ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

ABHW Policy Recommendations for Applied Behavioral Analysis (ABA)
Updated 6/18/26

Policy Recommendation: Establish reinforced credentialing

- **Credentialing:** CMS should establish uniform national credentialing standards and other provider requirements as a condition for Medicaid coverage of ABA services. This national credentialing framework for ABA providers should include licensure verification, comprehensive background checks, and organizational credentialing for provider agencies delivering ABA services.

Policy Recommendation: Establish supervision requirements

- **Establish Provider Standards/Supervision.** CMS should establish standards regarding supervision and delegation of treatment to Registered Behavior Technicians (RBTs) and other providers.

    - CMS should also establish supervision ratios for RBTs based on evidence to ensure care is consistently provided in accordance with coverage criteria**.**
    - Mandate evidence-based caseload limits for supervising BCBAs to ensure adequate clinical oversight and treatment quality. (duplicative with above but sharing for Policy Council discussion).

- NPI: The standards should include a requirement for RBTs to obtain individual National Provider Identifiers (NPIs) and enroll as rendering providers under supervising clinicians to improve transparency and oversight.
    - NPIs are a standard requirement across the healthcare system and are fundamental to transparency, accountability, and program integrity. While obtaining an NPI creates some administrative burden, the ability to identify the individual rendering services is essential for effective reimbursement oversight and fraud prevention. CMS should streamline NPI processes where possible, but NPIs should remain a requirement for ABA providers, as they are for other healthcare providers.
    - To minimize administrative burden, CMS should allow bulk or organizational NPI registration processes (e.g., group submission of RBTs), pre-populate provider enrollment information using existing state licensure and credentialing data, and align NPI maintenance requirements with existing Medicaid provider enrollment cycles to avoid duplicative administrative processes. CMS should also pursue a phased implementation approach by prioritizing NPI assignment for new providers before existing providers, focusing initially on high-risk or high-volume provider segments, and allowing reasonable compliance grace periods.

- NPIs should be integrated into claims processing and provider credentialing systems and supported through automated validation tools to reduce manual oversight and administrative burden. Requirements should remain narrowly tailored to providers directly involved in billing and care delivery, including rendering clinicians (e.g., BCBAs) and technicians delivering billable services (e.g., RBTs).

Policy Recommendation: Establish Guardrails to Demonstrate Clinical Independence in ABA Assessment and Service Delivery

- **Enhanced Oversight for Same-Entity Evaluation and Treatment:** Providers that both evaluate and deliver services should be subject to additional documentation requirements, periodic audits, and/or review requirements to ensure recommendations are clinically justified and free of conflicts of interest. ABHW recognizes that in some areas there may be a limited supply of qualified ABA providers, making separation of evaluation and treatment functions difficult. We want to ensure that clinical risks and provider availability are considered; however, when a single entity controls both the recommendation and the delivery, the recommendation must be independently verifiable, clinically justified, and free from any potential or actual conflict of interest.
  - **Conflict-free arrangements** are those in which assessment, treatment planning, and referral decisions are made independently and are not influenced by financial interests, organizational relationships, or incentives tied to service utilization. A conflict-free provider arrangement should demonstrate financial independence from treatment volume, clinical decision-making that is free from undue influence, operational separation of leadership or management functions that could affect care recommendations, and referral practices that preserve patient choice and avoid steering individuals to affiliated providers. When the same entity performs both evaluation and treatment functions, additional oversight or documentation is necessary to demonstrate clinical independence and mitigate potential conflicts of interest.

Policy Recommendation: CMS should work with stakeholders to develop evidence-based, standardized clinical and quality measures that reflect real-world practice and support improved outcomes. This effort should also include establishing clear, consistent best practices for treatment planning, measurable goals, ongoing reassessment to ensure clinically appropriate care, and standardized definitions for CPT codes. The CPT code definition should include clinical documentation requirements for higher reimbursement codes.

- Establish a national ABA medical necessity framework or recognized set of criteria to reduce variation across states, managed care organizations, and provider organizations, and promote more consistent coverage determinations.
- Establish service delivery standards across home, school, clinic, community, and telehealth-based ABA settings to promote consistency in quality, documentation, and treatment expectations.
- Require interdisciplinary care coordination and documentation with physicians, psychologists, speech-language pathologists, occupational therapists, schools, and other relevant providers when clinically indicated to ensure clear delineation of treatment responsibilities and avoid duplication of services.

