LBA Medicaid testimony SB FINAL.pdf

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Position: FAV

Senate Bill 469
Maryland Medical Assistance Program
Applied Behavior Analysis Services
Reimbursement

Finance Committee
February 10, 2021
POSITION: SUPPORT

Dear Chair Kelley and Members of the Committee:

Thank you for the opportunity to provide written testimony in support of SB 469. As Licensed Behavior Analysts (LBAs) in Maryland, long-standing members of the behavior analysis community in Maryland, founding committee members of the Behavior Analysts Advisory Committee for the Maryland Department of Health, and current Legislative Committee members for the Maryland Association for Behavior Analysis, we write to highlight the importance of this proposed bill.

In 2014, we were thrilled to have the Maryland Legislature pass two important laws (the Maryland Habilitative Service Mandate and the Maryland Behavior Analyst Act) so that families of children with autism would have access to the medically necessary Applied Behavior Analysis (ABA) therapy they needed, from the clinicians trained to provide these services – Licensed Behavior Analysts. Due to the passing of these two laws, many children with autism are successfully receiving the ABA services they need. Access to ABA therapy greatly improves the chances that individuals with autism, and their families, will need less support and resources over the course of their lifetime by building the skills necessary to be as successful and independent as possible. Unfortunately, the majority of children currently benefiting from this treatment are those with private commercial insurance. There are many Maryland families with Medicaid that are not receiving the ABA therapy they need due to the prohibitive requirement that a parent must be present during all therapy time. This is not a requirement within the state mandate, nor is it a requirement by any other insurance carrier. Moreover, it is simply not possible or feasible for a family to have one parent, sometimes the only parent, sacrifice their job, so that they can be present at their child's therapy for up to 40 hours per week. This unfair disparity across families, due to the type of insurance they have, despite a state mandate, is a disservice to these children, their families, and thus, our community.

There are nearly 700 Licensed Behavior Analysts in Maryland and thousands of children with autism that need this medically necessary service. Unfortunately, only a small percentage of those LBAs are Medicaid providers and a number of others have told us that they have dropped out of the program due to the structural barriers such as the parent presence requirement. While we understand the importance of caregiver training to a child's progress and do include this in our treatments, the parent presence requirement has too many unintended negative consequences. Per a recent list of providers obtained from Optum, there are only 65 Medicaid ABA providers in the state of Maryland available to address the needs of over 4,000 children with autism. This certainly does not provide the network of providers needed to adequately provide children with Medicaid access to the care they need. This unfortunate situation is only magnified when we know that Maryland has the skilled clinicians, LBAs, to provide this medically necessary treatment for our community.

The behavior analysts in Maryland are a dedicated group of ABA providers, scientists, and academics who have been called to understand how learning happens and to create behavior change systems that can make meaningful differences for our community. We are hopeful for the chance to serve a more equitable distribution of clients, regardless of whether they have private insurance or Medicaid. ABA therapy can reach every child with autism in Maryland, if the structural systems are in place to support these children and their families.

Sincerely,

Erin Camp
Erin Camp, Ph.D., BCBA-D, LBA
MABA Legislative Committee Chair

Erin Schaller
Erin Schaller, MA, BCBA, LBA
MABA Legislative Committee Member

Behav Analysis Practice (2017) 10:307–312
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BRIEF PRACTICE

A Program Evaluation of Home and Center-Based Treatment for Autism Spectrum Disorder

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Abstract The present study aimed to retrospectively compare the relative rates of mastery of exemplars for individuals with ASD (N = 313) who received home-based and center-based services. A between-group analysis found that participants mastered significantly more exemplars per hour when receiving center-based services than home-based services. Likewise, a paired-sample analysis found that participants who received both home and center-based services had mastered 100 % more per hour while at the center than at home. These analyses indicated that participants demonstrated higher rates of learning during treatment that was provided in a center setting than in the participant's home.

Keywords Autism spectrum disorder · Applied behavior analysis · Center-based services · Treatment

There is substantial empirical support for treatments based on applied behavior analysis (ABA) for autism spectrum disorder (ASD; Virués-Ortega, 2010), and researchers have begun to focus on the optimization of specific aspects of behavioral intervention. Individual child outcomes have been shown to vary, which may be due to disparities in intervention variables as well as individual differences. Researchers have employed different tools to measure progress of learning and determine treatment effectiveness or outcomes. These measures include changes in scores on standardized assessments as well as skill mastery (Fava & Strauss, 2014). Treatment variables that have been investigated include child's age, language skills, intellectual functioning, adaptive functioning, and severity of ASD, as well as treatment intensity and practitioner or teacher training (Fava & Strauss, 2014). However, one variable that has not been studied extensively is whether the setting in which the intervention occurs significantly impacts the child's rate of learning.

ABA can be delivered in settings such as community centers, homes, and schools, and many children receive ABA therapy across multiple locations. Roberts et al. (2011) found that children receiving services at a center (i.e., child play groups with a concurrent parent support and training program) made more gains than those who received service in their home (i.e., program delivered in the home with the parents), but the procedures and intensity of treatment (i.e., hours per week) differed across the two conditions. Currently, very little research has compared children's outcomes when practitioners consistently deliver the treatment in both locations.

There are several factors related to a setting that may influence the effectiveness of treatment, including distractors, amount and quality of supervision, and opportunities for socialization and generalization. Certain settings may allow for a more controlled environment while others may contain more distractions. Supervisors may be more available and provide additional direct supervision in center-based settings than in home settings. Lastly, the presence of other individuals with ASD and

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unfamiliar practitioners may allow for more opportunities for socialization as well as generalization of skills. These represent some aspects of treatment that may differ as a function of location and may ultimately influence a child's progress.

Due to the variability in both ASD symptom presentation as well as treatment implementation, it is necessary for researchers and practitioners to identify components of treatment that are most likely to optimize results. Given that few researchers have investigated whether location serves as an aspect of treatment that influences learning, the purpose of this study was to conduct a program evaluation to investigate whether children with ASD who had received ABA services learned more skills during home-based services (HBS) or center-based services (CBS). This was done through a retrospective analysis of clinical records comparing the relative rates of mastery of exemplars in each location. Given the potential benefits of treatment delivered in a center setting, we hypothesized that participants would have shown a greater rate of learning per hour during CBS than HBS.

