideline 1.2: To qualify for the Licensed Behavioral Health Practitioner license, an individual should possess one of the following:

- a. Certification by and in good standing with a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying



- Agencies in the design, supervision, and delivery of behavior analysis, provided the services are within the experience and competence of the licensee;
- b. Certification by and in good standing with a national entity that is accredited by the National Commission for Certifying Agencies in the design, supervision and delivery of behavioral health treatment, provided the services are within the experience and competence of the licensee, or
  - c. Demonstration of all of the following qualifications:
    - (i) Master's or doctoral degree in behavior analysis, developmental psychology, special education, or related field, as determined by the appropriate licensing board.
    - (ii) Significant supervised experience in the development of treatment plans, and supervision and provision of behavioral health treatment for individuals with autism. There can be several means of demonstrating significant supervised experience, including documented evidence or letters of attestation from a supervisor or from a currently licensed or certified practitioner—as defined in Section III's preamble—who is familiar with the candidate's experience.
    - (iii) Successfully pass an examination determined by the appropriate licensing board.
    - (iv) Letters of recommendation.

### **New License Implementation**

Guideline 1.3: Each one of these pathways to licensure should be established as soon as possible, and the license should be regulated by the California Board of Behavioral Sciences or another appropriate licensing board. An interim commission should be established to implement the new license until such time as the relevant licensing board is able to do so. The composition of this interim commission should be broadly representative of all of the relevant disciplines and pathways of those eligible for the license, including representatives of those being "grandfathered" under 1.2(c). The interim commission should also be reflective of the constituency of this Task Force and reflective of the make-up of the majority of health licensing boards (for example, significant representation of public/consumer members with a slight majority of no more than one additional member representing the professional groups). The permanent licensing board should have the same make-up as the interim commission.

The Task Force recognizes that developing the examination referenced in 1.2(c)iii will take time. In the interim, the commission should implement an expedient process for evaluating the competence of candidates pursuing the license via the pathway delineated in 1.2(c). Until an exam is established, candidates who meet all of the other qualifications of 1.2(c) above should be eligible to obtain a license, but they must sit for and pass the exam once it is established.

Guideline 1.4: The requirement for licensure of top clinicians should not take effect until three years after the new professional license is established. In the interim, until the requirement that top clinicians be licensed takes effect, top clinicians should be either licensed or certified as defined in the beginning of Section III.

Guideline 1.5: During the same interim period defined in 1.4, the following recommendations should also take effect:

- Section III, Element 6 (qualifications of treatment plan developers).
- Section III, Element 13 (qualifications of those supervising treatment providers).

## **New License Standards**

Guideline 2: In the creation of this new license, it is the intent of the Task Force that all individuals with a relevant credential should have that credential noted following the title of the license. For example, an individual certified in Behavior Analysis should bear a title such as “Licensed Behavioral Health Practitioner – BCBA.”

Guideline 3: Authorizing legislation or regulation should make explicit that individuals with this license must have competence in the behavioral health treatment and the patient population they are treating, that they are responsible for ensuring the competence of any unlicensed or uncertified people they supervise, and that individuals should only supervise others in the behavioral health treatment for which they are trained and competent.

Guideline 4: As a condition of maintaining the license of Behavioral Health Practitioner, licensees should complete continuing education in behavioral health treatment.

Guideline 5: The licensing board regulating the new license should develop ethical standards, complaint processes, and disciplinary procedures for the new license.

Guideline 6: Qualified academic institutions and related professional organizations should be encouraged to recommend criteria for competence and provide courses, training opportunities, and continuing education to support candidates’ pursuit of this new license and renewal of this license.

Guideline 7: To ensure sufficient consumer safety, all providers of autism services should be registered with the state’s Trust Line Registry<sup>13</sup>, or comparable system, as a condition of employment by service organizations and of contracting with health plans. Moreover, as a condition of maintaining the Licensed Behavioral Health Practitioner license, all licensees and the providers under the licensee’s supervision should be registered with a statewide consumer safety oversight body, such as the California Department of Social Services’ (CDSS) Trust Line Registry. Together, these recommendations hold both the individual practitioner and the licensed supervisor of practitioners responsible for this registration.

## **SECTION V: OTHER RECOMMENDATIONS**

In addition to addressing the specific requirements of SB 946, the Task Force made recommendations regarding care coordination, parent participation, health plan policies, consumer safety and practice guidelines. These recommendations are found in this section of the report.

### **Care Coordination**

Guideline 1: Within the medical system, care coordination should be provided for all individuals receiving behavioral health treatment for autism. The focus should be on the coordination of the medical and behavioral health treatments provided.

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<sup>13</sup> This process involves being screened via a Live Scan fingerprint-based criminal background check against three databases (FBI, California Department of Justice, and the Child Abuse Central Index), as well as being subject by CDSS to disciplinary action, including suspension and de-registration, for certain subsequent criminal convictions.

Care coordination should be provided by the provider team, supported by the health plan, and should include the following key roles:

- Help to educate the family on the process of diagnosis, treatment planning, treatment, and evaluation
- Provide support and information to the family
- Coordinate care across all of the medical and behavioral health treatments being provided to the individual, including coordinating and collaborating with the primary physician/medical home
- Coordinate communication among treatment providers and ensure providers' awareness of adjustments to the treatment plan
- Make referrals to other services or resources for the individual and/or family as appropriate

The degree of care coordination provided for individuals with autism may vary based on the acuity level and unique needs of each individual. Ideally, the same person/team should coordinate care throughout the duration of the individual's treatment in order to provide continuity.

