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Michigan Public Policies and Programs Pertaining to Autism Spectrum Disorder

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Executive Summary

Over the past several decades, growing awareness of and attention to the constellation of symptoms and social deficits encompassed under the diagnosis of Autism Spectrum Disorder (ASD) has led to greater emphasis on and increased expenditures of public health agencies and private insurance carriers in researching and treating individuals affected with ASD.

This report will provide a brief overview of the diagnosis and treatment of ASD, the state's Medicaid Program coverage and services for individuals diagnosed with ASD, Michigan's insurance mandate and insurance reimbursement program pertaining to ASD diagnosis and treatment, and recent public expenditures to support ASD provider education and family assistance initiatives. A few important facts and findings include:

- Since 2000, the estimated prevalence of ASD has increased by 119%, to every 1 in 68 individuals.
- While there is no cure for ASD, techniques known as applied behavior analysis are widely utilized.
- Michigan's Medicaid program currently provides ASD services and coverage for individuals under 6 years of age.
- Health insurance carriers are mandated to provide coverage for ASD diagnosis and treatment.
- The Autism Coverage Reimbursement Program (ACRP) was created in 2012 to reimburse health insurance carriers for claims related to ASD diagnosis and treatment.
- The Autism Coverage Fund (ACF) was created to support the ACRP and is financed with $26.0 million from the General Fund, of which approximately $2.7 million has been paid to insurance carriers for reimbursement of approximately 19,900 claims.
- $5.5 million from the ACF is appropriated in FY 2014-15 for provider education programs at various state universities and family assistance services by the nonprofit Autism Alliance of Michigan.

About Autism Spectrum Disorder

Diagnosis, Characteristics, and Prevalence

ASD encompasses a range of persistent and complex neurodevelopmental deficits of varying severities and is typically demonstrated via impaired social, emotional, and communicational abilities manifested across multiple contexts and frequently detected during early childhood. While the precise causes of ASD are currently unknown, it is likely that differences in the brains of individuals diagnosed with ASD are the result of multiple genetic, biological, and environmental factors which, taken together, contribute to the odds of developing and the actual onset of ASD.[1]

Recent revisions to diagnostic criteria for autism-related disorders established in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and effective beginning May 2013, resulted in the consolidation of the former diagnoses of autistic disorder, Asperger syndrome, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified, now collectively diagnosed as ASD.[2]

The revisions to the diagnostic criteria for ASD established by the DSM-5 restructured applicable symptom domains, resulting in the following symptoms which must be present during early childhood development, impair important areas of current functioning, and are not better explained by intellectual disability:

- Persistent deficits in social communication and social interaction across multiple contexts, manifested by the following:
  - Deficits in social-emotional reciprocity
  - Deficits in nonverbal communicative behaviors used for social interaction
  - Deficits in developing, maintaining, and understanding relationships

- Restricted, repetitive patterns of behavior, interests, or activities, manifested by at least two of the following:
  - Stereotyped or repetitive motor movements, use of objects, or speech
  - Insistence on sameness, inflexible adherence to routines, or ritualized patterns or behavior
  - Highly restricted, fixated interests that are abnormal in intensity or focus
  - Hyper- or hypo-activity to sensory input or unusual interests in sensory aspects of the environment

Many parents recognize manifestations of these symptoms within the first year of their child's development and specific ASD screening tests at 18 and 24 months are recommended by the American Academy of Pediatrics. Diagnosis for ASD is often a two-stage process involving a general developmental screening during regular checkups and, if a child exhibits certain developmental deficits, a thorough evaluation by a team of health professionals utilizing

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[1] Both the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), as well as numerous other public health organizations, emphasize that there is no scientific evidence that vaccination, or the compound thimerosal, causes or contributes to the development or diagnosis of ASD.

[2] "DSM-5 Diagnostic Criteria" available on the Autism Speaks website at http://www.autismspeaks.org/what-autism/diagnosis/dsm-5-diagnostic-criteria, accessed on 07/14/14. "DSM-5: The New Diagnostic Criteria for Autism Spectrum Disorders" presentation by Walter E. Kaufman, M.D. available on the Autism Consortium website at http://www.autismconsortium.org/symposium-files/WalterKaufmannAC2012Symposium.pdf, accessed on 07/14/14. "Autism Spectrum Disorder: Fact Sheet" available on the American Psychiatric Association's (APA) DSM-5 website at http://www.dsm5.org/Documents/Autism%20Spectrum%20Disorder%20Fact%20Sheet.pdf, accessed on 07/14/14. The APA, the publisher of the DSM-5, asserts that initial testing and analysis indicated that the revised diagnostic criteria would not result in significant changes to the prevalence of autism-related disorders, now collectively ASD, however the APA does cite a more recent comprehensive assessment which found that the DSM-5 diagnostic criteria identified 91% of children diagnosed with autism-related disorders under the immediately preceding version of the DSM (DSM-IV-TR).