Method

Participants

Pre-existing clinical records were selected from a pool of 804 children who had received behavioral intervention services from a large community-based behavioral health center during a 3-month period (September 1st to November 30th, 2015). Records were selected if they met the following criteria: a diagnosis of ASD (American Psychiatric Association [APA], 2013), autistic disorder (APA, 2000), pervasive developmental disorder, not otherwise specified (PDD-NOS; [APA, 2000]), or Asperger's disorder (APA, 2000), age between 3 and 12 years old. Of the 358 participants assessed for eligibility, seven were excluded because they did not have an ASD diagnosis and 38 were excluded because they were not within the age range. These criteria resulted in a sample size of 313 individual records. Of these 313 participants, 72 had received CBS (average weekly treatment hours = 16.97, SD = 7.88; average age = 6.68 years, SD = 2.17) and 241 had received HBS (average weekly treatment hours = 13.46, SD = 7.16; average age = 7.22 years, SD = 2.28). See Fig. 1 for the distribution of treatment hours. The age, diagnosis, and gender profiles of the individuals whose clinical records were used in the study were as follows: 276 males (age range 3–12 years, mean age: 7.11 years, 229 autistic disorder, 30 ASD, 15 PDD-NOS, 2 Asperger's disorder) and 37 females (age range 3–12 years, mean age: 7.0 years, 31 autistic disorder, 3 ASD, 3 PDD-NOS, 0 Asperger's disorder).

A secondary analysis was conducted to assess for differences in rate of learning within the same individual across both CBS and HBS sessions. For this analysis, only those participants who had received both CBS and HBS sessions were analyzed. This resulted in a sample size of 44 participants: 38 males (age range 3–12 years, mean age: 6.08 years, 31 autistic disorder, 6 ASD, 0 PDD-NOS, 1 Asperger's disorder) and 6 females (age range 3–9 years, mean age: 6.5 years, 3 autistic disorder, 2 ASD, 1 PDD-NOS, 0 Asperger's disorder). The average number of weekly treatment hours for these participants was 16.74 (range 6.06–34.58 h, SD = 7.82). Participants in this study resided and received services in the states of AZ, CA, CO, IL, LA, NY, TX, and VA.

Data Collection

Through the course of normal service delivery, practitioners used the Skills™ system to identify treatment targets, plan interventions, and track treatment response. The Skills™ assessment evaluates skills across all areas of development and has been shown to have good internal consistency as well as inter-rater and test-retest reliability (Dixon, Tarbox, Najdowski, Wilke, & Granpeesheh, 2011). Persicke et al. (2014) assessed the validity of the Skills™ Assessment by comparing direct observation and parent response to the Skills™ items and found that Pearson product-moment correlation coefficients ranged from moderate to high ($r = .65$–$.95$). These data were integrated with operational information (such as treatment hours) collected by the participating treatment centers.

Treatment

Participants had received one-on-one individualized behavioral intervention by trained behavioral practitioners. Each child's program had been customized to address the areas of functioning in which the child showed deficits, such as language, social skills, independent living skills, play, academics, motor skills, and executive functioning. All treatment programs were based on the Center for Autism and Related Disorders (CARD) model of treatment (Granpeesheh, Tarbox, Najdowski, & Kornack, 2014), which included the following components: (1) one-on-one treatment was delivered by trained behavioral practitioners, (2) both discrete trial training and natural environment training strategies were used, (3) language intervention used a verbal behavior approach, (4) both errorless and least-to-most prompting strategies were used, (5) research-based behavioral principles and procedures were used (e.g., reinforcement, extinction, stimulus control, generalization training, chaining, and shaping), (6) a function-based approach was employed for the assessment and treatment of challenging behaviors, (7) parents were

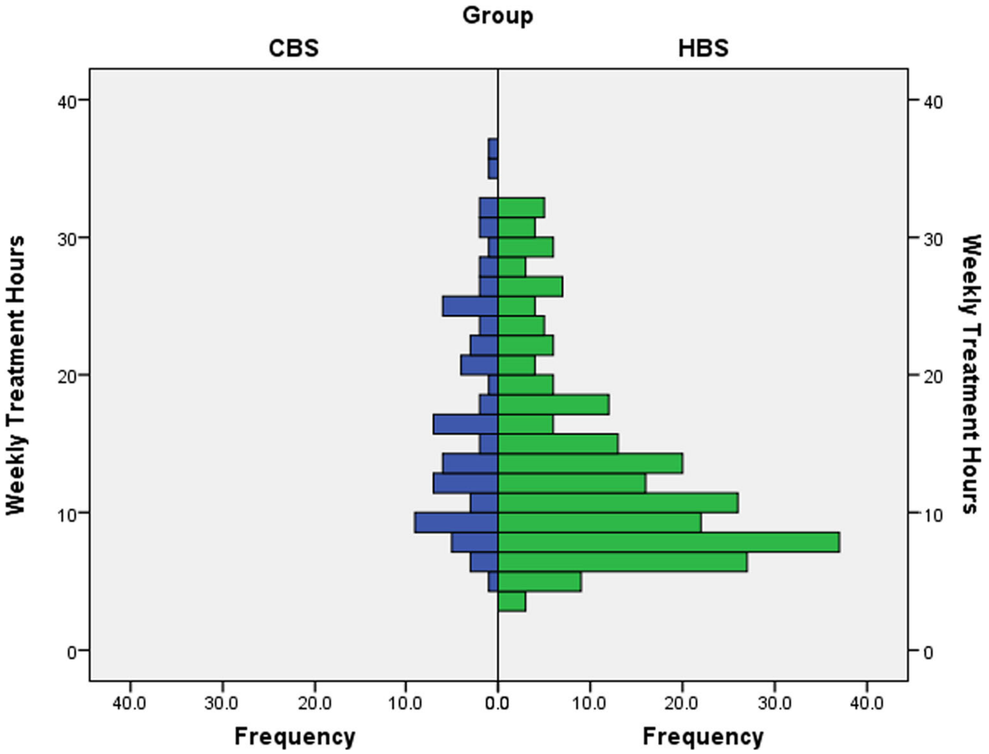


Fig. 1 Distribution of weekly treatment hours for CBS and HBS groups

included in all treatment decisions and received regular training; and 8) direct supervision was given on a regular basis.

Training for behavioral practitioners was multifaceted and included a combination of an eLearning program (www.ibehavioraltraining.com), classroom-style training, field-experience training, and evaluation. Practitioners received supervision from a Board Certified Behavior Analyst (BCBA) monthly or weekly and attended monthly professional development trainings that reviewed treatment procedures. Each participant had a monthly supervised clinic to ensure consistency and generalization across practitioners. Once mastered, programs were put on maintenance to continue to target them in more naturalistic settings to enhance generalization.

Each participant had a team of several practitioners who delivered sessions either in the participant's home or at the center. There were no explicit differences in treatment across locations (e.g., supervision, targeted skills). Participants were not randomly assigned to center-based or home-based treatment, as the session location was determined by parent preference as well as participant and practitioner availability.

