Date of Hearing: June 23, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 874 (Weber Pierson) – As Amended June 3, 2026

SENATE VOTE: 38-0

SUBJECT: Medi-Cal: behavioral health treatment workgroup.

SUMMARY: Requires the Department of Health Care Services (DHCS) to ensure individuals providing Behavioral Health Treatment (BHT) in the Medi-Cal program receive background checks, issue clinical guidance on the provision of BHT in Medi-Cal, and issue recommendations to the Legislature for any needed reforms to align reimbursement rules for BHT with federal program integrity standards. Requires DHCS to convene a workgroup, as specified, to inform the development of guidance and recommendations through discussion of various issues related to the provision of BHT, including clinical standards, appropriate use of services, and supervision. Specifically, **this bill**:

1) Requires, on or before July 1, 2027, DHCS to ensure any individual providing BHT services paid for by the Medi-Cal program, who does not hold a current and valid license issued by a California state licensing board requiring a fingerprint-based background check, undergoes a background check. Requires DHCS to specify to employers of such individuals how this information is to be collected and shared with DHCS prior to that date.

2) Requires DHCS to convene a stakeholder workgroup, with specified membership, in the first quarter of the 2027 calendar year, and requires the workgroup to meet no less than quarterly in the 2027 and 2028 calendar year, to advise DHCS on all of the following:

    a) Clinical guidelines for the provision of BHT services, including independent clinician assessment for treatment and reauthorization requirements;

    b) Treatment plan requirements, including the number of hours in a treatment plan, documentation of an individual's needs, and how treatment outcomes specific to the individual and the effectiveness of treatment are reviewed;

    c) Requirements for the provision of center-based services compared to services provided in the home, school, or otherwise in the child's natural environment to ensure only services that qualify as BHT services are billed;

    d) Supervision of unlicensed and uncertified professionals, including the number of hours of supervision required, location of the supervisor, and number of unlicensed professionals a licensed or board-certified professional may supervise, as specified;

    e) Standardization of Medi-Cal managed care plan documentation requirements, including credentialing; and,

    f) Best practices in prioritizing quality care in contracting with BHT services providers.

3) Requires the workgroup include all of the following:

a) BHT providers, which may include representatives of trade associations and licensing or certifying bodies, in addition to providers;

b) Providers of other services to children with autism, including, but not limited to, speech and hearing specialists, occupational therapists, psychiatrists, and vision specialists;

c) Managed care plans;

d) Consumers with autism; and,

e) Consumer advocates for organizations led by individuals with autism and organizations serving families of autistic children.

4) Requires DHCS to, on or before January 1, 2028, release and maintain clear clinical guidance for the provision of the BHT Medi-Cal benefit. Requires guidance to be consistent with federal recommendations on BHT services and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under 21 years of age and requires it to include any modifications based on input from the stakeholder workgroup.

5) Requires DHCS to, on or before January 1, 2029, report to the Legislature and publish on its internet website an analysis of the utilization of BHT services in California since 2014, a synopsis of changes made as a result of the stakeholder workgroup, and recommendations for statutory, regulatory, or administrative actions necessary to ensure Medi-Cal reimbursement practices align with federal Medicaid program integrity requirements.

6) Requires DHCS to consider all of the following in the development of the report described in 5) above:

a) Whether BHT services reimbursed under the Medi-Cal program meet federal Medicaid requirements governing rehabilitative services and EPSDT services;

b) Whether DHCS and Medi-Cal managed care plans utilize uniform, publicly accessible, evidence-based clinical standards for determining medical necessity and treatment intensity;

c) Whether reimbursed services include documented functional impairments, measurable treatment goals, and periodic assessment of clinical progress sufficient to demonstrate that services constitute therapeutic interventions covered under the Medicaid program; and,

d) Whether the supervision standards for BHT services are equivalent to or greater than the supervision, observation, documentation, and clinical oversight requirements imposed on comparable health services in other allied health professions regulated under the Business and Professions Code (BPC).

7) Sunsets the requirement for submitting the report described in 5) above on January 1, 2033, and allows DHCS to implement this bill through non-regulatory guidance such as all-county letters, plan letters, plan or provider bulletins, or similar instructions.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by DHCS, and under which qualified low-income individuals receive health care services. [Welfare and Institutions Code (WIC) § 14000, *et seq*.]

