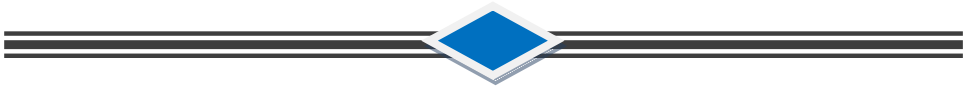
KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION

Report on Insurance Coverage for Autism Spectrum Disorder Pilot



Required by 2010
Senate Substitute for House Bill no. 2160

Kansas State Employees Health Care Commission
Report on Insurance Coverage for Autism Spectrum Disorder Pilot

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EXECUTIVE SUMMARY

Senate Substitute for House Bill number 2160 required the State Employee Health Plan (SEHP) to provide coverage for services for the diagnosis and treatment of Autism Spectrum Disorder (ASD) for members under the age of nineteen (19) beginning January 1, 2011. Modification of the SEHP was necessary to include the coverage. The coverage was added beginning January 1, 2011, to all three health plans offered to members of the SEHP. The bill requires the SEHP to provide this report to the legislature outlining the impact on the SEHP related to the coverage of Autism Spectrum Disorder (ASD).

During Plan Year 2011, the SEHP had 126 members who received services for ASD. This amounts to a prevalence rate of 1 in every 800 members. This prevalence rate is significantly lower than the prevalence rates sited by the Centers for Disease Control and Prevention (CDC) for ASD in the U.S. population.

For claims incurred and processed for services received during Plan Year 2011 with a diagnosis of ASD, the total allowed amount was $214,656 for all services. This figure includes $92,394 for Applied Behavioral Analysis (ABA) services. The average monthly treatment cost for each eligible member receiving ASD treatment was $141 for all services, of which $61 was for ABA services.

Due to the plan requirement that a treatment plan be developed and approved by the health plan, the number of services during the first quarter of 2011 may be lower. In addition, as members and providers become more aware of the services eligible for coverage provided under the autism coverage mandate, it is expected that more claims will be experienced by the plan in future years.

Report on Insurance Coverage for Autism Spectrum Disorder Pilot

Introduction

The Kansas State Employees Health Care Commission (HCC) was created by the 1984 Legislature through the enactment of K.S.A. 75-6501 et seq. to "develop and provide for the implementation and administration of a state health care benefits program. . . . [It] may provide benefits for persons qualified to participate in the program for hospitalization, medical services, surgical services, nonmedical remedial care and treatment rendered in accordance with a religious method of healing and other health services." Under K.S.A. 75-6504(b), the HCC is authorized to "negotiate and enter into contracts with qualified insurers, health maintenance organizations and other contracting parties for the purpose of establishing the state health care benefits program."

The State Employee Health Plan (SEHP) is administered by the Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF). The Director of the State Employee Health Benefits Program (SEHBP) reports to the Director of the Division of Health Care Finance and is responsible for bringing recommendations for the SEHP to the Health Care Commission and for carrying out the operation of the SEHP according to HCC policy. DHCF staff prepared this report.

The SEHP provides coverage to active employees on a calendar year basis under three different medical plan designs known as Plans A, B and C. All plans are preferred provider organization (PPO) plan designs. For Plan Year 2011, the SEHP contracted with four administrative service providers to provide network access and to process the medical claims on behalf of the plan. The four administrators are:

- Blue Cross and Blue Shield of Kansas
- Coventry Health Care of Kansas
- Preferred Health Systems
- UMR a UnitedHealthcare Company

Enrollment numbers as of February 1, 2011, for active State and Non State employees and direct bill members contracts were as follows:

Vendor	Plan A	Plan B	Plan C	Total
Blue Cross and Blue Shield of Kansas	38,248	2,227	n/a	40,475
Coventry Health Care of Kansas	994	86	173	1,253
Preferred Health Systems	3,784	333	70	4,187
UMR	249	64	48	361
Total Contracts	**43,275**	**2,710**	**291**	**46,276**

SEHP coverage is provided on a calendar year basis for eligible employees and direct bill members (retirees) of the State and certain Non State public employers who have contracted to participate in the self-funded plan. Self-funded means that the SEHP no longer transfers the risk of claims and losses to a health insurance company, but instead the State and Non State public employers covered by the plan are now responsible for financing all health care costs associated with the SEHP.

