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14 SUPERIOR COURT OF THE STATE OF CALIFORNIA
15 FOR THE COUNTY OF LOS ANGELES

17 CONSUMER WATCHDOG, a non-profit
18 organization; and ANSHU BATRA, M.D.,
19 F.A.A.P.,

20 *Petitioners and Plaintiffs,*

21 v.

22 CALIFORNIA DEPARTMENT OF MANAGED
23 HEALTH CARE; LUCINDA "CINDY" EHNES, in
24 her official capacity as Director of the California
25 Department of Managed Health Care; and DOES 1
26 through 20, inclusive,

27 *Respondents and Defendants.*

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ORIGINAL FILED
Superior Court of California
County of Los Angeles

DEC 06 2010

John A. Clarke, Executive Officer/Clerk
By A. Fajardo, Deputy
ANNETTE FAJARDO

CASE NO. BS121397

PETITIONERS' REPLY
MEMORANDUM IN SUPPORT OF
PETITION FOR WRIT OF MANDATE

Date: December 13, 2010
Time: 9:30 a.m.
Dept.: 85
Hon. James C. Chalfant

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1 INTRODUCTION

2 The writ petition in this case seeks a judicial determination that ABA therapy, when it is
3 prescribed by a licensed health care provider as a “medically necessary” treatment for a child’s autism
4 and is administered or supervised by a licensed or certified behavior analyst, must be covered by
5 health plans *as a matter of law* because (1) it is a “basic health care service” under the Knox-Keene
6 Act (“KKA”) and (2) it is a “medically necessary treatment” of the “severe mental illness” of autism
7 under the Mental Health Parity Act (“MHPA”). (See Health & Saf. Code, §§ 1367(i), 1374.72.)
8 Petitioners’ Opening Memorandum demonstrated that the overwhelming consensus of the medical
9 and scientific community — as reflected, *inter alia*, in the unbroken string of IMR decisions reversing
10 health plans’ denials of coverage for ABA — is that ABA is now deemed to be “an essential health
11 care service” for patients with autism (see, e.g., Pressley Decl., Exh. A, pp. 133, 163, 187) and,
indeed, is “the gold standard of treatment for autistic children” (*id.*, p. 32).

12 In its Opposition, DMHC does not dispute that health plans are required to provide coverage
13 for all basic “health care services” under the KKA and for all “medically necessary treatments” for
14 autism under the MHPA. Nor does DMHC attempt to refute the decades of empirical evidence and
15 expert opinion establishing the effectiveness of ABA therapy as the “standard of care” in the
16 treatment of children with autism. But DMHC continues to insist that health plans cannot be
17 compelled to provide coverage for ABA services under the KKA and the MHPA unless the therapy
is directly administered by a state-licensed health care professional.

18 DMHC recognizes that this Court *rejected that very argument* in overruling Respondents’
19 demurrer to the Petition, expressly holding that “unlicensed professionals may perform Knox-Keene
20 regulated health care services” and that “a requirement that ABA treatment only be given by licensed
21 professionals would conflict with the parity requirement of the MHPA.” (Demurrer Decision, p. 9.)
22 And aside from DMHC’s unsupported accusation that the Court’s demurrer ruling “was a product of
23 Petitioners’ mischaracterization of the law and the facts” (DMHC’s Opp., p. 20), DMHC makes no
24 attempt to show that any aspect of the Court’s decision was at all incorrect. Indeed, given the KKA’s
25 explicit mandate that health plans “shall employ and utilize *allied health manpower* for the furnishing
26 of services to the extent permitted by law and consistent with good medical practice” (Health & Saf.
27 Code, § 1367(f) [emphasis added]) and the Act’s directive that personnel employed by or under
28 contract to the plans must be licensed or certified *only* “where licensure or certification is required
by law” (*id.*, § 1367(b)), DMHC appears to have abandoned any argument that *the KKA itself*

1 prohibits the use of unlicensed professionals in delivering health care services.

2 Instead, DMHC now asserts — for the first time in this litigation or in any other forum — that
3 it is the *Business and Professions Code* that requires that all health care providers be licensed by the
4 state. Specifically, DMHC contends that B & P Code section 2052 *makes it a misdemeanor* for
5 unlicensed persons to provide *any health care treatment* for autism, including ABA therapy.
6 (DMHC Opp., p. 5.) According to DMHC, it therefore cannot order health plans to pay for ABA
7 services administered by certified but unlicensed behavior analysts, because doing so would “compel
8 plans to commit an illegal act.” (*Id.*, p. 3.)