2) Requires, under federal law, coverage for individuals under age 21 of all necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid state plan, known as the EPSDT benefit, and codifies this benefit in state law. [Title 42, United States Code § 1396d and WIC § 14132 (v)]

3) Codifies the definition of medical necessity under Medi-Cal, including under EPSDT. [WIC § 14059.5]

4) Further specifies that EPSDT services also include all age-specific assessments and services listed under the most current periodicity schedule by the American Academy of Pediatrics and Bright Futures, and any other medically necessary assessments and services that exceed those listed. [WIC § 14149.95]

5) Requires BHT to be a Medi-Cal covered service for individuals under 21 years of age only to the extent required by the federal government. [WIC § 14132.56]

6) Defines BHT as professional services and treatment programs, including applied behavior analysis (ABA) and evidence-based intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism (now called autism spectrum disorder, or ASD), and are administered by DHCS as described in the Medicaid approved state plan. [WIC § 14132.56]

7) Requires DHCS to develop and define eligibility criteria, provider participation criteria, utilization controls, and delivery system structure for services, subject to limitations allowable under federal law, in consultation with stakeholders. [WIC § 14132.56]

8) Requires health care service plan contracts and health insurers that provide hospital, medical, or surgical coverage to also provide coverage for BHT for pervasive developmental disorder or autism. [Health and Safety Code (HSC) § 1374.73 and Insurance Code § 10144.51]

9) Defines BHT as professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

    a) The treatment is prescribed by a physician or is developed by a psychologist;

    b) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by a qualified autism service provider or a qualified autism service professional or paraprofessional under supervision, as specified;

c) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated, and which:

   i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated;

   ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported;

   iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism; and,

   iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or are no longer appropriate;

d) The treatment plan is not used for purposes of providing or for the reimbursement of respite, daycare, or educational services and is not used to reimburse a parent for participating in the treatment program. [HSC § 1374.73]

e) Requires the Department of Managed Health Care (DMHC), in consultation with the Department of Insurance, to convene an Autism Advisory Task Force by February 1, 2012, in collaboration with other agencies, departments, advocates, autism experts, health plan and health insurer representatives, and other entities and stakeholders that it deems appropriate, to develop recommendations and issue a report regarding BHT that is medically necessary for the treatment of individuals with autism or pervasive developmental disorder; addressing interventions that have demonstrated clinical efficacy; interventions that have measurable treatment outcomes; patient selection, monitoring, and duration of therapy; qualifications, training, and supervision of providers; adequate networks of providers; and education, training, and experience requirements for unlicensed individuals providing autism services. [HSC § 1374.74]

FISCAL EFFECT: According to the Senate Committee on Appropriations, unknown ongoing General Fund costs, likely hundreds of thousands, for DHCS to enforce Medi-Cal BHT provider background checks, develop and maintain guidance for Medi-Cal BHT services, and provide a report.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to this author, this bill strengthens oversight and standardization of BHT services, including ABA in the Medi-Cal program. The author explains that in recent years, utilization of these services has grown significantly, both in California and around the country, bringing greater federal scrutiny to the provision of these services through the Medicaid program. Some of this growth is by design, as California enacted several bills to reduce barriers to these services. The author states that this bill requires background checks for providers not otherwise checked as part of their licensure, establishes a stakeholder workgroup to review service delivery, and directs DHCS to issue clinical guidance and report to the Legislature on utilization and program integrity. The author concludes this bill is a measured attempt to evaluate whether we have landed in the

right place to ensure that families can access the services they need, while at the same time protecting the program from potential waste or abuse.

2) **BACKGROUND**. According to the California Health Benefits Review Program (CHBRP), ASD is a developmental disability characterized by deficits in social interactions and communication, sensory processing, stereotypic (repetitive) behaviors or interests, and sometimes cognitive function. The symptoms of ASD fall along a continuum, ranging from mild impairment to profound disability. ASD diagnoses are often made early in life, as individuals often demonstrate symptoms in early childhood. ASD can sometimes be detected by the age of 18 months, with reliable diagnoses by age two.

   a) **BHT**. There is no cure for ASD; however, there is evidence that treatment, including BHT, may improve some symptoms. BHT aims to modify the behavior of individuals with ASD and improve their cognitive, language, and social functioning by assessing environmental stimuli and reinforcing appropriate responses. BHT includes treatments that use different theoretical frameworks, including those based on behavioral theory, those based on developmental theory that seek to strengthen emotional bonds and encourage children to learn through guided exploration, and those that are a hybrid of the two approaches.

   b) **ABA**. Treatments based on behavioral theory, such as ABA, are the dominant treatment modality; they are the most commonly provided and have been the most widely studied. They use behavioral reinforcement to teach people with ASD basic social skills such as attention, compliance, and imitation. Comprehensive ABA therapy can include 30-40 hours of direct treatment a week, while more focused therapy may still consist of 10-25 hours a week, according to guidelines released by the Council of Autism Service Providers (CASP), a non-profit trade association of provider organizations serving individuals with ASD. CASP indicates these are the generally accepted standards of care, as well as billing standards, for ABA providers.