Bill Requirements of the SEHP

Section 1 of Senate Substitute for House Bill No. 2160 (**Exhibit A**) required the State Employee Health Plan (SEHP) to implement a pilot program providing coverage for Autism Spectrum Disorder. Autism Spectrum Disorder (ASD) is defined by the bill as the following disorders within the autism spectrum: Autistic disorder, Asperger's Syndrome and pervasive developmental disorders not otherwise specified, as such terms are specified in the diagnostic and statistical manual of mental disorders, fourth (4^{th}) edition, text revision (DSM-IV-TR) or later rules.

Coverage may be subject to the plan's appropriate deductible, copays and coinsurance requirement for other covered services. Benefits are limited to an annual benefit maximum established based upon the age of the member. Members from birth to age seven (7) years have a maximum benefit of $36,000 per year for paid ASD care and treatment. Members who are over age seven (7) but younger than age nineteen (19) have an annual benefit maximum of $27,000 per year for ASD care and treatment.

Eligible services for reimbursement shall be provided by a licensed, trained and qualified medical provider or by an autism specialist or an intensive individual service provider as such terms are defined by the Department of Social and Rehabilitation Services Kansas autism waiver as it existed on July 1, 2010. Coverage provided shall include Applied Behavioral Analysis (ABA) when required and provided in recognized peer reviewed literature as providing medical benefit based upon the member's particular autism spectrum disorder. Applied Behavioral Analysis (ABA) means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Implementation

In order to incorporate the above requirements, the SEHP coverage required modification. The plan had not previously provided coverage for non licensed providers and therefore the requirement to cover autism specialists and intensive individual service providers added new types of eligible providers to the plan. The health plan had traditionally provided therapy services designed to restore function lost as a direct result of injury,

disease or illness, and not services designed to educate or develop member skills. Therefore, ABA services had not previously been covered under the plan.

Staff met with representatives from the health plan administrators for the SEHP and with interested parties in the autism community to develop the final plan coverage. As the benefits of this program are subject to specific dollar limits and include providers and services not eligible for coverage outside the treatment of autism, a benefit rider was used to add this coverage to all of the health plans. The rider outlines for members all requirements and coverage limits for coverage for autism services in one document. **Exhibit B** is a copy of the Autism Coverage Rider that outlines the coverage available under the plan.

The health plan administrators began contracting efforts with autism specialists and intensive individual service providers in 3rd quarter 2010 to develop their networks of providers. Member education regarding the benefit began in October 2010 during open enrollment. Benefit information was included in the open enrollment booklet, open enrollment meetings, the SEHP and health plan administrators websites, and the benefit description provided to each plan member.

Coverage for ASD services became available on January 1, 2011. Approval of the treatment plan by the plan administrators was required prior to services being received; therefore, the number of services during the first quarter of 2011 may be lower as providers prepared and submitted their treatment plans for approval. The plan administrators were aware of the need to handle these requests in a timely manner and made every effort to process these requests within seven (7) business days of receipt.

Experience

During Plan Year 2011, the SEHP had 126 members who received services for ASD. This amounts to a prevalence rate of 1 in every 800 members. This prevalence rate is significantly lower than the prevalence rates sited by the Centers for Disease Control and Prevention (CDC) for the population. The CDC website indicates that, "It is estimated that between 1 in 80 and 1 in 240 with an average of 1 in 110 children in the United States have an ASD."[1].

For claims incurred and processed for services received during Plan Year 2011 with a diagnosis of ASD the total allowed amount was $214,656 for all services. This figure includes $92,394 for ABA services. These amounts represent 0.05 and 0.02 percent of total claims incurred during the plan year. The average monthly treatment cost for each eligible member receiving ASD treatment was $141 for all services, of which $61 was for ABA services.

1. http://www.cdc.gov/ncbddd/autism/data.html

As members and providers become more aware of the services eligible for coverage under the autism coverage mandate, it is expected that more claims will be experienced by the plan in future years. This would be typical of any new benefit added to the plan and is not unique to autism services. Utilization builds over time with awareness of available coverage.