9 DMHC has thus “doubled down” on its licensure argument: It no longer maintains merely
10 that health plans have no obligation to provide *coverage* for medically necessary ABA therapy
11 performed by BACB-certified health care professionals; it now takes the position that under B & P
12 Code section 2052, the thousands of BACB-certified ABA therapists and assistants who are
13 furnishing ABA services to California’s autistic children every day — many of these services being
14 paid for by the state’s Regional Centers or by other health insurers under DMHC’s jurisdiction — are
15 actually *criminals*, allegedly practicing medicine without a license. Or at least they would be, but in
16 order to avoid such a preposterous implication, DMHC instead puts forward an equally absurd
17 proposition: that the ABA services provided by these unlicensed behavior analysts cannot be
18 considered to be “health care services” or autism “treatments” in the first place. (*Id.*, pp. 5-6.) And
19 it is on this basis that DMHC perversely concludes that health plans have no obligation to provide
20 coverage for the only well-documented, effective therapy for autism when it is administered by the
21 very health care professionals who are the most qualified by training and experience to do so.

22 As we show below, B & P Code section 2052 will not hold the weight that DMHC attempts
23 to impose on it. By its own terms, that section only prohibits the practice of *medicine* without a
24 physician’s and surgeon’s certificate; it does not purport to prohibit the delivery of all *health care*
25 *services* without a state license. To the contrary, both the Legislature and DMHC itself have
26 confirmed that no license is needed to provide *allied health care services* such as ABA therapy unless
27 the Legislature has specifically required one; and — as this Court found in its demurrer ruling and
28 as DMHC is forced to concede — the Legislature has established no licensing scheme or other
requirements with respect to the delivery of ABA therapy. DMHC’s latest argument is thus no more
persuasive than any of its prior attempts to justify the unique, and unlawful, policy it has adopted to
resolve complaints regarding health plans’ denial of coverage for medically necessary ABA services.

1 **I. BUSINESS & PROFESSIONS CODE SECTION 2052 DOES NOT PROHIBIT**
2 **BACB-CERTIFIED BEHAVIOR ANALYSTS FROM ADMINISTERING ABA**
3 **THERAPY TO AUTISTIC CHILDREN**

4 DMHC's contention that B & P Code section 2052 prohibits unlicensed behavior analysts
5 from treating autism through ABA therapy is disproved in the first instance simply by examining the
6 language of the statute and its placement in the Code. Section 2052 is found in Chapter 5 of
7 Division 2 of the B & P Code. Division 2, commencing with section 500, regulates all of the
8 "Healing Arts." Chapter 5, commencing with section 2000, is entitled the "Medical Practice Act" and
9 specifically regulates the practice of "medicine," not the remainder of the healing arts.¹ Section 2050
10 provides that the Division of Licensing of the Medical Board of California shall issue a "physician's
11 and surgeon's certificate" to all physicians and surgeons licensed by the Board, which authorizes them
12 "to use drugs or devices in or upon human beings and to sever or penetrate the tissues of human
13 beings and to use any or all other methods in the treatment of diseases, injuries, deformities, and other
14 physical and mental conditions." (B & P Code, § 2051.) Section 2052 then declares:

15 " (a) Notwithstanding Section 146, any person who practices or attempts to
16 practice, or who advertises or holds himself or herself out as practicing, any system
17 or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates
18 for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder,
19 injury, or other physical or mental condition of any person, *without having at the time
20 of doing so a valid, unrevoked, or unsuspended certificate as provided in this chapter
21 or without being authorized to perform the act pursuant to a certificate obtained in
22 accordance with some other provision of law is guilty of a public offense*" (*Id.*,
23 § 2052(a) [emphasis added].)²

24 By its own limiting terms, B & P Code section 2052 only prohibits the practice of *medicine*
25 by someone who does not possess a valid *physician's and surgeon's license* issued pursuant to the
26 Medical Practice Act (i.e., "this chapter"). Section 2052 does not purport to apply to any of the
27 myriad other "healing arts." In particular, section 2052 does not apply to the multitude of persons
28 who are engaged in any of the "allied health professions," which are clinical health care professions
distinct from medicine, dentistry, and nursing, and which provide a range of diagnostic, technical,

24 ¹Altogether, there are now some 34 different chapters within Division 2, regulating such diverse
25 healing arts as "dentistry" (Chap. 4), "occupational therapy" (Chap. 5.6), "dietitians" (Chap. 5.65),
26 "nursing" (Chap. 6), "psychologists" (Chap. 6.6), "optometry" (Chap. 7), "respiratory therapy"
27 (Chap. 8.3), "pharmacy" (Chap. 9), "psychiatric technicians" (Chap. 10), "veterinary medicine"
28 (Chap. 11), "acupuncture" (Chap. 12), and "marriage and family therapists" (Chap. 13).

