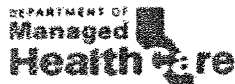
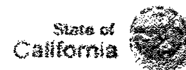




Supplement to an Application for an Award of Advocacy and Witness Fees

Entity Name:	Autism Health Insurance Project, Inc.
Proceeding:	Pervasive Developmental Delay and Autism Coverage
Date Submitted:	3/14/2013 2:17:05 PM
Submitted By:	Karen Fessel
Application version:	Supplement 2

1. For which proceeding are you seeking compensation?

   Pervasive Developmental Delay and Autism Coverage

2. What is the amount requested?

   $7,912.50

3. Proceeding Contribution:

   Provide a description of the ways in which your involvement made a substantial contribution to the proceeding as defined in California Code of Regulations, Title 22, Section 1010(b)(8), supported by specific citations to the record, your testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence.

   The Autism Health Insurance Project is a non-profit agency devoted to helping families with children on the autism spectrum and the professionals that serve them obtain medically necessary treatments from health insurance companies and health plans. We offer direct advocacy services, as well as co-moderate two message boards comprised of more than 1300 parents of children with autistic spectrum disorders. We have also been assisting providers get into health plan networks during this transitional phase. In this capacity, we are in an ideal situation to monitor the implementation of the SB 946, the new autism mandate. We reported on potential problems we envision with requiring licensed provider to deliver ABA services to CALPERS and Healthy Families clients, including provider shortages as well as violating CA government code 11346.5 (a) (13). We also reported on problems encountered by providers when plans were attempting to build networks. One such problem involved a plan trying to limit the number of supervisory hours providers could impose, which directly violates the new autism mandate, as autism service providers are supposed to determine the hours based on medical necessity. We noted that one plan repeatedly required an excessive number of evaluations and test batteries in order to process requests for ABA, even requiring copies of the IEP, which is a confidential educational document. The same plan repeatedly denies for medical necessity reasons for low functioning individuals, stating cognitive levels are too low to learn, and that the members no longer need treatment, for high functioning indidividuals. Such rulings are nearly always overturned in IMR, but delaying treatment is less costly than the costs of IMR and the plan often does not have to pay retroactively. One plan routinely underpays all claims. Claims must be resubmitted multiple times and even then, they are often paid out at rates that are much lower than what was pre-negotiated with providers.

Document Name	Date Uploaded	Uploaded By	
comments on PDD for autism coverage	3/14/2013 2:11:01 PM	Karen Fessel	View
comments on emergency rulemaking	3/14/2013 2:11:01 PM	Karen Fessel	View

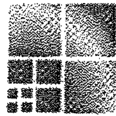
resier comments on emregency	3/14/2013 2:11:01 PM	Karen Fessel	View
Market Rates for ●PP program	3/14/2013 2:13:34 PM	Karen Fessel	View

4. Please attach your Time and Billing Record in the "Add Attachment" box below. If you do not have your own Time and Billing Record, please use the DMHC template.

Document Name	Date Uploaded	Uploaded By	
CPP Quickbook statements	3/14/2013 2:16:29 PM	Karen Fessel	View

I am authorized to certify this document on behalf of the applicant. By entering my name below, I certify under penalty of perjury under the laws of the State of California that the foregoing statements within all documents filed electronically are true and correct and that this declaration was executed at _Lafayette_ (City), _CA_ (State), on _March 14, 2013_ .

Enter Name: _Karen Fessel_

 Autism Health Insurance Project

Department of Managed Health Care

Jennifer Willis, [redacted]

[redacted]

August 30, 2012

Dear Ms Willis,

Thank you for taking the time and energy to develop this regulation. We understand that the intent behind it is to allow people with autism who have coverage through CALPERS and the Healthy Families program to access medically necessary behavioral therapy through their insurance, as required under the state mental health parity act. We appreciate that the DMHC is standing up to the insurance industry and making it clear that though the legislature did not include these entities in the recent autism mandate, they still are entitled to benefits which were already granted under the CA AB88. We agree wholeheartedly with this decision. We also appreciate that the department is clarifying the need for plans to build adequate provider networks, and what they intend to do to make sure that this happens.

While we support the intent behind the emergency regulation, we do have many concerns about many of the specifics which are mentioned in the ruling, and are voicing our concerns during the public comment process, with the hopes that you will use the information provided to revise and reconsider some of your positions.

