mhpa Medicaid Health Plans of America

February 11, 2026

Administrator Mehmet Oz
Deputy Administrator Daniel Brillman
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: MHPA Recommendations for Detecting and Combating Fraud, Waste, and Abuse in the Applied Behavioral Analysis Space – Follow-up from MHPA/CMCS Quarterly Call on January 27th

Dear Administrator Oz and Deputy Administrator Brillman,

On behalf of the Medicaid Health Plans of America (MHPA), we appreciate your leadership and commitment to stakeholder engagement at the Centers for Medicare & Medicaid Services (CMS). On January 27th, MHPA convened with staff from the Center for Medicaid and CHIP Services (CMCS) to discuss how Medicaid Managed Care Organizations (MCOs) are detecting and combating Fraud, Waste, and Abuse (FWA) in the Applied Behavioral Analysis (ABA) space, as well as to provide recommendations to support consistent administration across states. In that meeting, CMCS staff requested that we memorialize those recommendations and considerations to facilitate CMS' compilation of stakeholder feedback. MHPA and its member MCOs are grateful for the opportunity to collaborate with CMCS to address this critical issue, and stand ready to be partners to CMS, states, and providers as MCOs seek to provide appropriate access to these services. Access to ABA services is essential for many individuals and their families. Ensuring that those services are of high quality and readily available for those for whom the service is clinically appropriate is of the utmost importance to MHPA and its member plans.

MHPA has compiled feedback from its member plans on this important topic, including observations of FWA in the ABA space, best practice plans are leveraging to administer the benefit, and recommendations to support consistent and appropriate administration and oversight across states.

Key Observations

MHPA's member plans share this Administration's concerns with FWA in the ABA space, observing examples of these behaviors on a nationwide scale.

Significant increase in ABA utilization over recent years

MHPA's member plans have reported significant upticks in utilization in markets that have implemented ABA in recent years. This utilization has been driven in part by a significant

increase in ABA providers and services, which in turn has led to an increase in health plan and state spending. One health plan reported that contracted service providers for ABA services have nearly doubled between 2020 and 2023. Another health plan shared that the prevalence of members accessing ABA services was up 82% while the service units per thousand was up 89%. In one market, a health plan saw ABA costs increase by ~2000%, from $4.6M in 2020 to $86M in 2024. Plans have reported certain states disallowing prior authorization for ABA services, which is likely to exacerbate utilization increases.

ABA Staffing Issues

MHPA's member plans have reported several issues related to the clinical staff providing ABA services. One plan has identified individual staff working at multiple provider agencies and billing those agencies simultaneously. A plan reported that 37% of their member months do not meet the Council of Autism Service Providers (CASP) standard for ABA supervision, and in one market, 85% of services were rendered and billed by non-clinical, para-professionals, such as registered behavioral technicians (RBTs). While provision of services by RBTs is appropriate when conducted with adequate supervision, it could be problematic without qualified clinical oversight. Another plan saw RBTs delivering services without active certification or enrollment. Elsewhere, patients were not receiving diagnostic evaluations or treatment referrals before care was provided. One MHPA member plan shared that 61% of their members had at least one month with under-supervision or no supervision in the ABA space.

Insufficient Clinical Documentation and Billing Issues

Health plans have shared several examples of insufficient documentation or billing issues with MHPA in this environment. Plans noted a general lack of documentation to confirm that the ABA model is being adhered to, with documentation often not fitting the service that is being provided. In some instances, plans received session notes without detail to support the treatment plan or individual responses to treatment, raising suspicions of AI generation. Billing issues were shared by several health plans, with inaccurate services billed, billing for in-person treatment where care was delivered virtually, and billing for non-billable time (e.g., over 40 hours a week, naps). One plan saw billing for the maximum number of hours for every/most children served; with services rendered not being individualized. Some plans saw "bulk billing" or "lump sum billing" where individual days or patients were being bundled together, making it difficult for plans to audit instances of FWA. Often, plans have reported that billed ABA therapy units were not aligning with the time parents reported therapy. One plan reported that patients in some instances were spending 8+ hours a day at treatment centers, and certain providers were billing up to $265 per hour, far exceeding the standard rate for ABA services.