The Task Force acknowledges that at this time, care coordinators may not be widely available within the field. The lack of capacity for care coordination services should not limit access to treatment for individuals with autism.

Guideline 2: The Task Force acknowledges that individuals with autism may receive treatment or services within multiple systems of care (e.g., Regional Centers, educational system, medical system). Ideally, care would be coordinated across all services and settings to promote effective treatment for individuals with autism. The Task Force recommends that an appropriate group be established to develop guidelines for ensuring effective coordination of care across systems, including the implications of sharing information between systems. The Task Force views this as an urgent matter and requests that a group address this topic in the next 6 to 12 months.

### **Parent Participation**

Guideline 1: Research strongly supports the value of parent training and the participation by parents and/or caregivers in behavioral health treatments for individuals with autism. Parents and/or caregivers, as appropriate, should be strongly encouraged and given the opportunity to participate in the behavioral health treatments provided. In planning the appropriate level of parent and/or caregiver participation, providers should conduct a thorough assessment of the behavior and environmental factors that may affect that behavior. The provider should meet with the family members, talk with them about their participation, objectives, and circumstances and obtain their feedback – and factor that feedback into the treatment plan. Providers should then develop a treatment plan that includes the level of parent and/or caregiver participation needed. The treatment plan's expected level of parent and/or caregiver participation in training should accommodate the individual's and family's circumstances and availability. The health plan, through its contracting providers, should provide reasonable and appropriate opportunities for parent and/or caregiver participation that accommodates the individual's and family's circumstances and availability. In the unusual or extenuating circumstance that a parent and/or caregiver is unable to participate in training, then the course of treatment should be monitored closely and the treatment plan should be modified accordingly so that, in the judgment of the treatment plan developer and the treatment provider, the treatment will be effective.

## **Health Plan Policies**

Guideline 1: The Task Force acknowledges the importance of transparency of health plans' policies regarding behavioral health treatment for autism. Such transparency will allow health plan members, potential members, contracted providers, and the public to view and compare plans. Therefore, health plans should make their policies regarding behavioral health treatment for autism easily accessible to the public via their websites, and provide contact information for health plan representatives who can assist with questions.

Guideline 2: Health plans should not establish policies, such as algorithms, that would predetermine treatment decisions for individuals with autism. Consistent with the health plans' terms and conditions, authorization decisions by the health plans should be based on the individual's assessment and the clinician's recommended treatment plan. This is not intended to limit the health plans' ability to conduct pre-certifications and utilization review.

Guideline 3: The Task Force recommends that uniform CPT codes for behavioral health treatment be identified.

## **Consumer Safety**

Guideline 1: Restraint techniques should only be used as a last resort – and only by people trained in their use. A statewide standard for safe and appropriate restraint techniques should be established in order to protect the client, family members and providers from harm.

Guideline 2: All unlicensed front-line providers of autism services should complete training in staff and client injury prevention techniques that are effective for individuals with autism.

Guideline 3: Supervisors should be encouraged to make periodic unannounced visits to any provider who provides autism services without another adult present during the treatment.

## **Practice Guidelines**

Guideline 1: Providers should use evidence-based practices, as defined in Section II of this Framework, when delivering behavioral health treatments to individuals with autism. The Task Force recommends the development of practice guidelines based on evidence-based practices for the full range of behavioral health treatments. The Task Force acknowledges that such practice guidelines will necessarily evolve.

## **PART III: EXPLANATION OF TASK FORCE DECISIONS**

## **EXPLANATION OF TASK FORCE DECISIONS**

The Task Force approved virtually all of its recommendations by unanimous consent – meaning that the recommendations were approved unanimously by all Task Force members present. For those decisions reached by consensus, the recommendations speak for themselves.

This section of the report explains the one decision not reached by consensus – and also explains another issue where the Task Force did not reach a decision.

### **Section III, Guideline 11**

On a 9-4 majority vote,<sup>14</sup> the Task Force approved Section III, guideline 11, which states: “Specifically with regard to the provision of applied behavior analysis, the BACB practice guidelines should be followed. Supervision by the top supervisor should be 1-2 hours per 10 hours of direct therapy, and mid-level supervision should be adequate to ensure treatment objectives are met.”

The following nine Task Force members voted in favor of this recommendation:

- Gerald Caplan, Florence Clark, Robert Hendren, Kristin Jacobson, Areva Martin, Bryna Siegel, Lorri Unumb, Renee Wachtel, and John Youngbauer.

The following four members voted in opposition:

- Martin Glasser, Beth Gould, Sheldon Orloff, and Rhonda Robinson Beale.

The first sentence of this recommendation generated some disagreement. The majority wanted to recognize the practice guidelines developed by the Behavior Analysis Certification Board (BACB) and viewed this as a criterion for payment by the plans. Those opposed questioned the value of singling out one particular set of practice guidelines without referencing guidelines for other forms of BHT and the implication of additional payment.

The second sentence also generated disagreement. Those who voted in favor wanted to emphasize the importance of supervised hours – and to stress how important supervision is to the delivery of effective applied behavior analysis. Those who voted in opposition viewed the second sentence as being overly prescriptive.

### **Reimbursing providers for the costs of performing reviews**

The issue of requiring health plans to reimburse providers for the cost of performing reviews was the last issue taken up by the Task Force. Ultimately, the Task Force vote did not reach a conclusion.

