

# Applied Behavior Analysis Utilization Workgroup

Meeting #1  
September 22, 2026

# Agenda

1. Welcome and Introductions – Shamika Ward
2. Purpose of Workgroup and Background – Dr. Lisa Jobe-Shields
3. Statewide Utilization and Data Trends – Brian Campbell
4. Data on Utilization Trends – Dana Gray (United/Optum); Shawn Roberts (Sentara)
4. Overview of Clinical Best Practice Guidelines – Mariel Fernandez; Judith Ursitti
5. Public Comment and Wrap Up

# Mandate Language (Part 1)

"3. The Department of Medical Assistance Services (DMAS) shall convene an ABA benefit Utilization Workgroup for the purpose of examining Medicaid expenditures and utilization trends for this service and identifying strategies to control costs while still preserving access to care for those in need of the therapy."

# Mandate Language (Part 2)

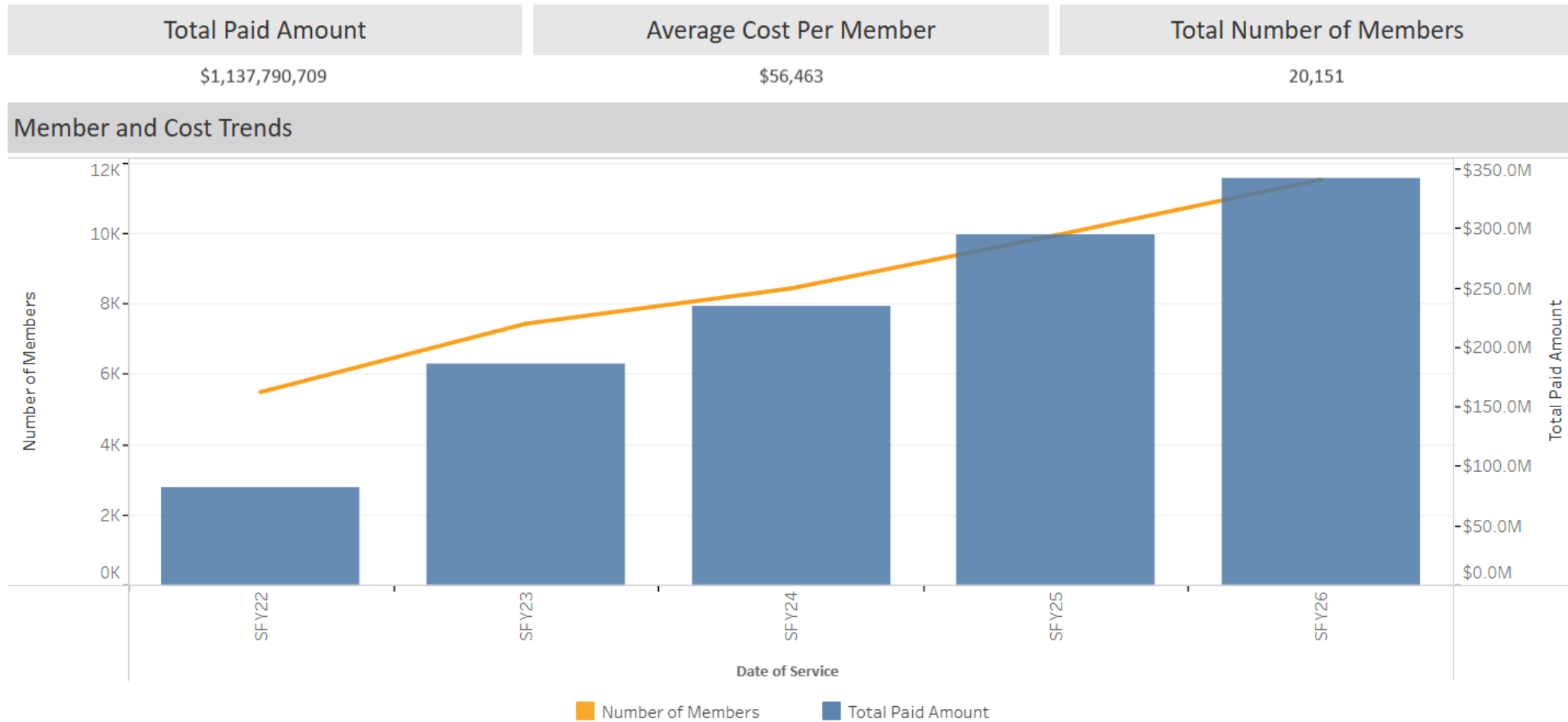
"...The workgroup shall: (i) identify utilization trends, including trends among those with different diagnosis acuity levels; (ii) examine different delivery methods of ABA services and their impact on utilization; (iii) review utilization and service authorization criteria including standard assessment tools and diagnostic criteria taking into account differing service intensity and duration requirements; (iv) evaluate utilization management tools that align with national clinic practice guidelines promulgated by independent national nonprofit organizations; (v) define medical necessity criteria taking into account behavioral factors, ability to learn, age and development, and skills development including clear criteria for eligibility, scope of services and documentation requirements; (vi) review provider qualification recommendations related to ABA practitioner certification and licensing; and current supervision requirements and standards to help ensure appropriate clinical oversight; (vii) evaluate the appropriateness of ABA services for children with diagnoses other than ASD; and (viii) review the MCO annual reporting data to identify any areas of potential improvement to the delivery of services and any needed changes in regulations or policies from DMAS.

The workgroup shall include stakeholders, including ABA service providers, including center-based models and home-based models, representatives from managed care organizations serving Medicaid patients, Virginia licensed behavioral analysts, and a child or adolescent psychiatrist. The workgroup meetings shall be open to the public and offer opportunities for public input."

# Background

- Virginia Medicaid Behavioral Therapy Program was initially implemented as an EPSDT benefit and later added to the State Plan
- In 2021, the benefit was updated to align with national Applied Behavior Analysis (ABA) CPT codes with rates developed as part of a larger rate study

