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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 a number of the proposed changes are acceptable, we are concerned that community behavioral health centers (CBHC), as businesses, will be negatively impacted as will individual practitioners, 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 (C)(1) uses the term "independent adaptive behavior service practitioner" as well as in OAC 5160-34-03 in paragraph (C)(2)(c) and is 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, aligning language with existing regulatory frameworks, and ensuring consistency across all sections of the proposal.

2. The requirements outlined in (A) of this rule as currently written would require 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 included 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 has a direct business impact that will result in increased expenses for 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: To mitigate the undue business expense and sustain access to existing services, 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)(c) fails to recognize existing Community Behavioral Health Centers (CBHCs) or hospital-based outpatient programs as eligible organizational providers that can deliver ABA services. This omission creates uncertainty for businesses offering care today. More importantly, individuals can currently receive ABA treatment alongside other behavioral health services in CBHCs or outpatient hospital programs, which allows for integrated and coordinated care. ABA is often most effective when paired with mental health interventions, especially for individuals with co-occurring needs. Today, families can access both services through a CBHC or outpatient hospital program, but under the proposed rule, this arrangement may not be preserved and is discretionary. This uncertainty for businesses, such as CBHCs adds unnecessary sustainability challenges and could disrupt existing care relationships that create barriers for individuals and families, particularly in rural and underserved areas where CBHCs may be the only available provider.

   Additionally, we are also concerned that this change could unintentionally create parity issues by limiting access to medically necessary services and introducing nonquantitative treatment limitations that impact network adequacy. Families should not be placed in a position to choose between services when both are needed to support behavioral and emotional functioning.

   Further, we understand the narrow list in paragraph (C) regarding the types of individuals practitioners and organization types may be due in part to ODM IT system challenges and costs associated with administrative and policy changes given CBHCs range of services and practitioners with a complex Medicaid enrollment crosswalk already. ODMs decision to omit CHBCs avoids the time and cost to update and modify this complex CBHC crosswalk but also cost shifts IT system costs to these businesses and creates new staffing costs. However, policy decisions regarding access to care should not be driven by system limitations. Many CBHCs have invested significantly in integrated service models and rely on licensed professionals who have ABA-related competencies within their existing scope of practice. Excluding CBHCs may create operational and financial strain, reduce service capacity, and limit access to care for youth with complex needs, including those who are multi-system involved. We believe these concerns can

be addressed through collaborative solutions that support both effective implementation and broad access to high-quality ABA services across settings.

Recommendation: In (C)(2)(c), include Community Behavioral Health Centers (CBHCs) as defined in 5160-27-01 and hospitals, which are referenced in 5160-34-03(F) as eligible for reimbursement, in the list of eligible organizational providers. Further, guidance should be provided indicating these organizations can provide ABA services and BH services in compliance with CPT and NCCI coding requirements.

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

4. We appreciate ODM's efforts to streamline the ABA rule package. However, the removal of 5160-34-02 raises concerns about clarity and consistency and will create unnecessary business and legal expense. This rule previously defined covered adaptive behavior services such as assessments, protocol-based treatments, caregiver guidance, and exposure-based interventions. These services remain listed in the reimbursement appendix to 5160-34-03 but are no longer described in rule, which may create uncertainty for providers.
Additionally, 5160-34-01(C)(2)(a) references 5160-34-02, despite its removal. This outdated cross-reference may cause confusion and should be updated.

   Recommendation: We recommend reintegrating key service definitions into 5160-34-03 or a new appendix. If 5160-34-02 is not reinstated, references to it in 5160-34-01 should be revised, and the numbering structure should be adjusted for clarity.

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

5. (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 appendices so the details of what the tools are, 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 are able to diagnose ASD 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.

6. (C)(1)(b) limits coverage of ABA assessment services to only those that are rendered in response to a referral from a licensed practitioner. This creates an unnecessary barrier for families by preventing self-referral and requiring an additional step before accessing care. Many families who recognize early signs of developmental concerns may face long wait times for medical appointments or difficulty obtaining referrals due to provider shortages, especially in underserved areas. Further, there is no clinical or regulatory justification for requiring a referral for adaptive behavior assessment services when the services themselves include a diagnostic review by qualified practitioners. This restriction is not consistent with the structure of other Medicaid behavioral health services and may delay access to early intervention, which is critical to improving outcomes.

   Recommendation: Revise (C)(1)(b) to allow self-referral or clarify referrals from any licensed behavioral health provider acting within their scope are acceptable under "licensed practitioner" language in this rule since 5160-34-01 narrowly defines these terms.

7. 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 and prior authorization is completed is likely 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. In (C)(1)(d) remove" and approved and prior authorized by the department or its designee."

8. (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) under the 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.

9. The revised rule now requires prior authorization for both the initiation and continuation of ABA treatment services, as outlined in 5160-34-03(C)(4) and (C)(5). Requiring prior authorization before services can begin presents an immediate barrier to access, even when a diagnosis and individualized treatment plan have already been completed and adds unnecessary administrative costs that are not present to access care for most other health conditions. This

approach delays medical care and places undue burden on families and providers. Additionally, these requirements raise concerns regarding compliance with federal and state mental health parity laws. Medicaid must ensure that authorization policies for behavioral health services are no more restrictive than those applied to comparable medical and surgical services. Requiring up-front prior authorization and time-limited approvals for treatment of autism spectrum disorder—a lifelong, neurodevelopmental condition—may violate this standard, particularly when ongoing medical treatments for chronic conditions are not subject to similarly burdensome requirements. Further, it escalates uncompensated costs associated with administrative challenges of prior authorization including diverting limited clinical time of highly licensed practitioners from patient care. Imposing rigid, time-limited treatment frameworks does not reflect the individualized, evolving nature of ASD-related care. Families and providers have consistently raised concerns about disruptions in service caused by short-term authorizations and inconsistent approval criteria among plans. The revised rule does not address these longstanding issues or offer guardrails to protect against care interruptions.

Recommendations: Revise 5160-34-03(C)(4) and (C)(5) to eliminate the prior authorization requirement for initiating ABA treatment services when supported by a valid diagnostic evaluation and treatment plan. If prior authorization is retained, the rule should specify that all authorization decisions must be based on the individualized needs of the person served and their caregivers and include language affirming compliance with mental health parity requirements. The rule should also establish expectations for continuity of care to reduce administrative burden and avoid service disruptions.

10. (D)(1)(d) requires each note to include measurable descriptions of behaviors, symptoms, and treatment response. While ABA emphasizes data collection, not all symptoms or responses can be measured during every session. Requiring that every session note include measurable language for all elements is overly rigid and inconsistent with general Medicaid documentation standards outlined in 5160-8-05, which also exceed federal Medicaid documentation requirements. Adding additional documentation requirements will require providers to upgrade their EHRs and compliance oversight which is an additional unexpected business cost that does not exist today.

    Recommendation: Revise (D)(1)(d) to, at a minimum, align with 5160-8-05 by requiring measurable terms when applicable and consistent with the treatment plan, while allowing for professional judgment in documenting clinical observations.

11. (D)(3)(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 should be explicitly defined in clear and operational language.

12. As drafted, (E)(7) raises concern that other services can't be provided to support an individual 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 ABA 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. The lack of clarity of the intent of this statement had direct implications for reimbursement and will result in unnecessary administrative and staffing costs for businesses to manage. Further, if ABA services continue to require prior authorization, this language is unnecessary.

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

13. (F)(1) references reimbursement and service settings, but Appendix A does not identify allowable place of service (POS) codes. 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 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.