State Medicaid & Children's Health Insurance Program

Applied Behavior Analysis Toolkit

August 2026

Contents

Introduction

The purpose of the Applied Behavior Analysis (ABA) Toolkit is to support state Medicaid and Children's Health Insurance Program (CHIP) agencies in making decisions regarding ABA service provision for Medicaid and CHIP beneficiaries with autism spectrum disorder (ASD). When delivered by trusted providers, ABA is a critical and important therapy for Medicaid and CHIP beneficiaries with ASD.

Medicaid and CHIP are seeing rapid growth in ASD diagnoses and in the use of ABA and other behavioral interventions for children and youth.[1,2] However, growth in ABA utilization has substantially outpaced growth in the number of children with an ASD diagnosis receiving services (see Figures 2 and 3a in Chapter 1). Medicaid data show that between 2021 and 2025 there was an 189 percent increase in the number of children with an ASD diagnosis who received ABA services, but a 421 percent increase in spending on ABA among children with an ASD diagnosis.[3] The Centers for Medicare and Medicaid Services (CMS) has a separate workstream exploring the process of receiving an ASD diagnosis and overall trends in diagnosis.

In addition to the rapid growth in utilization and costs, there have been a number of investigations leading to prosecution pointing to fraud, waste, and abuse in the ABA industry.[4,5] These trends, along with investigations and convictions of kickbacks and harms to children, have generated significant fiscal and oversight concerns from state Medicaid agencies and trusted providers. Every dollar lost to fraud, waste, and abuse is a dollar that cannot be used to provide ABA by trusted providers. These trusted providers should not be crowded out because of fraudsters. Increased spending is also likely related to intense lobbying pressure state legislative and executive branch officials experience to increase rates or limit competition. Stakeholders from many states expressed concern about these efforts and how they were impacting the ABA industry.

Several state and federal stakeholders have expressed interest in having additional tools and resources as they update coverage and payment policies in response to utilization trends and an evolving provider landscape. Providers have also raised concerns that bad actors are damaging the infrastructure and reputation of the industry. Overall, Americans want Medicaid

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[1] The Policy Impact Project. (2023, March). *National Autism Indicators Report: Introduction to Medicaid and Autism.* Retrieved Julu 29. 2026, from https://policyimpactproject.org/brief-report-medicaid/.

[2] Singh, Y., Mook, C., Perkins, J., Hostert, N., Arnold, D. (2026, May 22). The Business of Autism Treatment: Private Equity Implications for State Medicaid Programs. *Health Affairs.* https://www.healthaffairs.org/content/forefront/business-autism-treatment-private-equity-implications-state-medicaid-programs.

[3] Source: T-MSIS OT claims and associated eligibility data, 2021–2025, for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam.

[4] State of Connecticut, Division of Criminal Justice, Office of the Chief State's Attorney. (2026, June 5). *Former East Hartford Man Sentenced in Scheme to Defraud Medicaid*. https://portal.ct.gov/dcj/press-releases/division-of-criminal-justice/06052026patterson.

[5] Internal Revenue Service (IRS). (2025, December 18). *Six additional defendants charged, one defendant pleads guilty in ongoing fraud schemes.* https://www.irs.gov/compliance/criminal-investigation/six-additional-defendants-charged-one-defendant-pleads-guilty-in-ongoing-fraud-schemes.

fraud and waste eradicated, and fraud that reduces resources for vulnerable children is of substantial concern.

This toolkit addresses clinical standards for ABA as reflected in available literature and prevailing practical guidelines and guardrails; however, it does not include or represent clinical recommendations and should not be interpreted as establishing a standard of care or directing clinical judgment. The toolkit also addresses Medicaid benefit design, policy, and coverage; payment and utilization patterns; utilization management; provider enrollment, qualifications, and credentialing; and approaches to identify and address fraud, waste, and abuse. Appendix A includes a checklist of key questions to supplement each chapter that states can use to assess whether their ABA policies support effective implementation, program integrity, and ongoing oversight.

While not a regulation, this toolkit primarily discusses requirements and suggested practices for Medicaid ABA policies. Some of the content is also applicable to CHIP. All charts and statistics that were derived from the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) include both Medicaid and CHIP claims and encounters.

CMS does not endorse or require any particular treatment modality, including ABA, for ASD. Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements entitle eligible children under age 21 years to Medicaid coverage of health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Social Security Act (the Act) that are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not such services are covered under the state plan.[6,7] This may include services commonly provided as part of ABA that are coverable under section 1905(a), as well as other medically necessary services described in section 1905(a) to address ASD.

Toolkit Methodology

This toolkit was informed by a targeted review of 264 literature sources, including peer-reviewed articles, clinical and practice guidance, and federal and state policy documents. This review was complemented by an assessment of more than 240 publicly available state-level Medicaid coverage and policy references spanning all 50 states and the District of Columbia. Sources were identified using structured search strategies, and key findings were organized against a set of predefined research questions to support consistent interpretation and synthesis.

[6] U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS). (2014, July 7). *Clarification of Medicaid Coverage of Services to Children with Autism* [CMCS Informational Bulletin (CIB)]. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-07-14.pdf.

[7] Children covered through a Medicaid expansion CHIP are entitled to EPSDT. (42 C.F.R. § 457.70(c)(2)) Optional coverage of EPSDT services in separate CHIPs reflects all Medicaid EPSDT requirements, including coverage of all section 1905(a) services. As of the date of this toolkit, 18 states have elected the option to provide EPSDT in a separate CHIP. Of these 18 states, 13 states cover EPSDT for all separate CHIP-enrolled individuals: Arizona, Delaware, Georgia, Idaho, Kansas, Louisiana, Maine, Missouri, Oklahoma, Rhode Island, South Dakota, Washington, and Wisconsin. The other 5 states cover EPSDT for some but not all separate CHIP-enrolled populations: California, Florida, Massachusetts, Minnesota, and New Jersey.

The toolkit was also informed by qualitative input from a broad range of discussions with stakeholders, including state representatives, providers, and advocates, as well as insights gathered through state roundtable discussions. Interview and roundtable insights were analyzed thematically, and crosscutting themes were used to contextualize the literature findings and highlight real-world implementation considerations. CMS appreciates their insights and contributions.

In addition, CMS is grateful for the time and attention given to this toolkit by several external and federal reviewers. Their feedback is appreciated.

The issuance of this document will not answer all questions or end the need to continue discussing how to best utilize ABA in the treatment of ASD. Areas such as mental health parity, development of quality measures, facility licensure, and value-based models need further discussion and shared learning. CMS is also following U.S. Food and Drug Administration approved innovative technologies and data analytic tools that assist in diagnostics.

Chapter 1. Applied Behavior Analysis Overview

ASD can cause significant social, communication, and behavioral challenges and encompasses a range of conditions, including disorders previously referred to as pervasive developmental disorder and Asperger syndrome.[8,9] ASD symptoms vary widely in type and severity among individuals. For many individuals with ASD, the impact extends beyond social and communication challenges and can involve whole-body functioning, including an increased prevalence of a range of co-occurring medical conditions such as gastrointestinal disorders, seizure disorders, and immune dysregulation.[10,11,12] Sensory processing and regulation differences are also part of the recognized diagnostic framework, and a growing body of evidence points to complex challenges involving motor coordination, praxis, and motor planning that may affect communication, learning, self-care, and daily functioning.[13,14,15,16,17] These motor and sensory processing differences may require the delivery and implementation of a range of services and supports. Early intervention for children with ASD can improve developmental outcomes, daily functioning, and social and community participation. Treatment options for ASD include a range of evidence-based interventions that can be tailored to each

[8] Gitimoghaddam, M., Chichkine, N., McArthur, L., Sangha, S. S., & Symington, V. (2022). Applied behavior analysis in children and youth with autism spectrum disorders: A scoping review. *Perspectives on Behavior Science*, *45*(3), 521–557. https://doi.org/10.1007/s40614-022-00338-x.

[9] CMS, CMCS, Division of Quality and Health Outcomes. (2024). *2024 Medicaid and CHIP beneficiaries at a glance: Autism*, 1-3. https://www.medicaid.gov/medicaid/benefits/downloads/2024-autism-infographic.pdf.

[10] Liu, X., Sun, X., Sun, C., Zou, M., Luo, I., & Xia, W. (2022). Prevalence of epilepsy in autism spectrum disorders: A systematic review and meta-analysis. *Autism, 26*(1), 33–50. https://doi.org/10.1177/13623613211045029.

[11] Wang J, Ma B, Wang J, Zhang Z, Chen O. (2022). Global prevalence of autism spectrum disorder and its gastrointestinal symptoms: A systematic review and meta-analysis. *Frontiers in Psychiatry, 13*, Article 963049. https://doi.org/10.3389/fpsyt.2022.963102.

[12] Erbescu, A., Papuc, S. M., Budisteanu, M., Arghir, A., & Neagu, M. (2022). Re-emerging concepts of immune dysregulation in autism spectrum disorders. *Frontiers in Psychiatry*, *13*, Article 1006612. https://doi.org/10.3389/fpsyt.2022.1006612.

[13] Green, S. A., Hernandez, L., Tottenham, N., Krasileva, K., Bookheimer, S. Y., & Dapretto, M. (2015). Neurobiology of sensory overresponsivity in youth with autism spectrum disorders. *JAMA Psychiatry*, *72*(8), 778–786. https://doi.org/10.1001/jamapsychiatry.2015.0737.

[14] Bäckström, A., Johansson, A. M., Rudolfsson, T., Rönnqvist, L., & Domellöf, E. (2025). Atypical development of sequential manual motor planning and visuomotor integration in children with autism at early school-age: A longitudinal kinematic study. *Autism, 29(*6), 1530–1545. https://doi.org/10.1177/13623613241311333.

[15] Kangarani-Farahani, M., Malik, M. A., & Zwicker, J. G. (2024). Motor impairments in children with autism spectrum disorder: A systematic review and meta-analysis. *Journal of Autism and Developmental Disorders, 54*(5), 1738–1761. https://doi.org/10.1007/s10803-023-05948-1.

[16] Mody, M., Shui, A. M., Nowinski, L. A., Golas, S. B., David, M. M., & McDougle, C. J. (2017). Communication deficits and the motor system: Exploring patterns of associations in autism spectrum disorder (ASD). *Journal of Autism and Developmental Disorders*, *47*(1), 155–169. https://doi.org/10.1007/s10803-016-2934-y.

[17] Travers, B. G., Lee, L., Klans, N., Ausderau, K. K., Skaletski, E. C., Mason, A., & Taylor, C. R. (2022). Associations among daily living skills, motor, and sensory difficulties in autistic and nonautistic children. *American Journal of Occupational Therapy*, *76*(2), Article 7602205020. https://doi.org/10.5014/ajot.2022.045955.

child's needs. See Chapter 2 for more information on additional therapies and services to treat ASD.

ABA is an evidence-based behavior therapy for ASD that applies principles of learning and behavior to address the needs of children with ASD.[18] In 1968, Donald Baer, Montrose Wolf, and Todd Risley described a foundational framework with seven dimensions of ABA summarized below:

- **Applied**: focuses on behaviors that improve quality of life
- **Behavioral**: recognizes observable and measurable behaviors to track and measure progress
- **Analytic**: emphasizes data-driven and evidence-based practices for interventions and monitoring
- **Technological**: focuses on consistent, replicable procedures
- **Conceptually systematic**: emphasizes the scientific basis of methods used in ABA and validates techniques founded in theoretical approaches
- **Effective**: evaluates whether meaningful behavior changes are occurring and whether therapy is effective
- **Generality**: focuses on applicability across different environments and settings for long-term success[19,20]

These seven dimensions are considered along with methodological and ethical caveats. For instance, observable external actions do not consider internal emotional or cognitive states, may not consider complex human variables or unpredictable responses outside of identified environments and settings due to artificial control, prioritize societal definitions of what is deemed important rather than what the individual chooses, focus on rewarding compliance versus autonomy, and may create an imbalance of control/power in the hands of the practitioner over the individual.[21] Using the seven dimensions as absolutes does not account for all factors and should be considered with appropriate caveats. ABA is one of several intervention approaches used to support individuals with ASD, although it is not the only intervention. Even when implemented as intended, the cost-effectiveness of intensive ABA-based interventions has been questioned.[22] Recently, the exponential growth of utilization and costs of ABA has

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[18] Hyman, S. L., Levy, S. E., Myers, S. M., & Council on Children with Disabilities, Section on Developmental and Behavioral Pediatrics. (2020). Identification, Evaluation, and Management of Children With Autism Spectrum Disorder. *Pediatrics, 145*(1), e20193447. https://doi.org/10.1542/peds.2019-3447.

[19] Baer, D.M., Wolf, M.M., & Risley, T.R. (1968). Some current dimensions of applied behavior analysis. *Journal of Applied Behavior Analysis, 1*, 91-97. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1310980/pdf/jaba00083-0089.pdf.

[20] Advanced Therapy Clinic. (n.d.). *Exploring the principles of applied behavior analysis*. https://www.advancedtherapyclinic.com/blog/exploring-the-principles-of-applied-behavior-analysis.

[21] Critchfield, T. S., & Reed, D. D. (2017). The fuzzy concept of applied behavior analysis research. *The Behavior Analyst, 40*(1), 123–159. https://doi.org/10.1007/s40614-017-0093-x.

[22] Rodgers, M., Marshall, D., Simmonds, M., LeCouteur, A., Biswas, M., Wright, K., Rai, D., Palmer, S., Stewart, L., & Hodgson, R. (2020, July). Interventions based on early intensive applied behavior analysis for autistic children: a systematic Review and cost-effectiveness analysis. *Health Technology Assessment, 24*(35), 91. National Institute for Health Research. https://www.ncbi.nlm.nih.gov/books/NBK559599/pdf/Bookshelf_NBK559599.pdf.

also come under scrutiny, particularly when delivered by wasteful or fraudulent providers with financial incentives that may conflict with clinical quality.[23]

The selection of ABA as a treatment modality should be based on an individualized assessment to determine whether it or another treatment option would be most effective. In addition, ABA may be delivered in combination with other therapies, educational services, and community supports.

Has CMS Mandated Applied Behavior Analysis for Children Under 21 Years With Autism Spectrum Disorder?

No. ABA is one treatment modality for ASD. CMS is not endorsing or requiring any particular treatment modality for ASD. States are expected to adhere to long-standing EPSDT obligations for individuals from birth to 21 years, including providing medically necessary section 1905(a) services for ASD treatment.

Individualized treatment plans (ITPs) can have a focused or comprehensive scope of treatment.[24] Focused treatment is for improving a specific, limited number of fundamental adaptive behaviors and skills, or for addressing specific high-risk or challenging behaviors that are a priority for treatment. Comprehensive treatment is for improving many behaviors and skills across multiple domains and can support both establishing new skills and reducing high-risk/challenging behaviors. Decisions on scope of treatment should not be restricted by an individual's age, co-occurring conditions, ASD diagnosis, or cognitive level.

A core feature of ABA is the direct observation and measurement of behavior in real-life contexts rather than relying only on reported symptoms. Providers use ongoing data collection to understand how behavior is influenced by environmental events, identify the function or purpose a behavior may serve, and monitor whether intervention strategies are helping. This data-driven, dynamic process allows treatment goals and teaching strategies to be adjusted over time based on the child's progress.[25]

ABA typically builds skills gradually, recognizing that meaningful change often occurs through small, achievable steps that accumulate over time. ABA uses a range of evidence-based

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[23] Batt, R., Appelbaum, E., & Nguyen, Q. (2023, June 14). *Pocketing Money Meant for Kids: Private Equity in Autism Services*. Center for Economic and Policy Research. https://cepr.net/publications/pocketing-money-meant-for-kids-private-equity-in-autism-services/.

[24] Council of Autism Service Providers (CASP). (2024). *Applied behavior analysis practice guidelines for the treatment of Autism Spectrum Disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* [Clinical practice guidelines], 29-32. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[25] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines]. https://www.casproviders.org/asd-guidelines.

teaching strategies to support the development of skills across domains such as communication, social participation, self-care, play, and daily living skills.[26,27]

ABA has evolved significantly over time from the 1960s to today. Earlier ABA models often relied on highly structured, discrete trial training approaches.[28] As research on infant and child development, including early developmental learning processes, advanced in the 1980s and 1990s, ABA began shifting from older, highly structured models to more naturalistic, person-centered approaches that better reflected the priorities and daily lives of individuals with ASD and their families.[29] While the underlying behavioral principles and emphasis on data-driven decision making have remained consistent, contemporary ABA often embeds interventions into everyday activities.

When appropriately matched to the child's needs, and when driven by documented outcomes and provider performance evaluation, ABA has the potential to support functional skill development, adaptive behavior, and improve communication, social skills, and daily living skills.[30]

ABA services may be delivered in a home, school, clinic, or other community or inpatient setting, and ABA strategies can be integrated into everyday routines to support learning and participation in daily activities. An important goal is not only for an individual to demonstrate a skill during clinical intervention, but also to consistently use that skill across different routines, people, and settings, so that skills are maintained over time and generalized to daily activities in the individual's natural environment. Contemporary ABA emphasizes collaborative partnerships with families and caregivers so that intervention goals, strategies, and skill practice are meaningful and can be implemented across the child's everyday routines and environments.[31]

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[26] Wong, C., Odom, S. L., Hume, K. A., Cox, A. W., Fettig, A., Kucharczyk, S., Brock, M. E., Plavnick, J. B., Fleury, V. P., & Schultz, T. R. (2015). Evidence-based practices for children, youth, and young adults with autism spectrum disorder: A comprehensive review. *Journal of Autism and Developmental Disorders*, *45,* 1951–1966. https://doi.org/10.1007/s10803-014-2351-z.

[27] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines]. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[28] Odom, S. L., Hall, L. J., Morin, K. L., Kraemer, B. R., Hume, K. A., McIntyre, N. S., Nowell, S. W., Steinbrenner, J. R., Tomaszewski, B., Sam, A. M., & DaWalt, L. (2021). *Educational interventions for children and youth with autism: A 40-year perspective*. *Journal of Autism and Developmental Disorders, 51*(12), 4354–4369. https://doi.org/10.1007/s10803-021-04990-1.

[29] Schreibman, L., Dawson, G., Stahmer, A. C., Landa, R., Rogers, S. J., McGee, G. G., Kasari, C., Ingersoll, B., Kaiser, A. P., Bruinsma, Y., McNerney, E., Wetherby, A., & Halladay, A. (2015). Naturalistic Developmental Behavioral Interventions: Empirically Validated Treatments for Autism Spectrum Disorder*. Journal of Autism and Developmental Disorders, 45*(8), 2411–2428. https://doi.org/10.1007/s10803-015-2407-8.

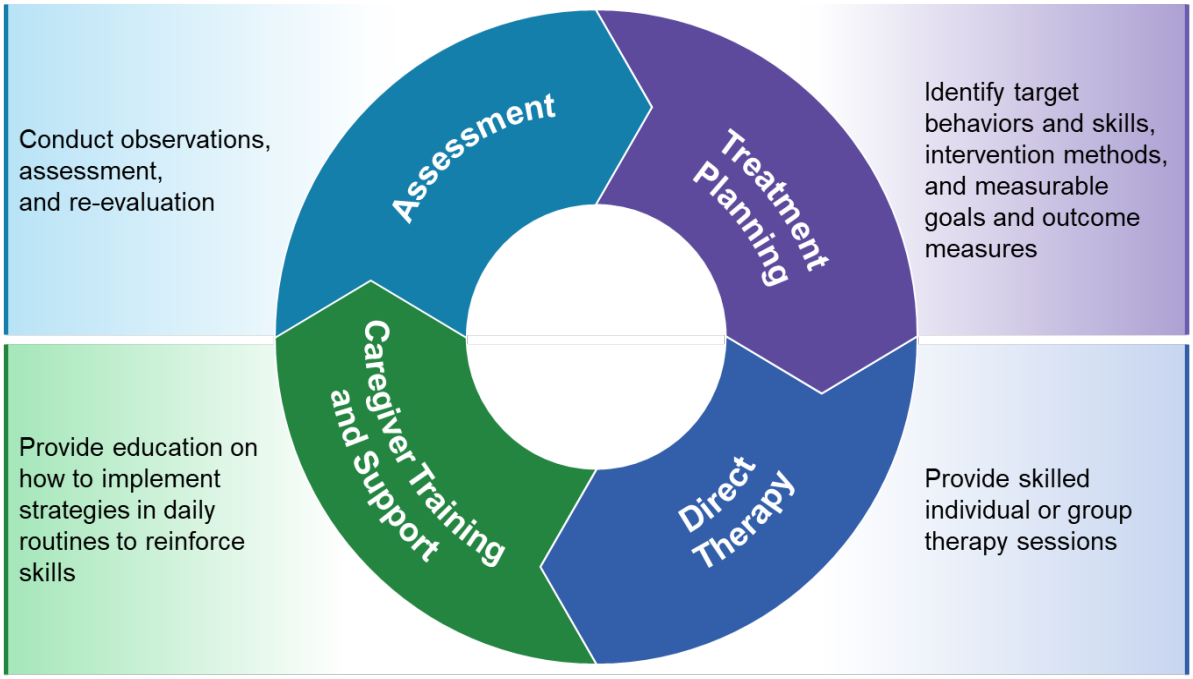
[30] National Academies of Sciences, Engineering, and Medicine. (2025). The Comprehensive Autism Care Demonstration: Solutions for Military Families. *The National Academies Press.* https://doi.org/10.17226/29139.

[31] Brown, K. R., Hurd, A. M., Randall, K. R., Szabo, T., & Mitteer, D. R. (2022). *A family-centered care approach to behavior-analytic assessment and intervention*. *Behavior Analysis in Practice, 19*(1), 126–142. https://doi.org/10.1007/s40617-022-00756-y.

The intensity and duration of ABA vary according to the child's needs and response to intervention.[32]

Figure 1 illustrates the common elements of ABA. This process is dynamic and iterative; components are revisited and refined as needed throughout treatment.

Figure 1: Common Elements of Applied Behavior Analysis



The ABA care team is collaborative and often includes: Board Certified Behavior Analysts (BCBAs), who are graduate-level providers who design treatment plans and provide oversight; Board Certified Assistant Behavior Analysts (BCaBAs), who work under BCBA supervision to implement programs; and Registered Behavior Technicians (RBTs), who deliver direct treatment to individuals in accordance with the individual's treatment plan and are closely supervised by BCBAs and BCaBAs (see Chapter 5 for additional details on provider qualifications).[33] Parents and caregivers must also receive training to reinforce learning and support the implementation of skills throughout daily routines, extending treatment beyond formal sessions. **ABA is most effective with active parent and caregiver support, training, and engagement.**

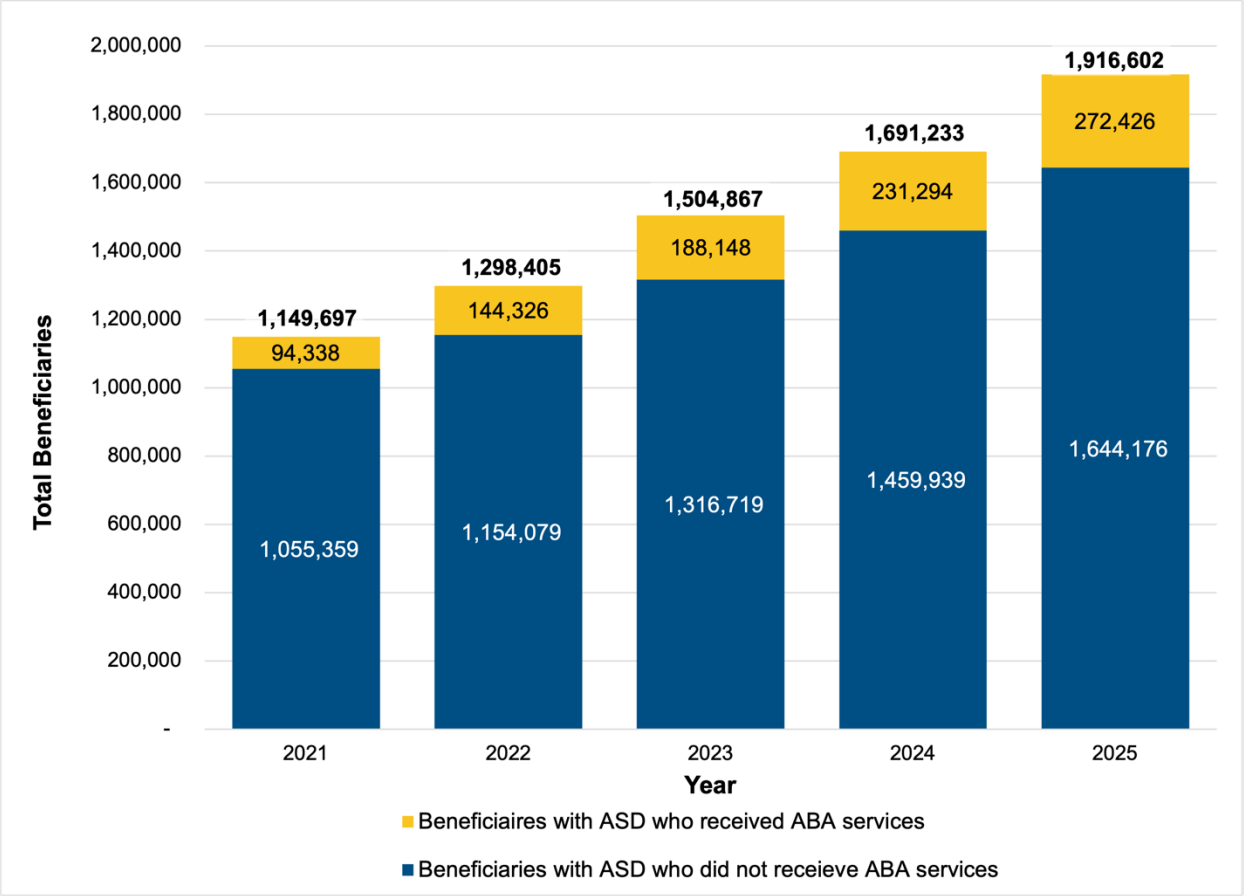
[32] Hustyi, K. M., & Yingling, M. E. (2025). *Variation in behavior analysts' treatment intensity recommendations for patients with autism spectrum disorder*. *Behavior Analysis in Practice, 18*(4), 958–970. https://doi.org/10.1007/s40617-025-01040-5.

[33] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines]. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

Applied Behavior Analysis Cost and Utilization Trends in Medicaid and CHIP Programs

In recent years, the delivery of and payment for ABA has grown significantly in Medicaid and CHIP programs across the country, outpacing the growth in beneficiaries receiving treatment for ASD. As shown in Figure 2, from 2021 to 2025 the number of beneficiaries with an ASD diagnosis who received any Medicaid or CHIP service increased 67 percent, rising from 1.15 million to 1.92 million. Of these beneficiaries, a small proportion received ABA treatment.

Figure 2: Total Medicaid and CHIP Beneficiaries With an Autism Spectrum Disorder Diagnosis by Receipt of Applied Behavior Analysis Services, 2021–2025

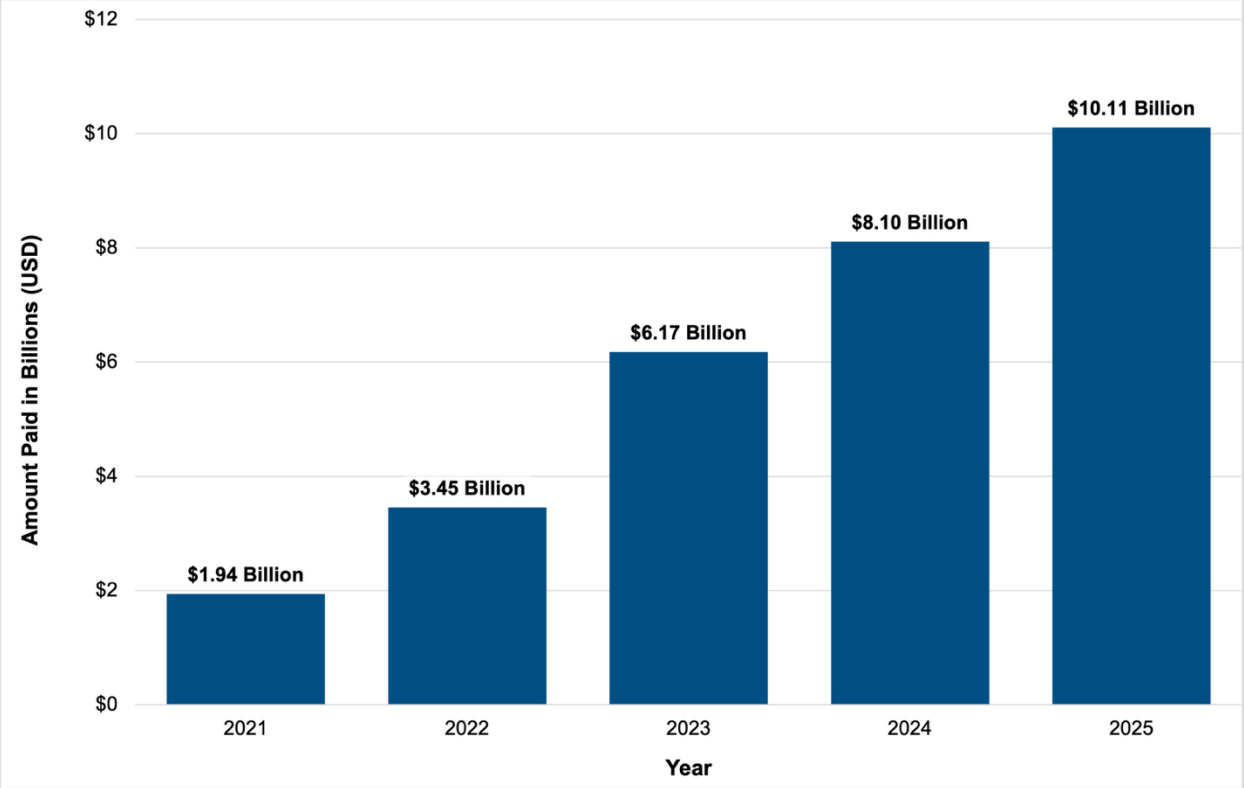


Source: T-MSIS Analytic Files Other Services (OT) claims and associated eligibility data, 2021–2025 for all 50 states, Washington, D.C., Puerto Rico, U.S. Virgin Islands (USVI), and Guam.[34] Analysis includes all unique beneficiaries who received services for a diagnosis code of F84.0; F84.5; F84.8; F84.9. Results are intended for analytic use.

[34] T-MSIS analysis in this toolkit did not include American Samoa or the Commonwealth of the Northern Mariana Islands (CNMI) because these territories operate their Medicaid and CHIP programs under a broad waiver granted under the authority of section 1902(j) of the Act. This provision, which is uniquely available to American Samoa and the CNMI, allows the Secretary of Health and Human Services to waive or modify any Title XIX Medicaid requirement except for the following: the funding cap set under section 1108 of the Act, the federal medical assistance percentage (FMAP), and the requirement that federal medical assistance payments only be made for

Across the same time period, as shown in Figure 3a, the total amount paid by Medicaid and CHIP for ABA services for all beneficiaries increased from approximately $1.94 billion in 2021 to $10.1 billion in 2025, an increase of 421 percent. The total amounts paid by states varied, as shown in Figure 3b. These trends are, in part, due to ABA being a mandated service for fully insured, state-regulated health plans,[35] the creation of ABA-specific Current Procedural Terminology (CPT) codes, and the Center for Medicaid and CHIP Services (CMCS) 2014 guidance that ABA is one option for states to consider for ASD treatment. Spending has also increased as a response to increases in the number of children diagnosed with ASD and the demand for ABA.

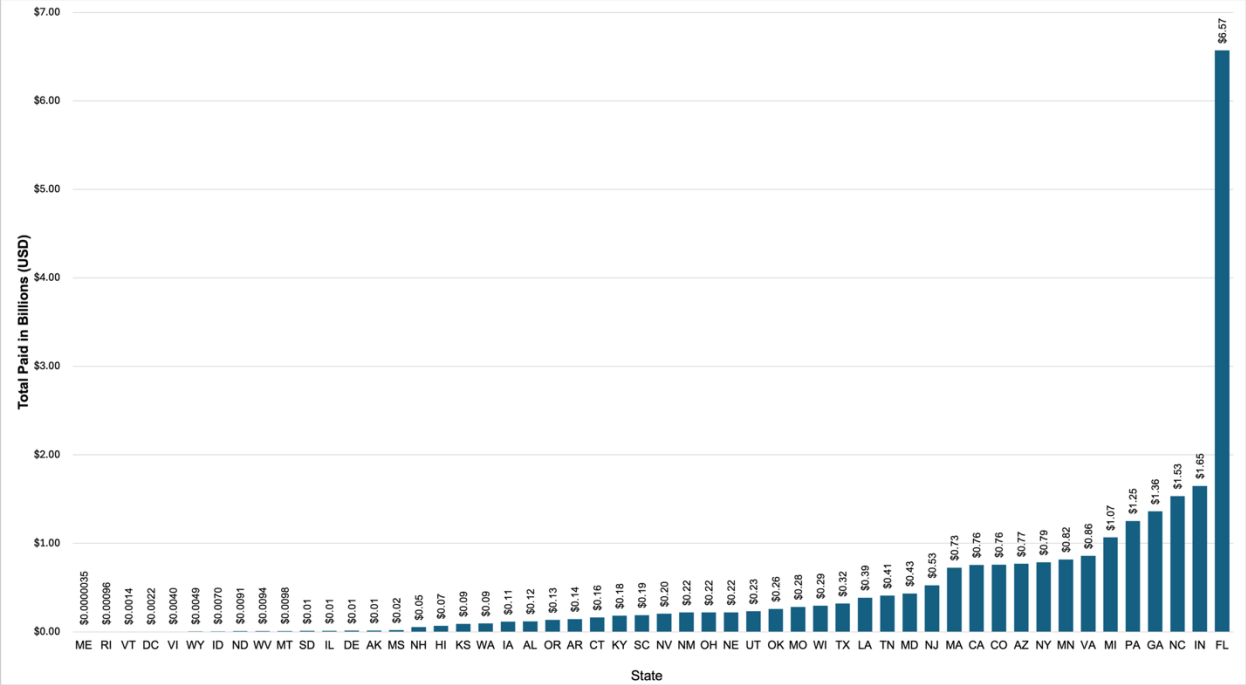
Figure 3a: Total Medicaid and CHIP Payments for Applied Behavior Analysis Services Among All Beneficiaries, 2021–2025



amounts expended for care and services described in section 1905(a) of the Act. As such, while neither of these territories provides all of Medicaid's mandatory benefits, they are considered in compliance with federal Medicaid law.

[35] Barry, C. L., Epstein, A. J., Marcus, S. C., Kennedy-Hendricks, A., Candon, M. K., Xie, M., & Mandell, D. S. (2017). Effects of state insurance mandates on health care use and spending for autism spectrum disorder. *Health Affairs*, *36*(10), 1754–1761. https://doi.org/10.1377/hlthaff.2017.0515.

Figure 3b: Total Medicaid and CHIP Payments for Applied Behavior Analysis Services, by State, 2023–2025



Source: T-MSIS OT claims and associated eligibility data, 2023–2025 for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam. Analysis includes the paid amount for procedure codes 97151–97158 across Medicaid and CHIP fee-for-service (FFS) claims and managed care encounters. Results are intended for analytic use.

In part, this growth reflects the way ABA has moved from a specialized service to a routine component of Medicaid services for certain conditions, with more children receiving ASD-related behavioral treatment and, in many cases, beginning services earlier in childhood.36,37 Moreover, while the majority of ABA services and payments are associated with ASD treatment, ABA-based interventions are also being used to address needs among children with other developmental or behavioral conditions, such as Attention-Deficit/Hyperactivity Disorder (ADHD). While this toolkit focuses on ABA as a treatment for ASD, it is noted that in 2025 $1.47 billion, or 14.5 percent of all Medicaid and CHIP ABA spending, was paid for ABA services to

[36] CMS. (2014, July 7). *CMCS Informational Bulletin: Clarification of Medicaid coverage of services to children with autism*, 1-5. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-07-14.pdf.

[37] Maenner, M. J., Warren, Z., Williams, A. R., Amoakohene, E., Bakian, A. V., Bilder, D. A., Durkin, M. S., Fitzgerald, R. T., Furnier, S. M., Hughes, M. M., Ladd-Acosta, C. M., McArthur, D., Pas, E. T., Salinas, A., Vehorn, A., Williams, S., Esler, A., Grzybowski, A., Hall-Lande, J., Nguyen, R. H. N., … Shaw, K. A. (2023). Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years - Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2020. *Morbidity and Mortality Weekly Report Surveillance Summaries, 72*(2), 1–14. https://doi.org/10.15585/mmwr.ss7202a1.

treat other conditions.[38] See Appendix C for additional details on ABA used to treat conditions and health needs other than ASD.

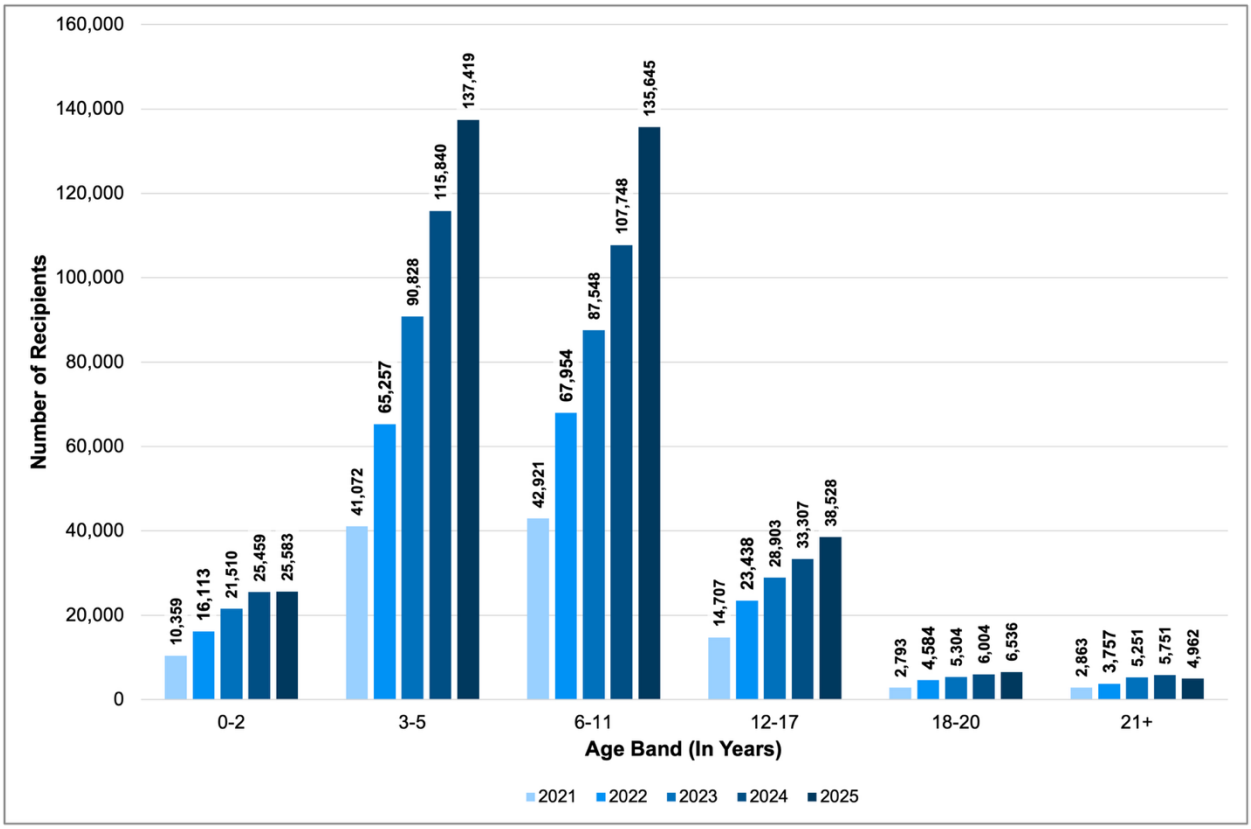
Recent research indicates that children with ASD incur substantially higher annual expenditures than peers without ASD, and that intensive behavioral and developmental services are a major contributor to these costs.[39]

Expenditures are further influenced by how services are delivered, not only by how many children receive ASD-related behavioral treatment such as ABA. As ABA has become increasingly utilized, prescribed hours per week are often high, and many children remain in treatment for extended periods of time. Stakeholders expressed recurring concerns that high service hours may be prescribed as a standard approach rather than being tied to outcomes, instead of reserving more intensive ABA for situations in which higher service intensity is clearly justified and documented based on the child's individual clinical needs. Figure 3c shows the increase in the number of beneficiaries receiving ABA by age band in recent years. The chart displays steady, notable increases in ABA recipients since 2021, particularly among children ages 3 to 5 years, 6 to 11 years, and 12 to 17 years.

[38] T-MSIS OT claims and associated eligibility data, 2021–2025 for all 50 states and Washington, D.C. Analysis includes the paid amount for procedure codes 97151-97158 across Medicaid and CHIP FFS claims and managed care encounters. Results are intended for analytic use.

[39] Monnet, J. & Zuvekas, S.H. (2025, August). *Treatment and Health Expenditures among Children with Autism Spectrum Disorder, U.S. Civilian Noninstitutionalized Population, 2018-2022* (Statistical Brief #565, AHRQ Publication No. 25-0062). Agency for Healthcare Research and Quality. https://meps.ahrq.gov/data_files/publications/st565/stat565.shtml.

Figure 3c: Number of Medicaid and CHIP Recipients Who Received Applied Behavior Analysis Services by Age Band, 2021–2025



Source: T-MSIS OT claims and associated eligibility data, 2021–2025, for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam. Analysis includes summed counts, which are not mutually exclusive, as beneficiaries may be included in more than one age band within a given year based on their birthdate. In each year, beneficiaries with an unknown age due to an unpopulated birthdate were excluded from Figure 3c. The number of beneficiaries with an unknown age ranged from 2,736 in 2021 to 7,624 in 2025. Results are intended for analytic use.

Alongside these trends, multiple federal and state audits and oversight reviews have examined improper Medicaid billing for ASD-related services, including ABA services delivered in

Colorado, Indiana, Wisconsin, Maine, Massachusetts, Nebraska, and Nevada.[40,41,42,43,44,45,46] Collectively, these reviews have reported at least $198.4 million in improper Medicaid payments. Across states, oversight reports describe similar issues for ASD-related services, including incomplete documentation, insufficient support for determining the medical necessity of treatment, and limited oversight of high-intensity service patterns. These risks are consistent with reported variability in provider quality and operational practices, including concerns about insufficiently rigorous diagnostic pathways, strong commercialization incentives, high-hour billing norms, and inconsistent supervision models. Documented fraud and waste, combined with unclear or inconsistently applied guardrails, can compound these factors and weaken confidence that services are medically necessary and likely to achieve their intended outcomes.

The remaining chapters of this toolkit build on this overview by moving from description to action. For instance, while the analysis depicted in Figure 3c indicates high utilization in children ages 6 to 11 years, the next chapter will explain the importance and evidence supporting that ABA is particularly beneficial for children under the age of 6 years. Subsequent sections will also provide more detail on what constitutes high-quality, evidence-based ABA, how Medicaid coverage and payment can be structured to support appropriate treatment, and how utilization management, provider qualifications, and program integrity activities can be aligned to safeguard access while ensuring responsible use of Medicaid and CHIP resources. Together, the chapters are intended to give states practical, flexible tools to navigate the growing role of ABA in treatment for ASD and to support decision-making that advances both effective care and sound stewardship of public funds.

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[40] HHS-OIG. (2026, February). *Colorado made at least $77.8 million in improper fee-for-service Medicaid payments for applied behavior analysis provided to children* (Report #A-09-24-02004). https://oig.hhs.gov/reports/all/2026/colorado-made-at-least-778-million-in-improper-fee-for-service-medicaid-payments-for-applied-behavior-analysis-provided-to-children/.

[41] HHS-OIG. (2024, December). *Indiana made at least $56 million in improper fee-for-service Medicaid payments for applied behavior analysis provided to children diagnosed with autism* (Report #A-09-22-02002). https://oig.hhs.gov/reports/all/2024/indiana-made-at-least-56-million-in-improper-fee-for-service-medicaid-payments-for-applied-behavior-analysis-provided-to-children-diagnosed-with-autism/.

[42] HHS-OIG. (2025, July). *Wisconsin made at least $18.5 million in improper fee-for-service Medicaid payments for applied behavior analysis provided to children diagnosed with autism* (Report #A-06-23-01002). https://oig.hhs.gov/reports/all/2025/wisconsin-made-at-least-185-million-in-improper-fee-for-service-medicaid-payments-for-applied-behavior-analysis-provided-to-children-diagnosed-with-autism/.

[43] HHS-OIG. (2026, January 22). *HHS-OIG audit finds Maine made at least $45.6 million in improper Medicaid payments for autism services*. https://oig.hhs.gov/newsroom/news-releases-articles/hhs-oig-audit-finds-maine-made-at-least-456-million-in-improper-medicaid-payments-for-autism-services/.

[44] Office of the Inspector General for the Commonwealth of Massachusetts. (2024, March 1). *MassHealth and Health Safety Net: 2024 annual report—MassHealth's applied behavior analysis program: Service providers*, 8. https://maoig.gov/wp-content/uploads/MassHealth-and-HSN-2024-Annual-Report-MassHealths-Applied-Behavior-Analysis-Program-Service-Providers.pdf.

[45] Nebraska Auditor of Public Accounts. (2025, September 23). *Attestation report of the Nebraska Department of Health and Human Services—Applied Behavior Analysis, calendar years ended December 31, 2023, and December 31, 2024*, 7-12. https://auditors.nebraska.gov/APA_Reports/2025/SA25-09232025-January_1_2023_through_December_31_2024_Applied_Behavior_Analysis_Attestation_Report.pdf.

[46] Nevada Legislative Counsel Bureau, Audit Division. (2021, January). *Delivery of treatment services for children with autism* (Report No. LA22-04), 12-17. https://www.leg.state.nv.us/Audit/Full/BE2022/LA2204DeliveryofTreatmentServicesforChildrenWithAutism.pdf.

Chapter 2. Applied Behavior Analysis Clinical Standards

When tailored to each child's needs and development, ABA has been shown to improve communication skills and reduce problematic behavior for individuals with ASD.[47,48,49] Children younger than 6 years may benefit particularly from both ABA and interventions using ABA.[50,51,52] While leading pediatric and psychological organizations, such as the American Academy of Pediatrics (AAP) and the American Psychological Association (APA), have not endorsed ABA or any specific intervention as the "gold standard" for ASD treatment, ABA is included in a list of appropriate interventions within clinical guidance published by the AAP and has been deemed an appropriate and evidence-based practice by the APA.[53,54]

Some individuals with ASD and advocacy groups have shared concerns about some ABA approaches.[55] They note that, in practice, goals may be set by adults and may focus on helping children act more like peers with neurotypical development, rather than focusing on what matters most to the child. From this perspective, efforts to reduce certain behaviors can be perceived by children with ASD as pressure to hide or change autistic traits, leading some individuals and stakeholders to not endorse ABA. This chapter aims to acknowledge those concerns and emphasizes the importance of using ABA in ways that support safety, communication, and quality of life for a child with ASD. It also offers research-informed guidance for states to support the development of policies that impact or are impacted by ABA clinical

[47] Warren, Z., McPheeters, M. L., Sathe, N., Foss-Feig, J. H., Glasser, A., & Veenstra-Vanderweele, J. (2011). A systematic review of early intensive intervention for autism spectrum disorders. *Pediatrics, 127*(5), e1303–e1311. https://doi.org/10.1542/peds.2011-0426.