# 2022-2026 Growth



Summary Across Multiple Years based on Total ABA Hours and Total Member Count per Year

| Age_GROUP   | 2023      |                     |                               |                            | 2024      |                     |                               |                            | 2025      |                     |                               |                            |
|-------------|-----------|---------------------|-------------------------------|----------------------------|-----------|---------------------|-------------------------------|----------------------------|-----------|---------------------|-------------------------------|----------------------------|
|             | Mem Count | Avg Hours Per Hours | Avg Hours Per Member Per Year | Avg Hours Per Mem Per Week | Mem Count | Avg Hours Per Hours | Avg Hours Per Member Per Year | Avg Hours Per Mem Per Week | Mem Count | Avg Hours Per Hours | Avg Hours Per Member Per Year | Avg Hours Per Mem Per Week |
| 0-4yrs      | 2,595     | 854,667             | 329                           | 6.33                       | 3,154     | 1,129,980           | 358                           | 6.89                       | 3,562     | 1,282,724           | 360                           | 6.93                       |
| 5-10yrs     | 4,012     | 1,264,082           | 315                           | 6.06                       | 4,803     | 1,458,580           | 304                           | 5.84                       | 6,152     | 1,924,936           | 313                           | 6.02                       |
| 11-13yrs    | 1,053     | 249,199             | 237                           | 4.55                       | 1,098     | 286,566             | 261                           | 5.02                       | 1,243     | 295,086             | 237                           | 4.57                       |
| 14-17yrs    | 738       | 212,884             | 288                           | 5.55                       | 830       | 214,138             | 258                           | 4.96                       | 936       | 240,795             | 257                           | 4.95                       |
| 18-20yrs    | 223       | 57,612              | 258                           | 4.97                       | 244       | 70,695              | 290                           | 5.57                       | 289       | 72,796              | 252                           | 4.84                       |
| Grand Total | 7,663     | 2,638,443           | 306                           | 6.62                       | 9,024     | 3,159,959           | 312                           | 6.73                       | 10,766    | 3,816,336           | 313                           | 6.82                       |

- Children in 5-10years and 0-4years combined comprise of more than 90% of the total Child population receiving ABA services
- Average Hours per member per week is highest for Children in Age Groups 0-4 and 5-10.
- The Growth rate for ‘Average Hours Per Member Per Week’ from 2022 to 2024 is 30% for 18-20 years; 26% for 0-4 years and 22% for 5-10 years which is much higher than growth rates for other age groups - 14% for 11-13 years and 19% for 14-17 years.

Note: Children in 5-10years and 0-4years age groups comprise of ~90% of the total Children's population receiving ABA services

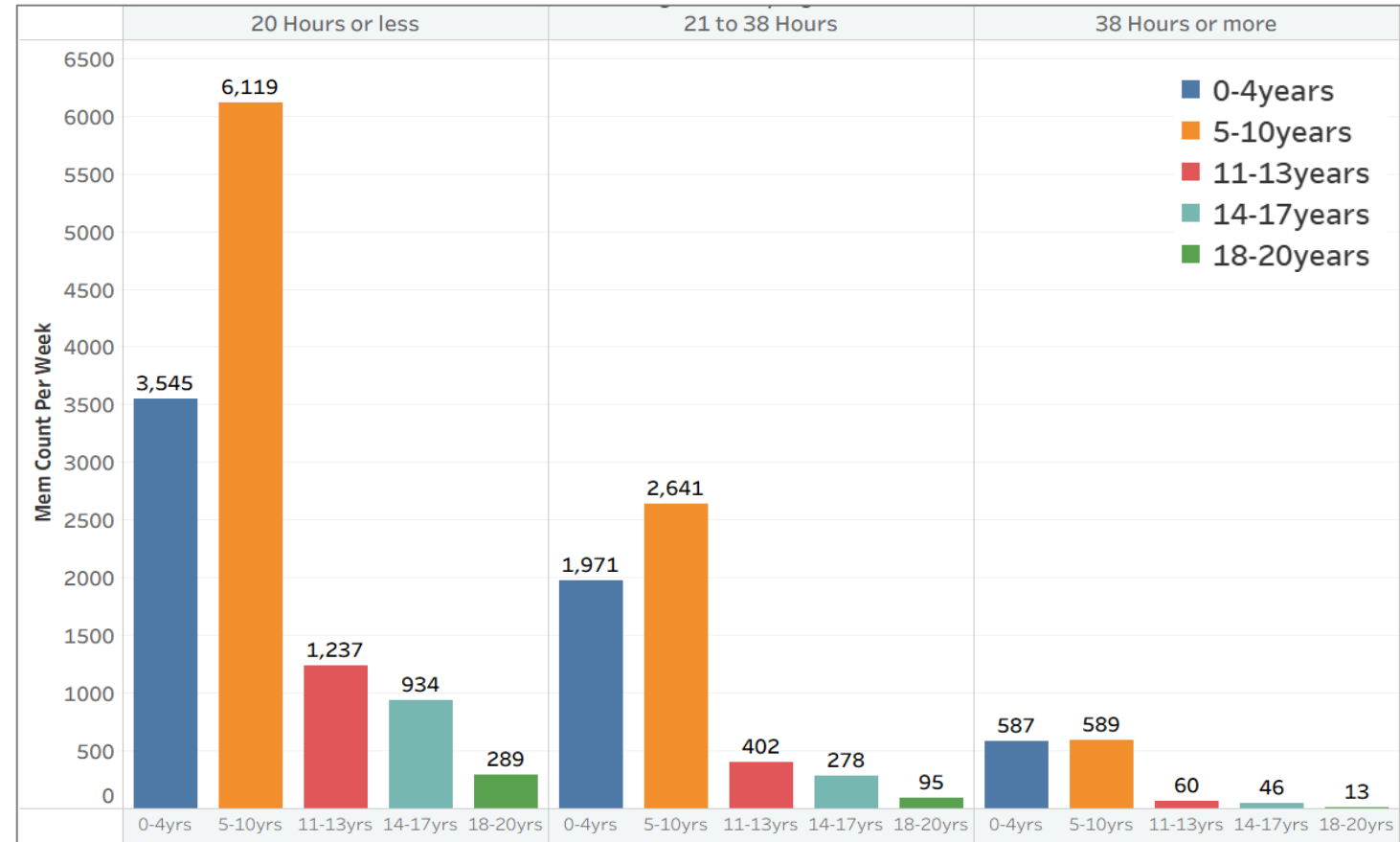
In 2025, Out of the 6,152 children in 5-10years age group

- **43%** of members received at-least 20 Hours and up to 38 hours of ABA Hours
- About **10%** of members received 38 hours or more in a week.

Out of the 3,563 children in 0-4years age group

- **55%** of members received at-least 20 Hours and up to 38 hours of ABA Hours
- About **16%** of members received 38 hours or more in a week

Note: The graph shows how many members received 20 hours or less, 21-38 hours and 38 hours or more in a week. The member counts are duplicated, which means a member could have been counted in one or more categories.