   c) **SB 946 and Commercial Coverage of BHT**. SB 946 (Steinberg and Evans), Chapter 650, Statutes of 2011, requires health plans and health insurers in California to cover BHT for individuals with ASD. SB 946 also establishes a structure of "qualified autism service providers" (Board Certified Behavioral Analysts or specified licensed health professionals who can design and supervise treatment), as well as the qualifications of qualified autism service professionals and paraprofessionals who oversee and deliver treatment, respectively. Additionally, SB 946 specifies requirements of treatment plans, including that they must delineate measurable goals for a specific patient, be reviewed no less than once every six months, and be modified whenever appropriate.

   d) **Medi-Cal Coverage of BHT**. In 2014, the federal Centers for Medicare and Medicaid Services released guidance requiring the coverage of BHT services pursuant to federal EPSDT requirements. SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014, the health trailer bill for the 2014 Budget Act, codified coverage of BHT to the extent required by federal law. DHCS issued interim guidance in that same year requiring coverage of BHT. Prior to commercial and Medi-Cal coverage, eligible children with ASD accessed BHT through regional centers.

   e) **Effectiveness of ABA**. CHBRP reviewed medical effectiveness of a number of BHT modalities, including ABA, in 2021 in their analysis of SB 562 (Portantino), a bill that

sought to expand the types of BHT covered by commercial plans. CHBRP found evidence that BHT modalities based on behavioral theory (ABA), developmental theory, and hybrids of both theories improve outcomes for people with ASD. Prominent outcomes include improvements in communication, social skills, cognition, adaptive behavior, language, motor skills, play skills, and ASD symptom severity. However, CHBRP pointed out that many studies are observational or quasi-experimental studies that do not randomly assign participants to the intervention or control condition, and that some do not include any sort of comparison group, which decreases confidence in some studies' findings.

In 2025, the National Academies of Sciences, Engineering, and Medicine convened a multidisciplinary committee of experts to study implementation of a pilot program to provide ABA within the federal military health benefits program, TRICARE. The committee reviewed literature, analyzed TRICARE claims data, evaluated program policies and procedures, and heard directly from researchers, military families, and ABA providers. The committee found that ABA is supported by a substantial and growing body of evidence indicating positive outcomes in cognitive functioning, adaptive behavior, and other key domains for autistic individuals, and that both comprehensive programs and focused ABA practices meet the Department of Defense's standards for reliable medical evidence and align with the evidence-based practice framework widely used in clinical care. However, the report notes, since autism is highly heterogeneous, with symptom presentation and needs varying from person to person, ABA will not be necessary for all.

Some recent studies and metanalyses have also pointed toward the need for more personalized assessment of the appropriate "dosage" of ABA services, or the number of hours per week of therapy. A 2025 study in *Journal of Autism and Developmental Disorders*, titled "Dosage in Applied Behavior Analysis: Effect on Adaptive Behavior, Goal Attainment, and Dangerous Behavior," notes that while some studies support a dosage effect, other studies find no predictive relationship between ABA treatment hours and a range of child outcomes. The authors conclude that while more research in this area is needed to provide optimal hour ranges for different ASD subpopulations, its findings and the findings of several others published within the last decade reveal a need to revise the one-size-fits-all guideline of 30–40 treatment hours per week of ABA for young children across the autism spectrum.

f) Private Equity Acquisition of ABA Providers. Private equity is a form of corporate ownership that often entails relying on loans to acquire a business, taking it private if not so already, and attempting to increase its value with the goal of selling it at a profit in three to seven years. A 2024 California Health Care Foundation report on private equity in health care concluded, based on a review of the evidence, that private equity acquisition of health care service providers is associated with a variety of negative outcomes, including higher costs for patients and insurers; lower patient satisfaction; mixed to worse quality of care; and worse financial outcomes for entities being acquired. According to a letter published in *JAMA Pediatrics* in March 2026, private equity acquisition of autism service delivery sites accelerated between 2015 and 2024, the timeline studied by the authors. Acquisitions of 574 sites were identified, including 97 in California. Private equity appeared more likely to enter states with higher autism prevalence and more generous insurance mandates. According to the Center for

Economic and Policy Research and industry publications, the largest for-profit providers of autism services are private equity-owned, and private equity investment is driving consolidation of these providers. Market fragmentation, increasing diagnostic prevalence, and the potential to bill for a high volume of service per week make this industry attractive for private equity investment and consolidation.