²Subdivision (b) of section 2052 imposes a similar punishment on any person who "conspires with
or aids or abets another to commit any act described in subdivision (a)," thus apparently making the
staff of the state's Regional Centers and any private doctors who refer their autistic patients to BACB-
certified ABA therapists criminals under DMHC's theory, as well.

1 therapeutic and direct patient care and support services.³ Allied health professions typically require
2 advanced education and specialized training, but they are not necessarily licensed by the state.
3 BACB-certified behavior analysts who administer ABA therapy are among this class of “allied health
4 professionals.” Their education and training is completely different from that of physicians and
5 surgeons; they do not practice “medicine,” nor do they hold themselves out as doing so. Simply put,
6 no reasonable person would suggest — and no authority has heretofore ever asserted — that by
7 providing ABA services to children with autism, behavior analysts are engaging in the unauthorized
8 practice of medicine in violation of section 2052. (See Kahr Decl., Exh. E.)

9 Contrary to DMHC’s argument that California law requires a license to treat any physical or
10 mental disorder, the Legislature plainly understood and contemplated that licensure was not necessary
11 for all persons who provide “health care services,” not even for those who engage in some practices
12 that might otherwise be considered to be “medicine.” The Court need only look two sections further
13 into the B & P Code for confirmation: In 2002, the Legislature enacted SB 577 (Stats. 2002, c. 820),
14 adding sections 2053.5 and 2053.6, which expressly authorize practitioners of complementary and
15 alternative medicine to provide health care services *without a license*, with certain enumerated
16 exceptions.⁴ In enacting SB 577, the Legislature found that “millions of Californians . . . are presently
17 receiving a substantial volume of *health care services* from complementary and alternative health
18 care practitioners.” (SB 577, § 1(a) [Supp. RJN, Exh. 6; emphasis added].) The Legislature
19 explained that “the provision of many of these services may be in technical violation of the Medical
20 Practice Act” and that “[c]omplementary and alternative health care practitioners could therefore be
21 subject to fines, penalties, and the restriction of their practice . . . even though there is no
22 demonstration that their practices are harmful to the public.” (*Id.*, § 1(b).) The Legislature therefore
23 enacted SB 577 “to allow access by California residents to complementary and alternative health care
24 practitioners who are not providing services that require medical training and credentials.” (*Id.*,

24 ³See Health & Saf. Code, § 1367(f) [health plans “shall employ and utilize allied health manpower
25 for the furnishing of services to the extent permitted by law and consistent with good medical
26 practice”]; Assn. of Schools of Allied Health Professions, “Definition of Allied Health Professionals,”
27 <www.asahp.org/definition.htm>; see also <http://en.wikipedia.org/wiki/Allied_health_professions>.

28 ⁴The prohibited services include performing surgery or any other procedure that punctures the skin
or harmfully invades the body; administering or prescribing X-ray radiation or controlled substances;
setting fractures; treating lacerations or abrasions through electrotherapy; and holding out, advertising,
or implying that one is a physician or surgeon. (B & P Code, § 2053.5 [“Actions that constitute
unlawful practice of medicine”].) ABA therapists engage in none of these prohibited practices.

1 § 1(c.) SB 577 thus plainly refutes DMHC's contention that the Legislature adopted a "bright line"
2 requirement of state licensure for all "health care services" in order to protect the public from harm.

3 Provisions of the Knox-Keene Act likewise reflect the Legislature's understanding that not
4 all health care services need to be delivered by licensed health care professionals. In addition to
5 section 1367(f) quoted above (see note 3, *supra*) — which expressly mandates that health plans
6 should use "allied health manpower" for furnishing services, without any reference to licensure —
7 section 1367(b) declares that "[p]ersonnel employed by or under contract to the plan shall be licensed
8 or certified by their respective board or agency, *where licensure or certification is required by law.*"
9 (Emphasis added.) The KKA therefore implicitly recognizes that there are health care personnel *who*
10 *are not required to be licensed or certified*, once again refuting DMHC's position that all persons
11 providing health care services must be licensed by the state.