[48] Virués-Ortega, J. (2010). Applied behavior analytic intervention for autism in early childhood: meta-analysis, meta-regression and dose-response meta-analysis of multiple outcomes. *Clinical Psychology Review, 30*(4), 387–399. https://doi.org/10.1016/j.cpr.2010.01.008.

[49] Sandbank, M., Bottema-Beutel, K., Crowley LaPoint, S., Feldman, J. I., Barrett, D. J., Caldwell, N., Dunham, K., Crank, J., Albarran, S., & Woynaroski, T. (2023). Autism intervention meta-analysis of early childhood studies (Project AIM): updated systematic review and secondary analysis. *BMJ, 383*, e076733. https://doi.org/10.1136/bmj-2023-076733.

[50] Virués-Ortega J. (2010). Applied behavior analytic intervention for autism in early childhood: meta-analysis, meta-regression and dose-response meta-analysis of multiple outcomes. *Clinical Psychology Review, 30*(4), 387–399. https://doi.org/10.1016/j.cpr.2010.01.008.

[51] Reichow, B., Hume, K., Barton, E. E., & Boyd, B. A. (2018). Early intensive behavioral intervention (EIBI) for young children with autism spectrum disorders (ASD). *The Cochrane Database of Systematic Reviews, 5*(5), CD009260. https://doi.org/10.1002/14651858.CD009260.

[52] Peters-Scheffer, N., Didden, R., Korzilius, H., & Sturmey, P. (2011). A meta-analytic study on the effectiveness of comprehensive ABA-based early intervention programs for children with autism spectrum disorders. *Research in Autism Spectrum Disorders, 5*(1), 60–69. https://doi.org/10.1016/j.rasd.2010.03.011.

[53] Hyman, S. L., Levy, S. E., Myers, S. M., & Council on Children with Disabilities, Section on Developmental and Behavioral Pediatrics. (2020). Identification, Evaluation, and Management of Children With Autism Spectrum Disorder. *Pediatrics, 145*(1), e20193447. https://doi.org/10.1542/peds.2019-3447.

[54] American Psychological Association (APA). (2017). *Applied behavior analysis.* Retrieved July 28, 2026, from https://www.apa.org/about/policy/applied-behavior-analysis.

[55] Autistic Self Advocacy Network. (n.d.). *What we believe.* Retrieved July 28, from https://autisticadvocacy.org/about-asan/what-we-believe/.

standards and that emphasize that treatment should remain individualized to promote clinically significant outcomes.

Populations Who Benefit from Applied Behavior Analysis

The way that ASD symptoms unfold through an individual's development and lifespan is neither linear nor universal and has implications for each of the steps in the process of seeking and receiving ASD treatment. While research indicates that there may be similar trajectories that individuals with ASD follow regarding social and communication functioning,[56] ultimately the individual's trajectory is unique and involves various body systems (e.g., neurological, musculoskeletal).[57] Developmental science, both in general and in the context of ASD, suggests that cognitive processes iteratively and cumulatively affect an individual via developmental cascades, for which developing skills capitalize on brain plasticity in children to build the neurological scaffolding and connections needed for gaining subsequent skills.[58,59,60,61]

Interventions such as ABA can support iterative, cumulative neurological and cognitive development. This process can impact each step in the process of seeking and receiving ASD treatment.[62] Research suggests that early initiation of interventions can capitalize on children's brain plasticity to support positive treatment outcomes.[63]

While ABA has been found to improve ASD symptoms in children who start ABA at any age, evidence suggests that structured programs initiated before the age of 6 years can maximize intervention success, showing consistent improvement in cognitive functioning, language

[56] Fountain, C., Winter, A. S., Cheslack-Postava, K., & Bearman, P. S. (2023). Developmental Trajectories of Autism. *Pediatrics, 152*(3), e2022058674. https://doi.org/10.1542/peds.2022-058674.

[57] Iverson, J. M., West, K. L., Schneider, J. L., Plate, S. N., Northrup, J. B., & Roemer Britsch, E. (2023). Early development in autism: How developmental cascades help us understand the emergence of developmental differences. *Advances in Child Development and Behavior, 64,* 109–134. https://doi.org/10.1016/bs.acdb.2022.10.005.

[58] Masten, A. S., & Cicchetti, D. (2010). Developmental cascades. *Development and Psychopathology, 22*(3), 491–495. https://doi.org/10.1017/S0954579410000222.

[59] Bradshaw, J., Schwichtenberg, A. J., & Iverson, J. M. (2022). Capturing the complexity of autism: Applying a developmental cascades framework. *Child Development Perspectives, 16*(1), 18–26. https://doi.org/10.1111/cdep.12439.

[60] DeMayo, M. M., Young, L. J., Hickie, I. B., Song, Y. J. C., & Guastella, A. J. (2019). Circuits for social learning: A unified model and application to Autism Spectrum Disorder. *Neuroscience and Biobehavioral Reviews, 107,* 388–398. https://doi.org/10.1016/j.neubiorev.2019.09.034.

[61] Sullivan, K., Stone, W. L., & Dawson, G. (2014). Potential neural mechanisms underlying the effectiveness of early intervention for children with autism spectrum disorder. *Research in Developmental Disabilities, 35*(11), 2921–2932. https://doi.org/10.1016/j.ridd.2014.07.027.

[62] Towle, P. O., Patrick, P. A., Ridgard, T., Pham, S., & Marrus, J. (2020). Is Earlier Better? The Relationship between Age When Starting Early Intervention and Outcomes for Children with Autism Spectrum Disorder: A Selective Review. A*utism Research and Treatment, 2020,* 7605876. https://doi.org/10.1155/2020/7605876.

[63] Sullivan, K., Stone, W. L., & Dawson, G. (2014). Potential neural mechanisms underlying the effectiveness of early intervention for children with autism spectrum disorder. *Research in Developmental Disabilities, 35*(11), 2921–2932. https://doi.org/10.1016/j.ridd.2014.07.027.

acquisition, and adaptive behavior.[64,65,66] Additionally, children who start ABA when they are school-aged may experience improvement in outcomes with reduced and appropriate duration and intensity of treatment.[67,68] This and other evidence indicates that while age is important, it alone is not indicative of ABA success, as age interacts with several factors, including the number of skills that need to be mastered.[69] As shown in Figure 4, most children enrolled in Medicaid and CHIP who had an ASD diagnosis began ABA between the ages of 3 and 5 years old. A discussion about how age is considered when developing ABA treatment plans and setting treatment intensity is provided later in this chapter.

[64] Virués-Ortega, J. (2010). Applied behavior analytic intervention for autism in early childhood: meta-analysis, meta-regression and dose-response meta-analysis of multiple outcomes. *Clinical Psychology Review, 30*(4), 387–399. https://doi.org/10.1016/j.cpr.2010.01.008.

[65] Reichow, B., Hume, K., Barton, E. E., & Boyd, B. A. (2018). Early intensive behavioral intervention (EIBI) for young children with autism spectrum disorders (ASD). *The Cochrane Database of Systematic Reviews, 5*(5), CD009260. https://doi.org/10.1002/14651858.CD009260.

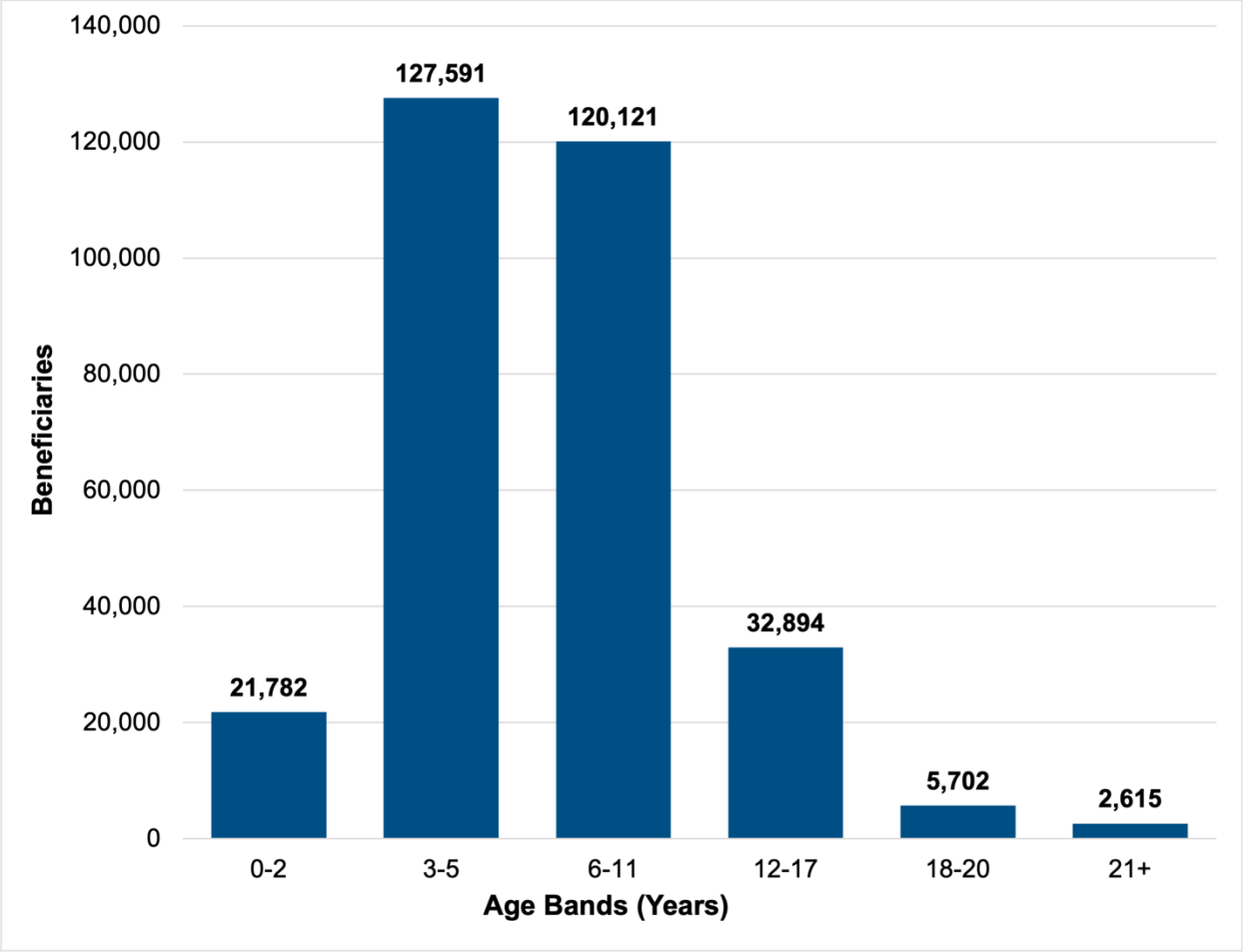
[66] Peters-Scheffer, N., Didden, R., Korzilius, H., & Sturmey, P. (2011). A meta-analytic study on the effectiveness of comprehensive ABA-based early intervention programs for children with autism spectrum disorders. *Research in Autism Spectrum Disorders*, *5*(1), 60–69. https://doi.org/10.1016/j.rasd.2010.03.011.

[67] Gitimoghaddam, M., Chichkine, N., McArthur, L., Sangha, S. S., & Symington, V. (2022). Applied Behavior Analysis in Children and Youth with Autism Spectrum Disorders: A Scoping Review. *Perspectives on Behavior Science*, *45*(3), 521–557. https://doi.org/10.1007/s40614-022-00338-x.

[68] Linstead, E., Dixon, D. R., Hong, E., Burns, C. O., French, R., Novack, M. N., & Granpeesheh, D. (2017). An evaluation of the effects of intensity and duration on outcomes across treatment domains for children with autism spectrum disorder. *Translational Psychiatry, 7*(9), e1234. https://doi.org/10.1038/tp.2017.207.

[69] Peterson, T., Dodson, J., Sherwin, R., & Strale, F., Jr. (2024). The effects of age and treatment intensity on behavioral target mastery with applied behavior analysis (ABA) intervention using causal moderation models. *Cureus, 16*(8): e67179. https://doi.org/10.7759/cureus.67179.

Figure 4: Medicaid and CHIP Beneficiaries With Autism Spectrum Disorder Who Received Applied Behavior Analysis Services, by Age Band, 2025



Source: T-MSIS OT claims and associated eligibility data, 2025 for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam. Analysis includes all unique beneficiaries for which procedure codes 97151–97158 were billed across Medicaid and CHIP FFS claims and managed care encounters in 2025. Beneficiaries with ASD were identified by diagnosis codes F84.0; F84.5; F84.8; F84.9. Please note: counts of beneficiaries in each age band are not mutually exclusive. When a child's birthday resulted in them being in two age bands in 2025, they were included twice. Therefore, the sum of beneficiaries included in all age bands in Figure 4 exceeds the unique number of beneficiaries with ASD receiving ABA shown in Figure 2. Beneficiaries with an unknown age due to an unpopulated birth date were excluded. Results are intended for analytic use.

Evidence suggests that individuals with ASD who have lower adaptive behavior levels at the start of ABA benefit particularly from ABA treatment. Adaptive behavior is defined as the ability to perform tasks required to engage in everyday life.[70] It can inform treatment intensity and influence the effectiveness of ABA therapy[71] and can be assessed utilizing an adaptive behavior assessment instrument (see Tables 1 through 3 in this chapter for examples of adaptive

[70] APA. (2023). *APA Dictionary of Psychology: Adaptive behavior*. Retrieved July 28, 2026, from https://dictionary.apa.org/adaptive-behavior.

[71] Eckes, T., Buhlmann, U., Holling, H. D., & Möllmann, A. (2023). Comprehensive ABA-based interventions in the treatment of children with autism spectrum disorder - a meta-analysis. *BMC Psychiatry, 23*(1), 133. https://doi.org/10.1186/s12888-022-04412-1.

behavior assessment instruments). Research suggests that those with the lowest adaptive levels at the start of the intervention may have larger improvements after both 12 and 24 months of ABA than those with higher adaptive levels.[72]

Coverage of Applied Behavior Analysis Services for Children in Foster Care and High-Risk Youth

Children in foster care represent one of the most clinically complex populations served by Medicaid and CHIP, often presenting with co-occurring conditions, trauma histories, and interrupted care. Children with ASD are disproportionately overrepresented within the foster care system compared to the general population and account for over 4 percent of the Medicaid population with ASD.[73]

Medicaid-eligible children and youth under age 21 in Title IV-E Foster Care are entitled to the full scope of Medicaid benefits and subject to EPSDT requirements.[74,75] Federal law also requires states to provide 12-month continuous eligibility for all children under age 19 years enrolled in Medicaid or CHIP, including those in foster care, which can help support continuity of care during placement transitions and reduce coverage disruptions that might otherwise interrupt ongoing treatment, including for ASD-related services.[76] Despite these protections, barriers to accessing ASD services persist for children with ASD in foster care, which can disrupt or delay services when placement changes occur. Foster care-specific considerations related to diagnostic evaluations and caregiver training requirements are addressed in the relevant sections of this chapter.

Steps in Establishing Applied Behavior Analysis Services

There are several steps that are integral for individuals with ASD to establish and engage in ABA services. After an individual is flagged as potentially having ASD, providers complete an ASD diagnostic evaluation, submit the administrative requirements necessary for accessing ABA services, and gather information to develop an ITP (Figure 5). ITPs are described in detail later in this chapter.

Of note, there is not a universal pathway that all patients follow to establish ABA treatment, and there are no nationwide requirements for specific documentation to be submitted to obtain ABA

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[72] Choi, K. R., Bhakta, B., Knight, E. A., Becerra-Culqui, T. A., Gahre, T. L., Zima, B., & Coleman, K. J. (2022). Patient Outcomes After Applied Behavior Analysis for Autism Spectrum Disorder. *Journal of Developmental and Behavioral Pediatrics, 43*(1), 9–16, 13 https://doi.org/10.1097/DBP.0000000000000995.

[73] Shea, L., Villodas, M. L., Ventimiglia, J., Wilson, A. B., & Cooper, D. (2024). Foster Care involvement Among Youth With intellectual and Developmental Disabilities. *JAMA Pediatrics*, *178*(4), 384-390. https://doi.org/10.1001/jamapediatrics.2023.6580.

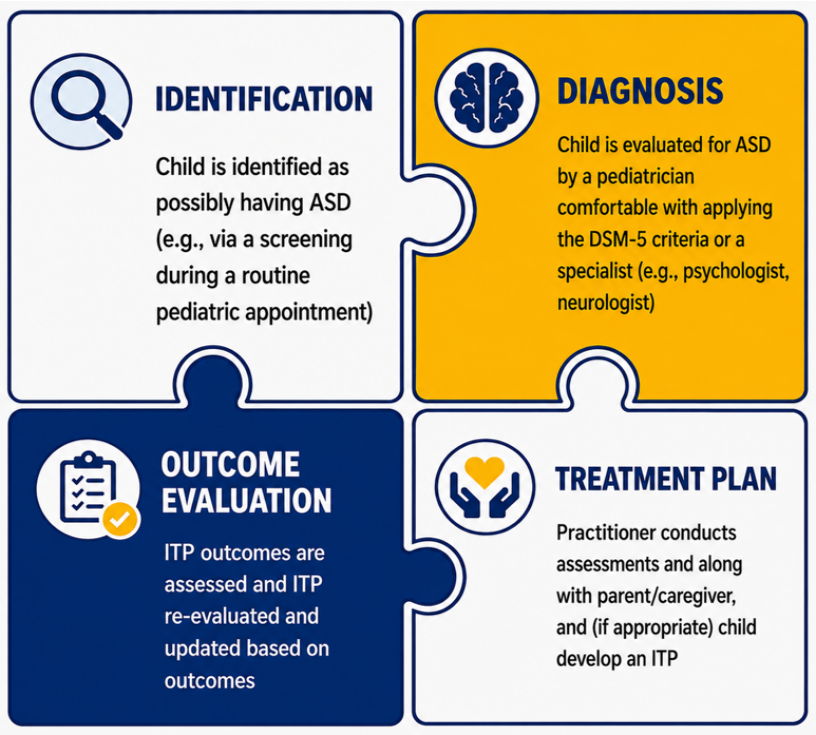
[74] CMS. (n.d.). *MACPro implementation guide: Children with Title IV-E adoption assistance, foster care, or guardianship care*. https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-children-with-title-ive-adoption-assistance-foster-care-guardianship-care.pdf.

[75] CMS, & Administration for Children and Families. (2020, October 5). *Support for family-focused residential treatment—Title IV-E and Medicaid guidance*.https://www.medicaid.gov/federal-policy-guidance/downloads/cib100520.pdf.

[76] Reynolds, A.; Medicaid and CHIP Payment and Access Commission. (2025, February 28). *Health care access for children in foster care* [presentation slides], 4, 11, 16, 19. https://www.macpac.gov/wp-content/uploads/2025/02/08_February-Slides_Health-Care-Access-for-Children-in-Foster-Care.pdf.

services. Requirements are set by each state's Medicaid program, which then leads to state-specific pathways that individuals with ASD must follow to obtain ABA treatment. For example, some states require that both a completed ASD diagnostic evaluation and an ITP be submitted as part of a prior authorization request to initiate ABA treatment.

Figure 5: Steps in Establishing and Engaging in Applied Behavior Analysis Therapy



Medical necessity is typically determined after the ITP is developed and before treatment begins, once the ABA provider submits documentation to the state or managed care plan[77] for prior authorization. However, the specific timing and requirements can vary by state and managed care plan. See Chapter 6 for additional details on prior authorization and establishing medical necessity.

Autism Spectrum Disorder Diagnostic Evaluation

For diagnosing ASD, the AAP recommends using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) criteria.[78,79] **Diagnosis should be completed by qualified and licensed medical providers, such as developmental**

[77] A managed care plan includes a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) as defined in 42 C.F.R. § 438.2.

[78] Hyman, S. L., Levy, S. E., Myers, S. M., & Council on Children with Disabilities, Section on Developmental and Behavioral Pediatrics. (2020). Identification, Evaluation, and Management of Children With Autism Spectrum Disorder. *Pediatrics, 145*(1), e20193447. https://doi.org/10.1542/peds.2019-3447.

[79] APA. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.) [DSM-5-TR]. APA Publishing. https://doi.org/10.1176/appi.books.9780890425787.

pediatricians, pediatricians comfortable using the DSM-5-TR, pediatric neurologists, child psychologists, psychiatrists, or other clinical providers as specified by a state.[80,81]

BEST PRACTICE

Initiating Applied Behavior Analysis Services

Best practice is to initiate comprehensive ABA only after a qualified, independent clinician has confirmed an ASD diagnosis. States should tie sustained ABA coverage to a confirmed ASD diagnosis, while recognizing that, under EPSDT, some states may authorize limited, time-bound ABA services when there is strong clinical suspicion of ASD and significant impairment while a full diagnostic evaluation is pending; these interim uses should be tightly defined and not substitute for diagnosis-driven treatment.

Due to the comprehensive nature of the multi-method and multi-informant assessment process, it may require 20 hours or more to complete the evaluation, and it should be completed in person whenever possible. Ideally, clinicians complete ASD assessments in person, given that ASD involves disruption of social-emotional reciprocity,[82] and many of these social-emotional behaviors are better observed in person to make a diagnosis. Telehealth, if used, should be a small component of the overall assessment process and should be reserved only for rare, well-justified circumstances for which both valid, reliable clinical information can still be obtained and in-person assessment is not feasible (e.g., a lack of qualified providers available within a reasonable travel distance for a family). Best practice is that telehealth be limited when completing assessments.

CMCS recognizes states' interest in preventing financial incentives from influencing ASD diagnosis and subsequent referral to ABA services. States should consider an approach consistent with Section 1877 of the Act, also known as the physician self-referral law or the "Stark Law" and its implementing regulations.[83] Under this law, which is extended to Medicaid at section 1903(s) of the Act, entities are not prohibited from furnishing both diagnostic and treatment services. Instead, the Stark Law targets the financial relationship: a provider may not benefit from an ownership interest, investment interest, or compensation arrangement that is tied to the volume or value of referrals for services it also provides. States may apply an analogous standard to ABA-related diagnosis and treatment, focusing oversight on:

- **Disclosure** of any financial or ownership relationship between the diagnosing clinician and the ABA provider to which a referral is made;

[80] Astra ABA. (2025, July 3). *Who Diagnoses Autism? A Look at the Key Professionals Involved*. https://www.astraaba.com/blog/what-types-of-professionals-typically-give-the-autism-diagnosis.

[81] Hyman, S. L., Levy, S. E., Myers, S. M., & Council on Children with Disabilities, Section on Developmental and Behavioral Pediatrics. (2020). Identification, Evaluation, and Management of Children With Autism Spectrum Disorder. *Pediatrics, 145*(1), e20193447. https://doi.org/10.1542/peds.2019-3447.

[82] APA. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.) [DSM-5-TR]. APA Publishing. https://doi.org/10.1176/appi.books.9780890425787.

[83] 42 C.F.R. § 411.350 – 411.389.

- **Prohibition on compensation tied to referral volume,** as diagnosing clinicians should not be compensated in a manner that varies based on the number of referrals made to a particular ABA provider or the volume of ABA services subsequently authorized; and
- **Audit-based monitoring** of referral and diagnosis patterns to identify outlier providers, rather than a categorical bar on integrated service delivery.

This approach allows states to address the underlying program-integrity concern without imposing a structural separation requirement that could delay ASD diagnosis and reduce service access, particularly in regions where few independent diagnostic providers are available.

For children with ASD in foster care, states should accept prior diagnostic evaluations that meet applicable clinical standards rather than requiring a new evaluation at each placement change, as repeated diagnostic requirements create unnecessary delays in care for an already vulnerable population. A screening conducted before Medicaid enrollment is sufficient to trigger EPSDT obligations after enrollment,[84] supporting the use of prior evaluations when they reflect a current clinical picture.

To make a diagnosis, providers complete an ASD diagnostic evaluation, which is sometimes called a comprehensive diagnostic evaluation (CDE). Comprehensive ASD diagnostic evaluations include caregiver-reported tools, direct observation and structured interview instruments, and adaptive-behavior assessments (see Tables 1 through 3 below for example assessment instruments).[85,86] These tools are intended to inform a thorough, multi-method clinical evaluation and should not be interpreted to suggest that ASD can appropriately be diagnosed through a brief encounter or a short telehealth-only assessment; best practice is a comprehensive, clinically appropriate evaluation that includes sufficient direct assessment and developmental history to support a reliable diagnosis.

[84] CMS. (2026). *State Medicaid & CHIP Toolkit for Children's Behavioral Health Services and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Requirements.* https://www.medicaid.gov/federal-policy-guidance/downloads/state-medicaid-chip-bh-epsdt.pdf.

[85] CMS. (2026). *State Medicaid & CHIP Toolkit for Children's Behavioral Health Services and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Requirements.* https://www.medicaid.gov/federal-policy-guidance/downloads/state-medicaid-chip-bh-epsdt.pdf.

[86] HHS, Centers for Disease Control and Prevention. (2025, April 16). *Clinical testing and diagnosis for autism spectrum disorder.* Retrieved July 29, 2026, from https://www.cdc.gov/autism/hcp/diagnosis/index.html.

Table 1: Examples of Parent/Caregiver-Reported Instruments Used to Diagnose Autism Spectrum Disorder

Caregiver-Reported Instruments	Description	Domains
Autism Diagnostic Interview-Revised (ADI-R)[87]	Standardized, semi-structured interview conducted with a caregiver to assess behaviors related to ASD; administered by a trained provider; focuses on the individual's developmental history as well as current and past behaviors relevant to ASD; covers 93 items which have been validated for children aged 4+ years but usable for children as young as age 18 months; often paired with Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) *Completed by: Trained provider*	• Reciprocal Social Interaction • Communication and Language • Restricted, Repetitive, and Stereotyped Behaviors and Interests • Abnormality of Development Evident by 36 Months
Autism Spectrum Rating Scale (ASRS)[88]	Norm-referenced, multi-informant rating scale used to identify behaviors and symptoms associated with ASD in children and adolescents aged 2 to 18 years *Completed by: Caregivers, teachers, or other providers who know the individual well*	• Social/Communication and Unusual Behaviors, with related treatment domains (e.g., peer socialization, social/emotional reciprocity, atypical language, stereotypy, behavioral rigidity, sensory sensitivity, and attention/self-regulation or attention depending on age group)
Gilliam Autism Rating Scale-Third Edition (GARS-3)[89]	Standardized behavior rating instrument designed to help identify characteristics associated with ASD and to support screening and diagnostic decision-making for children and young adults *Completed by: Caregivers, teachers, or other providers who know the individual well*	• Restrictive/Repetitive Behaviors • Social Interaction • Social Communication • Emotional Responses; Cognitive Style • Maladaptive Speech

[87] Rutter, M., Le Couteur, A., & Lord, C. (2003). *Autism Diagnostic Interview-Revised (ADI-R).* Western Psychological Services. https://doi.org/10.1037/t18128-000.

[88] Goldstein, S., & Naglieri, J. A. (2013). *Autism Spectrum Rating Scales (ASRS) technical manual.* Multi-Health Systems. https://storefront.mhs.com/collections/asrs%20.

[89] Gilliam, J. E. (2014). *Gilliam Autism Rating Scale–Third Edition (GARS-3).* PRO-ED. https://proedinc.com/products-13780.html.

Caregiver-Reported Instruments	Description	Domains
Social Responsiveness Scale (SRS-2)[90]	Standardized rating scale used to measure the severity of social impairment associated with ASD; used to identify difficulties in reciprocal social behavior and to quantify ASD-related traits across settings *Completed by: Caregivers, teachers, or other providers who know the individual well*	• Social Awareness • Social Cognition • Social Communication • Social Motivation • Restricted Interests • Repetitive Behavior

Table 2: Examples of Direct Observation and Structured Caregiver Interview Instruments Used When Diagnosing Autism Spectrum Disorder

Direct Observation and Structured Interview Instruments	Description	Domains
Autism Diagnostic Observation Schedule, Second Edition (ADOS-2)[91]	Standardized, semi-structured, provider-administered assessment used to evaluate behaviors associated with ASD; used during direct observation of the individual during structured and semi-structured social, play, and communication activities; often considered the gold standard for diagnosing ASD across ages and developmental levels	• Social Affect • Restricted and Repetitive Behaviors

[90] Constantino, J. N., & Gruber, C. P. (2012). *Social Responsiveness Scale (SRS-2)* (2nd ed.). Western Psychological Services. https://www.wpspublish.com/srs-2-social-responsiveness-scale-second-edition.html.

[91] Lord, C., Rutter, M., DiLavore, P. C., Risi, S., Gotham, K., & Bishop, S. L. (2012). *Autism diagnostic observation schedule, second edition (ADOS-2) manual (Part II): Toddler module.* Western Psychological Services. https://www.wpspublish.com/ados-2-autism-diagnostic-observation-schedule-second-edition.

Direct Observation and Structured Interview Instruments	Description	Domains

Childhood Autism Rating Scale, Second Edition[92]	Behavior rating scale that evaluates 15 domains to differentiate ASD from other delays, with scores indicating non-autistic to severely autistic ranges; includes different forms to match developmental and language levels	• Relating to People
		• Imitation
		• Emotional Response
		• Body Use
		• Object Use
		• Adaptation to Change
		  - Visual Response
		  - Listening Response
		  - Taste/Smell/Touch Response and Use
		• Fear or Nervousness
		• Verbal Communication
		• Nonverbal Communication
		• Activity Level
		• Level and Consistency of Intellectual Response
		• General Impressions

When challenging behaviors are present, additional assessments may be completed (examples provided in Table 3), including:

- Functional communication and social pragmatic assessments that look at how the child uses language in real interactions[93]
- Adaptive behavior scales that measure how a child manages daily living, communication, and social skills compared with peers[94]

[92] Schopler, E., Van Bourgondien, M. E., Wellman, G. J., & Love, S. R. (2010). *Childhood Autism Rating Scale* (2nd ed.). Western Psychological Services. https://www.wpspublish.com/cars-2-childhood-autism-rating-scale-second-edition.html.

[93] Chahin, S. S., Apple, R. W., Kuo, K. H., & Dickson, C. A. (2020). Autism spectrum disorder: psychological and functional assessment, and behavioral treatment approaches. *Translational Pediatrics*, *9*(Suppl 1), S66–S75. https://doi.org/10.21037/tp.2019.11.06.

[94] Sparrow, S. S., Cicchetti, D. V., & Saulnier, C. A. (2016). *Vineland Adaptive Behavior Scales* (3rd ed.). Pearson. https://www.pearsonassessments.com/en-us/Store/Professional-Assessments/Behavior/Vineland-Adaptive-Behavior-Scales-Third-Edition/p/100001622.

Table 3: Examples of Adaptive Behavior Assessment Instruments Used to Support Autism Spectrum Disorder Diagnosis

Adaptive-Behavior Assessment Instruments	Description	Domains
Vineland Adaptive Behavior Scales-3 (Vineland-3)[95]	Assesses adaptive behavior in four primary domains, plus an optional maladaptive domain	• Communication: Receptive (listening/understanding), Expressive (speaking), Written (reading/writing) • Daily Living Skills: Personal (eating, dressing, hygiene), Domestic (household tasks), Community (shopping, safety, time concepts) • Socialization: Interpersonal Relationships, Play and Leisure, Coping Skills • Motor Skills (optional): Gross Motor, Fine Motor
The Adaptive Behavior Assessment System, Third Edition[96]	Measures an individual's adaptive skills across the lifespan using ratings from caregivers, teachers, or others familiar with the person across three domains	• Conceptual: Communication, Functional Academics, Self-Direction, Health & Safety • Social: Leisure, Social • Practical: Self-Care, Home/School Living, Community Use, Health & Safety, Work (ages 16+ years), Motor (ages 0-5 years required, older ages optional)

[95] Sparrow, S. S., Cicchetti, D. V., & Saulnier, C. A. (2016). *Vineland Adaptive Behavior Scales* (3rd ed.). Pearson. https://www.pearsonassessments.com/en-us/Store/Professional-Assessments/Behavior/Vineland-Adaptive-Behavior-Scales-Third-Edition/p/100001622.

[96] Harrison, P. L., & Oakland, T. (2015). *Adaptive Behavior Assessment System* (3rd ed.). Western Psychological Services (WPS). https://www.wpspublish.com/abas-3-adaptive-behavior-assessment-system-third-edition.

STATE SPOTLIGHT: Evaluation and Development of an Applied Behavior Analysis Treatment Plan

Washington State uses a three-stage approach[97,98,99,100] as the pathway to ABA services:

1. **Receive a comprehensive diagnostic evaluation**. In Washington State, comprehensive diagnostic evaluations and the development of clinical treatment recommendations are conducted by a Center of Excellence (COE)—individual providers who meet certain state criteria, such as enrollment with the state Medicaid program, completion of COE training, experience diagnosing ASD, and understanding ABA medical necessity. If ABA services are determined to be medically necessary, the COE refers the individual to an ABA provider and sends the provider, as well as the individual or the individual's family, a prescription for the services. For individuals enrolled in a managed care plan, the plan can assist with finding an ABA provider or other services depending on the COE's recommendations.
2. **Identify an ABA provider, develop a treatment plan, and obtain prior authorization**. The identified ABA provider develops a treatment plan. The clinical rationale for the treatment plan must include information from the evaluation, a brief overview of the treatment plan, and an indication of how maintenance and generalization will be addressed, how the services will be faded, or how the individual will transition into less intensive services. Before services can begin, the ABA provider must obtain prior authorization; the prior authorization request must include documentation from the COE, the ABA assessment and therapy treatment plan, and a completed *ABA Level of Support Requirement* form that summarizes the individual's recent behavior, the severity of the behaviors, and a description of what other therapies have already been tried.
3. **Receive ABA services**. Once the steps above are completed, ABA services can begin. Authorization is granted in 3- to 6-month increments. ABA providers must submit reassessments and updated treatment plans that include the client's progress to request authorization of continued services.

While there are no established universal standards, the literature indicates that diagnostic reevaluations should be completed to ensure that services and treatment are appropriate. These evaluations should be conducted periodically, with a suggested timeframe of 1 year for children diagnosed at 2 or 3 years old, or at a more frequent interval if indicated, and at times of transition or significant life changes (such as starting school).[101]

Barriers to an Autism Spectrum Disorder Diagnosis That Can Delay Receipt of Applied Behavior Analysis Services

Stakeholders noted that, due to the comprehensive nature of the ASD diagnosis process and shortages of providers able to conduct the necessary evaluations, individuals with ASD often

[97] Washington Interdisciplinary Network of Community Leaders with a focus on the Underserved and Disability Education (WA INCLUDE). (n.d.). *Autism Center of Excellence trainings.* Retrieved July 28, 2026, from https://wainclude.org/echo/autism-center-of-excellence/.

[98] Washington State Health Care Authority (HCA). (n.d.). *Applied Behavior Analysis (ABA) Level of Support Requirement.* https://www.hca.wa.gov/assets/billers-and-providers/12_411.pdf.

[99] Washington State HCA. (2025). *Washington Apple Health (Medicaid: Applied Behavior Analysis (ABA) Program Billing Guide.* https://www.hca.wa.gov/assets/billers-and-providers/aba-services-bg-20250201.pdf.

[100] Washington Administrative Code (WAC) § 182-531A (2026). https://app.leg.wa.gov/wac/default.aspx-cite=182-531A.

[101] Huerta, M., & Lord, C. (2012). Diagnostic evaluation of autism spectrum disorders. *Pediatric Clinics of North America, 59*(1), 103–111. https://doi.org/10.1016/j.pcl.2011.10.018.

face an extensive wait to receive a diagnosis, with some families waiting two years between ASD screening and diagnosis.[102] As evaluation and diagnosis are typically required before starting treatment for ASD, this may significantly delay the start of ABA treatment.

Families and providers can face several barriers to seeking and providing timely ASD diagnoses. These include long waitlists, scheduling and transportation challenges, families' negative experiences with health care systems, the use of screening and diagnosis methods that do not account for social behaviors certain children may use to mask their symptoms, and other factors. Additional delays may also be caused by families seeking an ASD diagnosis having to travel long distances to reach a provider. Delays may also be the result of providers and individuals who defraud the system, thereby limiting access to children who rightfully need the services.

CMS understands the barriers to receiving an ASD diagnosis and the delays that might result. This is similar to other conditions that require a diagnosis to receive treatment such as sleep apnea, diabetes, and celiac disease. Best practice is to address the root causes of delays.

Developing an Individualized Treatment Plan

It is critical that an ITP be completed prior to the provision of ABA services to ensure the services are tailored to each child's needs and goals. ITPs, which are typically completed by a behavior analyst,[103,104] should include individual goals to address specific skills, approaches to meet those goals, and appropriate evaluations to measure goal progression to help achieve successful outcomes.[105] In addition, these plans should specify the scope, intensity, staffing, settings, and expected outcomes of the treatment. Figure 6 identifies the key components of an ITP for ABA services.

States should have a process to evaluate the quality of ITPs for ABA services to ensure that the plans do not exhibit a copy-and-paste approach for all children in a practice or all children receiving ABA from a single provider. Figure 6 identifies examples of ITP documentation that states should review to ensure the plans are specific to an individual, and documentation flags that states could use to identify potentially erroneous or improper billing.

[102] Chen, Y. H., Drye, M., Chen, Q., Fecher, M., Liu, G., & Guthrie, W. (2023). Delay from Screening to Diagnosis in Autism Spectrum Disorder: Results from a Large National Health Research Network. *The Journal of Pediatrics, 260*, 113514. https://pmc.ncbi.nlm.nih.gov/articles/PMC10805541/.

[103] CASP (2024). *Applied behavior analysis practice guidelines for the treatment of Autism Spectrum Disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* [Clinical practice guidelines]. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[104] The term "behavior analyst" is used throughout this document to refer to professionals who carry at least a master's degree and who are qualified by education, training, state licensure, and/or national certification to practice behavior analysis independently. This term includes Board Certified Behavior Analysts® (BCBAs®) certified by the Behavior Analyst Certification Board® (BACB®) and those licensed by states as behavior analysts.

[105] Hyman, S. L., Levy, S. E., Myers, S. M., & Council on Children with Disabilities, Section on Developmental and Behavioral Pediatrics. (2020). Identification, Evaluation, and Management of Children With Autism Spectrum Disorder. *Pediatrics, 145*(1), e20193447. https://doi.org/10.1542/peds.2019-3447.

Figure 6: Key Individualized Treatment Plan Content and Flags for Potential Erroneous or Improper Billing[106,107]

Appropriate Treatment Plan Documentation
• Assessment results and a reassessment schedule • Measurable, functionally relevant goals for both the child and the caregiver, with mastery criteria that target core ASD-related deficits; baselines should be established at the initial assessment • Planned treatment activities and hours (defined as direct ABA hours per week, excluding supervision, caregiver training, and other services), as well as any necessary equipment; caregiver training should be documented separately • Anticipated treatment duration (to prevent open-ended authorizations without time-bound goals), as well as a description of a transition plan • A plan to monitor progress and modify goals as needed while avoiding the use of ABA as a custodial, respite, or educational substitute • Updates to the plan should: - Describe the child's response to activities using established outcome measures, not provider-created measures - Identify when a child's goals are completed or when progress stalls, and indicate when a caregiver makes progress in, or has challenges with, meeting goals
Treatment Documentation Flags for Potentially Erroneous or Improper Billing
• Overlapping treatments • Lack of adaptation to personal needs • Excessive service hours and excessive service hours that continue without documented improvement in outcomes • Identical documentation across individuals by provider or clinic • Reevaluations that do not reflect progress or without adjustment to care plan • Participation in group therapy that accounts for more than 10 percent of treatment time • Interventions and goals that are inappropriate for the age of the individual • High staffing ratios without clinical justification (e.g., two ABA providers working with one child at a time) • Lack of parent/caregiver engagement

[106] AHIP. (2026, February). *Recommendations to the Centers for Medicare & Medicaid Services on ABA treatment plans.* [On file with authors.]

[107] Kornack, J., Unumb, D. R., & Williams, A. L. (2023). Preventing insurance denials of applied behavior analysis treatment based on misuse of medically unlikely edits (MUEs). *Behavior Analysis in Practice, 18*(2), 365–373. https://doi.org/10.1007/s40617-023-00877-y.

The ITP supports the provider to:[108]

- Formally manage initial and ongoing authorization of ABA;
- Clearly communicate to states, managed care plans, and caregivers the scope and intensity of ABA that are medically necessary to meet the individual child's needs;
- Monitor alignment between the prescribed, authorized, and delivered hours and compare them with the individual's progress toward measurable goals; and
- Provide progress updates at the end of authorization periods to support continuing or discontinuing ABA.

To avoid conflicts of interest and promote program integrity, those responsible for development of ITPs, referrals for services, and treatment must be cognizant of the self-referral requirements under Stark Law.[109] This law protects individuals from specific financial conflicts of interest that could influence service provision and delivery. It prohibits providers from benefiting from an ownership interest, investment interest, or compensation arrangement that is tied to referrals for services it also provides. Conflict of interest requirements are found in other Medicaid service agreements and authorities and are not unique to ABA. While Stark Law imposes separation of specific financial interests, it does not impose a structural separation requirement beyond those conflicts. Entities are not prohibited from furnishing both diagnostic and treatment services, which can be helpful in avoiding a delay in diagnosis or reducing access, particularly in regions where few independent diagnostic providers are available.

State Consideration

States should require that treatment plans accompany ABA reauthorization requests to document measurable progress, identify any plan modifications, and describe caregiver training, engagement, and expectations, including substantive participation and time standards, to assist states in determining the medical necessity of continued treatment.

For children in foster care, treatment plans should not lapse when a placement change occurs. Providers and states should ensure that planning for placement transitions is incorporated into the ITP itself, preserving continuity of care across settings.

Person-Centered Planning

Stakeholders noted that ABA authorized under the section 1905(a) Medicaid state plan benefits lack an explicit person-centered planning requirement, unlike Home and Community-Based Services (HCBS) authorities found in section 1915 of the Act, in which person-centered planning is foundational. The absence of a person-centered planning requirement in state plan ABA has contributed to standardized authorization patterns (for example, a default number of treatment hours) rather than tailoring intensity and modality to the individual's functional needs, caregiver

[108] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines]. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[109] 42 C.F.R. § 411.350 – 411.389.

context, and goals. CMS affirms the critical nature of ITPs and assessments in the provision of care to children under EPSDT, even in the absence of direct statutory or regulatory requirements. States can address this by applying person-centered planning elements from their HCBS authorities to the provision of ABA. This approach includes requiring an ITP for ABA to thoroughly document assessed needs, caregiver goals and support needs, and specify titration and step-down. Best practice is for states to describe in their state plan how they require an ITP for children receiving ABA.

Federal regulations on person-centered planning[110] include the following elements that can facilitate an individualized treatment approach to ABA:

- Documents services and supports that meet the child's needs and reflect the child's and caregiver's preferences for how services are delivered; and
- Specifies review timelines that allow for regular updates to reflect changes in need, goals, or preferences.

See Chapter 5 for information related to provider qualifications required for treatment plan development.

Frequency and Intensity of Applied Behavior Analysis Services

The scope of an ITP takes into consideration the individual's unique needs, goals, and the severity of their ASD. This collaborative process involves close coordination among the care team to ensure the treatment plan is appropriate. Plans vary in approach based on the age and severity of the individual's ASD, from structured and adult-led to naturally integrated and child-led. Additionally, plans vary in the number of hours per week of treatment, the number of new skills being developed, and the targeted ASD behaviors.

Individualized Treatment Plans

For successful outcomes, timelines for achieving goals in an ITP will be different for each individual with ASD. ABA is not a standardized treatment; instead, it is highly individualized.

The appropriate intensity of ABA, measured in hours per week, varies depending on the individual's needs. The number can range from as little as five hours per week for lower-intensity interventions to as much as 40 hours per week for higher-intensity interventions. Forty hours of ABA per week is not a best practice because it places states and managed care plans at risk of negative audit findings or other financial review penalties because children must be allowed time for activities of daily living such as toileting, napping, and eating, among others. Best practice is that states set a policy that prohibits more than a specified number of consecutive units to be delivered without a break. States and managed care plans should also consider not allowing consolidated billing, whereby all 15-minute units are billed under one claim line, because this does not allow providers to demonstrate that they stopped ABA to allow children to engage in non-therapy activities. While it is understood that ABA therapy may focus

[110] Regulatory definitions for person-centered plans may be found at 42 C.F.R. § 441.301(c)(2) for Section 1915(c) HCBS waivers and at 42 C.F.R. § 441.725 for Section 1915(i) state plan HCBS, for example.

on activities such as food selectivity or enuresis (the inability to control urination), providers and clinics should have written policies that address activities of daily living, and states and managed care plans should make recommendations on the number of consecutive 15-minute units that can be delivered before children need to address activities of daily living.

Currently, there are no metrics established or endorsed by organizations involved in ABA for what is considered a low- or high-level intensity intervention. Additionally, there is no consensus on a set number of hours recommended for treatment. To formulate appropriate frequency and intensity of an intervention, providers consider the patient's level of ASD severity, which the DSM-5-TR defines using three levels from least (Level 1) to most (Level 3) severe,[111] along with other factors as described elsewhere in this chapter. Best practice is that the number of hours detailed in the ITP be aligned with these levels; for example, 10, 20, and 30 hours for children in levels 1, 2, and 3, respectively.

Intervention intensity and frequency are not correlated with improvement in outcomes, in that high levels do not equate to better outcomes compared to lower levels. Figure 7 describes the findings across various studies on associations between hours per week in ABA and ASD outcomes, with some studies finding a positive association while others found no association.

[111] APA. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.) [DSM-5-TR]. APA Publishing. https://doi.org/10.1176/appi.books.9780890425787.

Figure 7: Research Findings on the Association Between Hours per Week of Applied Behavior Analysis Services and Goal Outcomes

Positive Association Between Intensity and Outcomes	No Association Between Intensity and Outcomes
Two meta-analyses indicate that the intensity of early intensive behavioral interventions (i.e., the number of ABA service hours per week) is positively associated with greater outcome improvements These included interventions where intensity was grouped into either: Two levels[112] ○ Low Intensity = less than 20 hours/week ○ High Intensity = 20-40 hours/week Three levels:[113] ○ Low Intensity = 5–12 hours/week ○ Moderate Intensity = 13–25 hours/week ○ High Intensity = 26–40 hours/week	Two meta-analyses of comprehensive ABA-based interventions found no differences in outcomes when looking at two levels of intensity: [114,115] • Low Intensity = less than 20 hours/week • High Intensity = 20 hours/week or more

Services at higher intensity levels should not be authorized by default and should only be authorized based on the ITP's documentation of needs and goals that warrant extensive treatment. These high-intensity weekly treatment schedules leave virtually no time for non-treatment activities like schooling and family time and can easily take on the characteristics of respite care and childcare.