Data Analysis

The independent variable for this study was the location of treatment services (i.e., home or center). The dependent variable for all analyses within this study was rate of mastery of learning objectives, which was calculated as the mean number of learning objectives mastered per hour. Mastery of a learning objective was defined by the treatment supervisor on an individual basis but had to include greater than 70 % accuracy of responding to the learning objective for at least two treatment sessions across two different days. A mastery criterion of 80 % accuracy is often used, but supervisors may deviate from this criterion if they believe it is clinically appropriate. Only mastered objectives from one-on-one discrete trial training sessions were included in this study.

The number of treatment hours and mastered learning objectives ranges over several orders of magnitude, which can result in a large amount of variance. The logarithmic transform was applied to reduce skew caused by this variance, as well as improve the interpretability of the data. Because this variance is due to the data itself, and not outliers, the logarithmic transform was used as it preserves the numerical relationship of variables.

Two separate analyses were run to examine potential differences in rate of mastery across condition. First, an analysis of covariance using group as the fixed factor, age and weekly treatment hours as covariates, was used to compare rate of mastery of all home-based sessions with all center-based sessions over the course of 3 months. The second was a within-subject analysis that was performed only for participants that received both HBS and CBS. This analysis compared within-subject rates of mastery in each location. The purpose of the within-subject analysis was to evaluate whether the results were consistent when the analysis controlled for individual differences (e.g., skill level, ASD symptoms, parent situation and involvement, etc.).

Results

For the first analysis, the covariate, participant age, was not significantly related to the rate of mastery $F(1, 309) = 2.696$, $p = 0.102$. The covariate, average weekly treatment hours, was significantly related to the rate of mastery, $F(1, 309) = 30.068$, $p < 0.001$. There was also a significant group effect after controlling for the effect of the average weekly treatment hours $F(1, 309) = 21.700$, $p < 0.001$. On average, participants mastered more learning objectives per hour of treatment in the CBS group ($M = 0.103$, SE = 0.016) than in the HBS group ($M = 0.053$, SE = 0.004). See Fig. 2.

A secondary analysis was conducted to evaluate differences in the rate of mastery within the same individual across both CBS and HBS sessions. As a group, participants mastered significantly more learning objectives per hour during CBS sessions ($M = 0.14$, SE = 0.023) than during their HBS sessions ($M = 0.07$, SE = 0.010). This difference was significant, $t(43) = 3.489$, $p = 0.001$ and showed a medium to large effect size ($r = 0.47$). See Fig. 3.

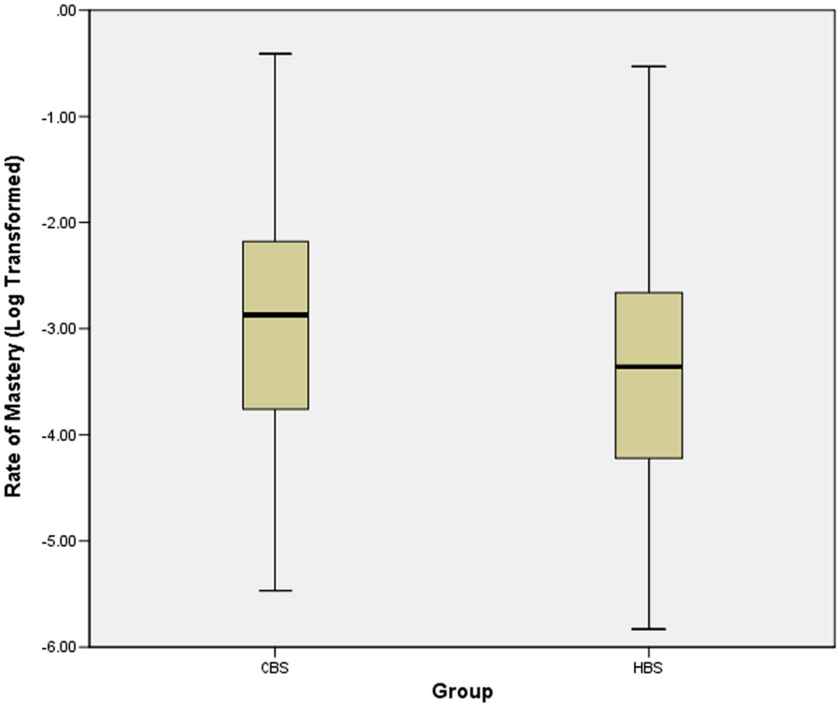
Discussion

The analyses for this study were conducted retrospectively using pre-existing clinical records of participants enrolled in ABA services. The results of the current study indicate that as a group, participants had mastered significantly more exemplars when receiving center-based services than home-based services. Also, the average treatment hours received per week, while only differing by 3.5 h between groups, showed a significant impact on the rate of mastery. That is to say that even a slight increase in average treatment hours per week increased the number of mastered learning objectives per hour.

In order to better account for individual differences, we also compared learning within the same participant for those who received both HBS and CBS. The results of this analysis showed that on average, individuals achieved 100 % more learning per hour during CBS relative to HBS. These complimentary analyses suggest that the observed improvements may be due to factors related to service location rather than individual differences (e.g., level of functioning, skills at intake, parental situations, intervention goals, etc.). These results are consistent with those of Roberts et al. (2011), and the current study expanded this research by focusing on one-on-one treatment delivered by trained behavioral practitioners. The findings of this study provide preliminary evidence that a setting may influence rates of learning during treatment.

One argument for favoring home-based sessions over center-based sessions is the idea that parents or caregivers are more likely to participate in treatment sessions if the sessions are located in their home. However, the idea that simple proximity to treatment will improve parent participation is similar to the failed strategy that Stokes and Baer (1977) noted as "train and hope." In contrast, center-based sessions may provide more structure and a more intentional environment for parents and caregivers to be trained within. Center-based services may allow for more control over the environment and

