Executive Order 25-31 Applied Behavior Analysis (ABA) Working Group Recommendations

Contents

1. Executive summary

Indiana is at a pivotal moment in the provision of Medicaid-funded Applied Behavior Analysis (ABA) therapy. High-quality ABA therapy has been transformative for many Hoosier children with autism spectrum disorder (ASD), helping them to gain essential skills, reduce barriers, and increase independence. ABA therapy is one intervention among several: Indiana supports a range of evidence-based interventions such as speech therapy, occupational therapy, and developmental supports, and must continue to ensure children with ASD grow and thrive in inclusive environments.

The state faces an urgent challenge to ensure continued access to high-quality, effective care in a fiscally sustainable way. Medicaid spending on ABA therapy in Indiana grew exponentially from $21 million in 2017 to $611 million in 2023, raising serious concerns about the long-term affordability of ABA therapy.

This report presents the findings and recommendations of Governor Braun's Working Group on ABA therapy in Indiana, convened in response to Executive Order 25-31. The order required the Secretary of the Family and Social Services Administration (FSSA), in collaboration with the Secretary of the Indiana Department of Education (IDOE), to organize a working group to evaluate cost containment strategies that minimize the negative impact felt by ABA therapy enrollees and their families.

From May to September 2025, the resulting Working Group, comprised of state leaders, clinicians, educators, parents, providers, and advocacy organizations, undertook a comprehensive review of Indiana's current ABA therapy landscape. Drawing on statewide data on ABA therapy utilization, national benchmarks, public feedback, and subject matter expertise, the group identified key challenges across utilization patterns, care quality, reimbursement structures, and systemic coordination. In response, the Working Group recommends a holistic package of five interdependent strategies designed to align clinical practice with evidence, improve quality oversight, support sustainable reimbursement, and strengthen the broader ecosystem of care beyond Medicaid.

Each recommendation is supported by implementation strategies (near-term priority recommendations) and future considerations (longer-term recommendations) that balance fiscal responsibility with continued commitment to family-centered care. Together, these strategies emphasize early intervention, appropriate and tailored intensity and duration of therapy, enhanced provider accountability, and greater collaboration with schools and insurers. Importantly, the recommendations are not isolated levers, but rather mutually reinforcing components of a cohesive vision for reform.

The Working Group affirms that thoughtful, timely action is essential to safeguard Indiana's ability to provide ABA therapy to those who need it, now and in the future. By pursuing these recommendations, the state can protect access, improve outcomes for children with ASD, and ensure that Medicaid-funded services remain a reliable and responsible source of support for Hoosier families.

Specifically, the Working Group recommends that Governor Braun consider the following:

1. **Align ABA utilization with clinical evidence** by implementing service allocations that encourage medically necessary[i] use of ABA therapy and support transitions from comprehensive (high intensity) therapy to more targeted ABA or other services as children progress, and ensure caregiver involvement.

2. **Ensure high quality care provision and optimal clinical outcomes for children** by implementing supervision ratios for Registered Behavior Technicians (RBTs), requiring accreditation of ABA therapy centers, and implementing a temporary moratorium on new ABA therapy sites and create incentives for provider engagement in underserved counties.

3. **Establish sustainable rates for ABA by adjusting individual and group rates** to reflect evidence-based practices, and by evaluating a phased quality incentive program to reward improved outcomes.

4. **Strengthen foundations for effective end-to-end ABA therapy management**, by establishing a dedicated program office within FSSA responsible for data monitoring, provider oversight, transparent reporting, and continuous refinement of policies and processes.

5. **Support a sustainable ecosystem for ABA** by ensuring commercial insurers meet coverage obligations and by strengthening collaboration with schools so children receive coordinated, effective supports in the educational system.

2. Introduction

2.1. Overview

Autism Spectrum Disorder (ASD) is a complex developmental condition. According to the Centers for Disease Control and Prevention (CDC), people with ASD often experience challenges in social communication and interaction, demonstrate restricted or repetitive behaviors or interests, and learn, move or pay attention in different ways. People with ASD have a wide range of abilities: some may be highly independent, while others may need significant daily support. ASD can be diagnosed in early childhood, with widespread consensus that early intervention and treatment is key to improving long-term outcomes.

ABA therapy is a widely used, evidence-based approach for children with ASD. According to the CDC, ABA therapy encourages desired behaviors and discourages undesired behaviors to improve a variety of skills. ABA therapy is the most common treatment option for ASD, alongside other therapies and interventions. These include occupational therapy, speech therapy, and physical therapy, which are often considered supplementary to ABA therapy. ABA therapy has been endorsed by numerous scientific, professional, and government organizations as one of the most effective interventions for children with ASD.[ii] Children typically enter ABA therapy through a multi-step process that begins with ASD diagnosis by a designated qualified healthcare professional.[iii]. If families elect to pursue ABA therapy after their child receives an ASD diagnosis, they are referred to an ABA therapy provider who develops an individualized

treatment plan based upon a thorough behavior assessment that includes a standardized assessment of the child's adaptive functioning, parent-child relationship, and an age-appropriate objective direct skills assessment. The Indiana Health Care Programs bulletin issued on November 29, 2024, identified specific measures that must be included in a treatment plan. Once approved, therapy is delivered, most often in ABA therapy centers, with progress monitored through ongoing data collection.

Board Certified Behavior Analysts (BCBAs) and RBTs comprise the majority of ABA therapy providers. To be credentialed by the Behavior Analyst Certification Board (BACB), BCBAs are required to have a master's degree, supervised fieldwork experience, and to pass the BCBA exam. RBTs must possess a high school diploma or equivalent, complete a 40-hour training, and pass a competency assessment and the RBT exam. Other qualified ABA therapy providers can include Health Service Providers in Psychology (HSPPs) with specific training and experience in ABA therapy, Board-Certified Assistant Behavior Analysts (BCaBAs), and can also include supervision of RBTs and BCaBAs by a Board Certified Behavior Analyst-Doctoral (BCBA-D).

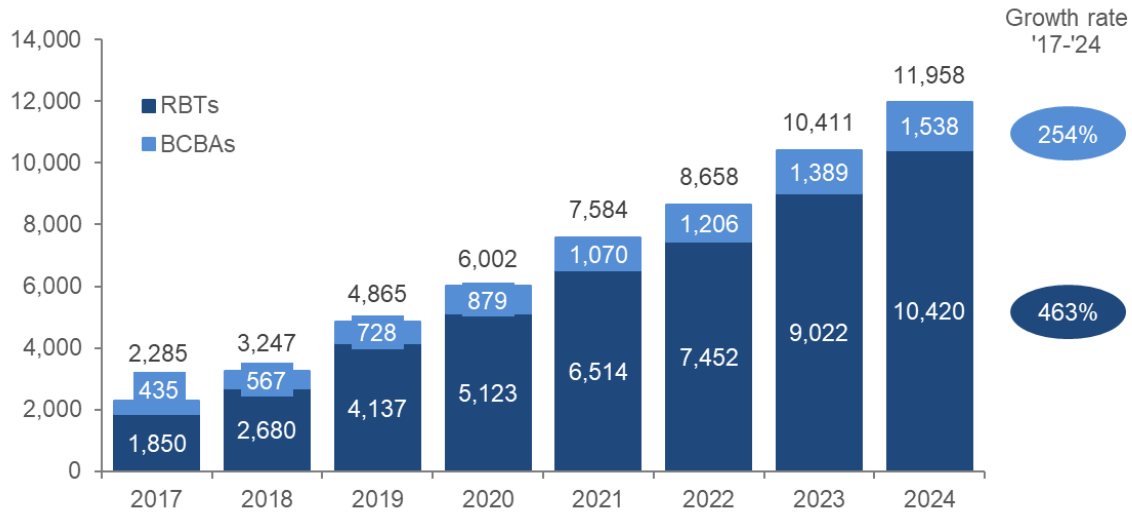
2.2. Recent trends

The prevalence of ASD has increased rapidly nationwide. According to the CDC's Autism and Developmental Disabilities Monitoring Network, in 2012, 1 in 68 eight-year-old children were identified to have ASD. In 2022 (the latest year for which data is available), this number had risen to 1 in 31, an almost 120% growth over 10 years. Although directly comparable data is not available for Indiana, in 2021, 1 in 37 school-going children in Indiana were diagnosed with ASD according to the CDC's National Survey of Children's Health, compared to 1 in 34 school-going children nationally. Across prevalence measures, Indiana appears to be in line with national rates.

Nationally and in Indiana, insurance coverage for ASD treatment is mandated. In 2001, Indiana became the first state in the country to enact an insurance mandate for ASD, and today, all 50 states have enacted mandates requiring insurers to cover autism-related services. Per guidelines from the Centers for Medicare & Medicaid Services (CMS), Medicaid programs across the country must cover particular medically necessary treatments, including intensive behavioral health services, necessary to correct or ameliorate a child's ASD when no alternative, equally effective treatment is appropriate for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) eligible member.

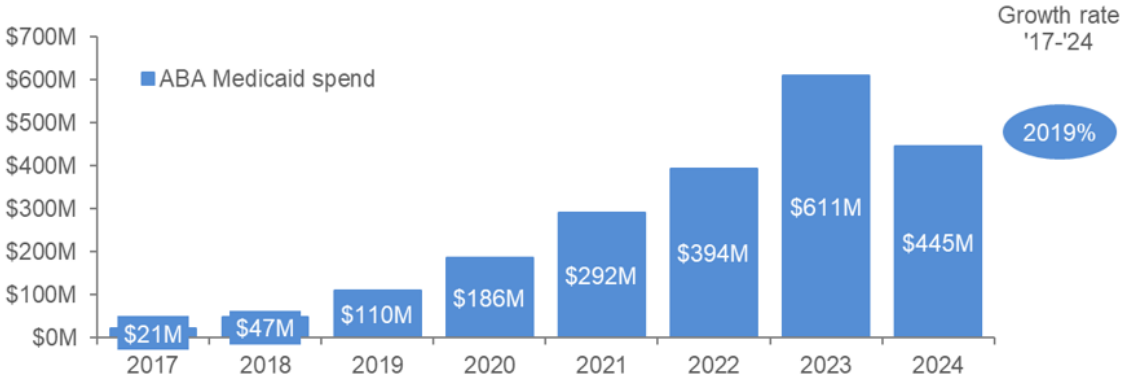
As ASD diagnoses and insurance coverage for treatment have expanded, the ABA therapy workforce and associated spending have grown rapidly. According to national BACB data, from 2017 to 2024, the number of BACB-certified BCBAs increased by 2.8x, and the number of BACB-certified RBTs increased 5.8x. Indiana saw similar growth rates over this period. In 2024, Indiana had approximately seven RBTs per BCBA, which is double the national average. This higher ratio is not explained by the greater prevalence of ASD. Even after adjusting for population size, Indiana has the 3rd highest number of RBTs in the country, after Florida and Hawaii.

Figure 1: Number of RBTs and BCBAs in Indiana by year



Indiana implemented Medicaid coverage for ABA therapy in 2016. In 2017, Medicaid spent $21 million on ABA therapy, across both fee-for-service and managed care. By the end of 2019, this number had grown to $110 million, and by the end of 2023, spending on ABA therapy was $611 million (covering approximately 8,000 children, averaging $75,000 per child annually). This represents a 2,867% increase in total spending over six years. Over this period, ABA's share of the total Medicaid budget grew from 0.2% to 3.4%, a 17x increase. Standardized reimbursement rates reduced spending to $445 million in 2024, or 2.3% of the total Medicaid budget, but this remains far above the approximately 0.6% of Medicaid enrollees receiving ABA therapy. Without further action, costs are expected to continue growing at unsustainable levels for Indiana.

Figure 2: Medicaid spending on ABA from 2017-2024



	2017	2018	2019	2020	2021	2022	2023	2024
Total Medicaid spend ($B)	11.6	11.8	13	14.8	17.2	17.3	17.8	19.5
% of Medicaid spending	0.2%	0.4%	0.8%	1.3%	1.7%	2.3%	3.4%	2.3%

Exacerbating this challenge is the limited visibility into, and oversight of, the quality of ABA therapy in Indiana. A 2024 report from the Office of the Inspector General (OIG) for the United States Department of Health & Human Services reviewed 2019-2020 fee-for-service Medicaid

claims for ABA therapy in Indiana. The audit identified an estimated $56.5 million in improper Medicaid payments and an additional estimated $76.7 million in potentially improper payments.