## Based on Total ABA Hours and Total Member Count per Year

| Diagnosis                                                                          | 2023      |           |                               | 2024      |           |                               | 2025      |           |                               |
|------------------------------------------------------------------------------------|-----------|-----------|-------------------------------|-----------|-----------|-------------------------------|-----------|-----------|-------------------------------|
|                                                                                    | Mem Count | Hours     | Avg Hours Per Member Per Year | Mem Count | Hours     | Avg Hours Per Member Per Year | Mem Count | Hours     | Avg Hours Per Member Per Year |
| ADHD and impulse/disruptive                                                        | 524       | 110,640   | 211                           | 546       | 110,949   | 203                           | 599       | 100,870   | 168                           |
| Autism                                                                             | 6,652     | 2,327,530 | 350                           | 7,923     | 2,815,280 | 355                           | 9,543     | 3,480,927 | 365                           |
| Depression, Anxiety, and Trauma                                                    | 55        | 9,306     | 169                           | 59        | 9,256     | 157                           | 51        | 9,138     | 179                           |
| Developmental, Language, and Unspecified psychological and physiological Disorders | 508       | 145,757   | 287                           | 589       | 156,538   | 266                           | 658       | 164,926   | 251                           |
| Other                                                                              | 345       | 45,210    | 131                           | 543       | 67,936    | 125                           | 571       | 60,475    | 106                           |
| Grand Total                                                                        | 7,663     | 2,638,443 | 326                           | 9,024     | 3,159,959 | 327                           | 10,766    | 3,816,336 | 334                           |

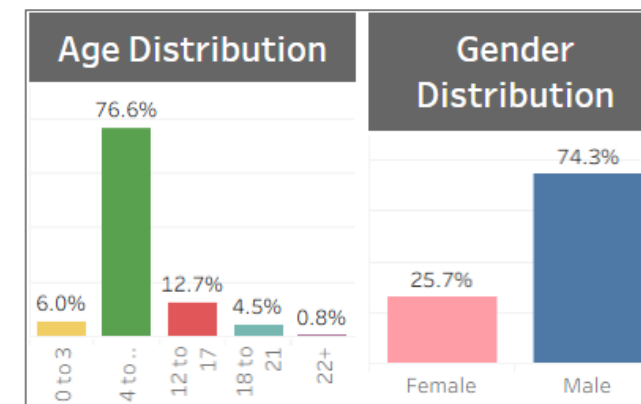
## Location & Intensity of Services

Over a 12-month period, ABA providers requested an average of 22.9 hours per week while delivering an average of 14.28 hours per week across all service codes

| Number of Members | Average Auth Hours per Week               | Avg. Direct Treatment Hours per Week | Avg. Assessment Hours per Week | Avg. Supervision Hours per Week | Avg. Caregiver Training Hours per Week | Average Tenure In Care |
|-------------------|-------------------------------------------|--------------------------------------|--------------------------------|---------------------------------|----------------------------------------|------------------------|
| 882               | 22.9<br><small>National AVG: 22.8</small> | 11.48                                | 0.51                           | 1.97                            | 0.32                                   | 0.7 years              |

| Location of Services   |          |      |       |  |
|------------------------|----------|------|-------|--|
| Primarily Home         | 0 to 3   | 1.3% |       |  |
|                        | 4 to 11  |      | 31.4% |  |
|                        | 12 to 17 | 6.2% |       |  |
|                        | 18 to 21 | 2.5% |       |  |
|                        | 22+      | 0.1% |       |  |
| Primarily Center       | 0 to 3   | 1.3% |       |  |
|                        | 4 to 11  |      | 19.7% |  |
|                        | 12 to 17 | 1.1% |       |  |
|                        | 18 to 21 | 0.1% |       |  |
| Mix Home and Center    | 0 to 3   | 0.8% |       |  |
|                        | 4 to 11  |      | 16.6% |  |
|                        | 12 to 17 | 2.7% |       |  |
|                        | 18 to 21 |      |       |  |
| Primarily School & Mix | 4 to 11  | 0.5% |       |  |
|                        | 12 to 17 |      |       |  |
| Unknown                | 0 to 3   | 1.1% |       |  |
|                        | 4 to 11  |      | 11.7% |  |
|                        | 12 to 17 | 1.7% |       |  |
|                        | 18 to 21 |      |       |  |

| Intensity of Services |          |      |       |  |
|-----------------------|----------|------|-------|--|
| Low <= 15             | 0 to 3   | 0.8% |       |  |
|                       | 4 to 11  |      | 15.6% |  |
|                       | 12 to 17 | 3.5% |       |  |
|                       | 18 to 21 | 1.1% |       |  |
|                       | 22+      | 0.1% |       |  |
| Moderate 16-25        | 0 to 3   | 0.8% |       |  |
|                       | 4 to 11  |      | 27.5% |  |
|                       | 12 to 17 | 4.6% |       |  |
|                       | 18 to 21 | 1.4% |       |  |
| High 26+              | 0 to 3   | 1.9% |       |  |
|                       | 4 to 11  |      | 27.1% |  |
|                       | 12 to 17 | 2.4% |       |  |
|                       | 18 to 21 | 0.8% |       |  |
| Null                  | 0 to 3   | 0.8% |       |  |
|                       | 4 to 11  |      | 9.8%  |  |
|                       | 12 to 17 | 1.3% |       |  |
|                       | 18 to 21 | 0.4% |       |  |

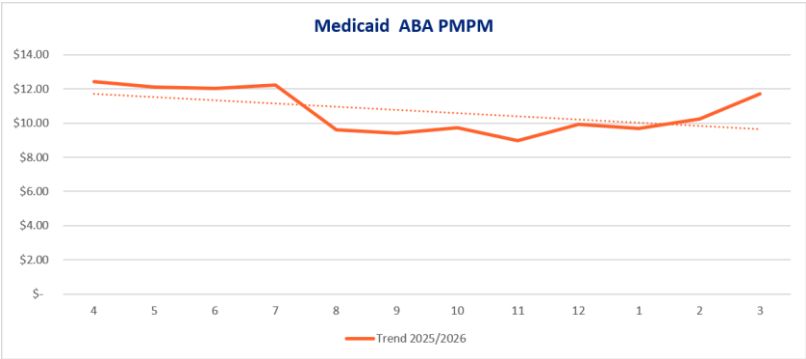


# ABA Top Codes

## 6% PMPM Trend driven by increase in 97153, 97155, & 97156

- ABA PMPM increased starting 1/1/2026 due to increased claimants accessing services

Rolling 12-Month View Comparing 202404-202503 to 202504-202603  
Paid through 202606. Excludes Redetermined Members



| Top CPT Codes                |            |            |                              |             |                                  |                  |                         |                 |
|------------------------------|------------|------------|------------------------------|-------------|----------------------------------|------------------|-------------------------|-----------------|
| MCAID                        | PMPM Trend |            | Utilization Trend Components |             |                                  | Units = Quantity | Claimant Count per Code |                 |
| Outpatient                   | Proc Code  | PMPM Trend | Utilization/K                | Claimants/K | Average Utilization per Claimant | Unit Cost        | Apr '24-Mar '25         | Apr '25-Mar '26 |
| Adaptive Behavior Treatment  | 97155      | 9%         | 7%                           | 13%         | -6%                              | 2%               | 879                     | 1,011           |
| Adaptive Behavior Treatment  | 97153      | 4%         | 5%                           | 12%         | -6%                              | -1%              | 872                     | 993             |
| Family Adaptive Behavior Tre | 97156      | 22%        | 21%                          | 12%         | 7%                               | 1%               | 770                     | 877             |
| Adaptive Behavior Treatment  | 0373T      | -          | 0%                           | 294%        | 0%                               | 0%               | 1                       | 4               |
| Group Adaptive Behavior Trea | 97158      | -75%       | -76%                         | -52%        | -49%                             | 1%               | 31                      | 15              |
| Other                        |            | -1%        |                              |             |                                  |                  |                         |                 |
| Grand Total                  |            | 6%         | 5%                           | 4%          | 1%                               | 0%               |                         |                 |