Fig. 2 Rate of mastery comparison between service locations: between groups



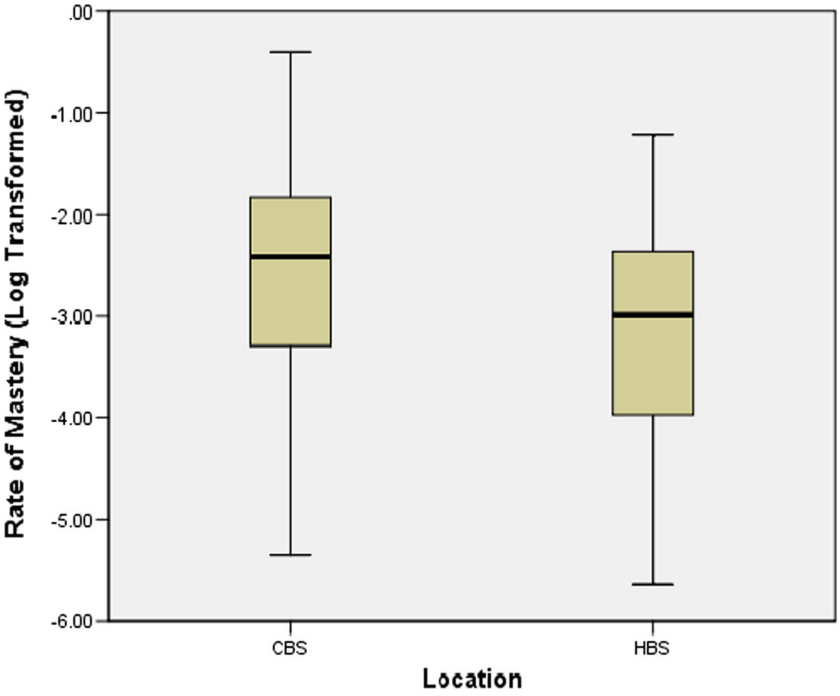


Fig. 3 Rate of mastery comparison between service locations: paired samples

therefore result in a decrease in potential distractors, which may facilitate increased rates of learning.

Another important aspect of CBS is that participants may have the opportunity to interact and generalize social skills with unfamiliar practitioners as well as with peers with ASD who also receive services at the center. Additionally, setting may influence the quality and quantity of supervision. Given the potential association between supervision and participant outcomes (Eikeseth, Hayward, Gale, Gitlesen, & Eldevik, 2009), additional supervision could be considered an advantage of CBS.

Decisions about treatment implementation may often be made based on convenience or availability rather than on how the setting may impact clinical outcomes. Location availability is often limited, as many ABA service providers only offer services either in the home or at a center. This indicates that there may not always be an option regarding location of services. Further, parents or caregivers also may choose the location based on convenience. While these represent practical considerations regarding the delivery of ABA services, these treatment decisions should be based on best-practice guidelines and not simply on convenience. As such, when a child and family are considered to be equally eligible for home-based or center-based services, the results of this study support the recommendation of Roberts et al. (2011) that center-based services may provide better outcomes.

A potential limitation of this study is that these findings represent the CARD model of ABA service delivery (Granpeesheh et al., 2014). While this promotes consistency in ABA delivery across the two conditions of this study, these results may not generalize to other models of ABA service delivery. For example, training methods may differ across different models and agencies. Future researchers would do well to evaluate the effect of service location on ABA outcomes across other models. Additionally, this study used pre-existing clinical records and as such, the treatment location was not randomly assigned. While factors related to individual differences were controlled for by the within-subject analysis, there are additional factors (e.g., time of day of treatment, whether new programs were targeted, generalization opportunities, skills targeted, and amount of supervision) that may have impacted rates of learning.

While the current study provides preliminary evidence for differences in progress between treatment settings, future research should focus on identifying and isolating the variables that may account for these differences. There are many factors related to setting that may impact participants' progress (e.g., distractors, opportunities for generalization and socialization, level of supervision, access to resources, and proximity to other practitioners). Additional research to evaluate the effects of these variables is warranted.

The general lack of research evaluating the impact of service location is a significant gap in the literature on intervention for ASD. The present study found that participants made significantly more progress in center-based locations compared to home-based location across groups as well as within participants. In light of these results and the absence of other studies, practitioners are encouraged to consider the appropriateness of center-based services when delivering treatment for ASD.

Compliance with Ethical Standards

Informed Consent The data collected for the present study were from a research database of de-identified archived clinical records. As such, the Institution Review Board (IRB00004971) concluded that 45 CFR part 46 of the U.S. Department of Health and Human Services regulation does not apply.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Funding This study did not receive external funding.

Conflict of Interest The authors declare that they have no conflict of interest.

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HB598_SB469 Written Testimony_AllyBehavior.pdf

Uploaded by: Couture, Rebecca

Position: FAV

ALLY
BEHAVIOR CENTERS
Changing Lives For Children With Autism

February 6, 2021

To Whom It May Concern,

This letter is offered as written testimony and support of HB598 and SB469.

We are: Ally Behavior Centers, 17810 Meeting House Road, Suite 100, Sandy Springs, MD 20860

We first want to express our thanks and appreciation to Delegate Ariana Kelly and Senator Mary Washington for sponsoring these bills. By doing so, they have boldly proposed a solution to neutralize the access disparities that currently exist for ABA services. We are also appreciative to organizations like Pathfinders for Autism and other ABA providers for their continued advocacy on this issue.

If successful, the passage of this bill would prohibit the Maryland Department of Health from conditioning reimbursement of applied behavior analysis (ABA) provided to Maryland Medical Assistance Program recipients on the presence or availability of the parent or caregiver of the program recipient in the setting where ABA services are provided to the program recipient.

Private insurance companies do not mandate a parent or caregiver be present.

Background on ABA: For young children diagnosed with Autism Spectrum Disorder (ASD), most struggle significantly with age-appropriate developmental milestones related to communication, life skills, school readiness and the ability to successfully interact with peers. Early intervention, full-time, center-based ABA therapy is often the recommended treatment by the developmental pediatricians and psychologists who diagnose them.

ABA therapy is delivered for 30-40 hours a week using a 1:1 therapist to child ratio, most often in a center-setting that resembles a preschool and natural play environment in the company of other children.

Current situation: We strongly object that center-based ABA therapy is not accessible to Maryland Medical Assistance Program recipients because reimbursement requires a parent or caregiver be present. **Having parents or caregivers present would violate HIPPA rights for our other clients therefore we are unable to offer our services to anyone but those who have private insurance or are self pay.**

This is discriminating and exacerbates socio-economic regression, making self-improvement and the hope of moving towards financial independence from public programming a less realistic goal for many. We are supporting the passage of these bills to make life easier for parents with a child in need of life-changing treatment for autism, no matter what type of insurance they have.

Additional counter effects of passing this bill include giving ALL children who need this therapy, access to full-time, center-based care while parents have the freedom to be contributing members of society, earn a living, care for themselves, care for others or whatever it is they need to attend to during their children's full-time therapy. Reimbursement of services should not depend on a parent or caregiver being present.

HB598 and SB469 are common-sense solutions to a rule that prevents equal access to care. Please accept this as our support for an obstacle-free future where everyone can access the care they need.

