



May 17, 2019

Via Email

publiccomment@okhca.org

Oklahoma Health Care Authority

Re: Comments on Proposed Emergency Rule for EPSDT Coverage of ABA Therapy for ASD, Ref. APA WF #19-03

Dear Sir or Madam,

The Oklahoma Disability Law Center and the Autism Legal Resource Center are submitting these comments in connection with proposed emergency rule for Early and Periodic Screening Diagnostic and Treatment (EPSDT) coverage of Applied Behavior Analysis (ABA) services for Medicaid eligible children under 21 years of age with Autism Spectrum Disorder (ASD). As President of the Autism Legal Resource Center LLC and previously as Executive Director of the Autism Speaks Legal Resource Center, I have worked on issues involving EPSDT coverage of ABA for ASD nationally and in almost every state. The Oklahoma Disability Law Center (ODLC) serves as the Protection and Advocacy Agency for the State of Oklahoma. ODLC provides federally funded legal services to persons with disabilities and is especially focused on systemic issues to protect and promote the rights of people with disabilities.

We commend the Oklahoma Health Care Authority (OHCA) for moving to implement coverage of necessary care for children with autism as required by EPSDT and re-emphasized in the CMS Informational Bulletin of July 7, 2014.¹ In its current form, however, OHCA's proposed coverage policy contains a number of provisions that limit or impede access to medically necessary care in contravention of EPSDT and other federal requirements. In particular, restrictions on the scope of treatment, apparent

¹ Center for Medicaid and CHIP Services. Informational Bulletin, Clarification of Medicaid Coverage of Services to Children with Autism, July 7, 2014 (hereinafter "CMS Informational Bulletin"), available at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf>.

“fail-first” requirements, improper pre-authorization and reauthorization criteria, extraneous diagnostic procedures, and conditioning a child’s access to medically care on compliance with mandatory parental participation requirements violate Medicaid’s Early Periodic Screening Diagnosis and Treatment (EPSDT) mandate, the federal Mental Health Parity and Addiction Equity Act (MHPAEA)², the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act,³ and Section 1557 of the Affordable Care Act.⁴

In addition to these specific defects, the policy itself appears to be based on a fundamental misconception of the nature of Applied Behavior Analysis (ABA) treatment for children with Autism Spectrum Disorder (ASD) and the requirements of EPSDT as applied to children with ASD.

To insure that EPSDT eligible children in Oklahoma are provided access to all medically necessary ABA services to correct or ameliorate their deficits and conditions so that they can enter into adulthood as functional as possible, we request that OHCA withdraw and revise the proposed coverage regulations and engage in an open collaborative process with knowledgeable stakeholders to develop an appropriate and effective policy. Our specific concerns and recommendations are set forth below.

I. Mandatory Parental Participation Requirements

317:30-65.12 (a)(5)

This section states that “services are designed to accomplish medically necessary management of severe and complex conditions in which there is a realistic expectation that within a finite and reasonable time the caregiver will be able to demonstrate knowledge and ability to independently and safely carry out the established plan of care.”

Concern:

The purpose of ABA treatment of ASD is not to train parents or other caregivers to become behavior technicians with the skills and expertise to manage the current problem behaviors of the beneficiary. Rather, consistent with EPSDT requirements, the

² See EPSDT-A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (2014), Centers for Medicare & Medicaid Services (hereinafter “EPSDT Coverage Guide”), p. 24 (medical management techniques used for mental health and substance use disorders should comply with the Mental Health Parity and Addiction Equity Act.”) MHPAEA prohibits imposing any treatment limitation on scope or duration of treatment for a mental health condition such as ASD where such limit is not imposed on substantially all outpatient medical/surgical treatment. 29 U.S.C. § 1185a (a)(3)(A)(ii). MHPAEA also prohibits nonquantitative treatment limitations such as medical management procedures and criteria not imposed on medical/surgical coverage 29 C.F.R. §2590.712 (c)(4).

³ Limiting persons with ASD from accessing medically necessary care and imposing procedures and restrictions not imposed on nondisabled members is contrary to the ADA and Section 504 and exposes children with autism to the risk of institutionalization in violation of the ADA’s integration mandate.