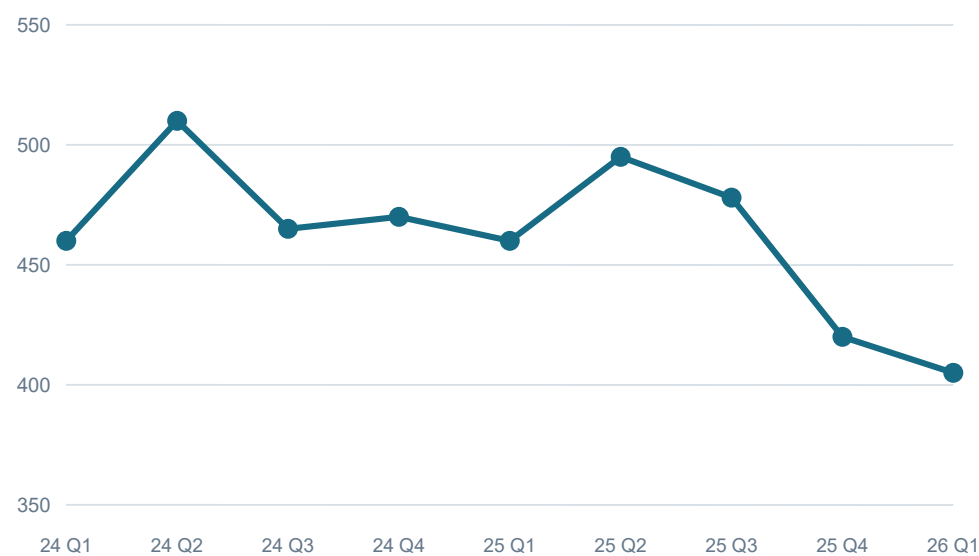
# ABA Utilization Trends

- Shawn Roberts, PharmD RPh
- Senior Director, SHP Behavioral Health

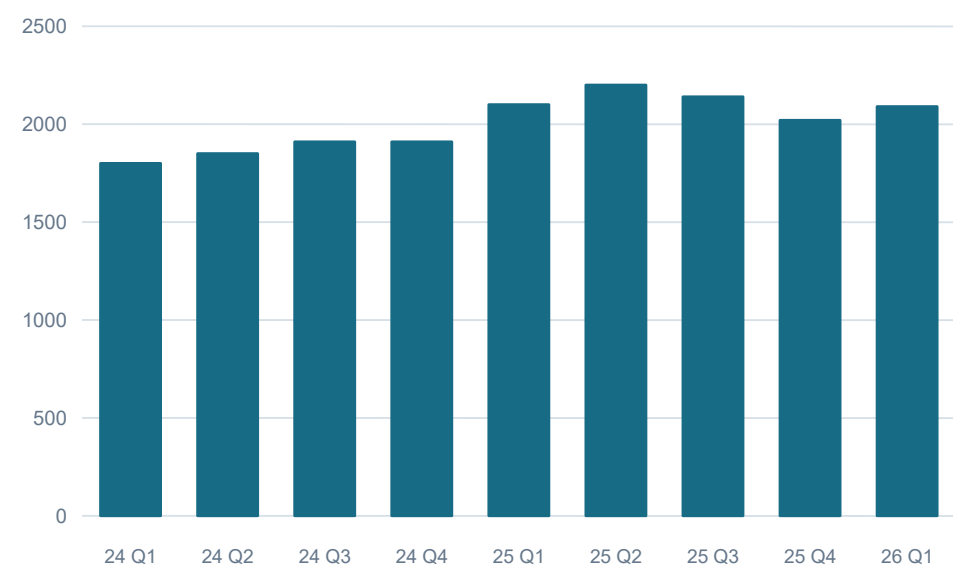
# Sentara Health Plans (SHP) Aggregate ABA Utilization Data

Quarterly view of distinct utilizers and units per distinct utilizer, 2024 Q1 through 2026 Q1

Average Units per Distinct Utilizer



Distinct Utilizers

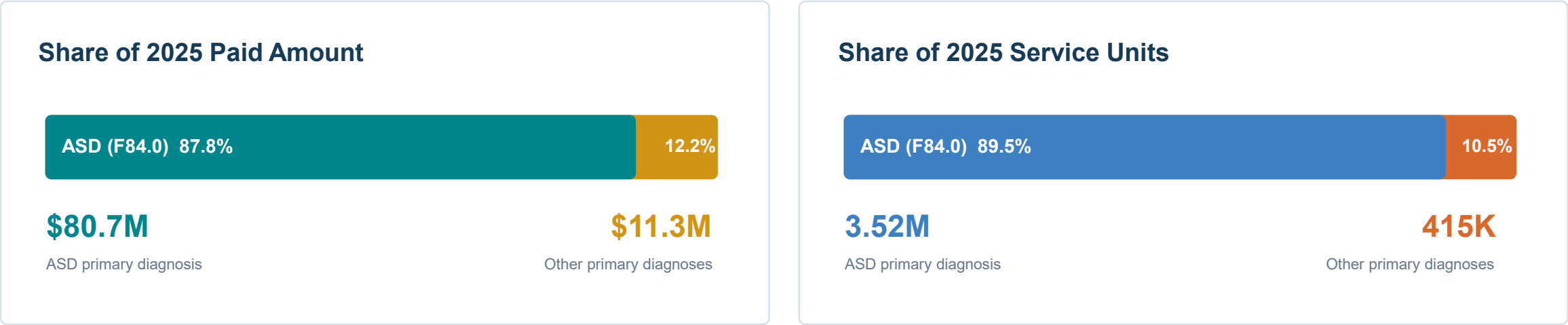
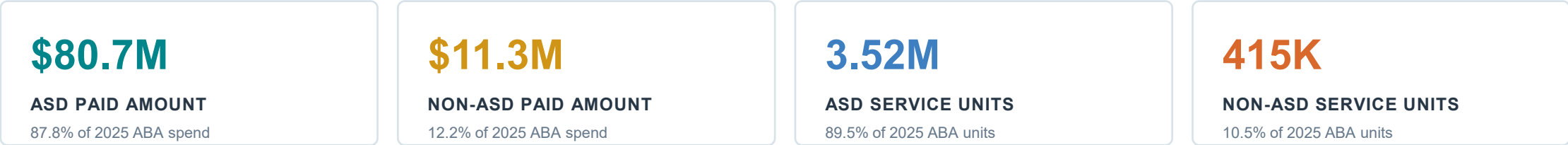


Executive Summary

Distinct utilizers remain above 2024 levels, while units per utilizer declined in late 2025 and 2026 Q1.

