



All-State Medicaid and CHIP Call September 15, 2026



Agenda

- Home and Community-Based Services (HCBS) in Medicaid: Best Practices for Program Integrity
- Recent Releases
 - Applied Behavior Analysis (ABA) Toolkit
 - Autism Spectrum Disorder and Applied Behavior Analysis Data Book
 - Medicaid Enterprise Systems (MES) IT Standards Request for Information
 - Key Functional Requirements for Community Engagement Implementation
- Q&A

Home and Community-Based Services (HCBS) in Medicaid: Best Practices for Program Integrity



CMCS All State Call
September 15, 2026

Crushing Fraud, Waste, and Abuse in Medicaid HCBS (1 of 2)

- Medicaid is the primary payor for long-term services and supports (LTSS) for older adults and people with disabilities. LTSS include institutional care received in nursing facilities, and home and community-based services (HCBS) such as personal care, assistive technologies, and respite.
- Over the past four decades, HCBS have accounted for a growing share of Medicaid-covered LTSS (from 1.1% of total Medicaid LTSS expenditures in 1981 to 63.8% in 2023), with HCBS recipients and expenditures increasing at a faster rate compared to institutional recipients and expenditures. This is part of a larger trend of rebalancing Medicaid LTSS away from institutional care and toward HCBS.
- 87.1% of Medicaid LTSS users received some HCBS in 2023.
 - There were 8.4 million Medicaid HCBS users, of which 32.8% were under the age of 20.
 - Of the \$129.4 billion in Medicaid HCBS expenditures, 12.9% was for individuals under the age of 20.
- Average LTSS expenditures for people receiving HCBS in 2023 was \$17,298 per user compared to \$54,462 per user for people receiving institutional services.

Sources: www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-brief-2023.pdf
<https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-user-character-brief-2023.pdf>

Crushing Fraud, Waste, and Abuse in Medicaid HCBS (2 of 2)

- More older adults and individuals with disabilities are being served in their homes and communities than ever before. CMS and states must work together to strengthen program integrity efforts to protect vulnerable beneficiaries and ensure sustainability of HCBS programs.
- Fraud, waste, and abuse (FWA) in HCBS puts beneficiaries at risk for harm and neglect, which in severe cases has resulted in hospitalizations and deaths. It diverts critical resources away from those who need help.
- HCBS delivered during an in-home visit by a provider are particularly vulnerable to FWA due to the limited direct oversight of services furnished in beneficiaries' homes.
- FWA schemes for certain HCBS have been well documented in Federal oversight actions and prosecutions and can have serious consequences for beneficiaries. For example:
 - In Fiscal Year 2025, Medicaid Fraud Control Units reported 326 fraud convictions for personal care attendants (PCAs), significantly higher than any other provider type.
 - In 2026, the U.S. Justice Department charged two defendants in connection to a \$46.6 million scheme to defraud a state's Medicaid autism program. They also charged a defendant in connection to a \$1.4 million scheme to bill for services not rendered in the same state's integrated community supports program.

Combatting Fraud Waste, and Abuse (1 of 2)

- CMS defines fraud, waste, and abuse (FWA) as distinct, but related, risks within Medicaid programs, including within 1915(c) HCBS waivers.
 - **Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or other persons or entities.
 - **Waste** is defined as loss through carelessness, inefficiency, or ignorance that, directly or indirectly, results in unnecessary cost to the health care system. Waste is generally not considered to be caused by deliberate actions to game the system but rather by the misuse of resources.
 - **Abuse** is defined as practices that are not consistent with professionally recognized standards and guidelines in the health care industry and, either directly or indirectly, resulting in unnecessary costs to the health care system.

Combating Fraud, Waste, and Abuse (2 of 2)

- Since FWA are three distinct actions, and no one-size-fits-all approach will address all three.
- Policies and mitigation strategies should be tailored to mitigate the type of action identified:
 - **Fraud.** Alignment between law enforcement, Attorney General (AG), and Medicaid Fraud Control Units (MFCUs); states must have the resources to prosecute and doing so must be a credible threat to potential fraudsters. Sanctions and fines must be high enough to prevent the activity.
 - **Waste.** State staff training, pre-payment review, provider education, data analytics.
 - **Abuse.** Alignment between executive and legislative branches, constant analytics.
- To effectively combat FWA in HCBS, states should adopt a multi-faceted approach focusing on strengthening eligibility and enrollment processes, improving program design and oversight, leveraging technology and data analytics. The following slides contain key recommendations to kick-start the process for states.
- In addition to best practices, CMS is reviewing regulatory changes and operational reforms that could help crush FWA.

Best Practices for Program Integrity in HCBS

Best Practices Overview

- In the next slides, we will explore best practices for enhancing program integrity across multiple HCBS program areas, including:
 - Eligibility and enrollment
 - Service utilization and case management
 - Person-centered service planning
 - Provider enrollment, screening, and training
 - Financial accountability, including billing, payment, and electronic visit verification
 - Self-direction and family caregivers
- We will also discuss broader, state-level policy considerations for strengthening program integrity.

Eligibility and Enrollment

- **Eligibility Assessments:**

- Use independent, standardized tools for functional needs assessments to prevent inflated service hours.
- Tier service levels based on need for assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) so that benchmarks can be determined and resources appropriately allocated.

- **Post Enrollment Data Match:**

- Implement post-enrollment measures to identify beneficiaries who may no longer be eligible in HCBS programs (i.e., conduct post enrollment data match to verify continued residency).
- As required by, the Working Families Tax Cut legislation, section 71104, States will be required to check the Social Security Administration's (SSA) Death Master File (DMF) on at least a quarterly basis and disenroll beneficiaries identified as deceased beginning January 1, 2027.

Service Utilization and Case Management

▪ Utilization Management:

- Require service authorization for all HCBS using either a prior authorization process and/or through person-centered service planning.
- Ensure state oversight to validate that services authorized are appropriate to individuals' needs.

▪ Case Management:

- Implement conflict-free case management for all HCBS by expanding required conflict of interest protections in 1915 waiver authorities to 1905(a) personal care services to ensure service plans are based on actual needs, not provider influence (i.e. independent assessment of 1905(a) personal care needs).
- Ensure use of electronic case management portals to capture case management notes.
- Determine case manager performance metrics and evaluate case manager performance to determine if they are consistently providing the highest level of services across all clients.
- Require periodic in-person case management.
- Require fraud mitigation as part of case manager training and use as a performance metric in annual evaluations.