Consumer advocates favored language requiring health plans to pay for providers’ costs in preparing for concurrent reviews. They favored language saying: “Going forward, all health plans, in contracting with providers, should outline all of the information that is required for a typical concurrent review. The cost of obtaining the review should be borne by the health plan.”

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<sup>14</sup> Four Task Force members were not present. Although the Chair was present, he is a non-voting member. Four voting members were not present with this decision.

The health plans favored language requiring providers to be reimbursed only for costs of reviews that are outside the terms of their contracts with the plans. They favored language saying: "Going forward, all health plans, in contracting with providers, should outline all of the information that is required for a typical concurrent review. If the health plan requests a specific assessment or additional information outside those contracted terms, the health plan should reimburse providers or enrollees for this information."

Some unaligned Task Force members and providers sided with the consumer advocates on this issue, while others sided with the health plans. A vote to remain silent on this issue failed. Votes on three versions of the language were ambiguous because some Task Force members voted for more than one alternative. Ultimately, time ran out and no conclusion could be drawn because the results were not definitive.

## **PART IV: APPENDIX**



## **APPENDIX I: TASK FORCE MEMBER BIOGRAPHIES**

### **Brent A. Barnhart, Chair**

Brent Barnhart was appointed by Governor Brown on August 11, 2011, to serve as the director of the Department of Managed Health Care. Prior to his appointment, he had retired from his position as a senior counsel at Kaiser Foundation Health Plan, where he assisted in compliance activities, including interactions with the DMHC. He also represented Kaiser Permanente at the National Association of Insurance Commissioners, dealing primarily with financial regulation standards and national insurance privacy standards.

He has extensive experience in both health care and government, having worked as a policy committee consultant to the California State Assembly for three years on a variety of assignments, including the Judiciary Committee, the Insurance Committee, and the Office of Research, where he dealt primarily with health, insurance, and corporate governance issues. Prior to his government service, he was an attorney and lobbyist for the health insurance industry in Sacramento – as legislative affairs director for Blue Cross of California, and as counsel and secretary to the Association of California Life and Health Insurance Companies. Previous experience also includes serving as the California legislative director of the American Civil Liberties Union, representing ACLU before the California Legislature.

Licensed to practice law in both California and Indiana, he received his juris doctorate from Indiana University, Bloomington, and his undergraduate degree in political science from the University of California, Riverside.

### **Rhonda Robinson Beale, M.D.**

After United Behavioral Health purchased PacifiCare in January 2006, Dr. Rhonda Robinson Beale became the Chief Medical Officer, External Affairs for the larger business entity, United Behavioral Health. She is responsible for clinical policy and facilitating key external relationships with customers, industry, organization, and societies to drive policy and change.

Dr. Robinson Beale has over 20 years' experience as a Medical Director of a health plan. Prior to her current position, she was the VP and Chief Medical Officer for PacifiCare Behavioral Health (2005-2006), SVP and Chief Medical Officer for CIGNA Behavioral Health (2002-2005), the National Medical Director for Blue Cross Blue Shield (2000-2002), Executive Medical Director of Medical and Care Management Clinical Programs – Blue Cross Blue Shield of Michigan, and Senior Medical Director for Behavioral Medicine for Health Alliance Plan (1990-1998).

As the Chief Medical Officer of a health plan, Dr. Robinson Beale has been involved in the implementation of autism legislation in over 20 states, focusing on finding approaches and creating provider systems that assure quality care for people with autism. As a health plan administrator, she understands the issues with implementation of autism legislation.

As a former practicing psychiatrist, Dr. Robinson Beale has over 15 years of direct experience working with children and adults with autism. As a past and current member of several national committees and advisory boards (such as membership on the Institute of Medicine's Board of

Neuroscience and Behavioral Health, NQF, and NCQA's Health Promotion Advisory Committee) and several IOM reports including "Crossing the Quality Chasm", Dr. Robinson Beale has experience using evidence and expert opinion to derive solutions to issues.

Her licensure and board certifications have included Diplomate to the American Board of Quality Assurance and Utilization Review Physicians, certified by the American Medical Society of Addiction Medicine (ASAM), and Diplomate to the American Board of Psychiatry and Neurology.

### **Gerald Caplan**

In 2001, Gerald Caplan completed his ninth year as the Dean of University of the Pacific, McGeorge School of Law and rejoined the law school faculty. Before serving as Dean, he enjoyed a distinguished legal career in government for over 25 years. Professor Caplan served as an Assistant U.S. Attorney and as general counsel for the Metropolitan Police of the District of Columbia. In 1973, Attorney General Elliot Richardson appointed him Director of the National Institute of Justice, U.S. Department of Justice. In 1977 he joined the law faculty at George Washington University. Subsequently, Professor Caplan was retained by the U.S. Department of Justice to review the use of deadly force by the Los Angeles Police Department. In 1985-86, he headed an independent commission that critiqued the Philadelphia Police Department following the MOVE bombing and row-house fire and recommended measures to reorganize the department to increase efficiency and reduce corrupt practices. Professor Caplan also served as interim president of Legal Services Corporation (1982), consultant to the President's Commission on Organized Crime (1985-86) and Deputy Director of the Federal Trade Commission's Consumer Protection Bureau (1991-92).