⁴ Section 1557 of the Affordable Care Act prohibits discrimination in the provision of federally funded healthcare, including discrimination in benefit design. Patient Protection and Affordable Care Act § 1557, codified at 42 U.S.C. § 18116.

purpose of ABA is to correct or ameliorate all debilitating conditions forming the basis of the ASD diagnosis so that dysfunctional behaviors are eliminated or reduced and social and communication skills are developed resulting in the individual being able to function as independently as possible.

Recommendation:

Delete 317:30-65.12 (a) (5) and replace with a statement consistent with EPSDT requirements and the generally accepted science and practice of ABA. For example, “Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention services, prevent or minimize the adverse effects of ASD and promote, to the maximum extent practicable, the functioning of a beneficiary.”⁵

317:30-65.12 (e)(2)(I) and (J) Parental Participation Requirements

These sections state:

(I) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

(J) Document parent(s)/guardian(s) participation in the training of behavioral techniques in the member’s medical record. Parent(s)/legal guardian (s) participation is critical to the generalization of treatment goals to the member’s environment

ABA Request for Services Pursuant to Early & Periodic Screening, Diagnostic, and Treatment (EPSDT) (Request Type Initial)

The form states:

The expectation is for the parent/guardian to attend & participate in each session with the member, so please list the recommended treatment hours per week . . . Lack or parental attendance/involvement will result in discontinuance of authorization of services.

⁵ Cal. Approved SPA, 14-026, p. 18-b. *See also* Iowa approved SPA, 14-0022, p. 12. (discussing “treating or minimizing the adverse effects of impairments to an individual’s mental health.”). *See also* Utah Medicaid Provider Manual, Autism Spectrum Disorder Related Services for EPSDT Individuals (July 1, 2015), Section 1-3 Definitions (“ABA is a behavioral health treatment that is intended to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual with ASD.”), available at <https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Autism%20Spectrum%20Disorder%20Services/AutismSpectrumDisorder8-15.pdf>.

ABA Request for Services Pursuant to Early & Periodic Screening, Diagnostic, and Treatment (EPSDT) (Request Type Extension)

The form states:

The expectation is for the parent/guardian to attend & participate in each session with the member. For each ABA session please document the date & time of each session, the goals and objectives that were utilized, and whether the member and parent/guardian were able to (a) understand the goals & objectives, (2) apply the ABA technique(s). ***Please Note: Lack of parental attendance/involvement will result in discontinuance of authorization of services.

Concern

Requiring parents to participate in 100 percent of therapy sessions and understand and perform sophisticated behavioral interventions and terminating medically necessary care for a child if parents are unable or fail to do so regardless of the clinical judgment of the treating provider as to how and when parents should be involved and regardless of whether the child is progressing and generalizing skills, violates EPSDT, MHPAEA, ADA and Section 504 and Section 1557 of the ACA. None of the states with Medicaid EPSDT coverage of ABA for ASD imposes such an extraordinary and discriminatory restriction. The requirements are contrary to general standards of care and improperly limit access to treatment regardless of the needs of the child and demonstrated individualized effectiveness of ongoing treatment. As set forth in the latest statement on this issue by the Behavior Analyst Certification Board (BACB) and the Association of Professional Behavior Analysts (APBA):

authorizations for services to the client should not be predicated on requirements for parents or other caregivers to participate in training or to implement treatment protocols with the client for any fixed, pre-determined amount of time. Further, that time must not be counted toward, substituted for, or offset against ABA services delivered directly to the client by professional behavior analysts, assistant behavior analysts, and behavior technicians. As the Guidelines state, "...while family training is supportive of the overall treatment plan, it is not a replacement for professionally directed and implemented treatment" (p. 37).⁶

Contrary to EPSDT requirements that children have access to all medically necessary care to correct or ameliorate their illness or condition based on individualized determinations⁷, OHCAs proposed parental participation requirements discriminate against the children of working parents, single parents, disabled parents, families with more than one child, older children, children receiving intensive services in a variety of

⁶ BACB APBA Clarifications Regarding *Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2nd ed.)*, p. 3 (February 2019) available at https://www.bacb.com/wp-content/uploads/Clarifications_ASD_Practice_Guidelines_2nd_ed.pdf

⁷ CMS Bulletin, p. 5.

community settings outside the home, including clinics, and generally and disproportionately affect lower income and culturally diverse families.