Person-Centered Service Planning

- **Monitoring and oversight of person-centered service plans:**
 - Regularly audit person-centered service plans to determine if the services authorized align with the assessment of individual's actual needs.
 - Monitor for plans that are identical and do not change over time.
 - Include methods of detecting patterns of over-authorization such as consistently assigning maximum service hours without justification.

Provider Screening, Enrollment, and Training (1 of 2)

▪ Provider Screening and Enrollment:

- Prohibit P.O. Boxes for provider addresses.
- Provide no exceptions for fingerprinting and background checks of HCBS providers. Providers who have been convicted of certain crimes should not be allowed to serve beneficiaries (e.g., murder, rape, senior abuse, etc.).
- Require reporting of ownership/corporate structure including managing employees. Require changes to be reported within 35 days.
- Revalidate providers at frequent intervals and check against the OIG exclusion list for providers who have been suspended or terminated.
- Conduct unannounced site visits within 90 days of provider enrollment and every three years thereafter to verify compliance with HCBS settings criteria to prevent billing for HCBS in settings that operate like institutional settings with higher reimbursement rates.
- Check for provider co-location and market saturation and consider a moratorium on new providers if necessary. Consider setting provider: beneficiary ratios or disallowing any willing and qualified enrollment using 1915(b) authority.
- Create a change in circumstances framework which requires providers to inform the state in circumstances such as significant increase in employees, mergers/acquisitions, etc.

Provider Screening, Enrollment, and Training (2 of 2)

- **Provider Training:**

- Mandate comprehensive training on an annual basis for all providers (including self-directed and family caregivers) that covers billing, FWA prevention, and service-specific skills with minimum training thresholds (e.g., supervised on-the-job training for 75 hours).
- Leverage national training and licensure resources and standardized training curricula to professionalize HCBS.
- Require added training requirements for addressing high-risk conditions such as dementia, co-occurring diagnoses, etc. Training should be aligned with vulnerability.
- Implement a Learning Management System to track hours and completed modules.

Financial Accountability (1 of 4)

▪ Billing and Payment:

- Move away from 15-minute billing increments, which are prone to fraud, toward per-diem rates with provider biometric verification.
- Require individual provider National Provider Identifiers (NPIs) on all claims.
- Establish automatic flags for billing anomalies, such as exceeding service hour limits or billing for services during a hospital stay.
- Regularly conduct rate reviews to determine how reimbursement compares to peer states.
- Review for billing patterns like service cliffs and drop-offs that can indicate a provider closed an NPI and moved to another.
- Review for billing by multiple providers at a single service site, for hours outside of organization operating hours, and for beneficiaries while in inpatient settings.
- Develop a clear overpayment and recovery process for fee-for-service and managed care claims.

Financial Accountability (2 of 4)

▪ FWA Monitoring and Oversight

- States should monitor high service utilization and increase utilization management controls to ensure that the level of resource intensity is needed.
- Monitor to ensure Medicaid dollars are not paying for union fees, sick leave for contractors, or other costs that are unallowable, in accordance with federal regulations and state policies defining other unallowable costs.
- Assign providers for each service in the person-centered service plan. The beneficiary has the autonomy to choose their providers, but the provider should not be able to coerce beneficiaries or provide kickbacks to sign with a particular provider. Reimbursement should only be made to assigned providers.
- Review the relationship between the agencies that design the program versus the payment and auditing functions. Create guardrails and public reporting requirements so that neither agency can prevent the mitigation of fraud.
- Employ enhanced data analytics to identify outliers, impossible travel times, and provider "tunneling" (e.g., a day center owning a required transportation company).
- Conduct unannounced site visits and secret shopper surveys to verify compliance and service quality.

Financial Accountability (3 of 4)

- **Fiscal Intermediaries (FIs):**

- Require FIs to use electronic visit verification data for timesheet validation.
- Require data analysis and reporting to the state of any anomalies within 10 days of discovery.
- Require automated budget adherence alerts that are tested for non-allowable costs, over-spending, etc. States should validate that the alerts are effective.
- Implement automatic payment edits such as hours per day, duplicate submissions, payments overlapping with multiple providers.

Financial Accountability (4 of 4)

▪ Electronic Visit Verification (EVV):

- Expand EVV use beyond federally mandated services to include other services such as day programs, private duty nursing, and case management.
- Integrate EVV data directly with billing systems for automated validation.
- Set a high compliance threshold (e.g., 95%) for EVV data collected through the EVV system and minimize manual overrides.
- Compare EVV data to claims and perform other data analytics to identify anomalies.
- Create a geolocation fence for providers and beneficiaries.
- Use EVV for scheduling so that it can be viewed as a positive for providers.
- Require pre-payment billing validation using EVV.
- Require EVV for live-in caregivers.
- Establish a minimum compliance threshold of claims that must have a valid EVV record.

Self-Direction and Family Caregivers (1 of 2)

- Apply the same training, background check, and oversight requirements to self-directed providers, including family caregivers, as agency providers.
- Require the fiscal intermediary to set guardrails on budgeting and payment.
- Have case managers routinely review, through provider/participant interviews and desk reviews, for kickback arrangements between participants and providers and to mitigate budget-padding. Provide training so case managers and fiscal intermediaries understand how to identify kickbacks.
- Ensure services are being provided in-person by the selected caregiver using authentication tools such as EVV.
- Require NPIs for personal care attendants, as described in CMS guidance: <https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/faqs-using-npis-for-medicaid-pcas.pdf>, and cross-check NPIs across beneficiaries.
- Set adequate penalties for perjury on time sheets.
- Require beneficiaries submit receipts for items purchased and review bills for non-covered services.
- Require more than one provider for high utilizers.

Self-Direction and Family Caregivers (2 of 2)

- Limit care by a single family member for people with high utilization and require additional caregivers. Avoid overutilization of family caregivers where other providers are available.
- Require added justification for multiple family caregivers and/or require one other non-family provider to deliver service in coordination with family members.
- Do not permit 24/7 service provision by family caregivers. Set hourly limits for services provided by family caregivers based on overtime laws and ensure they are adhered to across beneficiaries.
- Require EVV for family caregivers.
- Conduct unannounced home visits.
- Crosscheck against OIG list of excluded individuals.