Licensing: Your emergency rule states that under Knox Keene, only persons or institutions licensed by the state may furnish health care service. You further cite that the Business and Professions Code section 2052 provides that only licensed providers may diagnose or treat a person with a physical or mental illness **unless the legislature provides an exception to the prohibition.** The legislature HAS ALREADY provided an exception on who may provide behavioral health treatment to people autistic spectrum disorders, it is clearly laid out in SB 946 that autism service professionals and paraprofessionals may provide behavioral intervention therapy, so long as it is supervised by a qualified autism service provider, which is defined as anyone with an appropriate license **or a BCBA certification.** The reason that is was so clearly delineated in the law was because the DMHC had previously interpreted who could provide/deliver ABA services to be only persons with licenses. The problems

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inherent in this "solution" were obvious: there were and are simply not enough licensed providers trained in this field to fill the demand. Autism Service providers study and train in this field to design and supervise MANY cases, not to actually deliver the care to one or two children a week. The treatment delivery is traditionally done by autism paraprofessionals. This is the industry standard.

We believe that allowing only licensed professionals to deliver ABA was a solution devised by your department to avoid getting sued by the insurance industry. Now that the law SB 946 exists, who may deliver this program has been clearly defined and there is no need to bring families back to the dark ages of scrambling to find licensed providers or interns to deliver this care, or waiting for therapy for months and months. This "solution," in the rare instances when it actually worked, resulted in insurance companies paying WAY MORE MONEY than was standard or necessary for the service. Your agency is basically proposing that this be done yet again, but this time with PUBLIC FUNDS, because these two programs are publicly funded!! It is irrational and irresponsible. While we know that this law explicitly excluded the two populations being discussed, the law clearly defines who can deliver ABA services.

You erroneously state the following: "Since the Implementation of Mental Health Parity in 2000, health plans have been required to cover medically necessary treatments for autism, including ABA therapy, when provided by a licensed provider." This is blatantly false. The department sent these cases to IMR, when they came back overturned in favor of the families, your department ordered the care to be provided and did not get into the specifics of who was delivering the care FOR MANY YEARS. When you started to see denials stating that ABA was not a health care service and ABA was not delivered by licensed providers, you asked the IMR to rule on these issues. Here are some of the rulings:

Reviewers Findings:

The parent of an eight-year-old male enrollee has requested behavior modification therapy for the treatment of the enrollee's condition. Findings: The physician reviewer found that the medical literature confirms the success of ABA, both after several years of therapy and after long-term follow-up. In this instance, therapy is being supervised by qualified and licensed psychologists and social workers. **The utilization of trainees in the medical arts has a long tradition of encouraging and depending on unlicensed personnel.** Medical students and interns are supervised, but practice unlicensed medicine. Post-graduate psychologists and family therapists all need to spend three years of supervised clinical practice to be able to sit for the licensing examination. Thus, **supervised therapy by a licensed therapist is licensed therapy by proxy.**

Reviewer's Findings

The parent of a five-year-old male enrollee has requested for occupational therapy, speech therapy and applied behavioral analysis (ABA) therapy for treatment of the enrollee's autism. Findings: **Two physician reviewers found that ABA therapy is an intensive therapeutic modality that has been available for the treatment of children with autistic disorders for some time. It is considered a health care service in the treatment of autism spectrum disorders.** Several recent publications have suggested that ABA therapy can result in positive gains for autistic children.Occupational therapy has been widely utilized to improve motor skills in autistic children. The peer-reviewed papers referenced above discuss occupational therapy in autistic and developmentally disabled children. Occupational therapy is well established as beneficial and is often integral to the habilitation of autistic children.Speech therapy is also a well-accepted modality for children with autism and can play a vital role in helping improve communication skills in this patient population. A treatment plan with specific goals must be delineated and written, and progress must be measured using appropriate metrics on a relatively frequent basis.