# ASD Accounts for Nearly 90% of ABA Utilization and Spend

2025 paid ABA claims grouped by primary diagnosis: F84.0 compared with all other diagnosis codes.



**KEY INTERPRETATION**

ABA paid claims are highly concentrated in F84.0. Non-ASD primary diagnoses represent a smaller but material \$11.3M segment. Diagnosis mix describes claims coding and does not independently establish clinical indication or appropriateness.

**Largest non-ASD diagnosis categories**

ADHD, combined type (F90.2) \$2.09M • Other disorders of psychological development (F88) \$1.36M  
ADHD, unspecified type (F90.9) \$1.04M • Intermittent explosive disorder (F63.81) \$1.02M

# SHP ABA Cost and Service Volume Trends

Paid amount increased 16.8% while service units increased 10.5% from 2024 to 2025.

\$92.0M

2025 PAID AMOUNT

+16.8% vs. 2024

3.94M

2025 SERVICE UNITS

+10.5% vs. 2024

\$23.36

AVERAGE PAID PER UNIT

Blended across all ABA codes

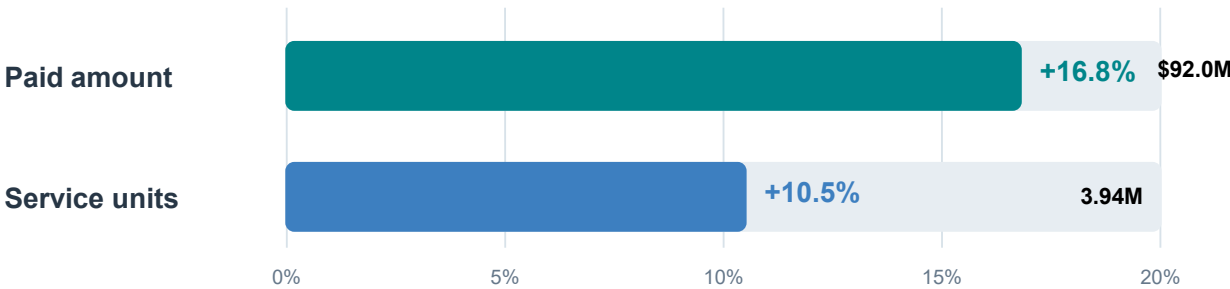
\$19.7M

2026 Q1 PAID AMOUNT

Partial-year result

## 2024–2025 Year-over-Year Growth

Percentage change in paid amount and service units



Paid amount grew 6.3 percentage points faster than service units.

## Key Interpretations

- 1 **Volume increased**  
Service units rose 10.5%.
- 2 **Spend increased faster**  
Paid amount rose 16.8%.
- 3 **Service mix contributed**  
Code mix helped widen the gap.

### Executive implication

Separate member growth, service intensity, procedure mix, and paid amount per unit when evaluating ABA spending trends.

# 97153 and 97155 Drive Most ABA Utilization and Spend

Together, the two codes represent 91.3% of 2025 units and 86.3% of paid amount.

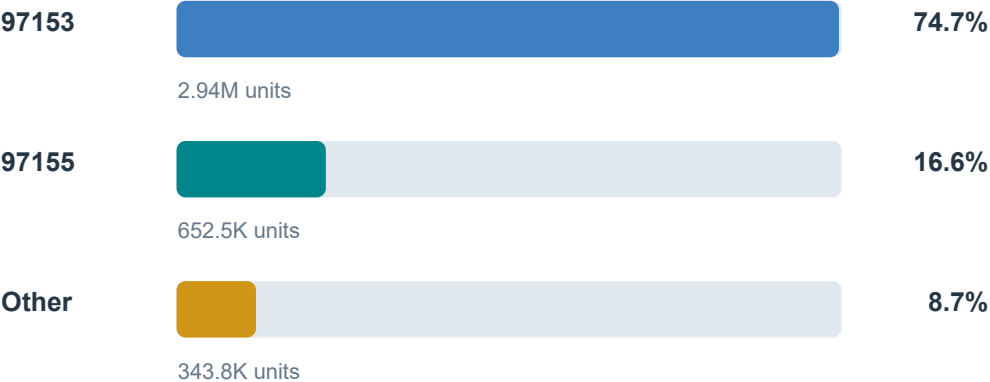
## 97153 Direct adaptive behavior treatment

Treatment delivered face-to-face with one patient by a technician under the direction of a qualified healthcare professional; each 15 minutes.

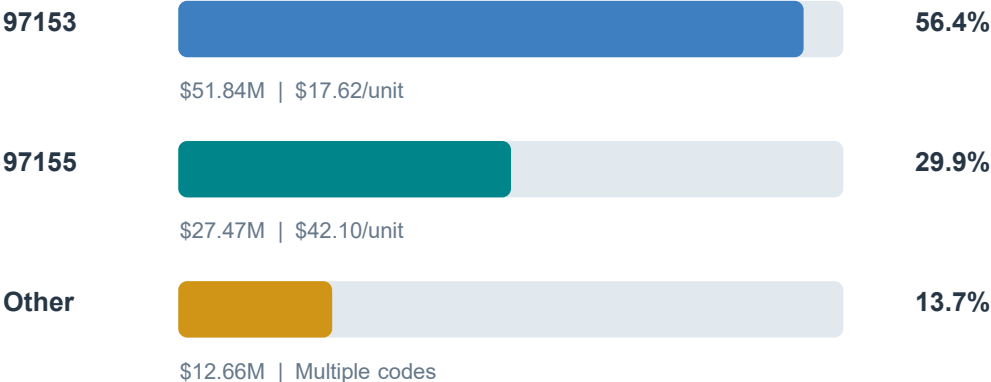
## 97155 Protocol modification and clinical oversight

Treatment with protocol modification delivered by a qualified healthcare professional, which may include direction of a technician; each 15 minutes.

2025 SHARE OF UNITS



2025 SHARE OF PAID AMOUNT



**KEY INTERPRETATION** 97153 drives service volume, while 97155 represents a larger share of spending relative to its unit volume. The difference reflects distinct service definitions and average paid amounts, so units should not be compared across codes as equivalent services.



# CMS ABA Toolkit — Key Takeaways

Mariel Fernandez, MS, BCBA, LBA

### Agency Support

Support state Medicaid and CHIP agencies in making decision regarding ABA service provision for Medicaid and CHIP beneficiaries with an autism spectrum disorder diagnosis.

### Protecting Providers

Trusted providers should not be crowded out because of fraudsters.