Parents are not therapists. The extent of their involvement and ability to support an ABA therapy program is dependent on individual and family factors and the professional judgment of therapist. The nature and degree of parental or caregiver support may vary based on numerous factors, including employment, other family responsibilities, health issues, disability and personal capabilities of the caregiver. Childcare workers may have a variety of personal and employment issues. Personal limitations based on a parent or guardian's particular social or economic situation cannot serve as a basis for refusing to provide medically necessary treatment to the child. In addition, the necessity of caregiver participation may vary depending on the nature and location of interventions and the age, symptoms and treatment targets of the individual receiving care.

Requiring a specific quantity, quality or type of participation by parents or guardians as a precondition to treatment would be an improper barrier to care in violation of EPSDT and an impermissible discriminatory treatment limitation in violation of MHPAEA. We note that regardless of caregiver participation, in order to continue with treatment, a child will need to meet appropriate medical necessity/efficacy requirements and as with any condition, this is all that should be required.

Recommendation

Delete the quoted sections from the initial authorization and reauthorization ("extension") forms. Delete sections I and J. Delete section 317:30-65.12 (f)(5) Refocus reauthorization request to data demonstrating progress towards treatment goals and objectives in the treatment plan. Do not require submission of all session notes and data which may be extremely voluminous with intensive programs and which will already have been provided in connection with billing claims.

II. Limitations on Providers

317:30-65.12 (b) Eligible Providers

This section lists only personnel authorized to direct and supervise ABA services in addition to rendering services. There does not appear to be any authorization for services performed by behavior technicians acting under the direction and supervision of BCBAs.

Concern

Behavior technicians are a critical component of the well-established tiered delivery system for ABA treatment of ASD.⁸ Because of the intensity of services required for

⁸ Behavior Analyst Certification Board, Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2nd ed. 2014) ("BACB Guidelines"), p. 28 ("Tiered service-delivery models that rely on the use of Assistant Behavior Analysts and Behavior Technicians have been the

effective treatment and the limited number of BCBAs, it is impossible to deliver adequate services without the use of trained behavior technicians who deliver the bulk of direct day to day services.⁹ All other EPSDT Medicaid coverage programs in the country recognize and use behavior technicians. CMS specifically amended the preventive care regulations to ensure that unlicensed providers, including unlicensed behavior technicians supervised by nationally certified BCBAs, could provide services recommended by a licensed provider acting within the scope of his or her license.¹⁰ Also, Oklahoma's Board Certified Behavior Licensure law recognizes the use of supervised behavior technicians. Okla. Admin. Code §340:100-18-1(b)(11), (c)(2).

In order to fulfill its obligation to deliver medically necessary ABA services with reasonable promptness, it is essential for OHCA to include this category of provider. There are insufficient numbers of BCBAs to perform direct treatment, nor would it be cost effective to do so. Nor, as discussed above, could parents be required to serve as behavior technicians in lieu of qualified healthcare personnel. Behavior technicians serving under the direction and supervision of BCBAs should be explicitly recognized as providers. To avoid unnecessary administrative costs, it is not necessary for OHCA to separately enroll and credential these providers as common practice in state Medicaid programs is for them to serve under and bill through Medicaid enrolled BCBAs who are responsible for their work.

Recommendation

Add behavior technicians as personnel authorized to deliver ABA services under the supervision and direction of eligible providers as currently set forth at 317:30-65.12 (b). Work with stakeholders to establish appropriate provider criteria for behavior technicians under 317:30-65.12 (c).

