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Of Behavioral Health & Family Services Providers

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ODM CSI ABA Rule Comments
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The Ohio Council of Behavioral Health & Family Services Providers (The Ohio Council) appreciates the opportunity to provide comments and feedback on the changes in the Medicaid coverage for Applied Behavior Analysis (ABA) Rules. The Ohio Council has had the opportunity to review the proposed rules and while many of the proposed changes are acceptable, we would like to provide feedback on proposed changes that will negatively impact practitioners, businesses, and most importantly those in need of ABA services. We appreciate the collaborative efforts to build this important service.

Below are our specific comments on the OAC 5160-34-01.

1. (A)(1) identifies that the term "independent practitioner" and defines how the term will be used in the rule, but three different terms are used throughout this rule package. (C)(1) uses the term "independent adaptive behavior service practitioner" as well as OAC 5160-34-02 in paragraphs (B)(2), (B)(3)(a), and (B)(5), in OAC 5160-34-03 in paragraph (C)(2)(c) and used exclusively in Appendix A. Consistent language in this rule package is essential to ensure clarity, uniform interpretation, and effective implementation of ABA services. Clear and standardized terminology minimizes the risk of miscommunication, reduces ambiguities, and fosters alignment among service providers, policymakers, and beneficiaries. This consistency is particularly crucial in complex systems, where varying interpretations can lead to discrepancies in service delivery, compliance challenges, and unintended outcomes. By adopting precise and universally understood language, regulatory rules can better support transparency, accountability, and equitable application, ultimately enhancing the quality and efficacy of the policies they govern.

   Recommendation: Ensure uniformity in terminology throughout the rule package. This process should involve identifying and defining key terms in an accompanying glossary, aligning language with existing regulatory frameworks, and ensuring consistency across all sections of the proposal. Additionally, input from subject matter experts and stakeholders should be solicited to validate the clarity and accuracy of the terms used. Establishing a clear, standardized language will mitigate potential misinterpretations, promote uniform application, and enhance the overall coherence and effectiveness of ABA services.

2. The requirements outlined in (A) of this rule as currently written would require a separate and additional certification to provide ABA services that practitioners of various licenses already have within their individual scope of practice based on completion of training and have been utilizing for years. This overly restrictive requirement represents an unfair limit of practice for psychologists, counselors, social workers, and marriage and family therapists, and other professionals who likely will not meet the proposed board certification requirements in (A)(1) and state certification in (A)(2). Ohio Revised Code Section 4783.02 states the behavioral analyst credential is not required in paragraph (B)(1) when, "An individual licensed under Chapter 4732. of the Revised Code to practice psychology, if the practice of applied behavior analysis

engaged in by the licensed psychologist is within the licensed psychologist's education, training, and experience" and (B)(2) when "an individual licensed under Chapter 4757. of the Revised Code to practice counseling, social work, or marriage and family therapy, if the practice of applied behavior analysis engaged in by the licensed professional counselor, licensed professional clinical counselor, licensed social worker, or licensed marriage and family therapist is within the licensee's education, training, and experience". This statutory language was intentionally intended to preserve the scope of practice and limit unnecessary regulatory requirements associated with dual credential requirements. As drafted, requiring this specific ABA board or state certification for current and future practitioners will result in increased expenses to both individuals and organizations to provide services that are currently within their scope of practice and deter entry level workers solely due to board certification requirements. The behavior analyst certification board requirement also, and most importantly, limits the availability of services to those individuals who would benefit from ABA services. Further, these rules may disrupt existing treatment and negatively impact patient care.

Recommendation: Add language in (A)(1) to include as eligible independent practitioners those licensed under the CSWMFT board or State Board of Psychology to provide ABA services when they have a personal competency within their scope of practice, which is determined by their education, training and practice experience. Additionally, add language in (A)(2) to recognize those licensed under the CSWMFT Board with dependent licenses when they have a personal competency within their scope of practice as determined by education, training, and practice experience.