specialized ASD screening instruments. While ASD can be reliably diagnosed by 2 years of age, children often are not diagnosed until after age 4.[3]

According to data collected and analyzed via the Autism and Developmental Disabilities Monitoring Network (ADDM), a consortium of multiple states established and funded by the Centers for Disease Control and Prevention (CDC), the overall prevalence of autism-related disorders in participating states is one in 68, ranging from a high of one in 46 to a low of one in 175, for children aged 8 years, the age of peak prevalence, in 2010.[4] Overall, one in 42 boys and one in 189 girls were identified as having an autism-related disorder, a ratio of approximately 4:1, and white children were 30% more likely than black children and 50% more likely than Hispanic children to be identified as having an autism-related disorder. The median age at which a child was first diagnosed with an autism-related disorder was 53 months, moreover, 46% of children identified with autism-related disorders had average or above intellectual ability (IQ > 85).

Since the earliest epidemiological studies on autism-related disorders were conducted in the 1960s, the global prevalence has increased between twentyfold and thirtyfold. Combined data gathered by the ADDM since its establishment in 2000, evidences a sustained increase in the estimated prevalence of autism-related disorders as exhibited in Table 1. From 2000 to 2010, ADDM estimates of the prevalence of autism-related disorders increased by approximately 119%. Specifically, the ADDM data indicate that a large proportion of the observed increased prevalence of autism-related disorders is impelled by children who are endowed with average or above intellectual ability (IQ > 85), which rose from 32% of diagnosed children in 2002 to 46% in 2010. Although the causes for the apparent increase in prevalence is not easily empirically verified, the CDC asserts that several studies suggest that much of the increase is likely attributable to extrinsic factors such as improved awareness and recognition and changes to diagnostic practice and service availability. However, an actual rise in the number of individuals with autism-related disorders cannot be ruled out.

Table 1
Prevalence of Autism-Related Disorders

Surveillance Year	Overall Prevalence	Prevalence Range	% Change in Overall Prevalence from Previous Estimate
2000	1 in 149	1 in 101 to 222	N/A
2002	1 in 152	1 in 94 to 303	-1.49%
2004	1 in 125	1 in 102 to 217	21.21%
2006	1 in 111	1 in 83 to 238	12.50%
2008	1 in 88	1 in 47 to 208	25.56%
2010	1 in 68	1 in 46 to 175	30.09%

Source: Autism and Developmental Disabilities Monitoring Network

[3] "Autism Spectrum Disorder" available on the National Institute of Mental Health website at http://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd/index.shtml, accessed on 07/14/14.

[4] "Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years—Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2010" available on the Centers for Disease Control and Prevention website at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6302a1.htm, accessed on 07/14/14. Note that because the revisions to the diagnostic criteria within the DSM-5 were not effective until after the ADDM data was analyzed, the ADDM data utilizes the criteria established by the DSM-IV-TR, the CDC is uncertain on how the revisions might alter the number of persons meeting the new diagnostic criteria for ASD in future ADDM studies.

Approaches to and Methods of Treatment

Although there is currently no cure nor single standard treatment for ASD, there are several diverse approaches to treatment which health professionals and caregivers variously advocate for and administer to facilitate improvement in the everyday functioning and quality of life for individuals diagnosed with ASD. According to the CDC and the National Institutes of Health (NIH), multiple studies demonstrate that early and intensive intervention, administered between birth and 3 years of age, can dramatically enhance a child's development, reducing or preventing the more severe symptoms associated with ASD and improving the cognitive, communicative, and daily coping skills of children diagnosed with ASD. The following descriptions of various treatment methods are not exhaustive nor are they mutually exclusive as the treatment of ASD may involve several concerted and complementary interventions and therapies provided via medical, educational, and familial sources to help meliorate the deficits engendered by ASD and experienced by individuals with ASD.[5]

While there are no medications that can cure ASD or treat the principal symptoms, certain medications can palliate ancillary symptoms, such as hyperactivity, inattentiveness, depression, or seizures, thereby enabling some individuals with ASD to function with greater ease and ability. Physicians may prescribe medications, for off-label use, which have been approved to treat other conditions that have similar symptoms to ASD or are expected to be effective for divergent age groups. Commonly prescribed medications for children diagnosed with ASD include antipsychotics to reduce serious behavioral problems, antidepressants to reduce emotional distress and repetitive behaviors, anticonvulsants to reduce tics and seizures, and stimulants to reduce hyperactivity. Currently, the Food and Drug Administration (FDA) has approved the antipsychotics risperidone (i.e., Risperdal) and aripiprazole (i.e., Abilify) to treat certain children with ASD for irritability manifested as aggression, temper tantrum, or self-harming acts.