317:30-65.12(g)

The proposed regulations do not identify the billing codes to be used nor have these been provided elsewhere

Recommendation

Identify the billing codes to be used correlated to provider type. Most funders have recently begun using the AMA Category 1 CPT Codes for Adaptive Behavior Treatment.

primary mechanism for achieving many of the significant improvements in cognitive, language, social, behavioral, and adaptive domains that have been documented in the peer-reviewed literature.”), available at https://www.bacb.com/wp-content/uploads/2017/09/ABA_Guidelines_for_ASD.pdf

⁹ According to the list of Oklahoma licensed BCBAs maintained by the Oklahoma Department of Human Services, available at <http://www.okdhs.org/services/dd/pages/oblbcba.aspx>, there are only 112 licensed BCBAs and 5 certified BCaBAs in the state—far too few to provide direct therapy at medically effective levels without the use of behavior technicians.

¹⁰ 42 C.F.R. § 440.130(c). See CMS Informational Bulletin, p.3.

III. Improper Restrictions on Scope of Treatment (severe behavior requirements)

317:30-65.12 (d)(3) Medical Necessity Criteria

The proposed policy requires that to demonstrate a reasonable expectation that the member will benefit from ABA, the member must exhibit:

- (A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and
- (B) The ability to develop generalized skills to assist in addressing the maladaptive behaviors associated with ASD.

Concern

No other state Medicaid program in the country imposes these requirements as a condition to receiving EPSDT required ABA treatment as they would significantly prevent access to care. Indeed, it is typically precisely because a child does not independently demonstrate the ability to learn and generalize skills that a child is prescribed ABA treatment.

Recommendation

Eliminate subparts (A) and (B) and revise 317:30-65.12 (d)(3) to state: There must be a reasonable expectation that the member will benefit from ABA.

317:30-65.12 (d)(5)

In addition to having to have an ASD diagnosis, for any ABA treatment to be considered medically necessary the member must exhibit “atypical or disruptive behavior within the most recent (30) calendar days that significantly interferes with daily functioning and activities that includes one (1) or more of the following. . . (A) Impulsive aggression towards others; (B) Self-injury behaviors; or Intentional property destruction.

Initial authorization and extension request forms require detailing severe behaviors within the preceding 30 day and 14-day periods.

Concern

This extraordinary severe behavior restriction plainly violates EPSDT and is not found in any other state’s Medicaid program for EPSDT coverage of ABA treatment for ASD.¹¹ The provision further violates the requirements of the Wellstone-Dominici Mental Health Parity and Addiction Equity Act (MHPAEA) and Section 1557 of the ACA prohibiting discrimination based on disability and by withholding treatment necessary to ameliorate

¹¹ Under this provision a child who is unable to communicate, has no self-help skills, and spends hours at a time obsessively hand-flapping and rocking is not eligible for treatment because it would not be deemed “medically necessary.”

a child's significant ASD deficits and exposing him or her to likely institutionalization, the ADA and Section 504 of the Rehabilitation Act.

Clinically significant deficits in the areas of communication, social interaction and behavior form the basis of the ASD diagnosis which the policy already requires in order to access care.¹² Placing further requirements on access to care or limiting that care to a subset of clinically significant conditions is plainly improper.

The EPSDT mandate requires that all deficits and conditions arising from a child's ASD are subject to treatment and treatment must be provided when medically necessary to correct or ameliorate any of the deficits and conditions of a child's ASD.¹³ It is axiomatic that services may be required in many instances to improve the symptoms of a child's ASD even though the child does not currently manifest specific, disruptive, problem behaviors as referenced by this provision.¹⁴ Moreover, in addition to treating current symptoms of ASD, treatment may often be necessary to prevent deterioration. This is especially important with young children with autism who are often at risk of losing skills. Also, precursor behaviors that may ultimately lead to more severe behaviors such as aggression should be addressed and treated as soon as possible to prevent more complex, challenging behaviors from arising.¹⁵ Other states that have considered similar severe behavior provisions, including Missouri, California, Florida and Nevada, have rejected them based upon consideration of public comments and EPSDT requirements. While a few states, such as Louisiana, have broadened their descriptions of behavioral and functional deficits to track the ASD diagnosis criteria,¹⁶ other states follow the better and clearer course of rejecting separate behavioral requirements and instead simply require an ASD diagnosis. For example, after stakeholder input, Colorado withdrew proposed requirements for severe behavior or behavior that interferes with community activities for those with ASD. Instead, recognizing that the ASD diagnosis already encompasses clinically significant behavioral and functional deficits, Colorado simply requires an ASD diagnosis.¹⁷

¹² See 317:30-65.12 (d)(1); Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, Fifth Edition (DSM-5), p. 50 (Autism Spectrum Disorder Diagnostic Criteria).