State-Level Policies and Oversight (1 of 2)

▪ Strengthen Regulations and Policies:

- Enact state-level False Claims Acts and increase fines and sanctions for substantiated FWA.
- Require Medicaid to publicly report cases referred, investigated and resolved. Medicaid agencies are often pressured by stakeholders to not recover funds. Require deconfliction of all fraud cases.
- Review and improve whistleblower protections and create a fraud tipline.
- Review civil monetary penalty policy caps and consider a sliding scale based on an organization's total revenue or total caseload. Fines and sanctions for provider fraud should be proportional to the organization's total revenue.
- Review and improve anti-kickback laws and ensure the appropriate threshold for compliance action (e.g., "knowingly," "knowingly & willingly," "intentionally," or "no explanation mens rea").
- Reassess the state's institutional level of care criteria and medical necessity criteria to determine if they are appropriate for the intended HCBS population.
- Do not allow provider marketing of Medicaid HCBS.
- Evaluate provider qualifications to ensure they are sufficient and appropriate.

State-Level Policies and Oversight (2 of 2)

▪ **Managed Care Oversight:**

- Strengthen requirements for managed care plan performance and contracts to ensure alignment and compliance with HCBS program integrity requirements.
- Enhance oversight of managed care plans by shortening the timeframe for fraud reporting, increasing penalties for non-compliance, requiring 5-year program integrity plans, and requiring public reporting of FWA metrics.
- Create excepted claims categories for claims under investigation so managed care plans are not penalized for reviewing and investigating.

▪ **Resource Allocation:**

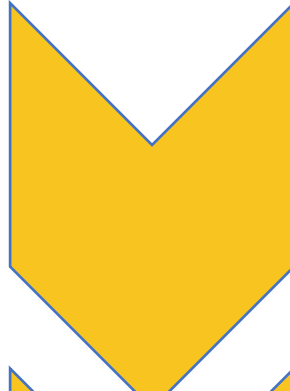
- Adequately fund state FWA units and leverage contingency-based contractors to increase investigation and recovery efforts.
- Review provider network adequacy for HCBS and allow exceptions or plans to be on a corrective action plan when providers are suspended or terminated.
- Review the role of Developmental Disabilities Councils and Protection and Advocacy in mitigating fraud and aligning when possible.

Applied Behavior Analysis (ABA) Toolkit

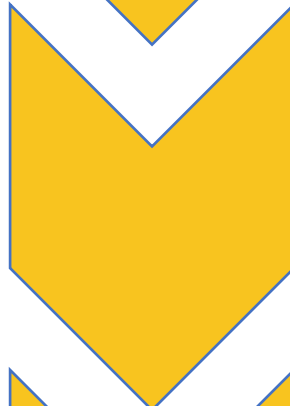


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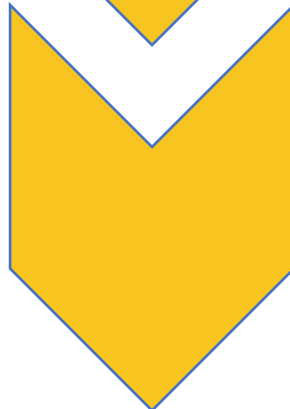
Applied Behavior Analysis Toolkit Summary



- **Medicaid and the Children's Health Insurance Program (CHIP)** are seeing rapid growth in autism spectrum disorder (ASD) diagnoses and in the use of ABA and other behavioral interventions for children and youth diagnosed with ASD.



- **Growth in ABA utilization has outpaced growth in ASD diagnoses**
- ABA has become a major area of Medicaid and CHIP spending for children with ASD



- **Gaps in policy, operations, or oversight** can lead to sizable improper payments
- Investigations leading to prosecution pointing to fraud, waste, and abuse in the ABA industry are generating concern about oversight

Applied Behavior Analysis Toolkit Summary (1 of 2)

- **The ABA Toolkit** supports state Medicaid and CHIP agencies to make informed decisions about covering ABA services for beneficiaries with ASD

The ABA toolkit focuses on the following key components:

Clinical Standards

- ABA should be individualized, grounded in a thorough diagnostic and functional assessment, and translated into an individualized treatment plan.
- States should consider that higher treatment intensity is not automatically better.
- Service levels should reflect the child's individual needs and response to treatment.

Medicaid and CHIP Coverage Framework

- Federal Medicaid EPSDT requirements entitle eligible children to medically necessary section 1905(a) services.
- States retain significant flexibility in how services are structured, funded, and regulated.
- States may provide ABA coverage while promoting access, improving quality, and managing costs.

Medicaid Payment Approaches

- ABA may be provided through -for-service or managed care delivery systems, and states may use procedure-code-based rates, credential-based rates, bundled payments, per diem rates, case rates, or value-based approaches.
- States should pair payment policy with clear documentation requirements, rate-setting methods, and claims or encounter-data oversight to support both access and accountability.

Applied Behavior Analysis Toolkit Summary (2 of 2)

The ABA toolkit focuses on the following key components:

Provider Qualifications, Credentialing and Enrollment

- States determine the qualifications of ABA providers, often relying on technicians supervised by practitioners with additional training/education.
- Oversight of provider enrollment ensures only eligible providers deliver and bill for ABA services.
- States should identify where clarification is helpful in provider manuals, enrollment standards, managed care contracts, and program integrity processes.

Utilization Management

- When coordinated with program integrity functions, utilization management can help identify unusual utilization patterns and flag issues.
- States should oversee how managed care plans use utilization management for ABA, including compliance with federal utilization management rules, access standards, prior authorization timeliness requirements, and notice, grievance, and appeal processes.

Preventing Fraud, Waste, and Abuse

- Federal and state oversight bodies identified significant vulnerabilities, including questionable billing for excessive units of service.
- States should implement effective ABA program integrity through coordination across analytics, utilization management, audit, and enforcement functions, with findings used over time to refine controls, improve provider guidance, and address emerging risks.



Chapter 1: Applied Behavior Analysis Overview

Autism Spectrum Disorder and Applied Behavior Analysis

What is autism spectrum disorder?

