CASP
The Council of Autism Service Providers

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Oklahoma Health Care Authority

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APA WF # 24-23 Applied Behavior Analysis (ABA) Changes

To Whom it may Concern:

CASP is a non-profit trade association of autism service provider organizations, with a demonstrated commitment to promoting and delivering evidence-based practices for individuals with autism. CASP represents the autism provider community to the nation at large, including government, payers, and the general public. CASP provides information, education, and promotes the generally accepted standards of care for applied behavior analysis (ABA). CASP is committed to addressing barriers that impact access to quality services delivered by qualified providers.

On behalf of CASP member organizations providing services to Oklahoma Health Care Authority (OHCA) beneficiaries, thank you for the opportunity to provide comment on APA WF# 24-23 Applied Behavior Analysis (ABA) changes.

CASP applauds OHCA for seeking approval of emergency rule revisions to update outdated ABA policies and ensuring that services meet a standard level of quality for all applicable OHCA beneficiaries. CASP and our member organizations appreciate OHCA's continuous commitment to quality improvement, and aligning the rule with best practices, Federal Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) requirements and generally accepted standards of care (GASC). We also recognize OHCA for the steps it is taking to ensure consistent application of the ABA policy across Sooner Select Managed Care Organizations (MCOs).

Now that Oklahoma Medicaid beneficiaries utilize Sooner Select MCOs the Federal Mental Health Parity and Addictions Equity Act (MHPAEA) applies to the ABA benefit, and any other mental health and substance use disorder benefits managed by the MCOs.[1]

The following proposed revisions are significant steps forward for OHCA beneficiaries:

- Aligning RBT supervision requirements with the BACB minimum expectation of 5%.
- Requiring treatment plan goals to relate back to the core deficits associated with autism spectrum disorder (ASD) as outlined in the Diagnostic and Statistical Manual of Mental DIsorders (DSM) and acknowledging functional limitations that interfere with participation in daily life and activities; rather than the previous reliance on maladaptive behavior, alone.

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/cib06122024.pdf

- Inclusion of an interdisciplinary team (IDT) to complete comprehensive diagnostic evaluations (CDE)
- Recognition that ASD is a life-long condition, and, therefore there is no need for the CDE to be updated on a set interval, every X years.
- Development of an expanded list of atypical or disruptive behaviors, including: aggression towards others, self injury, elopement, PICA, property destruction, severe disruption in daily functioning, and excessive self-stimulatory behaviors that impact the individual's ability to engage in functional behavior. Though this is not an exhaustive list, this list is more inclusive of the various topographical responses that might prevent an individual from accessing services in a less restrictive environment or may cause a family to seek access to specialized services, including applied behavior analysis.
- Aligning treatment plan and assessment activities to include trauma informed practices, and culturally responsive considerations, including goals related to generalization and maintenance in the natural environment.
- Emphasizing client safety and well being by including critical incident reporting requirements and clarifying the use of restraint.
- Inclusion of service quality review processes and audit expectations to ensure services are rendered in compliance with policy requirements and expectations.

Unfortunately, a number of the proposed policy revisions do not align with generally accepted standards of care, best clinical practice, MHPAEA, or are more restrictive than EPSDT allows. Many concerns fall into more than one category listed above. The comments to follow relate to our primary areas of concern with the draft policy, specifically the following sections:

- 317:30-5-313 (a) (1)
- 317:30-5-313 (b) (4) & (5)
- 317:30-5-314. (a) (1), (b) (1), (2) (J)
- 317:30-5-314 (b)(1) (b) (3) (B) & (L)
- 317:30-4-315 (2), (3), & (4)

On September 9, 2024, the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury released new final rules implementing MHPAEA. The final rules amend certain provisions of the existing MHPAEA regulations and add new regulations. In 2023, the Departments reported one of the most common NQTLs involved family guidance requirements to maintain access to medically necessary ABA services..[2]

> *"Example 9—More restrictive requirement for primary caregiver participation applied to ABA therapy. The medical necessity criteria for coverage of ABA therapy requires evidence that the participant's or beneficiary's primary caregivers actively participate in ABA therapy, as documented by consistent attendance in parent, caregiver, or guardian training sessions. In*

2 https://www.federalregister.gov/documents/2023/08/03/2023-15945/requirements-related-to-the-mental-health-parity-and-addiction-equity-act

adding this requirement, the plan deviates from independent professional medical or clinical standards, and there are no similar medical necessity criteria requiring evidence of primary caregiver participation to receive coverage for any medical/surgical benefits."