Behavioral approaches to treatment of symptoms experienced by individuals diagnosed with ASD are extensively utilized through a variety of scientifically accepted methods and models. Foremost among these is a range of techniques categorized as applied behavioral analysis (ABA), formerly known as behavior modification, which are intended to shape, encourage, and reinforce positive behaviors and discourage and reduce negative behaviors to facilitate personal independence and social integration via teaching processes such as errorless leaning and prompting, including, but not limited to:

- Discrete Trial Training: implements a series of controlled trials and positive reinforcements to teach each simplified step of desired behaviors and responses.
- Positive Behavioral and Support: investigates how the environment stimulates and reinforces specific behaviors and alters aspects of the environment to encourage desired behavior.
- Pivotal Response Training: identifies pivotal skills such as motivation to learn, monitoring and managing behavior, and initiating communication to affect a range of behavioral responses.
- Verbal Behavior Intervention: imparts verbal skills utilizing sequenced curriculum progressing from simple behaviors such as echoing to more functional communication skills.
- Joint Attention Therapy: develops shared attention skills and responses to nonverbal cues such as pointing, showing, and following eye contact.

Such ABA techniques are applied to varying extents contingent on the severity of symptoms and therapeutic needs of individuals diagnosed with ASD. Early Intensive Behavioral Intervention may encompass several ABA techniques through a comprehensive and intensive regiment with individualized behavioral instruction designed for young

[5] "Treatment" available on the Centers for Disease Control and Prevention website at http://www.cdc.gov/ncbddd/autism/treatment.html, "Autism Spectrum Disorder" available on the National Institute of Mental Health website at http://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd/index.shtml, and "What are the Treatments for Autism Spectrum Disorder (ASD)?" available on the Eunice Kennedy Shriver National Institute of Child Health and Human Development at http://www.nichd.nih.gov/health/topics/autism/conditioninfo/pages/treatments.aspx, all accessed on 07/14/14.

children, usually younger than 5 and often younger than 3. Conversely, Applied Behavior Intervention utilizes ABA techniques via a focal approach aimed towards achieving targeted and functional goals.

Other behavioral and communication strategies and therapies may also be effective as part of a complete treatment program for individuals diagnosed with ASD, including:

- Developmental, Individual Differences, Relationship-Based Model (aka "Floortime")
- Treatment and Education of Autistic and Related Communications-Handicapped Children
- Interpersonal Synchrony
- Picture Exchange Communication System
- Sensory Integration Therapy
- Cognitive Behavior Therapy
- Speech-Language Therapy
- Occupational/Physical Therapy

According to studies summarized by the CDC, the economic cost to provide medical, behavioral, and educational care and coordinated services for a child diagnosed with ASD totals to at least $17,000 more per year than a child without ASD, and over $21,000 more per year for a child with severe symptoms of ASD. Medical costs alone account for an average of between $4,110 and $6,200 more per year; between 4.1 and 6.2 times higher than medical cost for children without ASD. In addition to medical costs, intensive behavior interventions for children with ASD can cost from $40,000 to $60,000 per child per year. The average annual medical costs for children with ASD who are enrolled in Medicaid were $10,709 per child in 2005; approximately 6 times higher than costs for children without ASD. The CDC reports that, in 2011, estimated aggregate societal costs of caring for children with ASD amounted to over $9.0 billion.[6]

Medicaid Coverage and Services for ASD

Eligibility and Available Services

Medicaid is a joint federal-state partnership program that provides healthcare coverage for low income families and elderly and disabled individuals. In recognition of the large and growing demand for ASD services, Michigan updated its Medicaid State Plan and began appropriating funds in the Medicaid program specifically for that purpose in FY 2012-13. The Michigan Medicaid autism benefit has been in effect since April 2013.

Medicaid covers ABA treatments for eligible individuals between 18 months and five years of age who have been diagnosed with ASD.[7] The Medicaid State Plan identifies two levels of intensity for ABA services:

- Early Intensive Behavioral Intervention (EIBI): EIBI is the more comprehensive and intensive of the two approaches. The intent of EIBI is to "address skill deficits, behavioral issues, and improve overall functioning." One component of EIBI is training individuals who care for the child (family members, caregivers, etc.) to continue services beyond the duration of state administered intervention. While the exact mix of specific techniques is flexible, and tailored to each child's individual needs, goals, etc., the Medicaid State Plan identifies many of the evidence-based interventions referenced above. EIBI services are typically provided in service centers or in the child's home for an average of 10-20 hours per week. The duration of state administered EIBI services is often as much as two to three years.

[6] "Data & Statistics" available on the Centers for Disease Control and Prevention website at http://www.cdc.gov/ncbddd/autism/data.html, accessed on 07/14/14.

[7] Diagnostic specifications for ASD are outlined in the Medicaid State Plan.