Require Independent Accreditation of ABA Provider Organizations as a Condition of Medicaid Participation

- Recommend CMS, in coordination with the Office of the Inspector General (OIG), to establish a national accreditation requirement for ABA group and agency providers participating in Medicaid, with a phased compliance runway of 24 to 36 months.
- Adopt a "deeming" framework analogous to the one used for Medicare Conditions of Participation (CoPs), under which CMS recognizes specific accrediting bodies (e.g**.,** BHCOE, CARF, Joint Commission) whose standards meet or exceed federal minimums for clinical governance, supervision, outcome measurement, ethics, and billing compliance.
- ABHW members have concern with the inconsistent application, oversight, and accountability associated with accreditation standards. While accreditation plays an important role over time, we believe CMS should prioritize establishing clear federal standards, policies, and expectations for ABA services and providers rather than relying solely on the current accreditation system.

Require Defined Discharge Planning and Clinical Progression Standards in ABA Treatment Plans:

- Recommend CMS to require, in every Medicaid-funded ABA treatment plan and at every reauthorization, (i) measurable, time-bound clinical goals, (ii) defined discharge or step-down criteria tied to the attainment of those goals, and (iii) an explicit plan for parent or caregiver training sufficient to support generalization and maintenance of gains.
- Establish minimum data collection and reporting standards requiring ABA providers to use standardized, objective measures and report treatment outcomes, functional improvement, caregiver engagement, and discharge outcomes to health plans and regulators.
- Require documented clinical progress against treatment-plan goals at each reauthorization, with stagnation over a defined period (e.g., two consecutive reauthorization cycles without measurable progress) triggering either substantive

modification of the treatment plan, independent reassessment by an unaffiliated BCBA, or planned transition to a lower-intensity service modality.

- Establish that recurring authorization of high-intensity services for patients who have plateaued, in the absence of a documented clinical rationale and modified plan, constitutes a program-integrity concern subject to Unified Program Integrity Contractor (UPIC) review.
- Require that parent and caregiver training (CPT 97156) be incorporated into every treatment plan at clinically appropriate levels, with documentation of caregiver participation and skill acquisition. Sustained non-participation in caregiver training without a documented barrier should weigh against continued authorization of high-intensity services.
    - Strengthen caregiver training requirements by requiring documented caregiver goals, measurable competency benchmarks, and demonstrated skill acquisition rather than simply encouraging caregiver participation.
- Direct CMS, in coordination with clinical specialty societies, to develop model discharge and step-down criteria for ABA that state Medicaid agencies may adopt or adapt, including standardized criteria for what constitutes "meaningful progress" against goals.

Recommendation: Anchor Authorized Treatment Intensity to DSM-5-TR Severity Level and Evidence-Based Practice Parameters

- Recommend CMS to require, as a condition of payment for ABA services, that every initial assessment and every reauthorization document (i) the patient's current DSM-5-TR severity level for ASD, assessed separately for social communication and for restricted, repetitive behaviors, and (ii) the patient's functional impairment as measured by standardized, validated instruments.

Recommendation: ABA Considerations Under the MHPAEA Parity Framework

- ABHW and our member plans have been strong supporters of the Mental Health Parity and Addiction Equity Act (MHPAEA) since its inception and remain deeply committed to ensuring equitable coverage of mental health (MH) and substance use disorder (SUD) benefits. Our members have worked tirelessly over the past 17 years to implement parity for behavioral health services. As we continue working to advance parity compliance, we wanted to highlight some unique challenges associated with the application of parity requirements to Applied Behavior Analysis (ABA) services.
- ABA is often delivered as a high-volume, ongoing outpatient service, making it difficult to compare to traditional outpatient medical/surgical services, which are typically lower-volume, episodic, and non-recurring. As a result, there are few

comparable physical health services with similar treatment intensity, duration, frequency, and utilization patterns, making it difficult to identify appropriate medical/surgical comparators and evaluate utilization management practices, such as prior authorization, under the current parity framework.

- New regulations could explicitly permit health plans to apply soft limits, and provide guidance on acceptable sources that may be used to establish thresholds for authorization and other utilization management requirements.