Reviewer's Findings

The parent of a six-year-old male enrollee has requested speech therapy, occupational therapy and applied behavioral analysis (ABA) therapy for the treatment of the enrollee's autism. Findings: **Three physician reviewers found that the National Institutes of Mental Health discovered that among the many methods available for treatment of individuals with autism, ABA has become widely accepted as an effective treatment.** Filipek and colleagues indicate that treatment requires a comprehensive multidisciplinary approach that includes speech-language therapists and occupational therapists. Foxx and colleagues note that ABA is a state of the art treatment modality for this medical disorder. ABA utilizes methods derived from scientifically established principles of behavior. Various behavior and analytic methods are employed and individualized for the patients. Whenever possible, treatment should approximate the patient's natural environment. **ABA therapy is a therapeutic intervention and a health care service and is accepted in the professional standards of practice.** The medical records of this patient document the impairments and symptoms that support the need for the requested ABA therapy, speech therapy and occupational therapy. These requested services are medically indicated for treatment of this patient.

Your department chose not to include these rulings in your determinations, but rather created the argument that if the treating provider "opines" that ABA requires the skill and expertise of a licensed health care provider, then the services are likely to be considered health care services and consequently a covered benefit. We believe that you did this to avoid getting sued by the health plans. Many families went through a lot of gyrations, asking their doctors to write letters which included this stipulation, only to be put in a situation where there were no licensed providers who were able to actually deliver the care on the back end, once services were authorized. You stopped sending these cases to IMR, and issued "legal" rulings based on whether certain phrases were included in the authorization letters. When faced with the same set of circumstances, the Department of Insurance, your sister regulatory agency, continued to send these cases to IMR and allowed services to be delivered by paraprofessionals under supervision of licensed providers.

Your regulation goes on to state that its purpose is "to ensure that CALPERS and Healthy Families members continue to receive medically necessary BHT in a timely manner without interruption consistent with the existing mental health parity law." If you do not relax the licensing requirements, as defined in SB 946, how will you be able to ensure that members continue to receive this care? There simply are not enough licensed providers to deliver the care. We know this because many clients with BSC insurance waited for months and months to receive care, and were not able to obtain it until the settlement agreements went into effect. BSC insisted on only allowing

licensed providers to deliver care, and refused to build a network. Those who managed to find licensed providers to deliver the care, found them on their own.

We would argue that under the Law of Statutory Construction, requiring that plans have licensed providers deliver ABA for their CALPERS and Healthy Families clients but not for other state regulated clients violates the intent of the legislature in defining who can deliver ABA, and also will result in absurdity (families waiting for months to get a licensed provider to deliver care, expecting families with Healthy Families insurance to pay for the non-licensed portion of the ABA) rather than wise policy. You are advocating for harmonizing the two laws on the one hand, yet you are falling short of the mark because what you are proposing is simply not feasible, --it is in fact absurd.

In your response memorandum of August 27, 2012, to Kaiser Permanente in response to their request for clarification from your office on licensure and certification requirements for "Public Purchasers," DMHC stated "The Legislature, not the Department, is the appropriate entity to establish licensure and certification requirements for individuals who provide BHT." Yet half of the Emergency Rulemaking memorandum was devoted to the DMHC's "interpretation" that licensed providers should deliver this care. This is inconsistent with how you responded to Kaiser, who needed to know this information for what appears to be legitimate acturarial purposes.

We respectfully request that you reconsider this policy in light of the fact that there are simply not enough licensed providers to deliver the care.

Network adequacy:

Three Tiered System specified in law:

According to the Rulemaking section on network adequacy, each plan must report the number of qualified autism service providers and the number of qualified autism service professionals and paraprofessionals that work with them. We have been helping ABA agencies get credentialed within plans. MOST plans are not distinguishing between autism service professionals and paraprofessionals, they are only credentialing autism services providers, everyone else without the BCBA or the license is listed as a paraprofessional. From reading your regulation, it looks like the health plans will be legally obliged to list autism service professionals under each autism service provider/group. Most ABA agencies have this level / tier of provider, but if they are not licensed or certified, they are not being properly compensated or distinguished in any way from paraprofessionals. We believe that the intent of the law, as well as the intent of your regulation, is to have a list of these autism service professionals, and to allow them to be properly recognized and properly compensated. Of the plans and contracts that I have seen, ONLY Kaiser and Anthem Blue Cross are allowing recognition and compensation of this tier. None of the other plans, including the following, are recognizing this tier: Aetna, United Behavioral Health, Magellan (Blue Shield), TriCare, Cigna Behavioral Health, ASG/MHN/HealthNet, or Value Options.

