

FAQs Regarding Insurance Funding for Behavioral Health Treatment for Autism and PDD

September 28, 2012

Please note that this document provides information about a situation that continues to evolve. As such, ARCA anticipates that changes will be made to it as updated information becomes available.

1. Which insurance plans are required to provide funding for behavioral health treatments for autism and PDD?

As a result of Senate Bill 946, every privately-funded health insurance plan that provides hospital, medical or surgical coverage in addition to behavioral and health services, is responsible for the coverage of these services as of July 1, 2012. Additionally, the Department of Managed Health Care has indicated that as of this same date this responsibility also applies to plans funded by Healthy Families as well as certain plans funded by CalPERS under Assembly Bill 88 (Mental Health Parity). TRICARE has been funding for ABA services for active duty family members, but was recently ordered by a federal court to begin providing the service to all members. It may be some time before TRICARE expands coverage to all members.

2. Which CalPERS plans are required to fund behavioral health treatments for individuals with autism or PDD?

The three CalPERS HMO plans (Blue Shield of California Net Value, Blue Shield Access+ and Kaiser Permanente) are required to fund these services. CalPERS PPO plans (PERS Select, PERS Choice and PERSCare) are self-funded and are not required to offer these services.

3. Do different standards apply to plans funded by CalPERS and Healthy Families?

Yes. As of September 6, 2012 there is an emergency regulation in place that applies to plans funded by CalPERS and Healthy Families. Essentially, the regulation establishes that CalPERS and Healthy Families plans must provide "medically necessary" treatment for Autism and PDD under existing mental health parity law. This means that services provided under those plans must be provided by licensed mental health professionals rather than by unlicensed BCBA's and paraprofessionals. CalPERS funded Blue Shield plans and Healthy Families funded Blue Cross plans are permitted to utilize the services of unlicensed professionals under a settlement agreement with DMHC. ARCA will provide updates as this situation continues to evolve.

4. Are any self-funded plans providing coverage for behavioral health treatments for individuals with autism or PDD?

Self-funded plans are not required to provide funding for these services under California law. Some are, however, opting to provide this as a benefit to their members. At least one regional center is requiring that families in self-funded plans provide evidence that their plan is self-funded as well as an indication from their insurers whether this is a covered benefit.

5. When do the funding requirements go into effect?

Most insurance carriers were required to comply no later than July 1, 2012. TRICARE was already providing services as were some insurance companies that were part of a settlement agreement on this issue last year.

6. What is the process for requesting funding for behavioral health treatments for individuals with health care service plans based in other states?

Thirty states have mandates of one kind or another that require health insurers to fund behavioral health treatment for individuals with autism. For a list of those states, please visit <http://www.autismspeaks.org/advocacy/states>. If the state has a mandate, the referral process would be initiated by contacting the insurer. If problems arise in with these referrals, the regulatory agency overseeing health insurers in that state can be contacted for assistance (http://www.naic.org/documents/members_membershiplist.pdf).

7. As children now served by Healthy Families will be transitioning into Medi-Cal, what should regional centers do with those children in the meantime?

Healthy Families provides private HMO coverage through contracted insurance providers to income-eligible children. As a part of the 2012-2013 state budget, there was agreement to transition children served by Healthy Families into Medi-Cal. The timeline for termination of Healthy Families outlined in trailer bill language is very preliminary and dependent upon approval to changes in Medi-Cal. Funding for behavioral health treatments through insurers funded by Healthy Families remains available in the meantime. As such, regional centers should pursue funding for these services through those insurers.

8. What should regional centers do with children who are receiving behavioral health treatment services and are institutionally deemed?

As with other clients, check to ascertain whether they have health insurance in addition to Medi-Cal and pursue funding for behavioral health treatment through that insurance provider.

9. Will insurance companies implement these requirements consistently from one provider to the next?

No. Insurance companies have broad latitude in the implementation of the requirements. Insurance plans can choose what providers to contract with and what rates to pay. They will also individually determine what copayments will be charged for the services provided.

10. Will authorizations for these services be handled similarly to those for medical services that insurance companies authorize?

There are a couple of important distinctions to be aware of. First, some insurance plans contract out their behavioral health services to other providers such as Magellan or Optum Behavioral Health, so individuals may be redirected to call a different phone number once it is apparent that the request is for behavioral health treatment. Some insurance cards have a distinct phone number on the back for the behavioral health provider, but this is not necessarily the case. Second, some insurers that are anticipating a high volume of referrals for these services have established special units to address concerns related to these specific

services. For information regarding how to best access these services from many health providers, please see the document titled “Behavioral Health Treatment Insurance Referral Processes” that ARCA has developed.

11. What types of treatments are required to be covered?

The statute states that funding will be provided for ABA services in addition to “evidence-based behavior intervention programs”. There is a lot of ongoing discussion about what other therapies would be considered “evidence-based” and those that would not.

12. What efforts are in place to try to increase consistency?

Senate Bill 946 also required the creation of an Autism Advisory Task Force overseen by the Department of Managed Health Care that is exploring best practices related to evidence-based treatment options, duration of therapy as well as the qualifications of providers among other topics. This group will finish its work by the end of 2012 and must present a report to the Legislature at that time.