12 Indeed, DMHC itself has historically deemed certain therapeutic services similar to ABA to
13 be "basic health care services" under the KKA, even though *none* of the practitioners providing those
14 services were at the time licensed by the state. As originally adopted in July 1976, 28 Cal. Code
15 Regs. § 1300.67, entitled "Scope of Basic Health Care Services," provided in pertinent part:

16 "The basic health care services required to be provided by a health care service
17 plan to its enrollees shall include, where medically necessary, subject to any
18 copayment, deductible, or limitation of which the Commissioner may approve:

19 * * *

20 "(b) Inpatient hospital services, which shall mean short-term general
21 hospital services, including room with customary furnishings and equipment, meals
22 (including special diets as medically necessary), general nursing care, use of operating
23 room and related facilities, intensive care unit and services, drugs, medications,
24 biologicals, anesthesia and oxygen services, diagnostic laboratory and x-ray services,
25 special duty nursing as medically necessary, physical therapy, *respiratory therapy*,
26 administration of blood and blood products, and other diagnostic, therapeutic and
27 rehabilitative services as appropriate

28 "(c) Ambulatory care services, (outpatient hospital services) which shall
include diagnostic and treatment services, physical therapy, speech therapy,
occupational therapy services as appropriate, and those hospital services which can
reasonably be provided on an ambulatory basis." (Supp. RJN, Exh. 11 [emphasis
added].)

Yet at the time section 1300.67 was adopted, *there was no state regulation of occupational
therapy at all*, much less any licensure requirement. The following year, the Legislature adopted
certain qualifications for those representing themselves as "occupational therapists" or "occupational
therapy assistants," but *it was not until 2000* that the Legislature required occupational therapists to
be licensed by the state, creating the Board of Occupational Therapy and adopting the standards of

1 the private National Board for Certification in Occupational Therapy as the state standards for
2 licensure.⁵ B & P Code section 2052 was in existence throughout this period, but no one ever
3 suggested that occupational therapists were committing a crime by treating patients without a license.

4 Similarly, section 1300.67 included “respiratory therapy” as a “basic health care service” in
5 1976 even though *the Legislature did not require respiratory therapists to be licensed until 1982*,
6 when it passed AB 1287 (Stats. 1982, c. 1344), enacting the Respiratory Care Practice Act, B & P
7 Code § 3700 et seq., which imposed minimum education standards and required a passing grade on
8 an examination in order to engage in the practice of respiratory care. Ironically given DMHC’s
9 current position in this litigation, the Board of Medical Quality Assurance *opposed* the licensing of
10 the state’s 8,000 respiratory therapists and asked the Governor to veto AB 1287, explaining:

11 “At present there is no clear public policy on how emerging health care
12 professions and occupations should be regulated in the future. As a result, the
13 Legislature is besieged with efforts to impose licensure or other regulatory schemes
14 on various groups in the absence of any clear evidence of necessity. In the present
15 instance, no studies or other documentation have been produced demonstrating that
16 the unregulated practice of regulatory therapy poses a threat to the health or well-being
17 of Californians.” (Supp. RJN, Exh. 10, p. 12.)

18 As the above examples demonstrate, state licensure is not required for a particular therapeutic
19 technique or treatment to be considered a basic “health care service.” *Indeed, it could not be*
20 *otherwise*. Standard medical practice drives licensure, not vice versa. The Legislature does not create
21 a licensing scheme for an emerging health care service or specialty *before* that treatment comes into
22 vogue. There will thus always be a lag between the time that a particular health care treatment gains
23 acceptance in the medical community and the time that the Legislature sees a need to regulate its