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We have encountered numerous problems in Health Plans attempts to build adequate networks. We have experienced huge delays in building the networks. We contact them, get in our paperwork, and wait and wait and call and call. We have been at it nearly full time since April. Magellan would only offer contracts if the supervisors agreed not to bill concurrently with paraprofessionals. When we pointed out that this violates the evidence based part of SB946 (there is no evidence that shows that this is effective), they said that they would change it, but it has been over three months and they still have not offered a revised contract. One provider agency received a revised contract from Magellan, but it was accompanied by an e-mail which stated that they would not pay for anything done when the patient was not there. This is virtually impossible, as ABA includes team meetings as well as prep time. Children with autism cannot tolerate sitting through this kind of activity. We believe that these types of devices are stalling tactics.

A couple of health plans are refusing to negotiate the amounts that they are offering, and they are offering unacceptably low rates (Autism Services Group (HealthNet/MHN), Value Options, and Cigna. We don't feel that this represents good faith.

Kaiser and Easter Seals:

Kaiser, the largest insurance company in the state, has elected to use ONLY one provider, Easter Seals, in most areas of the state (the one exception is the Sacramento area, as the local Easter Seals voted against getting into the ABA industry). This is creating HUGE problems for Kaiser consumers. In most parts of the state, Easter Seals is in no way ready to accommodate the huge influx of patients needing services. We have heard reports from clients who requested ABA therapy up to six months ago and have been told that Easter Seals will get in touch. Or Easter Seals will get in touch and conduct an evaluation, and then tell the families that they will get in touch when they are ready to start, but then months go by and they still don't have the capacity to start services.

One parent told me the following: "When I told [the Easter Seals evaluator] that ______'s pediatrician had told me they were hiring 2000 new employees and I found it hard to believe they would be able to be trained and ready to go, she told me she agreed. ...And while the intent would be to provide a quality program, everyone was coming in from various agencies with various levels of skills. They expect there to be some turnover because not everyone would make it. I asked how they trained their new employees and she told me that most came in trained already. I asked her how they verify skills and she indicated it would happen on the job.

When I gave her the regional center progress report from [another agency], she said they didn't really need to do an evaluation with this information already in hand. I said 'absolutely not. She needs an evaluation by Easter Seals before you can recommend and provide treatment. Plus, this is based on the 10 hours a week that the regional center agreed to. _____ truly needs more hours of service. That's the purpose of an evaluation!' She tested ____ for two hours or so and then left. I told her _____ was only

in school until July 24th, she contacted me well after that and asked when was _____'s last day of school was so she could observe her in school. She never observed her in school. She left all of her notes behind, but I received a letter anyway from Kaiser recommending 10 hours a week."

The above description is a recipe for disaster, Easter Seals is not training their staff, and they are recommending the same level of treatment to everyone, regardless of medical necessity, level of severity, age, or goals.

An additional problem is that Easter Seals does not have contracts with school districts. MANY children with autism have services from the school district in the school and also have services from regional center or insurance in the home. Any ABA expert will tell you that it is detrimental and confusing to autistic children to have to negotiate completely different agencies in home and school. Children need one agency in the home and school to deliver the care. This is commonly agreed upon among the experts, and Kaiser, by contracting with an agency that does not have NPA status in most districts, is not eligible nor legally able to deliver care in both environments.

A network of one is not a network. Children with autism have diverse needs, it is unrealistic to expect that one agency can handle all these needs.

We have also heard numerous reports of stalling treatment initiation from Anthem. The client will send in all relevant paperwork, including a current treatment plans with goals. Anthem will ask for additional documentation, including things like speech and occupational therapy evaluations, when the patient is requesting ABA, and the initial diagnostic report (sometimes this document will be 15 years old!!) They will issue denials because "we do not have enough documentation to make a determination."

Clearly, all the plans need definite timelines. For example: 10 days from date that services are requested until the patient gets an evaluation. 14-21 days for the evaluation. 7 days from evaluation to start of therapy. We are including this here because we believe this is part of having an adequate and accessible network.