For 97 out of 100 sampled enrollee-months (i.e., all Medicaid claims and associated payments for a single enrollee during a specific calendar month), FSSA made payments for at least one claim that did not comply with the stipulated requirements. Improper payments were flagged because of the following:

- Session notes describing the ABA therapy provided did not meet documentation requirements (e.g., session notes did not support the CPT codes paid) (95 sampled enrollee-months)
- ABA therapy was provided by staff who did not have the appropriate credentials (26 sampled enrollee-months)
- ABA therapy was provided to children who did not receive the required diagnostic evaluations or treatment referrals for ABA (22 sampled enrollee-months)

For all 100 sampled enrollee-months, FSSA made potentially improper ABA therapy payments, meaning that the documentation supporting the ABA therapy provided was not detailed or the documentation was unreliable. Potentially improper payments were flagged because of the following:

- Session notes did not fully disclose the extent of services provided or did not include a detailed statement describing the services provided (e.g., the ABA therapy techniques used) and the duration of services provided (98 sampled enrollee-months)
- Session notes included potential non-therapy time (e.g., for meals, breaks, and naps) (97 sampled enrollee-months)
- Session notes referred to recreational or academic activities that may not have been allowable ABA activities (61 sampled enrollee-months)
- Session notes referred to group activities, but payments were made for individual ABA (37 sampled enrollee-months)

Although the OIG did not assess the clinical effectiveness or quality of ABA therapy, it highlighted systemic weaknesses that could affect oversight and care quality. The following issues were identified: referrals were outdated with no independent medical necessity review, there was insufficient detail in Medicaid claims for utilization review, inadequate documentation of RBT supervision, and lack of required staff background checks, and most facilities did not offer caregiver training.

Since the release of the OIG audit, FSSA initiated a program integrity review of Medicaid claims paid for ABA therapy from 2022 through 2025. This review takes a comprehensive look at ABA claims on a provider-by-provider basis, auditing claims through an in-depth medical records review process. Medical records are scrutinized to ensure compliance with Indiana Medicaid's policies, procedures, and guidelines. Upon completion, providers are required to refund any overpayments due to identified errors and receive additional training to ensure compliance moving forward. Further, FSSA is also auditing all claims identified in OIG's report and requiring refund of any identified overpayments.

Entry points to Medicaid-covered ABA

*In 2024, **35%** of individuals receiving Medicaid-covered ABA in Indiana were served through fee-for-service, where the state reimburses providers directly for services provided. Fee-for-service eligibility generally applies to children with a disability, who receive long-term services and support (LTSS) through institutional care or a home- and community-based services (HCBS) waiver. The other **65%** received ABA through managed care entities (MCEs), which are health insurance companies contracted by the state to manage Medicaid members' health needs. Most children on Medicaid who receive ABA therapy qualify based on income, not a formal disability diagnosis.*

ABA therapy delivers critical clinical care to Hoosier children and families. For many Hoosier families, access to ABA therapy can mean the difference between struggle and progress, isolation and inclusion. The Working Group recognizes the need for Indiana's Medicaid program to support children with ASD and their families effectively through covering the provision of appropriate, high-quality ABA therapy that delivers progress and helps Hoosier children live full and independent lives to the greatest extent possible.

However, without change, the integrity of the ABA program, and the sustainability of Medicaid are at risk. To urgently attempt to address this concern, the Indiana FSSA drafted a State Plan Amendment (SPA) for public comment January 15, 2025, through February 14, 2025, while recognizing that a broader and more comprehensive review of the state's ABA benefit was required in parallel. To date, CMS had placed the SPA in a formal request for additional information (RAI) status.

To this end, Governor Mike Braun issued Executive Order 25-31 in February 2025. The Executive Order required Indiana's FSSA and IDOE to organize a Working Group to evaluate cost containment strategies that minimize the negative impact felt by ABA Medicaid enrollees and their families. Specifically, Governor Braun's Executive Order tasked the Working Group to evaluate:

- The best clinical care models to provide the right therapy, at the right ages, in the right setting, to best serve children and families
- Recommendations for a better coordinated experience for children who need ABA therapy services, but in a financially sustainable manner
- Proper transitions for children as they grow in their educational, family, and social settings
- Quality metrics for ABA therapy services
- Potential caps on hours of therapy services provided per week
- Potential caps on the number of months a child can receive therapy services
- Creating an appeals process for extenuating services
- Establishing new provider enrollment and billing requirements for ABA providers to address issues identified in the federal audit

2.3. Working Group approach

Indiana's Working Group on ABA was launched by FSSA Secretary Mitch Roob in May 2025. Its diverse membership includes state leaders, clinicians, educators, parents, providers, and advocacy organizations, ensuring a broad range of experience and expertise and commitment to serving children with ASD and their families. Working Group members included:

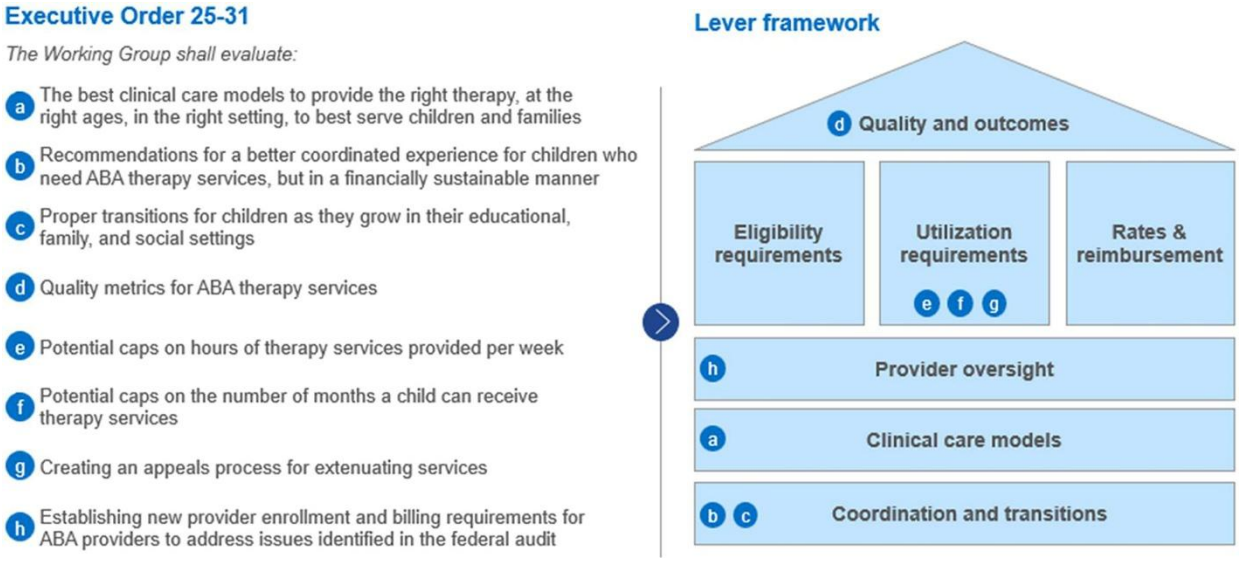
- State of Indiana representatives:
    - **Molly Collins**, M.A., Legislative Director for the Office of the Secretary of Education
    - **Christina Commons**, Bureau of Child Development Services / First Steps Director, FSSA
    - **Katrina Etter**, DNP, R.N., CMCN, Medicaid Director of Clinical Operations, Office of Medicaid Policy and Planning, FSSA
    - **Eric Miller**, M.P.A., M.B.A., Deputy Secretary / Chief of Staff, FSSA, and Parent
    - **Tara Morse**, M.Ed., PMP, Indiana 211 Director, FSSA
    - **Rebecca Roy**, LCSW, Integrated Care Team Director, Department of Child Services (DCS)
- Community-based members:
    - **Adam Burtner**, Senior Director of Government Relations, Elevance Health
    - **Susan Crowell**, Founder & Executive Director, My Autism Ally
    - **Jim Dalton**, Psy.D., HSPP, CSAYC, President & CEO, Damar
    - **Rachel Deaton**, Director of Training & Legislation, Autism Society of Indiana
    - **Kim Dodson**, CEO, The Arc of Indiana
    - **Jill Fodstad**, Ph.D., HSPP, BCBA-D, Clinical Psychologist, IU Health and IU School of Medicine, Department of Psychiatry
    - **Jessica Green**, M.D., Medical Director Developmental-Behavioral Pediatrics Clinic
    - **Robb Greene**, State Representative, House District 47
    - **Lori Goss-Reaves**, D.S.W., LCSW, State Representative, House District 31
    - **Cari Neal**, M.Ed., Parent, Northeast Indiana
    - **David Reed**, M.S.W., LCSW, Consultant, Human Services Group
    - **Judge Stephen Roger Kitts II**, J.D., Parent, North Central Indiana
    - **Jill Lambert**, President-Elect, Indiana Council of Administrators of Special Education
    - **Jason McManus**, CEO, Wabash Center
    - **Chad Sims**, M.B.A., Parent, Central Indiana
    - **Camille Svendsen**, M.A., BCBA, LittleStar ABA Therapy

From May to September 2025, the Working Group convened regularly to review a wide range of analyses, including data on Indiana's ABA therapy utilization patterns, ABA therapy providers, and policy benchmarks from Indiana and other states, to develop a thorough understanding of the current landscape, key challenges, and actionable levers for improving Medicaid-covered ABA therapy services.

To address all aspects of the Executive Order's charge, the Working Group's analyses were structured in seven distinct areas:

- Quality and outcomes
- Eligibility requirements
- Utilization requirements
- Rates and reimbursement
- Provider oversight
- Clinical care models
- Coordination and transitions

Figure 3: Seven areas of analysis relating to Executive Order 25-31



Additionally, the Working Group supported five public listening sessions across Indiana's northwest, east, southern, and central regions, and held a statewide virtual session. In total, almost 230 people attended the listening sessions and almost 60 shared their perspectives, enabling the Working Group to consider inputs from Hoosiers from all walks of life. Additionally, over 170 written submissions were received through a public email address. Throughout this process, the Working Group has taken a person-centered and outcomes-oriented approach, ensuring that the perspectives of families, providers, clinicians, and educators across the state of Indiana were duly considered.

With supporting evidence, this report presents the key findings and the Working Group's recommendations to Governor Braun on cost containment strategies that minimize the negative impact felt by ABA therapy Medicaid enrollees and their families.

3. Recommendations

3.1. Overview

This report outlines a set of recommendations, for consideration by Governor Braun, that aim to address all components of the Executive Order. To achieve meaningful and long-term cost containment without compromising care quality and access, a holistic set of actions is required by the state, providers, and families. Therefore, the Working Group is putting forward five overarching recommendations, with supportive implementation strategies, which ensure that:

- Growth in Medicaid spending on ABA therapy can be brought under control in a way that protects the benefit for those who need it
- FSSA is equipped to effectively implement these strategies
- Commercial insurers play their part to ensure appropriate access to ABA therapy
- The education system and individual schools also effectively facilitate appropriate access to ABA therapy, while ensuring that children maintain the right to an education

The first three recommendations, around ABA therapy utilization, oversight of providers and centers, and rates, are directly related to the provision of ABA therapy. The fourth recommendation covers internal state enablers that are foundational to achieving the first three.

This is to ensure that there is sufficient state capacity, with a focus on process excellence, to achieve meaningful change and ensure long term financial sustainability for Medicaid. The fifth and final recommendation covers the role of stakeholders other than the Medicaid program, specifically private insurers and schools. Medicaid funding for ABA does not and cannot exist in a vacuum: private insurers need to do their part to sufficiently cover ABA to ensure access for eligible beneficiaries and thereby reduce the burden on Medicaid. To help children with ASD get the most from their education, Indiana's public schools must work with ABA therapy providers to support children's inclusion in schools whenever possible, with ABA playing an important role when indicated.

Working Group recommendations:

1. **Align ABA utilization with clinical evidence** by implementing service allocations that encourage medically necessary[iv] use of ABA therapy and support transitions from comprehensive (high-intensity) therapy to more targeted ABA or other services as children progress, and ensure caregiver involvement.

2. **Ensure high quality care provision and optimal clinical outcomes for children** by implementing supervision ratios for Registered Behavior Technicians (RBTs), requiring accreditation of ABA therapy centers, and implementing a temporary moratorium on new ABA therapy sites and create incentives for provider engagement in underserved counties.

3. **Establish sustainable rates for ABA by adjusting individual and group rates** to reflect evidence-based practices, and by evaluating a phased quality incentive program to reward improved outcomes.

4. **Strengthen foundations for effective end-to-end ABA therapy management**, by establishing a dedicated program office within FSSA responsible for data monitoring, provider oversight, transparent reporting, and continuous refinement of policies and processes.

5. **Support a sustainable ecosystem for ABA** by ensuring commercial insurers meet coverage obligations and by strengthening collaboration with schools so children receive coordinated, effective support in the educational system.

Without intervention, at a 13% annual growth rate, Indiana's projected Medicaid payments for ABA therapy in calendar year 2029 are projected to reach $825 million. The Working Group's package of recommendations is projected to reduce the annual growth rate to around 7- 8%, while protecting current ABA access for those who need it. The implementation strategies detailed in the recommendations preserve the foundations of the ABA benefit for Hoosier children, and tailor the program to better suit the needs of children and families, with a stronger focus on outcomes.