24 ⁵AB 1100 (Stats. 1977, c. 836) enacted B & P Code section 2570, restricting use of the title
25 “occupational therapist” to those who met the qualifications for reimbursement of their services by
26 the Medi-Cal program, which included being a graduate of a curriculum in occupational therapy and
27 registration by the American Occupational Therapy Association. As explained in the Enrolled Bill
28 Reports, “[Occupational therapy] has for many years been an accepted part of the health care team
... [I]t does seem desirable that basic qualifications for those who practice in California are clearly
stated to the public. . . . *Since there are no existing provisions of law governing qualifications, . . .*
any person, regardless of training, may provide such services to the public at large, but may not be
reimbursed by Medi-Cal.” (Supp. RJN, Exh. 7, p. 8.) AB 1852 (Stats. 1993, c. 261) amended section
2570 to incorporate the Medi-Cal reimbursement qualifications directly into the B & P Code, but as
the Legislative Counsel’s Digest acknowledged, “[t]he law does not otherwise provide for the
licensing or regulation of occupational therapists. (Supp. RJN, Exh. 8.) It was not until SB 1046
(Stats. 2000, c. 697) enacted the Occupational Therapy Practice Act that occupational therapists were,
for the first time, required to be licensed by the state, effective January 1, 2003. (Supp. RJN, Exh. 9.)

1 practice. So it is with ABA therapy, which only recently has become the established “standard of
2 care” in the treatment of autism, and for which the Legislature has yet to adopt any requirement that
3 its practitioners be licensed. (See, e.g., Kahr Decl., Exh. D.) But the absence of any licensure scheme
4 for ABA therapists does not make ABA any less of a “health care service,” as DMHC contends.

5 In fact, the evolution of ABA therapy has in many ways paralleled that of occupational
6 therapy. Just as California law for many years relied upon Medi-Cal’s standards for reimbursing
7 occupational therapy services to regulate the qualifications of its practitioners, the state has
8 established qualifications for ABA therapists in the regulations governing payment for their services
9 by the Regional Centers, adopting BACB certification as the guiding standard. (See Gov. Code,
10 § 95021 [standards for ABA providers who contract with Regional Centers]; 17 Cal. Code Regs.,
11 § 54342(8) & (11) [adopting certification by BACB as the qualification for payment].) DMHC
12 attempts to dismiss all ABA provided by Regional Centers on the theory that they are not limited to
13 providing “health care services,” but that is not correct: Regional Centers are now prohibited from
14 purchasing any “educational services” for children ages 3-17, and any “nonmedical therapies”
15 whatsoever. (Welf. & Inst. Code, § 4648.5(a)(3) & (4).) The law likewise states that Regional
16 Centers may only purchase ABA services “that reflect evidence-based practices, promote positive
17 social behaviors, and ameliorate behaviors that interfere with learning and social interactions,” and
18 that they are specifically prohibited from paying for ABA for the purpose of “school services.” (*Id.*,
19 § 4686.2(b)(1) & (3).) Finally, Regional Centers must seek reimbursement for the cost of ABA
20 services from a family’s private insurance or health care service plan. (*Id.*, § 4659.) Taken together,
21 these provisions evidence the Legislature’s recognition that ABA administered or supervised by
22 BACB-certified behavior analysts are “health care services” that qualify for coverage by health plans,
23 and that these unlicensed therapists are certainly not violating the law by providing such treatment.⁶

24 At bottom, DMHC’s reliance on licensure to distinguish between ABA that is a covered
25 “health care service” and ABA that is supposedly “educational” is not only unsupported in the law,
26 but simply makes no sense. The characterization of ABA as either “health care” or “educational”

27 ⁶As detailed in the Declaration of Kristin Jacobson, several health insurers do include coverage for
28 ABA services provided by BACB-certified therapists and their assistants, further demonstrating the
absurdity of DMHC’s contention that such treatment is illegal under B & P Code section 2052. (See
Jacobson Decl., ¶¶ 19-22.)

1 does not depend upon *who* performs the service, or whether they happen to have a state license, but
2 on the *nature* of the therapy and the *symptoms* that it targets.⁷ If the therapy targets behaviors that
3 represent the core symptoms of autism that interfere with a child’s ability to function independently
4 (e.g., to communicate, to interact socially, or to refrain from repetitive behaviors), then it is a “health
5 care service” regardless of the licensure status of the provider. (See, e.g., Pressley Decl., Exh. A,
6 p. 58 [IMR decision finding that the requested ABA services “are all medical and are not
7 instructional, remedial, or caretaking procedures” because they “are directed toward improving the
8 patient’s communicative skills, socialization, and physical fine motor abilities”].) And to the extent
9 that there may be a legitimate dispute in any individual case as to whether the prescribed ABA therapy
10 is a “health care” or an “educational” service, that is precisely the type of determination that should
11 be made by independent medical professionals assessing the “medical necessity” of the treatment, not
12 by DMHC’s staff in the guise of determining “coverage.”