- Applied Behavioral Interventions (ABI): ABI is the less intensive of the two approaches offered through the Michigan Medicaid program. As opposed to the more comprehensive combination of treatments incorporated into EIBI, ABI focuses on specific treatment interventions for specific purposes and targeted goals. Many of the treatments available through EIBI are also available through ABI, but on a more focused, less comprehensive basis. The frequency, intensity, and duration of services is tailored to each child and reevaluated every six months. ABI is available to any eligible child who is not receiving EIBI.

The Centers for Medicare and Medicaid Services (CMS) issued an informational bulletin on July 7, 2014, clarifying that:

- Low income infants, children, and adolescents under the age of 21 are covered under the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefit,
- The EPSDT benefit is more robust than conventional Medicaid coverage, and "requires medically necessary diagnostic and treatment services," and
- Screening, diagnosis, and treatment services for ASD are required/included in the EPSDT benefit.

Therefore, while Michigan's autism benefit currently covers ABA services for children from 18 months to five years of age, the new CMS guidance requires expansion of services for children and adolescents up to the age of 21. The Executive Branch is processing the new federal guidance, identifying related issues, and developing cost estimates for compliance, but this new guidance appears to constitute a significant coverage expansion for ASD services.

Delivery System

Preliminary screening usually starts with the child's pediatrician or primary care physician, often at the request/suggestion of the parent(s). If results of the pediatric screening warrant further testing, the physician refers the patient to the regional Prepaid Inpatient Health Plan (PIHP) for a full diagnostic evaluation. If the evaluation leads to a diagnosis of ASD, the PIHP submits evidence, test results, and supporting information to the Behavioral Health and Developmental Disabilities Administration (BHDDA) within DCH for review and independent evaluation. The BHDDA evaluation determines if the child meets the required criteria for service eligibility.

If the child is eligible for services, the PIHP facilitates the development of an individual plan of services (IPOS) based on the initial diagnostic test results, BHDDA's independent evaluation, the goals of the family, and other available information. The IPOS is prepared by "a team of individuals, including the family." Further, "The case manager, supports coordinator or other qualified staff or independent facilitator that assists in developing the IPOS is not a provider of any other service for that individual." Separate PIHP utilization management staff then determine the level and duration of services, which are also outlined in the IPOS. Thus, PIHPs maintain a separation of responsibilities to ensure that the IPOS reflects an appropriate level of service for the child. The PIHP then organizes and coordinates service delivery through its provider network in accordance with the plan.

Funding

While additional support services are available through various behavioral health programs (Children's Waiver Home Care, for example), most of the direct DCH payments for autism services are processed through the Autism Services line in the Medical Services (i.e., Medicaid) budget unit. That line received appropriations of $17.5 million, $35.2 million, and $25.2 million for FYs 2012-13, 2013-14, and 2014-15, respectively. DCH and the provider community are still ramping up autism services, which may explain some of the fluctuation in appropriations and program expenditures. Unlike most services managed by PIHPs, autism benefit payments are processed as fee-for-service rather than capitated/risk-based managed care payments. According to DCH waiver documents, autism benefit payments will continue as fee-for-service until an adequate payment history is available to establish capitated payment rates.

In meeting minutes from February 2014, the Michigan Autism Council, an advisory body to DCH, indicated that at that time, 560 children had been approved for ABA treatment through the Medicaid and MIChild programs. However,

subsequent Autism Council meeting minutes discuss "a huge lack of capacity of ABA providers," which suggests the possibility of unmet needs within these programs.

Non-Medicaid Coverage and Services for ASD

Since January 1984, the Family Support Subsidy Program has been established within DCH in accordance with provisions of Public Act 249 of 1983, an amendatory act to Michigan's Mental Health Code of 1974. This program currently provides a monthly payment of $222.11 to income-eligible families with children living at home who are severely mentally impaired, severely multiply impaired, or *autistic impaired*.

The subsidy payments are used to meet the following special needs of the families: clothing, household expenses, educational toys and aids, transportation, special foods, medical expenses, camp/recreation, diapers, adaptive equipment, behavioral aides, and respite care. The statute stipulates that the payments are to complement rather than supplant governmental public assistance or social services benefits based on economic need.

An estimated annual average of 4,562 families with autistic children will receive financial support from the Family Support Subsidy line item appropriation financed solely with federal Temporary Assistance for Needy Families (TANF) revenue in the upcoming fiscal year.[8] In FY 2012-13, FY 2013-14, and FY 2014-15, $19.1 million, $19.4 million, and $18.2 million, respectively, have been appropriated for this program.

Autism Coverage Mandate and Reimbursement Program

In addition to direct publically-funded programs and services for individuals and families living with ASD, the Legislature enacted a mandate for private health insurance carriers to provide coverage for ASD diagnosis and treatment and established a program to reimburse carriers for claims associated with ASD diagnosis and treatment.