[112] Han, D. G., Lee, Y., Kim, H. S., Suh, H. W., Lee, J., Shin, S. H., Yang, M., Choi, H., Kim, T. H., Kang, J. G., Ko, E., Lee, J., & Park, M. H. (2025). Effectiveness and experiences of early intensive behavioral and naturalistic developmental behavior interventions for autism spectrum disorders: a mixed-methods systematic review and meta-analysis. *Child and Adolescent Psychiatry and Mental Health*, *20*(1), 14. https://doi.org/10.1186/s13034-025-00997-z.

[113] Eldevik, S., Strømgren, B., Eikeseth, S., Fields, A., Goetz, C. M., & Titlestad, K. B. (2026). Clinically Significant Outcomes of Early Intensive Behavioral Intervention for Children With Autism Spectrum Disorders: An Individual Participant Data Meta-Analysis. *Autism Research, 19*(1), e70169. https://doi.org/10.1002/aur.70169.

[114] Eckes, T., Buhlmann, U., Holling, H. D., & Möllmann, A. (2023). Comprehensive ABA-based interventions in the treatment of children with autism spectrum disorder - a meta-analysis. *BMC Psychiatry, 23*(1), 133. https://doi.org/10.1186/s12888-022-04412-1.

[115] Sandbank, M., Pustejovsky, J. E., Bottema-Beutel, K., Caldwell, N., Feldman, J. I., Crowley LaPoint, S., & Woynaroski, T. (2024). Determining Associations Between Intervention Amount and Outcomes for Young Autistic Children: A Meta-Analysis. *JAMA Pediatrics*, *178*(8), 763–773. https://doi.org/10.1001/jamapediatrics.2024.1832.

STATE SPOTLIGHT: Review of High-Intensity Plans

In 2026, North Carolina passed legislation that requires the state Medicaid agency to review plans with higher levels of intensity.[116] Specifically, individual service plans for ABA that include more than 16 hours of service per week must be approved by the U.S. Department of Health and Human Services (HHS) or the managed care plan. These service plans also must be updated and reapproved every three months.[117]

BEST PRACTICE

Determining Service Intensity

Research demonstrates the importance of an individualized approach to determining intensity, as there is evidence that a higher number of treatment hours does not necessarily lead to better outcomes.[118,119,120,] Thus, providers working with families must consider the individual's age, ASD symptoms and severity, needs, tolerance, and response to treatment when determining treatment intensity.

Appropriate utilization management policies can help states review whether requested service hours are medically necessary, individualized, and supported by clinical documentation. See Chapter 6 for additional discussion of utilization management.

As shown in Figure 8a, Medicaid and CHIP beneficiaries receiving ABA for ASD averaged 17.33 hours of weekly ABA treatment in 2025. This reflects a 22 percent increase in hours per week since 2021. Figure 8b shows the increase in the number of providers who billed for ABA services and the number of providers who rendered ABA services during that same time period.

[116] North Carolina General Assembly. (2025). House Bill 2025-696. https://www.ncleg.gov/sessions/2025/bills/house/pdf/h696v4.pdf.

[117] North Carolina General Assembly. (2025). Senate Bill 2026-41. https://www.ncleg.gov/Sessions/2025/Bills/Senate/PDF/S257v8.pdf.

[118] Han, D. G., Lee, Y., Kim, H. S., Suh, H. W., Lee, J., Shin, S. H., Yang, M., Choi, H., Kim, T. H., Kang, J. G., Ko, E., Lee, J., & Park, M. H. (2025). Effectiveness and experiences of early intensive behavioral and naturalistic developmental behavior interventions for autism spectrum disorders: a mixed-methods systematic review and meta-analysis. *Child and Adolescent Psychiatry and Mental Health*, *20*(1), 14. https://doi.org/10.1186/s13034-025-00997-z.

[119] Eckes, T., Buhlmann, U., Holling, H. D., & Möllmann, A. (2023). Comprehensive ABA-based interventions in the treatment of children with autism spectrum disorder - a meta-analysis. *BMC Psychiatry, 23*(1), 133. https://doi.org/10.1186/s12888-022-04412-1.

[120] Sandbank, M., Pustejovsky, J. E., Bottema-Beutel, K., Caldwell, N., Feldman, J. I., Crowley LaPoint, S., & Woynaroski, T. (2024). Determining Associations Between Intervention Amount and Outcomes for Young Autistic Children: A Meta-Analysis. *JAMA Pediatrics*, *178*(8), 763–773. https://doi.org/10.1001/jamapediatrics.2024.1832.

Figure 8a: Average Number of Applied Behavior Analysis Service Hours Per Beneficiary With a Diagnosis of Autism Spectrum Disorder Per Week, 2021–2025

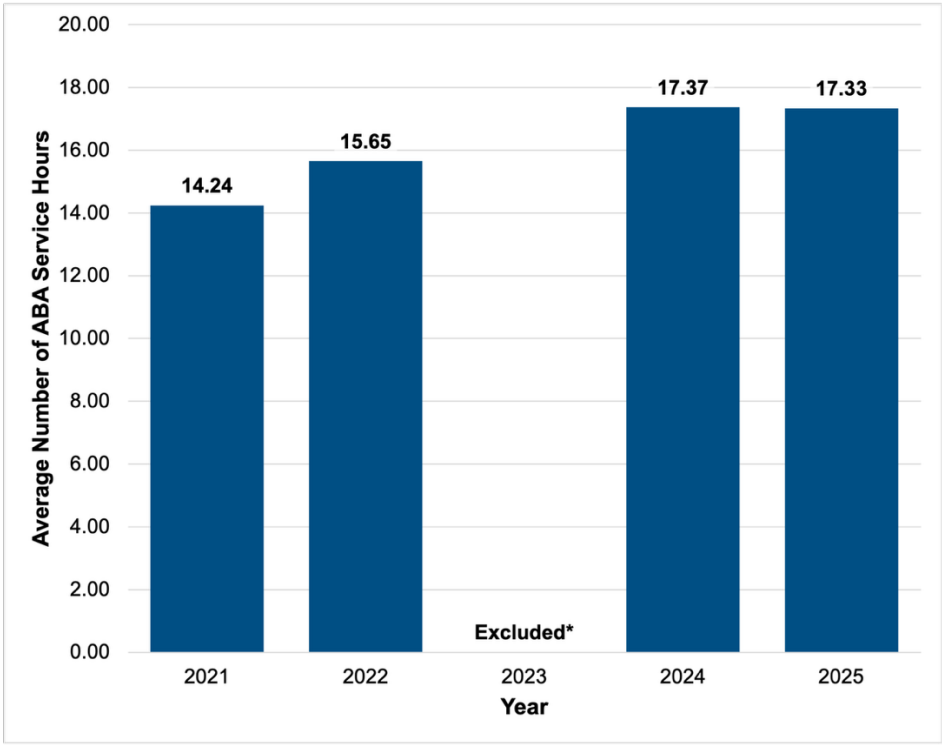
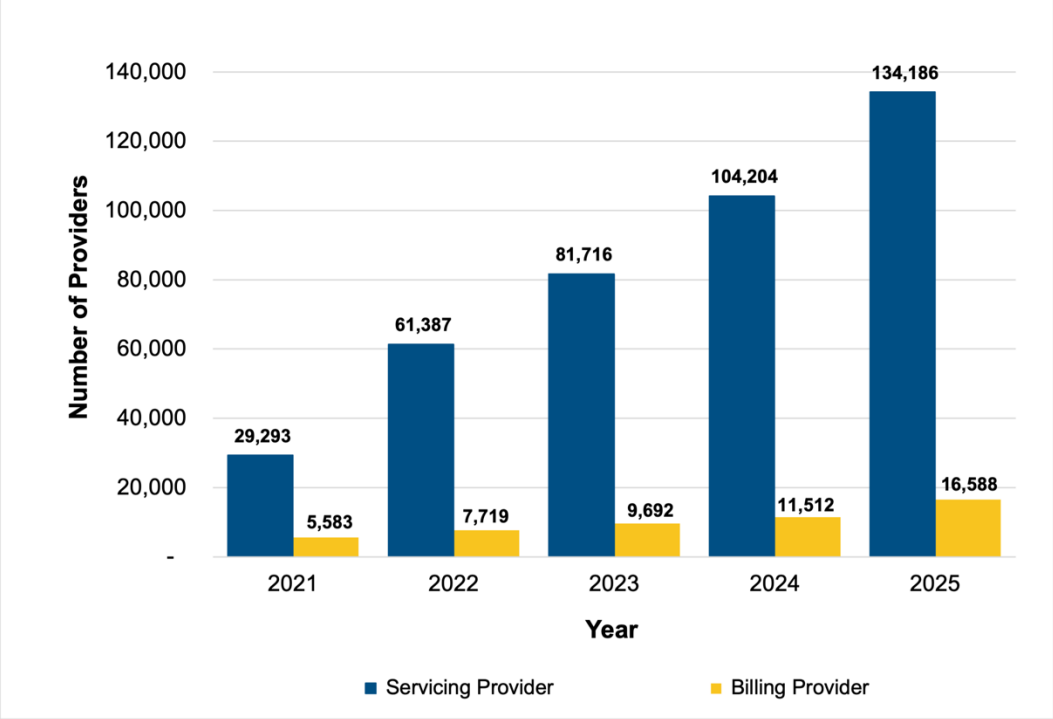


Figure 8b: Number of Providers Who Rendered Applied Behavior Analysis Services and Providers Who Billed for Applied Behavior Analysis Services, 2021–2025



Source: T-MSIS OT claims and associated eligibility data, 2021-2025 for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam. Analysis included all ABA Current Procedural Terminology (CPT) codes 97151–97158 for beneficiaries with a diagnosis code of F84.0; F84.5; F84.8; F84.9 (ASD) across Medicaid and CHIP FFS claims and managed care encounters from 2021–2025. Hours were constructed using units (15-minute increments) allowed. In 2023, the highest billing provider in the country had anomalous allowed service quantity amounts for managed care encounters, sometimes amounting to 3,300 units, or 825 hours, per encounter. There was no corresponding spike in costs, suggesting this was a data quality issue. However, this outlier had a significant impact on the average per beneficiary per week calculation for the entire year. As such, 2023 was excluded from Figure 8a. All other years were in a normal range. Results are intended for analytic use.

Re-evaluating the Individualized Treatment Plan and Assessing Outcome Measurements for Applied Behavior Analysis Services

After ABA treatment has started, the ITP should be re-evaluated and updated based on outcome assessments. Reevaluations may include ABA outcome measurements of ongoing activities, skills assessments, or treatments.[121] Clinical guidance is lacking about which evaluations should be completed or how often ITP reevaluations should occur;[122] however, as described by stakeholders and sources regarding specific states' Medicaid coverage for ABA, states should require specific time points for ITP re-evaluation for the individual to retain ABA coverage.

ITP reevaluations provide a key opportunity to review the child's treatment plan and determine whether updates are needed. There are several reasons why a treatment plan may need to be updated, such as to:

- Adapt the scope and intensity of treatment to adjust to the progress being made, or
- Allow for the tapering of services in preparation for discharge from the program, including increased caregiver participation and training to support maintenance and generalization of skills as formal treatment decreases.

Additional ITP reevaluations should be completed if the treatment plan stalls, the maximum number of hours per week is being suggested but the severity is not aligned with that suggestion, or a beneficiary's medical condition changes. ITPs must be evaluated for individual-specific documentation, goals, timelines, and recommendations.[123] Please see Chapter 6 for additional information on reevaluations, documentation, and utilization management.

[121] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines], 51-59. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[122] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines], 53. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[123] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines], 51-58. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

Evidence-Based Outcome Assessments for Applied Behavior Analysis Services

ABA providers complete various assessments to establish a baseline of skills and behaviors, measure response to ABA treatment, and monitor progress toward goals. Observable outcomes may include improvements in adaptive behaviors and cognitive functioning using instruments such as those in Table 4.[124] Key indicators used to assess ABA-derived improvements in ASD symptoms include minimized aggression, improved social engagement, and gain of functional skills (e.g., communication, self-care, play, and academic skills). Best practice is that states require the use of at least one standardized outcome assessment instrument from the list below. States should not allow for provider-created outcome measures.

Table 4: Examples of Individual Outcome Assessment Instruments for Applied Behavior Analysis Services

Instrument Name	Description	Appropriate Age Range
Assessment of Basic Language and Learning Skills-Revised (ABLLS-R)[125]	To identify motor, language, academic, and self-help skills to inform development and monitoring of individual interventions to improve skills	Age 0-12 years
Assessment of Functional Living Skills[126]	To support independence among individuals with ASD or developmental delays via evaluation, tracking, and teaching of skills (adaptive, functional, self-help)	Age 2 years and older
Essential for Living[127]	To improve quality of life by assessing functional life skills	Children and adults
PEAK Relational Training System Comprehensive Assessment[128]	To assess language, learning, and cognitive skills to inform ABA	Age 2 years and older
Verbal Behavior Milestones Assessment and Placement Program[129]	To assess current verbal behavior skill levels, guide curriculum and goal development to acquire/improve skills, and evaluate progress in meeting typical developmental milestones during treatment	Age 0-48 months

[124] CASP. (2025). *Evidence About ABA Treatment for Young Children with Autism: The Impact of Treatment Intensity on Outcomes*, 6-7, 14, 21, 26. https://assets-002.noviams.com/novi-file-uploads/casp/pdfs-and-documents/evidenceaboutabatreatment.pdf.

[125] Partington, J. W. (2006). *(ABLLS-R) Assessment of Basic Language and Learning Skills, Revised.* Western Psychological Services. https://www.wpspublish.com/ablls-r-assessment-of-basic-language-and-learning-skills-revised.html.

[126] Partington, J. W. & Mueller, M. M. (2012). *The Assessment of functional living skills (The AFLS)* (Version 1.1.). Behavior Analysts, Inc. https://www.wpspublish.com/afls-assessment-of-functional-living-skills.

[127] Essential for Living. (n.d.). [Homepage]. Retrieved July 28, 2026, from https://essentialforliving.com.

[128] Dixon, M. R. (2019). *PEAK Comprehensive Assessment.* Shawnee Scientific Press. https://www.peak2aba.com/copy-of-about.

[129] Sundberg, M.L. (2008). *Verbal Behavior Milestones Assessment and Placement Program.* AVB Press. https://avbpress.com.

ABA outcome evaluations are distinct from an ASD diagnostic evaluation, as the purpose and scope of each type of evaluation are different. ABA outcome evaluations are conducted using tools designed to assess progress towards goals, whereas ASD diagnostic evaluations are conducted using tools designed to diagnose ASD or mental health disorders.

While there are no ABA-specific quality measurements for ABA, there are quality evaluations integrated within requirements for ABA organizations to obtain Autism Commission on Quality (ACQ) accreditation, formerly Behavioral Health Center of Excellence Accreditation®.[130]

[130] ACQ. (n.d.). *ACQ Applied Behavior Analysis Accreditation Program Standards and Guide* (Version 1.0). Retrieved July 29, 2026, from https://autismcommission.org/standards/.

Consideration of an Autism Spectrum Disorder Diagnosis That Co-Occurs with Medical and Behavioral Health Conditions

Many individuals diagnosed with ASD experience co-occurring medical and behavioral health diseases, disorders, and conditions, including but not limited to intellectual disabilities, seizure disorders, psychiatric and psychological disorders, mobility difficulties, sensory impairments, chromosomal abnormalities, feeding disorders, sleep disorders, digestive and elimination disorders, autoimmune disorders, metabolic disorders, challenging behaviors (e.g., self-injury, property destruction, wandering), and a variety of other diseases and conditions that require additional medical or behavioral health treatment.[131,132,133,134,135,136,137,138,139,140,141,142,143,144,145,146,147,148,149,150,151,152,153,154,155,156,157,158,159,160]

Diagnosis and treatment of diseases, conditions, and disorders should be conducted independently of the ASD diagnosis and should follow clinical guidelines and EPSDT

[131] Liu, X., Sun, X., Sun, C., Zou, M., Luo, I., & Xia, W. (2022). Prevalence of epilepsy in autism spectrum disorders: A systematic review and meta-analysis. *Autism, 26*(1), 33–50. https://doi.org/10.1177/13623613211045029.

[132] Wang J, Ma B, Wang J, Zhang Z, Chen O. (2022). Global prevalence of autism spectrum disorder and its gastrointestinal symptoms: A systematic review and meta-analysis. *Frontiers in Psychiatry, 13*, Article 963049. https://doi.org/10.3389/fpsyt.2022.963102.

[133] Erbescu, A., Papuc, S. M., Budisteanu, M., Arghir, A., & Neagu, M. (2022). Re-emerging concepts of immune dysregulation in autism spectrum disorders. *Frontiers in Psychiatry*, *13*, Article 1006612. https://doi.org/10.3389/fpsyt.2022.1006612.

[134] Green, S. A., Hernandez, L., Tottenham, N., Krasileva, K., Bookheimer, S. Y., & Dapretto, M. (2015). Neurobiology of sensory overresponsivity in youth with autism spectrum disorders. *JAMA Psychiatry*, *72*(8), 778–786. https://doi.org/10.1001/jamapsychiatry.2015.0737.

[135] Bäckström, A., Johansson, A. M., Rudolfsson, T., Rönnqvist, L., & Domellöf, E. (2025). Atypical development of sequential manual motor planning and visuomotor integration in children with autism at early school-age: A longitudinal kinematic study. *Autism, 29*(6), 1530–1545. https://doi.org/10.1177/13623613241311333.

[136] Kangarani-Farahani, M., Malik, M. A., & Zwicker, J. G. (2024). Motor impairments in children with autism spectrum disorder: A systematic review and meta-analysis. *Journal of Autism and Developmental Disorders, 54*(5), 1738–1761. https://doi.org/10.1007/s10803-023-05948-1.

[137] Mody, M., Shui, A. M., Nowinski, L. A., Golas, S. B., David, M. M., & McDougle, C. J. (2017). Communication deficits and the motor system: Exploring patterns of associations in autism spectrum disorder (ASD). *Journal of Autism and Developmental Disorders*, *47*(1), 155–169. https://doi.org/10.1007/s10803-016-2934-y.

[138] Travers, B. G., Lee, L., Klans, N., Ausderau, K. K., Skaletski, E. C., Mason, A., & Taylor, C. R. (2022). Associations among daily living skills, motor, and sensory difficulties in autistic and nonautistic children. *American Journal of Occupational Therapy*, *76*(2), Article 7602205020. https://doi.org/10.5014/ajot.2022.045955.

[139] Hung, L. Y., & Margolis, K. G. (2024). Autism spectrum disorders and the gastrointestinal tract: Insights into mechanisms and clinical relevance. *Nature Reviews Gastroenterology & Hepatology, 21*(3), 142–163. https://doi.org/10.1038/s41575-023-00857-1.

[140] Al-Beltagi, M. (2021). Autism medical comorbidities. *World Journal of Clinical Pediatrics, 10*(3), 15–28. https://doi.org/10.5409/wjcp.v10.i3.15.

[141] Zarakoviti, E., Shafran, R., Skuse, D., McTague, A., Batura, N., Palmer, T., Dalrymple, E., Bennett, S. D., & Reilly, C. (2023). Factors associated with the occurrence of epilepsy in autism: A systematic review. *Journal of Autism and Developmental Disorders, 53*(10), 3873–3890. https://doi.org/10.1007/s10803-022-05672-2.

[142] Hirota, T., & King, B. H. (2023). Autism spectrum disorder: A review. *JAMA, 329(2), 157*–168. https://doi.org/10.1001/jama.2022.23661.

[143] Interagency Autism Coordinating Committee. (2017, October). *2016–2017 Interagency Autism Coordinating Committee strategic plan for autism spectrum disorder. HHS.* https://iacc.hhs.gov/publications/strategic-plan/2017/strategic_plan_2017.pdf.

requirements. Medically necessary 1905(a) services that correct or ameliorate a condition should be provided for any disease, disorder, or condition that arises. Because an individual has ASD does not mean that ASD is the cause of other medical and behavioral health conditions. Additionally, if needed for the diagnosed type of disease, condition, or disorder, follow-up services should be provided.

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[144] McElhanon, B. O., McCracken, C., Karpen, S., & Sharp, W. G. (2014). Gastrointestinal symptoms in autism spectrum disorder: A meta-analysis. *Pediatrics, 133*(5), 872–883. https://doi.org/10.1542/peds.2013-3995.

[145] Wang, J., Ma, B., Wang, J., Zhang, Z., & Chen, O. (2022). Global prevalence of autism spectrum disorder and its gastrointestinal symptoms: A systematic review and meta-analysis. *Frontiers in Psychiatry, 13*, 963102. https://doi.org/10.3389/fpsyt.2022.963102.

[146] Lukmanji, S., Manji, S. A., Kadhim, S., Sauro, K. M., Wirrell, E. C., Kwon, C. S., & Jetté, N. (2019). The co-occurrence of epilepsy and autism: A systematic review. *Epilepsy & Behavior, 98*(Pt A), 238–248. https://doi.org/10.1016/j.yebeh.2019.07.037.

[147] Estes, M. L., & McAllister, A. K. (2015). Immune mediators in the brain and peripheral tissues in autism spectrum disorder. *Nature Reviews: Neuroscience, 16*(8), 469–486. https://doi.org/10.1038/nrn3978.

[148] Erbescu, A., Papuc, S. M., Budisteanu, M., Arghir, A., & Neagu, M. (2022). Re-emerging concepts of immune dysregulation in autism spectrum disorders. *Frontiers in Psychiatry, 13*, 1006612. https://doi.org/10.3389/fpsyt.2022.1006612.

[149] Dziuk, M. A., Gidley Larson, J. C., Apostu, A., Mahone, E. M., Denckla, M. B., & Mostofsky, S. H. (2007). Dyspraxia in autism: association with motor, social, and communicative deficits. *Developmental Medicine and Child Neurology, 49(*10), 734–739. https://doi.org/10.1111/j.1469-8749.2007.00734.x.

[150] Kaur, M., M Srinivasan, S., & N Bhat, A. (2018). Comparing motor performance, praxis, coordination, and interpersonal synchrony between children with and without Autism Spectrum Disorder (ASD). *Research in Developmental Disabilities, 72*, 79–95. https://doi.org/10.1016/j.ridd.2017.10.025.

[151] Kangarani-Farahani, M., Malik, M. A., & Zwicker, J. G. (2024). Motor Impairments in Children with Autism Spectrum Disorder: A Systematic Review and Meta-analysis. *Journal of Autism and Developmental Disorders, 54*(5), 1977–1997. https://doi.org/10.1007/s10803-023-05948-1.

[152] da Silva, S. H., Felippin, M. R., de Oliveira Medeiros, L., Hedin-Pereira, C., & Nogueira-Campos, A. A. (2025). A scoping review of the motor impairments in autism spectrum disorder. *Neuroscience and Biobehavioral Reviews, 169*, 106002. https://doi.org/10.1016/j.neubiorev.2025.106002.

[153] Bäckström, A., Johansson, A. M., Rudolfsson, T., Rönnqvist, L., von Hofsten, C., Rosander, K., & Domellöf, E. (2025). Atypical development of sequential manual motor planning and visuomotor integration in children with autism at early school-age: A longitudinal kinematic study. *Autism, 29*(6), 1510–1523. https://doi.org/10.1177/13623613241311333.

[154] Miller, M., Chukoskie, L., Zinni, M., Townsend, J., & Trauner, D. (2014). Dyspraxia, motor function and visual-motor integration in autism. *Behavioural Brain Research*, *269*, 95–102. https://doi.org/10.1016/j.bbr.2014.04.011.

[155] Bhat, A. N., Boulton, A. J., & Tulsky, D. S. (2022). A further study of relations between motor impairment and social communication, cognitive, language, functional impairments, and repetitive behavior severity in children with ASD using the SPARK study dataset. *Autism Research, 15*(6), 1156–1178. https://doi.org/10.1002/aur.2711.

[156] Mody, M., Shui, A. M., Nowinski, L. A., Golas, S. B., Ferrone, C., O'Rourke, J. A., & McDougle, C. J. (2017). Communication Deficits and the Motor System: Exploring Patterns of Associations in Autism Spectrum Disorder (ASD). *Journal of Autism and Developmental Disorders, 47*(1), 155–162. https://doi.org/10.1007/s10803-016-2934-y.

[157] Travers, B. G., Lee, L., Klans, N., Engeldinger, A., Taylor, D., Ausderau, K., Skaletski, E. C., & Brown, J. (2022). Associations Among Daily Living Skills, Motor, and Sensory Difficulties in Autistic and Nonautistic Children. *The American Journal of Occupational Therapy, 76*(2), 7602205020. https://doi.org/10.5014/ajot.2022.045955.

[158] Pokoski, O. M., Furnier, S. M., Gangnon, R. E., Howerton, E. M., Kirby, A. V., Protho, T., Schweizer, M. L., Travers, B. G., & Durkin, M. S. (2025). Prevalence of Motor Milestone Delays in Autistic Children. *JAMA Pediatrics, 179*(7), 756–764. Advance online publication. https://doi.org/10.1001/jamapediatrics.2025.0216.

[159] Hannant, P., Tavassoli, T., & Cassidy, S. (2016). The Role of Sensorimotor Difficulties in Autism Spectrum Conditions. *Frontiers in Neurology, 7*, 124. https://doi.org/10.3389/fneur.2016.00124.

[160] Lord, C., Elsabbagh, M., Baird, G., & Veenstra-Vanderweele, J. (2018). Autism spectrum disorder. *Lancet, 392*(10146), 508–520. https://doi.org/10.1016/S0140-6736(18)31129-2.

Research has established ABA as an effective treatment modality for individuals diagnosed with ASD with these co-occurring conditions, and utilization management should align. The presence of co-occurring conditions is not a valid reason to deny or limit access to ABA or other services for the treatment of ASD, nor should an ASD diagnosis result in coverage limitations relating to the co-occurring conditions. Consistent with the Interagency Autism Coordinating Committee's (IACC's) recent focus on co-occurring conditions in ASD, states should recognize that assessment, care planning, and service delivery may need to be adapted to address co-occurring needs that affect clinical presentation, family burden, and treatment outcomes.[161,162] An ASD diagnosis by a qualified medical professional such as a developmental pediatrician, pediatric neurologist, child psychologist, or psychiatrist should not be presumed to explain all medical or behavioral health needs, and clinically appropriate follow-up services should be provided when indicated.

Applied Behavior Analysis Staffing and Service Settings

Staffing

ABA can be administered by various provider types, including RBTs, BCaBAs, BCBAs, and Board Certified Behavior Analyst-Doctoral (BCBA-D) providers.[163] Basic information on the variation in these providers' levels of education, supervision, and certification requirements is described in Figure 9. For more detailed information about these providers, including supervision requirements, see Chapter 5.

[161] Cellini, L. (2026, April 28). *Interagency Autism Coordinating Committee (IACC) Full Committee Meeting* [Online presentation]. HHS, IACC, 37-51. https://iacc.hhs.gov/meetings/iacc-meetings/2026/full-committee-meeting/april/April-2026-IACC-Meeting-Slides-Final.pdf.

[162] Daniels, S. A. (2024, September 23). *2024 Interagency Autism Coordinating Committee Strategic Plan Update Discussion* [Online presentation]. HHS, IACC, 7-21. https://iacc.hhs.gov/meetings/iacc-meetings/2024/strategic-plan-update/september23/slides.pdf.

[163] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines], 6-9. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

Figure 9: Applied Behavior Analysis Provider Types[164]

Board Certified Behavior Analyst-Doctoral (BCBA-D)	**Doctoral degree in behavior analysis or related field** Same certification requirements as a BCBA
Board Certified Behavior Analyst (BCBA)	**Graduate-level professional** Able to practice independently and provide supervision
Board Certified Assistant Behavior Analyst (BCaBA)	**Undergraduate-level professional** Practices under the supervision of a BCBA
Registered Behavior Technician (RBT)	**High school level technician** Practices under the close, ongoing supervision of a BCBA or BCaBA

ABA is typically provided via a 1:1 individual-to-RBT ratio, and then gradually introduces small-group involvement when appropriate. Small-group activities are often conducted specifically for the improvement of social skills.[165]

Treatment Settings

ABA can be offered in a variety of settings. The most common settings where ABA is offered are those where health practitioners are based, often called clinics or centers. Stakeholders described the most effective clinical setting as one where spaces are set aside for individuals, with specific areas for group sessions, and separate locations for individuals who may escalate to harming themselves or others, or who present with distracting behaviors.

There are also benefits to offering treatment in naturalistic settings such as the home, school, and community. Stakeholders referred to the advantages of supporting individuals in settings outside of the clinic, particularly as individuals prepare to transition to discharge. When services are delivered in settings that are not clinics or centers, states should consider how this will impact the quality of supervision and how much supervision should be allowed virtually.

[164] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines], 6-9. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[165] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines], 31-32. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

School-Based Settings

When ABA is delivered in a school-based setting, states must ensure that coverage and prior authorization policies clearly describe when school-based ABA may be billed to Medicaid and how it will be coordinated with services funded by the education system. Under current Medicaid policy, schools may bill for covered services furnished to Medicaid-enrolled students, including students without an Individualized Education Program (IEP), when all Medicaid requirements are met. States vary in how they structure school-based ABA, but many emphasize coordination between Medicaid and local education agencies to avoid duplicative billing and to support continuity across school and non-school-based settings. Schools must also meet the requirement of having qualified providers delivering ABA.

The presence of a service in an IEP or 504 plan does not automatically make that service medically necessary for Medicaid purposes, and states may determine that some educational services do not meet Medicaid medical necessity criteria. Conversely, there may be circumstances where medically necessary ABA in a school-based setting is appropriate for Medicaid coverage, even when the service is not specified in an IEP, provided all other Medicaid program requirements are met.

Parent and Caregiver Involvement

Parent and caregiver involvement is a critical component of successful ABA. Some stakeholders mentioned a requirement of four hours per week to be effective. It is an essential part of effective ASD diagnosis, as described earlier in the chapter, because caregivers provide the most complete developmental and behavioral history and can describe concerns, routines, triggers, adaptive skills, and how behaviors look across home, school, and community settings. Caregiver involvement is also key to ABA treatment planning and outcome evaluation, such as involvement in treatment plan development, goal setting, outcome assessments, and regular communication with the ABA team to update the treatment plan.[166] Studies indicate that parent-involved or -mediated ASD interventions, including ABA among other approaches, have several benefits, such as improvements in disruptive behavior and parent-child interactions; however, many of these studies have limitations that impact the ability to interpret and apply the study findings.[167,168]

Caregiver input helps establish which skills are most impaired, which behaviors are interfering with the desired quality of life, and which goals matter most to the child and caregiver. Some programs also rely on caregiver interviews and observation to help confirm functional needs and to inform whether ABA is appropriate and what intensity is reasonable.

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[166] Ferretti, L. A., Uhl, A., Zawacki, J., & McCallion, P. (2025). Understanding barriers and facilitators of parent/caregiver involvement in home-based applied behavioral analysis programming for their autistic child. *Children*, *12*(7), 850. https://doi.org/10.3390/children12070850.

[167] Conrad, C. E., Rimestad, M. L., Rohde, J. F., Petersen, B. H., Korfitsen, C. B., Tarp, S., Cantio, C., Lauritsen, M. B., & Händel, M. N. (2021). Parent-Mediated Interventions for Children and Adolescents With Autism Spectrum Disorders: A Systematic Review and Meta-Analysis. *Frontiers in Psychiatry, 12*, 773604. https://doi.org/10.3389/fpsyt.2021.773604.

[168] Oono, I. P., Honey, E. J., & McConachie, H. (2013). Parent-mediated early intervention for young children with autism spectrum disorders (ASD). *The Cochrane Database of Systematic Reviews, 2013*(4), CD009774. https://doi.org/10.1002/14651858.CD009774.pub2.

ABA can be co-implemented by parents and caregivers, which requires that clinical teams teach, model, and evaluate parent and caregiver skill proficiency. However, caregiver training requirements are not currently standardized, and the quality of training can be inadequate.[169] State requirements regarding parent and caregiver training and involvement vary, with some states setting hourly minimums and others requiring minimum frequencies.[170,171,172] States could consider requiring a provider to submit additional documentation on the need for ABA services at the same level if the percentage of sessions completed by the parent or caregiver falls below a certain percentage.

STATE SPOTLIGHT: Caregiver Involvement

Texas considers that effective ABA services would typically include parent or caregiver participation for behaviors to improve, but the state does make exceptions on a case-by-case basis for their involvement.[173] When parents or caregivers are involved, individualized ABA treatment plans are expected to account for family circumstances and must include parent or caregiver training as a separate component from the direct ABA services. It is a best practice for plans to include specific goals on the parent or caregiver's training and to require documentation of their progress on these goals.

State agencies and managed care plans should explicitly address foster care contexts within their caregiver training policies, including flexible participation modalities such as telehealth coaching and brief sessions conducted at drop-off or pick-up, and should extend participation requirements to encompass foster parents, kinship caregivers, and, where appropriate, school or residential placement staff. Authorization requirements that incorporate caregiver training hours into how ABA coverage is continued should be designed with sufficient flexibility to account for the realities of foster placement, where caregiver availability and continuity may be outside the child's or provider's control.

Mitigating Parent and Caregiver Burden

Parents and caregivers must devote time to implementing interventions at home, travel to and from clinics on a frequent basis, and experience challenges reaching and speaking with ABA

[169] Straiton, D., Groom, B., & Ingersoll, B. (2021). Parent training for youth with autism served in community settings: A mixed-methods investigation within a community mental health system. *Journal of Autism and Developmental Disorders*, *51*(6), 1983–1994. https://doi.org/10.1007/s10803-020-04679-x.

[170] Nebraska Department of Health and Human Services. (2025). *Provider bulletin 25-02: Applied behavior analysis*, 5. https://dhhs.ne.gov/Documents/PB2025-02-Applied-Behavior-Analysis.pdf.

[171] Indiana Family and Social Services Administration. (2026). *BT202662: Applied behavior analysis services updates*, 4. https://www.in.gov/medicaid/providers/files/bulletins/BT202662.pdf.

[172] Virginia Department of Medical Assistance Services. (2025). *Mental Health Services Provider Manual, Appendix D: Intensive Community Based Support – Youth (Applied Behavior Analysis)*, 23. MHS - Appendix D (updated 7.17.25)_Final.pdf.

[173] Texas Medicaid & Healthcare Partnership. (2026, June). *Texas Medicaid Provider Procedures Manual: Volume 2: Provider handbooks: Children's Services Handbook*. https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/pdf-chapters/2026/2026-06-june/2_04_childrens_services.pdf.

providers and accessing support services.[174,175,176] Yet parents and caregivers also have reported that taking a family-wide approach to treatment and training, improving communication with ABA providers, and having services available at home can facilitate their engagement in ABA.[175] Stakeholders reported that brief, structured check-ins (typically 15 to 20 minutes) or speaking to parents and caregivers around the visit drop-off or pick-up can help ABA providers reinforce treatment plans, address concerns, provide training, and share actionable guidance without imposing excessive demands on families. Research also suggests that digital solutions, such as telehealth coaching or self-paced computer courses, as well as engaging the whole family in the intervention process, can reduce burden related to caregiver involvement.[177] Telehealth is discussed in more detail throughout this toolkit.

Stakeholders noted that attendance-taking is critical in ABA and can be used as a performance metric and a goal in the ITP. When the prescribed number of ABA units included in the ITP are not utilized it will be difficult for the assessor to tell if ABA is effective and should be continued.

Additional Therapies and Services to Treat Autism Spectrum Disorder

While largely seen as an effective approach to treating ASD, ABA is not the only option available and can be combined with other therapies.[178] Additional therapies, such as occupational therapy, can be beneficial to treatment when offered in conjunction with or as alternatives to ABA and covered under Medicaid.[179,180]

Alternative treatments to ABA, as well as treatments that incorporate ABA principles with other theories or approaches, are also available to treat individuals with ASD. Table 5 provides examples of these alternatives, which states could cover under Medicaid authorities such as a 1905(a) state plan authority, an 1115 demonstration, or a 1915(c) HCBS waiver. Medicaid coverage options may vary based on state coverage policy, benefit category, and provider

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[174] Rusli, N. A. (2025). Parental involvement in applied behaviour analysis (ABA) therapy for autism spectrum disorder (ASD) children: A focus on logistical, emotional, social-relational, and systematic challenges. *Journal of Special Education Research*, *4*(1), 1–11. https://doi.org/10.5281/zenodo.15698527.

[175] Ferretti, L. A., Uhl, A., Zawacki, J., & McCallion, P. (2025). Understanding barriers and facilitators of parent/caregiver involvement in home-based applied behavioral analysis programming for their autistic child. *Children, 12*(7), 850. https://doi.org/10.3390/children12070850.

[176] Littman, E. R., Gavin, L., Broda, A., Hodges, A. C., & Spector, L. (2023). Barriers to receiving applied behavior analysis services in children with autism spectrum disorder. *Cureus*, *15*(11), e48585. https://doi.org/10.7759/cureus.48585.

[177] Bradshaw, J., Wolfe, K., Hock, R., & Scopano, L. (2022). Advances in Supporting Parents in Interventions for Autism Spectrum Disorder. *Pediatric Clinics of North America*, *69*(4), 645–656. https://doi.org/10.1016/j.pcl.2022.04.002.

[178] Hyman, S. L., Levy, S. E., Myers, S. M., & Council on Children with Disabilities, Section on Developmental and Behavioral Pediatrics. (2020). Identification, Evaluation, and Management of Children With Autism Spectrum Disorder. *Pediatrics, 145*(1), e20193447. https://doi.org/10.1542/peds.2019-3447.

[179] Gardiner, F. (2017). *First-Hand Perspectives on Behavioral Interventions for Autistic People and People with Other Developmental Disabilities*, 4-7. https://autisticadvocacy.org/wp-content/uploads/2017/07/First-Hand-Perspectives-on-Behavioral-Interventions-for-Autistic-People-and-People-with-other-Developmental-Disabilities.pdf.

[180] CMS. (2014, July 7). *CMCS Informational Bulletin: Clarification of Medicaid coverage of services to children with autism*, 1-5. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-07-14.pdf.

qualifications. Choices of alternative treatments are important to ensure each child receives services most appropriate to address individualized needs.

Table 5: Additional Autism Spectrum Disorder Treatment Examples

Treatment Name	Description of Treatment	Appropriate Age Range	Provider Requirements
Naturalistic Developmental Behavioral Intervention (NDBI)[181]	Integrates developmental science and ABA; core components: nature of intervention targets; contexts of intervention delivery; and instructional strategies	Not age specific	No restrictions
TEACCH (formerly known as Treatment and Education of Autistic and Related Communication Handicapped Children)[182]	Program tailored to an individual's interests, skill level, and needs; activities drawn from neuropsychology and psychology, focus on building activities that are meaningful	Not age specific	No restrictions
Early Start Denver Model (ESDM)[183]	NDBI that integrates ABA principles with developmental and social motivation; focused on infant-toddler development and learning that includes caregivers and everyday learning opportunities	Infant-toddler age	ESDM certification
Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER)[184]	Integrates behavioral and developmental principles; teaches social communication skills via play and naturalistic strategies	Age 12 months to 8 years	No restrictions

[181] Schreibman, L., Dawson, G., Stahmer, A. C., Landa, R., Rogers, S. J., McGee, G. G., Kasari, C., Ingersoll, B., Kaiser, A. P., Bruinsma, Y., McNerney, E., Wetherby, A., & Halladay, A. (2015). Naturalistic Developmental Behavioral Interventions: Empirically Validated Treatments for Autism Spectrum Disorder. *Journal of Autism and Developmental Disorders, 45*(8), 2411–2428. https://doi.org/10.1007/s10803-015-2407-8.

[182] Mesibov, G. B., Shea, V., & Schopler, E., Adams, L., Merkler, E., Burgess, S., Mosconi, M., Chapman, S. M., Tanner, C., & Bourgondien, M. E. (2004). *The TEACCH Approach to Autism Spectrum Disorders.* Springer. https://doi.org/10.1007/978-0-306-48647-0.

[183] Early Start Denver Model. (2017). [Homepage]. Retrieved July 29, 2026, from https://www.esdm.co.

[184] JASPER. (n.d.). *About JASPER.* Retrieved April 5, 2026, from https://www.jaspertraining.org/about.

Treatment Name	Description of Treatment	Appropriate Age Range	Provider Requirements
Developmental, Individual Difference, Relationship-based (DIR) model and DIRFloortime[185]	The model facilitates understanding of developmental needs, ways an individual understands and engages with the world, and relationships; DIRFloortime operationalizes the model into practice	No focus	No restrictions

Stakeholders highlighted the benefits of concurrent physical, occupational, and speech therapy, which may be provided by outpatient clinics or schools. They noted value in coordinating these services with schools to support comprehensive care. Some ABA clinics actively facilitate the integration of other therapies, with one reporting that licensed physical, occupational, and speech therapists collaborate on site to deliver comprehensive treatment. Stakeholders emphasized that these therapies offer different approaches and address different challenges related to ASD as compared to ABA and included respite and personal care services as additional services that support families and caregivers. More information is provided in the next chapter on Medicaid covered services and the benefit categories under which they are authorized.

[185] The International Council on Development and Learning (ICDL), Inc. (n.d.). *What is DIR®?* Retrieved July 29, 2026, from https://www.icdl.com/dir.

Chapter 3. Medicaid and CHIP Policy and Coverage of Services to Treat Autism Spectrum Disorder

Medicaid and CHIP programs across the country are navigating rapidly growing demand for behavioral intervention services—most notably ABA—for individuals with ASD. While federal Medicaid EPSDT requirements entitle eligible children to medically necessary section 1905(a) services,[186] states retain significant authority in shaping how these services are structured, funded, and regulated. The result is a landscape in which coverage is widespread, but implementation varies, with meaningful implications for service quality, provider capacity, cost control, and family outcomes.

This chapter addresses how states can structure coverage of ABA and other ASD treatments to meet EPSDT requirements while promoting appropriate access and leveraging each state's provider community. It highlights key federal authorities and common state coverage options. It also briefly discusses coverage for children and youth in foster care.

Federal Authorities for Covering Services to Treat Autism Spectrum Disorder

As noted previously, CMS does not endorse or require any treatment modality, including ABA, for ASD.[187] States that cover ABA as a treatment for ASD have flexibility in how they structure Medicaid coverage. They may use multiple federal authorities to balance mandatory pediatric health care requirements with other service options, helping beneficiaries access a wide array of treatments and providers. Table 6 is a tool that states may use to consider multiple authorities for covering ASD services and how additional authorities may be layered on EPSDT. It is intended to support discussions about potential advantages and disadvantages in cost, access, and administrative complexity regarding the Medicaid and CHIP authorities that can be used to cover ASD treatments, including ABA.

The first row of Table 6 below describes the EPSDT requirements that, for EPSDT-eligible children, apply to the 1905(a) state plan benefits described further down in the table. States are encouraged to reach out to CMS with any technical assistance requests to ensure that ABA or other services to individuals with ASD are provided in accordance with federal requirements and represent an array of treatment options to meet children's varying needs.

[186] Children covered through a Medicaid expansion CHIP are entitled to EPSDT (42 C.F.R. § 457.70(c)(2)). For states that elect the option to cover EPSDT in a separate CHIP consistent with all Medicaid requirements, EPSDT coverage requirements also apply to the separate CHIP.

[187] CMS. (2014, July 7). *CMCS Informational Bulletin: Clarification of Medicaid coverage of services to children with autism*, 1-5. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-07-14.pdf.

Table 5: Example Coverage Options for Services to Treat Autism Spectrum Disorder[188]

Federal Authority	Description, State Examples, Uses, Considerations, and Implementation
Section 1905(a)(4)(B) and 1905(r), EPSDT Can be used for: ☑ ABA ☑ Other ASD treatments ☑ Treatment for co-occurring conditions with ASD	**Description:** • EPSDT requirements outlined in section 1905(a)(4)(B) and defined in 1905(r) entitle eligible children under age 21 years to Medicaid coverage of health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act that are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by required screening services, whether or not such services are covered under the state plan. For example, for EPSDT-eligible children, states must cover ASD-related interventions that are coverable under section 1905(a) when the services are medically necessary. • Although ABA is not specifically referenced in section 1905(a), many of the discrete services that are commonly delivered as part of an ABA treatment plan are coverable under multiple benefit categories in section 1905(a) (for example, caregiver training and behavioral coaching under preventive services benefit) when those services meet the applicable benefit definition and are furnished by qualified providers. When such services are determined medically necessary to correct or ameliorate ASD or associated conditions, they must be covered for EPSDT-eligible children even if the state does not choose to offer ABA as a distinct, named benefit, and states may also elect to cover other ASD treatments instead of or in addition to ABA, so long as EPSDT requirements are met.[189,190] • A screening or diagnostic evaluation conducted before a child's Medicaid enrollment is sufficient to trigger EPSDT coverage, after enrollment, for follow-up diagnostic services and necessary treatment.[191] States should not require a new diagnostic evaluation because of a foster care placement change. **State Example:** • North Carolina's ASD services summaries explicitly note that the state must cover ASD services under EPSDT pursuant to sections 1905(a)(4)(B) and 1905(r).[192] **Uses:** • Covers concurrent treatments for psychiatric, behavioral, or physical conditions that frequently co-occur with ASD (such as anxiety, ADHD, sleep disorders, or gastrointestinal issues). • Authorizes hours of or frequency of services beyond standard state plan caps or utilization controls if a child's clinical presentation demonstrates an ongoing need to correct or ameliorate behavioral or developmental deficits. **Considerations:** • EPSDT does not include services covered through statutory authorities other than section 1905(a). • States are not permitted to apply "hard limits" or limits that can never be exceeded to any 1905(a) service when provided to EPSDT-eligible children.

[188] All state examples described in this table are effective as of the publication date of this toolkit.

[189] CMS. (2014, July 7). *CMCS Informational Bulletin: Clarification of Medicaid coverage of services to children with autism*, 1-5. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-07-14.pdf.

[190] Section 1905(r)(5) of the Act.

[191] CMS. (2026). *State Medicaid & CHIP Toolkit for Children's Behavioral Health Services and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Requirements.* https://www.medicaid.gov/federal-policy-guidance/downloads/state-medicaid-chip-bh-epsdt.pdf.

[192] North Carolina Department of Health and Human Services. (n.d.). *Behavioral Health Treatment for Autism Spectrum Disorder* (Clinical Coverage Policy No: 8F). https://medicaid.ncdhhs.gov/public-comment-8f-behavioral-health-treatment-autism-spectrum-disorder/.