ASD affects social, communication, and behavioral skills and includes conditions previously referred to as pervasive developmental disorder and Asperger syndrome.

Early ASD intervention can improve development, daily functioning, and participation in school and community activities.

What is applied behavior analysis?

ABA is an evidence-based behavior therapy that uses learning and behavior principles to support children with ASD.

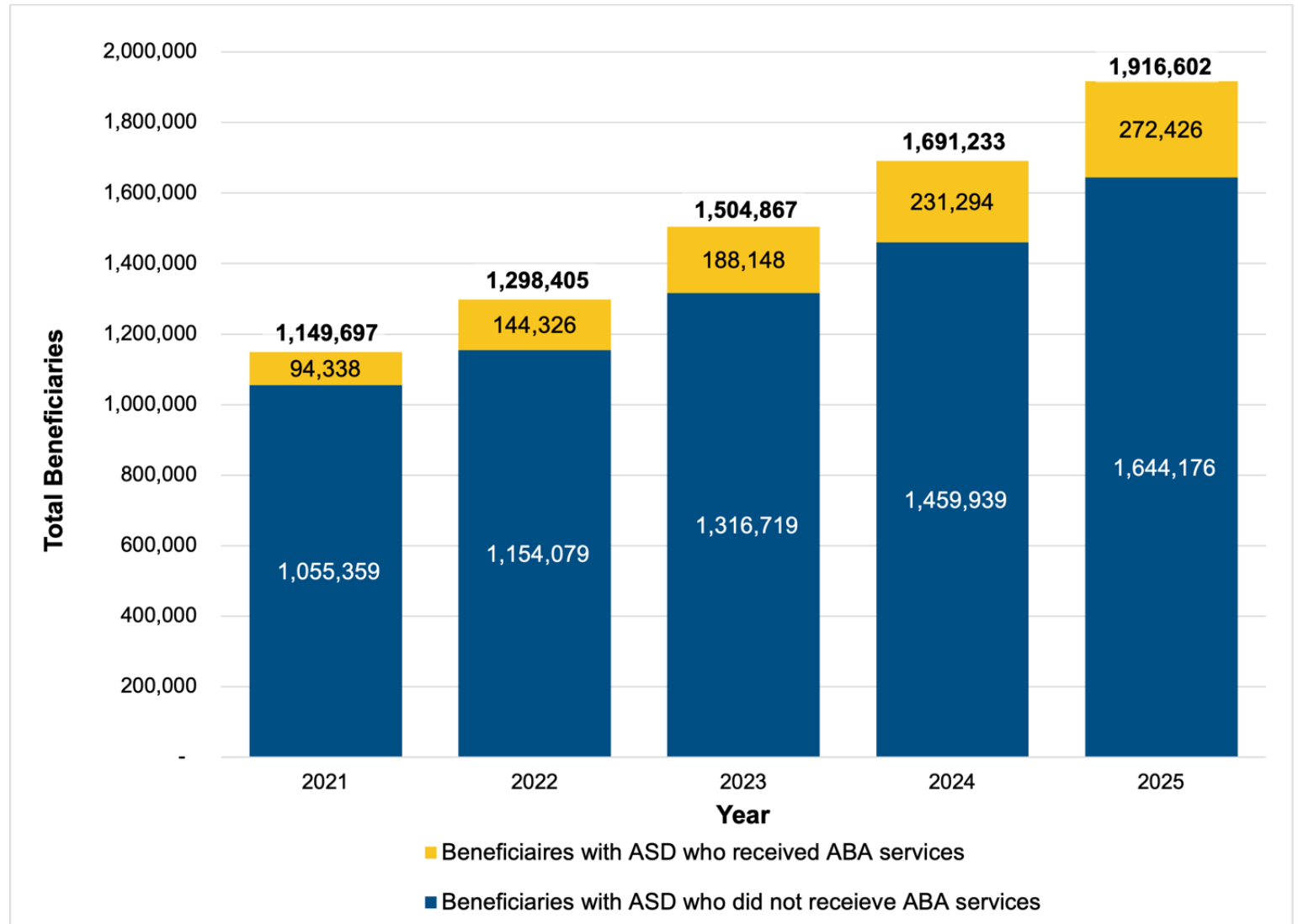
ABA is one of several intervention approaches available for people with ASD.

Utilization Trends

- Medicaid and CHIP have experienced **rapid growth** in beneficiaries receiving services for ASD
- The increase in service use highlights the **need for informed coverage and oversight decisions**

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. 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.