### Policy Tools\*

States requested tools and resources as they update coverage and payment policies in response to utilization trends and the evolving provider landscape.

### Industry Infrastructure

Providers have raised concerns that bad actors are damaging the infrastructure and reputation of the industry.

### Clinical Standards

Toolkit recommendations reflect existing clinical standards, practice guidelines and appropriate guardrails.

It does not establish standards of care or direct clinical judgement

# An overview of Applied Behavior Analysis

## Evidence-Based Therapy

ABA is an evidence-based therapy for ASD. It should be recommended as a treatment modality based on thorough, individualized assessment.

## Individualized Intensity & Need

The intensity, duration, and frequency of ABA services will vary directly depending on the individual beneficiary's unique clinical needs.

## Ongoing Data Collection

Continuous data collection and rigorous analysis are core hallmarks of effective and high-quality ABA intervention.

## Role of the QHP (Behavior Analyst)

A Qualified Healthcare Professional makes clinical decisions based on environment, antecedent/setting events, and how responses are strengthened or weakened by consequences.

# Varied approaches

## Scientific Foundation

ABA is based on the scientific study of behavior, and applied to real world situations.

## Individualized Domains

ABA is highly individualized, addressing multiple learning domains such as communication, social interaction, self-care, play, and daily living skills.

## Real-World Integration

ABA may be delivered across environments and is often integrated into the real world environment and everyday routines.

## Motivation & Effective Learning

Identifying what motivates someone, and how they most effectively learn, are critical components to success.

## Observational Learning

Includes teaching an individual how to attend to and learn from their environment; a hallmark of how neurotypical children gain skills through observational learning.

# Focused versus Comprehensive Services

## Focused Services: typically less than 25 hours per week

- Fewer hours per day
- Fewer days per week
- Focused on fewer learning domains

## Comprehensive Services: typically more than 25 hours per week

- More hours per day
- More days per week
- Focused globally on multiple domains related to the qualifying diagnosis

### Service Intensity Note

The intensity of services will vary depending upon a number of key factors.

# Considerations related to treatment intensity

**01**

age

**02**

duration in service

**03**

symptom severity level

**04**

safety risks or concerns

**05**

occurrence of harmful, dangerous, or destructive challenging behavior

**06**

current levels of performance on norm or criterion referenced assessments

**07**

deficits in learning domains directly related to the qualifying diagnosis (e.g., social communication, rigid routine oriented behaviors & insistence on sameness)

# A note on Profound Autism

## Extended Duration & Intensity

Individuals with Profound Autism are likely to require many more hours of ABA for a much longer period of time than their peers.

## Flexible Service Models

Individuals with Profound Autism may require either focused or comprehensive ABA services.

These needs may change (increase or decrease) over time.

# Goal of ABA

## Ultimate Objective

Behavior Analysts want to work themselves out of a job.

## Transition & Support

The goal is to transition the individual with autism to a natural setting (home, school, community) with the greatest number of skills possible, so that they can effectively advocate and communicate for themselves.

Parents and caregivers should also participate to gain skills they need to help support their child's continued growth, development, and ability to participate in the home and community.

Parents and caregivers are not a substitute for skilled professionals.

## Core Philosophy

ABA is not about curing autism or changing the person.

# Caregiver engagement

Caregiver engagement is a critical component to success. It looks different for every family and may change over the course of services. Caregiver engagement must be individualized.

## Structured Meetings

Meetings to discuss, role play, and practice how to respond in critical situations.

## Home Visits

Visits to the family home to work through specific activities or scenarios in the natural environment.

## Community Settings

Going to the store, park, or restaurant to address concerns directly where they occur.

## Brief Check-Ins

15-minute touchpoints at drop-off or pick-up to prepare, debrief, problem-solve, or gather details.

# Exceptions for children in foster care

## Broader Caregiver Definition

Caregivers may need to be defined more broadly than a parent or legal guardian.

## Targeted Flexibility

Flexibility must be available for children with the greatest risks; this includes children in foster care.

## Adapted Requirements

Diagnostic requirements and caregiver participation guidelines may require additional flexibility.

# Collaboration with other providers

## Multidisciplinary Network

Behavior Analysts want to collaborate with other providers; including teachers, occupational, speech, or physical therapists, counselors, social workers and various medical providers.

## Holistic Context

Children don't live in a vacuum; they live in a complex environment.

## Integrated Care

Integrated, collaborative care is the best care.

The MCO or Medicaid agency may be able to assist with care coordination through conflict free case management activities.

# Early Intervention

## Early Access & Outcomes

Early diagnosis or screening to identify a child at risk can result in early access to therapeutic services, including ABA.

The sooner a child enters medically necessary care, the better their outcome and ability to transition to school services.

## Critical Intervention

Early diagnosis is critical to ensure access to early intervention services.

Early intervention services occur during a period of critical development and may result in more rapid gains.

## Provisional Diagnosis

Consider provisional or at-risk diagnosis categories to open doors to treatment more quickly during **this** critical period of development.

# Diagnostics

## Access to Care

A formal diagnosis often opens the doors to ABA and other autism-specific services.

## Provisional Eligibility

Diagnostic wait times vary, and children at risk of an ASD diagnosis may be given provisional eligibility up to a specific age (e.g., 3 or 6 years of age).

## Qualified Providers

Diagnosis should be completed by a qualified provider, often a physician or psychologist.

State law may allow psychological associates (e.g., master's level psychologists) to participate. An educational eligibility determination (FIE) endorsed by a qualified diagnosing provider may also speed access to care.

# CDE requirements

## Core Evaluation Standard

Comprehensive Diagnostic Evaluations should align with the current edition of the DSM at the time of diagnosis.

The CDE should include a thorough review of medical records, family history, and interview with the parent.

## Assessment Tools

- Include an Autism-specific assessment tool, based on the diagnosing provider's clinical knowledge, expertise, and training.
- Include a measure of adaptive behavior such as the Vineland or ABAS-3.

## Differential & Severity

- Rule out other possible diagnoses.
- May include a symptom severity level, if the diagnosing provider feels confident assigning such a level based on the child's age.

# Updated Diagnostics

## Core Principle: Re-Diagnosis Is Generally Unnecessary

Once a child is diagnosed with autism, it is unlikely they will lose the diagnosis over time. Routine re-diagnosis should not be required.

### Valid Reasons for Update

An updated diagnosis can assist with treatment planning and referrals or recommendations for additional services in cases of:

- A significant change in symptomatology
- Suspicion of a co-occurring diagnosis or condition

### Standard Guidance

Otherwise, obtaining an updated diagnosis is unnecessary.

Providers and payers should not mandate repeated comprehensive diagnostic evaluations as a prerequisite for continuing standard ongoing care unless clinical indicators warrant it.

# Updated Referral

## Annual Referral Guidance

Obtaining an annual referral for ABA, or other autism services, from a Medicaid enrolled and qualified ordering, rendering, or prescribing provider (OPR) is appropriate.