Professor Caplan has written widely on issues relating to criminal justice and police practices. His most recent work, an essay on Justice Holmes, has been widely praised and his article on *Miranda v. Arizona* reprinted in several anthologies. He has written opinion-editorials for the Wall Street Journal, New York Times, Los Angeles Times, and the Washington Post. He received a J.D., M. A., and B.A. from Northwestern University and was a Falk Fellow and a Senior Guggenheim Fellow at Yale University.

### **Florence Clark, Ph.D.**

Dr. Florence Clark is Professor and Associate Dean of the Division of Occupational Science and Occupational Therapy at the Ostrow School of Dentistry of University of Southern California (USC). As current President of the American Occupational Therapy Association, one of Dr. Clark's chief responsibilities is to ensure that consumers have access to the full range of occupational therapy interventions they need, including behavioral health treatment.

Appointed as a charter member of the Academy of Research of the American Occupational Therapy Association, she has served as special consultant to the United States Army Surgeon General, been on the board of the National Center for Medical Rehabilitation Research, and been the recipient of an Eleanor Clarke Slagle Lectureship, the highest academic honor of the American Occupational Therapy Association. In 1999, the American Occupational Therapy Association honored her with its Award of Merit and in 2001 she received a lifetime achievement award from the Occupational Therapy Association of California. In 2004, she received the Presidential Medallion from the President of the University of Southern California, the ultimate honor for those who have brought honor and distinction to USC.

Since 1985, Florence Clark has attracted more than \$10 million in extramural funding from the National Institutes of Health (NIH), National Institute on Disability and Rehabilitation Research (NIDRR), and other federal agencies for research and training in the areas of healthy aging and the secondary conditions that impede the flourishing of people with disabilities in their real life circumstances. She is most well-known for having led the NIH-funded USC Well Elderly Studies, which demonstrated that a preventive occupational therapy program cost-effectively improved health in older people. Dr. Clark is currently leading a large-scale randomized controlled trial that is testing the efficacy of a life skills-based intervention approach in decreasing the incidence of medically serious pressure ulcers in adults living with spinal cord injury. Her expertise in outcomes research was recognized by NIH in 2011 when she was awarded an NICHD T32 Ruth L. Kirschstein Postdoctoral Training Grant to prepare postdoctoral scholars with a solid foundation for conducting methodologically sophisticated, community-based, randomized controlled trials.

### **Tim Gage**

Tim Gage was appointed by Governor Gray Davis in January 1999 as the Director of the California Department of Finance. He served in this capacity until January 2003. In this position, he directed a staff of 350 in preparation of the state budget and representation of the Administration on 70 state boards and commissions. Since leaving finance, Mr. Gage has worked as a consultant for a variety of clients and, in 2005, founded the Blue Sky Consulting Group, a public policy and economics consulting firm.

Mr. Gage served two terms as a member of the Board of Governors of the California Independent System Operator, the nonprofit, public-benefit corporation that manages the state's electric power grid. Mr. Gage is an adjunct professor in the Sol Price School of Public Policy at the University of Southern California.

Before being appointed Director of Finance, Mr. Gage spent 20 years working on fiscal issues for the California Legislature in various capacities, including Chief Fiscal Advisor to the Senate President pro Tempore and Chief Consultant to the Assembly Ways and Means Committee. He received his Master's degree from the Goldman School of Public Policy at the University of California, Berkeley and his Bachelor's degree in Philosophy from Harvard College.

### **Martin E. Glasser, M.D.**

Dr. Martin Glasser is Chief Medical Officer, Human Affairs International (HAI)/Blue Shield of California. His primary role is to oversee two behavioral health contracts (Blue Shield of California and Western Health Advantage) for behavioral health and substance abuse services for two million members.

Dr. Glasser is a Distinguished Life Fellow of the American Psychiatric Association and of the American Academy of Child and Adolescent Psychiatry. Dr. Glasser serves as a member of the American Academy of Child and Adolescent Psychiatry work group for Health Economics, a 12-member National Committee.

He was an Associate Clinical Professor at the Department of Pediatrics and Department of Psychiatry at UCSF and at UC Berkeley's Department of Public Health's MPH Program affiliated with UCSF. Dr. Glasser was co-founder of CASARC, for child sexual victims, and served as the Medical Director for the Infant Parent Program at UCSF.

Dr. Glasser has extensive experience with the diagnosis, treatment, and intervention of children and adults with autism, beginning as a Fellow in Child and Adolescent Psychiatry and Mental Retardation at the UCLA Neuropsychiatric Institute. There he participated in behavioral treatments for inpatient care and supervised the care of youth with both developmental disorders and psychiatric disorders. Behavior modification training was part of his Fellowship. He also participated in research on autism treatments with Barbara Fish, M.D. and Edward Ritvo, M.D. He was the consultant to the San Mateo School district to set up their first special education classroom for autistic students. He continued to participate in the diagnosis and treatment of autistic youth during an eight-year period when he was the Director of Developmental Pediatrics at the Child Study Unit at UCSF. The unit trained pediatricians, social workers, nurses, psychologists, and medical students. Subsequently he was the interim CEO for the San Diego Center for Children, where he established a classroom for young children with autism.

He currently serves on the NCQA Review Oversight Committee and has been a surveyor for over 20 years.

Since 1967 Dr. Glasser has received no less than 34 honors and awards, including the UCLA Neuropsychiatric Institute Alumnae Award (1995), Examiner, ABPN, Child and Adolescent Psychiatry Boards (2000), and Participant in the White House Conference for Mental Health (1999).