Autism Coverage Mandate

Public Act 100 of 2012 amended the Insurance Code of 1956 to mandate that expense-incurred hospital, medical, or surgical policies, certificates, or contracts for individuals or groups issued by private health insurers or health maintenance organizations (HMOs) include coverage for the diagnosis (i.e., assessments, evaluations, and tests performed by physicians or psychologists) and evidence-based treatment (i.e., behavioral, including ABA; pharmaceutical, if applicable; psychiatric; psychological; and therapeutic) of ASD.[9]

Under PA 100, the ASD coverage mandate applies to insured individuals through 18 years of age and is subject to annual dollar limitations on benefits, review of diagnostic observation schedules and treatment protocols and plans, and submission of an annual development evaluation.[10] Carriers are prohibited from terminating or otherwise refusing coverage because an individual is diagnosed with or receives treatment for ASD; from charging atypical copays, deductibles, or coinsurance; and from limiting the number of visits for ASD treatment, regardless of whether treatments are educational or habilitative. The ASD coverage mandate became effective for health insurance certificates and policies issued, delivered, amended, or renewed on or after October 15, 2012.

[8] Family estimate is based on findings included in Michigan Autism Spectrum Disorder State Plan Report – December 2012.

[9] See the text of 2012 PA 100 at http://www.legislature.mi.gov/documents/2011-2012/publicact/pdf/2012-PA-0100.pdf.

[10] The maximum annual dollar limitations for ASD benefits established by PA 100 are preempted by the prohibition of annual and lifetime dollar benefit limits under the federal Affordable Care and Patient Protection Act of 2010.

Autism Coverage Reimbursement

Moreover, Public Act 101 of 2012 established the Autism Coverage Reimbursement Program (ACRP) to offset additional costs incurred due to the ASD coverage mandate.[11] The ACRP provides for the reimbursement of private health insurance carriers (i.e., health insurers, including Blue Cross Blue Shield; HMOs; and specialty prepaid or sponsored group health plans (SGHPs) that self-adopt ASD coverage), either directly or via third party administrators (TPAs), for paid claims associated with the diagnosis and treatment of ASD rendered to residents of Michigan within Michigan. The ACRP does not reimburse public health programs or plans, nor are private carriers eligible for reimbursement if they increase their premiums or rates to compensate for additional costs generated by the ASD coverage mandate or for claims paid for services included within essential health benefits (EHB) required by the federal Patient Protection and Affordable Care Act of 2010 (ACA) or rules pursuant to the ACA.[12]

The Department of Insurance and Financial Services (DIFS) is responsible for administering and implementing the ACRP and for developing the application, approval, and compliance processes necessary to operate and manage the ACRP. PA 101 also empowers DIFS to review paid claims for ASD treatments to ensure that such treatments are consistent with current protocols and cost-containment practices described in state law. Reimbursements to private health insurance carriers for ASD diagnosis and treatment are made from the Autism Coverage Fund (ACF) created by PA 101 and administered by DIFS, subject to legislative appropriation. DIFS may expend up to one percent of the annual appropriation made to the ACF for the administration of the ACRP.[13]

Although PA 101 stipulates that the ACRP should reimburse private carriers for total approved paid claims associated with ASD from the ACF, the statute specifies that in the event that revenue within the ACF is insufficient to offset approved paid claims, DIFS shall notify carriers of the shortfall, who shall then be reimbursed in the order in which their applications for reimbursement are approved. Further reimbursements shall not be made unless or until revenue within the ACF becomes available, and increases in carriers' rates to offset unreimbursed claims shall not be considered compensation if determined reasonable by DIFS.

Appropriations for and from the Autism Coverage Fund

Because the ACF is not self-financing, the Legislature included appropriations from the General Fund (GF/GP) for an Autism Coverage Fund line item within the budget for the Department of Licensing and Regulatory Affairs (LARA) in FY 2012-13 and the DIFS budget in FY 2013-14, subsequent to Executive Order 2013-01 which transferred administration of the ACRP from LARA to the newly created DIFS.

Appropriations for the ACF were $15.0 million GF/GP in FY 2012-13 and $11.0 million GF/GP in FY 2013-14. Money within the ACF does not lapse and thus the previous fiscal year's balance carries forward into the subsequent fiscal year. There was no appropriation *for* the ACF in FY 2014-15, however a $5.5 million appropriation *from* the ACF was included in the budget for the Department of Community Health (DCH) for autism provider education programs at various state universities ($4.0 million) and family assistance services by the nonprofit Autism Alliance of Michigan ($1.5 million). These appropriations are discussed further in the following pages.

However, due to the restriction imposed on the ACF by PA 101, that money from the ACF shall only be expended for the purpose of operating the ACRP, legislation amending the statute, introduced as House Bill 5742, must be enacted

[11] See the text of 2012 PA 101 at http://www.legislature.mi.gov/documents/2011-2012/publicact/pdf/2012-PA-0101.pdf.

[12] While there is some ambiguity concerning the rationale for the statutory prohibition of reimbursing claims for services paid by carriers that are included within the EHB required under the ACA, such a prohibition, subsequent to state and federal actions concerning EHB, would seem to undermine the overall intent of the Legislature for the ACRP.