3. Paragraph (C)(2) as currently written lacks clarity on whether community behavioral health centers (CBHC) are eligible "organizational providers" that can deliver ABA services. Individuals can currently receive ABA treatment along with other mental health services from CBHCs. ABA is a neurocognitive condition that commonly benefits from ABA as well as other mental health service interventions. Today, families can access can and do access both services through a CBHC, but under the proposed rule, it's unlikely that would be continued which will be disruptive to those individuals and their families and may have unintended consequences that limit access to services particularly in rule and underserved areas. Families should not have to choose one service over another if both are necessary to support behavioral and emotional functioning. This may also raise parity concerns as it could be an NQTL that impacts network adequacy. Finally, ODM should not exclude CBHC as an organizational provider of ABA services due to challenges with IT system configuration because services and eligible practitioners create complexity. The demand for ABA and co-occurring mental health care is growing, particularly for youth that are multi-system involved, and systems must address the complexity not limit access to care.

   Recommendation: In (C)(2)(c) include Community Behavioral Health Centers (CBHC) to the list of organizational providers and clarify they can provide 9000 ABS codes and/or CBHC services such as CPST or TBS.

Below are our specific comments on the OAC 5160-34-02.

4. We appreciate the ODM's recognition of all adaptive behavior service CPT codes and its efforts to align service names and descriptions with the ABS CPT codes for consistency. However, it is important for this rule to clarify whether ABA coverage will be limited to individuals under the age of 21, as indicated in 5160-34-03 (C)(1)(a). Autism Spectrum Disorder (ASD) does not end at age 21, and adults with ASD may require periodic access to Focused ABA Interventions services

to maintain stability or develop essential skills for daily functioning, particularly when other interventions have not achieved the desired outcomes. According to the Mental Health Parity and Addiction Equity Act (MHPAEA), there is no age limit for accessing ABA treatment for ASD, and adults with ASD are entitled to request and be offered a medical necessity determination for ABA treatment under the protections of the law.

Recommendation: In (A) clarify this coverage is specifically for the ESPDT delivery of ABA and add language extending coverage for adults with ASD will be offered an individualized medical necessity determination through their enrolled managed care plan (MCO). MCOs are required to follow MHPAEA law.

5. (B)(6) and (C)(2)(b)(vi) refer to parent and caregiver; however, caregiver is undefined, and we are concerned this open interpretation could be unnecessarily limiting.

   Recommendation: In (C), add a definition of caregiver to include legal guardians, grandparents and other non-parent/guardian family members, foster parents, children's services case managers, teachers, education intervention specialists, direct service professionals delivering home health care or the developmental disability waivers, and other service professionals working with the child that could benefit from training found in Adaptive Treatment Guidance (97156).

Below are our specific comments on the OAC 5160-34-03.

6. (B)(1) defines comprehensive diagnostic assessment elements including the necessity of the use of validated psychometric tools as approved by the Department. We support the use of standardized autism assessment tools. However, the "approved" psychometric tools were not included in the rule proposals or appendixes so the details of what those are and who can administer them and how they are administered are unclear. Further, the Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR), the authoritative guide to diagnosis of mental disorders in psychiatry and psychology, notes that the diagnosis of ASD is a clinical diagnosis that does not require the use of additional testing modalities. A variety of practitioners of various license types can diagnose ASD within their scope of practice, but arbitrarily limiting the psychometric tools may create a cascading limit on which practitioners able to diagnose ASD in order to receive services under this rule. It may create a conflict with (C)(2)(c) which appears to recognize a wide range of professionals with a scope of practice that can diagnosis ASD, including pediatricians, family medicine physicians, psychologists, and those independently licensed by the CSWMFT Board. We agree that early diagnosis is essential so this rule should take steps to extend maximum flexibility to increase accessibility to early identification and treatment which is vital to optimizing positive outcomes, particularly in less resourced communities where health inequities exist.

   Recommendation: In (B)(1), remove "and approved by the department" to allow for clinical discretion on the selection and use of standardized assessment tools for diagnosis by qualified clinicians demonstrating competency within their scope of practice, which is determined by their education, training and practice experience and consistent with (C)(2)(c) to meet the individualized needs of the individual.