g) **Federal and Media Scrutiny of the Provision of ABA Services**. According to the United States Health and Human Services (HHS) Office of Inspector General (OIG), over the past few years, some federal and state agencies have identified questionable billing patterns by some ABA providers as well as federal and state payments to providers for unallowable services. HHS OIG is auditing Medicaid claims for ABA services provided to children diagnosed with autism to determine whether a state Medicaid agency's ABA payments complied with federal and state requirements. So far, reports issued by HHS OIG detail fee-for-service Medicaid payments for ABA therapy for Colorado, Maine, Wisconsin, and Indiana, with each report noting that all 100 sampled enrollee-months included payments for one or more claim lines that were improper or potentially improper. OIG notes tens of millions of dollars were likely improperly paid to ABA providers in each state.

   According to the U.S. Attorney's Office for the Southern District of California, in 2022, a company called Prism Behavioral Solutions paid $650,000 to resolve allegations that it billed Medi-Cal for services to autistic children without actually providing care to the children, according to a settlement agreement signed by Prism Behavioral Solutions, the United States, and the State of California.

   A May 2026 *New York Times* investigation concluded that the clinics providing ABA therapy often prioritize billing opportunities in ways that may harm children and overcharge the government. The article, "Short Naps, Long Hours: How Autism Clinics Squeeze Medicaid Dollars Out of Preschoolers," asserts that many clinics overprescribe hours and questions the efficacy of ABA. In a Letter to the Editor, the executive director of the Autistic Self Advocacy Network, agrees, stating, "Evidence for ABA's effectiveness is limited and often low quality, and high-quality studies show that more treatment doesn't cause better outcomes." The Council of Autism Services Providers has responded to the article, noting that "we have to acknowledge and address the prevalence of bad actors, hold ourselves accountable, and work with states to improve oversight," but also asserts the *Times* article draws sweeping, misguided conclusions about ABA's efficacy for kids with autism and defends the science of ABA by pointing to recent reviews and metanalyses.

h) **Increasing Utilization of ABA Services and DHCS May Revision Proposal**. Greater awareness and diagnosis of autism has led to more families seeking treatment for their children, and increased coverage of BHT by Medicaid programs and private insurers have increased provider supply. According to *KFF*, as of late last year, many states are trying to scale back spending on ABA therapy as their state Medicaid programs have seen spending balloon in recent years. Payments for the therapy in North Carolina, which were $122 million in fiscal year 2022, are projected to hit $639 million in fiscal 2026, a 423% increase. Nebraska saw a 1,700% jump in spending in recent years. Indiana saw a 2,800% rise.

In May 2026, DHCS released a May Revision budget proposal to strengthen utilization management (UM) controls for ABA/BHT in Medi-Cal. According to DHCS, over time, utilization of these services has increased significantly, with some patterns consistent with overuse and misuse. Some of DHCS' current UM policies around these benefits are less stringent than peer states and/or clinical guidelines regarding their use. DHCS proposes strengthening UM policies for ABA/BHT services by enabling managed care plans to implement the following:

i. **Utilization thresholds:** Establish thresholds that would trigger authorization reviews for services exceeding those defined thresholds (e.g., more than 25 hours per week), along with a defined exception process based on medical necessity. These thresholds are intended to align with clinical guidelines for appropriate levels of care. UM protocols could also establish various thresholds based on age when supported by the evidence base;

ii. **ASD diagnosis requirement:** Require an ASD diagnosis for members age 5 and older to receive ABA services, with provisional eligibility for children under age 5 and exceptions based on medical necessity; and,

iii. **Clinical documentation review requirements:** Enhance the ability to request supporting documentation, such as treatment plans and progress notes, to support medical necessity and authorizations.

At the time this analysis was published, the budget plan approved by both houses of the Legislature included these proposed UM restrictions for ABA/BHT.

This bill goes further than the May Revision proposal, requiring DHCS to perform a more comprehensive assessment of BHT and issue revised clinical guidance, conduct related stakeholder engagement, and issue recommendations for any further needed changes.