Federal Authority	Description, State Examples, Uses, Considerations, and Implementation
	• **Under EPSDT, states may apply "soft limits" to services that may be exceeded with prior authorization and/or a medical necessity review (e.g., a weekly limit on the hours of covered ABA services that can be exceeded with prior authorization).** **ABA Implementation:** • States have flexibility in how and whether they effectuate coverage of ABA pursuant to EPSDT requirements, but they must, at a minimum, have an approved reimbursement methodology for ABA services if covered in their state plan. • A coverage state plan amendment (SPA) is strongly encouraged to articulate the state's coverage of ABA services in keeping with the role of the Medicaid state plan as a comprehensive written statement of the nature and scope of services available. • A state may submit a SPA describing the covered ABA in the EPSDT section of the plan. The SPA should identify the section 1905(a) benefit or benefits (e.g., Other Licensed Practitioner (OLP) or preventive services) that encompass covered ABA services. • Alternatively, a state may submit a SPA amending the section 1905(a) benefit (e.g., OLP or preventive services) section of the plan and indicate that ABA services are only covered for EPSDT-eligible children under 21 years old.
Section 1905(a)(6), OLP Services (42 C.F.R. § 440.60): Can be used for: ☑ ABA ☑ Other ASD treatments ☑ Treatment for co-occurring conditions with ASD	**Description:** • The OLP benefit allows states to provide coverage for services (other than physicians' services) provided by a licensed practitioner acting within their scope of practice under state law, as well as the services furnished directly by non-licensed practitioners working under the supervision of a licensed practitioner when certain conditions are met. • States have the option to cover this benefit for adults. • CMS interprets the EPSDT requirements outlined in section 1905(a)(4)(B) and defined in 1905(r) to mean that, if an optional 1905(a) service[193] such as OLP services is not covered for adults, that service must still be made available to EPSDT-eligible children when medically necessary. **State Example:** • Louisiana covers Licensed Behavior Analysts (LBA) under the OLP benefit for EPSDT-eligible children.[194] The state plan specifies that services within an LBA's scope of practice must be provided by or under the supervision of a behavior analyst who is licensed by the Louisiana Behavior Analyst Board, a licensed psychologist, or a licensed medical psychologist. The state plan also describes LBAs' supervision requirements and provider qualifications. **Uses:** • Covers services delivered by licensed practitioners and non-licensed practitioners working under the supervision of a licensed practitioner in accordance with the practitioner's scope of practice under state law. • States may elect to require person-centered planning principles to ensure individualized services. • States may use this benefit to cover treatments other than ABA for individuals with ASD if the service is included in the practitioner's scope of practice. **Considerations:** • Requires provider licensure and/or licensed provider supervision of unlicensed practitioners. • The licensed provider bills for the service.

[193] Section 1902(a)(10) of the Act identifies whether services listed in 1905(a) are mandatory or optional.

[194] Louisiana Department of Health (2020). *Louisiana SPA No. LA-19-0005: School-based medical services covered in the Early and Periodic Screening, Diagnosis and Treatment Program and school-based behavioral health services* [State Plan Amendment]. CMS. https://www.medicaid.gov/medicaid/spa/downloads/LA-19-0005.pdf.

Federal Authority	Description, State Examples, Uses, Considerations, and Implementation
	ABA Implementation: • Under the OLP authority, states do not need to describe the covered services but do need to specify the licensed practitioners and any individuals delivering services under the supervision of the licensed practitioners. • A state can submit a SPA to add ABA-related licensed provider types (for example, licensed behavior analysts) under the OLP benefit and, if applicable, describe any technicians or other non-licensed practitioners who may deliver services under the licensed provider's supervision.
Section 1905(a)(13), Preventive Services (42 C.F.R. § 440.130(c)): Can be used for: ☑ ABA ☑ Other ASD treatments ☑ Treatment for co-occurring conditions with ASD	**Description:** • The preventive services benefit allows states to provide coverage for services recommended by a physician or other licensed practitioner of the healing arts, within the scope of authorized practice under state law, to: - Prevent disease, disability, and other health conditions or their progression - Prolong life - Promote physical and mental health and efficiency • States have the option to cover this benefit for adults. • CMS interprets the EPSDT requirements outlined in section 1905(a)(4)(B) and defined in 1905(r) to mean that, if an optional 1905(a) service such as preventive services is not covered for adults, that service must still be made available to EPSDT-eligible children when medically necessary. **State Examples:** • California covers ABA as part of its Behavioral Health Treatment (BHT) services benefit under both the Preventive Services and federal EPSDT state plan authorities, subject to utilization management controls and medical necessity. BHT, including ABA services, is covered when medically necessary to "correct or ameliorate" defects and physical and mental illnesses and conditions discovered through screening for Medicaid members under 21 years of age who have an autism spectrum disorder (ASD) diagnosis as well as for members with other clinically appropriate diagnoses and for whom a physician or psychologist determines BHT services are medically necessary. BHT services must be provided and supervised according to an approved behavioral treatment plan that is developed by a Qualified Autism Service (QAS) provider who meets the requirements in the California Medicaid State Plan. A BHT provider who is either a qualified autism service (QAS) provider, QAS professional, or QAS paraprofessional who meets the requirements in California's Medicaid State Plan can provide the services in accordance with California's Medicaid BHT coverage and billing policies.[195] **Uses:** • States have broad flexibility to establish qualifications for providers of preventive services, which may include licensure, education, training, experience, credentialing, supervision, and/or registration. This may include coverage of services provided by non-licensed providers. • States may elect to require person-centered planning principles to ensure individualized services. • States may utilize this benefit to cover treatments other than ABA for individuals with ASD. **Consideration:** • States may utilize this benefit to provide a group of services, but each component service must meet the requirements of the preventive services benefit. **ABA Implementation:**

[195] California Department of Health Care Services. (2025). *Behavioral Health Treatment.* https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/79D4E83F-FAA4-41C1-9D9F-E7B8A75B4BDF/bht.pdf.

Federal Authority	Description, State Examples, Uses, Considerations, and Implementation
	• A state can submit a SPA describing the covered ABA services, the providers who can furnish the services, and the provider's qualifications, as well as a reimbursement methodology.
Section 1905(a)(11), Therapy Services (42 C.F.R. § 440.110): Can be used for: ☐ ABA ☑ Other ASD treatments ☑ Treatment for co-occurring conditions with ASD	**Description:** • Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders may be covered under the therapy services benefit. • Physical and occupational therapy must be prescribed by a physician or OLP of the healing arts within the scope of their practice under state law and provided to a beneficiary by or under the direction of a qualified provider. Services for individuals with speech, hearing, and language disorders mean diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which an individual is referred by a physician or OLP of the healing arts within the scope of their practice under state law. • States have the option to provide this benefit to adults. **State Examples:** • For children (0–21 years old), every state covers physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders under 42 C.F.R. § 440.110. This means that these therapy services must be available to individuals with ASD when medically necessary. **Uses:** • Provides coverage specifically for physical therapy, occupational therapy, speech pathology, and audiology services. **Considerations:** • Specific federal provider qualifications must be met in accordance with 42 C.F.R. § 440.110. **ABA Implementation:** • A state can submit a SPA to add therapy services to its Medicaid plan including an assurance that the state covers therapy and audiology in accordance with 42 C.F.R. § 440.110. Additionally, the state would need to describe the supervisory arrangements if a provider is furnishing the therapy under the direction of a qualified provider, and the reimbursement methodology. However, these therapies are typically not considered components of ABA, and would be offered instead of, or in conjunction with, ABA. Therefore, "therapy services" does not include Medicaid coverage of ABA services. See above how Medicaid covers ABA services.
Section 1905(a)(13), Rehabilitative Services (42 C.F.R. § 440.130(d)): Can be used for: ☐ ABA ☐ Other ASD treatments ☑ Treatment for co-occurring conditions with	**Description:** • The rehabilitative services benefit includes any medical or remedial services recommended by a physician or OLP of the healing arts, within their scope of practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level. • States have the option to provide this benefit for adults. • CMS interprets the EPSDT requirements outlined in section 1905(a)(4)(B) and defined in 1905(r) to mean that, if an optional 1905(a) service[196] such as rehabilitative services is not covered for adults, that service must still be made available to EPSDT-eligible children when medically necessary. **Uses:** • May be utilized to cover mental health and substance use disorder services for individuals with ASD to address co-occurring conditions. **Considerations:**

[196] Section 1902(a)(10) of the Act identifies whether services listed in 1905(a) are mandatory or optional.

Federal Authority	Description, State Examples, Uses, Considerations, and Implementation
ASD	• States have broad flexibility to establish qualifications for providers of rehabilitative services, which may include licensure, education, training, experience, credentialing, supervision, and/or registration. • Requires the services provided to be restorative in nature. • Cannot be used to cover habilitative services such as services that help a person acquire skills. • States may utilize this benefit to provide a group of services, but each component service must be coverable under the rehabilitative services benefit. **ABA Implementation:** • A state can submit a SPA describing each of the covered services, the providers who can provide the services, and the provider's qualifications, as well as a reimbursement methodology. Rehabilitative services are typically not considered components of ABA, and would be offered instead of, or in conjunction with, ABA.
Section 1915(c) HCBS Waiver: Can be used for: ☑ ABA ☑ Other ASD treatments ☑ Treatment for co-occurring conditions with ASD	**Description:** • The 1915(c) HCBS waiver allows states to provide home and community-based services to individuals who, but for the provision of those services, would require the level of institutional care that is provided under the Medicaid state plan.[197] Authorized under Section 1915(c) of the Act, 1915(c) waivers allow states to waive certain Medicaid requirements — including statewideness, comparability, and income rules — to target specific populations, such as children or adults with ASD. • Section 1915(c) waiver services are delivered through individualized, person-centered plans of care. States have flexibility to target populations (e.g., by age and diagnosis), set enrollment caps, and define covered services. • Starting July 1, 2028, states may utilize a new waiver authority option created through Section 71121 of the Working Families Tax Cut legislation that added paragraph (11) to Section 1915(c) of the Act, creating a 1915(c)(11) waiver. The new Section 1915(c)(11) authority combines key features of section 1915(i) State Plan HCBS and Section 1915(c) HCBS waivers, giving states more flexibilities. This new waiver option allows states to provide HCBS to individuals whose needs may not meet an institutional level of care. Eligibility requirements for section 1915(c)(11) waivers specify that individuals must be eligible for Medicaid under one of the Medicaid eligibility groups covered under the state plan in the state in which the individual resides, meet the state-defined minimum needs-based criteria, and meet the state-defined target group requirements. **State Examples**: Many states use 1915(c) waivers to extend and enhance the delivery of EPSDT-covered services in community settings. Some states have developed ASD-specific waivers. California's HCBS 1915(c) Waiver for Californians with Developmental Disabilities covers Behavioral Intervention Services to assist waiver-eligible individuals in acquiring, retaining, and improving the skills needed to reside in a home or community setting. These services include intensive behavioral interventions, which is any form of ABA-based treatment that promotes positive social behaviors and reduces or ameliorates behaviors that interfere with learning and social interaction. These intensive behavioral interventions go beyond what is covered in the state's Medicaid state plan and can include training for family members on treatment regimens and risk management strategies to help the family support the individual.[198]

[197] Section 71121 of Public Law 119-21 added paragraph (11) to Section 1915(c) of the Act. Section 1915(c)(11) of the Act creates a new HCBS waiver option that, effective July 1, 2028, allows states to offer HCBS waiver services to individuals using a needs-based criteria that does not require an institutional level of care.

[198] California Department of Developmental Services. (2023). *CA 0336.R05.00 HCBS Waiver for Californians with DD renewal* [CA-0336.R05.00 waiver approval package]. 1, 6. CMS. https://www.dds.ca.gov/wp-content/uploads/2023/06/CA-0336.R05-Approval-Combined.pdf.

Federal Authority	Description, State Examples, Uses, Considerations, and Implementation
	Uses: • Allows states to layer specialized HCBS on top of core EPSDT/1905(a) services, potentially improving functional outcomes and caregiver support. • Can provide additional HCBS that complement and/or supplement services available under the Medicaid state plan, including medically necessary services available through EPSDT for eligible children, while supporting individuals with higher levels of need. • Provides structured, person-centered service packages that may support community integration and transitions to adulthood. • Provides services not typically covered under section 1905(a) such as respite, supported employment, and habilitation. **Considerations:** • Requires eligible individuals to demonstrate that they meet the waiver's institutional level of care criteria. • May increase administrative complexity (separate eligibility criteria, enrollment caps, waiting lists) that can affect timely access across populations and regions. • Requires careful design to avoid duplicating ASD treatment services already coverable under 1905(a) for children. • Monitoring and reporting obligations for waiver performance and HCBS compliance add to state oversight responsibilities. • Section 1915(c) services do not replace a state's responsibility to meet EPSDT requirements. • Many states historically offered ABA or behavioral interventions via 1915(c) waivers, especially for individuals with intellectual and developmental disabilities (IDD). However, CMS's 2014 CMCS Informational Bulletin (CIB) and subsequent Frequently Asked Questions clarified that EPSDT-eligible children should receive services to address ASD and associated conditions under Section 1905(a) authority through the state plan. **ABA Implementation:** • A state can submit a waiver application describing each of the services covered, the providers who can provide the services, the provider's qualifications, and the reimbursement methodology.
Section 1115 Demonstration: Can be used for: ☑ ABA ☑ Other ASD treatments ☑ Treatment for co-occurring conditions with ASD	**Description:** • Section 1115 of the Act gives states authority to design experimental, pilot, or demonstration projects to promote the objectives of the Medicaid program, often for selected regions or subpopulations. **Uses:** • Offers flexibility to test innovative approaches to ASD services while preserving EPSDT protections. • Can incorporate targeted financial incentives, alternative payment models, or cross-sector partnerships that may improve care coordination and outcomes. • Demonstration structure can support robust evaluation, restructuring, and learning to inform future statewide policy decisions. **Considerations:** • Demonstrations are time limited and may create differences in access or care models between regions or populations. • Adds administrative and reporting complexity, including waiver negotiations, budget neutrality, monitoring, and formal evaluation requirements. • Requires careful communication so families and providers understand how demonstration features relate to the underlying EPSDT entitlement and state plan benefits. **ABA Implementation:**

Federal Authority	Description, State Examples, Uses, Considerations, and Implementation
	• A state can apply for a section 1115 demonstration project by including a program description, goals and objectives, the proposed health care delivery system, eligibility requirements, benefit coverage, cost sharing, an estimate of enrollment and expenditures, and a plan for evaluating the demonstration project.
Section 1915(i) State Plan Amendment HCBS: Can be used for: ☑ ABA ☑ Other ASD treatments ☑ Treatment for co-occurring conditions with ASD	**Description:** • States may use the 1915(i) authority to provide person-centered HCBS to individuals with ASD or other developmental and/or intellectual disabilities who do not meet institutional level of care criteria. **State Example:** • North Carolina has a 1915(i) HCBS state plan benefit for individuals ages 3 years and older with serious emotional disturbance (SED), severe substance use disorder (SUD), traumatic brain injury, and intellectual and developmental disabilities (IDD), including ASD.[199] Available services include, among others, community living supports that empower individuals to live successfully in their homes through the acquisition of interpersonal skills, as well as skills for independent living, community living, self-care, and self-determination. **Uses:** • Beneficiaries must meet state-defined criteria that are less stringent than the state's institutional level of care criteria and that base eligibility on need, also known as needs-based criteria and risk factors. • States may target this benefit to defined populations, such as individuals with ASD or other developmental disabilities, within federal requirements. • States may provide additional HCBS that complement and/or supplement services available under the Medicaid state plan. **Considerations:** • Section 1915(i) services do not replace a state's responsibility to meet EPSDT requirements. • The state cannot place limits on the number of people served under the HCBS state plan. • Requires state-defined conflict of interest standards and independent evaluation standards. **ABA Implementation:** • A state can submit a 1915(i) SPA describing the covered ABA services, provider types, provider qualifications, and reimbursement methodology.
Section 2110 CHIP Child or Pregnancy-Related Health Assistance: Can be used for: ☑ ABA ☑ Other ASD treatments ☑ Treatment for	**Description:** • Similar to Medicaid, CHIP does not specifically reference ABA as a service or support in the definition of child or pregnancy-related health assistance; however, states have flexibility to provide ABA and other ASD services under existing CHIP benefit categories, consistent with the approved CHIP state plan. **State Example:** • In Virginia, children enrolled in Family Access to Medical Insurance Security Plan, the state's Title XXI CHIP program, may receive behavioral health care services, including ABA.[200] **Uses:**

[199] North Carolina Department of Health and Human Services. (2023). *New §1915(i) Home and Community-Based Services (HCBS) state plan benefit*. [NC Carolina's 1915(i) HCBS state plan benefit (NC-22-0026) State Plan Amendment]. CMS. https://www.medicaid.gov/medicaid/spa/downloads/NC-22-0026.pdf.

[200] Virginia Department of Medical Assistance Services, (n.d.). *Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*. Retrieved July 29, 2026, from https://www.dmas.virginia.gov/for-members/benefits-and-services/maternal-and-child-health/early-and-periodic-screening-diagnostic-and-treatment-epsdt/.

Federal Authority	Description, State Examples, Uses, Considerations, and Implementation
co-occurring conditions with ASD	• While ABA is not a mandated service under these requirements, it is one of several potential treatment modalities. States should consider whether their benefit array is sufficient to meet the needs of children with behavioral health conditions, which could include ASD. **Considerations:** • States with separate CHIPs that elect to provide EPSDT consistent with all Medicaid requirements must also adopt the same considerations discussed above for section 1905(a) services when determining coverage of services in CHIP. • Additionally, all separate CHIPs must ensure that CHIP coverage prevents, diagnoses, and treats a broad range of behavioral health conditions consistent with section 2103(c)(5) of the Act, which could include coverage of ABA services to treat ASD. **ABA Implementation:** • A state can submit a CHIP SPA to describe covered ABA services, including the amount, duration, and scope of the benefit.

STATE SPOTLIGHT: Programs for Adults With Autism Spectrum Disorder

Pennsylvania has two Medicaid programs specifically for adults with ASD:*

- **Adult Autism Waiver (AAW)**.[201] The AAW is a 1915(c) HCBS waiver that offers specialized, long-term supports to help individuals with ASD who are ages 21 years or older and who meet an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care to live in their communities. The waiver operates statewide and covers a broad package of supports, such as specialized skill development, which consists of behavioral specialist services and systematic skill building; day and residential habilitation; supported employment; respite; and therapies, including speech/language therapy and counseling.
- **Adult Community Autism Program (ACAP)**.[202] The ACAP is a prepaid inpatient health plan (PIHP) that operates in four counties and serves up to 200 Medicaid-eligible adults over the age of 21 years with ASD and substantial functional limitations. The program provides an integrated system of care, concentrates on decreasing social isolation, and covers services such as physical and behavioral health, therapeutic services, in-home support, and independent living services.

**Note: ABA therapy is not listed as a discrete covered service in either the AAW or the ACAP, and EPSDT requirements do not apply to individuals ages 21 years and older or to services covered under 1915(c) waivers.*

Care Coordination

Effective care coordination is critical for children with ASD receiving ABA services, particularly given the complexity of navigating multiple service systems, providers, and treatment modalities. Care coordination helps ensure that children receive comprehensive, integrated care that addresses their medical, behavioral, developmental, and social needs. For Medicaid-enrolled children with ASD, care coordination can facilitate timely access to ABA therapy, reduce fragmentation between behavioral health and physical health services, and support families in understanding available benefits, navigating authorization processes, and ensuring that the child receives all services included in their ITP.

For children enrolled in managed care, the managed care plan is responsible for care coordination; this applies to children with ASD, whether they receive ABA services or not. ABA services outlined in the child's ITP should be coordinated with other services the child is receiving.

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[201] Pennsylvania Department of Human Services. (2026, July). *PA 0593.R04.00. PA Adult Autism Waiver* [PA 0593.R04.00 PA waiver approval package]. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83056.

[202] Pennsylvania Department of Human Services (2020). *Medical Assistance and Children's Health Insurance Program Managed Care Quality Strategy*. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/hc-services/documents/Medical-Assistance-Quality-Strategy-for-Pennsylvania.pdf.

Sections 1945 and 1945A of the Social Security Act: Health Homes

States may consider whether Health Homes or similar care management models could support children and youth with ASD who have multiple chronic conditions or more complex care coordination needs. The optional Health Home benefit allows states to provide comprehensive care management, care coordination, health promotion, transitional care, individual and caregiver support, and referral to community and social supports for eligible Medicaid beneficiaries with chronic conditions. While their ASD treatment services must still be covered, where applicable, under the appropriate Medicaid authority, Health Homes may offer an additional structure for coordinating care across providers, settings, and systems for children with more complex needs.[203,204]

[203] CMS. (n.d.). *Health Homes.* Retrieved July 29, 2026, from https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes.

[204] CMS. (n.d.). *Health Home Information Resource Center*. Retrieved July 29, 2026, from https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center.

Chapter 4. Medicaid Payment Approaches for Applied Behavior Analysis

State Medicaid programs use different approaches to pay providers for ABA. This chapter identifies payment design considerations that may affect access, fiscal sustainability, provider participation, and oversight. It distinguishes between the delivery system context in which payment occurs, such as fee-for-service (FFS) or managed care, and the payment methodologies used to pay providers, such as procedure-code-based payment, credential-based rates, bundled payments, per diem payments, case rates, or value-based arrangements. Utilization management policies, prior authorization, medical necessity criteria, and ITP review processes are addressed in Chapter 6.

Setting Applied Behavior Analysis Rates

Federal law requires that Medicaid FFS payment rates be consistent with the goals of efficiency, economy, quality, and access, as specified in Section 1902(a)(30)(A) of the Social Security Act. States have broad flexibility in setting FFS rates and may use various methodologies, including published fee schedules, tiered rates based on provider credentials, bundled rates, and cost reconciliation approaches. This flexibility means that FFS rates for ABA vary widely and are influenced by provider availability, state budget constraints, and comparability with commercial insurance rates.

Applied Behavior Analysis in Fee-For-Service and Managed Care Delivery Systems

States can choose to provide ABA through the FFS and/or managed care delivery systems, and provider payment varies between these delivery systems:

- **FFS**: The state typically pays providers directly according to a Medicaid fee schedule or other state-established payment methodology.
- **Managed care delivery systems**: The state generally pays a managed care plan a capitation payment and then the managed care plan is responsible for negotiating provider reimbursement rates with contracted providers and paying providers.

How provider reimbursement is structured, in either the FFS or managed care delivery system, can vary and can include a fee schedule by procedure code, bundled payment, or value-based arrangement. The choice of payment methodology may influence state budget predictability, program integrity risk, administrative burden, and access to services. This section explains how FFS and managed care delivery systems shape who sets ABA rates, who pays providers, and how the state monitors claims and encounters.

Delivery in a Fee-For-Service System

Under FFS arrangements, states generally establish payment rates for ABA and pay enrolled providers directly for services furnished to Medicaid beneficiaries. As discussed in Chapter 3, states must have an approved SPA to implement FFS rates for ABA, which must include

comprehensive language to establish that the methodology is economic and efficient and sufficient to enlist providers.[205]

State Consideration

FFS arrangements offer administrative simplicity and a transparent billing framework, but, because providers are paid per service delivered, may create financial incentives to increase the volume of services rather than to improve individual outcomes.

Form CMS-64 and Form CMS-21 Reporting

Form CMS-64

States report Medicaid FFS expenditures quarterly on the Form CMS-64 (Quarterly Statement of Expenditures)[206]. There is currently no specific FFS reporting line item for ABA on the Form CMS-64. However, ABA is captured using specified Current Procedural Terminology (CPT) codes.

The following FFS lines (including but not limited to the below) that may include ABA include Forms CMS-64.9 Base, CMS-64.9 P, and CMS-64.9 Waivers:

- Line 4A – Intermediate Care Facility Services – Individuals with Intellectual Disabilities: Public Providers
- Line 4B – Intermediate Care Facility Services – Individuals with Intellectual Disabilities: Private Providers
- Line 5A – Physician and Surgical Services – Reg. Payments
- Line 5B – Physician and Surgical Services – Supplemental Payments
- Line 5C – Physician and Surgical Services – Evaluation and Management
- Line 5D – Physician and Surgical Services – Vaccine Codes
- Line 9A – Other Practitioners Services – Reg. Payments
- Line 16 – Rural Health Clinic Screening Services
- Line 28 – Federally Qualified Health Center
- Line 39 – School-Based Services
- Line 40 – Rehabilitative Services (non-school-based)

[205] Social Security Act (the Act), § 1902(a)(30)(A), 42 U.S.C. § 1396a(a)(30)(A) (2023). https://uscode.house.gov/view.xhtml-req=granuleid:USC-prelim-title42-section1396a.

[206] States report quarterly CHIP expenditures as required by Section 2107(b)(1) of the Act and 42 C.F.R. §§ 457.614(b) and 457.740(a)(1) on the Form CMS-21. For additional information on CHIP expenditure reporting, please see *CMS-21 Quarterly CHIP Expenditures Report*: https://www.medicaid.gov/medicaid/data-systems/medicaid-and-chip-business-information-solution/macbis-financial/medicaid-budget-and-expenditure-system-mbes/cms-21-quarterly-chip-expenditures-report.

Form CMS-21

States report CHIP FFS expenditures quarterly on the Form CMS-21 (Quarterly CHIP Statement of Expenditures for Title XXI). ABA therapy does not have its own standalone line. Instead, states categorize it under specific medical benefit lines depending on the provider type and delivery mode. ABA is captured using specified CPT codes.

Within the Form CMS-21 Base, ABA FFS therapy expenditures are mapped into lines determined by the billing entity provider taxonomy and state plan design:

- Line 29 – Other Care Services: This is the most common location for FFS ABA claims
- Line 12 – Clinic Services: If the ABA services are delivered directly by a certified, state-defined Medicaid/CHIP facility
- Line 13 – Therapy Services: Used rarely, and only if the state's Medicaid/CHIP manual text defines behavioral or rehabilitation therapies interchangeably with physical, occupational, or speech therapies for structural line purposes

Documentation Oversight

FFS expenditures reported on Form CMS-64 and CMS-21 must be supported by readily available, documented source records verifying actual payments, such as invoices, payment vouchers, provider cost reports, and Medicaid beneficiary eligibility records as requested by CMS. States must certify on Forms CMS-64 and CMS-21 that reported expenditures are actual, documented, and allowable. Specifically, there are several federal statutes and regulations governing state documentation requirements described in Table 7.

Table 6: Federal Statutes and Regulations Governing Form CMS-64 Documentation

Statute / Regulation	Requirement	Documentation Implication
Section 1902(a)(27) of the Social Security Act	Requires providers to agree to keep records necessary to fully disclose the extent of services provided and furnish information regarding payments claimed as requested by the state agency or the Secretary	States and providers must maintain records that support services delivered and payments claimed
Section 1902(a)(30)(A) of the Social Security Act	Requires states to establish methods and procedures to ensure Medicaid payments are consistent with efficiency, economy, and quality of care	States must maintain supporting documentation for rate-setting methodologies and payment determinations
42 C.F.R. § 430.30(c)	Requires states to submit Form CMS-64 within 30 days after the end of each fiscal quarter; form is an accounting of actual recorded expenditures	States must retain documentation supporting expenditures reported on the Form CMS-64 and claims for federal reimbursement
42 C.F.R. § 431.107	Requires providers to furnish the Medicaid agency, the Secretary, or the Medicaid Fraud Control Unit with any information maintained, including records needed to disclose the extent of services provided	Providers and states must maintain and make available records demonstrating services rendered and related claims
Section 2105(e) of the Social Security Act	Requires states to submit quarterly expenditure reports, using the Form CMS-21, as a strict condition for receiving federal matching payments for their Title XXI program expenses	Every dollar submitted on the Form CMS-21 must map directly to a verifiable paid claim, provider invoice, or capitation registry
Section 2107(b)(1) of the Social Security Act	States are required to maintain data and provide necessary reports, including financial data via the CMS-21, to ensure the federal government can verify state plan compliance and assess program effectiveness.	States must collect data, maintain records, and furnish reports upon request
42 C.F.R. Part 457 (Subpart F)	Requires states to submit Form CMS-21 within 30 days after the end of each fiscal quarter	Under Subpart I of 42 C.F.R 457, states must maintain complete individual applicant and enrollee records (including application data, verification sources, and enrollment dates) and comprehensive financial records detailing the exact type of services provided and the corresponding payments made

Furthermore, the following sections of the State Medicaid Manual (SMM) are applicable to Form CMS-64 reporting and documentation requirements described in Table 8.

Table 7: State Medicaid Manual Sections Applicable to Form CMS-64 Reporting

State Medicaid Manual Provision	Requirement	Documentation Implication
SMM § 2500(A)(1)	Directs that Form CMS-64 must reflect **"actual expenditures"**	States must maintain records demonstrating that expenditures reported on the Form CMS-64 were actually incurred and recorded in the accounting system
SMM § 2500 (General Guidance)	Requires that all supporting documentation be maintained in **"readily reviewable form"** and be compiled and available at the time the claim is filed	States must have complete supporting documentation prepared and accessible before submitting claims for federal reimbursement
SMM § 2500 (Documentation Standards)	States that if a state cannot document a claim for expenditures on a current basis, it must withhold the claim until the actual amount is determined and supported by final documentation	States may not claim federal financial participation (FFP) based on estimates or unsupported amounts and must retain final documentation substantiating the claimed expenditures

Documentation must be compiled and immediately available at the time of filing to substantiate all reported expenditures and adjustments. States must maintain documentation for auditing purposes as required under the federal statutes and regulations described in Table 9.

Table 8: Federal Statutes and Regulations Governing Form CMS-64.21 Documentation Retention

Regulation	Requirement	Record Retention Implication
42 C.F.R. § 433.32	Requires Medicaid agencies to maintain accounting systems and fiscal records that support claims for FFP	Supporting records must generally be retained for **at least three years** from the date of expenditure submission or until any audit findings, litigation, or claims are fully resolved
2 C.F.R. § 200.334	Establishes general federal record retention requirements for recipients and subrecipients of federal awards	Financial records, supporting documents, statistical records, and other grant-related records must generally be retained for **three years** from the date of submission of the final expenditure report, subject to exceptions for audits, litigation, or other unresolved matters

Regulation	Requirement	Record Retention Implication
42 C.F.R. § 447.202	Applies to Medicaid payments based on provider costs and related reimbursement methodologies	For providers who submit costs being audited under § 447.202, states must retain documentation supporting cost-based payments for **five years** after the closure of the cost report to substantiate payment calculations and compliance with federal requirements
42 C.F.R. § 425.314	Requires Accountable Care Organizations (ACOs) participating in Medicare Shared Savings Program arrangements to maintain books, contracts, records, documents, and other evidence	ACOs must retain required records for **10 years** and make them available for inspection, evaluation, and audit upon request
Section 2107(b)(1) of the Act	States are legally required to collect data, maintain comprehensive administrative and service delivery records, and furnish reports to the federal government to monitor program operations	States must design tracking frameworks that preserve the physical audit trail connecting individual beneficiary eligibility data directly to provider transactions to verify program effectiveness
Section 2107(b)(3) of the Act	States must afford the Secretary of HHS and the Comptroller General full access to any books, records, and data systems used to administer the State child health plan	Records must be systematically organized and continuously accessible for immediate federal inspection, audit, or program evaluation requests throughout their lifecycle
42 C.F.R. § 457.965(b)(2)	The State Medicaid/CHIP agency must maintain detailed individual enrollee records containing information about the types of services provided, dates of care, and corresponding payment amounts	Accounting files and clinical billing records supporting claims reported on Form CMS-21 must be preserved at the individual beneficiary level for **a minimum of three years**
42 C.F.R. § 457.965(c)	The State must maintain complete fiscal and accounting records that document the source of all programmatic expenditures and the overall financial administration of the plan	Ledger data, administrative cost trackers, and vendor invoices must be retained for **at least three years** to substantiate all quarterly financial lines claimed on the CMS-21

Claims developed through sampling, projections, or other estimating techniques are not allowed on the Form CMS-64. If states fail to provide requested supporting documentation, CMS may delay reimbursement (defer funds) under 42 C.F.R. § 430.40 or recover FFP (disallowance action) under 42 C.F.R. § 430.42 for unsupported claims.

Delivery in a Managed Care System

Many states operate Medicaid and CHIP programs using a managed care delivery system. When designing managed care programs, states have the option to include all services in the managed care contract or to exclude some services from the responsibility of the managed care plan and provide those services in the FFS delivery system.

Some states may choose to exclude ABA from the managed care contract and deliver these services in the FFS delivery system. For example, individuals enrolled in a Missouri Medicaid managed care plan receive ABA services on an FFS basis, outside of the plan benefit package.[207] Other states choose to include ABA in their managed care contract. Texas, for example, includes ABA services in its managed care contracts.[208]

In managed care delivery systems, states pay managed care plans capitation payments for beneficiaries enrolled under the managed care contract for the provision of Medicaid or CHIP services included in the managed care contract, including ABA.[209] Managed care plans are generally responsible for negotiating provider payment rates with contracted providers and paying providers. Medicaid managed care plans should consider payment strategies with their contracted providers that focus on both the outcomes and acuity associated with delivering these services. Such payment strategies could include an acuity- and outcomes-based case rate, or other such payment mechanism that aligns provider payments with value rather than volume. States may also consider utilizing state-directed payments (SDPs)[210] in Medicaid to direct managed care expenditures related to provider payment, such as value-based payment (VBP) SDPs that are based on both outcomes and acuity. All state-directed payments must comply with federal requirements, including any respective limit on total provider payment rates.

- **Form CMS-64 Reporting[211]:** States report Medicaid managed care expenditures for capitation payments made to managed care plans, which may include ABA on Managed Care – Line 18 *(series as applicable).*
- **Form CMS-21 Reporting:** States report expenditures on either Line 1A or 1C, depending on the family income level of the child receiving the care in reporting the managed care capitation payments. Specifically:
    - **Line 1A (Premiums - Up To 150 Percent of Poverty Level):** Use this line to report the gross capitation payments paid to health plans for children whose family income is at or below 150 Percent of the Federal Poverty Level (FPL).

[207] Missouri Department of Social Services. (2026, May). *Behavioral health Services Provider Manual*, 76. Retrieved July 28, 2026, from https://mydss.mo.gov/media/file/behavioral-health-services-provider-manual.

[208] Texas Medicaid & Healthcare Partnership. (2026, July). *Texas Medicaid Provider Procedures Manual, Provider Handbooks: Medicaid Managed Care Handbook* (Volume 2). https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/pdf-chapters/2026/2026-07-july/2_12_medicaid_managed_care.pdf.

[209] Managed Care: Definitions.42 C.F.R. § 438.2 and Definitions and use of terms.42 C.F.R. § 457.10.

[210] Managed Care: Definitions.42 C.F.R. § 438.2 and Special contract provisions related to payment. § 438.6(c).

[211] CMS. (n.d.). *State Budget & Expenditure Reporting for Medicaid and CHIP*. Retrieved July 28, 2026, from https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip.

    - **Line 1C (Premiums - Over 150 Percent of Poverty Level):** Use this line to report the gross capitation payments paid to health plans for children whose family income exceeds 150 Percent of the FPL.

- **Documentation Oversight:** For Medicaid and CHIP managed care, capitation payments paid to managed care plans and reported on Forms CMS-64 and CMS-21 are supported by encounter data, which serves as the managed care equivalent of paid FFS claims data. Because state expenditures for managed care programs are reflected in capitation payments rather than individual service costs, encounter data provides the necessary granular detail of the actual services delivered.

Because managed care plan-provider payment terms are generally negotiated by managed care plans and may not be publicly available, managed care provider payment for ABA may be more difficult to compare across states than FFS fee schedule rates. State oversight may focus on whether managed care plans maintain adequate provider networks, comply with contract requirements, report complete encounter data, and ensure access to medically necessary services consistent with Medicaid and CHIP requirements.

Payment Methodologies

The following sections describe common ABA payment methodologies for providers, and highlight how each approach affects administrative burden, access, and program integrity.

Fee-For-Service Provider Payment

FFS payment methodologies can vary substantially across states.[212] Below is a description of these payment structures, including fee schedules by procedure code, bundled payments, per diem, and value-based approaches.

Fee Schedule by Procedure Code

Many states pay for ABA under Medicaid FFS through a group of ABA-specific CPT codes (97151 through 97158) billed in 15-minute units:

Applied Behavior Analysis-Specific Current Procedural Terminology Codes[213]

97151 — Behavior Identification Assessment

97152 — Behavior Identification Supporting Assessment

97153 — Adaptive Behavior Treatment Using an Established Plan – most frequently billed

97154 — Adaptive Behavior Treatment With Group Using an Established Plan

97155 — Adaptive Behavior Treatment Modifying an Established Plan

97156 — Adaptive Behavior Treatment With Family Using an Established Plan

97157 — Adaptive Behavior Treatment With Multiple Family Members Using an Established Plan

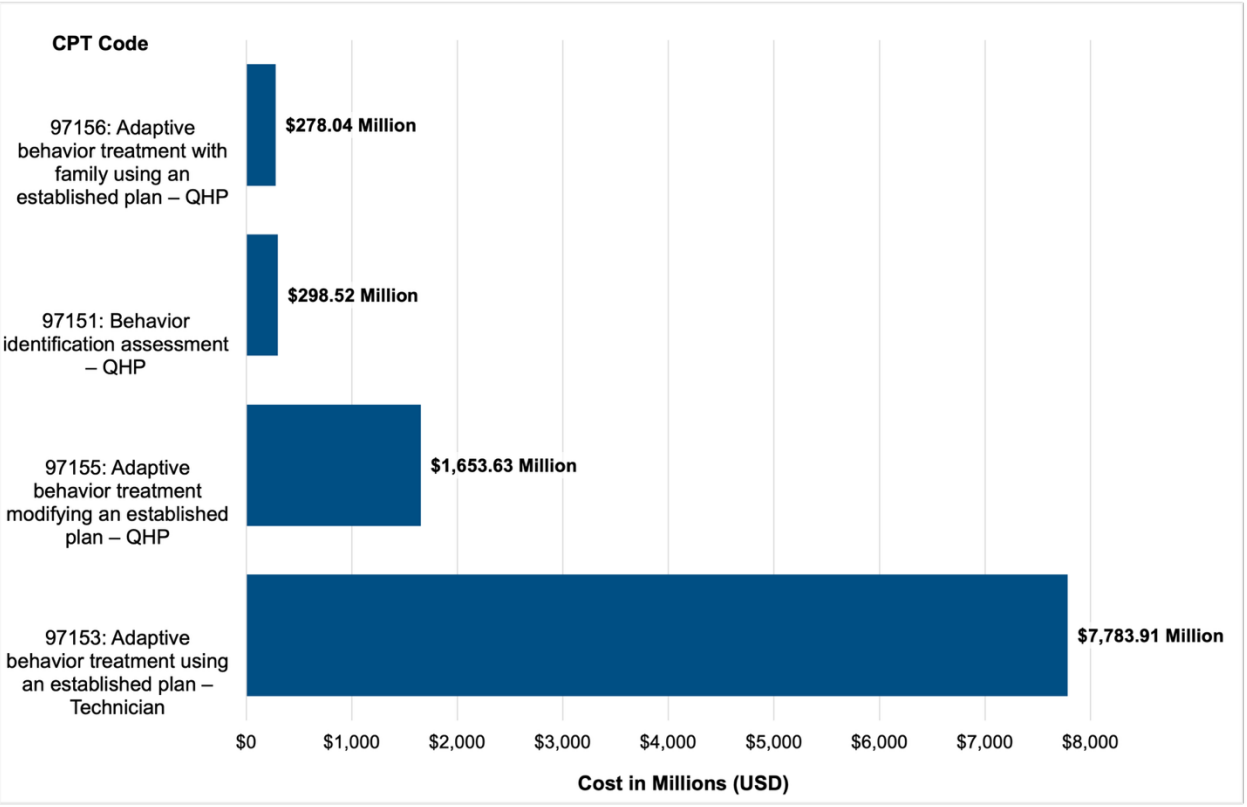
[212] Section 1902(a)(30)(A) of the Act requires that payment rates must be economic and efficient.

[213] American Medical Association (AMA). (2024). *CPT® Professional 2025*. AMA.

97158 — Adaptive Behavior Treatment With Group Modifying an Established Plan

Appendix D provides additional details related to the ABA-specific CPT codes. States may differentiate codes by site of service to consider travel costs and time associated with travel and often differentiate CPT codes by the credential level of the billing provider (e.g., BCBA versus BCaBA versus RBT). BCBA and BCaBA providers may receive a higher rate than an implementing technician. This reflects differences in levels of education, licensure requirements, and labor market costs between supervising BCBAs and implementing technicians, with some states paying BCBA and BCaBA providers and qualified health care professionals (QHPs) at substantially higher rates than technicians. Figure 10 shows the total amount paid for each CPT code delivered to beneficiaries across Medicaid and CHIP in 2025. Please see Chapter 5 for a detailed discussion on provider credentialing.

Figure 10: Total Amount Paid for Applied Behavior Analysis Services by Current Procedural Terminology Code, 2025



Source: T-MSIS OT claims and associated eligibility data, 2025 for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam. Analysis includes the paid amount for procedure codes 97151–97158 across Medicaid and CHIP FFS claims and managed care encounters. Results are intended for analytic use.

Note: Values less than $100,000,000 were too small to be visually distinguished and have been excluded. Excluded CPT codes include: 97157: multiple-family group adaptive behavior treatment ($685,232); 97158: Adaptive behavior treatment social skills group ($7,243,500); 97152: Supporting behavior assessment (technician/mid-level providers) ($19,704,194); and 97154: Group adaptive behavior treatment (technician) ($64,933,529).

State Considerations

Claims: can be submitted for each date of service rather than combining multiple days into one claim. This approach enhances payment integrity by enabling states to validate that claimed service hours correspond with actual treatment delivery records.

Payment Rate Review: evaluates the rates paid for covered services to ensure that the payment levels are set sufficiently to encourage provider participation while maximizing outcomes and value.

Documentation: fee schedules, state plan language, and provider guidance should consistently describe which provider types may bill each code and how supervision is reflected in the rate structure.

Bundled Payments

Under Medicaid FFS, bundled payment methods provide a single payment for a defined episode of care or treatment phase rather than individual service units. Under a bundled approach, a provider receives a fixed payment for a specified period or treatment goal (for example, an initial assessment and treatment planning phase, or a 90-day intensive treatment episode). This model creates incentives to deliver services efficiently and to move beneficiaries toward functional goals rather than maximizing billable units. Currently, no state Medicaid program has implemented a fully bundled payment model for ABA under Medicaid FFS.

Stakeholders voiced support for bundling specific activities such as the assessment phase (CPT 97151 and related assessment codes) into a single flat-rate encounter or bundled assessment payment, then paying FFS for ongoing treatment. However, stakeholders noted that poorly designed bundles could incentivize early discharge or case selection that disadvantages children with the greatest needs.

State Consideration

States considering bundled payments should pair the rate structure with session note requirements and periodic post-payment reviews to address oversight gaps that federal auditors have identified in ABA programs operating without sufficient claims-level controls. States considering bundled payments should review the CMS toolkit for Bundled Payment Methodologies.[214]

Per Diem Rates

Under Medicaid FFS, a per diem arrangement is a type of bundled payment in which a provider receives a fixed daily rate covering all services delivered on a given date. Per diem models reduce administrative burden for both providers and states by eliminating the need to track and audit individual 15-minute billing units. However, stakeholders noted that per diem approaches introduce their own integrity risks: without unit-level documentation requirements, it can be more difficult for states to verify that a full day of billable services was delivered, or to distinguish the amount and intensity of treatment provided on a specific day.

[214] CMS (2018). *Bundled Payments* [Bundled Rate Payment Methodology]. https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/bundled-rate-payment-methodology.pdf.

State Consideration

States considering per diem rates may wish to specify minimum service expectations, required session notes, and audit protocols to ensure that billed days reflect clinically appropriate treatment.

Value-Based Approaches

VBP models under Medicaid FFS for ABA tie some portion of provider payment to performance on defined process, quality, or outcome measures, rather than compensating for volume of services delivered. Interest in VBP for ABA has grown as states seek payment structures that reward appropriate reductions in service intensity over time, timely achievement of functional goals, and high-quality care. States considering VBP models should consider implementing safeguards (e.g., risk adjustment or stratification) so that providers are not incentivized to avoid treatment of individuals with higher support needs.

States have considerable flexibility under Medicaid statutes and regulations to develop VBP models for ABA providers. CMS issued State Medicaid Director Letter (SMDL) # 20-004 Value-Based Care Opportunities in Medicaid, that describes a number of VBP models available to state Medicaid agencies. Under value-based care (VBC) arrangements, providers are rewarded – based on specific evidence of performance on quality measures – for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives, as part of a larger health care system effort.[215] The principles of VBC arrangements may be applied to ABA in several ways, including, but not limited to:

1. **Provider training and certification**: CMS has approved numerous Medicaid state plan amendments that tier payments to providers for achieving training and certification milestones. Higher payments to providers who meet prespecified milestones create incentives for providers to add to their professional skills, leading to a workforce more capable of delivering high-quality ABA care. A Centers of Excellence distinction could be used to incentivize clinics and centers with strong outcomes, appropriate utilization, engaged caregivers, adequate documentation, and transition planning.
2. **Process measures**: States may reward providers for meeting process measures, such as reporting on quality measures. Process measure rewards may help to establish the expectations ABA providers must meet to participate in Medicaid programs, as well as provide initial data on ABA service outcomes. States are expected to evolve from rewarding providers for foundational process measure reporting to outcomes and quality measure reporting. For example, measures could be related to emergency department utilization, parent or caregiver satisfaction, and one of the outcome measures described in Chapter 2. ABA providers or clinics could have payment tied to process or outcome measures similar to other VBC arrangements.
3. **Episodes of care**: Episodes of care models are condition- or diagnosis-based pre-established payments or target cost amounts for an array of services provided in a specified period of time. CMS has approved these payment models under the Medicaid

[215] CMS. (2020, September 15). *SHO # 20-004 RE: Value-Based Care Opportunities in Medicaid* [State Medicaid Director Letter (SMDL)]. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf/.

state plan authority using expert panel clinical standards to define the diagnoses, included services, and treatment time limits. States may incorporate provider incentives to meet target costs while including minimum service provision requirements that aim to prevent underutilization incentive gaming. States may also include provisions that impose penalties on providers for not achieving required quality and outcomes performance and exceeding payment or target cost amounts.

4. **Risk-sharing models**: These models may include rewards (gainsharing) or penalties (risk-sharing). When providers achieve savings and meet performance (reporting, quality, outcomes) targets, they may be paid gainsharing rewards. Under risk-sharing models, state Medicaid agencies may impose penalties on providers when costs or payments exceed pre-established targets.[216]

Stakeholders noted that a VBP arrangement that incentivizes outcomes and appropriate reductions in intensity and length of care over time, while requiring standardized, risk-adjusted measures of progress, clear discharge criteria tied to functional outcomes, and payment structures that reward timely improvement may result in better incentives for providers, greater transparency for families, and more predictable spending for states.

State Consideration

- States exploring value-based models may consider measures that are feasible to collect, such as timely reassessment or reduction in emergency department visits, while longer-term functional outcomes are refined.
- States should include risk adjustment or stratification so that value-based arrangements do not inadvertently discourage providers from serving children with greater support needs.

Managed Care Provider Payment

Managed care plans also utilize a variety of payment methodologies when negotiating payment with contracted providers, including similar approaches to the methodologies described in the FFS section (e.g., fee schedule by procedure code, bundled payment, per diem, VBP, etc.).