¹³ 42 USC §1396(r)(5); 42 C.F.R. § 440.130(c). CMS Informational Bulletin, p.5; EPSDT Coverage Guide, p. 23. Behavior analysis is defined in Oklahoma's Board Certified Behavior Analyst licensure law as "the design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvements in human behavior through skill acquisition and the reduction of problematic behavior." Okla. Admin. Code §340:100-18-1(b)(1).

¹⁴ ABA may be needed to treat multiple affected domains such as cognitive, communicative, social, emotional, and adaptive functioning. BACB Guidelines, p. 14.

¹⁵ "The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible." EPSDT Coverage Guide, p. 1; CMS, State Medicaid Manual §§ 5010, 5121, 5310 (requiring states to "[a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.").

¹⁶ Louisiana's policy specifically includes "impaired development in the areas of communication and/or social interaction, etc." Louisiana, LAC 50, Ch.1, Sec. 103(A)(2).

¹⁷ Colorado Medicaid Criteria for Behavioral Therapies, available at <https://www.colorado.gov/pacific/sites/default/files/Colorado%20Medicaid%20Criteria%20for%20Behavioral%20Therapies%20October%202017.pdf>. Under Colorado's revised policy, those without an ASD diagnosis can still

In addition to provide treatment commensurate with a child's ASD diagnosis, OHCA should also make provision for children with other health conditions for whom ABA services are medically necessary. Also, the proposed regulation excludes coverage of ABA for children who are not "medically stable," who require 24-hour monitoring or who are in hospitals or intermediate care facilities. 317:30-65.12(d)(4). There may be situations where ABA services are medically necessary for such children and therefore must be available pursuant to the EPSDT mandate. Provisions should be made for this care either in this policy or another coverage policy applicable to these children.

Recommendation

Delete 317:30-65.12 (d)(5) and 317:30-65.12 (d)(6) and severe behavior data requirements on initial and subsequent authorization forms. The treating clinician may properly be required to show data demonstrating effectiveness of treatment on treatment plan targets in connection with the request for further treatment. Make provision for children identified in 317:30-65.12(d)(4) to access ABA services when medically necessary and eliminate prohibition on services for other diagnoses for which ABA is shown to be medically necessary.

317:30-65.12(d)(7)

The policy requires that it has been determined that there is no less intensive or more appropriate level of services which can be safely and effectively provided.

Concern

Combined with requirements to list other interventions attempted on the initial treatment request form, this section appears to contemplate a "fail first" requirement that other therapies must be used first and shown to not result in measurable improvement, and should be eliminated. Prompt, appropriate treatment based on individualized clinical determinations is critical in the treatment of ASD. ABA is generally recognized as the most proven effective treatment for ASD. Alternative treatments cannot be required by the state unless it can demonstrate that they would be equally effective.¹⁸ Forcing a child to first undergo other types of unrecommended and even potentially contraindicated treatment in place of the treatment recommended by his or her treating professional based on evaluation of relevant circumstances and professional judgment contravenes the EPSDT mandate to promptly provide necessary care based on individualized determinations and threatens to worsen the child's prognosis through delay in needed treatment. It is also improper to relegate a child to achieving merely "some" measurable benefit from an alternative, less-effective treatment, in place of generally accepted treatment recommended to substantially correct or ameliorate the full range of a child's ASD deficits and conditions to achieve maximum function and reduction of disability. No other state imposes this requirement on its EPSDT coverage

obtain services if they demonstrate behaviors or skill deficits that interfere with home, school or community activities.

¹⁸ EPSDT Coverage Guide, p. 25.

of ABA, and the few states that considered such a provision (e.g. Florida, Nevada, Colorado) ultimately withdrew it after stakeholder input.

Recommendation

Delete 317:30-65.12(d)(7) and references to other “interventions” on the initial authorization form.