### **Beth Gould**

Beth Gould's career accomplishments include over 25 years of progressively increasing executive responsibility serving the State of California specializing in health and human services policy, program administration, and legislative representation.

Most recently, Beth was appointed by Governor Schwarzenegger to serve as a Commissioner to the Mental Health Services Oversight and Accountability Commission to implement various provisions of the Mental Health Services Act in collaboration with clients, family members, and program providers to reform the Mental Health Service Delivery System.

Beth's public service career includes the Department of Developmental Services administering the Early Start Program for developmentally disabled and delayed children; the Health and Human Services Agency as Assistant Secretary overseeing policy and fiscal affairs issues for the Departments of Developmental Services, Mental Health, Alcohol and Drug Programs, and Rehabilitation; Assistant Director of the Crime Prevention Center of the Attorney General's Office implementing the Child Victim Witness Investigative Pilot Project; the Department of Economic Opportunity in the Legislative and Policy Services Division; and at the State Personnel Board as a policy analyst and legislative advocate.

Beth is currently serving as a member of the Board of Directors of the Liberty House Foundation and the Winchester Women's Golf Club. Previously she served on the Board of Directors for the Windward School Guild and the Sacramento Child Abuse Prevention Council.

Beth received her B.A. in Child Development and her California Elementary Teaching Credential from California State University, Sacramento.

## **Robert Hendren, D.O.**

Dr. Robert Hendren is Professor and Vice Chair of Psychiatry, Director of Child and Adolescent Psychiatry at the University of California, San Francisco (UCSF) and Director of the Autism and Neurodevelopment Program (ANP), UCSF. In this role he oversees the Autism Clinic teams that provide diagnostic assessment and individualized behavior, education, and medication plans for patients of all ages and ANP researchers who actively investigate the causes and treatments for autism and related disorders. Prior to joining UCSF, Dr. Hendren was the University of California, Davis, Tsakopoulos-Vismara Chair and Executive Director of the M.I.N.D. Institute (Medical Investigation of Neurodevelopmental Disorders).

Dr. Hendren lectures widely on the assessment, formulation and treatment of neurodevelopmental disorders; child and adolescent psychopharmacology and complementary and alternative treatments; and integrative treatment. His clinical expertise is the diagnosis and treatment of neurodevelopmental disorders such as Pervasive Developmental Disorder, Bipolar Disorder, Schizophrenia Spectrum Disorders, and impulse control disorders. His primary areas of research and publication interests are translational clinical pharmacology and nutritional trials using biomarkers (MRI, measures of inflammation, oxidative stress, immune function and pharmacogenomics) in neurodevelopmental disorders.

Dr. Hendren has been listed in each publication of “The Best Doctors in America” since it was first published in 1996. His professional associations include President, American Academy of Child and Adolescent Psychiatry (2007-2009) and President, Society of Professors of Child and Adolescent Psychiatry (2002-2004). He has held faculty positions at George Washington University School of Medicine, the University of New Mexico School of Medicine, and University of Medicine and Dentistry New Jersey, Robert Wood Johnson Medical School and New Jersey Medical Schools.

## **Kristin Jacobson**

Kristin Jacobson is the Co-Founder and President, Autism Deserves Equal Coverage; Founding Member and Steering Committee Member, Alliance of California Autism Organizations; and State Policy Chair, Autism Speaks California.

As part of a more than 20-year career in health care marketing and reimbursement, Kristin has advocated for autism related causes for more than seven years. She led a multi-year statewide effort to pass autism insurance reform in California and was a principal drafter and backer of SB 946. In 2009, Kristin co-founded Autism Deserves Equal Coverage to help families and providers access health care treatment through private insurance. She also co-founded the ASD Insurance Help Yahoo group to assist parents secure insurance coverage for autism. Through message boards and individual case advocacy, Kristin has helped hundreds of families successfully appeal insurance denials. More than 15 of her cases have resulted in enforcement actions taken by the Department of Managed Health Care and California Department of Insurance to require compliance by health insurers doing business in California.

Kristin is a founding member and has served on the Steering Committee of the Alliance of California Autism Organizations (ACAO) since its inception in 2008. ACAO represents more than 40 autism organizations around the state. Kristin has served as the statewide Advocacy or Policy Chair for Autism Speaks since 2007. She is a Council Member on the Statewide Coordinating Council of the Senate Select Committee on Autism and Related Disorders, Co-

Chair of its Statewide Insurance Workgroup, and Chair of its Bay Area Autism Regional Task-force (BAART). She also is a member of the Consumer Advisory Panel to the California Department of Insurance under Insurance Commissioner Dave Jones. In 2008 she served on the Autism Advisory Workgroup for the Department of Managed Health Care (DMHC).

Kristin has testified numerous times before the California Blue Ribbon Commission on Autism, the Senate Select Committee on Autism, and at California legislative panels and hearings. She has been featured as an autism insurance expert by many news organizations, including The New York Times, Los Angeles Times, San Francisco Chronicle, National Public Radio, ABC, NBC and Fox News.