As evidenced by the experiences of these health plans, MHPA can share that the concerns raised by this Administration are being felt nationally, with clear patterns of inconsistencies or lack of documentation, unqualified staff providing ABA services, and a rapid increase in spending and utilization of these services, potentially creating access challenges for individuals who need these services and creating rate challenges for states.

MCO Best Practices

MHPA's member plans have shared the best practices they have been leveraging in order to more effectively detect and combat FWA while administering the ABA benefit.

MCO oversight of provider networks

Several MHPA member plans shared their initiatives to conduct oversight of their provider networks, to ensure that services are high quality and appropriately rendered with supporting documentation. These interventions are in addition to the network contracting oversight, prior authorization and payment integrity efforts that are standard for nearly all plans when allowed by the State partner.

One health plan's program integrity department completed an analysis of ABA service providers reviewing a statistically valid, randomized sample of all ABA claims for a point in time to both assess baseline performance for providers and to gauge compliance with relevant rules and regulations. The plan found that more than half of all claims reviewed contained at least one billing error resulting in just over $193,000 in overpayments being identified from a sample of just over $350,000. Providers were informed of the findings, given education and training by the plan, and overpayments were recovered.

One health plan reviewed the ratio of supervision hours (97155) to treatment hours to ensure that they only account for 20% of direct therapy (97153, 97154), facilitating audits.

In order to avoid duplication of services, a health plan reviewed school individualized education programs (IEPs) to ensure that ABA is not replicating existing efforts.

A health plan noted they were able to use available staff rosters to screen for staff working for multiple agencies, and sorted for staff reporting a high number of hours per week across multiple agencies. Working with these providers, the plan made more than 100 referrals to the state's Medicaid Fraud Control Unit (MFCU).

Health plans engaged in the best practice of requiring providers to provide up-to-date background checks, fingerprint clearances, and other required documentation to maintain credentialing. This practice helped to ensure that care was safely delivered to the right individuals. For technicians providing direct care, the plans required proof of certification as a registered behavioral technician.

Plans noted that when FWA behavior is identified relating to ABA services, their internal investigation department follows compliance reporting requirements and initiates corrective actions, including a referral to the state Office of Inspector General, issuance of a refund demand letter, placement of provider on prepayment review, education for the provider, and/or a referral to provider network for consideration of network termination. Corrective actions are typically coordinated with the state Inspector General of the impacted Medicaid program.

Clinical Review

MHPA member plans leverage internal clinical review to support clinically appropriate care. Many member plans not using qualified staff such as individuals with Board Certified Behavioral Analyst (BCBA) credentials to conduct utilization management reviews, leading to positive interactions with providers and a shift to more appropriate utilization. Member plans noted the importance that diagnoses are provided by qualified clinicians which include psychiatrists, psychologists, physicians, and licensed clinicians with specialized training in developmental disorders.

Parent/Caregiver Engagement

Health plans noted the value of training parents and caregivers to improve outcomes for individuals receiving ABA treatment. One plan recommended that family training occur no less than 4-8 hours per month, with potential barriers being documented and a clear plan being developed to address these collaboratively.

Recommendations

MHPA health plans shared several recommendations to improve outcomes, support consistent administration and reduce the incidence of FWA while administering the ABA benefit. In providing this information, we want to acknowledge the Mental Health Parity and Addiction Equity Act (MHPAEA) financial and treatment limits that are enforced by the Department of Labor, CMS and states. These recommendations are organized below:

Recommendation	Details/Rationale
Establish clear medical necessity criteria for ABA	Clear medical necessity criteria for ABA (CPT codes 97151-97158) should be required, giving states and plans a baseline for medically necessary, billable services. We encourage this to be done at the federal level using nationally recognized, evidence-based criteria for consistency across programs and for greater oversight, evaluation and improvements in quality of care. Avoiding ambiguous language in clinical or coverage policies will support consistency and oversight. Common challenges:

	• Substantive (how much? Examples: 1 standard deviation / specific percent change from baseline?) • Measurable (according to what measurement tools?) • Successive (how many?) • Reasonable expectation (according to whom / what?)
Appropriate Diagnostics to Support Treatment	Diagnosis should be provided by a qualified clinician which includes psychiatrists, psychologists, physicians, and licensed clinicians with specialized training in developmental disorders. Such individuals should have comprehensively assessed and/or are actively treating the member. Ensuring the Comprehensive Diagnostic Evaluation (CDE) is completed by someone other than the ABA service provider and is accompanied by a referral for ABA services that includes goals for treatment to minimize conflicts of interest. Consider limiting ABA to ASD Diagnosis with consideration for exceptions for children under 4 who have a confirmed developmental diagnosis and symptom presentation that meets MNC for ABA. ABA Assessments (initial and subsequent) should be completed by appropriately qualified professionals to ensure treatment is aligned to needs identified in the current CDE and treatment plan goals are designed to address identified deficits.

Provide evidence-based guidance on intensity, frequency and duration	Provide evidence-based guidance on intensity, frequency and duration that inform or establish guardrails for optimal hours per day, number of hours per week, and the number of years of continuous service to establish clear and consistent practice and service patterns.
	
	• Treatment intensity should be informed by the number of direct interventions delivered weekly not including supervision, caregiver training, planning, or other non-direct services correspond to the scope, complexity, severity of deficits and evidence supporting:
	    ○ Low-Intensity (5-12 hours) - Treatment is focused and limited to a small number of treatment targets
	    ○ Moderate-Intensity (13-25 hours) - Treatment is focused or partially comprehensive
	    ○ High-Intensity (26-40 hours) - The treatment must be comprehensive in scope and clinical severity indicators are present

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<td>Establish reinforced credentialing and supervision requirements</td>
<td>CMS should require all RBTs delivering Medicaid-funded ABA to obtain a National provider Identifier (NPI) and enroll as rendering providers.

This would allow states, MCOs, and UPICs to verify credentials, monitor technician-level service delivery, enforce supervision rules, and improve program-integrity analytics— a low-burden, high-impact safeguard given OIG findings.

States that allow non-clinical staff to perform ABA services under the supervision of clinicians should clearly address how these staff are certified, trained, and supervised to ensure effective clinical care and improved member outcomes. Supervision of non-clinical staff is essential to maintaining fidelity of treatment protocols and achieving expected clinical outcomes.

The primary provider of ABA services should be a BCBA who is a Master's-level practitioner and has completed:
Coursework in behavior analysis.
Has undergone field-based supervision.
Passed a scored examination to receive certification.
The BCBA should supervise RBTs who provide direct treatment to the individual, evaluate progress, and identify treatment adjustments needed to improve skill development. RBTs are certified paraprofessionals who deliver ABA services under the direction and supervision of the BCBA. RBTs should be at least 18 years of age and have all of the following qualifications:
A minimum of a high-school diploma, or equivalent.
Complete a background check.
Complete 40 hours of training in ABA principles.
Complete a competency assessment.
Pass scored examination before they can receive certification.
RBT's should only practice under the supervision of a BCBA and should not responsible for analyzing behavior, determining the treatment approach, or collaborating with treatment providers. Supervision of RBTs ensures treatment is implemented with fidelity, progress is monitored, and barriers are addressed promptly. RBTs deliver treatment according to protocols designed by the BCBA.

RBTs should receive ongoing supervision equal to at least 5% of the hours they deliver ABA services each month, including at least one</td>
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	face-to-face, real-time supervision meeting and at least one supervision session that directly observes the RBT providing ABA services. In states where there is currently no registration or certification process for RBTs, we recommend RBTs be certified and registered. This registration and certification could be done online, require several hours of training, and completion of a competency assessment. A BCBA can supervise any number of RBTs as long as they can provide effective, ethically compliant supervision that meets all BACB requirements and protects client welfare, with caseload size determined by the BCBA's capacity. Case supervision, administered by the BCBA, should encompass both direct and indirect case supervision activities. Indirect supervision should include data review, team consultation, and treatment planning. Direct supervision includes observation and interaction with the member and should be documented through the delivery of CPT 97155.