Thank you for taking the time to carefully review, consider, and I hope, include my comments in the revision of your emergency regulation. Thank you also for taking the time to stand up to the insurance industry and require that they provide ABA to clients with CAL PERS and Healthy Families insurance.

Sincerely,

Karen Fessel, Dr PH

Executive Director and Founder

Autism Health Insurance Project

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Jennifer Willis

Office of Legal Services

Department of Managed Health Care

October 25, 2012

Dear Ms Willis,

I am writing formal comments in response to the DMHC regulation "Pervasive Developmental Delay and Autism Coverage." The Autism Health Insurance Project is a non-profit agency devoted to helping families with children on the autism spectrum and the professionals that serve them obtain medically necessary treatments from health insurance companies and health plans. We offer direct advocacy services, as well as co-moderate two message boards comprised of more than 1300 parents of children with autistic spectrum disorders. We have also been assisting providers get into health plan networks during this transitional phase. In this capacity, we are in an ideal situation to monitor the implementation of the SB 946, the new autism mandate.

Healthy Families, CalPERS

From my reading of the revised regulation, you be will evaluating the networks for CALPERS and Healthy Families for their adequacy to DELIVER care by licensed providers. If that is correct, how are you going to assess this adequacy, and distinguish those licensed providers that are in the network for supervision purposes, from those who will actually be delivering the care? What type of data will you be looking at to assess this?

Given that the state will be paying the premiums for CALPERS and Healthy Families, and given that health plans will turn around and raise costs at the earliest opportunity allowed, and given that it is less expensive for care to be delivered by paraprofessionals and supervised by licensed providers and BCBAs rather than be delivered by licensed providers, it makes economic sense to allow paraprofessionals to deliver the care.

According to the CA government code 11346.5 (a) (13): "The adopting agency must determine that no reasonable alternative considered by the agency or that has otherwise been identified and brought to the attention of the agency would be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed action." It is more effective and less burdensome for paraprofessionals rather than licensed providers to deliver the care. Having licensed providers deliver the care is not feasible, as there simply are not enough of them around to do this.

If I am incorrect in interpreting what this regulations is saying, please let me know. If I am correct, please let me know how you will assess network adequacy of licensed providers to DELIVER (rather than supervise) the care.

There are also other issues which have come to my attention in the course of helping providers get into networks with health plans and health insurance companies.

Limits on Supervisory Hours

The following statement appeared in letters sent to potential in-network providers with a large health plan (I have sent a copy of the letter to Ms Pearson, Mr Barnhart, and Ms McKennon): "We will now pay the supervisor and ABA provider when they are both present for services up to four hours a month." This is supposed to cover all supervision services that a member receives for ABA services.

Yet this restriction directly contradicts SB 946. The law specifically states that the autism service provider "designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives..." (section 1374.72 C (ii))

It is up to the autism service provider, not the health plan, to determine the number of hours needed to achieve the goals, and that includes the number of hours of supervision and provider time. Some cases are highly complex and require a great deal of tweaking and program modification. To limit providers to four hours of supervision for each child fails to provide children with medically necessary care, as explicitly specified in the law and also in the intent behind the law. Evidence based ABA, which is also specified in the law, does not include hard and fast limits on the amount of supervision that each child can get, each program is supposed to be developed in accordance with the individual needs of the child. The federal mental health parity law also does not allow for number of hours of services to be limited for mental health treatment if no more than 2/3s of medical services are also limited, which in most plans, are not. What are your thoughts on this? How should this restriction be handled? I've had many ABA

providers ask me what they should do, in terms of signing this contract. It appears to me to be violation of the law.

Excessive demands for evaluations:

We are seeing an excessive amounts of delays in many health plans and insurance companies in providing the statutorily mandated behavioral health treatments. We are seeing this in many ways:

One large plan repeatedly requests an excessive number of evaluations before they will process ABA requests. We have seen denials stating insufficient information to process the request if certain tests and psychological batteries have not been administered. The plan will state that they do not have adequate information to determine if ABA is medically necessary. We have been asked to provide individualized education plans (IEPs) for many patients, because the insurer or plan has told parents that is needed information before ABA can be approved. The IEP is a confidential EDUCATIONAL document and should not be required in order for a patient to obtain medical treatment. When we have asked this same company if they will pay for the testing and neuropsychological evaluation, since they are requiring it, they have responded that they will not. We have also been required to provide speech and occupational therapy evaluations and treatment plans for clients who were requesting ABA. This is hardly relevant when we have already provided a treatment plan for ABA. We have also had cases where the plan has disagreed with the autism diagnosis, even though some of the clients have had classic autism with numerous evaluations which attest to it. This same company requires that clients provide the initial autism diagnostic report. This document is sometimes more than ten years old and seldom has any relevance as to the level that the child functions at today. It is often hard for parents of older children to locate such documents. I have also seen several denials from this same company stating that cognitive levels are too low to learn or show adequate progress (sometimes this is even at baseline, before there is a chance to show progress). These cases have to go to regulatory IMR, and are nearly always overturned, but it costs the children several months of delays in getting service. Either the children get no services during this time, or the regional centers are forced to pay, even though the law is already in effect. Many families have also told me that that they have been told verbally, on the phone, that they are being denied because the child is too old to show benefit, but that reason never appears in writing, as the plans know that they can't officially use that as a reason for denial, as the law has no age limits. When the children are high functioning, we have seen this company say that the child no longer needs therapy, even though the child continually tantrums and exhibits behaviors which need remediation.

Repeated and deliberate "mistakes" and underpayment of claims

From another company, we have seen repeated "mistakes" in processing claims, which occur so frequently that it is virtually impossible to get paid the correct amount right off the bat. Recently we had a client that sent in 4 months of claims, the insurer paid one month at the out of network rate, and didn't process the other three. The provider had a letter of agreement, so the payments should have been processed at the in-network rate. When we called on the phone, they denied receiving two additional months of claims. We called the next day with the confirmation # from the post office, and miraculously the two additional months were found. To re-process the claims, one had to call on the phone and stay on the phone with them for approximately 30 minutes, while they resubmitted the claims for "re-processing." It doesn't mean they will get it right the next time, either. I had one case where the plan hadn't paid for several months, when all was said and done, there were over $80,000 worth of unpaid claims that hadn't been processed, over the course of eight months.

Network of One Incompetent Agency

Another very large plan has only contracted with one ABA agency. Families report that they often have to call repeatedly when they initially request services, violating state timely access standards. The agency routinely tells families that they are swamped and getting far more calls than they can handle. They have also told clients that they are not training their staff, but rather are trying to hire people with experience. When children finally get evaluated, the quality is generally poor. One high functioning six year old was recently tested with instruments designed for a child four years old or younger. The report totally underestimated her abilities. After the evaluation, families are told that the agency will call them when they have availability, which can take several months and violates state timely access standards. Many are getting fewer hours than stated in the evaluation, as this one agency does not have the capacity to serve them. It is a disaster.

No Transition Plan, Refusal to Negotiate with ABA agencies

Another plan has a limited number of ABA providers in their network because they offer very low rates and refused to negotiate in any way with providers. They are requiring their clients to switch over to their new in-network providers, even though many are with providers that were previously recommended by the plan. ABA industry standards generally includes a month of overlap when transitioning from one agency to another. This company was offering no transition plan. Children are being switched even if they

have specific medical reasons that require them to stay with their current providers. Medical necessity is not being considered.

Please feel free to contact me with any questions. Thank you for this opportunity to share these experiences. This is really just a small amount of the problems that I have seen. I am happy to go into more detail on any of these or other issues.

Sincerely,

Karen Fessel, Dr PH
Autism Health Insurance Project
http://www.autismhealthinsurance.org/
510-325-0975

This email is intended to provide comment on the Emergency Rule Making Package regarding Pervasive Developmental Disorder and Autism Coverage, Adopting Section 1300.74.73 in Title 28, California Code of Regulations; Control No. 1012-3681

I would like to submit comments as they relate to the requirements of health plans to "Maintain Adequate Networks".

I am an associate of Karen Fessel with Autism Health Insurance Project. I have been working to provide credentialing and contracting assistance to Applied Behavioral Analysis agencies in California. I have a 15 year background working with health care providers and contracting with health plans nation wide.

I admire the efforts of the Department of Managed Health Care to ensure that health plans regulated under it's authority are prepared to meet the needs of covered individuals under SB946.