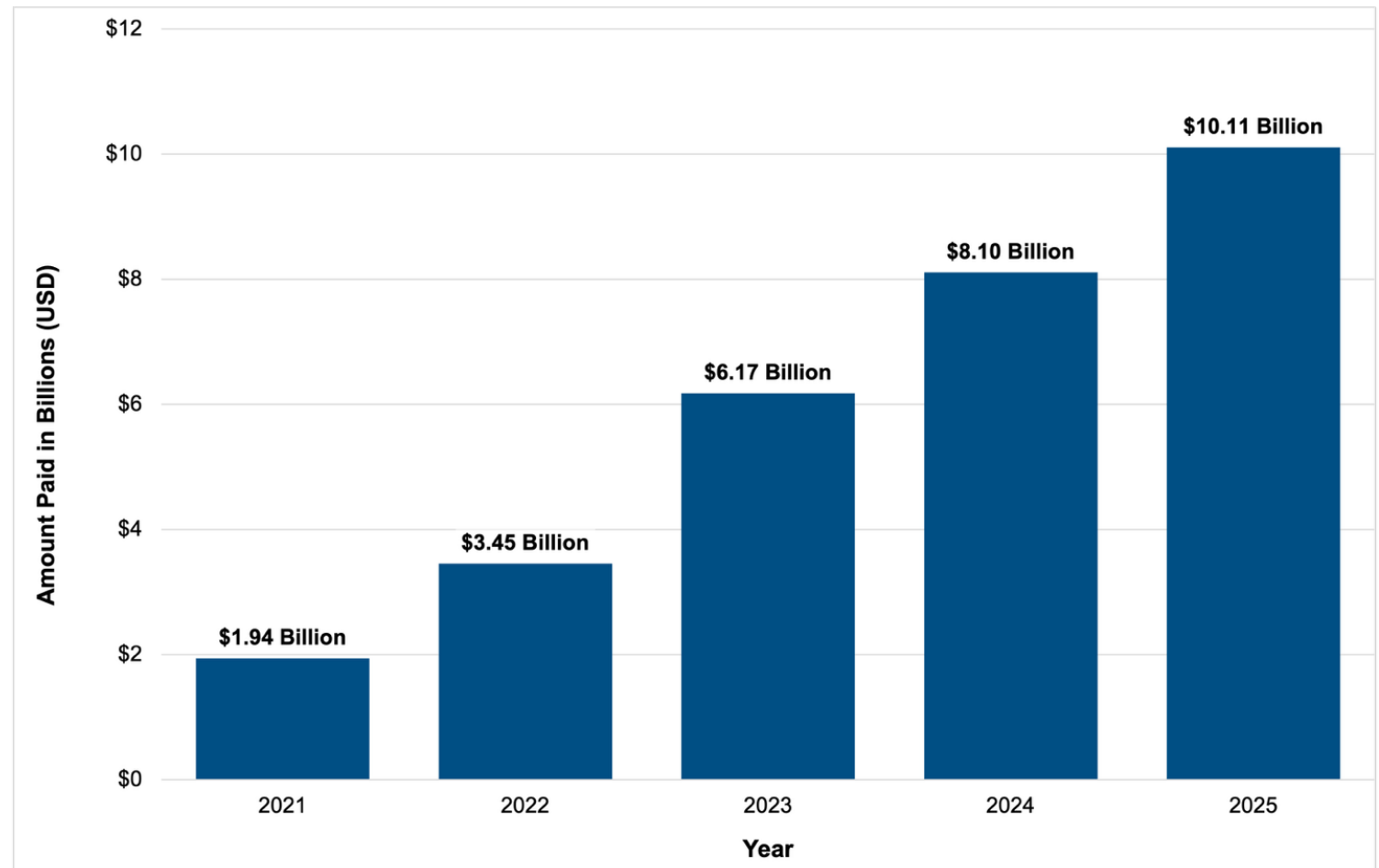
Total Medicaid and CHIP Beneficiaries with an Autism Spectrum Disorder Diagnosis by Receipt of Applied Behavior Analysis Services, 2021–2025



Cost Trends

- **The total amount paid** by Medicaid and CHIP for ABA therapy provided to beneficiaries has **increased by over 420 percent**, rising from approximately \$1.94 billion in 2021 to \$10.11 billion in 2025

Total Medicaid and CHIP Payments for Applied Behavior Analysis Services Among All Beneficiaries, 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, USVI, and Guam. Analysis includes the paid amount for procedure codes 97151-97158 across Medicaid and CHIP -for-service claims and managed care encounters. Results are intended for analytic use.*

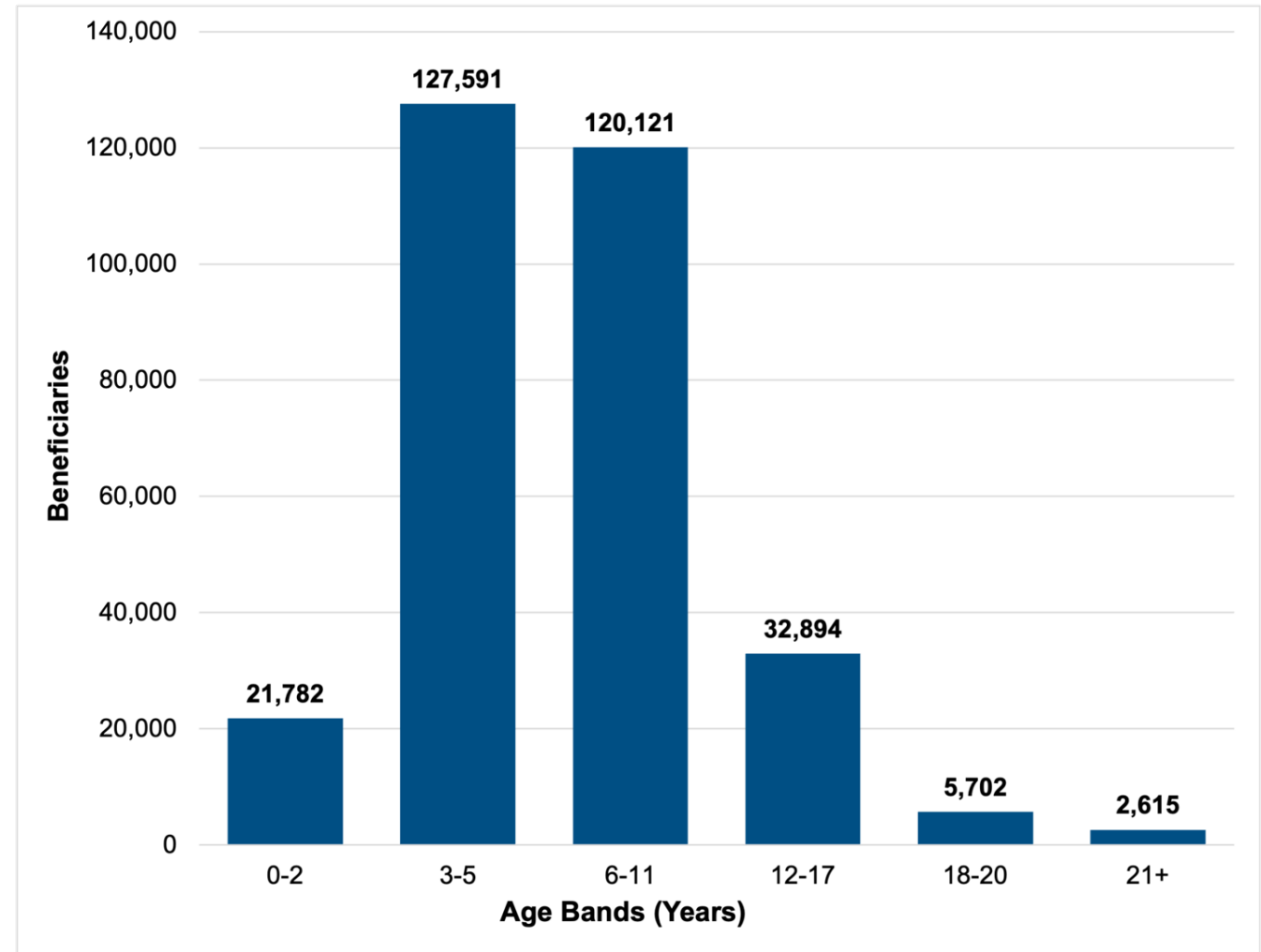


Chapter 2. Applied Behavior Analysis Clinical Standards

Age and ABA

- Children with ASD who start structured interventions, like ABA, **before 6 years old** can maximize success in improving cognitive functioning, language acquisition, and adaptive behavior.
 - Most Medicaid and CHIP children with ASD **begin ABA after 3 years old.**
- However, age is **only one of many factors** that impact ABA treatment success.