7. (B)(2) provides a definition of ABA Behavior Treatment Plan and how it's to be interpreted in the rule. Like feedback on OAC 5160-34-01, clear and standardized terminology minimizes the risk of miscommunication, reduces ambiguities, and fosters alignment among service providers,

policymakers, and beneficiaries. ABA Behavior Treatment Plan, treatment plan, individualized ABA behavior plan, and initial treatment plan are used throughout the proposed rule package including OAC 5160-34-02 paragraphs (B)(2), (B)(4), and (C)(1)(b)(vii).

Recommendation: Ensure uniformity in terminology throughout the rule package, and in this case, we recommend use of ABA Behavioral Treatment Plan throughout this rule.

8. As drafted, (C)(1)(c) delays coverage until such time as a comprehensive diagnostic assessment is completed. Currently, many families experience long wait times to receive the hours long comprehensive diagnostic assessments defined in this rule; however, there are reliable screening tools and routine psychiatric diagnostic assessments that can reliably result in the rendering of a diagnosis of ASD in order to initiate treatment, including ABA, and provide the medical necessity for services. Limiting coverage until after a comprehensive diagnostic assessment is completed may be another NQTL as CMS has previous issued communications that starting treatment services, including ABA, is based on medical necessity and a referral from a licensed practitioner within their scope of practice regardless of whether a formal, comprehensive diagnostic evaluation is available for review or not.

   Recommendation: In (C), add language that authorizes coverage when a reliable ASD screening tool or psychiatric diagnostic assessment has been completed by a licensed practitioner with a scope of practice to diagnose ASD has been completed and until such time as the comprehensive diagnostic evaluation can be conducted and completed.

9. (C)(1)(d) states that individuals must receive a documented evaluation confirming one or more of the listed conditions. The purpose of ABA services is not limited to individuals based on diagnosis, as it's an effective treatment method for a broad scope of symptoms and/or behaviors outside of the listed disordered in this paragraph. Limiting services to those with an ASD diagnosis, limits youth from accessing ABA services that have behaviors and symptoms that are effectively treated by ABA services. For example, several intellectual developmental disabilities and ADHD have symptoms that are appropriately treated by ABA services. Providing access to ABA services for related conditions through prior authorization creates a needless barrier focused on constraining cost rather than supporting access to care and improved outcomes – and it may be another NQTL.

   Recommendation: In (C)(2)(d) consider removing limitation of services based on diagnosis rather than symptoms and behaviors that are within the scope of ABA services to allow access to effective services for a broader range of youth who may benefit from service. If diagnosis remains a focus, then we suggest adding ADHD and intellectual disabilities to this list.

10. (C)(2)(e) states that services are based on the individual child and parent's or guardian's needs. Using the terms parent and guardian limits potential caregivers' perspective and needs from being included when determining appropriateness of the service. Additionally, listed in the considerations within this paragraph is school attendance. The requirement of school documents and school schedules as part of the medical necessity determination process would not meet the standards of care for ABA and all other types of medical/surgical or behavioral health services. It would be considered a non-treatment limitation (NQTL) within mental health parity (MHPAEA) law.

    Recommendation: Replace the terms parent and guardian with caregiver to incorporate the needs of others who should be considered when determining appropriateness of ABA services.

Remove the language "school attendance" from this paragraph.

11. (C)(4) states that ABA treatment services will require prior authorization to continue beyond the initial prior authorization 180-day approval, drawing into question if prior authorization is required for the first 180 days or if those services are guaranteed for 180 days before prior authorization is required. Requiring initial prior authorization for this service is an immediate barrier that again serves to delay access to care. Imposing time-limited treatment frameworks is not effective for lifelong conditions such as ASD, as these disorders require ongoing, individualized support to address their evolving nature and impact across the lifespan. To ensure effectiveness, treatment plans should be flexible, regularly reassessed, and tailored to the individual's long-term developmental and functional needs. As drafted, the rule does not address challenges individuals and families have faced with brief, episodic authorizations by MCOs or the administrative burden that places on providers. We feel strongly that the rule must include stronger language to support continuity of care based on the individualized needs of the person and their caregivers.