Autism
January Through December 2011

Number of Unique Members = 126

Services	Allowed Amount Medical	Patient Costs Medical	Net Pay Medical
ABA Services	$92,394.25	$9,525.65	$82,868.60
Anesthesia	$432.75	$334.15	$98.60
Assay of Minerals	$1,071.96	$997.06	$74.90
Immunization	$77.52	$0.00	$77.52
Medication Management	$6,060.70	$3,010.41	$3,050.29
Miscellaneous	$8,584.60	$7,343.57	$1,241.03
Molecule Testing	$8,433.02	$4,395.49	$4,037.53
Office/Hospital Care	$7,295.18	$1,319.71	$5,975.47
Psychology Evaluation and Meetings	$50,661.40	$17,785.54	$32,875.86
Speech Hearing Therapy	$21,948.94	$1,718.21	$20,230.73
Therapeutic Activities	$17,579.36	$4,715.59	$12,863.77
Venipuncture	$115.97	$80.33	$35.64
Grand Total	**$214,655.65**	**$51,225.71**	**$163,429.94**

Members from birth to age seven (7) years have a maximum benefit of $36,000 per year for paid ASD treatment. Members who are at least age seven (7) but are younger than age nineteen (19) have an ASD annual benefit maximum of $27,000 per year. Of the 126 members who received ASD treatment, only one member reached their benefit cap during Plan Year 2011. The member who reached the benefit cap was under the age of seven (7) and had expenses over $36,000. None of the eligible members who were over the age of seven (7)) reached the annual benefit cap of $27,000.

Conclusion

In order to pilot the ASD coverage, the SEHP coverage required modification to add coverage for ABA and for autism specialists and intensive individual service providers. Coverage for ASD services became available on January 1, 2011.

The ASD coverage pilot had minimal impact on the SEHP. During Plan Year 2011, the SEHP had 126 members who received services for ASD under the rider. For claims

incurred and processed for services received during Plan Year 2011 with a diagnosis of ASD the total allowed amount was $214,656 for all services. This figure includes $92,394 for ABA services. These amounts represent 0.05 and 0.02 percent of total claims incurred during the plan year. As members and providers become more aware of the services eligible for coverage under the autism coverage mandate, it is expected that more claims will be experienced by the plan in future years. The state health care benefits program would recommend coverage for autism spectrum disorder continue so additional utilization and cost data could be gathered.

EXHIBITS

Exhibit A

SENATE Substitute for HOUSE BILL No. 2160

AN ACT concerning insurance; providing coverage for autism spectrum disorder; providing reimbursement for orally administered anticancer medications; amending K.S.A. 2009 Supp. 40-2,103, 40-19c09 and 75-6501 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) In the coverage for the next health plan coverage year commencing on January 1, 2011, the state employees health care commission shall provide for the coverage of services for the diagnosis and treatment of autism spectrum disorder in any covered individual whose age is less than 19 years. Such coverage shall be subject to the following terms and conditions:

(1) Such coverage shall be provided in a manner determined in consultation with the autism services provider and the patient. Services provided by an autism services provider under this section shall include applied behavioral analysis when required by a licensed physician, licensed psychologist or licensed specialist clinical social worker but otherwise shall be limited to those services prescribed or ordered by a licensed physician, licensed psychologist or licensed specialist clinical social worker. Services provided pursuant to this paragraph shall be those services which are or have been recognized by peer reviewed literature as providing medical benefit to the patient based upon the patient's particular autism spectrum disorder.

(2) Such coverage may be subject to appropriate annual deductibles and coinsurance provisions as are consistent with those established for other physical illness benefits under the state employees health plan.

(3) Coverage for benefits for any covered person diagnosed with one or more autism spectrum disorders and whose age is between birth and less than seven years shall not exceed $36,000 per year.

(4) Coverage for benefits for any covered person diagnosed with one or more autism spectrum disorders and whose age is at least seven years and less than 19 years shall not exceed $27,000 per year.

(5) Coverages required under paragraphs (3) and (4) shall be subject to the same copays, deductibles and dollar limits as benefits for physical illness; and such other utilization or benefit limits as the state employees health care commission may determine.

(6) Reimbursement shall be allowed only for services provided by a provider licensed, trained and qualified to provide such services or by an autism specialist or an intensive individual service provider as such terms are defined by the department of social and rehabilitation services Kansas autism waiver as it exists on July 1, 2010.

(7) Any insurer or other entity which administers claims for services provided for the treatment of autism spectrum disorder under this section, and amendments thereto, shall have the right and obligation to:

(A) Review utilization of such services; and

(B) deny any claim for services based upon medical necessity or a determination that the covered individual has reached the maximum medical improvement for the covered individual's autism spectrum disorder.

(b) For the purposes of this section:

(1) ''Applied behavior analysis'' means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

(2) ''Autism spectrum disorder'' means the following disorders within the autism spectrum: Autistic disorder, Asperger's syndrome and pervasive developmental disorder not otherwise specified, as such terms are specified in the diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV-TR), of the American psychiatric association, as published in May, 2000, or later versions as established in rules and regulations adopted by the behavioral sciences regulatory board pursuant to K.S.A. 74-7507 and amendments thereto.