13. How will this change impact service provision for regional center clients in need of behavioral health treatment?

Under Welfare and Institutions Code Section 4659 (a)(2) regional centers are required to access funding from “private entities to the maximum extent they are liable for the cost of services, aid, insurance, or 4 medical assistance to the consumer.” As such, individuals and family members need to access available funding from insurance companies for behavioral health treatment associated with autism and pervasive developmental disorder before the regional center can offer funding for these services.

14. How can regional centers facilitate a referral for behavioral health treatment to an individual’s health insurer?

The procedure for each plan differs a bit. The larger plans have developed a distinct referral process for this transition. In general, the plans are requesting that either the current behavioral provider or regional center contact the plan and be able to provide at a minimum:

- Individual’s date of birth
- Individual’s health member identification number
- Diagnostic assessment confirming the diagnosis of autism or PDD
- Current behavioral treatment plan that includes:
 - o Measurable goals
 - o Current symptomatology
 - o Background of the individual
 - o Number of hours of service requested delineated by service level (i.e., BCBA and paraprofessional)

ARCA has developed detailed procedures for specific health plans on their preferred processes for transition. As noted in the following question, it is important to realize that different timelines for approval or denial of funding requests apply depending upon who initiates contact with the health plan. As additional plan contact information becomes available, ARCA will continue to expand the information provided related to accessing services through specific health plans.

15. Once a health plan receives a request for services, how long does the plan have to determine if funding

for the service will be granted?

This depends upon whether the request for services is initiated by a provider or another entity. If a provider (in-network or not) requests authorization to provide a service, the plan has five business days to determine whether to fund it, deny the request or request additional information necessary to make a decision. If a family requests the service, there are no firm timelines, but a health plan must initiate its internal grievance procedure if an enrollee or representative expresses dissatisfaction with the actions of the plan. The internal grievance procedure can take no longer than thirty calendar days. If either the five day or thirty day timelines pose an “imminent and serious threat to the health of the enrollee”, plans must issue an expedited decision within three calendar days.

16. Should regional centers refer only those clients with a firm diagnosis of autism or PDD to health plans, or should others be referred as well?

The statute stemming from Senate Bill 946 refers back to the statute that established mental health parity in the state of California. Per regulation, mental health parity requires services be provided to those with a “preliminary or initial diagnosis” until a final diagnosis can be made. If a health plan questions the validity or strength of the diagnosis of autism or PDD, it would then be incumbent upon the plan to seek further diagnostic clarity at its expense while providing medically necessary services to treat the condition. Most health plans follow the American Academy of Pediatrics screening guidelines for Autism and PDD and complete screening of toddlers at ages 18 and 24 months and full diagnostic assessments if indicated at that time.

17. Once a health plan has approved funding for behavioral health treatments, how long may an individual wait before services begin?

The health plan is responsible to offer an appointment to begin services within a specified period of time depending on the services being offered. This offer of an appointment may not work with the individual’s schedule and services may be delayed for that reason. Non-physician mental health provider appointments must be offered within 10 business days. An appointment must be offered for an occupational therapist, speech therapist or specialty physician (i.e., a psychiatrist) within 15 business days. Generally, these requirements are considered for the plan as a whole rather than in individual cases as it is a measurement of overall network adequacy.

18. If a regional center is currently funding a behavioral health treatment for a client, how can it discontinue funding for that service as a result of availability of funding for similar services through the individual’s health insurance?

As with other changes to the Individual Program Plan, this change requires the consent of the planning team. If agreement cannot be reached, the regional center will need to issue a notice of proposed action at least thirty days prior to discontinuing funding. Many regional centers have found that having personal conversations with impacted clients and families prior to sending written notification of the change is an important first step to take. Clients and their families will have an opportunity to appeal that decision.

19. How do regional centers and the people they serve know which providers have contracted with which

insurance companies?

Families and regional centers should access the health plan's on-line provider list. Since the providers change frequently, a printed listing would be quickly out of date. One regional center has indicated they have asked behavioral treatment vendors to provide this information so that they can match families with insurance to vendors that are contracted with their health plans. Lastly, regional centers and 6 health plans have been asked to provide liaison contact information to troubleshoot issues such as this as they arise. ARCA has provided regional centers with the insurance liaison contact information that has been received. If contact information for a specific plan is needed, please let Amy Westling in the ARCA office know so that efforts can be made to get that information for you.

20. Are all regional center vendors being accepted by health insurers into their network?

No. As long as an insurer can show that it has an adequate network of providers to serve various geographic areas as well as the volume of those needing services, it can contract with as few providers or as many as it would like. Some insurers have indicated a plan only to contract with providers associated with licensed professionals (i.e., psychologists or LMFTs) rather than those overseen by BCBAAs. This is permissible, and in response, many providers have recently associated themselves with licensed professionals that the insurance companies are willing to contract with.

21. What are the options if an individual or family is currently receiving services from a provider that is not contracted with their health provider and would like to continue with that same provider?