Applied Behavior Analysis Rates Across States

Medicaid ABA payment rates vary substantially across states. Rate variation may be the result of different cost-of-living environments, different rate-setting, and Medicaid spending philosophies. Table 10 below provides examples of the lowest and highest state-reported FFS 2025 rates for specific ABA CPT codes. Appendix E provides reported state rates for ABA CPT codes.

[216] CMS issued SMDL #13-005 *Shared Savings Methodologies* in 2013 to describe the requirements of shared savings payment models that may be implemented under Medicaid payment authorities. See: https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-005.pdf.

Table 9: Lowest and Highest Fee-For-Service 2025 Rates for Specific Applied Behavior Analysis Current Procedural Terminology Codes

ABA CPT Codes	Lowest Rate	Highest Rate
97151: Behavior Identification Assessment-QHP	$18.79 Washington State	$112.65 New Mexico
97152: Behavior Identification Supporting Assessment - Technician	$9.90 West Virginia	$41.74 Mississippi
97153: Adaptive Behavior Treatment by Protocol - Technician	$10.39 North Dakota	$22.63 Alaska

Source: Rates from CASP's *50 State Applied Behavior Analysis Medicaid Benefit Comparison* were verified by CMS using actual FFS claims-paid amounts from Medicaid claims data TAF. See: CASP. (2025). 50-state applied behavior analysis Medicaid benefit comparison. https://www.casproviders.org/medicaid-rate-data

Note: All rates listed are publicly available FFS rates. Rates are in 15-minute increments.

State Consideration

- When reviewing ABA rates, states may consider benchmarking local ABA rates against those in similar states to help assess whether rates are competitive enough to support provider participation while maintaining fiscal sustainability and cost-effectiveness.
- States should also ensure that rate comparisons are interpreted considering differences in service definitions, credentials, and delivery systems across states.

Chapter 5. Applied Behavior Analysis Provider Qualifications, Credentialing and Enrollment, and Ownership

ABA provider enrollment, qualifications, and credentialing have emerged as program design factors that are related to Medicaid and CHIP ABA spending and utilization trends as well as program integrity. This chapter discusses:

- ABA provider qualifications
- Medicaid provider enrollment and managed care plan credentialing processes
- Supervision
- Telehealth
- Organizational accreditation, corporate structures, and ownership
- Mechanisms to monitor provider ownership changes

The sections in this chapter describe which ABA providers and organizations are best qualified to furnish services, how states and managed care plans enroll and credential them, and how supervision and ownership structures shape program integrity and access.

Applied Behavior Analysis Provider Qualifications

States have flexibility in determining the qualifications of ABA providers. State-defined provider qualification and supervision standards serve three main purposes:

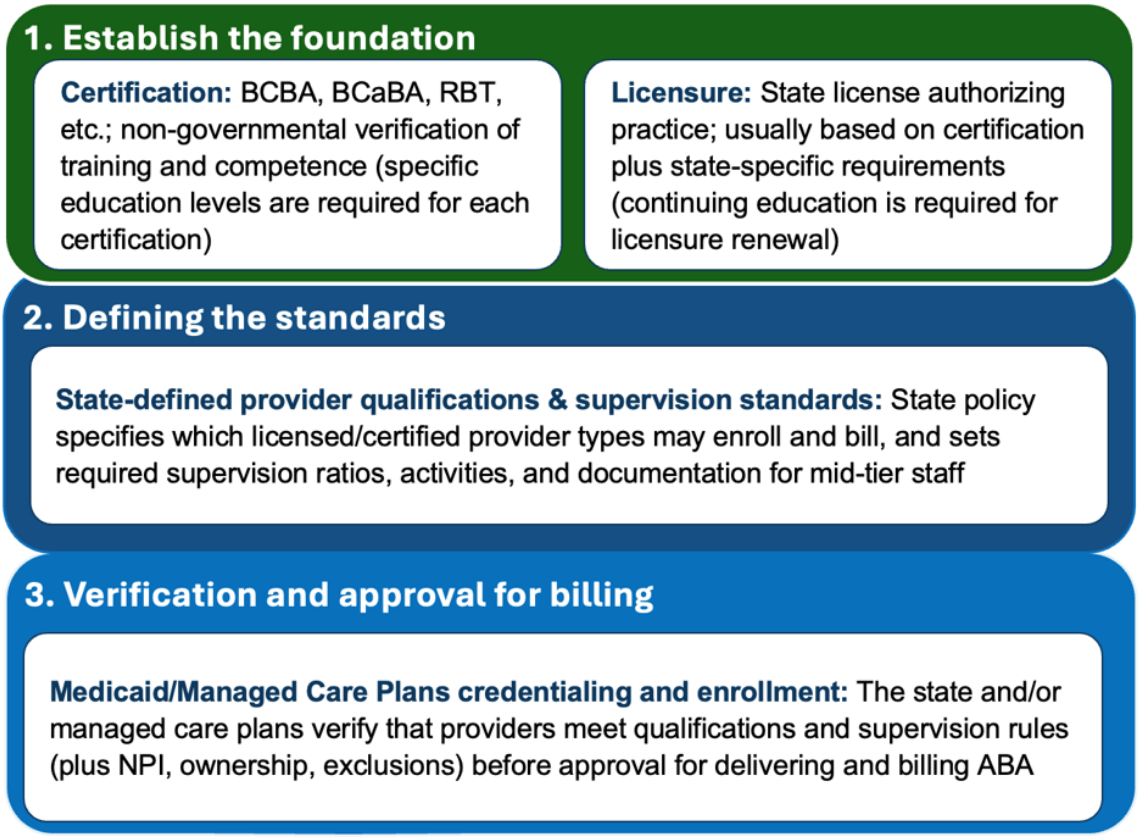
- Verifying that ABA providers meet minimum education and training
- Ensuring that only eligible provider types can enroll in and bill for ABA
- Creating a framework for taking action when a provider's credentials lapse, are restricted, or are revoked

ABA providers may have varied educational backgrounds in medical and behavioral health professions including psychology, counseling, social work, or other clinical practices. States commonly rely on nationally recognized behavior analysis credentials and state licensure requirements as the foundation for Medicaid and CHIP provider qualification standards (as discussed below). Therefore, training, certification, and licensure, as applicable, are important to ensure ABA providers adhere to professional and competency standards.[217] States should establish clear provider qualification standards for ABA that require appropriate training, certification, and licensure, as applicable, and that align with nationally recognized behavior analysis competency standards and relevant state scope-of-practice requirements. In the absence of federally prescribed ABA-specific provider qualifications, states should define the minimum credentials, supervision requirements, and competency expectations for each provider type to promote quality, consistency, and program integrity. Figure 11 below highlights how

[217] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines], 6. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

provider certification and licensure form the foundation for state-defined provider qualification and supervision standards that are then verified through provider enrollment and managed care plan credentialing before ABA providers can deliver and bill for services.

Figure 11: Provider Qualification Framework



Certification

The primary organization issuing ABA provider certification in the U.S. is the Behavior Analyst Certification Board (BACB), with most but not all states requiring BACB certification.[218,219, 220] This is a nonprofit 501(c)(3) corporation established for the purpose of certifying providers of behavior analysis services. The BACB sets the standards and criteria to be met by ABA providers to ensure that providers of these behavior analysis services meet the legal standards through state, national, and case law, and the best practice standards for the profession.[221] BACB certifications are the predominant ABA provider certification and are accredited by the National Commission for Certifying Agencies (NCCA), the accreditation arm of the Institute for

[218] See Table 12 for non-BACB certification organizations.

[219] BACB. (n.d.). *Behavior Analyst Certification Board*. Retrieved July 28, 2026, from https://www.bacb.com.

[220] BACP. (n.d.). *U.S. licensure of behavior analysts*. Retrieved July 28, 2026, from https://www.bacb.com/u-s-licensure-of-behavior-analysts/.

[221] BACB. (2026). *Board certified behavior analyst handbook*. https://www.bacb.com/bcba-handbook.

Credentialing Excellence. NCCA accreditation applies to personnel certification programs for individual practitioners, rather than to ABA provider organizations. The online BACB Certificant Registry can be used to verify an ABA provider's certification.[222] Additional details about state-specific requirements for ABA providers are listed in the sections below.

Certified Provider Types

Error! Reference source not found. There are various levels of BACB certification for ABA providers, and each type has different requirements.[223] Table contains a list of BACB-certified provider types along with descriptions of their roles:

[222] BACB. (n.d.) *BACB certificant registry.* Retrieved July 28, 2026, from https://www.bacb.com/services/.

[223] BACB. (n.d.). *Homepage*. Retrieved July 28, 2026, from https://www.bacb.com/.

Table 11: List of Behavior Analyst Certification Board-Certified Applied Behavior Analysis Provider Types

BACB certifications	Description	Requirements
Behavior Analysts (Board Certified Behavior Analysts [BCBAs])[224]	Independent providers with a graduate-level certification in behavior analysis; they are equipped to both provide ABA and supervise the other types of recognized mid-level providers; see BCBA Handbook for more details	• Completion of a master's degree in behavior analysis or a related field • Approved coursework • Supervised fieldwork • Successful passage of the BCBA examination
Board Certified Behavior Analyst-Doctoral (BCBA-D)[225]	Those with doctoral-level training in behavior analysis can attain the doctoral-level designation; they are equipped to both provide ABA and supervise the other types of recognized mid-level providers; see BCBA Handbook for more details	• Completion of a doctoral degree in behavior analysis or a related field • Approved coursework • Supervised fieldwork • Successful passage of the BCBA examination
Assistant Behavior Analysts (Board Certified Assistant Behavior Analysts® [BCaBAs®])[226]	Providers with an undergraduate-level certification in behavior analysis who provide services under the supervision of a BCBA; they are able to supervise RBTs® under the supervision of a BCBA or BCBA-D; see BCaBA Handbook for more details	• Completion of a bachelor's degree in behavior analysis or a related field • Approved coursework • Supervised fieldwork • Successful passage of the BCaBA examination
Registered Behavior Technicians® (RBTs®)[227]	Technicians with a high school diploma-level certification in behavior analysis who provide services under the close supervision of a BCBA or BCaBA; see Registered Behavior Technician Handbook for more details	• Completion of a high school-level education, or high school equivalency credential • Completion of a standardized 40-hour training • Successful passage of the competency assessment

BACB certifications are the most commonly referenced certifications in publicly available Medicaid manuals. However, other non-BACB certifications are available (see Table). As previously mentioned, certifications are specific professional qualifications awarded by a certifying body. The review of publicly available state Medicaid regulations did not indicate that these non-BACB certifications were determined by states to be sufficient to bill for ABA on their own, nor did the review of publicly available regulations provide specific information about

[224] BACB. (2026). *Board certified behavior analyst handbook,* 1-2, 5. https://www.bacb.com/bcba-handbook.

[225] BACB. (2026). *Board certified behavior analyst handbook,* 5, 66. https://www.bacb.com/bcba-handbook.

[226] BACB. (2026). *Board certified assistant behavior analyst handbook,* 1-2, 5. https://www.bacb.com/bcaba-handbook.

[227] BACB. (2026). *Registered behavior technician handbook,* 1-2,5. https://www.bacb.com/rbt-handbook.

whether providers with non-BACB certifications were to be supervised by BACB-certified providers. States should identify ABA provider qualifications under the relevant benefits in their state Medicaid plans, and only providers meeting those qualifications are eligible to receive Medicaid reimbursement.

Table 12: Non-Behavior Analyst Certification Board Certifications

Organization	Description	Certification	Links
Qualified Applied Behavior Analysis Credentialing Board (QABA®)	Founded in 2012 and accredited by the American National Standards Institute, the QABA provides three tiers of credentials	• ABA Technician (ABAT®): entry level • Qualified Autism Service Practitioner–Supervisor: supervisor level • Qualified Behavior Analyst–master's level	https://qababoard.com/
International Behavior Analysis Organization	An international ABA credentialing organization	• International Behavior Analyst® Certification • International Behavior Therapist® Certification	https://www.ibao.org
International Board of Credentialing and Continuing Education Standards (IBCCES)	International organization that provides training and certification in the fields of autism, neurodiversity, and accessibility	• Certified Autism Specialist • Advanced Certified Autism Specialist • Autism Certificate • Advanced Autism Certificate	https://ibcces.org/

Licensure

State ABA licensure is another option to ensure ABA providers possess the necessary qualifications. While ABA provider certifications and licenses have similar requirements for coursework, supervised training, and degrees, there are important distinctions between them. Certifications are voluntary and overseen by non-governmental entities (e.g., the BACB). These certifying entities enforce the requirements for their own certifications, but they cannot require providers to receive a certification. In contrast, licensure is a requirement for ABA providers that is regulated and enforced by state licensing boards. Most states (39 states plus Washington, D.C.) rely on national BACB certification plus state licensure or registration – rather than operating separate state ABA certification programs – when defining which providers may enroll in Medicaid and bill for ABA.[228] In non-licensure states, payers often rely on national BACB certifications.

[228] Quinn, N. R. (2026, March 19). *State-by-State Guide to ABA Licensing and Certification Requirements.* https://www.appliedbehavioranalysisedu.org/state-by-state-guide-to-aba-licensing/.

STATE SPOTLIGHT: Certification and Licensure at the State Level

In 2026, North Carolina passed legislation that requires Medicaid providers who deliver Research-Based Behavioral Health Treatments (RB-BHT) for ASD to obtain licensure or certification according to the state's statutes and to practice within the scope of practice as defined by the individual practice board.[229] The following provider types are recognized by the state as Licensed Qualified Autism Providers: physician, developmental, or behavioral pediatrician; licensed psychologist; licensed psychological assistant; occupational therapist; speech and language pathologist; licensed clinical social worker (LCSW); Licensed Professional Counselor (LPC) or Licensed Clinical Mental Health Counselor (LCMHC); Licensed Marriage and Family Therapist (LMFT); and other licenses allowed to independently practice RB-BHT (the state recognizes LBAs per the North Carolina Analyst Licensure Board[230]). Certified professionals must receive a Registered Behavior Technician certification from the BACB or an ABAT certification from the QABA.

The legislation also prohibits BCBA supervisors and Qualified Autism Service Practitioner supervisors from enrolling in the North Carolina Medicaid program as out-of-state providers.

- More information about both certification and licensure is provided below.[231] The **BACB certification** is foundational in that it demonstrates a provider has met the BACB's education and supervised experience requirements. Therefore, a BACB certification is often the basis for obtaining behavior analyst licensure granted by states.[232] This overlap in the criteria for certification and licensure is cost effective and ensures that the core competencies are regularly updated according to the latest best practices and research.
- **State licensure** then builds on the BACB certification, thus allowing providers to legally practice in a state and bill insurance.[233] Licensure is generally required for independent practice and may be necessary for Medicaid or managed care plan enrollment. Typical requirements include holding a BCBA credential, completing a background check, submitting an application to the licensing board, and maintaining continuing education.

In states with ABA licensure, the title for the qualifying provider is typically a Licensed Behavior Analyst (LBA) or a Licensed Applied Behavior Analyst (LABA). These titles vary across states, and, for the purposes of this toolkit, will be referred to as an LBA. LABAs provide ABA under the supervision of an LBA or another qualified provider. BACB maintains a list of the licensing boards for each state along with the most current information about state-specific

[229] North Carolina General Assembly. (2026). House Bill 696. https://www.ncleg.gov/Sessions/2025/Bills/House/PDF/H696v4.pdf.

[230] North Carolina Behavior Analyst Licensure Board. (n.d.). *Home.* Retrieved July 28, 2026, from https://ncbehavioranalystboard.org/.

[231] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines]. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[232] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines]. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[233] Quinn, N. R. (2026, March 16). *ABA Licensing Laws: Consumer Protection and How the Field Got Here.* Retrieved July 28, 2026, from https://www.appliedbehavioranalysisedu.org/aba-licensing-is-about-consumer-protection-heres-how-it-evolved/.

requirements.[234] Each state may have additional conduct standards or rules that apply to telehealth for licensees, which is explored in more detail later in this chapter. Each state licensing board or state agency is responsible for enforcing the rules and regulations for ABA providers. [235] Because licensure frameworks vary across states, a BCBA is not automatically an LBA, and a review of state credential categories does not indicate what proportion of certificants also hold state licensure. In non-licensure states, Medicaid and CHIP programs should at minimum require nationally recognized ABA certifications and clearly defined supervision and competency standards while working toward the development of a licensure framework that allows the state to regulate practice, enforce ethical standards, and align ABA provider requirements with other licensed behavioral health professions.

BEST PRACTICE

Provider Licensure

States should require state licensure (or registration under a state behavior analyst practice act) for independent ABA providers, using national credentials such as BACB certification as a baseline prerequisite for licensure or enrollment rather than a substitute for state oversight. Providers should meet licensure requirements before being able to bill for ABA.

Eligibility of Providers to Bill for Services

Each state is required to screen and enroll ABA providers as a condition of participation in the program, and generally before managed care plans can add a provider to their network.[236] Managed care plans must operate credentialing and recredentialing processes that align with state and federal requirements. At a minimum, ABA provider enrollment should include verification of identity, National Provider Identifier (NPI), licensure and certification status, education and training, ownership disclosures, and checks against federal and state exclusion lists. All ABA providers should have their own NPI, even those billing under a supervisor. Managed care plans often layer their own credentialing criteria on top of state minimums, such as requiring participation in organizational accreditation programs, additional background checks, or more frequent recredentialing cycles.

States authorize a variety of provider types to deliver and bill for ABA. These typically include BCBAs, BCaBAs, LBAs, RBTs, and state-defined technicians or assistant-level providers. Individual providers bill their services through the supervising provider or agency.

[234] BACB. (n.d.). *U.S. licensure of behavior analysts*. Retrieved July 28, 2026, from https://www.bacb.com/u-s-licensure-of-behavior-analysts/.

[235] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines], 9. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[236] Managed Care: State Responsibilities, 42 C.F.R. § 438.602(b)(2).

State Provider Enrollment Requirements

Each state must screen, enroll, and revalidate Medicaid and CHIP providers, including providers furnishing ABA, in accordance with federal Medicaid and CHIP enrollment and screening requirements. To provide ABA to Medicaid beneficiaries, providers generally must enroll in Medicaid and, if applicable, contract with the relevant managed care plan(s). These processes typically require basic provider enrollment and screening information, including an NPI and ownership information.[237]

States should have clear enrollment policies regarding:

- Whether the enrolling provider is the individual provider, the agency, or both;
- Whether technicians must enroll, register, or only be linked to a supervising provider;
- What credentials or licenses must be verified at enrollment; and
- How supervision relationships are documented for oversight and billing purposes.

Clear enrollment policies in these areas can help states reduce improper billing risk, support accurate claims processing, and avoid unnecessary barriers to provider participation.

Supervision Requirements

To ensure high-quality care and fiscal accountability, states must establish clear parameters for the ABA workforce. States set provider supervision standards to safeguard individual safety and maintain program integrity. Many states adopt tiered credentialing mirroring the BACB structure to maintain clinical integrity while expanding access. This alignment supports uniform standards and interstate portability of credentials. However, some states define more stringent requirements.

Typically, ABA providers operate with a tiered delivery service model, in which a BCBA is responsible for assessment, treatment design, and clinical oversight. Depending on the service model, payer requirements, and clinical needs of the individual, the BCBA may also directly deliver ABA. In a tiered delivery service model, the BCBA develops and oversees a treatment program that is usually executed by either a BCaBA and/or an RBT. [238] Supervision is a primary part of the BCBA role with the intent to:

- Observe the BCaBA/RBT implementing the treatment plan to ensure it fits the needs of the individual, and adapt the plan as needed
- Provide care coordination
- Monitor and report on progress
- Provide any support or training

[237] 45 C.F.R. § 162.406; 42 C.F.R. §§ 455.104-106, 42 C.F.R. § 455.410; 42 C.F.R. § 438.214.

[238] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines], 10-14, 19. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

Direct and Indirect Supervision

Supervision activities comprise direct and indirect activities. Some activities can be both direct and indirect, such as when the BCBA observes a treatment session and then analyzes and summarizes program data when documenting services in a session note. A list of both types is provided in Table below: [239]

Table 13: Types of Supervision Activities

Direct Supervision Activities	Indirect Supervision Activities
• Implementing and managing the treatment plan • Training technicians to carry out treatment protocols accurately, frequently, and consistently; record data on treatment targets; record notes; and summarize and graph data • Supervising implementation with technicians and caregivers • Conducting direct observation of performance on treatment targets • Observing treatment implementation for potential program revision • Training technicians to implement revised protocols • Directing technicians in the implementation of new or revised protocols (with the individual present) • Monitoring treatment integrity to ensure protocols are implemented appropriately • Reviewing progress with the individual and caregiver and revising the plan and/or goals based on that review	• Developing the treatment plan • Developing treatment goals, protocols, and data collection systems • Selecting treatment targets in collaboration with caregivers and other stakeholders • Writing protocols for treating and measuring all treatment targets • Developing treatment fidelity measures • Summarizing and analyzing data • Reviewing individual data and evaluating individual progress • Adjusting protocols based on data • Coordinating care with other providers • Directing and guiding the implementation of a crisis intervention • Modifying treatment targets and protocols based on data • Reporting progress toward goals • Developing and overseeing a transition or discharge plan • Reviewing individual progress with technicians without the individual present to refine treatment protocols • Directing technicians in the implementation of new or revised protocols, without the individual present

[239] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines], 55-56. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

Whether a supervision activity is billable should be determined by referring to a specific state's Medicaid ABA provider manual. Billable supervision activities typically involve individual-specific clinical services that are documented as direct treatment oversight. These can include supervision activities such as in-person observation for clinical decision-making, live clinical direction to the BCaBA/RBT, or caregiver training and treatment guidance. These activities are often associated with the CPT codes for adaptive behavior treatment by protocol (97153), adaptive behavior treatment with protocol modification (97155), and family adaptive behavior treatment guidance (97156).[240,241] The general guideline for whether a supervision activity is billable is determined by whether the supervision activity is a direct, medically necessary individual service (billable) compared to activities that are related to training, employment supervision, or administrative processes (non-billable).

> "BCBAs may spend 25-30 percent of their time performing indirect supervision activities (which may or may not be billable) and non-billable administrative, professional, or organizational activities."
>
> https://www.casproviders.org/asd-guidelines

Requirements for Supervision Hours

Clinical practice guidance and credentialing requirements emphasize supervision as a core component of ABA service quality.[242] It is important to distinguish between minimum supervision requirements for credentialed staff and broader clinical recommendations for case oversight. For services delivered by RBTs, BACB requirements specify that the RBT must receive supervision by a BCBA or BCaBA with the number of supervision hours being commonly determined based on the number of hours a RBT spends delivering ABA.[243] RBTs are required to obtain a minimum of ongoing supervision equal to 5 percent of the hours providing services in a calendar month[244] – this is specific to the RBT's service-delivery hours, not the BCBA's hours, and represents a minimum credentialing requirement rather than a recommended supervision level for all cases.[245]

Separately, clinical practice guidelines recommend approximately 10 to 20 percent supervision relative to direct treatment hours, such as 1 to 2 hours of supervision for every 10 hours of direct treatment, or 1 to 2 hours per week when direct treatment is 10 hours or less. Higher levels of supervision may be clinically appropriate for individuals with more complex needs, newly trained

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[240] AMA. (n.d.). *Behavioral health coding resource*, 3. https://www.ama-assn.org/system/files/behavioral-health-coding-resource.pdf.

[241] AMA. (2024). *CPT® Professional 2025* (1st ed.). AMA.

[242] Supervision requirements for other types of ASD treatment may vary.

[243] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines], 8, 59-61. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[244] BACB. (2026). *Supervision Checklist for RBT Supervisors and RBT Requirements Coordinators*. https://www.bacb.com/wp-content/uploads/2025/09/RBT-Supervisor-RBT-Requirements-Coordinator-Supervision-Checklist-260617-a.pdf.

[245] BACB. (2026). *Registered behavior technician handbook*. https://www.bacb.com/wp-content/uploads/2025/08/RBTHandbook_260529-2-a.pdf.

staff, telehealth-delivered services, or cases involving safety concerns or significant behavior challenges. States and payers may also impose additional supervision requirements.[246]

Guidelines for the Number of Supervision Hours per Direct Treatment Hour

- One to two hours of supervision for every 10 hours of direct treatment (1-2:10), or
- One to two hours of supervision per week if direct treatment is 10 hours or less per week.

The exact ratio of supervision hours per direct treatment hour varies per an individual's needs; therefore, providers are encouraged not to restrict the number of supervision hours to the minimum because some individuals with ASD may need more or less supervision.[247]

Additional Supervision Requirements

More frequent supervision may be needed when:

- Individuals with ASD are making rapid progress or having a lack of progress so the treatment plan can be adjusted to their needs
- Individuals with ASD have had barriers to accessing care and may need more supervision to problem-solve or adapt their treatment plan to facilitate progress
- Individuals with ASD have severe behaviors or other complexities
- It is early in the assessment period or the treatment plan
- There are transitions to the treatment plan
- There are changes in the number of direct treatment hours which can increase the number of supervision hours needed

Less frequent supervision may be adequate when:

- There is a plan to fade out or step-down services
- The treatment plan is to maintain the current function

A provider's ability to perform supervision activities may be impacted by various factors.[248] Table 14 below lists factors that can positively impact a provider's ability to provide supervision.

[246] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumer* (Version 3.0) [Clinical practice guidelines], 60. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[247] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumer* (Version 3.0) [Clinical practice guidelines], 60. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[248] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumer* (Version 3.0) [Clinical practice guidelines], 60. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

Table 14: Factors That Positively Impact the Ability to Provide Supervision

Factors	Explanation
Greater percentage of reimbursement for indirect supervision activities	Supervisors are financially incentivized to dedicate more time to supervision when more indirect supervision activities are reimbursable
Organizational support for clinical management and administrative activities	Providers who have access to integrated practice management systems have additional support, so less time is spent on administrative work
Higher levels of experience with specific individuals with ASD	Higher caseloads are possible when BCBAs have expertise in specific populations
Experienced BCaBAs supporting care or providing supervision for BCBAs	Higher caseloads are also possible when BCaBAs can help with supervising RBTs
More centralized locations for services	Providers have more time for supervision when the location of services is centralized rather than occurring across different locations (e.g., home, school)

States and payers may impose additional supervision requirements specific to caseloads, the ratio of direct treatment services, or the minimum or maximum number of RBTs supervised.[249] There are state-specific policies pertaining to supervision requirements spotlighted below.[250]

[249] CASP. (2025). *50 State Applied Behavior Analysis Medicaid Benefit Comparison*. Retrieved July 28, 2026, from https://www.casproviders.org/medicaid-rate-data.

[250] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* (Version 3.0) [Clinical practice guidelines]. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

STATE SPOTLIGHT: Medicaid Supervision Requirements for Applied Behavior Analysis Services

Minimum Requirements

In Arkansas, BCBAs must conduct in-person observations of the ABA therapy treatment performed by the BCaBAs/RBTs who are under their supervision.[251] The minimum thresholds for these observations are 5 percent of the total treatment hours provided by the BCaBA/RBT and 1 hour of treatment provided every 30 days. The BCBAs, who are ultimately responsible for the care provided, must be enrolled as Arkansas Medicaid providers, must be on-call and available to assist BCaBAs/RBTs during a therapy session, and must review and approve any of the data or progress notes completed by a BCaBA/RBT before a claim may be submitted for the therapy.[252]

Ratio-based Requirements

In Louisiana, state-certified assistant behavior analysts (CaBA) and registered line technicians must be supervised by a licensed behavior analyst (LBA) on a 2:10 basis.[253] That is, the CaBAs and registered line technicians must be supervised for 2 of every 10 hours of ABA services provided.

Supervisor Caseload Maximums

In Nebraska, when licensed assistant behavior analysts (LABA) or RBTs provide ABA services, they must be supervised and directed by a licensed clinician with training in ABA.[254] Specifically, LABAs must be supervised by LBAs, RBTs must be supervised by an LBA or a psychologist with ABA training, and provisionally licensed psychologists must be supervised by a licensed psychologist with ABA training. The caseload for supervisors of ABA services may not exceed 24 technicians.

Guidelines for Supervisor Role

BCBAs can supervise BCaBAs (mid-level providers) who provide supervision for RBTs. The exact proportion of hours and types of supervision activities divided among the BCBAs and the BCaBAs may vary based on the experience of the BCaBA and the needs of the individuals with ASD. However, BCBAs should maintain at least 25 percent of the supervision across their caseload, unless there are valid reasons why a BCaBA, for example, could manage more supervisory responsibilities (e.g., a planned fading out of services, a BCaBA's prior experience, etc.).[255] Table 15 provides detailed supervision requirements based on the type of provider.

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[251] Arkansas Department of Human Services, Division of Medicaid Services. (n.d.). *Applied Behavior Analysis Services Provider Manual, Section II*. Retrieved July 28, 2026, from https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/abatherapy-prov/.

[252] This example is based on Arkansas's requirements at the time this toolkit was published. However, based on extensive discussion with their ABA stakeholder group, the state anticipates updating their ABA Medicaid manual to revise the ABA services supervision requirements. For example, under the current requirements, a supervising BCBA must meet a minimum number of in-person observation thresholds for the providers in their caseload. However, under the proposed requirements, the minimum observation thresholds would apply to the beneficiaries under a BCBA's case supervision.

[253] Louisiana Department of Health. (2014). *Applied Behavior Analysis, Chapter Four of the Medicaid Services Manual*, 6. https://www.lamedicaid.com/provweb1/providermanuals/manuals/ABA/ABA.pdf.

[254] Nebraska Department of Health and Human Services. (2026, July). *Applied Behavior Analysis (ABA) service definitions*, 9-10. https://dhhs.ne.gov/Documents/Applied-Behavior-Analysis-Service-Definitions.pdf.

[255] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* [Clinical practice guidelines], 42-43, 61. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

Table 10: Supervision Requirements for Applied Behavior Analysis Provider Types

Provider Type	Supervision Requirements
BCBA/BCBA-D	• May supervise BCaBAs, RBTs, and behavior technicians • Must complete 8-hour supervision training and maintain continuing education units in supervision • Must regularly observe technicians delivering services • Must follow BACB Ethics Code and Supervisor Compliance Code
BCaBA	• Must practice under ongoing BCBA supervision • Supervision is typically two to five percent of monthly hours • May supervise RBTs only if allowed by state or payer rules • Cannot practice independently or hold full caseload responsibility
LBA	• Mirrors BCBA supervision authority unless state law imposes additional restrictions • May supervise technicians and assistant-level providers • Must comply with state licensing board requirements for supervision documentation and frequency
RBT	• Minimum five percent of monthly service hours supervised • At least two supervisory contacts per month • At least one direct observation per month • Supervision may occur in person or via synchronous video • Supervisors must be BCBA, BCBA-D, or LBA (BCaBA if permitted)
State-Defined Technicians/ Assistant-Level Providers	• Requirements vary by state and generally include: – Mandatory registration – Supervision ratio and frequency set by state law – Must work under an LBA/BCBA and cannot practice independently

Telehealth

Telehealth for ABA can include several types of activities, including consulting across providers regarding individuals with complex needs, coordinating care, providing clinical supervision, and even connecting individuals with ASD with peers.[256] Telehealth can also be used for case supervision, such as when the direct service provider is present in person and the supervising behavior analyst delivers observation and clinical oversight remotely.[257]

There are three categories of telehealth modalities that can be used in ABA provision:

[256] CASP. (2024). *Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* [Clinical practice guidelines], 42-43, 61. Retrieved July 28, 2026, from https://www.casproviders.org/asd-guidelines.

[257] Centene Corporation. (2025). *Applied behavior analysis (ABA) Follow-ups for CMS* [Internal report submitted to CMS]. [On file with authors.]

- **Synchronous**: real-time audio and video streaming between individuals and providers that could be used to provide care directly to an individual, coach the caregiver, or supervise the RBT working with the individual
- **Asynchronous**: stored and shared videos or data that could be used primarily to view specific or low-frequency behaviors, conduct clinical observations, complete clinical supervision, and provide protocol modifications
- **Hybrid**: a combination of telehealth and in-person service delivery

Telehealth modalities can provide the caregivers of the individual with more flexibility and allow them to work around any travel restrictions, address low-frequency behaviors, support families and caregivers with coaching, and provide social skills introductions to individuals with a group of their peers over video streaming.

Most states permit ABA via telehealth, but requirements vary:

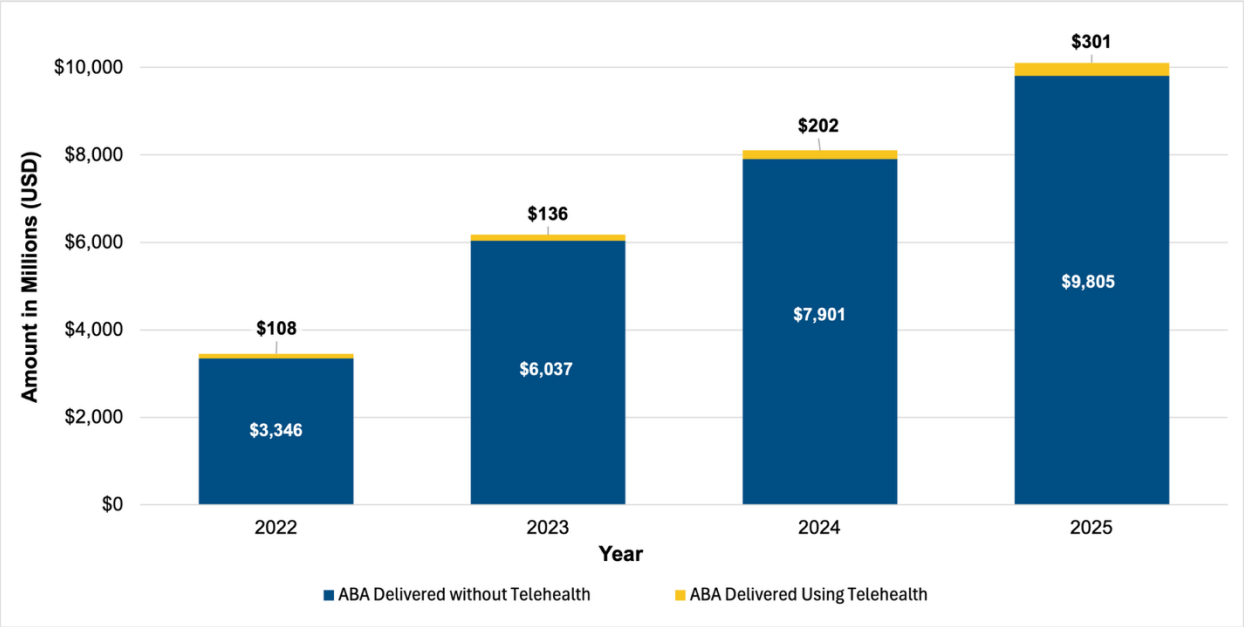
- BCBA assessments often must occur in person unless otherwise authorized.
- Ongoing supervision and caregiver training are generally allowed via telehealth but should not be completely rendered using telehealth.

Telehealth should generally not be used as the primary modality for assessments for ASD diagnosis and should be reserved only for clearly justified circumstances (for example, when in-person assessment is not feasible and the provider can still obtain valid, reliable clinical information via telehealth). Additionally, direct RBT-delivered ABA via telehealth should be less consistently permitted, with concerns about treatment fidelity and clinical appropriateness.

Telehealth is used to support ABA delivery, although states vary in requirements such as licensure, consent, or service limitations.[258] As shown in Figure 12, the amount of Medicaid and CHIP funding of ABA provided via telehealth has gradually increased since 2022, rising to over $300 million in 2025. However, states should treat telehealth as a limited adjunct to, not a substitute for, in-person ABA. Telehealth should not be used to establish an ASD diagnosis or complete the initial comprehensive assessment or care plan; it should be reserved for defined follow-up activities, targeted caregiver coaching, and limited supervisory contacts that still include direct observation, and generally avoided for intensive daily treatment blocks, group services, or routine technician supervision, which require in-person engagement, safety oversight, and verifiable attendance.

[258] Center for Connected Health Policy. (2025, October). *State telehealth laws and reimbursement policies report: Fall 2025.* https://www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-fall-2025/.

Figure 12: Medicaid Payments for Applied Behavior Analysis by Telehealth Delivery, 2022–2025



Source: T-MSIS OT claims and associated eligibility data, 2022–2025 for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam. Analysis includes the paid amount for procedure codes 97151–97158 across Medicaid and CHIP FFS claims and managed care encounters; telehealth claims and encounters were identified using claim line modifiers: 95, GT, GQ, 93, FQ, FR (prcdr_1_mdfr_cd - prcdr_4_mdfr_cd). Results are intended for analytic use.

Telehealth is well suited for ABA when used for caregiver training and data review, and when families and ABA providers have reliable, adequate access to internet and technologies needed to access telehealth platforms.[259,260] A systematic review found that telehealth has been successfully applied across a range of ABA procedures, including functional analysis, functional communication training, naturalistic teaching, behavior support, and comprehensive intervention programs.[261] It is generally less appropriate for interventions requiring physical prompting or intensive behavior reduction procedures. Decisions about using telehealth should be clinically driven and aligned with the individual's needs and treatment goals.

Using telehealth is not seen as a separate ABA service, but rather a means to deliver some aspects of ABA (e.g., caregiver training, clinical supervision, treatment planning, and data review). ABA providers must comply with the relevant federal telehealth parameters (see the

[259] CASP. (2022, May 16). *Practice parameters for telehealth-implementation of applied behavior analysis (ABA)* (2nd ed.), 17-18. Wakefield, MA. Retrieved July 28, 2026, from https://www.casproviders.org/practice-parameters-for-telehealth.

[260] National Quality Forum. (2017). *Creating a Framework to Support Measure Development for Telehealth*. https://digitalassets.jointcommission.org/api/public/content/b4e14b6b40414e71927b068358f8e6e8.

[261] Ferguson, J., Craig, E. A., & Dounavi, K. (2019). Telehealth as a model for providing behaviour analytic interventions to individuals with autism spectrum disorder: A systematic review. *Journal of Autism and Developmental Disorders, 49*(2), 582–616. https://doi.org/10.1007/s10803-018-3724-5.

State Medicaid & Children's Health Insurance Program Telehealth Toolkit) [262] and any state-level regulations for their jurisdiction. When applicable, states and managed care plans determine policies for coverage of telehealth for ABA. When there is telehealth coverage for ABA, ABA providers can use the Council of Autism Service Providers (CASP) Organizational Guidelines chapter on telehealth and the CASP Telehealth Practice Parameters along with the ABA Coding Coalition guidance on Reporting CPT Codes for Telehealth Delivery of ABA as resources to determine if individuals would benefit from services being delivered via telehealth.[263]

Based on a June 2026 analysis of each state's Medicaid state plan, 22 states permit use of telehealth for ABA without significant restrictions, while 28 states impose conditional access (e.g., in-person assessment before use of telehealth, telehealth limited to supervision/coaching). This analysis did not include the District of Columbia or any territories of the U.S.

BEST PRACTICE

Ensuring Improved Health Outcomes

- Telehealth should be used primarily for:
  - Caregiver coaching
  - Treatment supervision in a limited manner
  - Team meetings and progress reviews
- Direct individual work via telehealth is best limited to:
  - Older children or adolescents with strong attention skills
  - Programs that do not rely heavily on prompting or physical engagement
- Diagnostic and treatment authorization visits should occur in person.

States should consider whether additional guidance is needed regarding the use of telehealth for ABA. Relevant information to be communicated to providers includes:

- The components of ABA that the state will authorize to be provided via telehealth;
- The technologies that can be used to facilitate telehealth;
- The types of approval providers must obtain in advance of utilizing telehealth; and
- Any reimbursement differences between services delivered via telehealth versus in person.

Telehealth Supervision

States often use telehealth to increase providers' access to supervision. Under BACB requirements, remote supervision must be conducted synchronously via real-time video conferencing, must include direct observation of the technician delivering services, and must

[262] CMS. (2024, February). *State Medicaid & CHIP telehealth toolkit*, 3-6, 12. https://www.medicaid.gov/medicaid/benefits/downloads/telehealth-toolkt.pdf.

[263] ABA Coding Coalition. (2020, April). *Reporting CPT codes for telehealth delivery of adaptive behavior (ABA) services,* 1-2, 6-8. https://abacodes.org/wp-content/uploads/2020/05/ABACC-Reporting-CPT-Telehealth-Delivery.pdf.

meet the same minimum contact standards as in-person supervision. CMS provides broad flexibility to states in using telehealth delivery to furnish services, including which modalities to permit and which providers are eligible. States that permit ABA telehealth generally require use of synchronous audiovisual technology and Health Insurance Portability and Accountability Act (HIPAA)-compliant platforms, with some specifying applicable CPT codes and requiring a modifier to denote remote delivery. [264, 265] States that have not updated their state policies or managed care contracts to authorize telehealth supervision might risk creating coverage gaps that impact families in underserved areas, where telehealth may be the only path to timely BCBA oversight. Alternatively, states must ensure that supervision conducted via telehealth is sufficient to ensure the provision of high-quality ABA services to each child.

BEST PRACTICE

Telehealth Supervision

Since consistent supervision is essential to high-quality ABA provision, supervision should not be performed solely via telehealth and state supervision policies should include a minimum of in-person supervision.

Meeting ABA supervision requirements can be challenging for services provided in the school setting. Coordination across multiple classrooms, schedules, and service delivery models creates logistical barriers. States may need to clarify whether remote, synchronous supervision satisfies any on-site requirements in school-based settings, and how supervision ratios apply when a BCBA oversees technicians across multiple classrooms or buildings. Supervision should not be waived due to delivery of treatment in a school setting.

Variation in Provider Requirements by Care Delivery System

Each state has the discretion to classify ABA provider types as either limited, moderate, or high-risk for screening and enrollment in accordance with 42 C.F.R. § 455.450. This includes conducting all required screening activities and ensuring that providers are enrolled and revalidated in accordance with 42 C.F.R. § 455.410 and § 455.414. These Medicaid screening and enrollment requirements apply equally to FFS and managed care delivery systems. Once enrolled, ABA providers may face differences depending on the care delivery system. FFS and managed care delivery systems differ structurally in how ABA is authorized, reimbursed, and monitored, which directly affects provider experience and administrative requirements (see Table for key differences in federal requirements), and states may also impose additional state requirements.

[264] California Association for Behavior Analysis. (n.d.). *Telehealth and the practice of Applied Behavior Analysis (ABA)* [Practice brief], 2-3, 9. https://calaba.org/media/content/CalABA_TeleHealth_Practice_Brief_Final-2.pdf.

[265] Center for Connected Health Policy. (2025, October). *State telehealth laws and reimbursement policies report: Fall 2025.* https://www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-fall-2025.

Table 11: Key Differences in Federal Provider Requirements Between Fee-For-Service and Managed Care Delivery Systems

Requirement Type	Fee-For-Service	Managed Care
Provider Enrollment and Credentialing	State enrolls providers directly and sets provider type, required disclosures, and revalidation requirements	Providers generally must first be screened and enrolled by the state, and then complete managed care plan credentialing, contracting, and periodic recredentialing
Utilization Management	Utilization management requirements may exist but can be uniform and less intensive	Utilization management is typically more prescriptive, requiring periodic progress data, medical necessity reviews, and managed care plan-specific treatment plan formats
Documentation Requirements	Documentation must meet state-defined billing rules	Documentation may need to follow managed care plan-specific templates, outcome reporting, or additional data elements not required by the state
Network Requirements	Any provider who meets state requirements can participate	Providers must meet qualifications and sign a network agreement. Generally, managed care plans have discretion on the number and type of providers with which they contract and are required to maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered in the managed care contract and that meet states' network adequacy standards.
Quality and Oversight	Oversight is performed by the state through activities such as audits and claims review, data collection for Child and Adult Core Set reporting	Managed care plans may conduct ongoing monitoring, require corrective action plans, or evaluate performance via quality metrics, including data collection for Child and Adult Core Set reporting, using claims or encounter data
Accreditation Expectations	Accreditation is typically optional unless state mandated	Some managed care plans require or strongly encourage accreditation for network participation

Managed care plans frequently impose requirements beyond state Medicaid rules. These may include enhanced credentialing reviews, mandatory treatment plan templates, prior authorization processes, reauthorization requirements based on documented progress, site visits, quality monitoring programs, encounter data submission, staff qualification verification, ownership and control disclosures, and accreditation requirements. These expectations can facilitate network quality, program integrity, and adherence to managed care plan-specific standards but may increase administrative complexity for providers.

Organizational Accreditation Requirements for Applied Behavior Analysis Agencies

In contrast to NCCA accreditation of individual certification programs, some states and managed care plans require ABA agencies to obtain accreditation from organizations such as the ACQ,[266] the Commission on Accreditation of Rehabilitation Facilities,[267] or the Joint Commission.[268] Accreditation standards typically assess governance, documentation, supervision processes, safety practices, and quality improvement systems.

BEST PRACTICE

Accreditation

Accreditation is considered a best practice because it can enhance organizational transparency and quality consistency, and in some cases is required for network participation or higher reimbursement. Accreditation, while not a proxy for quality, can provide administrative safeguards.

Autism Commission on Quality [269]

- The only active ABA-specific accreditor for organizations
- Accreditation is valid for two years

Almost 50 organizations across 26 states offer ACQ accredited ABA healthcare service lines. CASP founded the ACQ in 2022, whose mission is to provide education and accreditation of provider organizations. Figure 13 provides a visual depiction of which states have ACQ-accredited providers based on the ACQ directory.[270] It is important to note that this map does not depict other types of accreditation for ABA provider agencies, and Alaska, Hawaii, and Puerto Rico were not included in the directory.

[266] Autism Commission on Quality. (2022, June 16). *Applied behavior analysis accreditation program standards and guide* (Version 1.0). Retrieved July 28, 2026, from https://autismcommission.org/standards/.

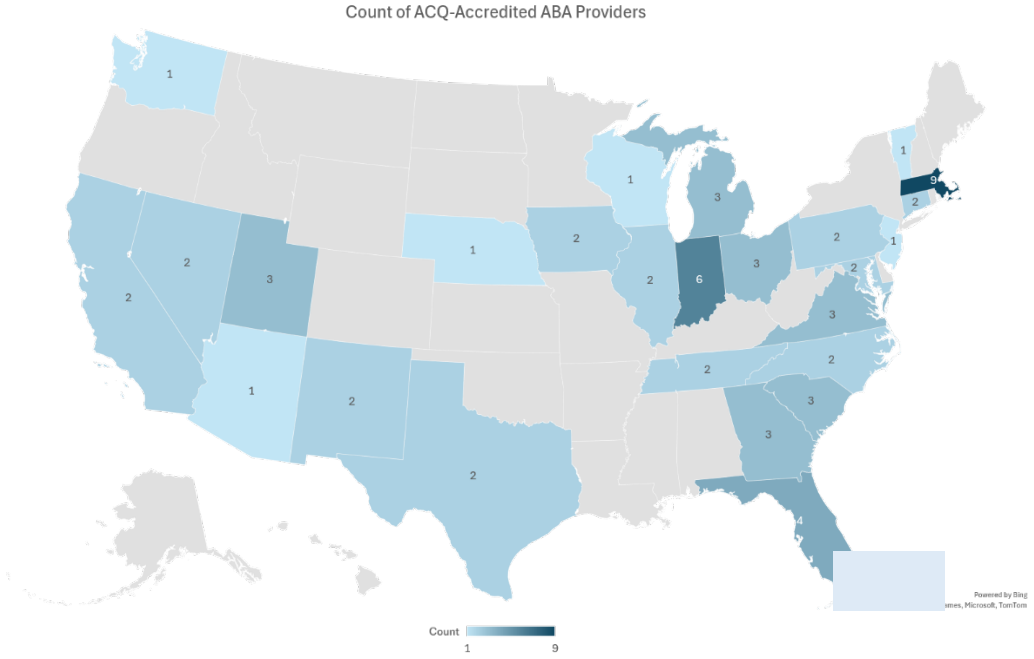
[267] CARF International. (n.d.). *Programs*. Retrieved July 28, 2026, from https://carf.org/accreditation/programs/.