12 **II. DMHC’S NEW PROCEDURES FOR PROCESSING ABA-RELATED**
13 **COMPLAINTS PURSUANT TO ITS MARCH 9, 2009, UNDERGROUND**
14 **REGULATION ARE ILLEGAL**

14 DMHC offers little defense of the legality of its March 9, 2009, Directive, merely repeating
15 its already-rejected argument that it is not an underground regulation because it embodies “the only
16 legally tenable interpretation of a provision of law.” (DMHC Opp., p. 18.) Petitioners would refer
17 the Court to its own Demurrer Decision for the refutation of that argument. (See Decision, pp. 9-10.)

18 DMHC also contends that it appropriately exercises its discretion to resolve the plans’
19 coverage objections without the use of IMR because the coverage determination must come before
20 any IMR under Health & Safety Code section 1374.30(b). But Petitioners’ point is that *there is no*
21 *legitimate coverage dispute* when ABA is prescribed as a medically necessary treatment for autism
22 by a physician or other licensed health care professional, because coverage is mandated *as a matter*
23 *of law* under the KKA and the MHPA. That DMHC allegedly resolves 88.6% of the ABA grievances
24 in favor of the enrollee (DMHC Opp., p. 4) only confirms the bogus nature of the plans’ boilerplate
25

26 ⁷Nor does the fact that ABA therapy is sometimes funded by schools or is included in a child’s IEP
27 mean that it is an “educational” rather than a “health care” treatment. Speech, occupational, and
28 physical therapy are frequently funded by schools and included in IEPs, as well, but DMHC
recognizes those therapies as health care services and requires plans to cover them. Just because a
treatment might be needed to help a child learn does not mean that it is not a “health care service.”

1 “coverage” objections. In the meantime, DMHC’s case-by-case review of each plans’ denials adds
2 months of delay during the most critical time in an autistic child’s development, and often results in
3 the rejection of the enrollee’s complaint altogether.⁸

4 **III. DMHC VIOLATED THE PUBLIC RECORDS ACT BY REFUSING TO 5 PRODUCE ANY RECORDS OF ENROLLEE COMPLAINTS**

6 In response to Petitioners’ April 2009 request for public records, DMHC contended that
7 records of consumer complaints involving health plans’ denials of coverage for ABA treatment are
8 *categorically exempt from disclosure* under the PRA, even when redacted to protect the identity of
9 the consumer. DMHC expressed this position in its initial written response to Petitioners’ PRA
10 request (see Declaration of Todd M. Foreman, ¶ 2 & Exh. A), and it continued to maintain that
11 position throughout an ensuing exchange of meet-and-confer correspondence (see *id.*, ¶¶ 4-5 &
12 Exh. B). Indeed, in its Response to Request for Admissions in this case, DMHC admitted that it
13 “does not produce documents from grievance files in response to requests under the California Public
14 Records Act because those documents are protected from disclosure.” (Kahr Decl., Exh. A, p. 10.)

15 But now, when the time has come to litigate this issue, DMHC *offers no substantive defense*
16 of its unfounded interpretation of the PRA. Instead, DMHC seeks to blame Petitioners for the
17 Department’s failure to promptly produce records of consumer complaints, bemoaning that they
18 refused to make any compromise in the scope of their request for documents that DMHC had insisted
19 — and continues to insist — that it would not produce *under any circumstances*.

20 DMHC’s emphasis on the alleged overbreadth of Petitioners’ request is a pure *non sequitur*.
21 First, the PRA requires public agencies to “[p]rovide suggestions for overcoming any practical basis
22 for denying access to the records or information sought.” (Gov. Code, § 6253.1(a)(3); see also *id.*

23 ⁸As an example, in the only grievance decision that DMHC cites in support of its assertion that it
24 “routinely overrules denials involving ABA and state-licensed health care providers” (DMHC Opp.,
25 pp. 4, 10 [citing Exh. G, pgs. DMHC 11517-11519]), it took the Department *eight months* to issue
26 a ruling, and the plan delayed *another three months* before finally authorizing the therapy because
27 DMHC’s grievance determination — unlike an IMR decision — is not “binding on the plan” and
28 enforceable through mandatory \$5,000/day fines. (See Jacobson Decl., ¶¶ 5-14; Supp. Donohue
Depo. Excerpts, pp. 396-436 & Exh. 36 [discussion and documents related to AY’s grievance].) As
Ms. Jacobson notes, DMHC’s current policy not only requires doctors prescribing ABA therapy to
articulate the “magic words” that will trigger a coverage determination in the enrollees’ favor, but its
insistence that only licensed providers can provide treatments severely limits the availability of ABA
services for autistic children because there are an insufficient number of licensed professionals to
meet even the tiniest percentage of the demand for ABA therapy. (Jacobson Decl., ¶¶ 17-18.)