    Recommendations: In (C)(4) clarify that ABA services may be provided for 180 days. Add language that prior authorization for additional ABA services will be based on the individualized needs of the person served and their caregivers.

12. (D)(1)(b) details the information required as documentation of services and (D)(1)(f) is understood to convey the same information by requiring a justification the need for ABA services. This appears redundant and duplicative.

    Recommendation: Clarify the distinction between (D)(1)(b) and (D)(1)(f) or remove one requirement.

13. (D)(2)(a) and (b) appear to greatly overlap in their intent to support care coordination in a manner that is confusing and unnecessarily complex. Certainly, we support care coordination but question whether care coordination is a function of the ABA Behavioral Treatment Plan as it is highly unlikely that a youth is only engaged in ABA services. Many youth and their families may be engaged with an SSA from a local DD Board, OhioRISE, or FCFC making care coordination within this plan duplicative. Further (D)(2)(b) requires completed ABA behavior treatment plan include a description of other services and supports being provided, including service plans issued by other systems and description on coordination which raises concerns that ABA services may be denied to individuals if the MCO determines that engagement in an alternative service is sufficient to address the individual's needs when the individual may require engagement in multiple services for best treatment outcomes. Additionally, if the caretaker chooses to not release specific service plans, that release of information should not be required for an individual to obtain necessary medical care. Obtaining records creates unnecessary barriers to receiving care as an individual's service plans from other systems would not impact the medical necessity of receiving ABA treatment to reduce and manage symptoms.

    Recommendation: Rework (D)(2)(a) and (b) to support a plan for coordination of care with other treatment and service providers as applicable and only when other care coordination services are not part of the plan. Remove the requirement to include other service plans as a required element of the ABA behavioral treatment plan.

14. (D)(2)(d), (e), (f) lack clarity to differentiate the plan for generalization, transition and fading plan, and measurable discharge criteria. The absence of clear distinction between the terms will

affect the ability to effectively plan services and implement targeted interventions, potentially compromising overall efficiency and alignment with intended outcomes. Including the individual's goals and desired outcomes is not required as currently proposed, but instead a plan to coordinate with the individual's formal and informal supports, rather than focus on the needs of the individual.

Recommendation: Clarification between terms listed in this paragraph be explicitly defined in clear and operational language.

15. As drafted, (E)(7) raises concern that other services can't be provided or support if an individual is engaged in ABA treatment. MCOs may use this language to deny coverage for ABA services if the individual is engaged in other mental health services like CPST, when to reduce impacts of symptoms most efficiently, a combination of services may be necessary to best serve individuals and families. Conversely, MCOs may interpret this language to mean that an individual receiving may not be eligible to receive other mental health services like CPST or TBS because they may be addressing similar behaviors or functional impairments. Individuals are entitled to receive all medically necessary services to address their individualized needs, particularly under EPSDT. If ABA services require some level of prior authorization, this language is unnecessary.

    Recommendation: Remove (E)(7) from rule.

16. Appendix A, does not include the eligible place of service codes as stated in (F)(1). Standards of care for ABA within CASP Practice Guidelines states "*ABA treatment must not be restricted a priori to specific settings but instead should be delivered in the settings that maximize treatment outcomes for the individual patient.*" Ensuring the service can be provided across multiple settings is essential for meeting treatment outcomes.

    Recommendation: Add allowable place of service codes to Appendix A.

In conclusion, we appreciate the opportunity to share comments on these rules and the Department's commitment to addressing the needs of youth and families who benefit from ABA treatment. Together, we can work through the complex policy and practice issues to ensure that children and families have the resources and opportunities they need to thrive. We look forward to further collaboration to achieve meaningful outcomes for those we serve. If you would like to discuss our comments further, please contact me at lampl@theohiocouncil.org.