[268] The Joint Commission. (n.d.). *Accreditation*. Retrieved July 28, 2026, from https://www.jointcommission.org/en-us/accreditation.

[269] ACQ. (n.d.) *Autism Commission on Quality.* Retrieved July 28, 2026, from https://autismcommission.org/.

[270] ACQ. (n.d.). *Accreditation directory*. Retrieved July 28, 2026, from https://autismcommission.org/accreditation-directory/.

Figure 13: Autism Commission on Quality-Accredited Providers Across the United States



Corporate Structures Involved in the Ownership of Applied Behavior Analysis Provider Agencies

Overall, ownership of ABA provider organizations is consolidated within two areas:[271]

- **Private equity backed chains** make up the majority of large, multi-site ABA organizations, spanning 42 states, with the largest number of private equity clinics located in California (97 sites), Texas (81 sites), Colorado (38 sites), Illinois, and Florida (with 36 sites each). A research analysis showed there were 574 private equity-acquired ASD service delivery sites from 2015-2024, with private equity sites more likely in states with higher rates of ASD and when state insurance coverage for ASD services was more generous.[272] Private equity firms have been buying out smaller firms to build larger chains with 12 leading private equity-owned chains employing at least 30,000 workers across 1,300 locations.[273]

[271] Singh, Y., Mook, C., Perkins, J., Hostert, N., & Arnold, D. R. (2026, May 22). *The business of autism treatment: Private equity's implications for state Medicaid programs.* Health Affairs. https://www.healthaffairs.org/content/forefront/business-autism-treatment-private-equity-implications-state-medicaid-programs.

[272] Arnold, D. R., Reddy, M., Cantor, J., McBain, R. K., Yu, H., Whaley, C. M., & Singh, Y. (2026). Private equity in autism services. *JAMA Pediatrics, 180*(3), 341–343. https://doi.org/10.1001/jamapediatrics.2025.5443.

[273] Blatt, R., Appelbaum, E., & Nguyen, Q-T. (2023, June14). *Pocketing money meant for kids: Private equity in autism services*. Center for Economic and Policy Research. https://cepr.net/publications/pocketing-money-meant-for-kids-private-equity-in-autism-services/.

- **Independent/founder-owned providers** make up the majority of small and independent ABA agencies.[274]

There are concerns among the ABA provider and caregiver communities that the growing prevalence of private equity firms acquiring ABA organizations could result in the prioritization of profit over the quality of individual care. This could result from possible lower levels of staffing and inadequate supervision.[275] States with concerns about quality related to private equity should consider outcomes-based models and formal monitoring plans. CMS has not taken a formal position on corporate ownership of ABA providers to date; however, regardless of ownership structure, ABA needs to be provided based on an ITP-driven individualized treatment model and not a one-size-fits-all model designed for revenue maximization.

BEST PRACTICE

Corporate Structure for Applied Behavior Analysis Providers

A well-designed corporate structure is critical for ensuring high-quality ABA delivery, maintaining program integrity, and supporting effective oversight. Best practices include:

- **Clear Governance and Leadership Structure**
  - Establish transparent lines of administrative and clinical authority and clinical supervision of ABA services and personnel
  - Ensure clinical leaders have influence over decisions that affect service quality
  - Maintain written policies outlining executive, clinical, and operational responsibilities
- **Ownership Transparency and Disclosure**
  - Maintain accurate ownership and control records
  - Report ownership changes promptly
  - Align disclosure practices with federal and state requirements (e.g., 42 C.F.R. § 455)
- **Clinical and Operational Separation**
  - Avoid structures where financial pressures override clinical judgment
  - Ensure clinical directors operate independently from revenue-generation demands
  - Use separate reporting lines for clinical quality and business operations
- **Strong Supervision and Workforce Supports**

[274] WebWire. (2025, May 20). *$4.4 billion U.S. autism treatment market still growing.* https://www.webwire.com/ViewPressRel.asp.

[275] Blatt, R., Appelbaum, E., & Nguyen, Q-T. (2023, June 14). *Pocketing money meant for kids: Private equity in autism services*. Center for Economic and Policy Research. https://cepr.net/publications/pocketing-money-meant-for-kids-private-equity-in-autism-services/.

- Build structures that support appropriate supervision ratios and manageable caseloads
- Implement formal pathways for raising safety concerns

- **Compliance and Quality Infrastructure**
  - Establish a compliance program with designated leadership
  - Implement quality improvement processes that monitor documentation, staff skills, individual progress, and family satisfaction
  - Conduct internal audits to identify risks such as rapid growth, turnover, or supervision gaps

BEST PRACTICE

Monitoring Ownership Change

Effective monitoring of ownership and control changes in ABA provider organizations is essential to maintaining program integrity. Federal regulations require Medicaid programs to track and validate ownership structures, ensure transparency, and prevent individuals or entities with a history of fraud or abuse from entering or remaining in the program. The following best practices align with federal requirements in 42 C.F.R. Part 455 (Program Integrity) and general Medicaid provider screening standards. Best practices include:

Requiring Timely Disclosure of Ownership Changes: Medicaid providers are required to disclose persons with ownership or control interests to Medicaid agencies. Programs should require providers to report any ownership, control, or managing employee changes within 35 days, consistent with:

- 42 C.F.R. §§ 455.104 and 457.935(b) — Disclosure of ownership and control
- 42 C.F.R. §§ 455.105 and 457.935(b)— Disclosure of business transactions

Conducting Background and Exclusion Screening on New Owners: States should verify U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) exclusion status, state Medicaid termination and criminal history (if required under state law). This aligns with 42 C.F.R. §§ 455.436 and 457.990 — Federal and state database checks

Validating Organizational Structure After Ownership Change: Require updated organizational charts, operating agreements, management contracts, and the identification of indirect ownership interests. This is consistent with 42 C.F.R. §§ 455.101 and 457.935(b) — Definitions of disclosing entity, managing employee, and indirect ownership.

Triggering Risk-Based Revalidation or Review: Ownership changes can increase program risk. States may require recredentialing or revalidation,

targeted audits or site visits, and review of supervision capacity and staffing. This is consistent with:

- 42 C.F.R. §§ 455.414 and 457.990 — Revalidation requirements
- 42 C.F.R. §§ 455.432 and 457.990 — Site visits for moderate and high-risk providers
- 42 C.F.R. §§ 455.434 and 457.990 — Fingerprint-based Criminal Background Checks for high-risk providers

Monitoring Growth and Staffing Post Acquisition: Ownership transitions can lead to rapid growth, staff turnover and reduced supervision. States should monitor staffing ratios, caseload growth, and continuity of supervision.

Requiring Updated Compliance and Quality Attestations: Providers should attest that they continue to meet Medicaid rules, licensure and supervision requirements, and credentialing standards. This is consistent with 42 C.F.R. §§ 438.608 and 457.1285 — Program integrity requirements for managed care plans.

Coordinating Information with Managed Care Plans: States should require managed care plans to collect ownership disclosures, share notices of ownership changes, and report concerns about post-transaction quality or billing patterns. This is consistent with: 42 C.F.R. §§ 438.602 and 457.1285 — State responsibilities for oversight of managed care.

Chapter 6. Applied Behavior Analysis Utilization Management

Utilization management is used to oversee the use of health care resources and is focused on getting beneficiaries the most medically appropriate and cost-effective health care. This chapter provides a comprehensive overview of utilization management processes for ABA and best practices for states to implement utilization management consistent with federal requirements. It examines how states and managed care plans can manage the utilization of ABA through prior authorization, concurrent review, and reauthorization.

Utilization Management for Co-Occurring Medical and Behavioral Health Conditions

Utilization management practices should recognize that individuals with ASD may also have co-occurring medical, developmental, or behavioral health conditions. The presence of a co-occurring condition should not, by itself, be used to deny or limit access to medically necessary ABA, if offered, or other ASD-related services. Likewise, an ASD diagnosis should not result in inappropriate coverage limits for services needed to diagnose, treat, correct, or ameliorate co-occurring conditions.

Federal Regulatory Foundation

Under EPSDT, states must cover section 1905(a) services for EPSDT-eligible children when medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not the services are covered under the state plan.[276,277] This includes coverage of medically necessary services to correct or ameliorate ASD symptoms or related developmental concerns.[278] However, coverage is contingent on a qualified provider documenting that ABA or other services are medically necessary for the child's identified needs, so not all children screened or flagged for concerns may meet medical necessity criteria. Additionally, while state plan services available to adults may include limits on the amount, duration, and scope of services that can never be exceeded (i.e., a "hard limit"), states are not permitted to apply these kinds of limits to any service covered under EPSDT. States are permitted to use utilization controls, such as prior authorization and medical necessity reviews, to safeguard against unnecessary use of care and services in a manner that is consistent with the EPSDT requirements.[279]

The regulations in Table 17 define a framework for states and managed care plans to align utilization management requirements for consistent application to correct or ameliorate ASD-related conditions.

[276] Section 1905(r) of the Act.

[277] Optional coverage of EPSDT services in separate CHIPs reflects all Medicaid EPSDT requirements, including coverage of all section 1905(a) services.

[278] CMS. (2024, September 26). *SHO # 24-005 RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements* [State Health Official (SHO) Letter]. 1, 7, 41. www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

[279] 42 C.F.R. § 440.230(d), 42 C.F.R. § 438.210.

Table 12: Utilization Management Regulations for States and Managed Care Plans

Regulations for States	Regulations for Managed Care Plans
• Amount/duration/scope of services; no arbitrary denial of medically necessary care: 42 C.F.R. § 440.230 • CHIP utilization control systems: 42 C.F.R. § 457.490(b) • Prior authorization decision timeframes (standard and expedited): 42 C.F.R. §§ 440.230(e) and 457.495(d)(2) • FFS adverse benefit determinations (ABD) notice: 42 C.F.R. §§ 435.917, 457.340(e), 457.495(d)(3) and 457.1180 • State fair hearing resolution timeframes (standard and expedited): 42 C.F.R. § 431.244(f) • CHIP review resolution timeframes (standard and expedited): 42 C.F.R. § 457.1160(b)	• Permitting appropriate limits on a service, including utilization management and prior authorization: 42 C.F.R. §§ 438.210(a)(4) and 457.1230(d) • Policies and procedures for the authorization of services: 42 C.F.R. §§ 438.210(b) and 457.1230(d) • Prior authorization decision timeframes (standard and expedited): 42 C.F.R. §§ 438.210(d) and 457.1230(d) • Adverse Benefit Determinations (ABD) notice: 42 C.F.R. §§ 438.404, 438.210(c) and 457.1260(c) • Appeals resolution timeframes (standard and expedited): 42 C.F.R. §§ 438.408 and 457.1260(e)

Under CMS's interpretation of section 1905(r), states may not impose prior authorization requirements for EPSDT screening services.[280] Additionally, states and managed care plans must ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.[281] September 2024 guidance from CMS reinforced that states' Medicaid prior authorization criteria, medical necessity standards, and coverage policies must reflect EPSDT obligations for children, and that managed care plans are equally bound by these requirements consistent with the scope of state contractual requirements.[282] Within this framework, states have the responsibility for defining specific medical necessity criteria and utilization management processes.[283,284,285]

[280] Treatment of requests for EPSDT screening services, 42 C.F.R. § 441.59(a).

[281] FFS: 42 C.F.R. § 440.230(b). Managed care: coverage and authorization of services, 42 C.F.R. § 438.210(a)(3)(i) (2026) and Structure and operation standards. 42 C.F.R. § 457.1233(d).

[282] CMS. (2024, September 26). *SHO # 24-005 RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements* [State Health Official (SHO) Letter]. www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

[283] Section 1905(r)(5) of the Act; per 42 C.F.R. § 438.210(a)(5)(i), each contract between a state and an MCP must specify what constitutes medically necessary services in a manner that is no more restrictive than that used in the state Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the state plan, and other state policy and procedure.

[284] 42 C.F.R. §§ 440.230(d), 438.210.

[285] CMS expects states to align prior authorization or other utilization controls broadly for services covered under EPSDT with what Congress has described as the "preventive thrust" of the EPSDT benefit. See H.R. Rep. No. 101-247 at 399-400, reprinted in U.S.C.C.A.N. 1906, 2125-26; https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf. See also 42 C.F.R. § 438.210(b)-(e).

Documentation for Utilization Management Review and Authorization Decisions

States commonly use utilization management processes that require sufficient documentation to support prospective and ongoing medical necessity reviews for the service in question, which should apply in utilization management of ABA.[286] This documentation may include evidence of functional impairment, a diagnostic evaluation or other clinical assessment supporting the need for ABA, and ITPs. EPSDT does not require a specific diagnosis for coverage of services. Chapter 2 provides additional details on clinical standards for ABA treatment, ASD diagnostic evaluations, and development of ITPs.

For utilization management purposes, documentation should help states and managed care plans determine whether the requested ABA is medically necessary, individualized, clinically appropriate, and supported by the child's functional needs and treatment goals. States differ substantially in diagnostic criteria, hour thresholds, prior authorization thresholds, documentation requirements, and review processes. States should make clinical documentation expectations clear, and, where possible, align them across FFS and managed care plans. Clear and consistent requirements can reduce provider burden, support more complete authorization submissions, and minimize variation in authorization decisions.

Higher-Intensity Applied Behavior Analysis Requests

States should consider how utilization management documentation requirements address requests for higher-intensity ABA, particularly when requested hours approach or exceed the amount of time a child would reasonably be available for treatment during a typical week. Higher-intensity requests may require closer review because they can be more difficult to support if the proposed schedule does not leave adequate time for age-appropriate daily activities, such as eating, sleeping or napping, attending school or childcare, and participating in family routines. Higher-intensity service utilization should be coupled with more frequent assessment of outcomes or ITP goals. Plans for tapering should be included in the ITP as appropriate.

This does not mean higher intensity ABA is never medically necessary. Some children may need more intensive services for a period of time based on their functional needs, safety concerns, or treatment goals. However, states should expect clinical documentation to clearly explain why the requested level of service is needed, how the hours will be used, how treatment will fit into the child's daily life, and how the plan supports the child's functioning across natural settings. Documentation should show that the requested intensity is individualized, clinically appropriate, and balanced with the child's developmental needs and family context.

[286] CMS expects states to align prior authorization or other utilization controls broadly for services covered under EPSDT with what Congress has described as the "preventive thrust" of the EPSDT benefit. See H.R. Rep. No. 101-247 at 399-400, reprinted in U.S.C.C.A.N. 1906, 2125-26; https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf. See also 42 C.F.R. § 438.210(b)-(e).

Clear expectations for higher-intensity requests can help providers submit more complete information, support consistent utilization management decisions, and strengthen the state's ability to explain authorization decisions during program integrity reviews or audits.

STATE SPOTLIGHT: Additional Documentation Requirements for High-Intensity Applied Behavior Analysis Requests

Virginia requires significant, detailed documentation and justification for ABA authorization requests for more than 20 hours per week.[287] The documentation must describe the individualized schedule of activities, how each activity relates to treatment goals, how each session would support the implementation of the individual service plan, and the therapeutic function of the requested hours. General schedules are not sufficient documentation to support a high-intensity request.

Utilization Management Process Framework

Utilization management should provide a structured framework for reviewing provider requests, evaluating supporting clinical documentation, authorizing services, monitoring ongoing needs, and documenting decisions. States and managed care plans should consider hiring experienced BCBAs to conduct these reviews, making the process more streamlined and decisions easier to understand by both parties.

STATE SPOTLIGHT: State Variation in Utilization Management Processes

Nebraska has a daily limit of 6 hours and a weekly limit of 30 hours for direct ABA services. However, providers may request to exceed those limits when additional hours of treatment are medically necessary and with prior authorization.[288,289]

Using Medical Necessity in Utilization Management

Medical necessity is the central threshold determination in ABA utilization management reviews. Federal statute does not define medical necessity; states define the specific medical necessity criteria and documentation standards used in utilization reviews of ABA requests. CMS does not review or approve states' medical necessity criteria.

When an ABA request is for an EPSDT-eligible child, the state's utilization review process should align with and be cognizant of EPSDT requirements. Children entitled to EPSDT must have access to services that can be covered under section 1905(a) of the Act when those services are necessary to correct or

[287] Virginia Department of Medical Assistance Services. (2025, December 16). *Applied Behavior Analysis (ABA) policy and regulatory clarifications*, 3. https://vamedicaid.dmas.virginia.gov/bulletin/applied-behavior-analysis-aba-policy-and-regulatory-clarifications.

[288] Nebraska Department of Health and Human Services. (2026, July). *Medicaid Behavioral Health Service Definitions*. Retrieved July 28, 2026, from https://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx.

[289] Nebraska Department of Health and Human Services. (2026, July). *Applied Behavior Analysis*. https://dhhs.ne.gov/Behavioral-Health-Service-Definitions/Applied-Behavior-Analysis.pdf.

ameliorate an identified medical need.[290] States are ultimately responsible for ensuring EPSDT-eligible children receive the coverage required by the Medicaid statute and regulations.[291] That said, states may impose utilization controls to safeguard against unnecessary use of care and services in a manner that is consistent with the EPSDT requirements.[292] For example, a state may establish limits on the amount, duration, or scope of services that may be exceeded with prior authorization for medical necessity and/or a utilization review.[293] Importantly, under CMS's interpretation of section 1905(r)(5), prior authorization must be conducted on a case-by-case basis, evaluating each child's needs individually, and it must not delay the delivery of needed treatment services.[294]

Medical necessity determinations and utilization reviews should occur after an ITP is developed and before treatment begins. States should ensure their medical necessity determinations consider an individual's clinical presentation and functional needs, along with the clinical appropriateness of a requested service as based on scientific evidence. A state's utilization review process should be fair and predictable, while also allowing for the flexibility to account for variations in age, developmental stage, co-occurring conditions, and treatment trajectories. This balance may help states promote consistency without limiting the need for individualized treatment. Utilization review that is not individualized and relies solely on singular factors such as diagnosis codes, age, or preset hourly thresholds, risks conflicting with EPSDT.[295]

When conducting a utilization review for ABA, states should consider whether:

- The diagnostic evaluation documents the individual's functional impairments in communication, behavior, and social skills, and is completed by a provider qualified to administer assessment tools and interpret the results.
- A diagnosis or identified clinical condition is supported by the diagnostic evaluation, and any ASD diagnosis is based on criteria in the DSM-5-TR[296] and made by a qualified provider acting in the scope of their practice.
- ABA is clinically appropriate for the identified needs of the individual and the proposed ITP is consistent with generally accepted standards of care for ASD.
- The requested services are tied to the functional needs of the individual rather than the diagnosis alone.

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[290] CMS. (2024, September 26). *SHO # 24-005 RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements* [State Health Official (SHO) Letter]. 21-22. www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

[291] CMS. (2024, September 26). *SHO # 24-005 RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements* [State Health Official (SHO) Letter]. 21-22. www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

[292] 42 C.F.R. § 440.230(d).

[293] CMS. (2024, September 26). *SHO # 24-005 RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements* [State Health Official (SHO) Letter]. 21-22. www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

[294] CMS. (2024, September 26). *SHO # 24-005 RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements* [State Health Official (SHO) Letter]. 21-22. www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

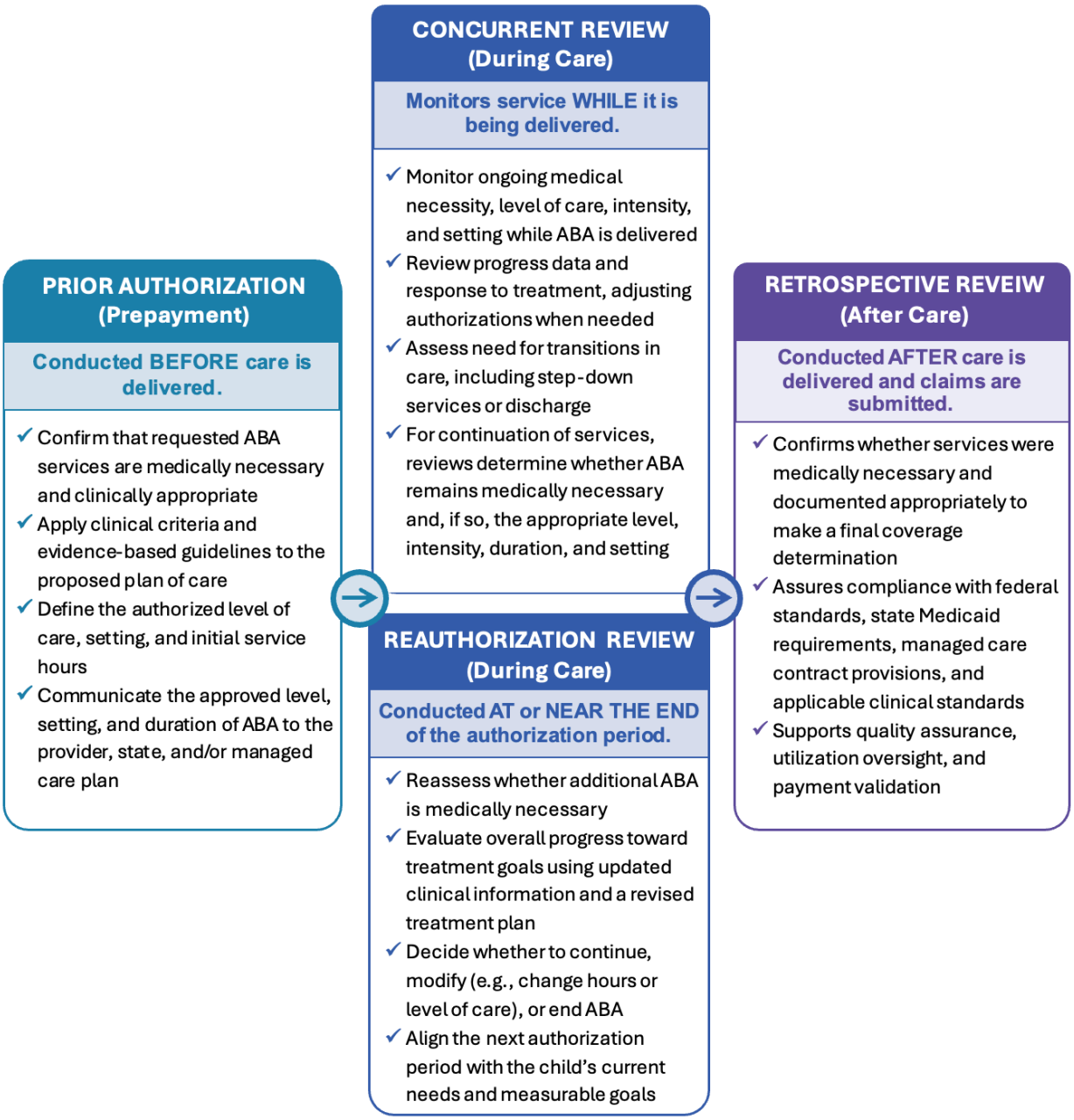
[295] CMS. (2024, September 26). *SHO # 24-005 RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements* [State Health Official (SHO) Letter]. 21-22. www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

[296] APA. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.) [DSM-5-TR]. APA. https://doi.org/10.1176/appi.books.9780890425787.

- The ITP is appropriate and based on the treatment goals and expected functional outcomes for the individual with ASD.
- The ITP identifies the proposed level, intensity, duration, and setting of services and includes baseline assessments and individualized, measurable goals based on identified functional deficits.

Figure 14 illustrates three types of utilization management that frame the review process and occur at different periods of care and/or payment: prior authorization, concurrent review, and reauthorization review. Additionally, retrospective reviews occur after services are delivered and payment is rendered. These types of utilization reviews are further described in this chapter.

Figure 14: Types of Utilization Management[297]



[297] Giardino, A. P., & Wadhwa, R. (2023, July 10). Utilization management. In *StatPearls* [Internet]. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK560806/.

Prior Authorization

Prior authorization is the primary utilization management mechanism used by states and managed care plans to evaluate whether ABA meets established medical necessity criteria before services are delivered.

When designed appropriately, prior authorization can support clinical accountability, promote consistency in coverage determinations, and help ensure that services are individualized, evidence-based, and aligned with the child's functional needs. Effective prior authorization should be data-driven, transparent, and aligned with clinical standards. Key features include:

- Standardized clinical assessment tools
- Clearly defined medical necessity criteria
- Service hour thresholds that trigger review
- Time-limited authorizations with required reassessment
- Required treatment plans and supervision documentation

Increasingly, states are moving toward technology-enabled prior authorization processes that leverage data analytics to streamline decision-making and reduce administrative burden. This approach is consistent with broader federal trends toward more electronic, data-informed, and transparent utilization management. CMS's Interoperability and Prior Authorization Final Rule reinforces this direction by requiring states and managed care plans to improve electronic prior authorization processes, including using application program interfaces to streamline and improve electronic data exchange.[298] However, any software used by states or their managed care plans to review prior authorization requests must be consistent with the EPSDT requirement to cover medically necessary care under section 1905(a), as well as regulatory requirements for coverage and authorization of services.[299] Appropriate information protections and compliance with the Health Insurance Portability and Accountability Act (HIPAA) are also required, along with any other applicable requirements under federal and state law for data sharing, confidentiality, privacy, and security.[300]

[298] CMS. (2024, February 8). *Medicare and Medicaid programs; Patient Protection and Affordable Care Act; Advancing interoperability and improving prior authorization processes for Medicare Advantage organizations, Medicaid managed care plans, state Medicaid agencies, Children's Health Insurance Program (CHIP) agencies and CHIP managed care entities, issuers of qualified health plans on the Federally-Facilitated Exchanges, Merit-based Incentive Payment System (MIPS) eligible clinicians, and eligible hospitals and critical access hospitals in the Medicare Promoting Interoperability Program. Federal Register, 89(27)*, 8758–8860. https://www.federalregister.gov/d/2024-00895.

[299] 42 C.F.R. § 438.210.

[300] Section 1902(a)(7) of the Act and 42 C.F.R. Part 431, Subpart F; 42 C.F.R. Part 2; the HIPAA Rules; 42 C.F.R. § 457.1110.

BEST PRACTICE

Centralized and Delegated Utilization Management

Some states use a centralized utilization management vendor or single state utilization management contractor to conduct prior authorization reviews across Medicaid and/or multiple managed care plans. This approach can create a more consistent review process by applying common documentation requirements, medical necessity criteria, and authorization standards across delivery systems.

Georgia uses the Georgia Medicaid Management Information System (MMIS) as its centralized electronic portal for prior authorization submissions. Providers can submit prior authorization requests, track the status of the requests, and receive the related decisions through the portal. This applies to Georgia's Medicaid services covered under FFS, as well as some of the state's managed care plans.[301]

Concurrent and Reauthorization Reviews

While some states and managed care organizations generally refer to all reviews that occur prior to payment as prior authorization, some utilization review activities occur as or after treatment ensues. Concurrent review refers to utilization management activities that occur during the same period as services are delivered to assess whether services remain medically necessary based on the individual's progress and ongoing clinical needs. During this time, states may consider using concurrent review to monitor:

- Ongoing medical necessity of services
- Clinical progress data
- Whether treatment is accurately and consistently delivered as outlined in the ITP
- Functionally meaningful progress (e.g., goal mastery, behavior reduction)
- Consistency between the amount of service delivered and the hours authorized
- Adjustments to treatment plans when progress stalls or goals are met
- Need for care transitions including step-down services or discharge

Concurrent utilization management reviews support mid-course corrections by using data-based progress monitoring (e.g., goal mastery, behavior reduction, generalization); comparing attendance and units of service to what was authorized; adjusting intensity when progress stalls or goals are met; identifying access barriers such as network adequacy or wait times; and determining whether to continue, modify, reduce, or end authorized services. These reviews typically include examination of the ITP, service intensity, progress toward measurable goals,

[301] Georgia Department of Community Health, Division of Medical Assistance Plans. (2026, April). *Part II Policies and procedures for autism spectrum disorder (ASD)* services [Provider Manuals]. Retrieved July 28, 2026, from https://www.mmis.georgia.gov/portal/PubAccess.Home/tabId/2/Default.aspx.

and ongoing medical necessity, with formal evaluation every six months and repeated validation assessments approximately every six to 12 months.[302]

Unlike concurrent review, which monitors care during an existing authorization, a reauthorization review is a discrete utilization management decision point that evaluates whether to approve a new authorization period and under what service parameters. Reauthorization reviews in utilization management occur at or near the end of an existing authorization period and focus on determining whether services remain medically necessary based on a child's progress, current functioning, and ongoing clinical needs. States have flexibility to define ABA reauthorization review periods and criteria, and should consider approaches that support individualized, goal-directed care and continuity of medically necessary services. Reauthorization review also provides an opportunity to assess whether treatment approaches should be modified, intensified, tapered, or transitioned based on the child's evolving developmental and functional needs.

STATE SPOTLIGHT: Outcomes-Inclusive Authorization

Georgia requires updated information from the previously authorized course of treatment to support continued ABA requests. This information should include assessment or progress information, revised treatment goals, and objective data rather than narrative alone. The state requires submission of updated behavioral assessment results that are dated no more than two months before the prior authorization effective date; progress summaries; updated plans of care; updated data that align with the most recent behavior assessment and were collected during the previous authorization period; and a service schedule.[303]

As reauthorization review frameworks are designed for ABA, states can consider the following elements:

- **Purpose:** Define the role of reauthorization review, such as confirming ongoing medical necessity, updating goals, and deciding if services should continue, change, or end.
- **Timing:** Set clear timeframes for providers to submit reauthorization requests.
- **Criteria:** Clarify continued-stay and discharge/transition criteria.
- **Documentation:** Specify documentation expectations for reauthorization review, including updated assessments, progress data, treatment plan revisions, and justification for the requested intensity, duration, and setting.
- **Progress:** Base reauthorization review on measurable indicators of progress, such as goal mastery, behavior reduction, skill generalization, and caregiver engagement.

[302] Papatola, K. J., & Lustig, S. L. (2016). Navigating a Managed Care Peer Review: Guidance for Clinicians Using Applied Behavior Analysis in the Treatment of Children on the Autism Spectrum. *Behavior Analysis in Practice, 9*(2), 13–145. https://doi.org/10.1007/s40617-016-0120-5.

[303] Georgia Department of Community Health, Division of Medical Assistance Plans (2026, April). *Part II policies and procedures for autism spectrum disorder services* [Provider Manuals]. Retrieved July 28, 2026, from https://www.mmis.georgia.gov/portal/PubAccess.Home/tabId/2/Default.aspx.

- **Plan changes:** Indicate whether services will be maintained, stepped down, intensified, or transitioned under new authorization requests and ensure changes are clearly documented in the ITP.
- **Monitoring non-therapeutic or primarily custodial use:** Use reauthorization to flag static, unchanged plans across multiple authorization periods as potential signals of custodial or non-therapeutic use (for example, when ABA is functioning primarily as respite or childcare) and to ensure such cases receive closer clinical review.
- **Continuity and EPSDT alignment:** Structure timelines and workflows to minimize gaps in medically necessary care, allow flexibility for individual variation, and align with EPSDT by avoiding hard limits or automatic terminations and maintaining individualized, child-specific medical necessity decisions.

When determining whether a child should continue an already authorized course of ABA for a new authorization period, states should collect information that shows objective progress and ongoing medical necessity. Additionally, using evidence-based or clinically appropriate assessments, as discussed in Chapter 2, can help to ensure that reauthorization decisions are based on objective progress data, including changes in functional skills, behavior, and treatment response, rather than narrative updates alone. This information may include:

- Updated standardized assessment scores
- Progress graphs or data summaries
- Evidence of goal mastery, revisions to goals, and rationale for maintaining or stepping down service intensity
- Updated information about barriers and treatment modifications
- Data on attendance and consistency between the amount of service delivered and the hours authorized

Using this information can improve clinical accountability and reduce automatic renewals of authorizations, while helping ensure continued services remain tied to measurable progress and ongoing medical necessity.

BEST PRACTICE

Utilization Management

States should establish a comprehensive utilization management process for ABA that includes prior authorization before services begin, concurrent review while services are being delivered, and reauthorization near the end of the approved period. This approach helps ensure ABA services are medically necessary, clinically appropriate over time, with the level of care, intensity, and duration adjusted as the individual's progress, needs, and treatment goals change.

Retrospective Review

Retrospective reviews for ABA occur after care is delivered and after claims have been submitted to determine if benefits will be covered after services have been delivered.[304] The primary purpose of these reviews is to evaluate whether services provided were (1) medically necessary, appropriately documented, and delivered in accordance with the authorized treatment plan, and (2) compliant with federal standards, state Medicaid requirements, managed care contract provisions, and applicable clinical standards. These reviews may include eligibility, coverage, medical necessity, clinical appropriateness, and/or level of care reviews, and may result in states recouping payments from providers, with the applicable FFP being returned to CMS.

Unlike prior authorization, concurrent review, or reauthorization review, ABA retrospective review focuses on evaluating clinical appropriateness and quality of care after service delivery. Retrospective reviews may be used for quality assurance, utilization oversight, and payment validation purposes. They can also be used for program integrity to detect fraud, waste, and abuse. (See Chapter 7.)

States that deliver ABA through managed care commonly require managed care plans to perform ABA retrospective review activities, including review of clinical and billing records to:

- Confirm medical necessity and ensure services were consistent with ITP goals, supported by clinical documentation, and delivered by qualified providers operating within their scope of practice;
- Assess whether documentation demonstrated measurable progress toward treatment goals, services matched the intensity and modality authorized, supervision and caregiver training requirements were met, and services complied with state-specific billing and documentation standards;
- Uncover any discrepancies in information from the pre-authorization and concurrent review processes;
- Determine if the codes used to describe care on the submitted bill are coded accurately and correctly to comply with CPT and the International Classification of Diseases (ICD) coding standards; and
- Collect quality and outcomes data (e.g., progress toward goals) for performance improvement and reporting.

In addition, retrospective review activities frequently support broader Medicaid oversight responsibilities related to quality improvement, encounter data validation, and compliance with EPSDT requirements for children under age 21 years. States typically require managed care plans to maintain written utilization management policies, apply consistent medical necessity criteria, provide due process protections for adverse benefit determinations, and ensure that retrospective review findings are clinically grounded and not based solely on arbitrary utilization thresholds.

[304] Giardino, A. P., & Wadhwa, R. (2023, July 10). *Utilization management*. In *StatPearls*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK560806/.

Federal Requirements for Prior Authorization Decision Timelines

States must adhere to federal standard decision timeframes for prior authorization, reflecting the same utilization management expectations that apply across covered Medicaid services.[305]

- **Standard prior authorization decision and notice**: For ABA provided by Medicaid managed care plans, prior authorization decisions for rating periods starting on or after January 1, 2026, must be made and notice provided as expeditiously as the enrollee's condition requires and within state-established timeframes that cannot exceed seven calendar days after receipt of the request, subject to limited extension rules by up to 14 calendar days (e.g., if the enrollee requests it, or if the provider requests the extension and justifies a need for additional information and shows that the delay is in the enrollee's interest). In FFS, state agencies may also extend the initial seven-calendar-day timeframe up to 14 calendar days if the state agency determines additional information from the provider is needed to make a decision.[306]
- **Expedited prior authorization decision and notice:** as expeditiously as the beneficiary's condition requires and no later than 72 hours. In FFS, no extensions to the expedited decision timeframe are available. In managed care, limited extension rules apply (e.g., the plan may extend that 72-hour timeframe by up to 14 calendar days if the enrollee requests it, or if the provider requests it and justifies the need for additional information and shows that the delay is in the beneficiary's interest).[307]

Utilization Management and Program Integrity Coordination

As described in the box below, utilization management and program integrity are different from each other and serve different purposes. However, they are both components of strong state oversight of service provision and should work in tandem. States should coordinate ABA utilization management program needs with ABA program integrity responsibilities to:

- Define post-payment audit triggers (e.g., abnormal hours, billing overlaps, inadequate supervision);
- Define recoupment/extrapolation approach as described in state policy;
- Review prepayment edits (e.g., same-day overlaps with school hours, billing on holidays, unit limits, exceeding daily limits);
- Conduct targeted audits; and
- Conduct provider screening/enrollment checks.

[305] Prior authorization requests must be made in accordance with 42 C.F.R. § 440.230(e)(1). Requests for managed care prior authorization are further subject to the requirements in 42 C.F.R. 438.210.

[306] 42 C.F.R. § 440.230(e)(1)(i) and 457.495(d)(2), 42 C.F.R. §§ 438.210(d)(1) and 457.1230(d).

[307] 42 C.F.R. § 440.230(e)(1)(i) and 457.495(d)(2), 42 C.F.R. §§ 438.210(d)(1) and 457.1230(d).

See Chapter 7 for more detail on program integrity.

Distinguishing Between Utilization Management and Program Integrity

ABA utilization management activities and ABA program integrity audits are often conflated because both involve oversight by the state and managed care plans, but they serve different purposes, occur at different points in the care and payment cycle, and rely on different tools.

- Utilization management for ABA is focused on care management (e.g., whether a service should be authorized and/or continued). Program integrity audits for ABA are focused on compliance enforcement (e.g., whether a service met coverage requirements and was billed correctly).
- Utilization management activities for ABA focus on clinical appropriateness and medical necessity in the context of routine care authorization and monitoring. Program integrity audits for ABA focus on fraud, waste, and abuse prevention, ensuring Medicaid funds are used correctly.
- Utilization management decisions for ABA focus on approving, modifying, or denying services and adjusting authorized hours or duration. Program integrity audit outcomes for ABA focus on recoupment of payments, corrective action plans, provider sanctions or termination, and referral to law enforcement (in severe cases).

State Oversight of Utilization Management in Managed Care

States are responsible for overseeing how managed care plans use utilization management. This oversight includes ensuring that managed care plans:

- Comply with federal utilization management requirements[308]
- Meet state-defined prior authorization timeliness standards[309]
- Maintain compliant adverse benefit determination (ABD) notice, grievance, and appeal processes[310]

To support this oversight, states should clearly define utilization management expectations in managed care contracts and regularly monitor how plans implement them. This may include reviewing utilization management policies, prior authorization criteria, ABDs, and turnaround times to identify whether plans are creating inappropriate barriers to medically necessary ABA or other services.

ABA coverage and utilization management requirements are often spread across several policy and operational documents. These sources may overlap; however, they do not carry the same authority. Table 18 identifies key sources states can review to determine whether a managed care plan's ABA utilization management policies are supported by appropriate authority, aligned with state and federal requirements, and applied consistently across coverage, authorization, billing, and beneficiary communications.

[308] 42 C.F.R. §§ 438.210 and 457.1230(d).
[309] 42 C.F.R. §§ 438.210 and 457.1230(d).
[310] 42 C.F.R. §§ 438.210(c), 438.400-438.424, and 457.1260.

Table 13: Utilization Management Policy Sources for Applied Behavior Analysis

Utilization Management Policy Source	Description	Authority/Use in Utilization Management Policy Review
State Medicaid Coverage Policy	Official state Medicaid requirements define ABA coverage, medically necessary services, prior authorization, continued stay rules, soft service limits, provider qualifications, and documentation.	Establishes the state's baseline authority for ABA coverage and medically necessary services requirements. Use this policy as a potential source to help evaluate whether managed care plan ABA utilization management policies comply with Medicaid requirements.
Managed Care Plan Contract	Executed contract and attachments establish plan obligations for ABA administration (e.g., EPSDT, nondiscrimination, network/provider credentialing requirements, utilization management timeframes, appeals, continuation of benefits, and reporting).	Establishes enforceable plan obligations. Use to assess whether the plan's ABA utilization management policies and processes meet contractual requirements.
Managed Care Plan ABA Clinical Policy and Utilization Management Guideline	Adopted plan or guideline describing how the plan intends to meet contractual obligations for ABA medical necessity and authorization requirements (e.g., required instruments, supervision ratios, authorization increments, hours methodology, discharge criteria).	Operationalizes state policy and contract requirements for utilization management review. Use to help assess whether utilization management processes align with state Medicaid policy, federal managed care requirements, and the managed care contract.
Billing Guide (codes/units/limits)	Official coding and billing instructions that define billable procedure codes, modifiers, unit definitions, medically unlikely edits (i.e., same-day billing rules), and reimbursement constraints that function as de facto utilization limits for ABA.	Establishes operational billing and payment rules that may affect utilization. Use to assess whether authorization and claims practices align with billing requirements.
Managed Care Enrollee Handbook / Evidence of Coverage	Beneficiary-facing documents describing ABA coverage benefits, prior authorization, appeals, grievances, state fair hearings, notice requirements, and continuation of benefits.	Explains ABA coverage and utilization management protections to beneficiaries. Use to assess whether beneficiary materials accurately reflect state policy and contract requirements.

As ABA utilization and spending continue to grow, states and managed care plans may benefit from strengthening utilization management processes that support both access and accountability. A strong ABA utilization management approach should help ensure that medical necessity reviews are conducted by appropriately qualified providers; diagnostic evaluations and ITPs are completed by qualified providers; and children receive timely access to medically necessary services consistent with EPSDT. States and managed care plans may also use utilization management to promote consistent medical necessity criteria and documentation expectations. When coordinated with program integrity functions, utilization management can also help states and managed care plans identify unusual utilization patterns, reduce unwarranted variation in authorized hours, and flag issues that may need follow-up, such as inadequate supervision or billing for services that were not provided. States can require reporting specifically for ABA to understand utilization management trends.

Chapter 7. Preventing Applied Behavior Analysis Fraud, Waste, and Abuse

Overview: Why Program Integrity Matters in Applied Behavior Analysis

As states expand coverage of ABA to meet the needs of individuals with ASD, they face a growing challenge of safeguarding these services from fraud, waste, and abuse. Not all improper payments are considered fraud, and they often represent waste, abuse, or other errors (e.g., lack of documentation). Family dissatisfaction with ABA can be related to underlying compliance failures or billing fraud, and families, among other whistleblowers, can also help to spot fraud, waste, and abuse, particularly when they are more involved in ABA services and have opportunities to review billing and observe providers.[311]

As shown previously in Figure 3a, ABA costs in Medicaid and CHIP grew more than 420 percent over the last five years, to over $10.1 billion in 2025. With this growth, new program integrity concerns have emerged as this is typically an indicator warranting additional oversight.

Federal and state oversight bodies, including the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG), have identified significant vulnerabilities in ABA services, including questionable billing for excessive units of service and billing for services that were not rendered or did not meet coverage requirements.[312,313,314]

[311] Everett, A., McLeod, M., McNight, J., & Cheung, T. (2025, December 29). *Fraud against Autistic Individuals, Their Loved Ones, and Beyond.* Sanford Heisler Sharp McKnight LLP. https://sanfordheisler.com/blog/fraud-against-autistic-individuals-their-loved-ones-and-beyond/.

[312] HHS-OIG. (2025, July). *Wisconsin made at least $18.5 million in improper fee-for-service Medicaid payments for applied behavior analysis provided to children diagnosed with autism* (Report #A-06-23-01002). https://oig.hhs.gov/reports/all/2025/wisconsin-made-at-least-185-million-in-improper-fee-for-service-medicaid-payments-for-applied-behavior-analysis-provided-to-children-diagnosed-with-autism/.

[313] HHS-OIG. (2024, December). *Indiana made at least $56 million in improper fee-for-service Medicaid payments for applied behavior analysis provided to children diagnosed with autism* (Report #A-09-22-02002). https://oig.hhs.gov/reports/all/2024/indiana-made-at-least-56-million-in-improper-fee-for-service-medicaid-payments-for-applied-behavior-analysis-provided-to-children-diagnosed-with-autism/.

[314] HHS-OIG. (2026, January 22). *HHS-OIG audit finds Maine made at least $45.6 million in improper Medicaid payments for autism services*. https://oig.hhs.gov/newsroom/news-releases-articles/hhs-oig-audit-finds-maine-made-at-least-456-million-in-improper-medicaid-payments-for-autism-services/.

Recent U.S. Department of Health and Human Services Office of Inspector General Autism Spectrum Disorder/Applied Behavior Analysis Medicaid Audits

Indiana – ABA services (A-09-22-02002): HHS-OIG found Indiana made at least $56.5 million in improper ABA payments and identified roughly $76.7 million in potentially improper payments. HHS-OIG recommended that Indiana refund $39.4 million to the federal government.

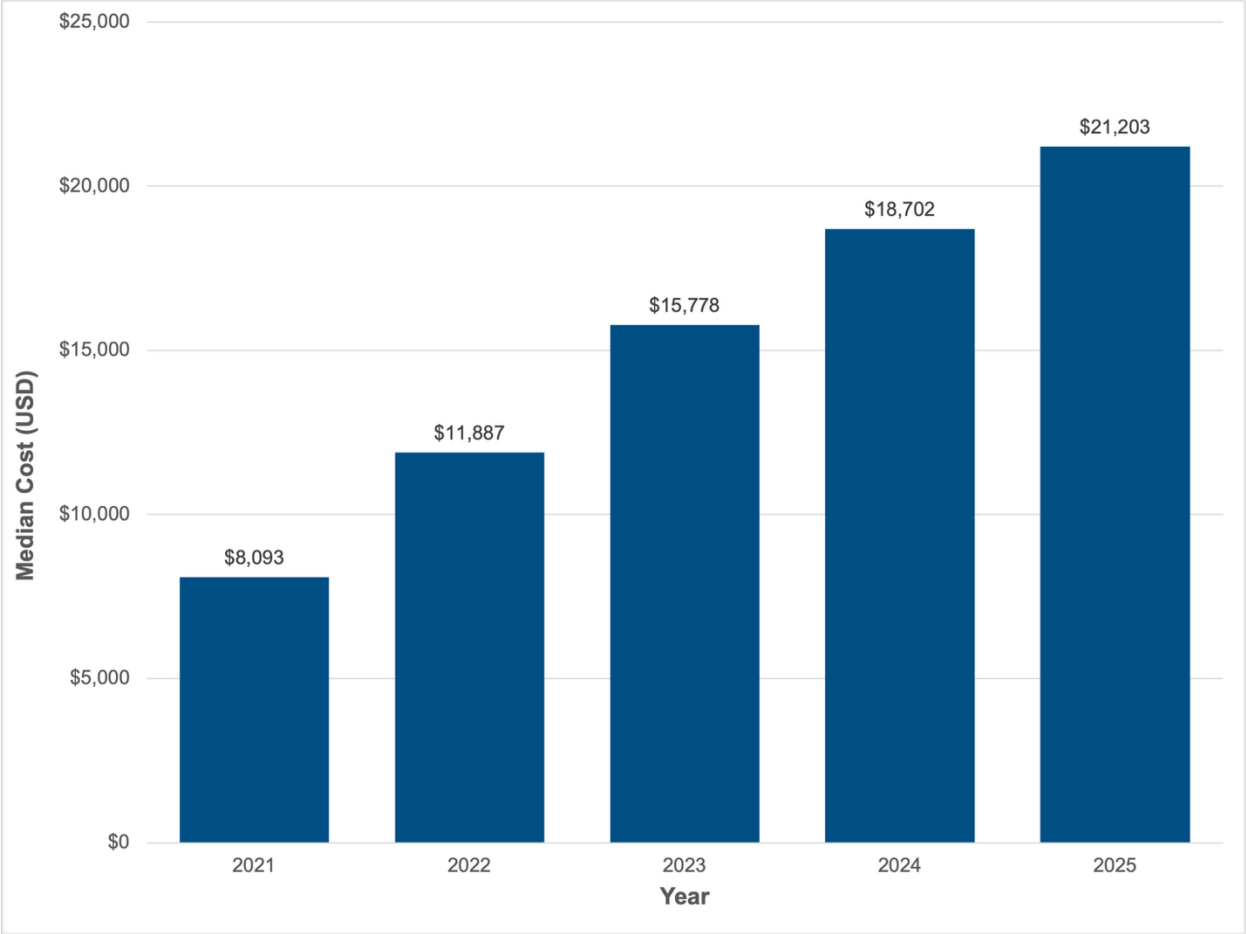
Maine – Rehabilitative and community support for ASD services (A-01-24-00006): HHS-OIG found Maine made at least $45.6 million in improper rehabilitative and community support payments for children with ASD in 2023 and estimated $22.4 million in potentially improper payments. HHS-OIG recommended that Maine refund $28.7 million to the federal government.