i) **Background Checks**. In addition to mandating coverage and codifying which providers can provide BHT services, SB 946 also required the DMHC to convene an Autism Advisory Task Force (Task Force) by February 1, 2012, to develop recommendations regarding medically necessary BHT for individuals with ASD, as well as the appropriate qualifications, training and supervision for providers of such treatment. The Task Force made a number of recommendations, including that all providers of autism services to be registered with the state's TrustLine Registry or comparable system as a condition of employment and contracting with health plans. TrustLine uses the criminal history background check system to check the fingerprints of applicants, and checks for evidence of additional criminal records. However, this was never done at a statewide level, and subsequent efforts to license these providers, such as AB 1715 (Holden) of 2016, have been unsuccessful. Despite their intensive work with children, there is no statewide requirement that all individual service providers undergo a background check as a condition of providing Medi-Cal services, leaving it up to individual providers to ensure paraprofessionals and professionals they employ to deliver services meet appropriate standards. In their audits of other states' ABA service delivery, the HHS OIG mentioned the lack of background checks as a potential quality-of-care issue that could have potentially put children in danger. This bill requires DHCS to ensure any individual providing BHT services paid for by the Medi-Cal program undergoes a background

check and requires DHCS to specify to employers of such individuals how this information is to be collected and shared with DHCS.

3) **SUPPORT**. California Association of Health Plans (CAHP) writes in support that the workgroup reviewing implementation of ABA services in Medi-Cal will promote clinical appropriateness, accountability, and program integrity. CAHP notes utilization of ABA therapy has increased dramatically throughout the country and notes an alarming trend of bad actors exploiting the system, resulting in inappropriate utilization and increased health care spending. Local Health Plans of California notes in support that establishing clearer guardrails and statewide standards for the BHT benefit has the potential to generate long-term cost savings for the Medi-Cal program by reducing inappropriate utilization, minimizing administrative duplication, improving oversight, and promoting more consistent and effective delivery of services. California Association for Behavior Analysis states in support that this bill strengthens oversight, accountability, and clinical consistency.

4) **OPPOSITION (UNLESS AMENDED)**. The Doogri Institute, an autistic-led activism organization, writes in opposition because the makeup of the stakeholder committee includes the BHT providers. The Doogri Institute believes the stakeholder committee should be made up of independent, licensed allied health professionals with no connection to the industry being evaluated. The Doogri Institute questions the efficacy and appropriateness of ABA therapy generally, and requests audits and investigations and makes numerous suggested policy changes to the provision of ABA services and other services for autistic individuals.

5) **RELATED LEGISLATION**.

   a) AB 277 (Alanis) would require persons who provide BHT services to undergo a background check if they do not hold a current and valid license issued by a California state licensing board that requires a fingerprint-based background check. AB 277 is pending in the Senate Public Safety Committee.

   b) AB 375 (Nguyen) would expand the definition of "health care provider," for purpose of telehealth services, to include a qualified autism service paraprofessional. AB 375 is pending in the Senate Appropriations Committee.

   c) AB 2233 (Ta) would prohibit health care plans (except Medi-Cal plans) from imposing hours limitations within an existing treatment plan's six-month authorization period. AB 2233 is pending on the Senate Floor.

6) **PREVIOUS LEGISLATION**.

   a) SB 402 (Valladares), Chapter 413, Statutes of 2025, moves the statutory framework outlining the qualifications for autism service providers from the Health and Safety Code and Insurance Code to the Business & Professions Code.

   b) AB 951 (Ta), Chapter 84, Statutes of 2025, prohibits a health plan or insurer from requiring an enrollee or insured previously diagnosed with PDD/A to receive a rediagnosis to maintain coverage for BHT for their condition.

   c) SB 562 (Portantino) of 2021 would have expanded the definition of BHT, for purposes of commercial health care coverage, to include programs based on behavioral,

developmental, relationship-based, or other evidence-based models; authorized additional types of providers and professionals to provide BHT; and prohibited the setting, location, or time of treatment recommended by the autism services provider from being used as a reason to deny or reduce coverage for medically necessary services. SB 562 was vetoed by Governor Newsom, who expressed concern about the evidence basis for the expanded services and encouraged the author to pursue a licensing scheme for autism service providers to uphold standards and qualifications.

d) SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014, codified Medi-Cal coverage for BHT.

e) SB 946 (Steinberg), Chapter 650, Statutes of 2012, required commercial health plans and insurers to cover BHT, established definitions for the types of personnel who could deliver BHT, and created a task force to study related issues.

7) **POLICY COMMENT**. As noted above, a stakeholder has raised concerns about the feasibility of implementing background checks as required in the bill, expressing that privacy restrictions in other areas of state law may pose a barrier for employers to share background check information with DHCS. The author has indicated a commitment to continued discussion on the background check requirement to ensure it is implemented effectively and efficiently. In addition, as this bill moves forward, the author is encouraged to consider how best practices and clinical guidelines issued by DHCS can inform standards of coverage in the commercial market, as appropriate, given such guidelines and best practices are certainly critical for the Medi-Cal program but could also be relevant for commercial coverage.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of Health Plans
California Medical Association
Local Health Plans of California

Opposition

One individual

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