However, it has been my recent experience that health plans regulated by the Department are confused about the credentialing requirements outlined in SB946; are unprepared to process and complete requests to join their networks in a timely fashion; and have prohibitive language in their contracts related to billing for ABA Services provided by the different tiers of professionals outlined in SB946.

In May and June of 2012, I began, on behalf of the multiple agencies I work with, to complete the Request For Application process for Blue Shield, Blue Cross, United Behavioral Health, Cigna, Aetna, and a number of other regional health plans. To date, only three plans have completed some credentialing and have provided contracts. It is my experience that the health plan process for reviewing and considering a request to join the network, completing the full credentialing process, and mailing out the contracts for signatures can take from 60 to 180 days. This delay in processing information, completing credentialing, and executing contracts, will produce a shortage of providers in the health plan networks and will be detrimental for those health plan members in need of critical therapies.

Additionally, at least three of the health plans we have worked with have contract language that prohibits concurrent billing of supervision by an autism professional and provision of ABA Therapy by a paraprofessional. This practice is not consistent with the health plan's stated desire to provide necessary, evidence based care to their members. In order for an ABA program to be successful and evidence based (as well as being the best practice in the industry), supervision of a paraprofessional must be provided in the same location and at the same time as the therapy is occurring, allowing for adjustment to the therapy program and appropriate oversight of the paraprofessional providing the therapy. ABA providers must also be able to bill for all of the indirect treatment time they spend on case meetings, parent and staff consultations, and other essential tasks that make ABA Therapy treatment successful.

I would ask that the DMHC consider a maximum time limit for health plans to process credentialing information for ABA providers and to ensure that contracts are negotiated and executed within a reasonable amount of time. I have been waiting for more than 60 days for responses to my contract negotiation requests from several of the larger health plans.

Thank you for your consideration of my comments.

Respectfully,

Sarah Resler
Autism Health Insurance Project
Credentialing Specialist

Fax

Market Rates

Dr Fessel has a doctorate in Public Health from UC Berkeley. She has five years of experience working as the executive director of the Autism Health Insurance Project, where she has done significant advocacy and policy work in the area of autism and health insurance coverage. She co-chairs the autism subcommittee on insurance with the East Bay Autism Regional Task Force of the Senate Select Committee on Autism and Related Disorders. Karen served as a parent advocate on the initial DMHC Autism Advisory Workgroup, and is a member of the Consumer Advisory Panel to the California Department of Insurance. Dr. Fessel is a board member of Through the Looking Glass, and a co-founder of the ASDinsurancehelp yahoo users group, a group for parents needing assistance with insurance issues. She founded The Autism Health Insurance Project to support families in their journey through the insurance maze, so that they can be treated fairly through the process, and their children can get the coverage for interventions that they so desperately need.

Prior work experience includes working as a research specialist for the California Center for Autism and Developmental Disabilities Research and Epidemiology (CADDRE), developing technology assessments and clinical practice guidelines for the Permanente Medical Group and the Permanente Federation, and several positions conducting public health research.

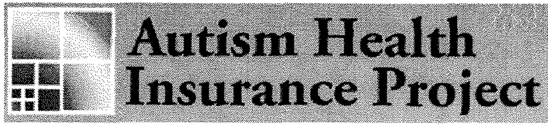
Billing rate classification: Non-attorney expert with over 13 years of relevant experience. According to the PUC adopted ranges, current rates range from $155 - $390. Ms Fessel is requesting $270/hour.

Sarah Resler

Ms Resler has worked as the credentialing director at Autism Health Insurance Project since July of 2011. She has over ten years of progressive medical management leadership in hospital, health system, and private practice environments. She has demonstrated success in revenue management, accounts receivable, and cost management. She has experience in physician relations, managed care contracting, physician credentialing, practice management systems implementation, medical office construction management and regulatory compliance. Special interest in advocacy for developmentally disabled children and their families.

Billing rate classification: Non-attorney expert with over 7 to 12 years of relevant work experience.

According to the PUC adopted ranges, current rates range from $155 - $270. Ms Resler is requesting $160/hour.