Kristin began her career as a Business Analyst at McKinsey & Company, a global management consulting firm, earned her M.B.A. from Stanford University where she was an Arjay Miller Scholar, and has spent her career in health care marketing, with a specialty in health insurance reimbursement. She held various marketing, sales, and executive positions at several medical device and pharmaceutical companies. As a senior executive at Eclipse Surgical Technologies, Kristin co-lead a team that secured FDA approval, a national Medicare coverage policy and multiple third party coverage recommendations for its lead cardiac product. She also headed up product introduction, clinical training and implementation of the new approval and Medicare coverage policy across the United States. While running the clinical publications group, Kristin was instrumental in securing several publications in major medical journals, including the New England Journal of Medicine.

#### **Areva D. Martin, Esq.**

Known to audiences across the country from her regular appearances on *The Dr. Phil Show*, *Anderson Cooper 360*, *The Ricki Lake Show*, *The Dr. Drew Show* and other national and local news and daytime talk shows, Areva is an accomplished and multi-award winning attorney, on-air legal and social issues expert/host, author, and public speaker who has also been featured on the pages of publications ranging from *Ebony Magazine* to *Redbook* and the *Los Angeles Times*.

Areva is the founding and Managing Partner of Martin & Martin, LLP, one of the largest African American-owned law practices in Southern California. The firm serves a diverse range of clients including Fortune 500 companies, governmental entities and individuals in high-stakes and high-profile cases. Areva's practice includes representing individuals with disabilities in administrative matters and in state and federal court litigation. Areva's firm has won numerous awards, including the California Minority Counsel's Client Service Award and in 2008 and 2011, she was selected as one of Los Angeles' Top Attorneys by *LA Focus*.

Areva is a nationally recognized autism advocate and spokesperson. She has developed a signature program on grassroots and community organizing and parent advocacy and is a frequent speaker at regional centers and conferences for disability and community groups on special education law and procedures. She has also published hundreds of articles on autism, advocacy, accessing special education and other services for kids with autism.

Areva is the co-founder and President of Special Needs Network, Inc., (SNN) a non-profit organization created specifically to help minorities and low-income families advocate for children and individuals with autism and other developmental disabilities. Under Areva's leadership, SNN played a key leadership role in the drafting and passage of SB 946 and was one of its co-sponsors. Areva has raised millions of dollars for autism-related causes and with a dedicated

board and staff, SNN has provided services to over 25,000 families in communities across California and has become the "go-to" nonprofit organization in California working on behalf of underserved populations impacted by autism and related disorders.

The recipient of numerous awards including the Los Angeles County *Women of the Year*, L'Oreal *Women of Worth* and the California Legislative Black Caucus *Martin Luther King Trailblazer Award*, Areva served as one of the Vice-Chairs on the California Blue Ribbon Commission on Autism and she currently is the Chair of the South Los Angeles Regional Task Force and Co-Chair of the Autism Equity and Diversity for the Senate Select Committee on Autism.

An honors graduate from the University of Chicago and Harvard Law School, Areva shares her story as a mother of an autistic child and legal expertise in her best-selling second book, *The Everyday Advocate: Standing Up for Your Child with Autism and Other Special Needs* (Penguin 2010). What critics are calling the most comprehensive and compelling book to date addressing the issues of the special needs community and the importance of advocacy in this country, *The Everyday Advocate* soared to the top of Amazon's best seller list upon its release.

### **James McCracken, M.D.**

Dr. James McCracken is the Director of the Division of Child and Adolescent Psychiatry at the UCLA NPI-Semel Institute (formerly the Neuropsychiatric Institute) and the Joseph Campbell Professor of Child Psychiatry, UCLA School of Medicine.

Dr. McCracken has long-standing clinical and research involvement in treatment for autism spectrum disorders. He is the principal investigator of the National Institute of Mental Health (NIMH) Research Center's "Translational Research to Enhance Cognitive Control," which aims to develop and test innovative treatments for cognitive defects associated with child psychiatric illness. Other areas of current research include family-genetic studies of childhood disorders and the testing of new pharmacologic treatments for a variety of neuropsychiatric disorders in children, including attention-deficit/hyperactivity disorder (ADHD), autism, obsessive-compulsive disorder, and anxiety disorders. He has published over 200 research papers in the area of child psychiatry, authored chapters in numerous books, and was the Associate Editor of *Textbook of Pediatric Neuropsychiatry* (1998).

Dr. McCracken is the recipient of several honors and awards, including the American Psychiatric Association (APA) Young Psychiatrist Research Award. He is listed in both the Best Doctors in America and America's Top Doctors databases. He serves on the editorial board of the *Journal of Child and Adolescent Psychopharmacology* and holds memberships in various local, national, and international professional organizations, including the APA, American Academy of Child and Adolescent Psychiatry, International Society for Research in Child and Adolescent Psychopathology, International Society of Psychoneuroendocrinology, and the Society for Neuroscience.

### **John Moulds**

For over 27 years John Moulds has enjoyed a distinguished career as a federal court judge. In 1985 he was appointed as the U.S. Magistrate Judge, Eastern District of California. He was appointed Chief Magistrate Judge in 1987 and served in that position for 10 years. In 2003 he retired and continues to serve as a retired U.S. Magistrate Judge carrying a fifty-percent caseload.

Prior to these appointments Judge Moulds practiced law as a founding partner with Blackmon, Isenberg and Moulds. Before that he was the Director of the Sacramento and Marysville offices of California Rural Legal Assistance. During law school he was a Legal Editor for California Continuing Education of the Bar and prior to that he was Administrative Assistant to California State Senator Albert S. Rodda.