Best,

Michael Rudy

Michael B. Rudy
Founder & CEO
Ally Behavior Centers

SB 469.pdf

Uploaded by: Craley, Sarah

Position: FAV

Senate Bill 469

Position: Support

My name is Sarah Craley. I am a Master's Level Licensed and Board Certified Behavior Analyst. I work with children 2-10 years old who live in Cecil and Harford County, MD who are diagnosed with Autism Spectrum Disorder.

Autism has become a very prevalent condition in our society. The CDC estimates that approximately 1 in 54 people is currently diagnosed with Autism. People with Autism can struggle with severe communication deficits and significant, even dangerous, behavior challenges. According to research done over the last 50 years it has been determined that the best way to help these individuals is to provide a high number of intensive ABA therapy. It is recommended for many that they receive 30 hours of ABA (Applied Behavior Analysis) therapy per week. Currently, the Medicaid system requires that parents or guardians remain on site during therapy. While it is important to involve caregivers in training and therapy, it is unrealistic to expect that a parent would be able to quit his or her job to sit in a clinic for 30 hours a week. It is also unrealistic to expect that they would be able to work a full-time job around 30 hours of therapy for therapy for their child. Students on Medicaid receive a small portion of the recommended services as parents cannot sit with siblings in a clinic for the recommended therapy hours, nor can they remain at home (not working) for the therapy to be provided in home. I will share 2 personal examples here:

One is a preschool student. He cannot speak more than a handful of words. His communication is often in the form of crying and screaming. Sometimes he throws, hits, kicks, or bites to express his frustration. His school is trying to help him, but they do not offer 1:1 support with people specifically trained in Autism. I recommend (as he research and this individual case assessment showed) 30 hours of ABA a week in order to increase appropriate communication and decrease problem behaviors including elopement and aggression. He has received 10 hours per week because his mother is a single mother. She needs to work to provide for him. She cannot stay at home or in a clinic for 30 hours a week while he receives necessary therapy. She has tried daycares and babysitters, but it became too expensive to keep him in daycare and have us visit there. After 2 years of working with us we have seen increased communication from no words or other appropriate means, to use of pictures and some words, but if he had been able to access the recommended hours it is possible, we would be seeing much better progress.

Another family has a similar situation. This child is a kindergartener. He has been receiving ABA for 3 years in home, but has only received 8 hours of the 30 recommended hours because, in addition to having the same restrictions listed for the previous child, this mother has another, younger child that would need to sit with her while waiting for the sibling with Autism to receive therapy. This child has even less spoken language, and no other reliable communication. He struggles to use pictures and signs to communicate, so he has a lot of frustration and for about a year had severe Self Injurious Behaviors. Through the hard work and coordination of the family and professional team this behavior decreased, but it took approximately 12 months to get him to the point where he was safe enough that a helmet was no longer needed. For that time, if he did not have the helmet, he was causing severe harm to himself including a concussion. As a kindergartener he has actually moved to a new town that will allow him access to ABA services through his home school, but he missed 3 years of learning opportunities because he could only receive about 1/3 of the recommended services.

Respectfully Submitted,

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2014 CMS Bulletin Referenced in Sen. Washington Te

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Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: July 7, 2014

FROM: Cindy Mann, Director
Center for Medicaid and CHIP Services

SUBJECT: **Clarification of Medicaid Coverage of Services to Children with Autism**

In response to increased interest and activity with respect to services available to children with autism spectrum disorder (ASD), CMS is providing information on approaches available under the federal Medicaid program for providing services to eligible individuals with ASD.

Background

Autism spectrum disorder is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder. Currently, the Center for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD. [1]

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine. [2] While much of the current national discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan (see link below)[3]. This bulletin provides information related to services available to individuals with ASD through the federal Medicaid program.

The federal Medicaid program may reimburse for services to address ASD through a variety of authorities. Services can be reimbursed through section 1905(a) of the Social Security Act (the Act), section 1915(i) state plan Home and Community-Based Services, section 1915(c) Home

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[1] http://www.cdc.gov/ncbddd/autism/facts.html

[2] http://www.cdc.gov/ncbddd/autism/treatment.html

[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf

and Community-Based Services (HCBS) waiver programs and section 1115 research and demonstration programs.

State Plan Authorities

Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services. States electing these services may need to update the Medicaid state plan in order to ensure federal financial participation (FFP) is available for expenditures for these services. In addition, for children, as discussed below, states must cover services that could otherwise be covered at state option under these categories consistent with the provisions at 1905(a)(4)(B) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Below is information on these coverage categories for services to address ASD. Under these section 1905(a) benefit categories all other state Medicaid plan requirements such state-wideness and comparability must also be met.

Other Licensed Practitioner Services

Other Licensed Practitioner services (OLP) services, defined at 42 CFR 440.60, are “medical or remedial care or services, other than physicians’ services, provided by licensed practitioners within the scope of practice as defined under State law.” If a state licenses practitioners who furnish services to address ASD, the state may elect to cover those providers under this section of their state plan even if the providers are not covered under other sections of the plan (e.g., physical therapist, occupational therapist, etc.). A state would need to submit a state plan amendment (SPA) to add the new licensed provider to their Medicaid plan. The SPA must describe the provider’s qualifications and include a reimbursement methodology for paying the provider.

In addition, services that are furnished by non-licensed practitioners under the supervision of a licensed practitioner could be covered under the OLP benefit if the criteria below are met:

- Services are furnished directly by non-licensed practitioners who work under the supervision of the licensed practitioners;
- The licensed provider is able to furnish the service being provided;
- The state’s Scope of Practice Act for the licensed practitioners specifically allows the licensed practitioners to supervise the non-licensed practitioners who furnish the service;
- The state’s Scope of Practice Act also requires the licensed practitioners to assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision; and
- The licensed practitioners bill for the service;

Preventive Services

Preventive Services, defined at 42 CFR 440.130(c) are “services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to—

(1) Prevent disease, disability, and other health conditions or their progression;
(2) Prolong life; and
(3) Promote physical and mental health and efficiency”

A regulatory change that took effect January 1, 2014, permits coverage of preventive services furnished by non-licensed practitioners who meet the qualifications set by the state, to furnish services under this state plan benefit as long at the services are recommended by a physician or other licensed practitioner. Under the preventive services benefit, in the state plan, the state must 1) list the services to be provided to ensure that services meet the definition of preventive services as stated in section 4385 of the State Medicaid Manual (including the requirement for the service to involve direct patient care); 2) identify the type(s) of non-licensed practitioners who may furnish the services; and 3) include a summary of the state's provider qualifications that make these practitioners qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/ or registration.