Wisconsin – ABA services (A-06-23-01002): HHS-OIG found Wisconsin made at least $18.5 million in improper fee-for-service Medicaid payments for ABA provided to children with ASD and identified an additional $94.3 million in potentially improper payments. HHS-OIG recommended that Wisconsin refund $12.2 million to the federal government.

Across these audits, HHS-OIG highlighted vulnerabilities including weak session-note documentation, billing for non-billable or non-therapy time, services furnished by unqualified or insufficiently supervised staff, inadequate diagnostic and functional assessments, and limited routine post-payment review and provider guidance. HHS-OIG recommended that these states provide additional provider guidance on service documentation and conduct periodic statewide post-payment Medicaid reviews to reinforce requirements.

Medicaid data analytics further illuminate these potentially significant risks by revealing rapidly growing utilization trends on a per-recipient basis (Figure 15).

Figure 15: Median Annual Medicaid and CHIP Payment for Applied Behavior Analysis Services, Per Recipient, 2021–2025



Source: T-MSIS OT claims and associated eligibility data, 2021–2025 for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam. Analysis includes the paid amount for procedure codes 97151–97158 across Medicaid and CHIP FFS claims and managed care encounters for all beneficiaries, regardless of ASD diagnosis. Results are intended for analytic use.

The rapid escalation in ABA expenditures underscores the urgent need for effective federal and state program integrity strategies for ABA. A robust program integrity strategy should include a comprehensive framework that prevents improper payments before they are made, detects aberrant patterns in real-time, and ensures decisive administrative actions are taken to protect program resources–all while ensuring access to needed services is protected.

Proactive Prevention, Detection, and Risk Identification

By systematically analyzing claims and utilization data, states can better balance reactive “pay-and-chase” models with preventive “stop-and-catch” models. For ABA services, which have often involved high-frequency and long-duration treatment, data analytics is an indispensable tool for identifying patterns that require additional attention.

Leveraging National Insights: Healthcare Fraud Prevention Partnership

The Healthcare Fraud Prevention Partnership (HFPP) is a public-private collaboration that offers states a powerful lens into national and cross-payer fraud schemes.[315] Partners include federal entities, such as CMS and HHS-OIG; state entities, such as state Medicaid agencies and Medicaid Fraud Control Units (MFCUs); and other payers, such as Medicare Part C and Part D plans, Marketplace plans, and private payers. This broad range of partners allows HFPP to conduct nationwide data analytics to identify trends and billing patterns that no single partner could identify within its own claims data. States and managed care plans are strongly encouraged to join HFPP to gain access to valuable analytic findings and benchmark their own data against national trends.

Each month, the HFPP releases studies to partners on different high-risk billing areas, and participating states receive a data report specific to their claims data and provider network. States can use that data to further investigate and determine whether administrative actions, policy changes, or oversight monitoring changes are needed.

BEST PRACTICE

Participation in the Healthcare Fraud Prevention Partnership

By participating in the HFPP, states and Medicaid managed care plans can receive state-specific data about their provider networks and claims related to these and other emerging fraud schemes, enabling more targeted and effective oversight.

CMS's Medicaid Emerging Vulnerabilities Dashboard and State-Level Analytics

Similar to how national insights provide valuable context, the combination of federal analytic tools with state-specific data and policy context enhances a state's ability to better understand its providers' billing behaviors and service delivery trends. CMS developed a data analytics tool for states, known as the Medicaid Emerging Vulnerability Intelligence and Actions (MEVIA) dashboard (available June 2026 via the HFPP portal), which provides standardized ABA-related utilization and risk indicators at no cost to states. These tools are updated regularly, incorporate consistent cross-state metrics, and include predictive modeling that identifies emerging program integrity and service-specific risks.

At the same time, states should ensure that they have analytic capabilities that reflect their own coverage policies, utilization controls, and provider requirements, which can vary significantly across states. State-specific dashboards or analytic views may be necessary to contextualize federal metrics and support targeted oversight.

To identify aberrant billing and utilization patterns, data analytics should monitor ABA-specific risk indicators, including:

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[315] CMS. (n.d.). *Healthcare Fraud Prevention Partnership*. Retrieved July 28, 2026, from https://www.cms.gov/medicare/medicaid-coordination/healthcare-fraud-prevention-partnership.

- High service hours per beneficiary (i.e., 32 units per day, 160 units per week)
- Technician-to-supervisor ratios that exceed expected norms
- Rapid growth in billing following provider enrollment
- Claims clustering[316] around supervision codes or modifiers
- High-volume providers (i.e., maximum number of hours are billed for 80 percent or more of patients) with limited credentialed supervisory staff
- Excessive use of telehealth or supervision conducted via telehealth

States should incorporate time-series analysis into their analytic workflows to identify trends and anomalies in utilization patterns (e.g., changes over time or spikes in billing). Peer comparison methodologies can be used to identify providers whose billing patterns deviate from similarly situated providers.

Data analytics should include both FFS claims and managed care encounter data to ensure comprehensive oversight. Analytics should also be interpreted within the context of state-specific ABA coverage and utilization management policies. These policy differences directly affect what constitutes “typical” versus “high-risk” utilization and should be reflected in analytic thresholds and business rules. To support a comprehensive data analytics framework, states should:

- Establish clear coverage and medical necessity criteria
- Standardize provider qualifications and supervision requirements
- Implement prior authorization and define utilization guardrails
- Strengthen coding and billing controls (including modifiers and unit rules)
- Enhance documentation requirements
- Ensure that managed care plan monitoring activities, encounter data, and identified program integrity concerns are incorporated into state analytic and oversight workflows
- Utilize data-driven program integrity tools and analytics
- Develop audit, monitoring, and enforcement protocols
- Promote quality and outcomes by incorporating risk and performance metrics into state analytics, utilization management processes, provider monitoring activities, and managed care oversight

[316] Because ABA services often involve repeated use of time-based treatment and supervision codes, frequent billing of these codes alone does not necessarily indicate inappropriate utilization. States should evaluate clustering patterns in context, including authorized hours, supervision ratios, peer utilization patterns, and consistency with individualized treatment plans. Patterns that deviate substantially from comparable providers or expected service delivery models may warrant additional review.

BEST PRACTICE

Medicaid Emerging Vulnerability Intelligence and Actions Dashboard

States should use CMS's MEVIA dashboard to identify state-specific trends and high-risk service areas to supplement state data analytics to determine appropriate administrative actions and/or policy and oversight enhancements necessary to address the risks.

Assessing and Mitigating Emerging Risks

ABA delivery models and business structures are not static. They continue to evolve with trends like the expansion of telehealth, the integration of services into school settings, and the rise of new ownership models (e.g., private equity investment).

To remain effective, states should establish a regular process for reassessing their program integrity risk indicators and updating their analytic models accordingly. The Government Accountability Office (GAO) developed a Fraud Risk Management Framework for managing fraud risks in federal programs, which provides methods and leading practices for identifying and mitigating organizational risks.[317] CMS implemented this framework and developed a Risk Assessment Template for states to tailor and use within their Medicaid program.[318] This Risk Assessment Template provides a suggested step-by-step approach for identifying, assessing, prioritizing, and addressing program integrity risks in state Medicaid programs. This is a dynamic tool that can be continually updated and maintained to identify new and emerging risks and update mitigation strategies as needed.

BEST PRACTICE

Risk Assessment Template

States should use CMS's Risk Assessment Template to ensure ABA program integrity risks are evaluated on an ongoing basis and determine whether the mitigations are having the intended impact or need to be adjusted.

Implementing Prepayment Safeguards and System Edits

By embedding data-driven rules into their Medicaid Management Information System, states can implement powerful prepayment safeguards. These safeguards often take the form of automated claims edits, which are rules that check claims for compliance before payment is made. Common and effective controls for ABA include:

- **Authorization matching**: verifying that a submitted claim has a corresponding and valid prior authorization on file.

[317] U.S. Government Accountability Office (GAO). (2015, July 28). *A framework for managing fraud risks in federal programs* (GAO-15-593SP). https://www.gao.gov/products/gao-15-593sp.

[318] CMS. (n.d.). *Risk Assessment Template*, 1, 3, 6, 8. https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.pdf.

- **Automated hour limits**: system edits that automatically pend claims exceeding a reasonable daily or weekly hour limit.[319]
- **Service overlap edits**: controls that detect duplicate claims or when claims indicate a provider is providing services in two places at once.
- **Coding integrity**: States are required by the Affordable Care Act to incorporate the methodologies of the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and control improper coding.[320] NCCI includes several types of automated edits:
    - Procedure-to-Procedure (PTP) edits to prevent improper payment when certain procedures are billed together
    - Medically Unlikely Edits (MUEs) that define a maximum number of units of service that can be reported for a single code on a single day
    - Add-on Code Edits to ensure proper payment with their corresponding primary procedure codes

NCCI has several pre-built edits for some ABA; however, these are only mandated for use within FFS claims. NCCI edits are only applicable for Medicaid managed care plans if required by the state's managed care contract. In cases where NCCI does not have an applicable PTP or MUE, the state should develop its own edits that align with state-based coverage policies.

BEST PRACTICE

Periodic Evaluation of Claims Processing Systems

States should periodically evaluate all claims processing systems for edit logic to ensure that it reflects current ABA billing patterns, emerging risks, and program-specific service delivery models.

States should require consistent implementation of applicable NCCI methodologies across both FFS and managed care delivery systems to promote uniform coding oversight, reduce improper payments, and improve program integrity.

Validating Service Delivery with Electronic Visit Verification

Electronic visit verification (EVV) is a key tool for validating that certain HCBS were delivered as billed. EVV systems capture and verify critical details of service delivery, including:

- Service type
- Date and time of service
- Location of service

[319] States may use utilization thresholds as program integrity/review tools. However, under EPSDT and Medicaid amount, duration, and scope requirements, utilization thresholds and authorization limits should not operate as absolute caps when additional medically necessary services are needed to correct or ameliorate a condition.

[320] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6507, 124 Stat. 119 (2010). https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf#page=759.

- Rendering provider
- Service recipient

Although federal law only requires EVV to be implemented for personal care services and home health services, states should consider extending EVV to ABA. Applying EVV to home-based ABA would address an extensive vulnerability given the high volume and decentralized nature of service delivery.

Effective EVV requirements for ABA include:

- Monitoring provider compliance with EVV requirements and identifying noncompliant providers
- Establishing data completeness thresholds (e.g., percentage of claims matched to EVV records)
- Implementing corrective action processes, including education, payment holds, or sanctions for persistent noncompliance
- Integrating EVV data with claims, clinical documentation, and provider data (i.e., credentials) to detect discrepancies and support program integrity activities

To maximize effectiveness, EVV data should be incorporated into broader analytics and audit workflows, allowing states to identify inconsistencies between billed services and verified service delivery and to support targeted program integrity interventions.

BEST PRACTICE

Electronic Visit Verification Data for Claims Processing and Investigations

States should incorporate the aforementioned elements into EVV requirements for ABA and use EVV data as part of claims processing and preliminary investigations under 42 C.F.R. § 455.14.

Clinical Documentation

Clinical documentation is the primary evidence that services were delivered and medically necessary and serves as the foundation for audit findings, potential recoupment, and administrative actions. Documentation must be sufficient, accurate, timely, and organized in a manner that allows independent reviewers to validate services and replicate findings.

States should define clear documentation requirements in provider manuals and align those requirements with audit protocols. At a minimum, documentation should include:

- Comprehensive ITPs tied to assessment results and medical necessity determinations
- Detailed progress notes that clearly document services rendered, including date, duration, and activities performed
- Supervision logs demonstrating appropriate oversight and compliance with supervision requirements

Documentation should be sufficient to:

- Substantiate each billed service
- Support medical necessity determinations
- Verify provider qualifications and supervision
- Provide a clear audit trail for review and any recoupment decisions

Federal and state audits have identified documentation deficiencies, particularly insufficient session notes and unclear definitions of billable time, as key drivers of improper payments in ABA.[321,322,323] In some states, audits have found that 100 percent of claims were lacking documentation or had incomplete documentation. States should establish clear guidance on documentation expectations, including what constitutes billable ABA, and ensure that providers are trained on these requirements. Session-level documentation should include sufficient detail to demonstrate that:

- The service was provided (including date, duration, and location, as applicable)
- The service delivered is consistent with the ITP
- The services billed are supported by the documentation
- The rendering provider and, where applicable, supervising clinician meet program requirements

Prepayment Medical Review

States may implement targeted prepayment medical review to prevent improper payments before they occur. Prepayment medical review involves identifying higher-risk claims or providers and requesting supporting documentation prior to payment.

States should design prepayment medical review processes to be data-driven, risk-based, targeted, and operationally efficient. Key design considerations include:

- **Risk-based targeting:** Use analytics, prior audit findings, and referrals to identify high-risk services, providers, or billing patterns for review.
- **Defined selection criteria:** Clearly document the criteria used to select claims or providers for review (e.g., outlier utilization, rapid growth, high-risk codes).

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[321] HHS-OIG. (2025, July). *Wisconsin made at least $18.5 million in improper fee-for-service Medicaid payments for applied behavior analysis provided to children diagnosed with autism* (Report #A-06-23-01002). https://oig.hhs.gov/reports/all/2025/wisconsin-made-at-least-185-million-in-improper-fee-for-service-medicaid-payments-for-applied-behavior-analysis-provided-to-children-diagnosed-with-autism/.

[322] HHS-OIG. (2024, December). *Indiana made at least $56 million in improper fee-for-service Medicaid payments for applied behavior analysis provided to children diagnosed with autism* (Report #A-09-22-02002). https://oig.hhs.gov/reports/all/2024/indiana-made-at-least-56-million-in-improper-fee-for-service-medicaid-payments-for-applied-behavior-analysis-provided-to-children-diagnosed-with-autism/.

[323] HHS-OIG. (2026, January 22). *HHS-OIG audit finds Maine made at least $45.6 million in improper Medicaid payments for autism services*. https://oig.hhs.gov/newsroom/news-releases-articles/hhs-oig-audit-finds-maine-made-at-least-456-million-in-improper-medicaid-payments-for-autism-services/.

- **Standardized review protocols:** Apply consistent clinical and billing criteria to evaluate documentation, including medical necessity, service authorization alignment, and supervision requirements.
- **Timely processing:** Establish clear timelines for documentation submission and review decisions to minimize disruption to provider cash flow and beneficiary access.

Prepayment medical review activities may include:

- Flagging high-risk claims based on utilization patterns, billing anomalies, or prior audit findings
- Requesting and reviewing supporting documentation prior to payment
- Holding or pending claims until review is completed

States may also consider iterative, education-focused approaches similar to Medicare's Targeted Probe and Educate model,[324] which combines focused review cycles with provider education to improve compliance and reduce error rates over time.

To support consistency and defensibility, states should:

- Maintain documentation of review determinations and supporting rationale
- Ensure that staff with appropriate clinical expertise are involved in review decisions
- Establish quality assurance and supervisory review processes
- Provide clear communication to practitioners regarding findings and expectations

BEST PRACTICE

Prepayment Medical Review

States should implement targeted, risk-based prepayment medical review processes for higher-risk ABA claims while balancing timely provider reimbursement and beneficiary access to medically necessary care.

Prepayment medical review should be coordinated with audit and analytics functions. Findings from prepayment reviews should be used to refine targeting criteria, update claims edits and utilization management controls, and inform future audit selection and program integrity strategies.

Post-Payment Audit and Medical Review Best Practices

Robust audit and medical review processes are central to detecting and correcting improper payments; identifying potential fraud, waste, and abuse; and strengthening overall program

[324] CMS. (*2026*, March. 4). *Targeted Probe and Educate.* Retrieved July 28, 2026, from https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/targeted-probe-and-educate-tpe.

integrity. States should establish standardized, risk-based audit programs tailored to ABA service delivery and aligned with clearly defined documentation and utilization management requirements.

Audit Design and Planning

Audit planning should define the audit's scope, objectives, methodology, evidence sources, timeframe, and relevant risks. Clearly defined audit plans are essential to ensure that audit work is aligned with program requirements and produces defensible findings.

Audit scope should specify:

- Provider type and service category
- Applicable federal and state regulations and policies
- Time period under review
- Claims, codes, or populations of interest
- Documentation and billing requirements to be validated

Audit planning should also identify:

- Required subject matter expertise (e.g., clinical, coding, or program staff)
- Data sources and evidence needed to support findings
- Corrective action plans or recommendations from previous reviews or audits

States should use a collaborative approach involving program staff, clinicians, and data analysts to ensure audits reflect both policy requirements and clinical realities.

Sampling and Data Integrity

States may use full claim reviews or statistical sampling methods (e.g., simple random or stratified sampling) for post-payment audits. Sampling methodologies should be documented, consistently applied, sufficient to support defensibility, and, where applicable, result in extrapolation of findings.

Data integrity is critical throughout the audit process. States should ensure that all data used in audit selection and findings are:

- Accurate and complete
- Consistent with source systems
- Traceable and reproducible

Strong data integrity controls are necessary to ensure that audit conclusions are reliable and can withstand administrative and legal review.

Audit Execution

During audits, states should conduct comprehensive reviews of both clinical and administrative documentation to determine whether it is sufficient to support that services were delivered, medically necessary, and billed in accordance with program requirements.

Audit activities should include:

- Review of complete medical records and supporting documentation
- Validation of medical necessity and alignment with authorized services
- Verification of provider credentials and supervision requirements
- Reconciliation of claims with EVV and other service verification data, where applicable

Consistent with documentation standards, each billed service must be fully supported by documentation.

Audit Documentation

States should maintain comprehensive audit files that clearly document all audit activities, evidence, and findings. Audit documentation should be sufficient to support conclusions and allow an independent reviewer to replicate the audit results.

Audit files should:

- Include all relevant evidence, correspondence, interviews, and analyses
- Clearly link findings to supporting documentation and applicable requirements
- Support overpayment calculations and recoupment decisions
- Maintain a clear and organized audit trail

Well-organized documentation is critical to support administrative actions, appeals, and potential legal proceedings.

Audit Outcomes and Continuous Improvement

Audit outcomes with negative findings may include:

- Overpayment recovery and repayment arrangements
- Provider education and outreach, and corrective action plans
- Referrals to licensing boards or law enforcement
- Identification of policy, system, or control weaknesses
- Surveillance of corrective actions

Audit findings should be reviewed through established quality assurance and supervisory processes and used to inform broader program integrity efforts.

States should use audit findings to:

- Refine analytics and risk models

- Strengthen utilization management and claims edits
- Improve provider guidance and documentation requirements
- Inform future audit selection and program integrity strategies
- Evaluate the effectiveness of fraud prevention practices

BEST PRACTICE

Audit and Medical Review Processes

States should establish standardized, risk-based audit and medical review processes that incorporate clearly defined methodologies, sufficient documentation requirements, quality assurance processes, and multidisciplinary expertise. Audit findings should be used to identify and recover improper payments and to strengthen analytics, utilization management controls, provider education, and future program integrity activities.

Office of Inspector General Audit Findings

The HHS-OIG announced a series of audits of Medicaid ABA services provided to children diagnosed with ASD to determine whether a state's ABA payments complied with federal and state requirements. In its completed audits to date, the HHS-OIG found that state agencies made improper and potentially improper payments for Medicaid ABA FFS and Residential Care Services due to insufficient oversight of provider compliance with documentation and billing requirements.[325]

Inadequate Provider Guidance

The HHS-OIG found that state agencies failed to issue sufficient guidance to ABA and Residential Care Services providers on key compliance requirements. Specifically, the guidance lacked clarity in the following areas:

- **Documentation standards**: Providers did not receive clear guidance on the documentation necessary to support the use of specific CPT codes for ABA and Residential Care Services
- **Signature and session note requirements**: Guidance was insufficient regarding signature requirements and the required elements within session notes, including documentation of enrollee progress toward identified goals or outcomes.
- **Billing practices**: Providers lacked clear direction on proper billing practices, including a definition of what constituted billable ABA time.

[325] HHS-OIG. (2022, January 24; updated 2026, February 25). *Series: Audits of Medicaid applied behavior analysis for children diagnosed with autism* (Series No. SRS-A-25-029). https://oig.hhs.gov/reports/work-plan/browse-work-plan-projects/srs-a-25-029/.

- **Provider credentialing requirements**: Guidance on provider credentialing requirements was inadequate, leaving providers without a clear understanding of the qualifications necessary to render and bill for ABA services.

Absence of Post-Payment Reviews

In addition to the guidance deficiencies noted above, none of the state agencies conducted statewide post-payment reviews of Medicaid ABA claims to verify compliance with federal and state documentation standards or provider qualification requirements. This emphasizes the need for both prepayment and post-payment approaches to program integrity.

This lack of oversight further contributed to the occurrence of improper and potentially improper payments and could have had a significant effect on the quality of care.

BEST PRACTICE

Oversight Findings for Program Improvement

States should use findings from HHS-OIG audits and other oversight reviews to strengthen provider guidance, documentation standards, post-payment review activities, and program integrity oversight processes.

Administrative Actions and Overpayment Recovery

When potential fraud, waste, or abuse is identified through data analytics, utilization management, or audit activities, states must validate findings and take appropriate corrective and administrative actions. Effective response processes ensure that improper payments are addressed, providers are held accountable, and program integrity controls are strengthened over time.

Identifying Targets with Surveillance and Utilization Review Systems

The Surveillance and Utilization Review Subsystem (SURS) is a data-driven tool used by states to identify aberrant utilization patterns and flag providers or claims that may warrant further review. SURS analyzes claims and utilization data to support post-payment review, audit targeting, and investigative activities.[326] States should use SURS in coordination with analytics and program integrity functions to:

- Identify providers with sustained high utilization or billing patterns that exceed peer norms
- Detect aberrant billing patterns, including services inconsistent with supervision or authorization requirements
- Prioritize providers and claims for prepayment review, post-payment audit, or further investigation

[326] CMS. (2001). *Guidance and best practices relating to the states' surveillance and utilization review functions*. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/surutil.pdf.

- Support risk-based targeting and efficient use of audit and investigative resources

Administrative Actions

When post-payment review identifies noncompliance or improper billing, states should apply appropriate administrative actions to recover identified overpayments, return the required federal share, and address provider noncompliance, consistent with federal Medicaid program integrity requirements.[327] Actions should be proportional to the severity and nature of the findings, taking into account factors like the amount of overpayment, frequency of noncompliance, provider history, and whether findings indicate potential fraud. States should maintain documentation supporting the determination of overpayments, the rationale for selected administrative actions, and any law enforcement referrals made.

Administrative actions may include:

- Overpayment recovery and recoupment, including repayment plans where appropriate and returns of the federal share on the CMS quarterly expenditure reports[328]
- Provider education and corrective action plans to address identified deficiencies
- Payment suspension in cases involving credible allegations of fraud,[329] in accordance with 42 C.F.R. § 455.23, unless good cause exists not to suspend payments[330]
- Referral to law enforcement, including MFCUs, for suspected fraud
- Referral to licensing or oversight bodies, as appropriate

States should establish clear processes for determining when each action is appropriate, including thresholds for referral, documentation requirements, and internal review procedures.

Continuous Improvement

In addition to corrective and enforcement actions, states should use findings to improve program integrity systems. This includes:

- Updating claims edits, utilization management controls, and provider guidance
- Refining analytics and risk models to better identify emerging risks
- Incorporating findings into provider education and training initiatives

Regular post-payment review and ongoing provider education are critical to identifying deficiencies, improving compliance, and preventing future improper payments.

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[327] Medicaid, 42 C.F.R. Part 455.

[328] 42 C.F.R. Part. 433, Subpart. F.

[329] Suspension of payments in cases of fraud, 42 C.F.R. § 455.23 (2026). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-A/section-455.23.

[330] CMS. (2014, September). *Medicaid payment suspension toolkit*, 1–5. https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/medicaid-paymentsuspension-toolkit-0914.pdf.

BEST PRACTICE

Risk-Based Program Integrity Actions

States should integrate SURS outputs, audit findings, and post-payment review results into a coordinated program integrity framework that supports risk-based targeting, efficient use of program integrity resources, timely overpayment recovery, provider education, and resolution of improper billing patterns. States should also establish clearly documented processes for administrative actions, including overpayment recovery, corrective action plans, payment suspensions, and law enforcement referrals that are aligned with state and federal program integrity requirements.

CMS Focused Program Integrity Reviews

CMS is committed to continued focus on program integrity in the area of ABA services. To ensure that FFP for ABA services is paid for legitimate services only, CMS will continue to conduct focused program integrity reviews of state quarterly expenditure reports (Form CMS-64) to confirm that services, including ABA claimed for FFP, are properly supported with service and administrative cost documentation that is reasonable and appropriate and correlates with the services claimed. Moreover, if CMS is aware of any providers that may be a program integrity risk, CMS may review claims specifically submitted by those providers during its quarterly expenditure report review. During these reviews, CMS will request state claims data and possibly provider claims data as well. It is critically important that states are able to produce and provide supporting claims documentation at the time of Form CMS-64 certification to ensure that services can be matched with federal funds in a timely manner.

Site Visits

Unannounced site visits are a routine and critical tool that can be used to ensure that providers and clinics are delivering the care reflected in billing and medical records, understand billing anomalies, investigate complaints, and validate staffing or supervision ratios, etc. States and managed care plans should incorporate unannounced site visits into their program integrity strategy or plan.

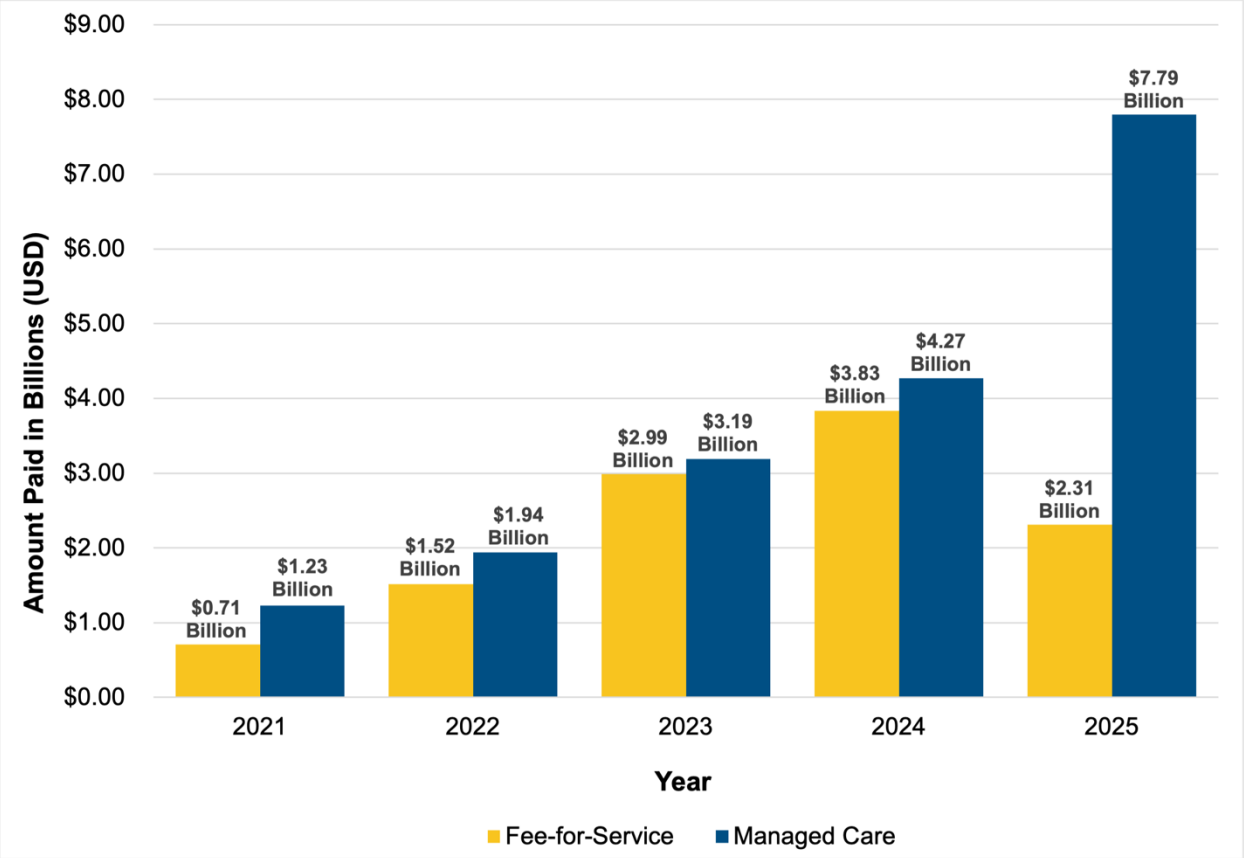
Managed Care Oversight

Some managed care plans have reported significant year-over-year growth, including increases in beneficiaries accessing ABA services, service units, provider supply, and total spending, which has contributed to increased managed care plan, state, and federal spending.[331] Medicaid data show that 2025 may have marked an inflection point. As shown in Figure 16, after years of cost trends rising mostly in concert across FFS claims and managed care encounters, the total amount paid for Medicaid and CHIP managed care encounters almost doubled in 2025 while

[331] Medicaid Health Plans of America (MHPA). (2026, February 11). *MHPA Recommendations for Detecting and Combating Fraud, Waste, and Abuse in the Applied Behavioral Analysis Space* [MHPA-ABA-FWA recommendations for CMCS], 2-3, 5-6. https://medicaidplans.org/wp-content/uploads/2026/02/MHPA-ABA-FWA-Recommendations-for-CMCS-2.11.26.pdf.

total paid amount for Medicaid and CHIP FFS claims notably declined. There are many factors that are impacting this changing landscape, including that more states are including ABA in managed care delivery systems, and managed care plans are providing care to enrollees with high needs. This shift in spending highlights the need for states to ensure they have appropriate oversight in managed care delivery systems to address fraud, waste, and abuse concerns.

Figure 16: Total Medicaid and CHIP Payments for Applied Behavior Analysis Services by Delivery System, 2021–2025



Source: T-MSIS OT claims and associated eligibility data, 2021–2025 for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam. Analysis includes the paid amount for procedure codes 97151–97158 across Medicaid and CHIP FFS claims and managed care encounters. FFS claims and managed care encounters were delineated using the Claim Type Code data element. Results are intended for analytic use.

For states delivering ABA through a managed care delivery system, program integrity oversight requires additional safeguards, including enhanced contractual requirements, data access, and monitoring mechanisms to address differences in data visibility, utilization management, enforcement authority, and managed care plan program integrity requirements and capabilities.

While many program integrity functions are delegated to managed care plans, states remain ultimately responsible for ensuring that ABA services are delivered in accordance with program requirements and that fraud, waste, and abuse are identified and addressed. States must

establish clear and enforceable contractual requirements and oversight mechanisms tailored to the unique risks associated with ABA.

State oversight of ABA in managed care should align with CMS program integrity guidance and requirements, including compliance programs,[332] overpayment recovery,[333] fraud referral processes,[334] and payment suspension frameworks.[335]

Alignment of Managed Care Contracts with ABA Program Integrity Requirements

States should ensure that managed care contracts explicitly require managed care plans to apply program integrity safeguards consistent with those described throughout this chapter, including:

- Applying standardized documentation requirements for ABA, including session-level documentation expectations
- Using data analytics and encounter data to identify high-risk providers and aberrant utilization patterns
- Implementing utilization management and prior authorization processes consistent with federal requirements, including that medically necessary services are defined in a manner that is no more restrictive than that used in the state Medicaid program (42 C.F.R. § 438.210(a)(5)), and conducting post-payment medical review and audit activities consistent with state audit protocols, including state-directed audit and validation activities

States should establish financial penalties for managed care plans that do not comply with program integrity safeguards required by the contract.[336]

Compliance Programs and Internal Controls

States should require managed care plans to maintain effective compliance programs consistent with federal managed care program integrity requirements[337, 338] and CMS guidance. These programs should include:

- Internal monitoring and auditing systems
- Training and education for staff and providers

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[332] CMS. (2023, November 1). *Compliance program requirements: 42 C.F.R. § 438 Subpart H, § 438.608(a)(1)*, 1, 3-4, 6, 8. https://www.cms.gov/files/document/managed-care-compliance.pdf.

[333] CMS. (2023, November 1). *Treatment of overpayments and recoveries: 42 C.F.R. § 438 Subpart H, §§ 438.608(a)(2) and (d),* 1-2, 4, 8. https://www.cms.gov/files/document/managed-care-overpayment-recoveries.pdf.

[334] CMS. (2025, June 16). *Prompt referrals of potential fraud, waste, or abuse: § 438.608(a)(7),* 1-3, 6. https://www.cms.gov/files/document/managed-care-fraud-referral.pdf.

[335] CMS. (2023, November 1). *Payment suspensions based on credible allegations of fraud: § 438.608(a)(8),* 1-2, 6-7. https://www.cms.gov/files/document/managed-care-payment-suspensions.pdf.

[336] 42 C.F.R. § 438.702(b), 42 C.F.R. § 457.1285.

[337] CMS. (2023). *Medicaid and CHIP Managed Care Program Integrity Toolkit: 42 C.F.R. 438 Subpart H Compliance Program Requirements §438.608(a)(1),* 3-4, 6. https://www.cms.gov/files/document/managed-care-compliance.pdf.

[338] 42 C.F.R. § 457.1285.

- Mechanisms for reporting suspected fraud, waste, and abuse
- Policies and procedures to prevent and detect improper payments[339]

Overpayment Identification and Recovery

Managed care plans are responsible for identifying, reporting, and recovering overpayments in accordance with state and federal requirements[340, 341] and CMS guidance on managed care overpayment recovery. States should ensure that:

- Managed care plans have processes to identify overpayments related to ABA, including documentation deficiencies and billing inconsistencies
- Overpayments are reported to the state in a timely manner
- Recovery processes are clearly defined and consistently applied
- Managed care plans have processes to ensure that all identified overpayments as well as all recovered overpayments are excluded from data and adjustments utilized for developing managed care capitation rates

States should retain oversight of managed care plan overpayment identification and recovery activities to ensure consistency with federal requirements and alignment with state program integrity actions.

Fraud Identification, Referral, and Enforcement Coordination

Federal regulations at §§ 438.608(a)(7) and 457.1285 require states to include contract provisions ensuring that managed care plans have processes to identify and promptly refer potential fraud, waste, or abuse. These requirements apply to all Medicaid and CHIP services included in managed care contracts, and states should ensure that managed care contracts clearly define how these processes apply to ABA, if different.

States are responsible for evaluating referrals submitted by managed care plans and, where appropriate, referring cases to MFCUs in accordance with federal requirements. When a credible allegation of fraud is identified, states are responsible for determining whether to suspend Medicaid payments to the provider, consistent with federal requirements and CMS guidance.[342]

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[339] CMS. (2023). *Medicaid and CHIP Managed Care Program Integrity Toolkit: 42 C.F.R. 438 Subpart H Compliance Program Requirements §438.608(a)(1),* 3-4, 6. https://www.cms.gov/files/document/managed-care-compliance.pdf.

[340] 42 C.F.R. § 438.608.

[341] 42 C.F.R. § 457.1285.

[342] Suspension of payments in cases of fraud, 42 C.F.R. § 455.23.

BEST PRACTICE

Managed Care Fraud Referrals

States should establish clear processes describing how managed care plans should notify the state of suspected cases of fraud, provide supporting documentation, and coordinate with state program integrity staff. Managed care contracts and state procedures should clearly define the respective responsibilities of states and managed care plans related to payment suspensions and ensure that state review and approval steps do not create unnecessary delays or barriers.

States should periodically assess whether their own forms, documentation requirements, and decision-making timeframes support timely action on credible allegations of fraud, and revise procedures where referrals are routinely delayed or closed without clear resolution. These processes should be coordinated with broader state program integrity activities.

Key Applied Behavior Analysis Program Integrity Takeaways for States

To strengthen program integrity for ABA, states should implement a coordinated framework of preventive, detective, and corrective controls that operate across both FFS and managed care delivery systems.

Key actions for states include:

- **Leverage data analytics and SURS** to identify high-risk providers and aberrant utilization patterns early
- **Implement strong utilization management and documentation standards**, including clear expectations for session-level documentation and billable services
- **Use prepayment and post-payment medical review** to validate services and prevent improper payments
- **Establish structured audit and validation processes** that are aligned with defined protocols and supported by sufficient documentation
- **Ensure clear processes for overpayment recovery, fraud referral, and payment suspension**, including returns to the federal government, consistent with federal requirements
- **Align managed care oversight with FFS program integrity safeguards**, including clear contractual expectations, data access, and state oversight of managed care plan activities

Effective ABA program integrity requires continuous coordination across analytics, utilization management, audit, and enforcement functions. States should use findings from monitoring and

review activities to refine controls, improve provider guidance, and address emerging risks over time.

Appendix A. State Checklists

State Checklist for Clinical Standards

This checklist is intended to support discussions among Medicaid and CHIP program staff as they review clinical standards related to ABA for ASD. It can help staff identify program design options and where additional clarification or refinements may be helpful.

Establishment of Clinical Need

- ☐ Is there a clear requirement for diagnostic evaluations to be conducted by qualified providers?
- ☐ Does the diagnostic evaluation include the following?
  - Use of at least two assessment tools: one caregiver-report instrument and one provider observation measure
  - In consideration of the above, include involvement of a multidisciplinary team of providers, with a qualified medical provider integrating results from a multi-method, multi-informant assessment with evaluations from behavioral health, speech and language pathology, occupational therapy, physical therapy, and cognitive testing, as indicated. The construct of the team should align with the complexity and level of need of the individual.
  - Direct observation and structured caregiver interview with use of a validated standardized testing instrument
  - A comprehensive functional or adaptive-behavioral assessment when challenging behaviors are present as a primary treatment target
- ☐ Do referrals and treatment conform with Stark Law requirements, which ensure that a provider may not benefit from an ownership interest, investment interest, or compensation arrangement that is tied to the volume or value of referrals for services it also provides?

Confirm the Existence of an Individualized Treatment Plan

- ☐ Do we have an explicit requirement that each child have an ITP that drives ABA treatment authorization and provision?
- ☐ Do our policies describe what an individualized ABA treatment plan should include, such as baseline functioning, measurable goals, treatment intensity, duration, setting, supervision, caregiver training, and transition or discharge criteria?
- ☐ Are the specific individualized goals and intervention activities being reviewed and updated at each reassessment?
- ☐ Have the goals been designed to align with family routines?
- ☐ Does the documentation describe progress toward identified goals and indicate when goals, benchmarks, or strategies have been revised in response to limited or stalled progress?
- ☐ Are authorization and reauthorization decisions tied to the ITP rather than standardized hour packages or preset treatment levels?

- Do concurrent review and reauthorization processes include review material beyond diagnosis to assess whether services remain medically necessary such as progress data, treatment response, delivered versus authorized hours, and current functional needs?
- Do reauthorization processes allow services to be continued, modified, intensified, reduced, transitioned, or discontinued based on individualized clinical review?

Parent and Caregiver Involvement

- Is parent and caregiver training a specific part of the treatment plan with identified goals to improve outcomes and maintain treatment progress?
- Are parents and caregivers being provided with guidance regarding task execution and reporting changes?
- Is a flexible approach being used when working with families who may have multiple caregiving responsibilities or constrained schedules?
- Is effective caregiver coaching treated as a comprehensive process instead of replacing provider-patient time?

Applied Behavior Analysis Coverage for Children in Foster Care and High-Risk Youth

- Have we reviewed ABA policies to identify requirements that may be difficult for children in foster care to meet (for example, stable home address for home-based services, new diagnostic evaluation at each placement, strict caregiver training quotas)?
- Do our policies allow acceptance of prior diagnostic evaluations that meet clinical standards when children change placements?
- Do caregiver-training expectations for ABA explicitly account for foster care contexts (for example, allowing flexible modalities and participation by foster parents, caregivers, and placement staff)?

Applied Behavior Analysis and Other Services

- Have we acknowledged, where appropriate, stakeholder and self-advocate perspectives on ABA and considered how coverage language emphasizes safety, communication, self-advocacy, and mental health outcomes rather than behavior “normalization”?
- What other services are we offering for the treatment of ASD? Do families understand the range of services available when their child is diagnosed with ASD?
- Do parents have a clear ability to decline ABA in favor of other services?

State Checklist for Applied Behavior Analysis and Autism Spectrum Disorder Coverage

This checklist is intended to support discussions among Medicaid and CHIP program staff as they review how ABA and related ASD services are structured. It contains information to help teams identify program design options and determine where additional clarification and refinements may be helpful in state plan or waiver language, managed care contracts, and provider guidance.

Federal Authorities and Early and Periodic Screening, Diagnostic, and Treatment

- ☐ Have we identified which Medicaid authorities are being used to cover ABA and other ASD-related services (e.g., section 1905(a) state plan services, 1915(c) HCBS waivers, 1915(i) state plan HCBS, and any 1115 demonstrations)?
- ☐ Is it clear in our documents how these authorities interact with EPSDT for children and youth under age 21, including that medically necessary 1905(a) services must be covered for EPSDT-eligible beneficiaries?
- ☐ Where multiple authorities are in use, have we described the distinct roles of each (for example, core treatment under the state plan versus wraparound supports through HCBS waivers or 1115 demonstrations)?
- ☐ If separate CHIP coverage is relevant, have we clarified how ASD-related services, including ABA, are addressed under CHIP benefit categories and how EPSDT-equivalent requirements apply when a state elects that option?

Technology to Support Applied Behavior Analysis

- ☐ Has telehealth been considered if an individual is unable to attend in person?
- ☐ If telehealth is being used, is the individual able to participate at an appropriate level to benefit from the therapy?
- ☐ Are there established state parameters for the percentage of treatment that can be offered via telehealth?
- ☐ Are there digital resources available to help parents and caregivers find support and ABA in their area?

State Checklist for Reviewing Applied Behavior Analysis Payment Approaches

This checklist is intended to support discussions among Medicaid and CHIP program staff as they review how ABA and related ASD services are reimbursed. It helps teams identify payment design options and determine where clarification or refinements may be helpful.

Applied Behavior Analysis Delivery Systems

- ☐ Have we identified whether ABA is paid through fee-for-service, managed care, or a combination of both delivery systems, and is that structure clearly described in state policy documents and operational guidance?
- ☐ Where ABA is delivered through more than one financing or delivery system, have we clarified the distinct payment rules, oversight responsibilities, and points of coordination across those systems?

Fee-For-Service Delivery

- ☐ If ABA is paid through FFS, have we documented that the state has direct control of claims processing, rates, and oversight?

Managed Care Delivery

- ☐ If ABA is included in the managed care plan contract, have we assessed whether capitation rate development appropriately reflects ABA utilization trends and spending risk?

Fee-For-Service Provider Payment Rates on Fee Schedules

- ☐ Have we identified which ABA procedure codes are covered under FFS, including whether the state uses CPT codes 97151 through 97158 or state-specific equivalents?
- ☐ Is it clear how rates vary, if at all, by provider credential, provider type, or site of service?
- ☐ Have we reviewed whether current ABA payment rates are sufficient to support provider participation, enrollee access, and compliance with the requirement that rates be consistent with efficiency, economy, quality, and access?
- ☐ Do our fee schedules, state plan materials, and provider manuals consistently describe the same ABA billing structure and reimbursement rules?

Fee-For-Service Alternative Payment Methodologies

- ☐ If bundled or per diem payment is being considered, have we identified the documentation, service verification, and post-payment review safeguards needed to address program integrity risks?

- Have we considered whether alternative payment approaches create incentives that could unintentionally encourage under-service, early discharge, or avoidance of children with higher support needs?
- Where value-based payment is being explored, have we identified measures, safeguards, and risk-adjustment approaches that are appropriate for ABA?

State Checklist for Applied Behavior Analysis Provider Enrollment, Qualifications, Credentialing, and Ownership

This checklist is intended to support discussions among Medicaid and CHIP program staff as they review ABA provider qualifications, enrollment, supervision, telehealth, and ownership oversight. It can help teams identify where additional clarification and refinements may be helpful in provider manuals, enrollment standards, managed care contracts, and program integrity processes.

Provider Qualifications and Enrollment

- ☐ Have we identified which ABA provider types may furnish and/or bill for ABA in our program (for example, BCBAs, BCaBAs, LBAs/LABAs, RBTs, state-defined technicians, and any other licensed providers we permit)?
- ☐ Do our policies clearly distinguish among certification, licensure, and state/managed care plan credentialing requirements, and explain how those requirements interact?
- ☐ Have we clarified which providers must enroll directly, which must register, and which bill through a supervising provider or agency?

Technicians and Supervision

- ☐ Have we clearly established the training, credentialing, and supervision requirements for technician- or assistant-level providers?
- ☐ Do our policies clearly identify which providers may practice independently, which must work under supervision, and which may supervise other staff?
- ☐ Have we established minimum supervision standards for BCaBAs, RBTs, and technicians, including supervision frequency, direct observation, and documentation expectations?
- ☐ Have we clarified which supervision activities may or may not be billable?
- ☐ Do our policies allow supervision intensity to vary based on clinical need and complexity, progress, transitions, and changes in treatment hours?

Telehealth

- ☐ Have we clearly identified which components of ABA may be delivered via telehealth, which must occur in person unless otherwise authorized, and the clinical criteria for telehealth use?
- ☐ Do our policies specify telehealth modality, technology, privacy, and billing requirements, including any needed modifiers?

- Have we clarified expectations for telehealth supervision, including real-time video and direct observation requirements?
- If ABA is delivered in school-based settings, have we clarified whether remote supervision satisfies any on-site requirements and how supervision ratios apply across multiple classrooms or buildings?