Judge Moulds' judicial activities include Member, U.S. Judicial Conference on the Administration of the Magistrate Judges System (1992-1998), Coordinator, Ninth Circuit Court of Appeal Death Penalty Task Force (1987-1991), and Member, Ninth Circuit Capital Case Committee (1991-1995). He attended Stanford University, received a B.A. with honors from California State University, Sacramento, and a J.D. from Boalt Hall School of Law, University of California, Berkeley.

### **Sheldon Orloff, M.D.**

Dr. Sheldon Orloff currently holds the following concurrent positions at Kaiser Permanente Northern California: Regional Director of Pediatric Subspecialties, Chief Pediatric Nephrology; Regional Director of Pediatric Rehabilitation, Physical Medicine and Rehabilitation (PM&R); Co-Director, Early Disabilities Screening Program; and Director, Regional Center Review Committee. He has been a pediatric physician of the Kaiser Permanente Medical Group for over 30 years assuming a variety of positions during this time.

Dr. Orloff graduated from the University of Illinois, College of Medicine in Chicago, IL and then moved to Boston, MA where he completed his pediatric residency training at Tufts New England Medical Center. Following his residency, he completed a fellowship in pediatric nephrology at University of California at San Francisco. After successfully completing his subspecialty training he did a fellowship in Biochemical Genetics and Nutrition at the National Institutes of Health, National Institute of Child Health and Development, Bethesda Maryland. Dr. Orloff joined the Permanente Medical Group as a career physician in 1979 and has been a member of the Department of Pediatrics in Oakland since 1987 and is board-certified in general pediatrics.

In his role as Regional Director for Pediatric Rehabilitation for Northern California (NCAL) Kaiser, Dr. Orloff was involved in the development of physical, occupational, speech, and feeding therapy services for the Kaiser pediatric population. He has been involved in both establishing and participating in various interdisciplinary committees within Kaiser to review cases involving health care service requests for individuals with autism and developmental disabilities. He has represented the medical group on several steering committees regarding guidelines for service development, finance and strategy for providing these services for Kaiser members, reporting directly to Kaiser Health Plan and Medical Group leadership.

### **Rick Rollens**

Rick Rollens, 61, resides with his wife of 35 years, Janna, and their two sons Matthew, 27, and Russell, 22, in Granite Bay, California. Rick is President of Rollens Consulting, a government relations and lobbying company in Sacramento representing clients from the brain injury, autism and developmental disabilities community. He is the Legislative Advisor to the Association of Regional Center Agencies (ARCA).



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

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

Rick was one of the co-founders of the U.C. Davis M.I.N.D. Institute, having secured, in 1998, the passage of state legislation creating what has become one of the world's largest private or public entities dedicated to research and treatment of neurodevelopmental disorders in children. Rick is directly responsible for raising millions of dollars for ongoing funding, from state and private sources, for M.I.N.D., and for autism research.

Rick has testified before Congress and the California legislature on autism as well as vaccine safety and proposed new vaccine mandates. He has participated in NIH Committees setting autism research agendas and spoken at many meetings around the world, including an invitation from the government of Ireland to address the European Union (EU) in 2007 on the U.S. autism epidemic. His son, Russell, was featured on the cover the July 31, 2000 issue of Newsweek, which became the all-time best selling issue of the magazine. Rick has contributed to or been featured in hundreds of media reports, including *60 Minutes*, *Reader's Digest*, *The Washington Post*, *The New York Times*, and BBC and was featured in the best-selling book *Evidence of Harm*.

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

### **Bryna Siegel, Ph.D.**

Dr. Bryna Siegel is the Director of Autism Clinic, Langley Porter Psychiatric Institute and Adjunct Professor at the UCSF Department of Psychiatry, as well as founder of Jump Start Learning-to-Learn, a parent training and coaching program for families living with autism.

Dr. Siegel has worked with individuals with autism since the early 1970s, first as a teacher, then researcher, clinician, and treatment designer. She co-founded the Autism Clinic at Stanford University in 1983, and founded the Autism Clinic at UCSF in 1989. Her clinical expertise

includes differential diagnosis of autistic spectrum disorders and linking diagnostic assessment and treatment planning. Dr. Siegel participated in the DSM-III-R and DSM-IV diagnostic field trials and is the developer of the PDDST-II, an early identification autism screener. She has evaluated over 5,000 children with Autism Spectrum Disorders in California and has been qualified as an autism expert over 100 times in educational due process hearings and civil litigation in California, several other states, and Canada.

Since 1985 Dr. Siegel has authored or co-authored over 130 peer-reviewed publications and abstracts, including an early peer-reviewed study on the efficacy of ABA, and written four books on autism treatment (translated into several languages). Her research areas include early identification of autism and behavioral, psychological, and education treatments for autism and family functioning with autism. Her current research focuses on training parents, adult outcomes, and autism treatment responder characteristics as a function of autistic learning disabilities and autistic learning styles.

In addition to having current memberships in the Autism Society of America, International Society for Autism Research, and the American Psychological Association, Dr. Siegel was a member of the California State Autism Diagnostic Standards Committee (2001-2003), the California Department of Developmental Services Director's Advisory Committee & Governor's Blue Ribbon Panel on Autistic Spectrum Services (2001-2002), and the California State Autism Treatment Standards Committee (2005-2007).

### **Lorri Unumb, J.D.**

Lorri Unumb is a lawyer and the mother of three children — Ryan (10), who has autism; Christopher (7); and Jonathan (4). In 2005, while working as a law professor, she wrote groundbreaking autism insurance legislation for South Carolina ("Ryan's Law") that passed in 2007 and served as a catalyst for the national movement toward autism insurance reform.