IV. Improper Authorization Requirements

The initial authorization form requires IQ testing to be submitted to demonstrate that the treatment will not be custodial.

Concern

Generally accepted standards of care do not require IQ testing as a prerequisite for commencing treatment.¹⁹ Studies indicate that IQ scores may increase with treatment as a child develops attending skills. In any event, children with relatively low IQ scores can still make significant progress with ABA treatment. Again, other states, consistent with the EPSDT mandate, do not require IQ scores as a condition for accessing treatment and imposing this unnecessary requirement will improperly delay access to treatment.

Recommendation

Delete requirement for IQ testing.

317:30-65.12 (e)(2)

This section states that ABA treatment will be time limited.

Concern

References throughout the policy refer to ABA as “time limited.” It is not clear what the intent is, but it would be wholly improper to deprive a child of necessary care merely because of the duration of treatment. EPSDT requirements prohibit imposing hard caps on intensity or duration of services.²⁰ Care must be provided based on individual medical necessity. As long as a child is making substantial progress towards ameliorating the deficits of ASD treatment should continue. Moreover, as with many long-term, often chronic disorders, some level of treatment may be necessary for maintenance of function and prevention of deterioration. It is well established, that EPSDT requires coverage of such treatment.²¹

¹⁹ BACB Guidelines, p. 21 (IQ scored should not be used to deny or discontinue ABA treatment).

²⁰ EPSDT Coverage Guide, pp. 23-24.

²¹ *A.M.T. v. Gargano*, 781 F. Supp. 2d 798 (S.D. Ind. Feb. 10, 2011) (requiring Medicaid coverage of physician-prescribed physical, occupational, respiratory and speech therapy as maintenance therapy and to prevent regression); Louisiana Applied Behavior Analysis-Based Therapy Services, LAC 50, Ch.1, Sec. 103(F)(2) (requiring Medicaid ABA coverage where “necessary for maintenance of function or to prevent deterioration.”)

Recommendation

To avoid confusion and potential improper denials of care, delete references to ABA as being “time limited.”

317:30-65.12 (e)(2)(a)(b)

Treatment (presumably treatment plan) requirements are to be strength specific and least intrusive as possible.

Concern

General language such as this can be subject to confusion and potentially improper second-guessing of individualized clinical judgments by treating professionals. While strengths may be considered in treatment planning, as with any condition, treatment of ASD is focused on amelioration of deficits and weaknesses. Making significant progress can entail highly intrusive protocols and techniques that will ultimately result in a child being able to function in mainstream environments. ABA is inherently an individualized treatment applied and generalized in natural environments in addition to structured teaching environments.

Recommendation

Delete 317:30-65.12 (e)(2)(a) and (b) or limit language in sections to state that treatment will be based on individualized needs and goals and delivered in a culturally competent manner.

317:30-65.12 (e)(2)(h)

ABA treatment must “document planning for transition through the continuum of intervention, services, settings, as well discharge criteria.”

Concern

Transition and discharge from services is highly individualized and subject to change as treatment progresses. There is no set course through a continuum of services. There may or may not be a transition to other services depending on attainment of treatment goals, current issues and whether any other services are needed and likely to be effective. The quoted section seems to imply this is to be determined at the outset of treatment which is unrealistic and inconsistent with general standards of care. Discharge criteria may evolve and must be consistent with EPSDT goals of maximum reduction of the debilitating aspects of a child’s ASD.

Recommendation

Revise section to require documentation of planning for transitions or discharge when expected to occur during current authorization period.

317:30-65.12 (f)(6)

It is required that the “treatment plan documents a gradual fading of higher intensities of intervention and shifting to supports from other sources (i.e. schools) as progress occurs.

Concern

This section is inconsistent with EPSDT requirements and generally accepted standards of care. Treatment decisions must be based on individualized determinations of medical necessity and what treatment is necessary to correct or ameliorate a child’s condition. Schools services are not a substitute for medically necessary care. For some children proper care may involve a tapering of hours as a child completes therapy for others continued high intensity treatment may be necessary to allow a child to build the range of requisite skills and extinguish problem behaviors to correct or ameliorate the child’s ASD and achieve maximum function. Treatment typically takes place over multiple authorization periods with new medically necessary treatment targets being addressed as others are mastered. It is manifestly improper and contrary to sound medical practice to require tapering to occur in every authorization period where progress is made.²²

317:30-65.12(f) (2) ABA extension requests

The frequency of the target behavior has diminished since last review. Or if not, there has been modification of the treatment or additional assessments have been conducted.