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.

Initiating Applied Behavior Analysis Services

- ABA is often initiated after a **Comprehensive Diagnostic Evaluation (CDE)** is completed to confirm ASD
 - For diagnosing ASD, the American Academy of Pediatrics recommends using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (**DSM-5-TR**) criteria
 - CDEs include a **history of symptoms** and findings from **structured observations** of symptoms
 - CDEs should be **completed by qualified and licensed medical providers**

Best Practice

Initiate ABA only after a qualified, independent clinician has confirmed an ASD diagnosis. 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.

Individualized Treatment Plan (ITP)

- ITPs define treatment **scope, intensity, staffing, settings**, and expected **outcomes**
- ITPs are **tailored to a child's needs/goals**
- Purposes of ITPs:
 - **Provide the blueprint** for ABA implementation
 - Support ABA **(re)authorization**
 - Communicate **medically necessary services**
 - **Monitor authorized and delivered services compared to** a child's progress
 - **Document progress** to support decisions about continuing or ending ABA

Best Practices

- States should have a **process to review ITP quality**
- ITPs submitted with authorization requests should:
 - Show **measurable progress**
 - Explain any **changes to the plan**
 - Document **caregiver training/participation**
- To continue Medicaid coverage of ABA services, **states should require re-evaluations** that inform adjustments to the ITP (e.g., intensity of services)



Chapter 3. Medicaid and CHIP Policy and Coverage

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Requirements

- Federal Medicaid EPSDT requirements **entitle eligible children to medically necessary section 1905(a) services**
 - States retain **significant authority in shaping** how these services are structured, funded, and regulated
- CMS **does not endorse or require any treatment modality**, including ABA, for ASD



EPSDT requires coverage of **medically necessary** services to **correct or ameliorate** ASD and associated conditions for those <21 years old, even if not listed in the state plan.



EPSDT does not mandate ABA. ABA is one treatment option that states may find medically necessary.



States may describe ABA in the state plan but must have an approved reimbursement methodology.



EPSDT prohibits hard limits on hours, visits, or service costs. Prior authorization is allowed.

Federal Authorities

States can **structure ABA and other ASD treatment coverage to meet EPSDT requirements** while **promoting appropriate access** and leveraging each state's provider community

Federal Authorities and Common State Coverage Options	ABA	Other ASD Treatment	Treatment for co-occurring conditions with ASD
Section 1905(a)(4)(B) and 1905(r), EPSDT	✓	✓	✓
Section 1905(a)(6), OLP Services (42 CFR § 440.60)	✓	✓	✓
Section 1905(a)(13), Preventive Services (42 CFR § 440.130(c))	✓	✓	✓
Section 1905(a)(11), Therapy Services (42 CFR § 440.110)		✓	✓
Section 1905(a)(13), Rehabilitative Services (42 CFR § 440.130(d))			✓
Section 1915(c) HCBS Waiver	✓	✓	✓
Section 1115 Demonstration	✓	✓	✓
Section 1915(i) State Plan Amendment HCBS	✓	✓	✓
Section 2110 CHIP Child or Pregnancy-Related Health Assistance	✓	✓	✓



Chapter 4. Medicaid and CHIP Payment Approaches

Applied Behavior Analysis in FFS and Managed Care Delivery Systems

States can provide ABA through the FFS and/or managed care delivery systems

Payment methodology for reimbursement varies in both delivery systems

- Methodologies can include a schedule by procedure code, bundled payment, or value-based arrangement
- The choice of payment methodology may influence state budget predictability, program integrity risk, and administrative burden
- For questions regarding CHIP payment, please reach out to your state lead for more information

State Consideration

States should pair payment policy with **clear documentation requirements, sound rate-setting methods, and strong claims or encounter-data oversight** to support both access and accountability

Payment Methodologies: FFS Payment Rates

- Many states pay for ABA under Medicaid FFS through a group of **ABA-specific CPT codes billed in 15-minute units**
- Payment rates **vary significantly across states**
- If states have questions regarding CHIP payment, please reach out to your state lead.

Lowest and Highest -For-Service 2025 Rates for Specific Applied Behavior Analysis Current Procedural Terminology Codes Across States

ABA CPT Codes	Lowest Rate	Highest Rate
97151: Behavior Identification Assessment, qualified health care professional	\$18.79	\$112.65
97152: Behavior Identification Supporting Assessment, technician/mid-level provider rates only	\$9.90	\$41.74
97153: Adaptive Behavior Treatment Using Established Plan, technician	\$10.39	\$22.63

State Considerations

- 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 remaining fiscally sustainable
- States should also ensure that **rate comparisons are interpreted considering differences** in service definitions, credentials, and delivery systems across states

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>



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

Applied Behavior Analysis Provider Qualifications

States have flexibility in determining the provider standards, framework, and process to **ensure only qualified, eligible provider types can bill** for ABA.