[13] If the Legislature does not appropriate new revenue for the ACF within a given fiscal year, instead relying on the balance within the ACF to support reimbursements, DIFS would necessarily support the administrative costs of the ACRP with existing resources from other appropriated funds to the extent permissible by state law.

prior to expending the money from the Fund appropriated within the FY 2014-15 DCH budget. HB 5742 was passed by the House on September 18, 2014.

ACRP Paid Claims Data

Since it became operational in October 2012, the ACRP has approved approximately 19,900 claims related to the diagnosis or treatment of ASD, totaling approximately $2.7 million in reimbursements to private health insurance carriers.[14] As exhibited in Table 2, the number of claims and the amount paid during FY 2013-14 was substantially higher than in FY 2012-13, potentially a consequence of insurance policies being revised of renewed after the effective date of the mandate and insurance carriers becoming familiar with the application process of the ACRP. Withal, the average payment per claim has generally increased; by approximately 21% from FY 2012-13 to FY 2013-14.

In December of 2013, when claims and payments were significantly lower than previously anticipated, DIFS conjectured the following rationales:

- Lack of awareness about the ACRP among carriers and providers of ASD diagnosis and treatment.
- Limited number of providers of ASD diagnosis and treatment services within the state.
- Lag time due to missing or inaccurate coding within applications for reimbursement.
- Low utilization due to relatively higher administrative costs to apply for reimbursement; thus, carriers would rather cover costs or raise rates.

Considering the subsequent escalation in the reimbursements during FY 2013-14, it is possible that the impediments described by the first three potential rationales are diminishing as awareness of the ASD coverage mandate and ACRP broadens, the provision of ASD services expands, and carriers become more familiar with the application process. Nonetheless, an interpretation of data provided by DIFS could support the supposition that numerous private health insurance carriers are opting to absorb the costs of ASD services or procuring compensation by adjusting their premiums or rates rather than applying for reimbursement under the ACRP.

As evidenced by Table 3, a total of 16 carriers have received payments from the ACRP since October 2012; five HMOs, nine SGHPs, and two TPAs (contracted by group health plans). Approximately 86% of the number of claims and amount of payments are attributable to HMOs, of which 16,384 claims were approved and approximately $2.2 million was paid to just two HMOs (Blue Care Network and Health Alliance Plan). SGHPs, or TPAs contracted by SGHPs, accounted for the remaining claims and payments.

Since none of the private health insurers and only a fraction of HMOs in the state have applied for reimbursements under the ACRP, it is evident that these types of carriers are electing not to utilize the ACRP and are likely absorbing the costs associated with the ASD coverage mandate or obtaining compensation through the rate filing and approval process. Yet, based on a recent survey of carriers, DIFS anticipates that approved payments to carriers for reimbursement of claims associated with ASD services will continue to increase throughout FY 2014-15, by approximately $2.0 million over the anticipated FY 2013-14 total, to an annual total exceeding $4.0 million.

[14] A "claim" is defined by DIFS to consist of an actual service (properly coded) provided to a patient; reimbursements generally contains numerous claims associated with various patients.

Table 2
ACRP Statistics by Month

Month	$Paid	# Claims	$/Claim
Dec. 2012	$244	2	$122
Jan. 2013	$6,981	57	$122
Feb. 2013	$4,324	52	$83
Mar. 2013	$2,172	59	$37
Apr. 2013	$0	0	--
May 2013	$0	0	--
Jun. 2013	$1,091	29	$38
Jul. 2013	$0	0	--
Aug. 2013	$394	5	$79
Sep 2013	$86,851	710	$122
FY 2013 Total	**$102,057**	**914**	**$112**
Oct. 2013	$0	0	--
Nov. 2013	$396,269	2,752	$144
Dec. 2013	$3,265	18	$181
Jan. 2014	$5,535	55	$101
Feb. 2014	$0	0	--
Mar. 2014	$438,071	3,046	$144
Apr. 2014	$153,684	1,396	$110
May 2014	$471,571	3,318	$142
Jun. 2014	$24,106	214	$113
Jul. 2014	$56,599	346	$164
Aug. 2014	$0	0	--
Sep. 2014	$1,008,462	7,824	$129
FY 2014 YTD	**$2,557,562**	**18,969**	**$135**
GRAND TOTAL	**$2,659,619**	**19,883**	**$134**

Source: Office of Financial and Administrative Services, DIFS, 10/2/2014

Table 3
ACRP Statistics by Carrier Type

	HMO	TPA	SGHP	Total
Carriers	5	2	9	16
%	31.3%	12.5%	56.3%	100%
Claims	17,158	105	2,620	19,883
%	86.3%	0.5%	13.2%	100%
Payments	$2,279,775	$12,922	$366,922	$2,659,619
%	85.7%	0.5%	13.8%	100%