Therapy Services

Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 CFR 440.110. Physical and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law and provided to a beneficiary by or under the direction of a qualified therapist. Services for individuals with speech, hearing and language disorders mean diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

States would need to include an assurance in the state plan that the state furnishes the therapy in accordance with 42 CFR 440.110. States would also need to describe the supervisory arrangements if a practitioner is furnishing the therapy under the direction of a qualified therapist. Finally, for audiology services, the state plan must reflect the supervision requirements as set forth at 42 CFR 440.110(c)(3).

Section 1915(i) of the Social Security Act

States can offer a variety of services under a section 1915(i) state plan Home and Community-Based Services (HCBS) benefit. The benefit may be targeted to one or more specific populations including individuals with ASD and can provide services and supports above and beyond those included in section 1905(a). Participants must meet state-defined criteria based on need and typically receive a combination of acute-care medical services (like dental services, skilled nursing services) and other long-term services such as respite care, supported employment, habilitative supports, and environmental modifications.

Other Medicaid Authorities

There are several other Medicaid authorities that may be used to provide services to address ASD. Below is a discussion of each of those authorities:

Section 1915 (c) of the Social Security Act

The section 1915(c) Home and Community-Based Services waiver program allows states to provide a combination of medical services and long-term services and supports. Services include but are not limited to adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Participants must meet an institutional level of care but are served in the community. Section 1915(c) waiver programs also require that services be furnished in home and community-based settings. For individuals under the age of 21 who are eligible for EPSDT services, an HCBS waiver could provide services and supports for ASD that are above and beyond services listed in section 1905(a), such as respite care. Additionally, for individuals who are receiving state plan benefits as part of EPSDT that are not available to adults under the state plan, waiver services may be used to help these individuals transition into adulthood and not lose valuable necessary services and supports.

Section 1115 Research and Demonstration Waiver

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services broad authority to authorize experimental, pilot, or demonstration programs that promote the objectives of the Medicaid program. Flexibility under section 1115 is sufficiently broad to allow States to test substantially new ideas, including benefit design or delivery system reform, of policy merit. The Secretary can approve an 1115 demonstration for up to five years, and states may submit extension requests to continue the program for additional periods of time. Demonstrations must be "budget neutral" over the life of the program, meaning they cannot be expected to cost the Federal government more than it would cost without the demonstration.

EPSDT Benefit Requirements

Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and not assuming that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child’s health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting.

The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child’s needs; that is, all services that can be covered under section 1905(a), including licensed practitioners’ services; speech, occupational, and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and dental services.

If a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a state's Medicaid State Plan, the state will nonetheless need to arrange for and cover it for the child as long as the service or supply is included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act. This longstanding coverage design is intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under age 21, including for those with ASD, based on individual determinations of medical necessity.

Implications for Existing Section 1915(c), Section 1915 (i) and Section 1115 Programs

In states with existing 1915(c) waivers that provide services to address ASD, this 1905(a) policy clarification may impact on an individual's eligibility for the waiver. Waiver services are separated into two categories: waiver services and extended state plan services. Extended state plan services related to section 1905(a) services are not available to individuals under the age of 21 (individuals eligible for EPSDT) because of the expectation that EPSDT will meet the individual's needs. There are therefore a limited number of services that can be provided to this age group under 1915 (c) waivers, primarily respite, and/or environmental/vehicle modifications.

For states that currently provide waiver services to individuals under age 21 to address ASD, the ability to provide services under the 1905(a) state plan may have the effect of making these individuals ineligible for the waiver unless another waiver service is provided. This implication is especially important for individuals with ASD who may not otherwise be eligible for Medicaid absent the (c) waiver. States need to ensure that these individuals are receiving a waiver service, not coverable under section 1905(a), to ensure that they do not lose access to all Medicaid services by losing waiver eligibility. Individuals age 21 and older may continue to receive services to address ASD through the waiver if a state does not elect to provide these services to adults under its Medicaid state plan.

The same issues arise for children under the 1915(i) authority, which allows for services above and beyond section 1905(a) to be provided under the state plan. CMS is available to provide technical assistance to states that currently have approved waivers or state plans that may be impacted by this clarification. Similarly, states with existing 1115 demonstrations authorizing reimbursement for services provided to children with autism should contact CMS to ensure that EPSDT requirements are met.

We hope this information is helpful. If you have questions please send them to AutismServicesQuestions@cms.hhs.gov.

Senator Mary Washington Written Testimony_SB469.pd

Uploaded by: griffin, christine

Position: FAV

MARY L. WASHINGTON, PH.D
Legislative District 43
Baltimore City

Education, Health, and
Environmental Affairs Committee

Chair
Joint Committee on Ending
Homelessness

Chair
Joint Committee on Children,
Youth, and Families

THE SENATE OF MARYLAND
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TESTIMONY IN SUPPORT OF SB469
Maryland Medical Assistance Program - Applied Behavior Analysis Services - Reimbursement

Finance Committee
February 10, 2021

Dear Chair Kelley, Vice Chair Feldman and members of the committee:

SB469 is being introduced to address increasing access to critical treatment for autism by eliminating an unacceptable inequity between Medicaid families and families with private insurance.

In 2012, this Committee passed and the Governor signed into law legislation establishing a Technical Advisory Committee within MDH to make decisions about the medical appropriateness of specific coverage under our existing Habilitative Services insurance mandate for Autism Spectrum Disorder, including an intensive and remarkably effective treatment called applied behavior analysis, or “ABA”. This Technical Advisory Committee determined that coverage for ABA services was required under the state’s Habilitative Services Mandate. The result was long awaited coverage for ABA as autism treatment within the state regulated insurance market, the State employee’s self-funded plan, and in Medicaid. Many families were helped.

In 2014, a CMS bulletin also clarified that ABA services for children are required to be covered by Medicaid. In particular, these benefits are required under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit program. The bulletin has been uploaded with my testimony. “States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.”

Please note, states are required to cover these therapies for children, regardless if their parent is willing or able to be present for the service.

After Maryland passed this bill, subsequent state Medicaid regulations mandated that a parent be present during ABA services, though this has never been required of privately-insured parents.

In Maryland we have evolved into a system where children in private insurance plans have options for treatment to improve their outcomes for the rest of their lives, whereas children in Medicaid have the door shut on them. The children who are Medicaid eligible deserve the same access to care as all other children.

ABA treatment is so intense that it can require up to 40 hours per week. Maryland's parental participation mandate for Medicaid recipients means that families have a simple and stunningly unfair choice - accompany a child to treatment and provide the best opportunity for a high-quality life, or go to work so they can pay rent, buy food and attend to other necessities and children. It is unbelievably cruel to families that are already struggling with parenting special needs children.