CASP respectfully requests that OHCA reconsider the following sections of 317:30-5 to align parent participation requirements with the generally accepted standards of care and MHPAEA requirements.

- 317:30-5-313(b) (5) Parent guidance participation requirements (85%), and
- 317:30-4-315 (2) (3) (4) Increased parent participation requirements to request an increased level of overall care in subsequent authorization periods

Generally accepted standards of care indicate:

> *"While caregiver participation can be additive to effective treatment, it is not a substitute for treatment and is not a condition for providing services. Numerous modalities and methods exist to include caregivers in a treatment program, even when direct participation is not possible or advisable."*[3]
>
> *"... it is not a replacement for professionally directed and implemented treatment, nor should it be a requirement for access to treatment. The dynamics of a family, their well-being, and how ASD impacts them should be reflected in how the treatment is implemented in individual cases. The ability of family members to support treatment goals outside treatment hours will be partially determined by how well-matched the treatment protocols are to the family's culture, values, needs, priorities, abilities, and resources."*[4]

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting periods, or other similar limits on the scope or duration of treatment.[5] Unless similar medical/surgical benefit (Med/Surg) limitations exist and are applied to predominantly all Med/Surg benefits, then the following aspects of the policy are clear quantitative and non quantitative treatment limitations under MHPAEA:

317:30-5-313 (a) Medical Necessity Criteria and covered Services for members under twenty-one (21) years of age and frequency and duration.

(1)... with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers within the state of Oklahoma or within 50 miles of the Oklahoma border (as per OAC 317:30–3-89 through 92):

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[3] https://assets-002.noviams.com/novi-file-uploads/casp/pdfs-and-documents/ASD_Guidelines/ABA_Practice_Guidelines_3_0.pdf

[4] Id

[5] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

The proposed language does not allow individuals who move from out of state and have a comprehensive diagnostic evaluation that meets the requirements set forth by OHCA (i.e., was completed in the last two years, by an approved provider, includes the criteria outlined in the most common version of the DSM, including symptom severity levels access to care). Respectfully, this requirement creates an undue burden and delay in accessing medically necessary care. There is a known issue with timely diagnostic services, across the country, EPSDT requires timely access to care. [6] [7]

CASP respectfully requests the removal of these requirements for comprehensive diagnostic evaluations.

317:30-5-313 (b) Frequency and Duration

As written the entire Frequency and Duration section do not meet MHPAEA requirements. The language is prescriptive in nature and does not allow for individualization based on unique OHCA beneficiary needs. CASP recommends significant revisions to reflect the opportunity for additional considerations within each proposed intensity category, or the removal of these categories all together. Language indicating "at least two of the following" while including only two options is misleading. As written, individuals must have ASD level 2 or level 3 and engage in challenging behavior to access comprehensive services. This directly contradicts best clinical practice and generally accepted standards of care, which recognize the importance of early intensive behavioral intervention.

> *"Intervention must be implemented as early as possible to improve the developmental trajectory of children diagnosed with autism. Effective early intervention focuses on establishing foundational skills, such as environmental awareness, imitation, functional communication, self-management, daily living skills, and the building blocks for social interaction. These foundational skills reduce the pervasive impact of ASD and minimize the likelihood of additional disability in the form of intellectual impairment. In addition to building skills, early development is the optimal period to reduce and mitigate challenging behaviors."*[8]

Furthermore, EPSDT requires;

> *"...that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible...Ultimately, the goal of EPSDT is to assure that children get the health*

[6] Yu-Hsin Chen, Madison Drye, Qiushi Chen, Madison Fecher, Guodong Liu, Whitney Guthrie, Delay from Screening to Diagnosis in Autism Spectrum Disorder: Results from a Large National Health Research Network,The Journal of Pediatrics,Volume 260,2023,113514,ISSN 0022-3476, https://doi.org/10.1016/j.jpeds.2023.113514.

[7] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-07-14.pdf

[8] https://assets-002.noviams.com/novi-file-uploads/casp/pdfs-and-documents/ASD_Guidelines/ABA_Practice_Guidelines_3_0.pdf

care they need, when they need it – the right care to the right child at the right time in the right setting."[9]

The right time and right setting, include timely access to comprehensive care, when medically appropriate, based on the qualified licensed behavior analyst's (LBA) clinical judgment.