(3) ''Diagnosis of autism spectrum disorder'' means any medically necessary assessment, evaluation or test to determine whether an individual has an autism spectrum disorder.

(c) (1) Pursuant to the provisions of K.S.A. 40-2249a, and amendments thereto, on or before March 1, 2012, the state employees health care commission shall submit to the president of the senate and to the speaker of the house of representatives, a report including the following information pertaining to the mandated coverage for autism spectrum disorder provided during the plan year commencing on January 1, 2011, and ending on December 31, 2011:

(A) The impact that the mandated coverage for autism spectrum disorder required by subsection (a) has had on the state health care benefits program;

(B) data on the utilization of coverage for autism spectrum disorder by covered individuals and the cost of providing such coverage for autism spectrum disorder; and

(C) a recommendation whether such mandated coverage for autism spectrum disorder should continue for the state health care benefits program or whether additional utilization and cost data is required.

(2) At the next legislative session following receipt of the report required in paragraph (1), the legislature may consider whether or not to require the coverage for autism spectrum disorder required by subsection (a) to be included in any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which is delivered, issued for delivery, amended or renewed in this state on or after July 1, 2013.

Sec. 2. K.S.A. 2009 Supp. 75-6501 is hereby amended to read as follows: 75-6501.

(a) Within the limits of appropriations made or available therefor and subject to the provisions of appropriation acts relating thereto, the Kansas state employees health care commission shall develop and provide for the implementation and administration of a state health care benefits program.

(b) *(1) Subject to the provisions of paragraph*

(2), the state health care benefits program may provide benefits for persons qualified to participate in the program for hospitalization, medical services, surgical services, nonmedical remedial care and treatment rendered in accordance with a religious method of healing and other health services. The program may include such provisions as are established by the Kansas state employees health care commission, including but not limited to qualifications for benefits, services covered, schedules and graduation of benefits, conversion privileges, deductible amounts, limitations on eligibility for benefits by reason of termination of employment or other change of status, leaves of absence, military service or other interruptions in service and other reasonable provisions as may be established by the commission.

(2) The state health care benefits program shall provide the benefits and services required by section 1 and amendments thereto.

(c) The Kansas state employees health care commission shall designate by rules and regulations those persons who are qualified to participate in the state health care benefits program, including active and retired public officers and employees and their dependents as defined by rules and regulations of the commission. Such rules and regulations shall not apply to students attending a state educational institution as defined in K.S.A. 76-711, and amendments thereto, who are covered by insurance contracts entered into by the board of regents pursuant to K.S.A. 75-4101, and amendments thereto. In designating persons qualified to participate in the state health care benefits program, the commission may establish such conditions, restrictions, limitations and exclusions as the commission deems reasonable. Such conditions, restrictions, limitations and exclusions shall include the conditions contained in subsection (d) of K.S.A. 75-6506, and amendments thereto. Each person who was formerly elected or appointed and qualified to an elective state office and who was covered immediately preceding the date such person ceased to hold such office by the provisions of group health insurance or a health maintenance organization plan under the law in effect prior to August 1, 1984, or the state health care benefits program in effect after that date, shall continue to be qualified to participate in the state health care benefits program and shall pay the cost of participation in the program as established and in accordance with the procedures prescribed by the commission if such person chooses to participate therein.

(d) (1) Commencing with the 2009 plan year that begins January 1, 2009, if a state employee elects the high deductible health plan and health savings account, the state's employer contribution shall equal the state's contribution to any other health benefit plan offered by the state. The cost savings to the state for the high deductible health plan shall be deposited monthly into the employee's health savings account up to the maximum annual amount allowed pursuant to subsection (d) of 26 U.S.C. 223, as amended, for as long as the employee participates in the high deductible plan.

(2) If the employee had not previously participated in the state health benefits plan, the employer shall calculate the average savings to the employer of the high deductible plan compared to the other available plans and contribute that amount monthly to the employee's health savings account up to the maximum annual amount allowed pursuant to subsection (d) of 26 U.S.C. 223, as amended.

(3) The employer shall allow additional voluntary contributions by the employee to their health savings account by payroll deduction up to the maximum annual amount allowed pursuant to subsection (d) of 26 U.S.C. 223, as amended.

(e) The commission shall have no authority to assess charges for employer contributions under the student health care benefits component of the state health care benefits program for persons who are covered by insurance contracts entered into by the board of regents pursuant to K.S.A. 75-4101, and amendments thereto.