1 § 6253(a) [requiring agencies to make available any “reasonably segregable portion” of requested
2 public records].) DMHC did not do so in this case. More importantly, DMHC informed Petitioners
3 on several occasions that *all records* of consumer complaints are *categorically excluded* from the
4 PRA’s disclosure mandate. What bearing could a more specific request have had on DMHC’s *legal*
5 *determination* that such records were, under all circumstances, outside the PRA’s reach?⁹

6 DMHC also seems to suggest, in passing, that Petitioners cannot prevail on their PRA claim
7 because DMHC produced thousands of pages of documents in discovery. It is well-established,
8 however, that the subsequent production of requested documents through discovery cannot cure a
9 PRA violation. (See *Fairley v. Superior Court* (1998) 66 Cal.App.4th 1414, 1417 [concluding that
10 subsequent production of documents did not moot PRA claim because if cited exemption “was never
11 properly applicable,” then the petitioner would be entitled to recover statutory attorney fees and costs
12 incurred in petitioning the trial court to obtain the requested documents].)¹⁰

13 As explained in Petitioners’ opening brief, the records of consumer complaints requested by
14 Petitioners *are not* categorically exempt from production under the PRA, and DMHC was wrong to
15 assert otherwise. Such records are exempt *only if* compiled primarily for a licensing purpose, which
16 is not the case here. (See *Uribe v. Howie* (1971) 19 Cal.App.3d 194, 213.) By failing to offer any
17 substantive legal arguments in support of its position, DMHC has effectively conceded that the
18 requested records are *not* exempt from disclosure, and the Court should adopt an order so declaring.
19 (See *Bd. of Trustees v. Superior Court* (2005) 132 Cal.App.4th 889, 896 [agency bears the burden of
20 establishing that a given PRA exemption applies].)

21 ⁹DMHC cryptically asserts that “[h]ad Petitioner agreed to narrow its unreasonable requests as to
22 the non-privileged, non-exempted, documents earlier, then only the privileges and exemptions as to
23 the other categories would be at issue.” (DMHC Opp., p. 21.) But the privileges and exemptions that
24 DMHC claimed in response to Petitioners’ PRA request *are at issue*. DMHC made its position
25 regarding its asserted exemption for records of consumer complaints crystal clear — the notion that
DMHC somehow would have changed its legal interpretation of the PRA if only it had been presented
with a more specific request is implausible on its face and is not supported by any evidence.

26 ¹⁰DMHC attempts to distract or confuse the Court with an irrelevant reference to a separate
27 October 22, 2010, PRA request that Petitioners submitted to DMHC *after* the close of discovery in
28 this case, and more than *eighteen months* after they submitted the April 10, 2009 request that is at
issue here. The October 22, 2010 request did not seek records of consumer complaints, and it in no
way relates to the instant legal dispute over whether properly redacted records of consumer complaints
are categorically exempt from the PRA.

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CONCLUSION

Perhaps DMHC believes that it is exhibiting Solomonic wisdom in steering a middle course between Petitioners' contention that medically necessary ABA therapy provided by BACB-certified behavior analysts must *always* be a covered health care service and the health plans' insistence that it is *never* a covered benefit. But as in the biblical parable itself, "splitting the baby" in this manner will only result in its death — in this instance, in the unwarranted delay and denial of the most effective medical treatment for children afflicted with autism. Sometimes, there can be no compromise, and only one party's position is legally correct. In this instance, it is Petitioners who are correct, and the Court should so find by granting the Petition for Writ of Mandate and declaring that ABA therapy, when it is prescribed by a licensed health care professional as a medically necessary treatment for autism and it is administered or supervised by a licensed or BACB-certified analyst, is a "basic health care service" that is a "covered benefit" *as a matter of law* under the KKA and the MHPA.

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Respectfully Submitted,

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