For each recommendation below, an overview of the relevant findings is provided, followed by the implementation strategies the state should employ to action the recommendation. For each of these implementation strategies, the current state, rationale for change, and

recommendations are provided. For a few recommendations, there are future considerations which include initiatives the state should pursue in the next few years, either dependent on nearer-term implementation strategies or do not warrant the same urgency.

3.2. Detail

3.2.1 Align ABA therapy utilization with clinical evidence

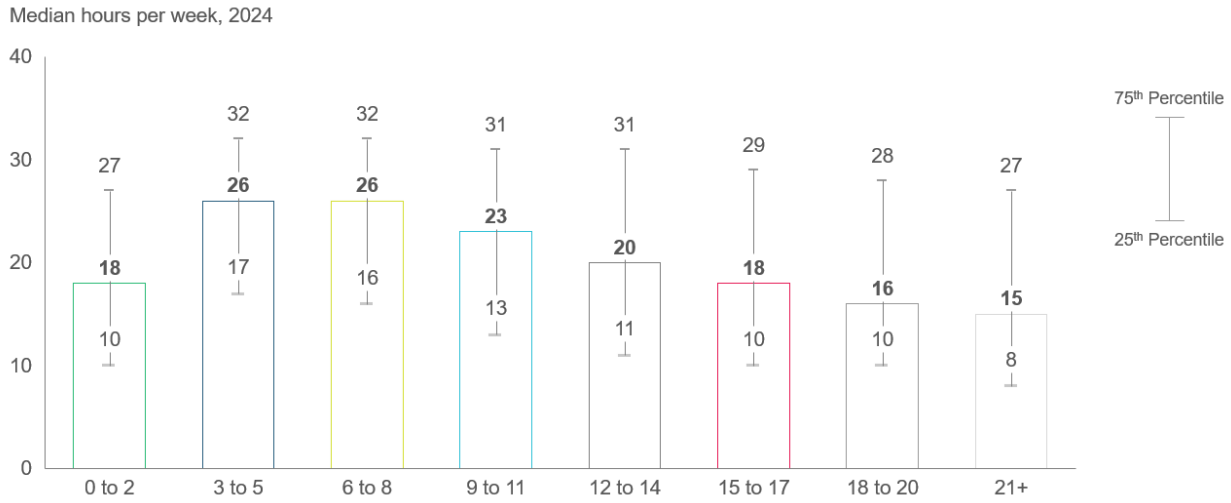
Recommendation	Implementation strategies:
Align ABA therapy utilization with clinical evidence	• Implement a flexible approach that does not include caps, that allows children to receive comprehensive ABA therapy when clinically appropriate, followed by more targeted ABA therapy as needs change • Develop clear criteria for functional impairments required for ABA services • Maintain policy of requiring ASD diagnosis for ABA therapy with exceptions for other developmental disabilities (DD) for medical necessity • Explicitly tie the ABA therapy benefit to EPSDT • Require caregiver involvement in ABA therapy for 9-18 hours per 6-month authorization period • Ensure group therapy hours are included in the treatment plan when clinically appropriate

Overview

Two very important aspects for the Working Group's consideration were how Medicaid-funded ABA therapy is being used, and who is using it. ABA therapy spending growth in Indiana has been driven by an increase in individuals receiving ABA therapy, rather than the number of hours per user: average weekly utilization of ABA therapy has remained relatively constant from 2019 to 2024. In 2024, on average, a child receiving Medicaid-funded ABA therapy received 23 to 27 hours of care per week.[v] In 2019, this range was 21 to 27 hours per week.

In 2024, almost 70% of individuals receiving ABA therapy were between the ages of three and eight, with almost 40% aged three to five and 30% aged six to eight. In 2024, 50% of individuals used more than 25 hours per week, and 34% of individuals used more than 30 hours per week. Only 7% of individuals receiving ABA therapy used more than 38 hours per week. Children aged three to six have the highest average weekly utilization in Indiana, around 25 hours per week. Older children and young adults tend to use fewer hours of ABA therapy per week on average, in the range of 15 to 20 hours. From available data, ABA therapy duration often exceeds two to three years: 40% of individuals who started using ABA therapy in 2020 are still in treatment in 2024. Following cohorts of users who began care in 2020, there was no observable decline in average weekly hours after 36 months of comprehensive ABA, suggesting that transitions to lower-intensity or alternative supports may not be occurring consistently or effectively as intended.

Figure 4: Distribution of weekly ABA hours utilization by age group



Any limitations on utilization are subject to the federally guaranteed EPSDT requirement in Medicaid. EPSDT ensures access to required healthcare for children and ensures exceptions to service limitations based on medical necessity.

Implementation strategy: **Implement a flexible approach that does not include caps, that allows children to receive comprehensive ABA therapy when clinically appropriate, followed by more targeted ABA therapy as needs change**

Definitions of comprehensive and targeted ABA therapy

Comprehensive ABA is an **intensive, broad-based therapy** typically used with young children, targeting multiple areas with the goal of **improving overall functioning** and reducing ASD symptoms. **Targeted ABA** involves more **focused and specific intervention**, concentrating on a **limited set of behaviors or skill areas**, such as communication, social skills, self-help, or specific challenges like sleep disruptions or aggression. This approach is appropriate for individuals across age groups and is often used as a transition from comprehensive services or to address specific concerns.

Current state

Indiana submitted a State Plan Amendment (SPA) with an effective date of July 1, 2025, to revise the Medicaid reimbursement methodology for Applied Behavioral Analysis (ABA) therapy services. At the time this document was written, the CMS had placed the SPA in a formal RAI status. Historically, FSSA has not had specific guidelines on ABA therapy allocations over any time duration of time. Authorizations were determined solely based on treatment plans submitted through the prior authorization (PA) process without any established guidance on the number of hours that could be approved.

Rationale for change

Rather than limiting care to a fixed weekly schedule or a set number of years, a cumulative allocation (e.g., up to 4,000 hours of comprehensive care over multiple years) provides flexibility for providers and families. This allows use of the appropriate comprehensive hours per week. This approach is adaptable to the evolving care needs of children with ASD and is responsive to the realities that children and families face, such as illness, vacations, school schedules, and family needs.

The Working Group emphasizes the importance of maintaining this flexibility. At the same time, it is critical to clearly distinguish between comprehensive and targeted ABA, and to actively support transitions out of comprehensive care when appropriate. ABA therapy is clinical care, and comprehensive delivery of ABA therapy should lead to measurable progress for children with ASD over a multi-year period. Targeted therapy should be used to maintain progress and address specific skill deficits or behaviors that persist. If providers and families disagree with authorization determinations, there is an established appeals process.

It is important that comprehensive services be rendered early in development given that clinical evidence shows that early intensive behavioral interventions are the most effective at making long term behavioral gains.[vi] Earlier initiation of comprehensive, intensive ABA, particularly before ages three to four is consistently associated with greater gains in IQ, adaptive behavior, language, and reduction in challenging behaviors.

Clear distinctions between comprehensive and targeted ABA therapy can help to encourage transitions by creating the imperative to phase down the number of hours when it is clinically appropriate. Providers should plan for transition from the outset of treatment, considering how children can move from high-intensity ABA into more integrated educational and community settings. Currently, this is not occurring consistently: nearly 40% of children still receive ABA therapy after three years at an average of over 20 hours per week. Given that many children are remaining in high-intensity ABA services for extended periods, establishing guidelines for when and how to step down from comprehensive care can help ensure that high-intensity services are available for children at the developmental stage where they are most effective.

Successful transitions depend on the collaboration of multiple stakeholders, notably schools. Children receiving targeted ABA (of up to 15 hours per week) should be included in classrooms with adequate support wherever possible and feasible. Effective transition planning not only promotes inclusion, but also ensures that service capacity is available for other children in need.

Recommendation

FSSA should implement guidance of up to 4,000 hours of comprehensive ABA therapy for eligible individuals (up to age 21). This would enable providers and families to use as many hours in each week, or month, as is appropriate (within the bounds of the PA) and roll-over unused hours to subsequent authorization periods. Once the 4,000 hours of comprehensive ABA therapy has been exhausted, individuals would be eligible for continued targeted ABA therapy (defined as up to 15 hours per week). If continued comprehensive care is required beyond the targeted hours guidance, this would be subject to additional review beyond the current requirements of the prior authorization (PA) process every 6 months.

Note that the actual number of hours authorized for each individual per prior authorization (PA) period would be determined according to clinical guidelines and demonstrated medical

necessity. These hours would include all direct treatment, caregiver training, and assessment hours, and exclude supervision hours. To implement appropriate hours guidelines, a review of the existing code sets and potential new codes and billing rates must be reviewed and adjusted, including the implementation of maximum unit edits (MUE). A review of lump sum billing practices should be included in this analysis. This policy would not be applied retroactively, i.e., all eligible individuals (current and new) would follow the guidelines of up to 4,000 hours of comprehensive ABA therapy from the effective implementation date of the policy.

Comprehensive ABA should be defined by clinical criteria (patient needs, weekly hour ranges, and evidence on effective duration), applying to requests over 400 hours per 6 months, while targeted ABA applies to 400 hours or fewer. This policy would require assigning modifiers to ABA codes that count toward the 4,000-hour lifetime guidelines, tracked through an accumulator in the PA portal with utilization management vendors confirming usage in the Indiana Health Coverage Programs (IHCP) portal. This centralized tracking will also be vital to ensure that the allocation is tracked for individuals who move between fee-for-service and managed care.

Implementation strategy: **Develop clear criteria for functional impairments required for ABA services**

Current state

As evidence for medical necessity, the prior authorization (PA) process requires documentation that the individual cannot adequately participate in home, school or community activities, or that the individual presents a safety risk. FSSA does not currently have specific functional impairment standards as part of the PA process.

Rationale for change

Developing clear functional impairment criteria for children with ASD will help ensure that ABA therapy focuses on documented behaviors that significantly interfere with daily functioning. At least 20 states use functional impairment criteria for Medicaid-funded ABA, including:

- **Virginia**, which requires significant functional impairment in at least two of six behavioral areas
- **Michigan**, which requires documentation of functional impairments in social communication, patterns of behavior, and social interaction
- **Montana**, which requires active symptomatology in at least two of six behavioral areas

Recommendation

FSSA should establish clear, standardized criteria outlining the number and types of functional impairments required to qualify for Medicaid-funded ABA services.

Implementation strategy: **Maintain policy of requiring ASD diagnosis for ABA therapy with exceptions for other developmental disabilities (DD) for medical necessity**

Current state

Indiana's current Medicaid policy limits ABA therapy to Medicaid members with an ASD diagnosis. In 2024, there were around 100 individuals receiving ABA therapy without an ASD diagnosis (around 1% of total users), who qualify for care based on medical necessity exceptions.

Rationale for change

The most robust body of clinical evidence supports the use of ABA therapy for children with ASD diagnoses.[vii] While studies suggest potential benefit for children with other developmental disabilities, the research base is less robust. Automatically, extending eligibility to conditions such as Attention-Deficit/Hyperactivity Disorder (ADHD) or Oppositional Defiant Disorder (ODD) without requiring medical necessity review, could lead to inappropriate use of ABA. Approximately 15 states, including Michigan, North Carolina, and Texas, require an ASD diagnosis for a child to be eligible for Medicaid-funded ABA therapy.

Recommendation

FSSA should maintain its current policy to limit ABA therapy to individuals 20 years of age and younger with an ASD diagnosis, with exceptions made for medical necessity. This would not create any change for current or future ABA therapy users with a DD other than ASD.

To consider a member eligible for IHCP coverage of ABA therapy, a child must first receive an ASD diagnosis or have another DD and be assessed to have significant areas of behavioral or adaptive functioning impacting their success in home, school, or community settings or be a safety risk to self along with an accompanying physician's recommendation for medically necessary ABA. This diagnosis must be made by a qualified healthcare professional with appropriate training and experience in the current diagnostic guidelines of ASD.[3] The qualified health care professional should not benefit financially from diagnoses connected to any ABA provider or business they work for or with whom they have a contract.

Implementation strategy: **Explicitly tie the ABA benefit to EPSDT**

Current state

Indiana's current Medicaid policy limits ABA therapy to individuals 20 years of age and younger with an ASD diagnosis, with some exceptions based on appeals. In 2024, there were around 75 individuals over the age of 20 receiving ABA therapy. Although this represents less than 1% of the total user base, the number of individuals over the age of 20 has increased 6x from 2020 to 2024 and will continue to grow as the current user base ages.

Rationale for change

All states have an age limit of Medicaid-funded ABA to individuals 20 years of age and younger, consistent with EPSDT, which guarantees medically necessary services for children and youth. Research shows ABA is most effective when starting early, making EPSDT the most appropriate legal and clinical framework. State examples of this include:

- **Colorado** and **Utah**, which use explicit language to tie their Medicaid funded ABA benefit to EPSDT
- **Montana** and **Wyoming** have incorporated ABA into the EPSDT section of their State Plan

Recommendation

FSSA should maintain its current policy to limit Medicaid-funded ABA therapy to individuals 20 years of age and younger, with new language tied explicitly to EPSDT. To ensure clarity and consistency, FSSA should reinforce EPSDT framework while introducing a phased transition process. This process should include transition planning to connect individuals to appropriate adult services.