Source: Office of Financial and Administrative Services, DIFS, 08/05/2014

The Patient Protection and Affordable Care Act

PA 100 excluded qualified health plans (QHP) offered via a health benefit exchange (e.g., Healthcare.gov) from the ASD coverage mandate to the extent that the ASD mandate exceeded coverage included within the essential health benefits (EHB) provided by individual and small group health insurance plans as required under the federal Patient Protection and Affordable Care Act of 2010 (ACA) and rules promulgated pursuant to the ACA.[15] However, as permitted by federal rules promulgated pursuant to the ACA, DIFS issued Order No. 13-003-M on January 7, 2013, requiring that all QHP offered via an exchange provide coverage for ABA treatment under the EHB category of "rehabilitative and habilitative services and devises".[16] Consequently, coverage for ABA treatment is mandated for all individual and small group health insurance policies issued, delivered, or renewed in Michigan, whether offered on or off an exchange.[17]

Order No. 13-003-M also acknowledged that the annual dollar limits on ASD benefits specified by PA 100 are unenforceable since ASD treatment, including ABA, are now included within the EHB and pursuant to the ACA could not be subject to annual or lifetime dollar limits. Moreover, Order No. 14-017-M issued by DIFS on April 18, 2014 reaffirms that the annual dollar limits in PA 100 are preempted by the ACA and further recognizes that PA 100 prohibits all insurance policies from imposing qualitative limits on ASD treatment, such as limits on the number of visits for treatment or amount of time devoted to treatment.[18]

State Appropriations for ASD Provider Education and Family Assistance

In recent years the state has provided funding to universities to increase access to care for persons with autism. The appropriations support development of education and treatment programs for persons with autism, and development of education programs to build the workforce of health care professionals trained to assess, diagnose and provide treatment services for persons with autism spectrum disorders, especially board certified behavior analysts.

The history of state appropriations in the DCH budget for this purpose is shown in Table 4 (FY 2011-12 appropriations were made in the state Higher Education budget). Most of the funds have been designated as one-time appropriations. Appropriation amounts are from GF/GP revenue except that, as noted earlier in this report, in FY 2014-15 one-time funding of $4.0 million to universities and $1.5 million to family assistance services is from the ACF.

For FY 2014-15 the enacted budget directs that the one-time appropriations be allocated to five universities, along with a new separate allocation to the Autism Alliance of Michigan for autism family assistance services. All of the recipient universities will be targeting use of the FY 2014-15 funds for continued development and expansion of educational programming to increase the number of trained health care professionals in the workforce able to assess and provide treatment services to persons with ASD.

Use of funds by recipients in prior fiscal years are described as follows, and in some cases anticipated use of funds for FY 2014-15 are discussed.

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[15] This clause was included in PA 100 so to prevent an obligation pursuant to the ACA for the state to pay for benefits additional to those included within the EHB required by the ACA to be offered by QHP.

[16] See the text of Order No. 13-003-M at https://www.michigan.gov/documents/lara/1.7.13_Order_No_13-003-M_EHB_Habilitative_Services_407955_7.pdf.

[17] Although large group plans are not required to provide EHB, nor mandated to offer coverage for ABA treatment, if any EHB are included within a large group plan, such benefits must comply with the ACA's provisions on annual and lifetime dollar limits.

[18] See the text of Order No. 14-017-M at https://www.michigan.gov/documents/difs/Order_14-017-M_ASD_454005_7.pdf.

Table 4
Appropriations for ASD Education and Assistance

Fiscal Year	Recipient	Amount	Source
2011-12	Eastern Michigan University	$500,000	GF/GP
2012-13	Eastern Michigan University	$500,000	GF/GP
2013-14	Central Michigan University	$500,000	GF/GP
	Eastern Michigan University	$1,000,000	GF/GP
	Oakland University	$500,000	GF/GP
	Western Michigan University	$500,000	GF/GP
	Total	**$2,500,000**	
2014-15	Central Michigan University	$500,000	ACF
	Eastern Michigan University	$1,500,000	GF/GP
	Michigan State University	$1,000,000	GF/GP
	Oakland University	$500,000	ACF
	Western Michigan University	$4,000,000	GF/GP & ACF
	Autism Alliance of Michigan	$1,500,000	ACF
	Total	**$9,000,000**	

University Autism Programs - Central Michigan University

The budget directs funding to the Central Assessment Lending Library at Central Michigan University, which houses a previously established program supporting school district assessment and instruction for special needs children. FY 2013-14 funding has been used to initiate new undergraduate and graduate training programs for students to become board certified behavior analysts, and creation of an on-campus clinical center for assessment and treatment of children with ASD. The clinic will increase access to services for children, and provide experience for students enrolled in the new programs and other academic programs.