Early intervention and ABA are proven to improve lives for autistic children and reduce future occupational, physical, and speech therapy. In the long run, early intervention and ABA saves money, including Medicaid money.

Imposing a parental participation mandate forces parents to make a personal Sophie's Choice that is painfully unfair and fiscally irresponsible. Our shared commitment to equity in healthcare requires elimination of this requirement. Amending this regulation will remove a barrier to care, and create treatment equity between children served by Medicaid and those covered by private insurance.

For these reasons, I ask you for a favorable report on SB469.

In partnership,

Senator Mary Washington, District 43, Baltimore City

Autism Speaks Written Testimony In Favor of SB469.

Uploaded by: Headrick, Kelly

Position: FAV

autism speaks

February 9, 2021

Finance Committee
Maryland Senate

RE: Support of SB469

Dear Chair Kelley and Members of the Committee:

Thank you for the opportunity to provide written testimony in strong support of SB469 by Senator Mary Washington. This important bill will pave the way for more meaningful and equitable access to critical autism-related therapies for children who need them. It will do so by removing a burdensome and unnecessary requirement within current Maryland Medicaid reimbursement practice, which often has the impact of forcing a parent to choose between paid work or other household duties and ensuring their autistic child receives medically necessary services.

Applied behavior analysis (ABA) is a common and often life-changing behavioral health therapy for individuals with autism and their families. Together with other prescribed services for some autistic children and adults, such as occupational therapy and/or speech therapy, ABA helps people with autism reach their full potential in areas including education, employment, independent living, and life satisfaction.

In 2014, the Maryland Legislature passed a law requiring state-regulated private insurance plans to provide coverage of autism-related services including ABA. Under this law, there is NO mandate that a parent or caregiver of children receiving ABA services must be present and available at all times in the setting of that service provision.

"The new year signified a fresh start and a reason to celebrate for our family: our 7-year-old son, Owen, who was diagnosed with autism at 19 months, returned from winter break to his first FULL DAY in a mainstream, general education classroom. In his words, "It was awesome!"

Now, it may be difficult for families without children on the spectrum to understand why this was such an important day for us but trust me – this was huge! This is a moment that he's worked for since he was diagnosed. Nearly six years of 20+ hours of [ABA] therapy a week….working through more challenges than we even knew existed: being non-verbal, echolalia, scripting, teeth grinding, transitions, meltdowns, stimming, splinter skills and difficulty with gross and fine motor skills.

And finally, in 2021, it happened! Owen's first full day in a general education classroom was a success! We share O's story because early intervention/diagnosis was so instrumental in bringing him to this awesome day."

"As a mom, I felt a lack of understanding and connection with my son, Kenden, better known as Mr. K. I knew something was missing from our relationship. He was nonverbal with screaming and crying as his only form of communicating.

His behaviors were very impulsive and uncontrollable. He would hit, kick, bite, throw himself into doors, walls, or fall on the floor. I had no clue how to handle or help him. Kenden's autism journey began at the age of 2.

His diagnosis provided a relief. It gave me permission to stop holding my breath and to breathe. I knew this would be work but I was definitely up for the challenge and welcomed it.

Now, Kenden is a thriving 8-year-old little boy. His smile is contagious, and his self-confidence will give you strength. He defines the saying 'if there is a will, there is a way!'"

Two years later in 2016, the Maryland Department of Health filed a Medicaid State Plan Amendment (SPA) to add ABA therapy coverage for children with an Autism Spectrum Disorder diagnosis, as is a federal Medicaid requirement. This SPA was approved by the Centers for Medicare and Medicaid Services (CMS) and it took effect on January 1, 2017.

That 2016 SPA contained NO mandate that a parent or caregiver of children receiving ABA services must be present and available in the setting of that service provision, and such mandates are not common in other state Medicaid programs.

While a component of ABA therapy for an individual with autism is training of the family to support that individual at home, the majority of hours spent are between just the Registered Behavior Technician and/or the Board-Certified Behavior Analyst working with the autistic person. Some children require very intensive ABA therapy, up to 40 hours per week.

For most families to function – typically with one or more parent(s) working, a household to run, and sometimes with the needs of other children to be met – a parent or caregiver does not have the ability to spend up to 40 hours a week at the site of the child's ABA therapy, as is currently required under Medicaid. Often in only the most privileged families can a parent or caregiver devote this much of their time to being present during all of their child's autism-related care.

I urge your support of SB469 to help solve this problem and create greater access and equity for the growing number of children with autism. Thank you.

Respectfully submitted,

Kelly Headrick

Kelly Headrick
Senior Director, State Government Affairs
kelly.headrick@autismspeaks.org
720-207-8102

LittleLeaves Medicaid Testimony SB0469 022021.pdf

Uploaded by: Major, Marina

Position: FAV

Little Leaves
BEHAVIORAL SERVICES

To: The Honorable Delores Kelley, Chairperson Finance Committee

From: Marina Major, President, Little Leaves Behavioral Services

Re: Letter of Support- SENATE BILL 469: Maryland Medical Assistance Program –Applied Behavior Analysis Services–Reimbursement

Dear Chair Pendergrass and Members of the Committee:

Thank you for the opportunity to provide written testimony in support of SB 469.

Little Leaves Behavioral Services is an Applied Behavioral Analysis ("ABA") therapy practice that originated in the state of Maryland. We were founded almost 10 years ago, and in that time, we treated nearly 100 Maryland children with Autism Spectrum Disorders ("ASD"). We serve children 1-6 years of age (below mandatory school age) in our centers. Currently Little Leaves operates six ABA centers offering intensive intervention services, three in Maryland, two in Virginia, one in Florida, and have plans to open additional centers in all three states. Most children enrolled at our centers receive intensive treatments of 30-40 hours per week. Our approach and duration of intensive therapy aligns with a large body of research supporting the correlation of intensive ABA therapy and improved long-term outcomes[1]. Our children show progress in areas such as communication, play skills, social skills, self-care, and school readiness, and experience a reduction in challenging behaviors, during their time with us and after. This progress helps prepare our clients for a more successful path in school and life.

Despite the success of advocates in securing commercial health plan insurance coverage of ABA and the Centers for Medicare and Medicaid (CMS) clarifying that treatment for ASD is a covered service under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit under Medicaid, access to early intensive ABA therapies is a challenge and the disparities between Maryland Medicaid beneficiaries and those with commercial insurance continue, in part due to the parent/guardian supervision requirement SB 469 proposes to eliminate.