Implementation strategy: **Require caregiver involvement in ABA therapy for 9-18 hours per 6-month authorization period authorization period**

Current state

Indiana does not require caregiver involvement in ABA therapy, either for coaching or training through participation in sessions, to promote 'learning by doing'. Coaching is defined as real-time, individualized guidance provided during or alongside therapy sessions, whereas training is defined as structured, educational instruction delivered outside of sessions. In 2024, only 1% of total ABA therapy hours formally involved caregivers (i.e., through CPT code 97156, family adaptive behavior treatment guidance).

Rationale for change

Caregiver participation is a critical factor in reinforcing ABA strategies across daily routines. Providers should actively support caregivers in learning and applying behavioral techniques so they can extend interventions beyond therapy sessions. The goal is for caregivers to reinforce the treatment plan consistently and help the child apply learned skills in natural home, school, and community settings. Literature shows that caregiver-involved ABA improves behavioral outcomes and promotes generalization of skills.[viii] Multiple states have requirements for caregiver involvement in ABA:

- **Nebraska** mandates 2-4 hours per month of documented caregiver training or involvement for Medicaid-funded ABA therapy
- **Oklahoma** has various parent training requirements as part of its extension requests (similar to Indiana's PA):
    - An increase in RBT hours on the first extension request is dependent on parent training by the BCBA or BCaBA for a minimum of 1 hour per week for 3 months
    - A further request for an increase in RBT hours will require that parent training has been provided for 2 hours per week for 3 months
    - Absence or less than 2 hours per month of appropriate parent training/ or involvement documented results in a reduction of hours and possibly denial of services
- **Florida** stipulates that up to 2 hours per week of training to parents or guardians may be provided via telemedicine by the Lead Analyst (BCBA equivalent)

Recommendation

FSSA should require 9-18 hours of caregiver coaching in ABA therapy over a 6-month period, documentation of which is required for subsequent authorizations of care. Using the 6-month authorization period allows for caregiver flexibility to reduce potential caregiver burden. Guidance should stipulate that both caregiver training and caregiver-involved sessions should be included in the hours allocation, to enable effective caregiver coaching in different ways. Session note details can be reviewed using encounter and claims data and may be included in

audits to check for compliance. Note that special consideration would need to be applied in the case of youth in the care of DCS, i.e., in foster care.

Implementation Strategy: **Ensure group therapy hours are included in the treatment plan when clinically appropriate**

Current state

There are currently no FSSA guidelines on the conditions in which group ABA therapy might be appropriate and/or optimal for different individuals. In 2024, only 1% of total ABA therapy hours were in group therapy delivered by RBTs (i.e., CPT code 97154, group adaptive behavior treatment by protocol).

Rationale for Recommendation

Although there is limited academic research on the outcomes of group ABA therapy, group-based social skills interventions (GSSIs) significantly enhance social competence in autistic individuals,[ix] and the benefits of group ABA therapy have been recognized by many provider groups. Small group ABA therapy can enable children with ASD to build and practice skills with their peers in a more natural setting. By participating in high-quality small group therapy, children have an opportunity to develop these skills collaboratively, which can improve their potential for a successful transition from comprehensive ABA therapy into more inclusive settings with same-age peers. Examples of managed care providers and private insurers that encourage group ABA provision include **CareSource** and **Blue Cross Blue Shield**, which both highlight the use of group therapy to support social skills development.

Recommendation

FSSA should create guidance on appropriate incorporation of group hours in a child's treatment plan, considering factors including the number and type of behaviors in the treatment plan and the safety of the child in a group setting. FSSA should implement guidelines for group therapy hours, included as part of the 4,000 hours as part of comprehensive ABA therapy. Group therapy hours should be thoroughly evaluated during the PA process to ensure they are clinically appropriate and aligned with the child's individualized treatment goals. Session note details can be reviewed using encounter and claims data and may be included in audits to monitor for appropriateness. This strategy can be implemented with updated group rates (see recommendation #3 for more detail).

3.2.2 Ensure high quality care provision and optimal clinical outcomes for children

Recommendation	Implementation strategies:
Ensure high quality care provision and optimal clinical outcomes for children	• Establish standardized BCBA-to-RBT supervision ratios for ABA therapy provision • Require state-recognized accreditation for ABA therapy provider entities or centers to bill Medicaid • Implement a temporary moratorium on new ABA therapy sites and create incentives for provider engagement in underserved counties • Minimize additional requirements for RBTs to be considered in-network by MCEs **Future considerations:** • Develop and track ABA-specific quality and outcomes metrics for fee-for-service providers and MCEs

Overview

Although ABA therapy lacks a single, nationally recognized framework for measuring quality or outcomes, state Medicaid programs can still implement methods to monitor both. Two critical mechanisms are (1) documentation standards and monitoring, and (2) provider and workforce oversight.

Indiana's current documentation practices fall short, the recent OIG audit found insufficient documentation in 95% of sampled months for fee-for-service payments across 2019 and 2020. This underscores the urgent need for enhanced compliance and monitoring.

Oversight of ABA provider entities is also essential. Approximately 90% of ABA therapy spending in Indiana is on care delivered in ABA therapy centers. There are more than 320 ABA therapy locations across the state, including multiple sites run by three large multi-state providers. ABA therapy centers are concentrated in urban areas in central and northern Indiana; there are noticeably fewer providers in southwest Indiana.

At the workforce level, most care is delivered by RBTs under BCBA supervision. However, the OIG report also identified lapses in supervision evidence, inadequate state background checks, and missing or invalid providers credentials (26% of sampled months). These findings point to the need for standardized supervision requirements and formal accreditation to ensure providers meet consistent quality benchmarks.

Implementation strategy: **Establish standardized BCBA-to-RBT supervision ratios for ABA therapy provision**

Current state

To maintain certification by the BACB, each full-time RBT requires at least 5% of their service delivery hours to be supervised by a BCBA, amongst other requirements. For an RBT working full-time (approximately 160 hours per month), this translates to 8 hours of supervision per month. The BACB can audit these supervision requirements and impose disciplinary action if not met. Indiana Medicaid currently does not have additional supervision requirements of RBTs by BCBAs.

Rationale for Recommendation

The OIG audit found that many ABA therapy centers could not provide adequate documentation of required RBT supervision, and some clearly failed to meet BACB standards. Without reliable documentation to support, FSSA cannot confirm children are receiving services under proper clinical oversight. Inadequate supervision risks lowering the quality of care and limits the ability to adjust treatment in response to a child's progress.

RBTs play a vital role in ABA therapy delivery but also require adequate supervision to ensure maintenance of standards for treatment quality, ethical practice, and ongoing professional development. Establishing a state-defined supervision ratio, beyond the BACB's 5% requirement would align Indiana with other states that have strengthened oversight. Various states have mandated supervision ratios of RBTs (or equivalent) by BCBAs (or equivalent):

- **Georgia** allows providers including BCBAs to supervise up to 6 RBTs or Board-Certified Assistant Behavior Analysts (BCaBAs) at a time
- **Louisiana** mandates 2 hours of supervision for every 10 hours of ABA therapy
- **Massachusetts** mandates 1 hour of supervision for every 10 hours of ABA therapy

Massachusetts' OIG audit of ABA therapy supervision

*A 2024 report from the Office of the Inspector General (OIG) for the Commonwealth of Massachusetts found that over **1,800** MassHealth members received inadequately supervised ABA services, resulting in **overpayment of $16.7 million**. The report's recommendations included additional oversight controls to screen for improper billing, and improved coordination with MCEs to better prevent and detect fraud, waste and abuse.*

Recommendation

To ensure sufficient oversight of RBTs, FSSA should require one supervision hour (by a BCBA or equivalent) for every eight hours of technician-delivered care (by a RBT or equivalent), inclusive of individual and group hours. This supervision must be delivered in-person (not virtually or remotely). This ratio should be monitored by FSSA through encounter data and claims tracking of the total RBT and BCBA hours billed by provider group, location, and/or therapy recipient.

Implementation strategy: **Require state-determined accreditation for ABA therapy provider entities or centers to bill Medicaid**

Current state

Indiana Medicaid does not require any accreditation or licensure of ABA therapy provider entities or centers for them to bill to Medicaid.

Rationale for Recommendation

As ABA therapy continues to be one of the fastest growing health care sectors in Indiana and the United States, there is increased need for vigilance and oversight to ensure that the growing number of ABA therapy providers maintain the program's integrity. Hoosier families deserve to know if their ABA therapy center is adhering to good practice and sufficient quality standards. Requiring accreditation of ABA therapy provider entities would give the state a much-needed mechanism for systems-level oversight, ensuring that organizations delivering Medicaid-funded ABA therapy services meet consistent standards for quality, accountability, and patient safety. Unlike individual licensure or credentialing, entity-level accreditation enables the state to assess the infrastructure, clinical practices, and operational capacity of providers – critical in a landscape with rapid service expansion.

Given that Indiana currently lacks accreditation or licensure requirements for ABA therapy organizations, this policy would establish consistent quality standards and bring Indiana in line with broader health care quality assurance practices. For example, Indiana currently licenses agencies that provide nursing services, physical therapy, occupational therapy, speech therapy, medical social worker, home health aide, and other therapeutic services to ensure quality of care and compliance with state law and rules. Leveraging established accrediting bodies or existing state quality review infrastructure allows for efficient implementation while promoting standardization, ethical practice, and improved outcomes.

Recommendation

To have better oversight of ABA therapy at the systems-level, FSSA should implement an accreditation requirement for ABA therapy provider entities or centers to complete as part of the process for their BCBAs and RBTs to begin billing Medicaid. Accreditation requirements can include:

- Quality and outcomes monitoring (e.g., regular reporting on ABA therapy metrics)
- Clinical operations (e.g., documentation requirements, supervision ratios)
- Risk management and patient safety (e.g., crisis management protocols)
- Transition planning (e.g., adherence to plans submitted in prior authorization)

The state should use an existing accreditation body such as the Autism Commission on Quality (ACQ) to benefit from existing standards for areas including billing, clinical, and supervisory best practice. However, if an external vendor is used, Indiana Medicaid would need to ensure that their standards are fit-for-purpose for the behaviors and practices that the state is looking to encourage and discourage. Along with accreditation with a specified accrediting entity, the state should also consider using its External Quality Review Organization (EQRO) to conduct the review of the ABA provider entities and centers to ensure compliance with the set accreditation standards. The state should allow sufficient time for all providers to comply and ensure the bandwidth of the accrediting organization to complete the process timely.

Implementation strategy: **Implement a temporary moratorium on new ABA therapy sites and create incentives for provider engagement in underserved counties**

Current state

Between Q1 2023 and Q1 2025, the number of ABA therapy providers increased by 25%. Some states use certificate of need (CON) laws, requiring health care providers to get state approval before opening or expanding facilities or services, to prevent duplication of service provision and unnecessary spending. In Indiana, CON laws only apply to nursing homes; 35 other states have CON laws applicable to mental health care providers, but not ABA therapy specifically. Indiana currently has no limits or restrictions on ABA therapy provider growth.

Rationale for Recommendation

The OIG report flagged documentation issues and other substantial quality concerns. This, combined with the time required to implement the new accreditation process, highlight the need for Indiana to establish mechanisms to facilitate increased access in underserved counties during this critical period. The moratorium will provide FSSA with an opportunity to align provider entry and growth with accreditation standards, ensuring that future expansion prioritizes quality and compliance in addition to access.

Florida's Agency for Health Care Administration (AHCA) imposed a temporary moratorium in 2018 in response to an investigation that found significant fraudulent overbilling that potentially compromised the quality of ABA therapy delivered. The moratorium blocked new provider enrollments in Miami-Dade and Broward counties. Existing providers stayed in Medicaid and could continue billing, while pending applications filed before the start date were still processed. Initially, the freeze applied to both individuals and group practices. Beginning in 2019, new individuals could enroll only if they joined an existing Medicaid-approved group; however, new group practices and solo providers remained barred. The moratorium was renewed every six months until it expired in late 2022. During the period of the moratorium, Florida implemented stricter fraud-control measures alongside stricter prior authorization, clinic licensure enforcement, and electronic visit verification pilots.

AHCA used the moratorium to:

- Audit existing providers
- Require compliance with the Health Care Clinic Act (clinic licensure or exemption)
- Tighten prior authorization reviews
- Roll out Electronic Visit Verification (EVV) pilots in 2019 to track ABA sessions

Recommendation

FSSA should create incentives for providers who expand access in underserved counties. During this time, FSSA should request CMS approval of a 6-month moratorium (with the possibility of extension) in designated counties to suspend new ABA therapy provider groups or new centers or locations for existing groups from billing to Medicaid. Applicable counties would be determined by FSSA through an analysis of ABA therapy provider concentration (per relevant population) and provider growth. This would not prevent ownership changes over this period. Over the period of the moratorium, FSSA should closely monitor impact through metrics including provider-to-member ratios, regional access disparities, and per-member-per-month spending. Recognizing the reason for the moratorium, which is to facilitate provider establishment in underserved areas of the state, FSSA will carefully evaluate the implications of

imposing a moratorium in select counties to ensure it does not create unintended incentives for providers to either establish in-home ABA services or establish centers in adjacent counties that serve the same area where significant need does not exist.