University Autism Programs - Eastern Michigan University

The Autism Collaborative Center at Eastern Michigan University has received funding since FY 2011-12. An ongoing appropriation of $500,000 has been provided annually, with additional one-time funding beginning in FY 2013-14. The first year grant supported furnishing of therapy and family areas, and installation of a TeleHealth live video conferencing and recording system to increase access to evaluation and treatment services. Funding in FY 2012-13 was used to increase the Center's operations and services, and support costs of new clinical team members including board certified behavior analysts, speech pathologists, a music therapist, an occupational therapist, the managing director, family and community relations staff, and support staff.

FY 2013-14 funds were used to improve and expand the facilities at the Autism Collaborative Center including restrooms, personal care skills rooms, a life skills laboratory, and two therapy rooms. Security, safety, and compliance with the Americans with Disabilities Act were also addressed, and a social worker was hired to join the clinical team.

University Autism Programs - Oakland University

The Center for Autism at Oakland University, known as OUCARES, first received funding in FY 2013-14. About 40% of the funding has been used to develop a 15-week employable skills Practical Film Workshop for students and other adults with ASD, starting February 2014. Participants develop film production and social skills to prepare them for employment in the film, media, and entertainment industry. The University has requested an extension to expend the balance of the funds in the coming fiscal year for the program.

The University plans to expend 80% of the FY 2014-15 funding to develop a clinical program providing diagnostic assessment and services in applied behavioral analysis for young children with autism, provide partial scholarships to graduate students in the applied behavior analysis program, and reconfigure the present assessment center into a central therapy area with six individual therapy rooms. The remaining 20% of the funding will be used to expand the film workshop program established with the FY 2013-14 state grant.

University Autism Programs - Western Michigan University

The FY 2013-14 grant of $500,000 to the Autism Center of Excellence at Western Michigan University has been used to fund multiple projects related to ASD assessment and treatment including tele-consultation services to increase provider skills, a podcasting project of best-practice instructional resources for providers, the annual Michigan Autism Conference, and training of supervisors required to work with practitioners who are training to become board certified behavior analysts.

Western Michigan's FY 2014-15 funding will be used to develop and expand training programs for students in psychology, education and related disciplines to increase the number of professionals trained to qualify as board certified associate behavior analysts (bachelors level), board certified behavior analysts (masters and doctoral levels), and regular and special education teachers with an autism endorsement. FY 2014-15 funding will also be used to continue and expand community consultation resources, provide community care and treatment center for young children, establish on-campus support networks for students with ASD, and create a replicable model for other universities for similar programming.

University Autism Programs - Michigan State University

New funding to Michigan State University in FY 2014-15 will be used to develop and provide opportunities for ASD focus training for physicians, and for paraprofessionals in the education field who often work with ASD children.

Autism Family Assistance Services - Autism Alliance of Michigan

The new FY 2014-15 appropriation for autism family assistance services is included to fund efforts to help guide families in choosing ASD treatment and services. The $1.5 million appropriation is included as one-time funding using available ACF monies. The non-profit Autism Alliance of Michigan will use the funds to establish a website resource clearinghouse and centralized 1-800 call line for health professionals and families of children and adults with ASD, as a pilot project in six regions of the state. The project also will establish an autism registry and collect data to assess achievement of outcomes.

Conclusion

An understanding of the public policies and programs already implemented is important as legislatures are, and will continue to be, confronted with and consider new evidence about ASD and appeals for state-supported assistance for practitioners and patients. To that end, the information included within this report provides an overview of recent state actions and appropriations pertaining to treatment of and training for ASD, including the ACRP and the ACF. Table 5 exhibits the revenues deposited into, expenditures withdrawn from, and estimates of the approximate current balance within the ACF. Of the $26.0 million appropriated for the ACF in FY 2012-13 and FY 2013-14, $2.7 million has been paid to health insurance carriers for reimbursements of ASD diagnosis and treatment services, while $5.5 million is appropriated for provider education and family assistance during FY 2014-15 as summarized above. The resultant $17.8 million balance remains available for future carrier reimbursements.

Table 5
ACF Revenues, Expenditures, and Balance

Legislative Appropriations (from GF/GP)	$26,000,000
ACRP Reimbursements (as of 10/02/14)	($2,659,619)
Provider Education/Family Assistance (DCH)	($5,500,000)
Miscellaneous Expenses (DIFS/DTMB)	($22,149)
Common Cash Earnings	$14,874
Approximate Fund Balance	**$17,833,107**

Source: Office of Financial and Administrative Services, DIFS, and HFA queries of MAIN accounting system on 10/02/2014.

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NOTE: This report was written by Paul Holland, Fiscal Analyst, Margaret Alston, Senior Fiscal Analyst, Susan Frey, Senior Fiscal Analyst, and Matthew Ellsworth, Senior Fiscal Analyst. Kathryn Bateson, Administrative Assistant, prepared the report for publication. The House Fiscal Agency is solely responsible for the content of the report.