This depends a bit upon the type of health plan involved. If the coverage is provided through an HMO, the provider can request a "single case agreement" or to be paid as an out-of-network provider if there is a strong justification to not change providers. HMOs have wide discretion on whether to approve such requests or not. In a PPO plan, contracted providers are in the network and those meeting necessary qualifications that have not contracted with the PPO are not. Individuals and families may choose to utilize a non-network provider and pay a higher coinsurance for the service. As regional centers are the payers of last resort, ongoing funding of alternative providers at family request may not be permissible.

22. What should a regional center do with new requests for behavioral health treatment for this population?

As health insurance funding for these services began on July 1, 2012, regional centers should assist families to pursue funding for these services through their private insurance before making funding commitments. This will ensure the smoothest access to services for individuals and their families.

23. How do health care service plans determine the amount of service they will fund?

In most cases, the plan determines the number of service hours that it believes is medically necessary. A few health plans (Blue Shield and Blue Cross included) entered into settlement agreements last year that resulted in the granting of hours without considering medical necessity. In some areas of the state, it has been reported that the number of hours that a health care services plan has granted exceeds the service level that the regional center would have authorized, which may be related to the settlement agreements.

24. What if insurance companies deny funding for these services?

Most impacted health plans are licensed by the Department of Managed Health Care. The Department of Managed Health Care (DMHC) needs specific information about problems that have arisen to be reported to their Help Center at 1-888-466-2219 in order to be able to intervene with health providers on a case-by-case as well as systemic basis. DMHC has four complaint processes, including:

- ☑ Quick Resolution – Routine matters that can be resolved within a couple of days via telephone with the health plan.
- ☑ Urgent Complaints – Issues that cannot wait thirty days for resolution such as prescriptions and delays in obtaining appointments.
- ☑ Standard Complaint Resolution – Coverage disputes and concerns about the quality of care (i.e., a plan indicates it does not cover ABA).
- ☑ Independent Medical Review – Medical necessity for a covered benefit (i.e., a plan covers ABA but indicates a belief that the client does not need it).

Regional centers can act as an authorized representative for the individual and family in the complaint and Independent Medical Review process through completion and submission of forms available on the DMHC website.

25. Do insurance companies provide aid paid pending during the appeal process if they decide not to support ongoing authorization for services?

No. Services are authorized for a specified period of time. Before the authorization ends, the insurer makes a decision as to whether to authorize additional service hours for another period of time. If the decision is not to authorize additional services that are being requested, the individual or family of a minor child is notified in writing and given the opportunity to appeal.

26. How is information exchanged between regional centers and health care service plans related to an individual's diagnosis, treatment and progress?

Both health care service plans and regional centers are subject to the requirements of HIPAA. Regional centers have additional requirements related to their practice outlined in Welfare and Institutions Code Section 4514. Section 4514 (c) allows for an exception to normal confidentiality of regional center records "to the extent necessary for a claim, or for a claim or application to be made on behalf of a person with a developmental disability for aid, insurance, government benefit, or medical assistance to which he or she may be entitled."

27. Is there a means for regional centers to recover funds from health care service plans for services funded during periods that individuals or their families are appealing a decision by a health care service plan?

The Department of Managed Health Care cannot require insurers to reimburse regional centers or any third parties that provide funding even when the funding decision by the health care service plan is overturned on appeal. There is a provision in Welfare and Institutions Code Section 4659.11 that appears to allow for regional centers to submit claims to health care service plan in this instance. ARCA is working to get clarification related to the mechanics of this process.

28. What are regional centers doing relative to requests for assistance with funding of the copayments

associated with behavioral health treatments funded by health care service plans?

Regional centers are in the process of developing practices for their individual centers around this issue. In some instances, centers are planning to pay the copayments to providers directly under the service code that they are already vendored for. There is a commitment to ensuring that there remains access to needed services.

29. Are providers permitted to accept third-party (i.e. , regional center) payments for copayments?

Yes. Providers can accept third-party payments for copayments if they choose to.

30. How do families know when they've reached their annual copayment maximum?

ARCA has heard reports that health insurers are less consistent at tracking copayments for behavioral health than for medical services. Families should be encouraged to keep track of copayment amounts paid in order to avoid an overpayment of copayments. Some insurers provide information about copayment expenditures on their websites to make this simpler to follow.

31. Is it permissible for a BHT provider to accept a contracted rate from a health care plan and subsequently bill the regional center or family for the difference between the provider's typical rate and the contracted rate?

No. This is known as "balance billing" and is not allowed. Providers are expected to charge copayments and coinsurance consistent with the terms of the health plan, but an in-network provider in an HMO plan should not be engaging in this practice.

32. How does the implementation of the Affordable Care Act impact the future of health care funding for behavioral health treatment for those diagnosed with Autism or PDD?

The California Legislature passed two bills last week which outlined the "essential health benefits" that many health plans will have to provide after January 1, 2014. One included benefit is behavioral health treatment for individuals diagnosed with Autism or PDD. These requirements apply to new plans issued to individuals or small employers after January 1, 2014. Additionally, Medi-Cal will be required to provide some form of behavioral health treatment but the exact parameters of that are unclear at this time.