Fail first requirements indicate for coverage of intensive outpatient treatment for MH/SUD, the plan/insurer requires that a patient has not achieved progress with non-intensive outpatient treatment of a lesser frequency.[10] This requirement is a NQTL and a violation under MHPAEA.

Fail First requirements were noted within the Frequency and Duration subsection, specifically:

(4) It has been determined that there is no less intensive or more appropriate level of service which can be safely and effectively provided.

CASP recommends removing this language from the final policy.

317:30-5-314. Prior Authorization, Service limitation, and exclusions to treatment.

(a) Prior authorization (1) lists several assessments that may be utilized, however, the list is not exhaustive, and does not allow for clinical judgment and evaluation of an individual beneficiary's strengths, weaknesses, and areas of concern. Rather than provide a list, CASP recommends language that is consistent with the generally accepted standards of care and best clinical practice. Specifically:

"Individualizing ABA care is critical to achieving optimal patient outcomes. Behavior-analytic services are designed to support the development of skills to enhance patient well-being, autonomy, and independence and to expand opportunities throughout the lifespan. The course of treatment is guided by assessment and a treatment plan tailored to support the needs of the patient."[11]

(2) (J) The requirement to document a beneficiaries schedule, hour by hour, including all possible members of the treatment team, with name and credential, is onerous and a NQTL under MHPAEA, unless this requirement exists for substantially all Medical/Surgical benefits by the Sooner Select Managed Care Organizations (MCOs).[12] Alternatively, CASP recommends a daily schedule that includes general information about the specific goals, objectives, and activities that may be addressed during ABA. This allows the necessary flexibility to ensure overall compliance with OHCA's expectations, while not limiting the LBA and

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[9] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-07-14.pdf

[10] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

[11] https://assets-002.noviams.com/novi-file-uploads/casp/pdfs-and-documents/ASD_Guidelines/ABA_Practice_Guidelines_3_0.pdf

[12] https://www.federalregister.gov/documents/2023/08/03/2023-15945/requirements-related-to-the-mental-health-parity-and-addiction-equity-act

their team from making appropriate adjustments to an individual's treatment team, schedule, or appropriate modifications based on program evaluation, data analysis, and clinical decision making.

317:30-5-314 (b)(1) Service limitations.

EPSDT requires the right care, to the right child, at the right time, in the right setting. Part 1 (A) (B) and (C) limit access to care in specific settings that directly contradict EPSDT and MHPAEA requirements. CASP agrees that services rendered by the LBA, or the individuals they supervise, should not be educational or custodial in nature. Providing stringent limitations on access in these settings may compromise appropriate transition and discharge planning, and adequate assessment and treatment of challenging behavior(s) in the environment where they occur. Rather than the current language regarding service limitations in the school or daycare setting, CASP recommends removing references to these services being time limited to three (3) months or less.

317:30-5-314 (b)(3)

(B) ABA addressing goals only related to performative social norms that do not significantly impact health, safety, or independence.

(L) ABA authorized for toilet learning/ toilet training.

EPSDT allows for authorization of treatment that can maintain a health condition, including preventing a condition from worsening. The core diagnostic criterion associated with ASD include deficits in social communication and insistence on sameness through rigid/ routine oriented responding. These deficits impact an individual's ability to interact safely and independently within their environment. Deficits are often addressed through social communication goals that may not directly address health, safety, or wellbeing but are a required prerequisite behavior that leads to a long-term impact in these areas. Toilet learning/ toilet training often addresses both deficits in social communication and rigid/routine oriented responding. When toileting is directly related to these deficits, and not for the convenience of the parent or caregiver, these programs meet the EPSDT requirement of ameliorating, or preventing the worsening of, the health condition.

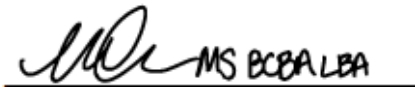
CASP recommends further clarification for (B) such as:

> *"when the treatment plan does not clearly indicate how the proposed goal relates back to a core deficit associated with autism, or a prerequisite skill necessary to address a core deficit, and is related to performative social norms that do not significantly impact, health, safety or independence."*

CASP recommends the removal of toilet learning and toilet training from (L)

CASP is thankful and appreciative for the steps to improve the ABA policy, ensure consistent implementation, and establish increased oversight and protections for some of Oklahoma's most vulnerable citizens, children with autism. On behalf of CASP and our Oklahoma member organizations, I am happy to answer questions and look forward to serving as a resource for this policy and any future policies impacting behavior analysts and the autism community.

Respectfully Submitted,



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