Implementation strategy: **Minimize additional requirements for RBTs to be considered in-network by MCEs**

Current state

Prior to the OIG report, only BCBAs (billing providers) had to individually enroll in Medicaid. Since August 2025, RBTs have been required to enroll with IHCP, and submit separate documentation to each MCE to ensure they are recognized within their claims processing system and can be considered in-network.

Rationale for Recommendation

Enrollment of RBTs through IHCP provides the state with a comprehensive view of the workforce delivering services, ensuring that quality standards are upheld through background checks, fingerprinting, and credential verification. It also enables oversight of supervision ratios between RBTs and BCBAs, promoting accountability and consistent quality of care. A few states enroll RBTs:

- **Florida**, who has faced similar billing concerns to Indiana, enrolls RBTs individually
- **Nevada** enrolls RBTs individually and requires attestation to report fraud

However, provider groups have expressed concerns about the administrative burden of enrolling with both IHCP and submitting duplicative applications to each MCE, and the delays in the latter.

Recommendation

FSSA should require MCEs to accept the IHCP credential for RBTs, with no further credentialing required by MCEs.

Future consideration: **Create and track quality and outcomes metrics specific to ABA therapy for fee-for-service providers and MCEs**

Current state

Nationally, CMS does not publish or prescribe ABA-specific quality standards but emphasizes that all Medicaid-funded behavioral health services should be evidence-based and outcomes-driven. In its ethics code, the BABC states that treatment must be “based on ongoing, evidence-based data collection,” but does not prescribe an outcomes collection method.

Indiana Medicaid does not specifically track the quality of ABA therapy in a systemic way. ABA therapy is included only in general quality monitoring with FSSA able to access reports on prior authorization and case management data for members receiving ABA therapy. However, there is no consolidated collection outcomes that would demonstrate the impact of ABA therapy on children’s functioning, family satisfaction, or progress over time.

Rationale for Recommendation

Hoosier children with ASD and their families deserve access to high-quality ABA therapy that delivers measurable improvements in functioning, inclusion, and quality of life. Given the significant state investments in ABA therapy, FSSA should have visibility into whether that investment is achieving intended outcomes. Establishing ABA-specific quality and outcome measures would allow FSSA to proactively monitor ABA therapy without overreliance on audits, address documentation and integrity gaps, and ultimately enable value-based or incentive payments for providers delivering high-quality care:

- **Michigan** established an intra-regional provider performance monitoring protocol for
- ABA provider networks, including a standard for >95% of members to receive ABA therapy within 90 days of established eligibility
- **Louisiana** uses a monitoring tool to assess provider quality and outcomes. Several categories are assessed through a comprehensive checklist, such as treatment plans, continuity of care, patient safety, and discharge planning
- **Vermont** incentivizes providers with bonus payments for for quantity of service provided, percentage of billed hours that are direct service hours, and timely claims submission

Recommendation

To achieve optimal visibility into the quality of ABA therapy and outcomes for members, FSSA's quality and clinical teams should define a concise set of ABA-specific measures and embed the reporting requirements in both fee-for-service and managed care contracts. Measures should balance process, access, and outcomes, for example:

- Process metrics (e.g., timeliness of provider claims submission)
- Access metrics (e.g., wait times for initial appointment, considering differences in provider availability by area of Indiana)
- Outcome metrics (e.g., successful transition to lower levels of care or mainstream school where appropriate)

3.2.3 Establish sustainable rates for ABA by adjusting individual and group rates

Recommendation	Implementation strategies:
Establish sustainable rates for ABA by adjusting individual and group rates	• FSSA may reduce current rates for individual ABA therapy as deemed necessary to stay within the agency's appropriated budget • Create rate modifiers for RBT-delivered group therapy to account for group size and encourage additional usage **Future considerations:** • Create a quality incentive program offering bonus payments to providers that meet specific quality measures

Overview

Until January 2024, Indiana Medicaid's rates for ABA therapy were both highly variable (ranging from $22 to $800 for 1 hour of RBT-delivered individual ABA therapy) and excessively high on average (around $97 for 1 hour of RBT-delivered individual ABA therapy, 30% above the

national average). This was driven by FSSA's historical policy to reimburse 40% of what providers billed, rather than using standardized rates.

In 2024, FSSA implemented a significant policy change, standardizing all ABA therapy rates to more accurately reflect the cost of service provision. As a result, ABA therapy spending decreased by approximately $170M between 2023 and 2024, without any reduction in the number of children served, hours used per member, or number of providers enrolled in Medicaid. In fact, between Q1 2023 and Q1 2025, the number of ABA therapy providers in Indiana increased by 25%. From 2019 to 2024, over 80% of total ABA therapy Medicaid spending each year was on RBT-delivered individual ABA therapy (CPT code 97153).

Implementation strategy: FSSA may reduce current rates for individual ABA therapy as deemed necessary to stay within the agency's appropriate budget.

Current state

For 1 hour of different types of individual ABA therapy, Indiana Medicaid currently reimburses the following rates:

Service description	**CPT code**	**Provider**	**Effective rate (per hour)**
Behavior identification assessment	97151	BCBA	$110.52
Behavior identification supporting assessment	97152	RBT	$68.24
Individual ABA therapy	97153	RBT	$68.24
Group adaptive behavior treatment by protocol	97154	RBT	$19.48
Adaptive behavior treatment with protocol modification	97155	BCBA	$110.52
Family adaptive behavior treatment guidance	97156	BCBA	$112.92

Background

When rates were standardized in 2024, they were set 5% to 40% lower than the current rates (detailed above). Rates for codes involving supervision were increased to reflect the time supervisors spend supporting therapy (which is not directly billable). However, Indiana Medicaid permits concurrent billing of RBT and BCBA-delivered treatment when a BCBA is actively guiding protocol modifications while the RBT delivers treatment. Indiana applied a 20% administrative overhead factor (compared to 15% for most other home-and-community based services), based on provider self-reporting of 35% administrative costs from a provider survey.

Indiana does not set its rates based on national benchmarks. However, the current rate for RBT-delivered individual ABA therapy hourly rate of $68.24 is in the top one third nationally and significantly above the national average of $61, despite Indiana being in the lowest third of states in terms of the cost of living. Other states have recognized the need to lower rates. Since 2019, multiple states have decreased their rates for ABA therapy. In 2025:

- **New York** cut rates for the equivalent of RBT-delivered individual ABA therapy from $77 per hour to $52 per hour, after an initial state proposal of $38 per hour
- **North Carolina** is planning to cut rates for ABA therapy by 10% in October 2025

Figure 5: Effective rate for 1 hour of 97153 (or equivalent) provided by a technician

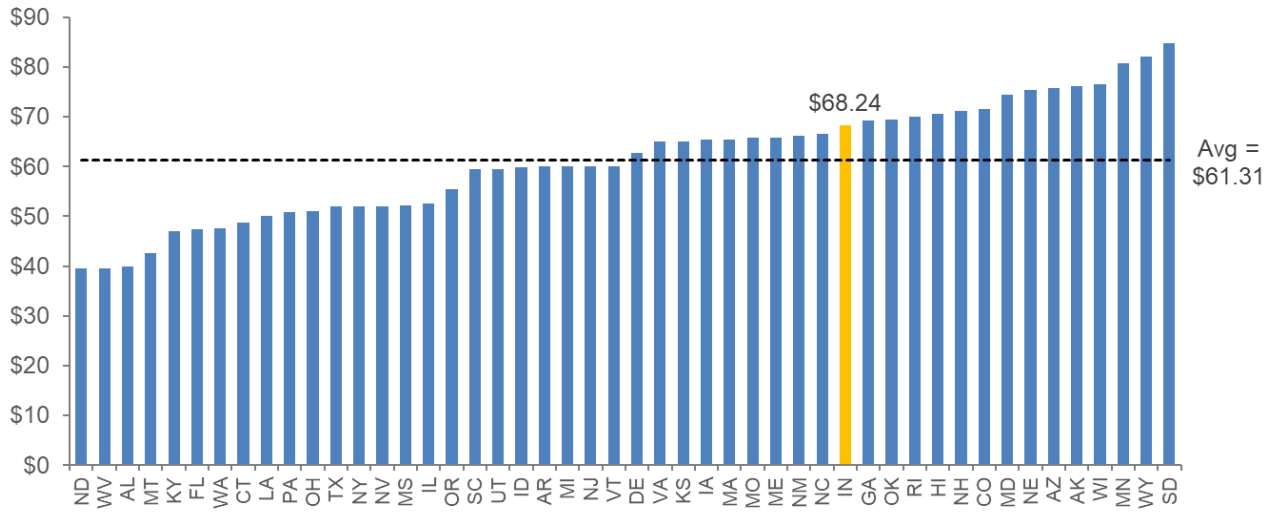
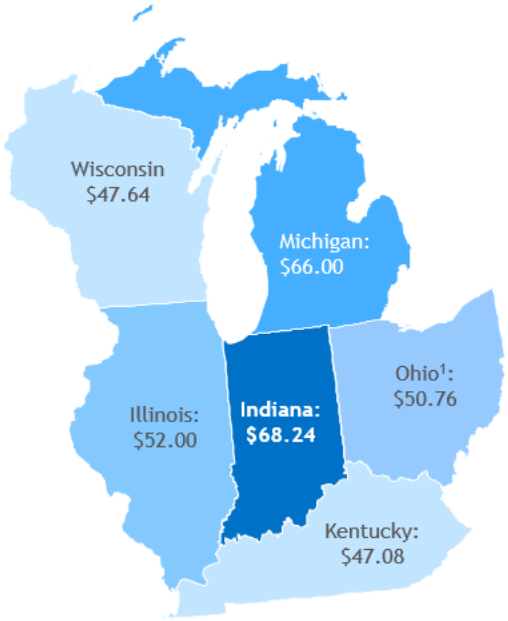


Figure 6: Effective rate for 1 hour of 97153 (or equivalent) provided by a technician in states surrounding Indiana



Sources: WI: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeDynamicSearch.aspx;

FSSA Change

The rate structure was discussed in working group meetings, while there was not unananimous agreement amongst the working group to support recommending rate reductions, there was an acknowledgement amongst working group members that the FSSA has the authority and responsibility to ensure ABA therapy in Indiana is sustainable. Given the overall Medicaid spending growth limitations, the workgroup understands that the FSSA may decrease individual

therapy rates as deemed necessary and will have appropriate data and assessment tools to ensure that the agency stays within its appropriated budget.

Implementation strategy: **Create rate modifiers for RBT-delivered group therapy to account for group size and encourage additional usage**

Current state

Indiana Medicaid's current rate for 1 hour of RBT-delivered group ABA therapy (intended for approximately 4 to 5 children at a time) is $19.48 per hour (per child). There is no separate or adjusted rate based on smaller group sizes.

Rationale for Recommendation

Experts have highlighted the importance of group ABA therapy where appropriate, to enable behavior development in a more natural environment and promote social skills development, vital for the transition from comprehensive ABA therapy to more targeted care. However, across all years from 2019 to 2024, less than 1% of ABA therapy hours billed were for group therapy delivered by an RBT.

The significantly lower reimbursement rate for group therapy (compared to individual) has been highlighted as one of the drivers of the low utilization of group therapy, as it is often not feasible to have 4 to 5 children in a single group. Increasing the rate for smaller groups may incentivize providers to deliver group care in a way that is cost-effective for the state while accounting for the cost pressures ABA therapy centers take on when implementing groups safely and appropriately without becoming unprofitable. Thirteen states use modifiers for different sized groups. These include:

- **Florida**, which in 2022 updated its group code to include modifiers to indicate the number of individuals receiving group service, with a maximum of 6
- **Utah**, which has 6 modifiers to reflect groups sizes of 2, 3, 4, 5, or 6 or more children (up to a maximum of 8)

Group therapy can be effective when a child is ready to begin transitions by working on various skills, such as classroom readiness and social and developmental growth. When approached appropriately it can provide an appropriate step-down service approach, with great benefit, at a reduction in cost for ABA therapy. This can maximize limited Medicaid funds for more intense therapies for other children.

Recommendation

FSSA should implement modifiers to increase reimbursement rates for RBT-delivered group ABA therapy based on group size, paying more (per child) for smaller groups where children are receiving more individualized attention. By adjusting group-based care rates, they become financially viable, and allow one-on-one therapy time for children with the most significant needs, while providing a cost-effective, appropriate "step-down" option for others. In the future, FSSA should also consider prorating group hours and/or carving out group hours from the 4,000 hour "bank" post-implementation of modifiers to increase reimbursement rates for RBT-delivered group ABA therapy.