In 2008, Unumb became employed by the New York-based non-profit Autism Speaks, where she advocates full-time on behalf of individuals with autism. As head of state government affairs, she has testified over 75 times on health insurance issues in state legislatures around the country. For her advocacy efforts, Unumb has been recognized with the Jefferson Award for Public Service; the Autism Society of America 2008 "Parents of the Year" award (along with her husband); and the Behavior Analyst Certification Board's Michael Hemingway Award.

Ms. Unumb is the founder and organizer of Autism Law Summits, which are free, national gatherings of parents and professionals interested in effecting legislative change related to autism. She also is the host and Associate Producer of "Autism – A Family Struggle," a television documentary that received the 2007 "Golden Palmetto" award for Excellence in Community Relations.

Unumb's work has been profiled on CNN, on NPR's "Morning Edition," and in Town & Country magazine, from whom she received one of three 2009 "Women Who Make a Difference" awards. Unumb teaches a law school seminar at George Washington University called "Autism and the Law." Last year, she and her husband Dan released the first-ever comprehensive textbook on legal issues related to autism, also called "Autism and the Law." Unumb is presently working in her home state to establish the non-profit Autism Academy of South Carolina, the only ABA-based, one-on-one school for children with autism in the state.

Ms. Unumb was one of the primary drafters and consumer-backers of SB 946. She is currently working with the U.S. Department of Health and Human Services on issues related to autism and the essential benefits package under the PPACA.

### **Renee C. Wachtel, M.D**

Dr. Renee Wachtel is in private practice as a developmental-behavioral pediatrician, is a Staff Scientist at Children's Hospital Oakland Research Institute in Oakland, California, and the Medical Director at Medical Management and Rehabilitation Services, Inc.

As a pediatrician Dr. Wachtel has been clinically involved with children with autism spectrum disorders and their families for over 30 years. Her past appointments include, but are not limited to, the following: Director, Division of Developmental and Behavioral Pediatrics, Children's Hospital and Research Center at Oakland, California (2000-2008); Professor of Pediatrics, University of Maryland School of Medicine (1996-2000); Associate Professor of Pediatrics, the Johns Hopkins School of Medicine (1985-2000); Director, Division of Behavioral and Developmental Pediatrics, University of Maryland School of Medicine (1996-2000); and Pediatrician, Department of Pediatrics at both The Johns Hopkins Hospital and The John F. Kennedy Institute in Baltimore, Maryland (1975-1996).

As an active member of the American Academy of Pediatrics (AAP), Dr. Wachtel has served as the Chairperson, Committee on Developmental and Behavioral Pediatrics, Northern California Chapter, since 2000 and served as the Chairperson, Committee on Disabilities, Maryland Chapter, from 1988-1995 and 1999-2000. She also served as co-chair of the State of Maryland Interagency Coordinating Council.

Dr. Wachtel recently served with the CA Health Benefits Review Program as an autism expert consultant and is the Chair of the Bay Area Autism Consortium. She is currently involved in autism research through Children's Hospital Oakland Research Institute (CHORI) and serves as an autism grant reviewer for the Department of Defense. In 2007-2008 Dr. Wachtel was appointed Chair, Autism Task Force, Children's First Medical Group and has received the "Best Doctors of America" award from 2007 to 2012, Dr. Wachtel been awarded research grants, conducted many individual research projects, and authored numerous journal articles, book chapters, and abstracts.

### **John Youngbauer, Ph.D.**

Dr. John Youngbauer is the Behavioral Services Supervisor at the North Los Angeles County Regional Center (NLACRC), a licensed Marriage and Family Therapist, and a Board Certified Behavior Analyst-Doctoral. He is a part-time faculty member in the Department of Psychology at California State University, Northridge.

In 2003, Dr. Youngbauer adapted the Alaska Autism Intensive Early Intervention Model (Todd Risley, 2001) to the needs of persons with autistic disorder living in North Los Angeles County. The North Los Angeles County adaptation became NLACRC intensive ABA services for autism model. Since its implementation in 2003, about 1,100 children with autism have received early intensive ABA services at NLACRC per year. The first cohort of children completed the program in 2006 with 47% starting school without needing an IEP or any other specialized services; the remaining 53% made clinically significant gains in communication, socialization, and self-help skills. Dr. Youngbauer presented the model's initial outcomes at the 2007 Association for Behavior Analysis International Conference. He continues to work with NLACRC's vendor

community to improve training and quality of services and participate in the development of effective and cost effective services for children with autism.

In addition to over 20 research publications, Dr. Youngbauer has authored chapters in the DDS Best Practices in Behavioral Services at California Regional Centers and contributed to the conceptual design of the National Standards Project at the National Autism Center. He is on the advisory boards for the both the California Department of Developmental Services and the California Department of Education project on Best Practices in Autism Treatment and for the Center on Autism Research and Training at UCLA. Dr. Youngbauer was asked by the Directors of the Association of Regional Center Agencies to write and define the parameters of behavioral services which is reflected in Section 4686.2 of the Lanterman Act.

Dr. Youngbauer received a Ph.D. in Developmental and Child Psychology and a M.A. in Human Development from the University of Kansas and a M.A. in Educational Psychology and a B.A. in Psychology from California State University, Northridge. He has a younger brother with autism.