Fee-For-Service and Managed Care Requirements

- Have we identified how provider requirements differ between FFS and managed care for credentialing, utilization management, documentation, network participation, and quality oversight?

Organizational Accreditation and Ownership

- Have we determined whether organizational accreditation is required, encouraged, or tied to reimbursement or network participation for ABA organizations?
- Do we require providers to maintain accurate ownership and control records and to report ownership changes promptly?

Program Integrity and Ownership Change Monitoring

- Do we monitor post-acquisition risks such as rapid growth, staff turnover, reduced supervision, or unusual billing patterns?
- Do we require managed care plans to collect ownership disclosures, share notices of ownership changes, and report concerns about post-transaction quality or billing patterns? Do we collect this same information in FFS programs?

State Checklist for Applied Behavior Analysis Utilization Management

This checklist is intended to support discussions among Medicaid and CHIP program staff as they review how ABA utilization management is structured. It can help teams identify where additional clarification or refinement may be helpful in state policy, FFS guidance, managed care contracts, provider manuals, prior authorization materials, and beneficiary notices.

Utilization Management Structure and Early and Periodic Screening, Diagnostic, and Treatment Alignment

- ☐ Have we clearly identified which ABA services are subject to utilization management, including prior authorization, concurrent review, reauthorization, and retrospective review?
- ☐ Do our utilization management policies distinguish between EPSDT screening services, which may not be subject to prior authorization, and treatment services that may be subject to prior authorization and medical necessity review?
- ☐ Do our utilization management policies allow individualized exceptions to service limits, hour thresholds, authorization periods, or review triggers when medically necessary under EPSDT?
- ☐ Have we reviewed ABA utilization management policies to ensure they do not impose hard limits, automatic terminations, or other limits that could restrict medically necessary EPSDT services?
- ☐ Does utilization management consider the diagnostic evaluation and functional needs, expected benefit, and treatment goals in the ITP?

Medical Necessity

- ☐ Has the state or managed care organization defined the medical necessity criteria used to review ABA requests?
- ☐ Do review criteria and processes support consistent review, while being flexible enough to account for each child's age, developmental stage, co-occurring conditions, treatment history, and clinical presentation?

Prior Authorization

- ☐ Do prior authorization requirements clearly identify the documentation needed to support the review, such as a diagnostic evaluation, functional impairment documentation, ITP, and caregiver participation information?
- ☐ Have we clarified who may conduct clinical utilization management reviews, including whether reviewers must have ABA or developmental-behavioral health expertise?

Retrospective Review

- ☐ Do retrospective review processes evaluate the clinical appropriateness and quality of care after service delivery and support ongoing quality assurance, utilization oversight, and payment validation purposes?

- Do we maintain sufficient written utilization management policies to ensure that retrospective review findings are clinically grounded and not based solely on arbitrary utilization thresholds?
- When concerns are identified, do we have mechanisms in place for provider education, corrective action plans, recoupment of improper payments, referral for fraud investigation, or recommendations for modifications to future treatment planning and authorization practices?

Managed Care Oversight

- Do managed care contracts require managed care plans to comply with federal Medicaid requirements related to EPSDT and federal requirements on coverage and authorization of services?
- Have we reviewed whether managed care plan ABA utilization management policies, clinical criteria, provider guidance, and beneficiary materials are consistent with state Medicaid policy and federal requirements?
- Have we removed state barriers that restrict managed care plans' ability to identify and address fraud, waste, and abuse (e.g., state prohibition on utilization management and prior authorization, state requirement to contract with any willing provider, etc.)?
- Do contracts or guidance define minimum managed care expectations for prior authorization documentation, review timelines, reviewer qualifications, ABD notices, appeals, and continuation of benefits?
- Do we monitor managed care utilization management performance using data such as prior authorization approvals, partial approvals, denials, reductions in requested hours, turnaround times, appeal outcomes, fair hearing outcomes, retrospective review findings, and variation across managed care plans?
- Do we have a process to address managed care practices that appear to improperly restrict access to medically necessary ABA, including corrective action, penalty enforcement, or policy clarification?

State Checklist for Preventing Applied Behavior Analysis Fraud, Waste, and Abuse

This checklist is intended to support discussions among Medicaid and CHIP program staff as they review program integrity safeguards related to ABA services. It is designed to help states assess whether their FFS and managed care policies, provider requirements, oversight processes, and enforcement pathways are structured to prevent fraud, waste, and abuse while maintaining access to medically necessary services.

Program Integrity Strategy and Governance

- ☐ Has the state identified ABA as a distinct area of program integrity focus within Medicaid and CHIP oversight activities?
- ☐ Is there a documented cross-functional strategy that aligns program integrity staff with policy, clinical, provider enrollment, managed care oversight, and data analytics teams?
- ☐ Are ABA-related fraud, waste, and abuse risks reviewed regularly and updated based on utilization trends, complaints, audits, and referral patterns?
- ☐ Has the state identified which ABA risks are best addressed through provider screening, utilization review, prior authorization, claims edits, prepayment review, post-payment review, managed care oversight, or enforcement actions?

Data Monitoring and Risk Identification

- ☐ Does the state use claims data, encounter data, provider enrollment data, ownership information, complaints, and utilization patterns to identify ABA billing outliers and emerging risks?
- ☐ Are surveillance activities able to flag unusually high hours, overlapping services, duplicate billing, excessive units, rapid provider growth, high use of certain modifiers or codes, or billing patterns inconsistent with a child's age, treatment plan, or setting of care?
- ☐ Are data monitoring methods applied across both FFS claims and managed care encounter data?
- ☐ Does the state validate the completeness, accuracy, and timeliness of managed care encounter data before relying on it for ABA oversight?
- ☐ Are findings from dashboards, utilization review, complaints, and audit activity used to refine state edits, provider guidance, and audit priorities?

Provider Screening and Enrollment Safeguards

- Do provider enrollment policies require ABA providers and ordering or referring practitioners to meet all applicable screening, disclosure, and revalidation requirements?
- Does the state collect and review ownership, managing employee, and affiliation information relevant to ABA agencies and related entities?
- Are there procedures to identify ABA providers with prior terminations, exclusions, sanction history, or concerning ownership changes?
- Do screening and enrollment processes verify that rendering and supervising providers hold required licenses, certifications, registrations, or other qualifications before claims are paid?
- Are provider records updated promptly when supervision status, credentialing, enrollment status, or business ownership changes?

Prepayment Safeguards and Claims Controls

- Are there claim edits or system controls to prevent duplicate billing, overlapping time, impossible units, incompatible code combinations, or billing that exceeds state-defined limits without review?
- Are there controls to ensure that billed ABA procedure codes, modifiers, rendering provider types, and places of service are consistent with state policy and coverage rules?
- Has the state considered prepayment medical review for high-risk ABA providers, billing patterns, or services?
- Are prepayment controls designed to distinguish between legitimate high-need cases and aberrant billing patterns so that safeguards do not improperly restrict medically necessary care?
- Where electronic visit verification or other service validation tools are used, are they integrated into oversight in a way that supports confirmation of service delivery without creating unnecessary burden on compliant providers and families?

Medical Record and Documentation Standards

- Do state policies clearly describe the documentation needed to support ABA billing, including session notes, treatment plans, supervision records, caregiver training activities, and progress data?
- Do documentation standards clearly distinguish billable therapy from travel, idle time, observation that is not separately reimbursable, administrative work, or other non-covered activities?

- ☐ Are provider instructions clear on how session notes must support billed units, procedure codes, staff credentials, supervision, and the location and timing of services?
- ☐ Are documentation requirements aligned across FFS policy manuals, managed care contracts, provider bulletins, and audit tools?
- ☐ Does the state periodically assess whether provider guidance is clear enough to support compliance and withstand audit review?

Post-Payment Review and Audit Practices

- ☐ Does the state conduct routine post-payment review of ABA services, either directly or through contractors or managed care plans?
- ☐ Are ABA audit methodologies designed to examine medical necessity, treatment planning, documentation sufficiency, provider qualifications, supervision, and claims accuracy?
- ☐ Does the state use statistically valid sampling or other defensible review methods when extrapolation or large overpayment findings may result?
- ☐ Are audit protocols standardized enough to promote consistency, while allowing reviewers to assess individualized clinical context?
- ☐ Are audit findings translated into corrective actions, provider education, recoupment, referral, or policy changes when systemic problems are identified?

Managed Care Oversight

- ☐ Do managed care contracts explicitly require plans to maintain ABA-specific fraud, waste, and abuse detection and referral processes where appropriate?
- ☐ Do contracts clearly describe plan responsibilities for claims monitoring, provider screening, documentation review, overpayment identification, and referral of potential fraud, waste, or abuse?
- ☐ Are plans required to report ABA-related audits, provider investigations, suspected fraud referrals, payment suspensions, overpayment recoveries, and corrective actions to the state?
- ☐ Does the state review whether plans apply ABA utilization and program integrity requirements consistently across subcontractors and delegated entities?
- ☐ Does the state test whether managed care plan oversight is operational in practice, rather than relying only on contractual language?

Fraud Referral and Enforcement Coordination

- ☐ Are there clear processes describing how managed care plans and FFS staff should refer suspected ABA fraud, waste, or abuse to the state?

- Do referral protocols specify what documentation should accompany a referral, expected submission timelines, and how the state will communicate receipt and disposition?
- Has the state reviewed whether its own forms, documentation demands, internal routing, or approval steps create unnecessary barriers to timely referrals or payment suspension decisions?
- Are referrals tracked to resolution, including whether they were screened out, referred for investigation, resulted in overpayment recovery, led to administrative action, or were referred to the MFCU or other enforcement entities?
- When a credible allegation of fraud is identified, are responsibilities for evaluating payment suspension, documentation, notice, and coordination clearly assigned consistent with federal requirements?
- Does the state monitor whether referral and suspension decisions are timely, consistently documented, and free of avoidable administrative bottlenecks?

Overpayment Recovery and Administrative Action

- Are there clear procedures for identifying, quantifying, reporting, and recovering ABA overpayments in both FFS and managed care delivery systems?
- Are administrative actions available and used when warranted, such as corrective action plans, payment suspension, prepayment review, termination, disenrollment, or referral to law enforcement?
- Does the state define when education or corrective action is sufficient and when stronger sanctions are necessary because of repeated noncompliance, concealment, or suspected fraud?
- Are overpayment and sanction decisions communicated across relevant units so that provider enrollment, claims processing, managed care oversight, and legal staff act consistently?

Continuous Improvement

- Does the state regularly review ABA audit findings, managed care reports, beneficiary complaints, provider feedback, and enforcement outcomes to identify recurring vulnerabilities?
- Are provider manuals, contract provisions, training materials, and claims edits updated in response to identified ABA risks?
- Does the state assess whether its own processes are contributing to delays, inconsistencies, or avoidable burden for plans, providers, families, or investigators?

- Has the state identified a process for periodically reassessing whether ABA program integrity controls remain effective as the market, workforce, and service delivery models evolve?

Appendix B. Suggested Practices

Suggested Practices for Applied Behavior Analysis

This checklist highlights suggested practices for states to consider.

Diagnosis

- ☐ An ASD diagnosis should be made by a qualified, licensed provider in a manner that does not violate the Stark Law.
- ☐ Expansion of ABA services to individuals beyond those with an ASD should be done based on a data-driven understanding of clinical need once access to ABA services by individuals with an ASD has been adequately met.
- ☐ Plan time accordingly to conduct a diagnostic evaluation, which may take up to 20 hours. Ensure that it includes sufficient direct assessment and developmental history. It will likely need to be billed in more than one encounter.
- ☐ Include elements of in-person assessment in the diagnostic evaluation to ensure it is not 100 percent telehealth.

Utilization Management

- ☐ Establish a comprehensive utilization management process that includes prior authorization before services begin, concurrent review while services are delivered, and reauthorization near the end of the approved period.
- ☐ Consider using a centralized utilization management vendor or single state utilization management contractor to conduct utilization management reviews.
- ☐ Ensure when implementing state limitations on ABA services that limits on ABA hours per week comply with EPSDT and are “soft” and appropriate for the level of need, tapering off over time. Hours should not be unlimited, and higher intensity hours per week may require more frequent reassessment of outcomes.
- ☐ Hire BCBAs or higher to conduct managed care prior authorization and utilization review and to support denials and appeals.
- ☐ Follow clinical evidence to support ABA hours accounting for factors such as age, communication, functioning, medical complexity, and risk.
- ☐ Consider how breaks for daily living will be accounted for in service delivery. Hours at the maximum daily dosage that do not account for napping, eating, toileting, etc. are at risk for negative Center for Program Integrity audit findings or CMS deferral. While it is understood that therapy may focus on activities such as food selectivity or enuresis, providers and clinics should have written policies that address activities of daily living, and states and managed care plans can make recommendations on the number of consecutive 15-minute units that can be delivered before children need to

address activities of daily living. Refer providers who are withholding sleeping, eating, and toileting to the Special Investigative Unit or OIG, etc. as appropriate.

- Design managed care plan protocols that include review of the ITP at least every 12 months or more often as appropriate.

Individualized Treatment Plan

- Consider requiring an ITP, even if ABA is a state plan service.
- Ensure that medical necessity is met as defined by the state.
- Ensure ITP development is completed by a qualified provider (BCBA or other licensed provider as identified by the state), and that referrals and treatment conform with Stark Law requirements.
- Include outcomes that can be measured by a standardized instrument in the ITP.
- Offer parents and caregivers forms of treatment other than ABA.
- Add a quality check for ITPs to demonstrate that they do not exhibit a copy-and-paste approach and that children are fully assessed.
- Require reevaluations at specific intervals.
- Promote integration of quality measures into provider services, for example by integrating them into electronic health records or case management platforms.

Applied Behavior Analysis Provider Qualifications and Supervision

- Require completion of licensure and certification before a provider can be paid.
- Ensure all ABA providers are licensed and certified and have an NPI.
- Ensure ABA providers are accredited and have a well-designed corporate structure.
- Ensure all providers are trained on identifying, referring, and mitigating fraud, waste, and abuse.
- Include parallel level of need in provider training, meaning that providers who treat children with higher intensity should have added training.
- Ensure supervision ratios are 1 to 2 hours of supervision for every 10 hours of direct treatment (1-2:10), or 1 to 2 hours of supervision per week if direct treatment is 10 hours or less per week.
- Reduce over-reliance on telehealth for supervision and service delivery. Telehealth should not be the only modality for ABA service provision and should be used primarily for caregiver coaching, treatment supervision, and team meetings and progress reviews.
- Consider state rules regarding telehealth supervision including whether or not telehealth across state lines should not be permitted.

Parent and Caregiver Involvement

- Implement requirements for expected parent and caregiver involvement that are communicated clearly yet allow for extenuating circumstances.

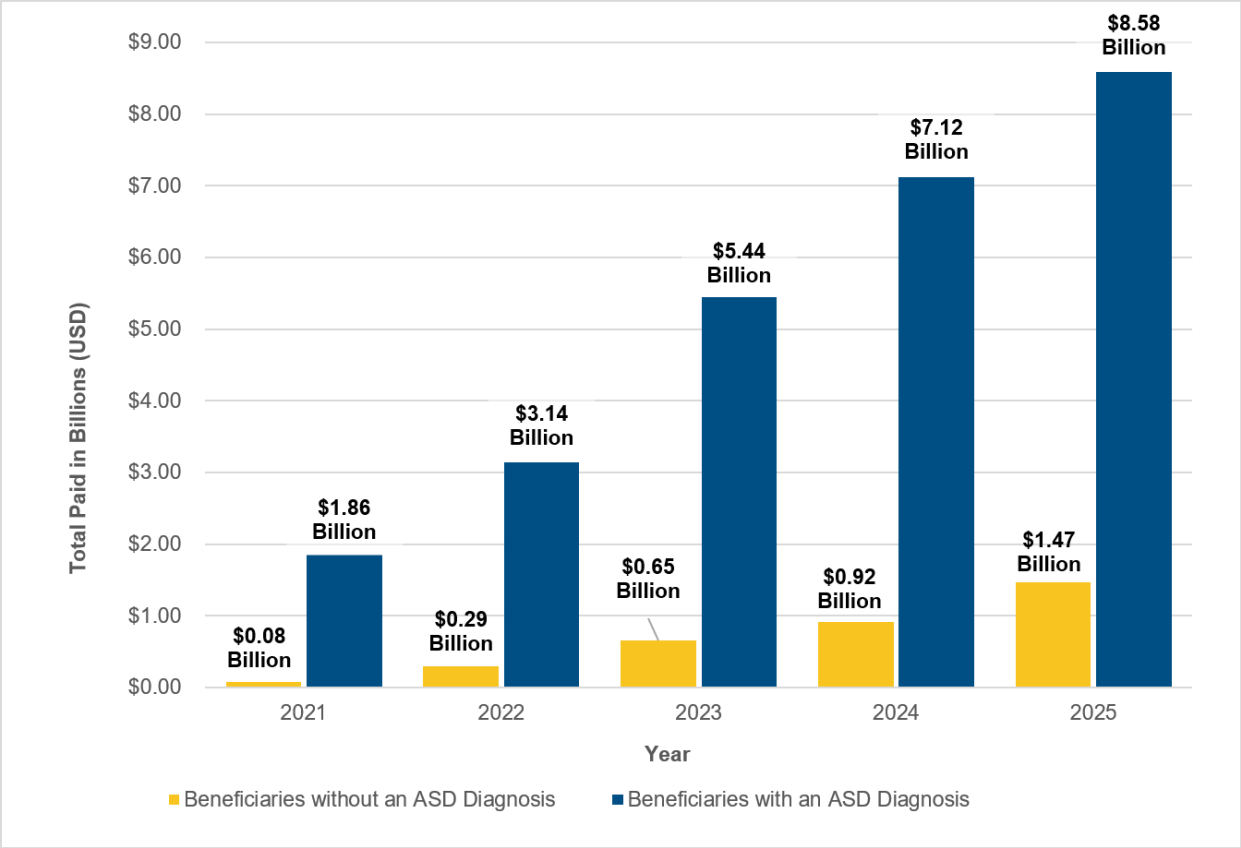
Program Integrity

- Use advanced data analytics to identify and sample ABA providers for post-payment review, including a review of documentation for clinical guidance, billing practices, and session notes.
- Participate in the HFPP and access the HFPP's MEVIA dashboard to review state-specific ABA data analytics.
- Use CMS's Risk Assessment Template to ensure ABA program integrity risks are evaluated on an ongoing basis.
- Periodically evaluate all claims processing systems for edit logic to ensure that it reflects current ABA billing patterns, emerging risks, and program-specific service delivery models.
- Extend EVV requirements to ABA.
- Establish standardized, risk-based audit and medical review processes.
- Unannounced site visits should be considered as part of risk-based audits.
- Use findings from OIG audits and other oversight reviews to strengthen provider guidance, documentation standards, post-payment review activities, and program integrity oversight processes.
- Integrate SURS outputs, audit findings, and post-payment review results into a coordinated program integrity framework.
- Establish clear processes describing how managed care plans should notify the state of suspected cases of fraud, provide supporting documentation, and coordinate with state program integrity staff.
- Collect ownership information.
- Consider prepayment and post-payment review, especially for new providers.

Appendix C. Applied Behavior Analysis for Individuals Without Autism Spectrum Disorder[343]

While ABA therapy is most commonly used as a treatment for ASD, it is also used to treat other conditions. In recent years, spending on ABA therapy for Medicaid and CHIP beneficiaries without an ASD diagnosis has increased even faster than ABA spending for those with an ASD diagnosis. As shown in Figure C1, between 2021–2025, the total amount paid for ABA delivered to beneficiaries without an ASD diagnosis increased 1,789 percent, from $77.6 million to $1.47 billion.

Figure C1: Total Medicaid and CHIP Payments for Applied Behavior Analysis Services for Beneficiaries With and Without an Autism Spectrum Disorder Diagnosis, 2021–2025



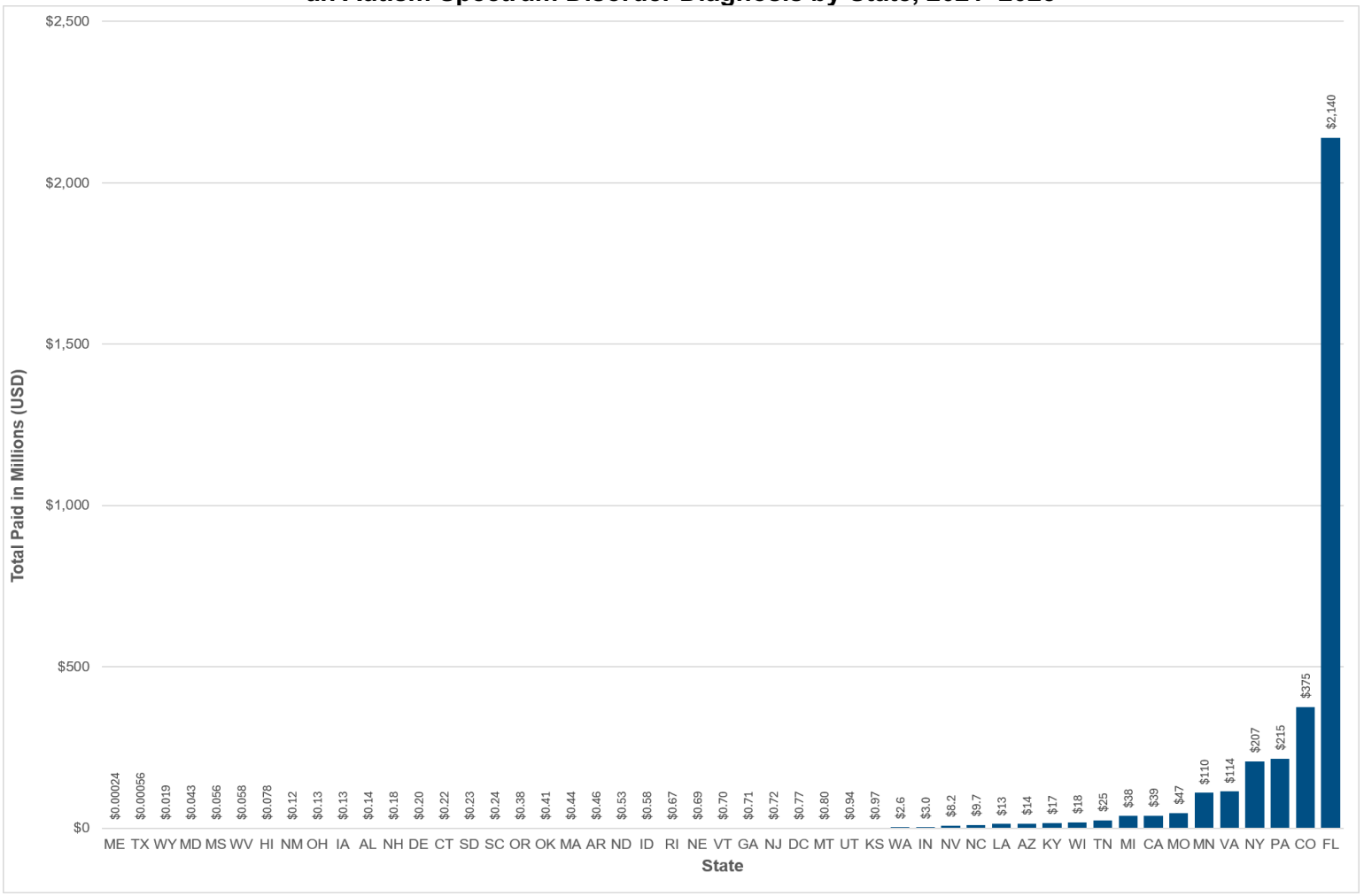
Source: T-MSIS OT claims and associated eligibility data, 2021–2025 for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam. *Analysis includes the paid amount for procedure codes 97151–97158 across Medicaid and*

[343] All data in Appendix C is derived from T-MSIS OT claims and associated eligibility data, 2021–2025 for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam. Analysis includes the paid amount for procedure codes 97151-97158 across Medicaid and CHIP FFS claims and managed care encounters. Results are intended for analytic use.

CHIP FFS claims and managed care encounters. Beneficiaries with an ASD diagnosis include all unique beneficiaries that received services for a diagnosis code of F84.0; F84.5; F84.8; F84.9. Results are intended for analytic use.

At the state level, Florida paid the most for ABA delivered to beneficiaries without an ASD diagnosis. As shown in Figure C2, between 2021–2025, Florida paid over $2.1 billion, while Colorado, the state with the next highest ABA spending for beneficiaries without an ASD diagnosis, spent just over $375 million over that same time.

Figure C2: Total Medicaid and CHIP Payments in Millions for Applied Behavior Analysis Services for Beneficiaries Without an Autism Spectrum Disorder Diagnosis by State, 2021–2025



Source: T-MSIS OT claims and associated eligibility data, 2021–2025 for all 50 states, Washington, D.C., Puerto Rico, USVI, and Guam. Analysis includes the paid amount for procedure codes 97151–97158 across Medicaid and CHIP FFS claims and managed care encounters.

Non-ASD ABA service delivery is used to treat multiple conditions, with ADHD being the most prevalent. ADHD combined type (ICD-10 diagnosis code F902) accounted for the largest proportion (40.3 percent) of all non-ASD ABA spending between 2021–2025. As shown in Table C1, five ADHD ICD-10 diagnosis codes (F902 for ADHD plus F900, F901, F908, and F909) appeared in the top 20 non-ASD diagnoses for which ABA therapy was delivered, and combined spending on ABA delivered for these five diagnoses accounted for 57 percent of all non-ASD ABA spending between 2021–2025. It is critical that, regardless of diagnosis, states ensure that ABA treatment is medically necessary, clinically appropriate, and tailored to the individual needs of the beneficiary.

Table C1: Top 20 Diagnoses Among Beneficiaries Without Autism Spectrum Disorder Receiving Applied Behavior Analysis Services, 2021–2025

Non-ASD Diagnosis Description	ICD-10 Diagnosis Code	Beneficiaries	Total Paid (2021–2025)	Medicaid/CHIP Per Beneficiary Per Month (2021–2025)	Service Quantity (2021–2025)
Attention-deficit hyperactivity disorder, combined type	F902	19,189	$1,246,569,182	$4,740	98,228,671
Other disorders of psychological development	F88	6,729	$262,047,017	$4,344	18,426,354
Attention-deficit hyperactivity disorder, predominantly inattentive type	F900	2,785	$137,308,909	$4,643	10,826,143
Oppositional defiant disorder	F913	2,878	$120,997,508	$4,252	9,336,055
Attention-deficit hyperactivity disorder, predominantly hyperactive type	F901	2,358	$115,013,552	$4,532	8,915,085
Attention-deficit hyperactivity disorder, unspecified type	F909	2,912	$104,604,518	$4,129	7,555,578

Non-ASD Diagnosis Description	ICD-10 Diagnosis Code	Beneficiaries	Total Paid (2021–2025)	Medicaid/CHIP Per Beneficiary Per Month (2021–2025)	Service Quantity (2021–2025)
Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F989	1,452	$64,137,801	$4,737	5,052,226
Developmental disorder of speech and language, unspecified	F809	1,902	$58,241,448	$4,196	14,885,248
Conduct disorder, unspecified	F919	1,579	$46,089,831	$2,947	2,956,783
Other conduct disorders	F918	824	$37,160,629	$4,128	2,827,199
Mild intellectual disabilities	F70	2,065	$36,760,151	$1,291	1,616,975
Receptive language disorder	F802	3,301	$34,116,406	$1,943	1,702,771
Unspecified disorder of psychological development	F89	3,321	$30,941,500	$1,743	1,467,381
Unspecified intellectual disabilities	F79	1,510	$29,786,411	$1,699	1,200,450
Conduct disorder, childhood-onset type	F911	557	$27,013,597	$4,900	2,104,927
Specific developmental disorder of motor function	F82	1,305	$24,189,491	$2,815	1,744,671
Moderate intellectual disabilities	F71	1,197	$21,740,393	$1,538	1,035,943

Non-ASD Diagnosis Description	ICD-10 Diagnosis Code	Beneficiaries	Total Paid (2021–2025)	Medicaid/CHIP Per Beneficiary Per Month (2021–2025)	Service Quantity (2021–2025)
Disruptive mood dysregulation disorder	F3481	1,031	$19,532,355	$2,336	1,300,643
Attention-deficit hyperactivity disorder, other type	F908	463	$19,260,396	$4,285	1,510,580
Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F988	315	$15,701,229	$4,831	1,225,232

Appendix D. Applied Behavior Analysis-Related Current Procedural Terminology Codes and Descriptions

Providers use ABA-related CPT codes 97151 through 97158 for medical billing and insurance claims and to facilitate tracking patient care. These codes are typically billed in 15-minute units and may be differentiated by site of service to reflect travel costs and time associated with travel, as well as the credential level of the billing provider (e.g., BCBA versus BCaBA versus RBT). A description of the ABA-related CPT codes, typical provider types, and common Medicaid coverage parameters is provided in Table D1 below.

Table D1: Applied Behavior Analysis-Related Current Procedural Terminology Code Descriptions and Coverage Limitations

CPT Code	Description	Provider Types	Coverage Parameters
97151	**Behavior identification assessment – QHP**: Behavior identification assessment that is administered by a QHP; includes face-to-face time with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face time interpreting the assessment and developing a treatment plan	QHP	• 15-minute increments
97152	**Behavior identification supporting assessment – technician**: Face-to-face time with the patient for a behavior identification-supporting assessment that is administered by a technician under the supervision of a QHP	Technician under the direction of a physician or other QHP (not required to be on site)	• 15-minute increments
97153	**Adaptive behavior treatment using an established plan – technician**: Adaptive behavior treatment for a patient using an established plan that is administered face-to-face by a technician under the direction of a QHP	Technician under the direction of a physician or other QHP	• 15-minute increments • One patient only • Telehealth eligibility varies by state
97154	**Adaptive behavior treatment with group using an established plan – technician**: Adaptive behavior treatment for two or more patients using an established plan that is administered face-to-face by a technician under the direction of a QHP	Technician under the direction of a physician or QHP RBT/behavior technician under BCBA/LBA or other QHP supervision	• 15-minute increments (per member, not per group) • Group sizes generally have to be 2–8 to maintain therapeutic value • Documentation must include a link to the client's autism diagnosis per DSM-5-TR, and

CPT Code	Description	Provider Types	Coverage Parameters
			show how peers speed up skills
97155	**Adaptive behavior treatment modifying an established plan – QHP**: Adaptive behavior treatment using an established plan that is administered face-to-face by a QHP and may include simultaneous direction of a technician	Physician or other QHP BCBA, psychologist, physician, or other QHP	• 15-minute increments • Some states limit concurrent billing with other codes • If delivered remotely, modifiers like 95 or GT must be used with 97155 • General oversight (staff training, credentialing) is not billable
97156	**Adaptive behavior treatment with family using an established plan – QHP**: Adaptive behavior treatment guidance for guardian(s)/caregiver(s) that is administered face-to-face by a QHP (with or without the patient present)	Physician or other QHP BCBA/LBA, psychologist, physician, or other recognized QHP	• 15-minute increments (per family, not per member) • Code is for caregiver training to implement behavior strategies at home/school, not direct patient treatment
97157	**Adaptive behavior treatment with multiple family members using an established plan – QHP**: Adaptive behavior treatment for multiple sets of guardian(s)/caregiver(s) that is administered face-to-face by a QHP (without the patient present)	Physician or other QHP BCBA/LBA, psychologist, physician, or other recognized QHP	• 15-minute increments (per family, not per member) • RBTs or technicians cannot bill CPT 97157; they may assist under the BCBA's lead, but cannot lead or bill for it • Telehealth must use 95 or GT modifiers • Often capped at 6 units per day
97158	**Adaptive behavior treatment with group modifying an established plan – QHP**: Adaptive behavior treatment for multiple patients using an established plan that is administered face-to-face by a QHP	BCBA/LBA, psychologist, physician, or other recognized QHP	• 15-minute increments (per member, not per group)

CPT Code	Description	Provider Types	Coverage Parameters
0362T	**Adaptive Behavior Assessments, Category III** – Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient who exhibits destructive behavior and is completed in an environment that is customized to the patient's behavior	A physician or other qualified health care professional who is on site with the assistance of two or more technicians	• QHP must be physically on site and interruptible during service • Documentation must justify need for multiple staff
0373T	**Adaptive Behavior Treatment, Category III** – Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient who exhibits destructive behavior and is completed in an environment that is customized to the patient's behavior	RBT/behavior technician under BCBA/LBA or other QHP supervision	• QHP must be physically on site and interruptible during service • Documentation must justify need for multiple staff

Source: ABA Coding Coalition (2026). *Billing Codes*. Retrieved July 1, 2026, from https://abacodes.org/codes/.

Note: For the specific naming and details for CPT codes, see: AMA. (2024). *CPT® Professional 2025* (1st ed.). AMA.

Appendix E. Reported State Rates for Applied Behavior Analysis Current Procedural Terminology Codes

This appendix provides, when available, state Medicaid agencies' FFS rates for ABA-specific CPT codes. States may differentiate these codes by site of service to consider travel costs and time associated with travel, as well as the credential level of the billing provider (e.g., BCBA versus BCaBA versus RBT). BCBA and BCaBA providers may receive a higher rate than an implementing technician, which reflects differences in levels of education, licensure requirements, and labor market costs between supervising BCBAs and implementing technicians, with some states paying BCBA and BCaBA providers and QHPs at substantially higher rates than technicians.

Table E1 identifies FFS rates in 2025 for ABA-specific CPT codes by state. The rates below are based on the state-reported rates in CASP's *50 State Applied Behavior Analysis Medicaid Benefit Comparison*[344] and were verified by CMS using actual FFS claims-paid amounts from Medicaid claims data TAF. Blank spaces in the table indicate that the rates were not included in the CASP report and/or could not be verified by CMS.

Table E1: Reported 2025 State Fee-For-Service Rates for Applied Behavior Analysis Current Procedural Terminology Codes

State	97151: Behavior identification assessment – QHP	97152: Behavior identification supporting assessment – technician	97153: Adaptive behavior treatment using an established plan – Mid-Level Provider (MLP)	97153: Adaptive behavior treatment using an established plan – technician	97154: Adaptive behavior treatment with group using an established plan – technician	97155: Adaptive behavior treatment modifying an established plan – QHP (BCBA)	97155: Adaptive behavior treatment modifying an established plan – QHP (MLP: BCaBA, LABA, or equivalent)	97156: Adaptive behavior treatment with family using an established plan – MLP (BCaBA, LABA, or equivalent)	97156: Adaptive behavior treatment with family using an established plan – QHP	97157: Adaptive behavior treatment with multiple family members using an established plan – QHP	97158: Adaptive behavior treatment with group modifying an established plan – QHP
Alabama						$15.00			$30.00	$2.50	
Alaska	$29.78			$22.63	$9.04	$29.78			$18.69		$12.67

[344] CASP. (2025). *50-state applied behavior analysis Medicaid benefit comparison*. https://www.casproviders.org/medicaid-rate-data.

State	97151: Behavior identification assessment – QHP	97152: Behavior identification supporting assessment – technician	97153: Adaptive behavior treatment using an established plan – Mid-Level Provider (MLP)	97153: Adaptive behavior treatment using an established plan – technician	97154: Adaptive behavior treatment with group using an established plan – technician	97155: Adaptive behavior treatment modifying an established plan – QHP (BCBA)	97155: Adaptive behavior treatment modifying an established plan – QHP (MLP: BCaBA, LABA, or equivalent)	97156: Adaptive behavior treatment with family using an established plan – MLP (BCaBA, LABA, or equivalent)	97156: Adaptive behavior treatment with family using an established plan – QHP	97157: Adaptive behavior treatment with multiple family members using an established plan – QHP	97158: Adaptive behavior treatment with group modifying an established plan – QHP
Arkansas	$20.00			$15.00		$22.50			$20.00		
Colorado				$17.20		$25.80					
Connecticut									$21.20		
Delaware	$43.76										
Florida	$19.05	$12.19		$12.19	$7.58	$19.17	$15.37	$15.24	$19.05		$9.58
Georgia				$18.69							
Indiana	$27.63	$17.06		$17.06	$4.87	$27.63	$21.85	$21.87	$28.23	$7.89	
Iowa	$35.73	$17.16									
Kentucky	$20.32	$11.77			$11.77	$21.25	$18.60	$14.43	$16.51	$8.36	$8.36
Maine	$27.59										
Maryland	$38.34	$19.17	$20.91	$19.17	$6.96	$38.34		$20.91		$12.91	$10.62

State	97151: Behavior identification assessment – QHP	97152: Behavior identification supporting assessment – technician	97153: Adaptive behavior treatment using an established plan – Mid-Level Provider (MLP)	97153: Adaptive behavior treatment using an established plan – technician	97154: Adaptive behavior treatment with group using an established plan – technician	97155: Adaptive behavior treatment modifying an established plan – QHP (BCBA)	97155: Adaptive behavior treatment modifying an established plan – QHP (MLP: BCaBA, LABA, or equivalent)	97156: Adaptive behavior treatment with family using an established plan – MLP (BCaBA, LABA, or equivalent)	97156: Adaptive behavior treatment with family using an established plan – QHP	97157: Adaptive behavior treatment with multiple family members using an established plan – QHP	97158: Adaptive behavior treatment with group modifying an established plan – QHP
Minnesota	$50.11					$20.17			$20.17	$6.72	
Mississippi	$34.18	$41.74			$7.44	$21.19			$20.19		
Missouri	$25.26								$25.26		$3.16
Montana	$40.41	$11.36			$3.78	$20.46			$20.46		
Nevada	$29.14		$18.06	$13.01	$7.08	$30.10	$19.92		$21.32	$11.70	$15.63
New Hampshire						$16.43			$16.43		
New Jersey	$25.00				$4.80	$21.25					
New Mexico	$112.65			$19.85		$39.69			$25.78		
New York	$19.26									$3.31	
North Dakota	$30.53	$22.60		$10.39	$2.62	$30.53			$28.33		

State	97151: Behavior identification assessment – QHP	97152: Behavior identification supporting assessment – technician	97153: Adaptive behavior treatment using an established plan – Mid-Level Provider (MLP)	97153: Adaptive behavior treatment using an established plan – technician	97154: Adaptive behavior treatment with group using an established plan – technician	97155: Adaptive behavior treatment modifying an established plan – QHP (BCBA)	97155: Adaptive behavior treatment modifying an established plan – QHP (MLP: BCaBA, LABA, or equivalent)	97156: Adaptive behavior treatment with family using an established plan – MLP (BCaBA, LABA, or equivalent)	97156: Adaptive behavior treatment with family using an established plan – QHP	97157: Adaptive behavior treatment with multiple family members using an established plan – QHP	97158: Adaptive behavior treatment with group modifying an established plan – QHP
Oklahoma	$23.55			$17.35		$23.55			$23.55		
Oregon	$20.85	$19.81									
Pennsylvania					$5.13						
South Carolina	$23.51	$20.50		$14.88	$9.10	$21.25			$21.25	$13.31	
South Dakota	$37.99	$21.17			$5.29	$37.99				$12.67	$12.69
Texas						$25.10			$23.01		
Vermont		$30.00			$7.50						$17.01
Virginia	$46.63	$15.00			$12.77		$23.48	$23.48			
Washington	$18.79					$14.09			$18.32		
West Virginia	$29.14	$9.90			$4.50						$11.91

State	97151: Behavior identification assessment – QHP	97152: Behavior identification supporting assessment – technician	97153: Adaptive behavior treatment using an established plan – Mid-Level Provider (MLP)	97153: Adaptive behavior treatment using an established plan – technician	97154: Adaptive behavior treatment with group using an established plan – technician	97155: Adaptive behavior treatment modifying an established plan – QHP (BCBA)	97155: Adaptive behavior treatment modifying an established plan – QHP (MLP: BCaBA, LABA, or equivalent)	97156: Adaptive behavior treatment with family using an established plan – MLP (BCaBA, LABA, or equivalent)	97156: Adaptive behavior treatment with family using an established plan – QHP	97157: Adaptive behavior treatment with multiple family members using an established plan – QHP	97158: Adaptive behavior treatment with group modifying an established plan – QHP
Wisconsin	$25.90	$22.93			$6.39	$22.93			$28.03		$6.39
Wyoming	$19.15	$20.50			$3.54	$20.50			$20.50		

Notes:

For the specific naming and details for CPT codes, see: AMA. (2024). *CPT® Professional 2025* (1st ed.). AMA.

The CASP report included caveats for the rates by CPT code:

- 97151: Behavior Assessment: All rates listed for assessment services (97151 or equivalent) are publicly available FFS rates. Location Differentials: For states with differential rates by service location (e.g., home versus center/community), we selected the highest available rate.
- 97152: Supporting Behavior Assessment – Technician/MLP: Vermont's listed rates only apply when Medicaid is secondary. Rates included are only for technicians and mid-level providers (e.g., BCaBAs/LABAs or state-specific qualifications). If supporting assessment is authorized for the BCBA/LBA, those rates were not included above.
- 97153: Adaptive Behavior Treatment by Protocol – MLP: Many states do not include differentiated rates for direct one-to-one treatment (97153 or equivalent) by a BCaBA, LABA, or MLP.
- 97153: Adaptive Behavior Treatment by Protocol (Technician): All rates listed for direct one-to-one treatment by a technician (97153 or equivalent) are publicly available FFS rates.
- 97154: Group Adaptive Behavior Treatment – Technician: Vermont's rate applies only to clients with Medicaid as the secondary payer. Many states have a rate per participant for group services (97154 or equivalent); this rate varies by group size (2–8), location, and provider type. If multiple rates exist, the lowest rate was included. States with different rates by provider type or number of group members include Florida, Maryland, Nevada, Pennsylvania, and Wisconsin.
- 97155: Adaptive Behavior Treatment with Protocol Modification – QHP (BCBA): Rates include protocol modification/direction (97155 or equivalent) for the BCBA/LBA provider type only. Some states include a differential rate for these services by an MLP. Those rates are reported separately.
- 97155: Adaptive Behavior Treatment with Protocol Modification – QHP (MLP: BCBA, LBA, or equivalent): Not all states include a differentiated rate for protocol modification or direction (97155 or equivalent) by a BCaBA/LABA/MLP.
- 97156: Family Adaptive Behavior Treatment – MLP: Rates are included for the BCaBA/LABA or MLP only. Not all states include a differentiated rate for BCaBA/LABA/MLP. For states that provide differential rates by location, such as Maryland, the table depicts the highest rate.

- 97156: Family Adaptive Behavior Treatment by QHP (BCBA/LBA): Family guidance (97156 or equivalent) rates are included for BCBA/LBA only. For states that provide differential rates by location, such as Maryland, the table depicts the highest rate.
- 97157: Group Family Guidance by QHP (BCBA/LBA): Many states have multiple rates for group family guidance (97157 or equivalent) depending on group size (2–8), location, or provider type.
- 97158: Group Protocol Modification/Direction by QHP (BCBA/LBA): Vermont rates only apply to clients with Medicaid as the secondary payer. Many states have multiple rates for group protocol modification or direction (97158 or equivalent); rates can vary by group size (2–8) or location. If multiple rates exist, the lowest rate was included. Florida has different rates by location or group size. Kentucky has different rates by provider type.

Appendix F. Acronym List

Acronym	Definition
AAP	American Academy of Pediatrics
AAW	Adult Autism Waiver
ABA	Applied Behavior Analysis
ABAT	ABA Technician
ABD	Adverse Benefit Determination
ABLLS-R	Assessment of Basic Language and Learning Skills – Revised
ACAP	Adult Community Autism Program
ACO	Accountable Care Organization
ACQ	Autism Commission on Quality
ADHD	Attention-Deficit/Hyperactivity Disorder
ADI-R	Autism Diagnostic Interview-Revised
ADOS-2	Autism Diagnostic Observation Schedule, Second Edition
AMA	American Medical Association
APA	American Psychological Association
ASD	Autism Spectrum Disorder
ASRS	Autism Spectrum Rating Scale
BACB	Behavior Analyst Certification Board
BCaBA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctoral
BHT	Behavioral Health Treatment
C.F.R.	Code of Federal Regulations
CaBA	Louisiana State-Certified Assistant Behavior Analysts
CASP	Council of Autism Service Providers
CDE	Comprehensive Diagnostic Evaluation
CHIP	Children's Health Insurance Program
CIB	CMCS Informational Bulletin
CMS	Centers for Medicare and Medicaid Services
CNMI	Commonwealth of the Northern Mariana Islands

Acronym	Definition
COE	Center of Excellence
CMCS	Center for Medicaid and CHIP Services
CPT	Current Procedural Terminology
DIR	Developmental, Individual Difference, Relationship-based model
DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ESDM	Early Start Denver Model
EVV	Electronic Visit Verification
FFP	Federal Financial Participation
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
GAO	Government Accountability Office
GARS-3	Gilliam Autism Rating Scale-Third Edition
HCA	Health Care Authority
HCBS	Home and Community-Based Services
HFPP	Healthcare Fraud Prevention Partnership
HHS	U.S. Department of Health and Human Services
HHS-OIG	U.S. Department of Health and Human Services Office of Inspector General
HIPAA	Health Insurance Portability and Accountability Act
IACC	Interagency Autism Coordinating Committee
IBCCES	International Board of Credentialing and Continuing Education Standards
ICD	International Classification of Diseases
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IDD	Intellectual and Developmental Disabilities
IEP	Individualized Education Program
ITP	Individualized Treatment Plan
JASPER	Joint Attention, Symbolic Play, Engagement, and Regulation
LABA	Licensed Applied Behavior Analyst
LBA	Licensed Behavior Analyst
LCMHC	Licensed Clinical Mental Health Counselor

Acronym	Definition
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LPC	Licensed Professional Counselor
MCO	Managed Care Organization
MEVIA	Medicaid Emerging Vulnerability Intelligence and Actions
MFCU	Medicaid Fraud Control Unit
MLP	Mid-Level Provider
MMIS	Medicaid Management Information System
MUE	Medically Unlikely Edit
NCCA	National Commission for Certifying Agencies
NCCI	National Correct Coding Initiative
NDBI	Naturalistic Developmental Behavioral Intervention
NPI	National Provider Identifier
OIG	Office of Inspector General
OLP	Other Licensed Practitioner
OT	T-MSIS Analytic Files Other Services claims
PAHP	Prepaid Ambulatory Health Plan
PIHP	Prepaid Inpatient Health Plan
PTP	Procedure-to-Procedure
QABA®	Qualified Applied Behavior Analysis Credentialing Board
QAS	Qualified Autism Service
QHP	Qualified Health Care Professional
RB-BHT	Research-Based Behavioral Health Treatments
RBT	Registered Behavior Technician
SDP	State-Directed Payment
SED	Serious Emotional Disturbance
SMDL	State Medicaid Director Letter
SMM	State Medicaid Manual
SPA	State Plan Amendment
SRS-2	Social Responsiveness Scale, Second Edition
SUD	Substance Use Disorder

Acronym	Definition
SURS	Surveillance and Utilization Review Subsystem
TAF	T-MSIS Analytic Files
TEACCH	Treatment and Education of Autistic and Related Communication Handicapped Children
T-MSIS	Transformed Medicaid Statistical Information System
USVI	U.S. Virgin Islands
VBC	Value-Based Care
VBP	Value-Based Payment
WAC	Washington Administrative Code