### Verify Medical Necessity

The OPR provider can verify that ABA continues to be a medically necessary and appropriate service for the beneficiary.

### Assess Progress & Satisfaction

The OPR provider can identify if parents are satisfied with services and if there have been meaningful improvements over time.

### Coordinate Care

The OPR provider can help coordinate care if conflict-free case management services are not available through the Medicaid agency or MCO.

# Developing an Initial Treatment Plan

## Assessment & Eligibility Determination

After diagnosis and referral, the ABA provider will conduct a separate assessment to determine eligibility for ABA services, and identify appropriate goals and objectives for the initial treatment plan.

### Records Review

Review of CDE, referral, medical records & other treatment plans/ IEP

### Parent Interview

In-depth parent or caregiver interview to gather clinical history and priorities.

### Direct Observation

Direct observation of the client across relevant natural environments.

### Direct Assessment

Direct assessment utilizing norm & criterion referenced instruments.

### Functional Assessment

Functional assessment conducted for age inappropriate challenging behaviors.

# The Treatment Plan

## Background & Diagnostic Information

Will include all relevant background, diagnostic and medical information.

## Assessments & Results

- Performance on norm & criterion referenced assessments
- Results of the functional assessment

## Areas of Concern & Goals

- Identified areas of concern per parent report & observation/assessment
- Initial goals & objectives directly related to qualifying diagnosis & symptomatology
- Parent or caregiver goals

## Case Conceptualization

- Identify specific number of hours requested & why medically necessary for beneficiary
- Rationale on why more hours are too many and fewer hours are not enough

## Transition & Discharge

- Transition & Discharge planning

# Initial Treatment Request

## Step 01

### Plan & Recommendations

Develop an individualized treatment plan and treatment recommendations

## Step 02

### Guardian Review

Review with parent or legal guardian

## Step 03

### Goal Refinement

Modify and goals or objectives to reflect what is socially significant and meaningful, based on legal guardian feedback

## Step 04

### Treatment Intensity

Discuss recommended treatment intensity  
Agree or disagree  
Adjust plan accordingly

## Step 05

### Consent & Signatures

Obtain consent to treat and appropriate signatures

## Step 06

### Prior Authorization

Submit treatment request through prior authorization process.

# Subsequent Treatment Plans

Following the initial treatment plan, each subsequent authorization request should include the following information:

## 01 | Active & Mastered Goals

Updated data for each active or mastered goal or objective.

## 02 | Goals that were not Introduced

Rationale for why any goal/objective was not introduced during authorization, and when it will be introduced.

## 03 | Progress Data & Graphs

Progress data on all active goals (including graphs with event and phase change lines for analysis and technician direction).

## 04 | Updated Assessments

Updated observations, interview info, and norm/criterion assessments at publisher cadence (e.g., 6m, 1y, 2y).

## 05 | Transition & Discharge

Updated transition and discharge plans to outline long-term progress expectations.

## 06 | Background, Case Conceptualization & treatment intensity

Updated background information, case conceptualization, and rationale for treatment intensity and specific requested units across CPT codes.

# A note on treatment intensity

## 01 | Individualized Care

Treatment requests must be individualized.

40-hour per week requests across the board are not best practice.

## 02 | Flexible Intensity

Intensity needs vary significantly by individual.

Some individuals may require 40 hours per week; others may require as few as 5 hours per week.

## 03 | Direct 1:1 & Group

Generally, treatment intensity focuses for direct 1:1 and group services.

97153

97154

\*\*0373T

\*\*97159/ 97160

\*\* 2019 v 2027 CPT corset changes

## 04 | Group Service Role

Typically used for :

Generalization and maintenance.

To address

social & communication goals,  
transition or discharge services

# Provider Types

## 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

# Behavior Technicians

## 01 | Credential Mandates

Not every state Medicaid agency requires technicians to obtain a credential.

## 02 | State Allowances

Some state Medicaid agencies allow for behavior technicians.

## 03 | CMS Guidelines

The CMS toolkit recommends that states establish clear educational, experiential, and ongoing oversight requirements for behavior technicians.

## 04 | Best Practice

Requiring technicians to obtain a credential (RBT, ABAT, BCAT) is the easiest way to ensure these requirements are met.

# Supervision

## 01 | Primary Objectives

Processes through which a QHP ensures the supervisee:

- **Competence & Ethics:** Practices in a competent, professional, and ethical manner.
- **Compliance:** Engages with and follows employer policies and procedures.
- **Skill Growth:** Continues developing job knowledge and skills.
- **Personal Support:** Receives support to cope with role stressors and demands.

## 02 | Credentials & Ethics

Supervision activities also facilitate compliance with professional requirements:

- **Credentialing Standards:** Enables supervisor and supervisee to obtain or maintain paraprofessional or professional credentials (certification or licensure).
- **Ethical Duties:** Fulfills core ethical responsibilities required within the profession.

## 03 | Billing & Reporting

Guidelines for reporting supervision to health plans:

- **Indirect Services:** Activities not involving direct patient delivery are generally not reportable/billable via CPT codes (some payers permit HCPCS/other codes).
- **Direct Delivery:** Services involving direct patient care to maximize outcomes may be billable and also satisfy supervision requirements.
- **Reporting Rule:** Only direct service delivery should be reported to the health plan.
- **Note:** Changes are coming with the 2027 CPT code set.

# Direction

## 01 | Core Definition

QHP direct monitoring of treatment delivery:

- **Direct Monitoring:** Refers to the QHP directly monitoring the delivery of treatment to a patient by a behavior technician.
- **Primary Focus:** Ensuring treatment protocols are implemented correctly to maximize benefit to that patient.
- **Face-to-Face Rule:** Time reported and billed must be face-to-face time with the patient.

## 02 | Key Activities

Direction includes, but is not limited to:

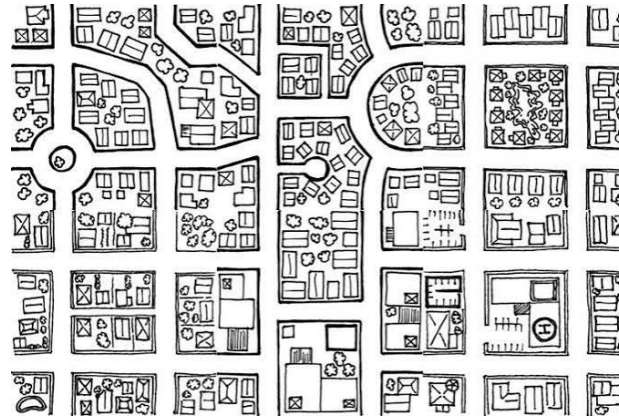
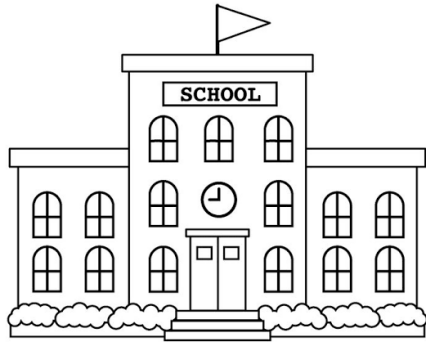
- **Observation:** Frequently observing the technician implementing the patient's protocols with the patient.
- **Instruction & Feedback:** Providing instructions and confirming or corrective feedback as needed.
- **Demonstration:** Demonstrating correct implementation of new or modified protocols while technician observes.