Concern

This section and others in the paragraph do not seem to take into account skill building targets as opposed to deceleration of problem behavior which is merely one type of treatment goal.

Recommendation

Revise section to simply require submission of data showing progress on goals and objectives of the treatment plan.

²² Cf. *Wit v. United Behavioral Health*, No. 14-cv-02346, (N.D. Cal.) Findings of Fact and Conclusions of Law, February 28, 2019, pp. 104-106 (ERISA action, coverage guidelines for residential mental health treatment that placed excessive emphasis on acuity and crises stabilization, pushed patients to lower of care when safe to do so even if this would be less effective and failed to take into account the developmental state of children, violated generally accepted standards of care).

317:30-65.12(e)(2)(K)

Ensure that recommended ABA services do not duplicate, or replicate services received in a member's primary academic education setting or provided within an individualized Education Plan (IEP) or Individualized Service Plan (ISP).

Concern

Care must be taken not to conflate education related services schools must provide with medically necessary care which remains the responsibility of OHCA. IDEA services are provided by school personnel to allow a child to access the educational curriculum to achieve an educational benefit. EPSDT services are medically necessary care to correct or ameliorate the defects and conditions of a child's ASD and are provided by qualified healthcare providers in accordance with professional standards pursuant to an approved treatment plan.

Services set forth in an IEP would typically not be duplicative of EPSDT services and would not be coverable as medical assistance, so the exclusion in the rule should be very limited. It is possible that some medically necessary ABA care could be included in an IEP as a related service or in a 504 plan as an accommodation, however, in such circumstances, the Medicaid agency would continue to be responsible for this care if Medicaid service delivery requirements, including provider credentials, have been met.²³ If such requirements are not met, the service should not be considered duplicative.

Recommendation

Add to the section a statement that services will not be considered duplicative or a replication of school services unless such services meet Medicaid EPSDT standards and that ABA treatment in a school setting will be covered by OHCA when medically necessary.

317:30-65.12(d)(6)

This section requires that the focus of the treatment is not custodial in nature which it defines as care provided when the member has reached the maximum level of physical and mental functioning and is not likely to make further significant improvement or where the primary purpose of the type of care provided is to attend to the members daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.

²³ See 42 U.S.C. § 1396b(c); *Detsel by Detsel v. Sullivan*, 895 F.2d 58, 66 (2d Cir. 1990) ((state may not “preclude a claimant who resides at home from receiving Medicaid reimbursement for [services] rendered during those few hours of each day when her normal life activities take her outside her home to attend school”); CMS, Dear State Medicaid Director 13 (Dec. 15, 2014), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>

Concern

Care must be taken to ensure that treatment for maintenance of function is covered.²⁴ In addition, treatment targets that may involve functional living skills are not custodial in nature and not for the purpose of providing attendant care but for the purpose of allowing the member to develop essential functional skills that have not been acquired naturally because of the members ASD deficits.

Recommendation

Add language that developing, restoring, or maintaining self-help, daily living, or safety skills of the member as part of the ABA treatment plan for correcting or ameliorating conditions attendant to the member's ASD does not constitute custodial care. Add statement that ABA services to maintain function or prevent deterioration do not constitute custodial care.

Thank you for considering these comments. If you require anything further, please do not hesitate to contact us.

Respectfully submitted,



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²⁴ *A.M.T. v. Gargano*, 781 F. Supp. 2d 798 (S.D. Ind. Feb. 10, 2011) (requiring coverage of physical, occupational, respiratory and speech therapy needed to maintain function and prevent regression); Louisiana Applied Behavior Analysis-Based Therapy Services, LAC 50, Ch.1, Sec. 103(F)(2) (requiring Medicaid ABA coverage where “necessary for maintenance of function or to prevent deterioration.”)