(f) Nothing in this act shall be construed to permit the Kansas state employees health care commission to discontinue the student health care benefits component of the state health care benefits program until the state board of regents

has contracts in effect that provide student coverage pursuant to the authority granted therefore in K.S.A. 75-4101, and amendments thereto.

New Sec. 3. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization, municipal group-funded pool and the state employee health care benefits plan which provides coverage for prescription drugs and which is delivered, issued for delivery, amended or renewed on and after July 1, 2011, shall provide coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits.
(b) Any policy, provision, contract, plan or agreement under this section may apply the same deductibles, coinsurance and other limitations as apply to other covered services.
(c) (1) From and after the effective date of this act, the provisions of this section shall apply to the state employees health care benefits program.

(2) Pursuant to the provisions of K.S.A. 40-2249a, and amendments thereto, on or before March 1, 2011, the state health care benefits commission shall submit to the president of the senate and to the speaker of the house of representatives, a report indicating the impact the provisions of this section has had on the state health care benefits program, including data on the utilization and costs of such coverage. Such report shall also include a recommendation whether such coverage should continue for the state health care benefits program or whether additional utilization and cost data is required.

Sec. 4. K.S.A. 2009 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114, 40-2,160, 40-2,165 through 40-2,170, inclusive, 40-2250, K.S.A. 2009 Supp. 40-2,105a and*,* 40-2,105b *and section3*, and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. 5. K.S.A. 2009 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. (a) Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40- 219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2,153, 40-2,154, 40-2,160, 40-2,161, 40-2,163 through40-2,170, inclusive, 40-2a01 et seq., 40-2111 to 40-2116, inclusive, 40-2215 to 40-2220, inclusive, 40-2221a, 40-2221b, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-2254, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, K.S.A. 2009 Supp. 40-2,105a and*,* 40-2,105b *and section 3*, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.
(b) No policy, agreement, contract or certificate issued by a corporation to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.
(c) Violation of subsection (b) shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

Sec. 6. K.S.A. 2009 Supp. 40-2,103, 40-19c09 and 75-6501 are hereby repealed.

Sec. 7. This act shall take effect and be in force from and after its publication in the statute book. I hereby certify that the above BILL originated in the HOUSE, and passed that body.

Exhibit B
Autism Rider

This rider outlines the coverage provided for treatment of autism in covered children under the age of Nineteen (19). Unless otherwise specified all other provisions of the Benefit Description apply to benefits outlined in this Autism Rider, including deductibles, copays, coinsurance, network provider arrangements and prior authorization.

Definitions:

Autism Spectrum Disorder means the following disorders within the autism spectrum:

- Autistic disorder,
- Asperger's syndrome, and
- Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS),
  as specified within the diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV-TR), of the American psychiatric association.

Applied Behavior Analysis (ABA) means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism Specialist means a person who:

- Has at least a masters degree in human services or education or fully Board Certified Behavior Analysis; and
- Maintains all standards, certifications, and licenses required for their specific Professional field; and
- Has successfully completed the state approved curriculum and passed the test with a score of at least 80%; and
- Has 2,000 hours of supervised experience working with a child with an Autism Spectrum Disorder; and
- Has successfully passed a background check with the Kansas Bureau of Investigation (KBI), or Adult Protective Services (APS), or Child Protective Services (CPS), or Kansas Department of Health and Environment (KDHE), or the Kansas Nurse Aid Registry, and the Motor Vehicle screen; and
- Is a Medicaid Enrolled Provider

Comprehensive Assessment means completion (by an appropriate professional) and submission of results of:

- A Vineland II Survey Interview Adaptive Behavior Scales by an qualified evaluator who is a level 3 user based on the Pearson Assessments; and
- An IQ Test (optional); and
- A Neurological evaluation by a medical doctor to rule-out primary neurological disorder; and
- A lead poisoning assessment; and
- A Speech Assessment to rule-out primary speech disorder; and
- A Hearing Assessment to rule-out primary hearing disorder; and
- DSM-IV Diagnostic Criteria; and
- An Assessment by one of the following:
  - Checklist for Autism in Toddlers (CHAT); or
  - Childhood Autism Rating Scale (CARS); or
  - Modified Checklist for Autism in Toddlers (M-CHAT); or
  - Screening Tool for Autism in two-year olds (STAT); or

- Social communication Questionnaire (SCQ) (recommended for children four-years of age or older); or
- Autism Behavior checklist (ABC); or
- Gilliam Autism Rating Scale (GARS); or
- Autism Diagnostic Observation Scale (ADOS); or
- Autism Diagnostic Interview – Revised (ADI).
- Autism Spectrum Screening Questionnaire (ASSQ); or
- Childhood Asperger Syndrome Test (CAST); or
- Krug Asperger's Disorder Syndrome (ASAS); or
- Australian Scale for Asperger Syndrome (ASDS); or
- Asperger Syndrome Diagnostic Scale (ASDS).
- Pervasive Developmental Disabilities Screening Test (PDD-ST).