Future consideration: **Create a quality incentive as a bonus payment for providers for meeting specific quality measures**

Current state

FSSA currently lacks value-based payments, quality incentives or withholds, or other programs to promote delivery of high-quality ABA therapy.

Recommendation

Paying for quality is a common form of incentive across health care that motivates providers to improve service. However, very few states currently have ABA-specific quality incentives. **Vermont** is one example where providers earn performance bonuses (starting at 1% of total service-level tier payments) for meeting quality benchmarks. These incentives were initially funded with enhanced federal HCBS funds and reconciled post-service. For Indiana, implementing such a model would depend on identifying ABA specific quality and outcomes measures (see recommendation #2) and establishing a reliable system for performance tracking. If done, Indiana would be one of the few states in the nation to do so, positioning the state as a leader in value-based autism services.

Recommendation

To drive improvements in ABA therapy quality, FSSA should establish a targeted financial incentive program that rewards providers for meeting defined benchmarks on key quality and outcome metrics. Incentives could be structured as bonus payments tied to performance during reconciliation or as tiered reimbursement adjustments to promote sustained quality improvement. This is a future consideration as it is dependent on aligning ABA-specific quality metrics and regularly tracking performance against them (see recommendation #2).

3.2.4 Strengthen foundations for effective end-to-end ABA therapy management

Recommendation	Implementation strategies:
Strengthen foundations for effective end-to-end ABA therapy management	• Create an ABA therapy program office in FSSA to oversee ABA-specific quality and utilization management • Enhance processes, coordination, and technical assistance to providers to facilitate timely care transitions **Future considerations:** • Review authorization processes and documentation guidelines, and audit compliance on an ongoing basis

Overview

To make the Working Group's recommendations effective, Indiana needs stronger infrastructure to manage ABA therapy across the Medicaid program. Fragmented oversight contributed to rapid cost growth, inconsistent supervision, and little accountability. Establishing clear

structures, processes, and capacity at the state level will help ensure recommendations are implemented consistently and sustained over time. Strategic investment in these foundational elements is critical to protect program integrity, improve quality, and support long-term, fiscally responsible access to ABA therapy for Hoosier children and families.

Implementation strategy: **Create an ABA program office in FSSA to oversee ABA-specific quality and utilization management**

Current state

Indiana does not have a designated program office or role focused specifically on Medicaid-funded ABA therapy benefit. Instead, responsibility is spread across several divisions within FSSA:

- The Division of Family Resources (DFR) determines financial and categorial eligibility for Medicaid.
- Once a child is enrolled in Medicaid, different teams within the Office of Medicaid Policy and Planning (OMPP) oversees the ABA therapy benefit as a State Pan service. OMPP manages the benefit design, prior authorization requirements, utilization management, provider enrollment, and reimbursement for both fee-for-service and managed care.
- The Division of Disability, Aging, and Rehabilitative Services (DDARS), through the Bureau of Developmental Disability Services (BDDS), manages HCBS waiver programs (e.g., Family Supports Waiver (FSW)), but are separate from the State Plan ABA benefit. While families of children with ASD may interact with BDS for waiver services, waiver eligibility is not required for State Plan ABA therapy. FSSA's Division of Disability, Aging and Rehabilitative Services (DDARS) manages eligibility processes for children with ASD who qualify for the Family Supports Waiver.

This division of responsibilities has contributed to fragmented oversight, with no single office dedicated to coordinating ABA policy, provider oversight, and quality management.

Rationale for Recommendation

The rapid cost growth and quality concerns outlined in this report were influenced, in part, by previously limited ABA-specific oversight at the state level. The Working Group's recommendations will take significant capacity and capabilities to implement. Several states have specific roles to coordinate Medicaid services for people with ASD, including ABA therapy:

- **Washington** has an ABA-specific role (ABA Program Manager) that is responsible for the operational oversight of Medicaid-covered ABA services in the state
- At least 10 other states (Connecticut, Kansas, Massachusetts, Michigan, Missouri, Nevada, New Jersey, North Dakota, Pennsylvania, South Carolina) have ASD-specific roles to coordinate all Medicaid services for people with ASD

Recommendation

FSSA should establish an ABA therapy program office with responsibility for ABA therapy benefit design and management, and associated provider and program integrity measures. This office would coordinate across OMPP and DDARS, as well as liaise with relevant partner agencies such as the IDOE, DCS, and the Bureau of Child Development Services – First Steps Early Intervention Program to strengthen cross-system alignment. The role of the ABA therapy program office could include the following responsibilities:

- Manage eligibility related to diagnosis criteria, and functional impairment thresholds for ABA services; and utilization policies for Medicaid-funded ABA therapy, including keeping them up to date based on the latest clinical evidence and state requirements
- Oversee the credentialing of ABA therapy providers, notably BCBA and RBT
- Work with the Professional Licensing Agency (PLA) to ensure all RBTs and BCBAs have the appropriate certification
- Monitor utilization and spending data to track trends and inform policy
- Implement program integrity measures, including accreditation (see recommendation #2), fraud, waste, and abuse audits of providers
- Work with MCEs in the state to ensure ABA therapy policies are aligned with fee-for-service
- Collaborate with the Indiana Department of Insurance to ensure that private insurers are adequately and appropriately covering ABA therapy for Hoosier children enrolled in their plans
- Engage relevant external stakeholders (families, providers, advocacy groups) to address concerns and challenges and improve statewide quality and access
- Perform ongoing quality review of all ABA providers occurs in perpetuity

The office's structure should be determined by FSSA, but it should include relevant clinical expertise (i.e., a BCBA) to ensure decisions are informed by practice realities.

Implementation strategy: **Enhance processes, coordination, and technical assistance to providers to facilitate timely care transitions**

Current state

As part of the PA process every six months, transition plans are required to be completed by the ABA provider. The transition plan must detail how the number of ABA therapy hours per week will be reduced over time, specifying the transition to less intensive services like focused ABA, or other therapies that support the individual's needs. Although transition plans are meant to be reviewed as part of the PA process, there is evidence from providers of a lack of effective enforcement of committed transitions to ensure providers follow-through.

Rationale for Recommendation

Providing structured transition support is essential to help children and families successfully move through developmental milestones, reduce reliance on ABA over time, and ultimately transition out of treatment. Strengthening and enforcing transition processes can lead to better outcomes in school readiness, long-term care needs and planning, and social integration, while also ensuring service capacity is available for other children in need.

Recommendation

To strengthen transition throughout treatment, FSSA should consider improving the clarity, actionability, and enforcement of biannual transition plans, and clearly communicating expectations to ABA therapy providers as part of the ABA-specific quality metrics to be developed as part of recommendation #2. Enhancements could include requirements for:

- Increasing provider engagement to identify and address the barriers to transition (e.g., lack of appropriate support in school)
- Updating requirements for transition plans (e.g., documented coordination with schools, and provider role in supporting children through discharge process)

- Implementing enforcement methods (e.g., audits of documentation that indicate follow-through, review of follow-through in subsequent PA cycles)
- Embedding measures of successful transitions in quality incentives programs (see recommendation #3), while also addressing the risk that providers may prioritize children with milder needs who are easier to transition

Future consideration: **Review authorization processes and documentation guidelines, and audit compliance on an ongoing basis**

Current state

In Indiana, prior authorization (PA) for Medicaid-funded ABA generally requires an ASD diagnosis, the completion of a standard form, three prescribed assessments, and the development of a treatment plan. These documents are required on a bi-annual reauthorization cycle. If an authorization request gets denied, there is a formal medical necessity appeals process, including a written appeal within 7 days of denial, summary letter detailing why the services are medically necessary, and all supporting documentation regarding the service need. These authorization processes can be audited, though no formal, ongoing process exists for fee-for-service. Currently, FSSA does ad hoc audits of top billing providers. For managed care, FSSA collects quarterly reports from plans on care management, prior authorization, and behavioral health.

Rationale for Recommendation

The Working Group's analysis surfaced multiple examples where other states require additional information in the PA process to ensure the medical necessity of ABA and confirm the robustness of the treatment plan. For example, **Virginia** requires progress goals, caregiver involvement and objectives, discharge plan, and a care coordination plan as part of PA. If the proposed treatment plan includes more than 20 hours of ABA per week, a specific schedule of activities and their role in overall treatment is required. There are also states that do more regular auditing of ABA. For example, **California** includes ABA as a specific category in their regular managed care compliance audits. Care management and coordination, access to care, and quality of care are monitored on an annual basis with published results on ABA specifically.

Recommendation

To strengthen oversight and ensure consistent quality of ABA services, FSSA should consider enhancing its prior authorization and documentation requirements and establishing a formal, ongoing compliance monitoring and audit process. FSSA should consider replacing ad hoc audits of top billing providers with regular, rigorous monitoring to enforce new guidelines from the Working Group, ensure high-quality services are delivered for the optimal attainment of outcomes for children with ASD and their families, and to prevent fraud, waste, and abuse.

3.2.5 Support a sustainable ecosystem for ABA

Recommendation	Implementation strategies:
Support a sustainable ecosystem for ABA	• Ensure that group health insurers reimburse ABA therapy above Medicaid rates • Enhance state's third-party liability (TPL) tracking methods to bill additional costs of ABA therapy to commercial insurers • Develop comprehensive guidance for schools and districts on how to coordinate with external ABA therapy providers and integrate therapy goals where consistent with Article 7 and IDEA requirements • Support schools to collaborate with external ABA therapy providers, when appropriate and consistent with the IEP process, to support medically necessary care and facilitate smoother transitions

Overview

One way to improve the sustainability of Medicaid-funded ABA for children in Indiana is to ensure a holistic ecosystem of care, where all relevant parties play a role in providing necessary ABA therapy. Two of the key players in this ecosystem are private insurance companies and the education system, including IDOE, local school districts, and schools themselves. Although private insurers and the education system play very different roles, it is essential that all stakeholders fulfill their responsibilities, so Hoosier children receive the coordinated care they deserve, in a manner that keeps Medicaid sustainable.

Private insurers must fulfill their obligation for the appropriate provision of ABA for their members for at least two reasons: their beneficiaries pay premiums that include support for ABA services, and to appropriately reduce undue fiscal burden on Medicaid. Medicaid is the payer of last resort for ABA. Thus, if a Hoosier has documented their inability to receive full ABA coverage through private insurance coverage, Medicaid is responsible for funding medically necessary care. Roughly 45% of children using fee-for-service ABA have private insurance, necessitating ways to ensure private insurers are sufficiently covering ABA therapy for their covered members.

Types of private insurance plans

*Private insurance plans come in two main types: **group** and **self-insured**. Group plans are typically purchased by employers from insurance carriers, which are regulated by state insurance departments. In contrast, self-insured plans are funded directly by employers and are regulated under federal law – the Employee Retirement Income Security Act of 1974 (ERISA) – not by states. This distinction limits states' authority to mandate benefits or set premium rates for self-insured plans, reducing their influence over a significant portion of the privately insured market. In Indiana, over **70%** of Hoosiers with private insurance are enrolled in self-insured plans.*

School-based ABA plays a critical role in helping children transition from intensive early intervention to educational settings, wherever possible and appropriate. Comprehensive ABA treatment often exceeds 20 hours per week, creating scheduling and developmental challenges when children begin preschool or kindergarten. To support a smoother transition, close collaboration between ABA providers and schools is needed to develop phased transition plans that gradually reduce therapy hours while increasing classroom time.

This collaboration is particularly important when children struggle to remain in school. By working with educational teams – and drawing on IEPs, parent and teacher notes, and related clinical documentation – ABA providers can better understand the barriers to inclusion, address behavioral needs, and align therapy goals with educational priorities. While schools are already required under Article 7 to provide behavioral support necessary for educational access, medical ABA can, in some cases, complement these efforts. For example, coordinated school-based ABA may support transitions for returning to a Pre-K special education setting or entering kindergarten, by helping the student engage with peers while maintaining consistent therapeutic support. In practice, fewer than 5% of Medicaid-funded ABA hours in 2024 occurred in school settings, underscoring the importance of stronger partnerships between schools and external ABA providers without shifting schools' responsibilities for educational supports into medical therapy.

Implementation strategy: **Ensure that group health insurers reimburse ABA therapy above Medicaid rates**

Current state

Indiana currently does not regulate the rates that private insurers pay for ABA therapy, and evidence suggests that, in general, private insurers pay below Medicaid rates for ABA. This creates perverse incentives for providers to prefer Medicaid-covered children. Additionally, Medicaid has to pay the difference between the private rate and Medicaid rate for children who have both insurance types.