Best Practice

States should **require state licensure** for independent ABA providers, **using national credentials such as BACB certification** as a baseline prerequisite

1. Establish the foundation

Certification: BCBA, BCaBA, RBT, etc.; non-governmental verification of training and competence (specific education levels are required for each certification)

Licensure: State license authorizing practice; usually based on certification plus state-specific requirements (continuing education is required for licensure renewal)

2. Defining the standards

State-defined provider qualifications & supervision standards: State policy specifies which licensed/certified provider types may enroll and bill, and sets required supervision ratios, activities, and documentation for mid-tier staff

3. Verification and approval for billing

Medicaid/Managed Care Plans credentialing and enrollment: The state and/or managed care plans verify that providers meet qualifications and supervision rules (plus NPI, ownership, exclusions) before approval for delivering and billing ABA

Eligibility of Providers to Bill for Services

- Each state **screens and enrolls ABA providers** to participate in the program
 - In general, this happens before managed care plans can add a provider to their network
- 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
 - How supervision relationships are documented for oversight and billing purposes

ABA provider enrollment typically includes:

- Verification of identity
- National Provider Identifier
- Licensure and certification status
- Education and training
- Ownership disclosures
- Checks against federal and state exclusion lists

Supervision Requirements

- States set **provider supervision standards** to safeguard individual safety and maintain program integrity
- 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 as needed
 - Provide care coordination
 - Monitor and report on progress
 - Provide any support or training

Guidelines for the Number of Supervision Hours Per Direct Treatment Hour *

- One to two hours of supervision for every 10 hours of direct treatment (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 needs¹

*For additional supervision requirements and factors that positively impact the ability to provide supervision, please reference page 87 in the ABA Toolkit

1. The 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 (Version 3.0)* [Clinical practice guidelines]. Retrieved July 28, 2026, from <https://www.casproviders.org/asd-guidelines>.



Chapter 6. Utilization Management

Access, Appropriateness, and EPSDT Compliance

- **EPSDT requires coverage of medically necessary section 1905(a) services** to correct or ameliorate conditions for children under 21 years old
- Co-occurring conditions should **not be used to deny ABA or limit** other medically necessary services
- **Utilization management should ensure ABA is** medically necessary, individualized, clinically appropriate, and cost-effective

Types of Utilization Management

Four practices frame the review process and occur at different periods of care and/or payment:

1. **Prior authorization** (Prepayment): Conducted BEFORE care is delivered.
2. **Concurrent review** (During Care): Monitors services WHILE they are being delivered.
3. **Reauthorization review** (During Care): Conducted AT or NEAR THE END of the authorization period.
4. **Retrospective review** (After Care): Conducted AFTER care is delivered and claims are submitted.

Best Practice

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.

Evidence-Based Applied Behavior Analysis Authorization

- Prior authorization should be based on **clinical documentation, functional needs, CDE, assessment findings, and the ITP**
- **High-intensity ABA requests warrant additional justification** showing how hours fit the child's daily life and treatment goals
- Reauthorization should rely on **objective progress data, updated assessment, goal mastery, behavior reduction, and treatment change plans**

Best Practices: Standardizing Utilization Management

- States should **align FFS and managed care utilization management expectations** to reduce variation, provider burden, and inconsistent decisions
- Managed care contracts should **clearly define** utilization management criteria, documentation, timelines, notices, appeals, and reporting expectations
- **Utilization management and program integrity should work together while serving distinct roles**
 - Utilization management focuses on care management
 - Program integrity audits compliance and billing



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

Why Applied Behavior Analysis Program Integrity Matters

- Medicaid and CHIP ABA spending **grew more than 420% in five years**, reaching over **\$10.11 billion in 2025**
 - Federal and state oversight bodies (e.g., the HHS-OIG) identified significant vulnerabilities including questionable billing for excessive units of service and billing for services that were not rendered or did not meet coverage requirements

Federal and State programs should:

- Adopt program integrity strategies that prevent improper payments before they are made
- Detect aberrant patterns in real-time
- Ensure decisive administrative actions are taken to protect program resources

Key Prevention and Detection Strategies

By **systemically analyzing claims and utilization data**, states can better balance reactive “pay-and-chase” models and preventive “stop-and-catch” models

Strategies states should implement:

Participate in the Healthcare Fraud Prevention Partnership (HFPP) to have a powerful lens into national and cross-payer fraud schemes

Use the Medicaid Emerging Vulnerability Intelligence and Actions (MEVIA) to identify state-specific trends and high-risk service areas

Use CMS’ Risk Assessment Template to ensure ABA program integrity risks are evaluated on an ongoing basis

Implement periodic evaluation of claims processing systems

Validate service delivery with electronic visit verification (EVV)

Implement targeted, risk-based prepayment medical review processes for higher-risk ABA claims

Audit, Enforcement, and Managed Care Oversight

Effective ABA program integrity **requires coordinated prevention, detection, audit, and enforcement** across both -for-service and managed care including:

- Using **robust audit and medical review** processes to detect and correct improper payments
- Using **findings from OIG audits and other oversight reviews** to strengthen provider guidance and program integrity oversight processes
- **Validating findings** of potential fraud, waste, or abuse and taking appropriate corrective and administrative actions
- **Establishing clear processes** for how managed care plans should **notify the state** of suspected cases of fraud

Autism Spectrum Disorder and Applied Behavior Analysis Data Book

- CMS sought to better understand the drivers of national and state-level ABA cost and utilization growth by conducting detailed analyses of T-MSIS Analytic Files (TAF) from 2021-2025 across all Medicaid and CHIP fee-for-service claims and managed care encounters.
- CMS also evaluated trends in non-ABA services to treat ASD.
- The results of this analysis were compiled into seven sections in the [Autism Spectrum Disorder \(ASD\) and Applied Behavior Analysis \(ABA\) Data Book](#).
- This data book helped inform the [Applied Behavior Analysis toolkit](#).

Additional Recent Releases



CMCS All State Call
September 15, 2026

Medicaid Enterprise Systems (MES) IT Standards – Request for Information

Medicaid Enterprise Systems (MES) IT Standards – Request of Information

I. Background

The Centers for Medicare & Medicaid Services (CMS) is committed to modernizing the Medicaid Enterprise Systems (MES) to improve interoperability, promote modularity, and drive better health outcomes for Medicaid beneficiaries. This commitment involves a strategic shift towards standards-based, commercial-off-the-shelf (COTS) modular solutions and cloud-based technologies, moving away from monolithic, “one-off” custom-built systems. These forthcoming IT standards are part of a larger initiative to shape and evolve a reusable and modern Medicaid technology ecosystem. This evolution is guided by federal regulations, including those at 42 CFR Part 433 and Part 95, which govern Medicaid cost allocation and system requirements.