Intensive Individual Service Provider means a person who:

- Has at least a bachelors degree in human services or education; and
- Maintains all standards, certifications, and licenses required for their specific license/certification; and
- Has successfully completed the state approved curriculum and passed the test with a score of at least 80%; and
- Has 1,000 hours of supervised experience working with a child with an Autism Spectrum Disorder; and
- Has successfully passed a background check with the Kansas Bureau of Investigation (KBI), or Adult Protective Services (APS), or Child Protective Services (CPS), or Kansas Department of Health and Environment (KDHE), or the Kansas Nurse Aid Registry, and the Motor Vehicle screen; and
- Adheres to the DBHS/CSS training and professional development requirements; and
- Is a KMAP Enrolled Provider for intensive individual supports; and
- Works under the direction and supervision of an Autism Specialist.

Periodic Assessment means an evaluation that shows an assessment of the improvement in the individual based upon the diagnosis and approved treatment plan. Timing of the periodic assessments will be based upon the treatment plan, but no less than every six months. Statistically significant improvement in the stated goals and objectives of treatment must be achieved to authorize continued treatment. A Vineland II Survey will be required on at least an annual basis. An annual IQ test is optional.

Treatment Plan means a submission by a provider or group of providers and signed by both the provider(s) and parent(s)/caregiver(s) that includes:

- the type of therapy to be administered and methods of intervention,
- the goals, including
  - specific problems or behaviors requiring treatment
  - frequency of services to be provided
  - frequency of parent or caregiver participation at therapy sessions
  - description of supervision, and
- periodic measures for the therapy, including the frequency at which goals will be reviewed and updated,
- who will administer the therapy, and
- the patient's current ability to perform the desired results of the therapy.

Benefit Provisions:

Autism Spectrum Disorder (ASD) Coverage is available for the diagnosis and treatment of ASD as defined. Diagnosis shall be the appropriate listed assessment instrument from the listed options, performed by an appropriately licensed medical provider. Benefits must be pre-approved by the Plan and may include Applied Behavioral Therapy, developmental Speech Therapy, developmental Occupational Therapy, or developmental Physical Therapy as appropriate. Periodic re-evaluations and assessments are required and continuous improvement must be shown in order to qualify for continued treatment. Results of a Vineland II Survey will be required for the initial assessment to establish a baseline and must be repeated at least annually to establish improvement.
Services are limited as follows:

- Coverage limits for Network and Non Network services combined:
  - Children under age 7 limited to $36,000/year
  - Children age 7-19 limited to $27,000/year
  - Children age 19 and over, not covered

All services are subject to the applicable deductible, coinsurance and copay arrangements of the health plan. Providers will be reimbursed based upon network status.

All health claims with a diagnosis of Autism Spectrum Disorder will be subject to the limitations stated above.

Prior Approval: To qualify for this benefit, a comprehensive assessment may be required (see submission guidelines below). The treatment plan must be submitted to the Plan Administrator in advance of the initiation of treatment and outline measurable goals and objectives for treatment of the member. Benefits will be provided for the initial Comprehensive Assessment whether or not the member is approved for continued treatment. If approved for continued treatment, benefits will be available only for services received following the approval of the treatment plan.

The provider must submit:

- For newly diagnosed members with eligible autism diagnosis, a Comprehensive Assessment must be completed and submitted within 90 days of treatment beginning under this rider.
- All members must have a treatment plan detailing the individuals who will be performing the various therapies and/or interventions and the type and frequency of the services to be performed. Services must be pre-approved by the health plan. Periodic Assessments must be submitted no less than every six months and include objective evidence of progress (a Vineland Survey).

Exclusions:

- Respite care
- Vocational rehabilitation
- Residential care
- Transportation
- Animal based therapy programs
- Hydro Therapy
- Camps
- Vitamin Therapy
- Programs and/or services administered within the Public, Private or Home School
- Vocational or Job training programs
- Services provided by relatives