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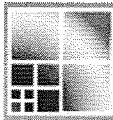
Date	Invoice #
10/25/2012	355

Bill To
C●nsumer Participati●n Pr●gram Department ●f Managed Health Care

Date of Service	Item	Description	Hours	Rate	Amount
8/20/2012	Reviewed d●cu...	Reviewed Pr●p●sed Emergency Rulemaking regulati●n, PDD/Autism Karen Fessel	3	270.00	810.00
8/20/2012	Reviewed d●cu...	Reviewed Pr●p●sed Emergency Rulemaking regulati●n, PDD/Autism Sarah Resler	3	160.00	480.00
8/28/2012	ph●ne call	ph●ne call with Jennifer Willis asking for clarifying informati●n re: whether and why DMHC was requiring that licensed pr●viders deliver the care. Ms Willis clarified that was in fact the p●siti●n ●f the department. I explained t● Ms Willis that there w●uld be pr●blems with netw●rk adequacy if that was the requirement. I als● explained t● Ms Willis that there were MANY ●ther pr●blems that pr●viders were experiencing in attempts t● bec●me in-netw●rk with health plans, and als● pr●blems that c●nsumers were experiencing in ●btaining medically necessary treatments. She enc●uraged me t● include this in the c●mments that I shared ab●ut this regulati●n, as she felt it w●uld be helpful t● the department as well as further inform what needed t● g● int● the regulati●n. Karen Fessel	0.5	270.00	135.00
8/28/2012	Reviewed d●cu...	Reviewed Kaiser letter t● DMHC ●n this issue	0.5	270.00	135.00
8/28/2012	Reviewed d●cu...	Reviewed Anthem letter DMHC ●n this issue	0.5	270.00	135.00
8/28/2012	Reviewed d●cu...	Reviewed Blue Shield letter t● DMHC ●n this issue	0.5	270.00	135.00
8/28/2012	Reviewed d●cu...	Reviewed letter fr●m California Ass●ciati●n ●f Health Plans	1	270.00	270.00

Total	
Credits	
Balance Due	



Autism Health Insurance Project

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Lafayette, CA 94549

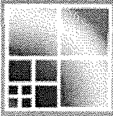
Invoice

Date	Invoice #
10/25/2012	355

Bill To
Consumer Participation Program Department of Managed Health Care

Date of Service	Item	Description	Hours	Rate	Amount
8/28/2012	e-mail	consulted with CAL ABA members on reasonable timeframes in which to conduct evaluations, and reasonsable timeframes from completion of evaluations to establish a team and start ABA services,Karen Fessel	1	270.00	270.00
8/30/2012	wrote letter	Wrote letter for emergency rulemaking. As instructed by Ms Willis, included information about problems that consumers and providers were experiencing in obtaining medically necessary approvals and setting up networks.	5	270.00	1,350.00
9/6/2012	Reviewed docu...	Reviewed OAL's notice of approval of emergency regulation, Karen Fessel	0.5	270.00	135.00
9/4/2012	wrote letter	Sarah Resler wrote letter on challenges facing ABA agencies in becoming in-network	3	160.00	480.00
10/5/2012	Reviewed docu...	Reviewed proposed rulemaking action "Pervasive Developmental Disorder and Autism Coverage," section 1300.74.73 of Title 28 of the California Code of Regulations., Karen Fessel	1.5	270.00	405.00
10/9/2012	e-mail	Re-reviewed proposed rulemaking action "PDD and Autism Coverage" specifically, section on the duty of the state to spend state monies efficiently, in order to write e-mail to Holly Pearson.	1	270.00	270.00

Total	
Credits	
Balance Due	



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Date	Invoice #
10/25/2012	355

Bill To
Consumer Participation Program Department of Managed Health Care

Date of Service	Item	Description	Hours	Rate	Amount
10/9/2012	wrote letter	Wrote E-mail to Holly Pearson (2 hours) asking about licensing issue, questioned money and efficiency burden to state to have licensed providers deliver ABA care, Holly forwarded the e-mail to Jennifer Willis, and encouraged me to write up a formal comment, including all the concerns that consumers and providers had encountered. Karen Fessel	2	270.00	540.00
10/25/2012	wrote letter	Wrote formal letter, including comments from e-mail and added additional challenges that our organization has been experiencing, in helping consumers obtain treatment, and in helping providers get into the plan networks. Karen Fessel	5	270.00	1,350.00

Total	$6,900.00
Credits	$0.00
Balance Due	$6,900.00