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Autism Care Should be Measured by Outcomes, Not Hours | Guest Column

The Centers for Medicare & Medicaid Services recently took a welcome step toward bringing greater accountability to one of the fastest-growing areas of Medicaid spending: Applied Behavior Analysis, or YABA, for children with autism.

CMS **released** a new toolkit to help states strengthen oversight, combat fraud, waste, and abuse, and ensure children receive medically necessary and appropriate care. The action comes amid extraordinary growth. Between 2021 and 2025, Medicaid and CHIP spending on ABA increased **421%**, while the number of children with an autism diagnosis receiving services grew **67%**.

With Medicaid autism therapy spending rising more than 400%, CMS's push for stronger ABA oversight and outcomes-based autism care is a critical step toward reducing fraud, improving treatment quality and ensuring children receive medically necessary services, writes Debbie Witchey.

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The action also comes amid high-profile instances of waste, fraud and abuse. HHS's Office of Inspector General has **identified** more than $197 million in improper ABA payments across just four

states. Federal prosecutors have brought multimillion-dollar cases involving autism services, including allegations of billing for services that were never provided.

All of this should force us to ask whether increased spending is translating into better care for children. This is why CMS is right to act: Rapid growth in ABA utilization and spending makes stronger clinical standards, accountability and program integrity increasingly important.

The problem is that ABA has too often been judged by the amount of treatment delivered rather than the results it produces. Recommendations of 20, 30, or even 40 hours a week can become the starting point, even though children with autism have vastly different needs. Yet treatment intensity should be driven by each child's clinical needs and demonstrated progress, not by a default expectation about how many hours of ABA a child should receive.

The evidence gives us good reason to question the assumption that more hours necessarily mean better outcomes. A 2024 JAMA Pediatrics analysis examined 144 studies involving more than 9,000 young autistic children. Researchers assessing early childhood autism interventions found little evidence that greater intervention intensity was associated with greater benefit, challenging the assumption that more treatment hours result in better outcomes. Another study from 2020 found that ABA did not clearly improve most of the areas researchers examined, including daily living skills, overall autism symptoms and repetitive behaviors.

The answer is not to replace one arbitrary metric with another. A high-intensity treatment recommendation should explain why that child needs that many hours, what meaningful improvement is expected and how progress will be measured. If the child improves, the treatment plan should be adjusted accordingly. If progress stalls, authorizing more of the same should not be the default. It’s also important to leave room for innovation so that new, potentially better treatments can be available to augment or replace ABA if they prove more effective.

CMS is right to increase ABA oversight and focus autism care on outcomes, ensuring effective treatment, reducing waste, and measuring success by results rather than therapy hours, writes Debbie Witchey.
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That is where CMS's new effort can make a lasting difference.

Good oversight means more than catching fraudulent bills after the money is gone. Providers should meet consistent credentialing standards. Registered behavior technicians, who provide much of the direct care, should receive meaningful clinical supervision. Treatment should be coordinated with physicians, psychologists, schools, speech-language pathologists and occupational therapists rather than operating in a silo.

There should also be safeguards when the same organization evaluates a child, recommends how many hours of treatment the child needs, and then gets paid to provide those hours. That arrangement creates an obvious financial incentive that warrants transparency and oversight.

Most importantly, we need to get serious about outcomes. Treatment plans should have measurable goals from the beginning. Progress should show up in a child's life outside the therapy room. Reauthorization should be informed by measurable progress, maintenance of important functional gains or other documented clinical benefit. Fraud wastes taxpayer dollars. Unnecessary treatment wastes something even more precious: a child's time.

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