The MES ecosystem is structured around a distributed federal-state model in which states exercise significant autonomy over IT investment decisions and vendor procurement, while CMS provides technical assistance, strategic oversight, financial stewardship, and policy guidance. However, this framework has not prevented, and in some ways has contributed to, a fragmented and aging technology landscape with several distinct and compounding problems: siloed modules and systems that cannot easily communicate with one another, unnecessary and unintended variability across similar platforms, where states performing identical Medicaid functions have implemented widely divergent technical solutions, and vendor lock-in driven by aging infrastructure that forces costly workarounds and limits the ability to adopt new capabilities or transition to modern vendors. Recent reviews of state Advance Planning Documents (APDs) and system certification packages have reinforced these concerns, surfacing recurring technical deficiencies and persistent misalignments with federal health IT goals.

Together, these compounding problems drive duplicative costs, impede modernization, and delay implementation of critical policy changes. Addressing them will require a unified approach that reduces siloing, establishes consistent standards across similar platforms, and creates clear pathways for states to modernize legacy systems without being constrained by entrenched vendor relationships or outdated architectures.

In response, CMS is launching a new MES IT Standards initiative to establish clear, outcome-driven technical standards for data exchange, system integration, and technical architecture. The program aims to align state-level MES implementations with modern

- CMS released this Request for Information (RFI) as part of an effort to launch a new MES IT standards initiative.
- The goal of this RFI is to gather specific, actionable information to ensure the program effectively addresses the most significant barriers to MES transformation.
- The RFI closes on **September 25**. Submit responses via email to MACBIS-Enterprise-Services@cms.hhs.gov and aaron.blackshire@cms.hhs.gov.

Key Functional Requirements for Community Engagement Implementation

Key Functional Requirements for Community Engagement Implementation Key Functional Requirements for Community Engagement Implementation Purpose: This document refreshes the December 18, 2025, Community Engagement (CE) MVP feature and functional-requirements checklist to reflect some key requirements established by the CMS-2454 Interim Final Rule with Comment Period (CMS-2454-IFC). It is for states and vendors building or modifying Medicaid eligibility and enrollment systems to implement the CE requirement. States and vendors should read the full for additional details and clarity before implementing any system. The original checklist described pre-decisional functional expectations for CE implementation. This refresh incorporates the IFC guidance directly into the checklist, reflecting where the IFC changes expectations or adds detail that extends or clarifies it. This is not an update to the CMS-2454-IFC guidance in full. States retain the flexibility to design workflows, channels, and sub-infrastructure and policy choices. Not every function described will be implemented in every state. Some capabilities reflect underlying statutory or regulatory requirements (e.g., accepting online applications and renewals), while others are prescriptive approaches or leading practices that can help states achieve complete beneficiary experience, monitoring, and program integrity over time. This document does not represent an exhaustive list of all considerations for CE implementation requirements. Completion of all items does not guarantee compliance or systems approval; it is intended as an optional tool for states, vendors, and other stakeholders are working from a shared understanding of systems' functionality. As of Aug2026											
Key Functional Requirements for Community Engagement Implementation <table><tr><th>Features</th><th>Functional Requirements</th><th>MVP?</th></tr><tr><td>Application</td><td> Modify the State's MAGI-based applications (e.g., health coverage-only applications, multi-benefit applications, and, where applicable, presumptive eligibility forms) to support CE requirements. The updates should ensure CE-related questions collect information to conduct necessary verifications, and request/collect supporting auditable self-declaration documentation at the point of application and integrated into downstream eligibility determinations and system logic. These functionality expectations currently include: • Add or update application questions on work and qualifying activities and hours, and on whether applicable individuals qualify for CE exceptions or exclusions (e.g., medical frailty screening, veteran status) • Structure self-declaration and attestation collection to reflect the tiered use of "other information": • Through 2027, accept a self-declaration to verify CE compliance, exceptions, and exclusions when reliable information is unavailable • Beginning January 1, 2028, obtain documentation where reasonably available and accept other information only when documentation does not exist or is not reasonably available • For medical frailty, accept other information such as a completed medical screener once per enrollment period beginning January 1, 2028, then verify through an electronic data source or documentation at the next renewal • Incorporate CE screening into presumptive eligibility (PE) intake forms and qualified-entity workflows for adult group or hospital PE: • Obtain an attestation and assess whether the individual appears to be a specified excluded individual, an applicable individual, or eligible for an exception • For an applicable individual, assess whether they met the CE requirement for the State-elected number of months (1, 2, or 3) before the PE application </td><td>Yes</td></tr><tr><td>Audits</td><td> Implement auditing and recordkeeping capabilities across eligibility and case management systems to support oversight of CE determinations, including but not limited to compliance, deemed compliance or qualification for an exclusion, verifications, and adverse actions. Systems must ensure that each individual's case record contains the required documentation to substantiate eligibility decisions, consistent with federal recordkeeping requirements. All CE-related evidence must be retained in an auditable, accessible format to support QA, appeals, and audits, including PERM. These functionality expectations currently include: • Maintain an audit log of CE-related decisions (e.g., applicable individual status, exception or exclusion approvals, compliance assessments, disenrollment triggers) • Capture system- and worker-initiated CE actions with time and date stamps and outcome codes • Store supporting documentation (e.g., verification evidence, forms, notices) in an auditable format • Align audit logs with PERM record retention and retrieval standards for CE populations • Build automated QA review reports to flag CE inconsistencies or incomplete documentation • Create CE-specific audit views and extract files for CMS or external audit entities • Integrate the CE audit trail with State-level program integrity and risk management systems • Align the audit record for each CE decision with the State's CE verification plan supplement so audit and PERM extracts show how and why each determination was made • Record each medical frailty reverification event, which must occur at least every 12 months, including the date, basis, and evidence type • Retain any attestation used as other information to support verification of exclusions, exceptions, or compliance </td><td>Yes</td></tr></table> As of AUG2026			Features	Functional Requirements	MVP?	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- Updated resource to support states as they continue to implement systems changes related to community engagement requirements.
- Identifies functional considerations across key system and operational areas, and identifies which capabilities are considered part of the Minimum Viable Product (MVP) for implementation.
- Not an exhaustive descriptive of implementation requirements.

Questions