Require expanded data-driven oversight	This approach would help states and plans to detect outlier billing early.
	
	• Support enhanced use of:
	    ○ Claims analytics and peer comparisons
	    ○ Cross-state and cross-plan data sharing to identify emerging risk patterns
	• Focus on:
	    ○ Excessive hours
	    ○ Long service duration without functional gains
	    ○ Inconsistent documentation patterns
	    ○ Low parent training hour utilization
	    ○ High RBT-to-supervisor ratios
	
	Requiring the rendering provider on the claim to match the signature on the clinical note would improve audit reliability and deter fraudulent billing.
	
	Prohibiting lump sump or bulk billing, where providers submit multiple days of service in a single claim without date-level granularity, would enhance oversight, enable accurate service tracking, and support payment integrity initiatives.
	
	Ensure codes billed on the same day have adequate clinical justification to reduce unnecessary dual billing.

Clearer telehealth guardrails	Clear telehealth guidelines are needed especially for caregiver training. Preference for in person treatment – requests for virtual services should be supported in the documentation and should note substantial barriers related to proximity and/or limited access to services. Exceptions should be granted for rural communities that lack access to comprehensive ABA services. The CASP has a best practices document, accessible here (https://www.casproviders.org/news/applied-behavior-analysis-telehealth-parameters-best-practices-document), which can help in the development of these guardrails.
A CMS-developed ABA provider integrity toolkit	We recommend that CMS develop a toolkit to give states and providers consistent, practical guidance and reduce post-payment corrections. Should CMS decide to move forward with a more formal process such as rulemaking, we encourage the agency to grant sufficient time for implementation. **Potential Toolkit Components for State Consistency in ABA** • National Clinical Coverage Policy • Standardized Authorization Request Form • Comprehensive Diagnostic Evaluation (CDE) Template or List • Tools / Guidelines for Hour Allocation • Physician or Provider Referral for ABA Criteria & Template • Treatment Plan Template • Recommended Norm-Referenced & Criterion/Skills-Based Assessments • Model Coverage Policy (ABA Coding Coalition) • Practice Guidelines
Establish clearer, more standardized measures of patient-centered outcomes	This will provide a basis for comparing outcomes across different providers and settings, leading to greater accountability and improved patient outcomes.
Caregiver/Parent Engagement and Training	• Given the important role of caregivers in the outcome of ABA treatment, it is important to have expectations for caregiver engagement and training to be included in the treatment plan to

	support generalization and maintenance of skills in the home and community. ◦ Encourage states to require, when clinically indicated, family adaptive behavior treatment guidance, ensuring caregivers can successfully deliver treatment plan interventions helping children with disabilities achieve optimal health outcomes. ◦ For the purposes of caregiver training, a *caregiver* is defined as a parent, legal guardian, or another adult who holds substantial and ongoing responsibility for the child's upbringing, daily care, or supervision. Caregivers must have a significant role in supporting the child's development and participating in the implementation or generalization of treatment-related skills. • Center based providers should deliver structured family and caregiver training and coaching, beyond routine progress updates, as part of treatment implementation when clinically indicated. Such training should include individualized goals, active instruction including modeling and practice with feedback, and documentation of caregiver skill acquisition and plans for generalization. ◦ Caregiver observation of sessions or receipt of progress updates alone does not constitute caregiver training and should not meet this requirement.

We thank CMS for their consideration of MHPA's recommendations to address FWA in the ABA space, and applaud the Administration for its efforts to address this critical issue. Reducing the incidence of FWA will ensure that ABA is provided by qualified clinicians and is accessible to individuals who need these services.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
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