Rationale for Recommendation

Lawmakers in other states have argued that private insurers have deflated rates for behavioral health services, including ABA, thereby disincentivizing provider participation and reducing access to care. Multiple families shared with the Working Group that, as a result, they have turned to Medicaid-funded care, thereby shifting the financial responsibility from private insurers to the state. A standard rate minimum across payers will encourage care access and prevent potential cost shifting from private plans to Medicaid. For example:

- **Rhode Island** proposed a Medicaid rate reimbursement floor for ABA
- More broadly, **New York** implemented a Medicaid rate reimbursement floor for behavioral health

Recommendation

The state administration should consider supporting legislation to require group health insurers to adopt a rate schedule above Medicaid rates. This change would require legislative action, and an associated IHCP bulletin detailing the specific rates and related rules. The state should also ensure that sufficient reviews are done of group health insurers' policies, including those for prior authorization, deductibles, and coverage, to ensure that families are not by default being driven towards using Medicaid waivers.

Implementation strategy: **Enhance state's third-party liability (TPL) tracking methods to bill additional costs of ABA therapy to commercial insurers**

Current state

Third-party liability (TPL) is the process by which the Medicaid program identifies and collects payments from other responsible parties – most often private insurance companies – when a Medicaid beneficiary has other coverage. Medicaid is considered the payer of last resort, meaning it only pays for covered services after all other responsible insurers have paid their share.

FSSA currently conducts TPL tracking for fee-for-service enrollees who have private insurance. This is done both on the front-end, when a Medicaid claim is initially received, and on the back-end, through retrospective payment audits. A similar approach is used by MCEs for their members. In 2024, approximately 9% of total fee-for-service Medicaid spending on ABA therapy was recovered through private insurer payments.

Rationale for Recommendation

ABA therapy is often used frequently and over long periods of time, which makes it one of the more expensive services for Medicaid. If the state doesn't consistently improve how it ensures private insurance pays its share, Medicaid could end up covering more of the cost than it should – even for services that private insurance is supposed to pay for.

Moreover, commercial insurers are contractually and legally obligated to act as the primary payer when coverage exists. Optimizing TPL ensures Medicaid remains the payer of last resort, in alignment with federal regulations. Enhancing both front-end coordination of benefits (e.g., real-time eligibility verification, claim edits) and back-end auditing (e.g., post-payment recovery, improved data matching) can increase the accuracy and completeness of billing to commercial insurers. This, in turn, improves the state's fiscal sustainability and frees Medicaid dollars for other high-need populations.

Recommendation

FSSA should engage in continuous process improvement, confirming that providers are billing private insurance companies first and appropriately, making sure as much of the cost as possible is covered by them, both when claims are first submitted and after payments are made. Key improvements could include better data integration to identify dual-covered members, automated claim edits, analytics-driven audits, family outreach on private insurance reporting, and stronger TPL incentives for MCEs. A good example of this is the 'pay and chase' model used by First Steps, which could be emulated.

Implementation strategy: **Develop comprehensive guidance for schools and districts on how to coordinate with external ABA therapy providers and integrate therapy goals where consistent with Article 7 and IDEA requirements**

Current state

The current landscape of ABA therapy in schools varies widely across the state. Some school districts have longstanding partnerships with ABA providers, while others may lack the

resources and expertise to manage the complexities of these relationships. In practice, schools may approach ABA support in different ways: some hire their own staff or create classrooms designed for students with intensive behavioral needs, while others contract with outside ABA providers or use a combination of in-house and contracted support. Regardless of the model, the shared goal is to help students transition successfully into educational settings and participate meaningfully in the classroom.

Rationale for Recommendation

Indiana currently does not provide clear statewide guidance to districts on how ABA intersects with educational services and responsibilities. Without this guidance, schools, ABA centers, and families may face challenges in determining how to support these students both behaviorally and academically, particularly when medical and educational systems overlap. Clear best practices would help schools, providers, and families navigate these complexities while avoiding misinterpretation of schools' obligations under Article 7 (Indiana's special education regulations).

Recommendation

FSSA should consider partnering with IDOE and other autism-related organizations that already work with schools to develop a comprehensive guidance document for schools that includes:

- Clarifies the distinction between ABA provided as medically necessary service (funded through Medicaid or private insurance) and behavioral support required under Article 7 (funded by schools as part of a Free Appropriate Public Education)
- Outlines how schools can effectively assess and address behavioral support needs for students with ASD as part of the IEP process
- Explain when and how schools may seek Medicaid reimbursement for certain services.
- Identification of tools and grant opportunities to acquire them in a school setting, such as tools that assist children with ASD in the classroom while remaining in the educational setting. One such example is the Robokind Grant Opportunity which is a program that has shown effectiveness in helping students develop cognitive skills through consistent interaction with robots. The program has shown increased engagement, confidence, and motivation to learn.

Implementation strategy: **Support schools to collaborate with external ABA therapy providers, when appropriate and consistent with the IEP process, to support medically necessary care and facilitate smoother transitions**

Current state

As noted above, some Indiana school districts have longstanding relationships with ABA providers, while others may be hesitant to engage due to associated barriers or complexities they often encounter. Importantly, if ABA is written into a student's individualized education program (IEP), as an educationally necessary service, the district is legally obligated to provide and fund it per the Free Appropriate Public Education (FAPE) program and the Individuals with Disabilities Education Act (IDEA). This can be challenging especially for school districts that may lack ABA providers in their area or encounter large RBT or BCBA staff turnover.

If a student has ABA identified in their IEP and is Medicaid eligible, the school can submit for Medicaid reimbursement for school-based services. However, some schools have vocalized

complexities with navigating the reimbursement process, which either deters them from utilizing ABA in their schools completely or causes them to utilize their special education dollars that support all their special education students.

Rationale for Recommendation

Sharing best practices from schools that have successfully partnered with ABA providers can help other districts navigate the incorporation of ABA by addressing potential barriers, clarifying roles, and adopting collaborative approaches.

Recommendation

FSSA and IDOE should consider championing exemplary schools that demonstrate effective collaboration with ABA providers by:

- Highlighting schools with collaborative relationships with ABA providers through newsletters and other professional learning opportunities
- Connecting interested schools with exemplary schools and ABA providers who can speak to successes of school and provider collaboration
- Sharing strategies to minimize classroom disruption, ensure coordination, and clarify when Medicaid reimbursement may apply

Role of assistive technology in schools to support the delivery of ABA in the classroom

Assistive technology is increasingly integral to delivering ABA therapy in schools, helping improve communication, engagement, and individualized instruction for students with ASD and other developmental needs. Tools such as **speech-generating devices**, **behavior-tracking software**, and **adaptive learning platforms** enable more effective therapy by supporting real-time data collection, personalized interventions, and increased student participation. By incorporating these technologies, schools can enhance the impact of ABA services and better support student progress, but should be aware of potential costs.

4. Conclusion

The Working Group reaffirms the critical importance of maintaining access to high-quality, evidence-based ABA therapy for Indiana's children with ASD. For thousands of Hoosier families, this benefit represents a vital lifeline, unlocking the opportunity for children to reach their fullest potential. At the same time, the current trajectory of Medicaid spending on ABA therapy is unsustainable, placing the long-term viability of the benefit itself at risk. Indiana must act decisively to rebalance the system, ensuring continued access to care while adopting necessary guardrails to control cost and improve outcomes.

Achieving this will require sustained action not only from the state, but also from key partners across the Medicaid ecosystem. FSSA must lead the implementation of the recommendations in this report with urgency and transparency, while collaborating closely with ABA providers, MCEs, the IDOE, local school systems, families, advocacy organizations, and private insurers to build a stronger, more sustainable, and coordinated ABA infrastructure.

Appendix I: Recommendations overview

Recommendation	Strategies & considerations	Details
Align ABA therapy utilization with clinical evidence	**Implementation strategy:** Implement a flexible approach that does not include caps, that allows children to receive comprehensive ABA therapy when clinically appropriate, followed by more targeted ABA therapy as needs change	FSSA should implement guidance of up to 4,000 hours of comprehensive ABA therapy for eligible individuals (up to age 21). This would enable providers and families to use as many hours in each week or month as is appropriate (within the bounds of the PA) and roll-over unused hours to subsequent periods. Once the 4,000 hours of comprehensive ABA therapy has been exhausted, individuals would be eligible for continued targeted ABA therapy (defined as up to 15 hours per week). If continued comprehensive care is required beyond the targeted hours guidance, this would be subject to additional review beyond the current requirements of the prior authorization (PA) process every 6 months. Note that the actual number of hours authorized for each individual per prior authorization (PA) period would be determined according to clinical guidelines and demonstrated medical necessity. These hours would include all direct treatment, caregiver training, and assessment hours, and exclude supervision hours. To implement appropriate hours guidelines, a review of the existing code sets and potential new codes and billing rates must be reviewed and adjusted, including the implementation of maximum unit edits (MUE). A review of lump sum billing practices should be included in this analysis. This policy would not be applied retroactively, i.e., all eligible individuals (current and new) would follow the guidelines of up to 4,000 hours of comprehensive ABA therapy from the effective implementation date of the policy. Comprehensive ABA should be defined by clinical criteria (patient needs, weekly hour ranges, and evidence on effective duration), applying to requests over 400 hours per 6 months, while targeted ABA applies to 400 hours or fewer. This policy would require assigning modifiers to ABA codes that count toward the 4,000-hour lifetime guidelines, tracked through an accumulator in the PA portal with utilization management vendors confirming usage in the Indiana Health Coverage

		Programs (IHCP) portal. This centralized tracking will also be vital to ensure that the allocation is tracked for individuals who move between fee-for-service and managed care.
	Implementation strategy: Develop clear criteria for functional impairments required for ABA services	FSSA should establish clear, standardized criteria outlining the number and types of functional impairments required to qualify for Medicaid-funded ABA services.
	Implementation strategy: Maintain policy of requiring ASD diagnosis for ABA therapy with exceptions for other developmental disabilities (DD) for medical necessity	FSSA should maintain its current policy to limit ABA therapy to individuals 20 years of age and younger with an ASD diagnosis, with exceptions made for medical necessity. This would not create any change for current or future ABA therapy users with a DD other than ASD. To consider a member eligible for IHCP coverage of ABA therapy, a child must first receive an ASD diagnosis or have another DD and assessed to have significant areas of behavioral or adaptive functioning impacting their success in home, school, or community settings or be a safety risk to self along with an accompanying physician's recommendation for medically necessary ABA. This diagnosis must be made by a qualified healthcare professional with appropriate training and experience in the current diagnostic guidelines of ASD.[3] The qualified health care professional should not benefit financially from diagnoses connected to any ABA provider or business they work for or with whom they have a contract.
	Implementation strategy: Explicitly tie the ABA therapy benefit to EPSDT	FSSA should maintain its current policy to limit Medicaid-funded ABA therapy to individuals 20 years of age and younger, with new language tied explicitly to EPSDT. To ensure clarity and consistency, FSSA should reinforce EPSDT framework while introducing a phased transition process. This process should include transition planning to connect individuals to appropriate adult services.
	Implementation strategy: Require caregiver involvement	FSSA should require 9-18 hours of caregiver coaching in ABA therapy over a 6-month period, documentation of which is required for

	in ABA therapy for 9-18 hours per 6-month authorization period	subsequent authorizations of care. Using the 6-month authorization period allows for caregiver flexibility to reduce potential caregiver burden. Guidance should stipulate that both caregiver training and caregiver-involved sessions should be included in the hours allocation, to enable effective caregiver coaching in different ways. Session note details can be reviewed using encounter and claims data and may be included in audits to check for compliance. Note that special consideration would need to be applied in the case of youth in the care of DCS, i.e., in foster care.
	Implementation strategy: Ensure group therapy hours are included in the treatment plan when clinically appropriate	FSSA should create guidance on appropriate incorporation of group hours in a child's treatment plan, considering factors including the number and type of behaviors in the treatment plan and the safety of the child in a group setting. The allocation of group therapy hours should be thoroughly evaluated during the PA process to ensure they are clinically appropriate and aligned with the child's individualized treatment goals. Session note details can be reviewed using encounter and claims data and may be included in audits to monitor for appropriateness. This strategy can be implemented with updated group rates (see recommendation #3 for more detail).
Ensure high quality care provision and optimal clinical outcomes for children	**Implementation strategy:** Establish standardized BCBA-to-RBT supervision ratios for ABA therapy provision	To ensure sufficient oversight of RBTs, FSSA should require one supervision hour (by a BCBA or equivalent) for every eight hours of technician-delivered care (by a RBT or equivalent), inclusive of individual and group hours. This supervision must be delivered in-person (not virtually or remotely). This ratio should be monitored by FSSA through encounter data and claims tracking of the total RBT and BCBA hours billed by provider group, location, and/or therapy recipient.
	Implementation strategy: Require state-recognized accreditation for ABA therapy provider entities or centers to bill Medicaid	To have better oversight of ABA therapy at the systems-level, FSSA should develop an accreditation process for ABA therapy provider entities or centers to complete prior to allowing the BCBAs and RBTs they employ to bill to Medicaid. Accreditation requirements can include:

		• Quality and outcomes monitoring (e.g., regular reporting on ABA therapy metrics) • Clinical operations (e.g., documentation requirements, supervision ratios) • Risk management and patient safety (e.g., crisis management protocols) • Transition planning (e.g., adherence to plans submitted in prior authorization) The state should use an existing accreditation body such as the Autism Commission on Quality (ACQ) to benefit from existing standards for areas including billing, clinical, and supervisory best practice. However, if an external vendor is used, Indiana Medicaid would need to ensure that their standards are fit-for-purpose for the behaviors and practices that the state is looking to encourage and discourage. Along with accreditation with a specified accrediting entity, the state should also consider using its External Quality Review Organization (EQRO) to conduct the review of the ABA provider entities and centers to ensure compliance with the set accreditation standards. The state should allow sufficient time for all providers to comply and ensure the bandwidth of the accrediting organization to complete the process timely.
	Implementation strategy: Implement a temporary moratorium on new ABA therapy sites and create incentives for provider engagement in underserved counties	FSSA should create incentives for providers who expand access in underserved counties. During this time, FSSA should request CMS approval of a 6-month moratorium (with the possibility of extension) in designated counties to suspend new ABA therapy provider groups or new centers or locations for existing groups from billing to Medicaid. Applicable counties would be determined by FSSA through an analysis of ABA therapy provider concentration (per relevant population) and provider growth. This would not prevent ownership changes over this period. Over the period of the moratorium, FSSA should closely monitor impact through metrics including provider-to-member ratios, regional access disparities, and per-member-per-month spending. Recognizing the reason for the moratorium, which is to facilitate provider establishment in underserved areas of the state, FSSA will carefully evaluate the implications of

		imposing a moratorium in select counties to ensure it does not create unintended incentives for providers to either establish in-home ABA services or establish centers in adjacent counties that serve the same area where significant need does not exist.
	Implementation strategy: Minimize additional requirements for RBTs to be considered in-network by MCEs	FSSA should require MCEs to accept the IHCP credential for RBTs, with no further credentialing required by MCEs.
	Future consideration: Create and track quality and outcomes metrics specific to ABA therapy for fee-for-service providers and MCEs	To achieve optimal visibility into the quality of ABA therapy and outcomes for members, FSSA's quality and clinical teams should consider defining a concise set of ABA-specific measures and embed the reporting requirements in both fee-for-service and managed care contracts. Measures should balance process, access, and outcomes, for example: • Process metrics (e.g., timeliness of provider claims submission) • Access metrics (e.g., wait times for initial appointment, considering differences in provider availability by area of Indiana) • Outcome metrics (e.g., successful transition to lower levels of care or mainstream school where appropriate)
Establish sustainable rates for ABA by adjusting individual and group rates	**Implementation strategy:** FSSA may reduce current rates for individual ABA therapy as deemed necessary to stay within the agency's appropriated budget	To ensure ABA therapy in Indiana is sustainable, given overall Medicaid spending growth limitations, FSSA may decrease rates as deemed necessary to stay within the agency's appropriated budget.
	Implementation strategy: Create rate modifiers for RBT-delivered group therapy to account for group size and	FSSA should implement modifiers to increase reimbursement rates for RBT-delivered group ABA therapy based on group size, paying more (per child) for smaller groups where children are receiving more individualized attention. By adjusting group-based care rates, they become financially viable, and allow one-on-one therapy time for children with the most significant needs,

	encourage additional usage	while providing a cost-effective, appropriate "step-down" option for others. FSSA should also consider prorating group hours and/or carving out group hours from the 4,000 hour “bank” post-implementation of modifiers to increase reimbursement rates for RBT-delivered group ABA therapy.
	Future consideration: Create a quality incentive program offering bonus payments to providers that meet specific quality measures	To drive improvements in ABA therapy quality, FSSA should consider establishing a targeted financial incentive program that rewards providers for meeting defined benchmarks on key quality and outcome metrics. Incentives could be structured as bonus payments tied to performance during reconciliation or as tiered reimbursement adjustments to promote sustained quality improvement. This is a future consideration as it is dependent on aligning on ABA-specific quality metrics and regularly tracking performance against them (see recommendation #2).
Strengthen foundations for effective end-to-end ABA therapy management	**Implementation strategy:** Create an ABA therapy program office in FSSA to oversee ABA-specific quality and utilization management	FSSA should establish an ABA therapy program office with responsibility for ABA therapy benefit design and management, and associated provider and program integrity measures. This office would coordinate across OMPP and DDARS, as well as liaise with relevant partner agencies such as the IDOE, DCS, and the Bureau of Child Development Services – First Steps Early Intervention Program to strengthen cross-system alignment. The role of the ABA therapy program office could include the following responsibilities: • Manage eligibility related to diagnosis criteria, and functional impairment thresholds for ABA services; and utilization policies for Medicaid-funded ABA therapy, including keeping them up-to-date based on the latest clinical evidence and state requirements • Oversee the credentialing of ABA therapy providers, notably BCBA and RBT • Work with the Professional Licensing Agency (PLA) to ensure all RBTs and BCBAs have the appropriate certification • Monitor utilization and spending data to track trends and inform policy

		• Implement program integrity measures, including accreditation (see recommendation #2), fraud, waste, and abuse audits of providers • Work with MCEs in the state to ensure ABA therapy policies are aligned with fee-for-service • Collaborate with the Indiana Department of Insurance to ensure that private insurers are adequately and appropriately covering ABA therapy for Hoosier children enrolled in their plans • Engage relevant external stakeholders (families, providers, advocacy groups) to address concerns and challenges and improve statewide quality and access The office's structure should be determined by FSSA, but it should include relevant clinical expertise (i.e., a BCBA) to ensure decisions are informed by practice realities.
	Implementation strategy: Enhance processes, coordination, and technical assistance to providers to facilitate timely care transitions	To strengthen transition throughout treatment, FSSA should consider improving the clarity, actionability, and enforcement of biannual transition plans, and clearly communicating expectations to ABA therapy providers as part of the ABA-specific quality metrics to be developed as part of recommendation #2. Enhancements could include requirements for: • Increasing provider engagement to identify and address the barriers to transition (e.g., lack of appropriate support in school) • Updating requirements for transition plans (e.g., documented coordination with schools, and provider role in supporting children through discharge process) • Implementing enforcement methods (e.g., audits of documentation that indicates follow-through, review of follow-through in subsequent PA cycles) • Embedding measures of successful transitions in quality incentives programs (see recommendation #3), while also addressing the risk that providers may prioritize children with milder needs who are easier to transition

	Future consideration: Review authorization processes and documentation guidelines, and audit compliance on an ongoing basis	To strengthen oversight and ensure consistent quality of ABA services, FSSA should consider enhancing its prior authorization and documentation requirements and establishing a formal, ongoing compliance monitoring and audit process. FSSA should consider replacing ad hoc audits of top billing providers with regular, rigorous monitoring to enforce new guidelines from the Working Group, ensure high-quality services are delivered for the optimal attainment of outcomes for children with ASD and their families, and to prevent fraud, waste, and abuse.
Support a sustainable ecosystem for ABA	**Implementation strategy:** Ensure that group health insurers reimburse ABA therapy above Medicaid rates	The state administration should consider supporting legislation to require group health insurers to adopt a rate schedule above Medicaid rates. This change would require legislative action, and an associated IHCP bulletin detailing the specific rates and related rules. The state should also ensure that sufficient reviews are done of group health insurers' policies, including those for prior authorization, deductibles, and coverage, to ensure that families are not by default being driven towards using Medicaid waivers.
	Implementation strategy: Enhance state's third-party liability (TPL) tracking methods to bill additional costs of ABA therapy to commercial insurers	FSSA should engage in continuous process improvement, confirming that providers are billing private insurance companies first and appropriately, making sure as much of the cost as possible is covered by them, both when claims are first submitted and after payments are made. Key improvements could include better data integration to identify dual-covered members, automated claim edits, analytics-driven audits, family outreach on private insurance reporting, and stronger TPL incentives for MCEs. A good example of this is the 'pay and chase' model used by First Steps, which could be emulated.
	Implementation strategy: Develop comprehensive guidance for schools and districts on how to coordinate with external ABA therapy providers and integrate therapy goals where	FSSA should consider partnering with IDOE and other autism-related organizations that already work with schools to develop a comprehensive guidance document for schools that includes: • Clarifies the distinction between ABA provided as medically necessary service (funded through Medicaid or private insurance) and behavioral supports

	consistent with Article 7 and IDEA requirements	required under Article 7 (funded by schools as part of Free Appropriate Public Education) • Outlines how schools can effectively assess and address behavioral support needs for students with ASD as part of the IEP process • Explains when and how schools may seek Medicaid reimbursement for certain services • Identify tools and grant opportunities to acquire them in a school setting, such as tools that assist children with ASD in the classroom while remaining in the educational setting. One such example is the Robokind Grant Opportunity which is a program that has shown effectiveness in helping students develop cognitive skills through consistent interaction with robots. The program has shown increased engagement, confidence, and motivation to learn.
	Implementation strategy: Support schools to collaborate with external ABA therapy providers, when appropriate and consistent with the IEP process, to support medically necessary care and facilitate smoother transitions	FSSA and IDOE should consider championing exemplary schools that demonstrate effective collaboration with ABA providers by: • Highlighting schools with collaborative relationships with ABA providers through newsletters and other professional learning opportunities • Connecting interested schools with exemplary schools and ABA providers who can speak to successes of school and provider collaboration • Sharing strategies to minimize classroom disruption, ensure coordination, and clarify when Medicaid reimbursement may apply

Appendix II: Glossary

Acronym	Definition
ABA	Applied Behavior Analysis
ACQ	Autism Commission on Quality
ADHD	Attention-Deficit/Hyperactivity Disorder
AHCA	Agency for Health Care Administration
ASD	Autism Spectrum Disorder
BACB	Behavior Analyst Certification Board
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst–Doctoral
BCaBA	Board Certified Assistant Behavior Analyst
BDDS	Bureau of Developmental Disabilities Services (Indiana)
CDC	Centers for Disease Control and Prevention
CDE	Comprehensive Diagnostic Evaluation
CMS	Centers for Medicare & Medicaid Services
CMCN	Certified Managed Care Nurse
CON	Certificate of Need
CPT	Current Procedural Terminology
CSAYC	Credentialed Sexual Abuse Youth Clinician
DCS	Department of Child Services (Indiana)
DD	Developmental Disabilities
DDARS	Division of Disability, Aging and Rehabilitative Services (Indiana)
DFR	Division of Family Resources
DSM	Diagnostic and Statistical Manual of Mental Disorders
EIBI	Early and Intensive Behavioral Intervention
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
ERISA	Employee Retirement Income Security Act of 1974
EVV	Electronic Visit Verification
FAPE	Free Appropriate Public Education
FSSA	Family and Social Services Administration (Indiana)
FSW	Family Supports Waiver
HCBS	Home- and Community-Based Services
HHS	United States Department of Health & Human Services
HSPP	Health Service Provider in Psychology
IDEA	Individuals with Disabilities Education Act

IDOE	Indiana Department of Education
IEP	Individualized Education Program
IHCP	Indiana Health Coverage Programs
LCSW	Licensed Clinical Social Worker
LTSS	Long-Term Services and Supports
MCE	Managed Care Entity
MUE	Maximum Unit Edits
ODD	Oppositional Defiant Disorder
OIG	Office of the Inspector General
OMPP	Office of Medicaid Policy and Planning (Indiana)
PA	Prior Authorization
PLA	Professional Licensing Agency (Indiana)
PMP	Project Management Professional
RAI	Request for Additional Information
RBT	Registered Behavior Technician
SPA	State Plan Amendment
TPL	Third-Party Liability

[i] Note that *medical necessity* is defined as required by EPSDT and section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). For more information, please refer to Indiana Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Policy.

[ii] American Association on Intellectual and Developmental Disabilities, Centers for Disease Control and Prevention, American Academy of Child and Adolescent Psychiatry, National Institute of Mental Health, Organization for Autism Research, National Autism Center's National Standards Report, National Institute of Child Health and Human Development (NICHD), The Association for Science in Autism Treatment, and the Surgeon General of the United States.

[iii] Defined in IHCP bulletin BT202562 as follows: the IHCP considers qualified healthcare providers performing the comprehensive diagnostic evaluation (CDE) to have specialized training in the application of the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) autism criteria and hold one of the following credentials: Doctoral-level licensed clinical psychologists, endorsed as a health service provider in psychology (HSPP), Licensed physicians, Licensed advanced practice registered nurses (APRNs), Licensed physician assistants.

[iv] Note that *medical necessity* is defined as required by EPSDT and section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). For more information, please refer to Indiana Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Policy.

[v] Average of 23 hours per week of individual therapy delivered by an RBT is calculated based on user months, i.e., for each month in which a user received ABA therapy, their average hours per week was 23. Average of 27 hours per week of individual therapy delivered by an RBT is calculated based on user weeks, i.e., for each week in which a user received ABA therapy, their average hours per week was 27.

[vi] (1) Jane S. Howard, Harold Stanislaw, Gina Green, Coleen R. Sparkman, Howard G. Cohen,

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