## 03 | Billing & Reporting

Reporting rules under CPT codes:

- **Code 97155:** Used to report QHP direction (adaptive behavior treatment with protocol modification).
- **Code 97153:** Technician's time is separately reportable under 97153 (administered under QHP direction).
- **Requirement:** All reported and billed time must be face-to-face time with the patient.

# Location of Service



CMS toolkit recognizes the importance of individualized service locations, based on need and medical necessity.

# Soft Caps

## 01 | Utilization Management

### Core Permissibility Standards:

- **Permissible Tool:** Soft caps are permissible as a utilization management tool.
- **No De Facto Limits:** May not function as a defacto hard cap.

## 02 | Medical Necessity

### Exceptions & Individualized Care:

- **Method to Exceed:** Must include a method to exceed subject to medical necessity.
- **Individualized Criteria:** Medical necessity must be individualized.
- **EPSDT Mandate:** EPSDT requirements still apply.

## 03 | Federal Regulations

### Rationale & Disclosure Rules:

- **Specific Rationale:** Federal regulations require that a health plan provide a specific rationale why a service is not medically necessary.
- **Required Tools:** Must include all available tools, guidelines, or medical necessity criteria used when a denial is issued.
- (42 CFR 438.404(b)(1) & 42 CFR section 438.404(b)(2), respectively)

# Clinical Documentation

## 01 | Core Documentation Standards

### Session Notes & Treatment Alignment:

- **Service Delivery:** Session notes must accurately reflect the actual delivery of service.
- **Medical Necessity:** Documentation must explicitly show that services were medically necessary.
- **Plan Alignment:** All rendered interventions must align directly with the established treatment plan.

## 02 | Consecutive / Back-to-Back Units

### CMS Scrutiny & Rationale Requirements:

- **CMS Guidance:** CMS toolkit notes that multiple back-to-back units of service may be of concern.
- **Clinical Rationale:** Applies when an individual lacks skills to remain safe or actively engaged during therapeutic "breaks".
- **Required Documentation:** Both the treatment plan (case conceptualization) and subsequent session notes should reflect this necessity.

Generally Accepted Standards of Care

INDEPENDENT. NONPROFIT. EVIDENCE BASED.

**CASP is a 501(c)(6) nonprofit trade association whose sole membership requirement is the use of evidence based practice.**

Not a vendor. Not an insurer. Not a single provider group.

Its mission is to establish and advocate for best practices grounded in peer reviewed science.

CASP publishes standards, not products. The guideline development process exists so that funders, regulators, and providers can work from one evidence based reference, rather than each relying on a different informal or proprietary set of criteria.

# What the Guidelines Are

A reference for deciding whether ABA is medically necessary, efficacious, and cost effective treatment for autism spectrum disorder, and for planning, authorizing, and evaluating that care at every stage.

Healthcare funders and managers

Service providers

Regulatory bodies

Consumers and families

## What's inside

- Definitions of medical necessity and generally accepted standards for ABA
- Essential practice elements: assessment, treatment planning, qualified providers, and clinical supervision
- Focused and Comprehensive treatment models, including typical intensity ranges
- Treatment settings, caregiver involvement, and coordination of care across providers
- Discharge and transition planning

1st edition, 2012 (Behavior Analyst Certification Board) → transferred to CASP, 2020 → 3rd edition, 2024

# How the 3rd Edition Was Built

A structured, multi step revision, not a single author's opinion

## 1. Comprehensive literature review

The steering committee, working with subject matter experts, reviewed the peer reviewed research published since the prior edition. Every existing recommendation was checked against that evidence, not simply carried forward.

## 2. Steering committee and subject matter experts

Board certified behavior analysts, researchers, physicians, and public policy experts served on the steering committee or contributed as subject matter expert reviewers throughout development.

## 3. Practicing clinician and funder input

Draft language was weighed against real utilization review scenarios and treatment plans, so the document reflects how ABA is actually authorized and delivered, not just how it is described in theory.

## 4. Public comment and external review

The draft was opened to a public comment period so the wider field, not only the steering committee, could weigh in before the document was revised again and finalized in 2024.

CASP's steering committee, working closely with subject matter experts across research, clinical practice, and public policy, led development of the 3rd edition.

# The Strength of the Evidence Base

The ABA Practice Guidelines are not a policy position or a single organization's preference. They are built the way clinical practice guidelines are built across medicine, an expert panel working systematically from the published evidence, with structured opportunities for the field to weigh in before anything is finalized.

- Grounded in the peer reviewed literature on applied behavior analysis and autism spectrum disorder, spanning hundreds of published studies
- Recommendations are not simply carried forward from edition to edition, each one is checked against current research before being retained, revised, or removed
- Drafted by subject matter experts across research, clinical practice, and public policy, then reviewed by a wider panel before release
- Opened to public comment so the broader field, not only the drafting committee, had a chance to weigh in before the document was finalized

**This is the same evidentiary discipline used in professional practice guidelines throughout medicine, not something informal or unique to ABA.**

# Virginia Recognizes This

## INSURANCE LAW, VA. CODE § 38.2-3412.1

***"Consensus guidelines and recommendations of nonprofit health care provider professional associations and specialty societies"***

That definition governs medical necessity determinations, and insurers may not apply criteria that go beyond, conflict with, or are stricter than it.

## DMAS REGULATION, 12VAC30-60-181

***"Apply the ASAM criteria to review and coordinate service needs"***

That is the standard DMAS already uses for Medicaid substance use treatment, published by the American Society of Addiction Medicine, a nonprofit medical specialty society.

## Aligned With This Workgroup's Own Charge

### ITEM (IV)

*Evaluate utilization management tools that align with national clinic practice guidelines promulgated by independent national nonprofit organizations.*

The guidelines already meet that description.

- The guidelines set individualized, evidence based medical necessity criteria, developed by a nonprofit trade association through peer review and public comment
- Focused treatment ranges 10 to 25 hours weekly, comprehensive treatment 25 to 40, set case by case rather than by a fixed number

Item (iv) of this workgroup's charge already describes this approach: evaluating utilization management tools that align with national **clinical** practice guidelines promulgated by independent national nonprofit organizations.

# Public Comment

# Thank you!