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[1] Rogers SJ, & Vismara LA (2008). Evidence-based comprehensive treatments for early autism. Journal of Clinical Child & Adolescent Psychology, 37(1), 8–38.

Little Leaves
BEHAVIORAL SERVICES

After recent events in our nation amplifying racial inequity, Little Leaves reflected on ways that we could serve a broader range of children impacted by such inequities and began exploring how to enroll as a Maryland Medicaid provider. Up until this point, we had only contracted as a provider of commercial health insurance plans including, Carefirst, United, Aetna, Cigna, Kaiser, and Johns Hopkins, all of which authorize treatment in our centers without parent/guardian supervision. During the latter part of 2020, calls from Maryland Medicaid families significantly increased -- so we know there is a need and lack of access. It has been very difficult for us to turn these families away, knowing we can help their children.

In pursuit of becoming a Maryland Medicaid provider, we spoke extensively with Optum (the current administrator of ABA benefits for Maryland Medicaid) about the process, reimbursement, and requirements for us to treat Maryland Medicaid families and were confident in our ability to gain provider status until we learned of the conditioning of ABA services on supervision by a parent/guardian for the entire duration of therapy. At this juncture, it is worth noting that intensive early intervention services can be 6-8 hours in duration daily. As providers of center-based services, we knew it was unrealistic and virtually impossible for parents/guardians to forego work and jobs to supervise multiple times per week, and in the rare event of possibility, we could not accommodate additional adults in our building all day. Doing so would restrict space that would allow us to treat other children, and especially in this time of COVID, would introduce health risks to our staff and clients. As such, this requirement is a significant barrier to our ability to offer services to Medicaid beneficiaries and an even greater impediment for Medicaid beneficiaries who have a need to access early intervention ABA therapies.

We remain strong in our conviction to offering services and access of ABA therapies to all children in the communities we serve and will continue to work to eliminate the barriers of access for Medicaid insured children and families. Elimination of the parent/guardian presence requirement for the delivery of ABA therapy would greatly increase our ability to serve those children when medically necessary and help to eliminate disparities created by this Maryland Medicaid requirement. Medicaid beneficiaries in other states (such as Pennsylvania) are not faced with this same restriction nor are families who have access to commercial insurance. SB 469 is a step in the right direction to address this multi-faceted problem and improve the health of our Maryland youth.

PFA SB 469 Testimony.pdf

Uploaded by: Rienzi, Rebecca

Position: FAV

PATHFINDERS FOR AUTISM

SENATE BILL 469: Maryland Medical Assistance Program –Applied Behavior Analysis Services–Reimbursement

Finance Committee
February 10, 2021
POSITION: SUPPORT

Dear Chairwoman Kelley and Members of the Committee:

Pathfinders for Autism (PFA) is Maryland's largest autism organization dedicated to helping individuals, parents, and professionals find resources, support, and training while working to increase the awareness of autism spectrum disorders. We accomplish this through a variety of programs and services, all of which are offered FREE of charge. Last year our programs served over 19,300 people.

PFA supports Senate Bill 469 which seeks to prohibit the Maryland Department of Health from conditioning reimbursement of applied behavior analysis (ABA) provided to Maryland Medical Assistance Program recipients based on the presence or availability of a parent. ABA is a common behavioral health therapy that helps people with autism reach their full potential in areas including education, employment, independent living, and life satisfaction. Some children may require intensive ABA therapy, up to 40 hours per week.

The arbitrary requirement for a parent to be present and available creates inequity in access to medical care between those with private insurance sold in Maryland and recipients of Medicaid. This burdensome requirement puts parents in the position of having to choose between work or other family responsibilities and getting medically necessary treatment for their children with autism.

One in 52 Maryland children are diagnosed with autism.[1] There are over 12,500 children in Maryland public schools with an autism diagnosis.[2] One third of children in Maryland are covered by Medicaid.[3] The requirement that a parent be present and available for services is NOT clinically necessary or appropriate; is NOT a requirement under the 2014 mandate that ABA services be covered by policies sold in Maryland; and is NOT included in the Medicaid State Plan Amendment approved by the Centers for Medicare and Medicaid Services in 2017. Maryland Medicaid has perpetuated a system of care that benefits the most privileged in our state while creating systemic barriers for thousands of the most vulnerable.

Beyond the issue of equity, this requirement is fiscally irresponsible. It forces a family to choose between employment or treatment. Employment that may reduce the need for public assistance programs or treatment that could, over time, reduce the child's need for special education services and/or adult service programs covered by the state.

Nothing about this requirement makes clinical, equitable, or fiscal sense. I respectfully ask that you vote in favor of SB 469 and create greater access and equity for the growing number of children with autism. For more information, please contact Rebecca Rienzi, Executive Director, Pathfinders for Autism at 443-330-5370 or rrienzi@pathfindersforautism.org.

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[1] Autism and Developmental Disabilities Monitoring (ADDM) Network 2020 report

[2] Maryland State Department of Education 2018 Special Education Census Data

[3] Kaiser Family Foundation 2018 State Medicaid Report

Maryland Senate Bill 469 CASP Written Testimony.pd

Uploaded by: Ursitti, Judith
Position: FAV

CASP
The Council of Autism Service Providers

February10, 2021

Senate Bill 469
Maryland Medical Assistance Program - Applied Behavior Analysis Services – Reimbursement
Health and Government Operations Committee
POSITION: SUPPORT

Dear Chair Kelley, Vice Chair Feldman and Members of the Senate Finance Committee:

I write to you today on behalf of The Council of Autism Service Providers (CASP) in support of Senate Bill 469. CASP is a non-profit association of organizations committed to providing evidence-based care to individuals with autism. CASP represents the autism provider community to the nation at large, including government, payers, and the general public. We provide information and education and promote standards that enhance quality of care.

Of particular interest to our members is the coverage of evidence-based care in both private health insurance plans as well as through Medicaid. As you may recall:

- Maryland finalized regulations in March, 2014 that required state-regulated health insurance plans cover medically necessary care for ASD, including applied behavior analysis (ABA).
- Later, in July, 2014, the Centers for Medicare and Medicaid Services (CMS) issued a bulletin[1] clarifying the inclusion of coverage of medically necessary care for children diagnosed with autism spectrum disorder (ASD) as part of its Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirement. The CMS bulletin[2] indicates that states are required to cover treatment

> *that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible.*

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[1] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf

[2] Ibid.

- Subsequently, in January, 2017, the Maryland Department of Health implemented coverage of ABA for Medical Assistance Program-enrolled children diagnosed with ASD as required under EPSDT.

These developments have been lifechanging for many in the autism community. That said, there are implementation issues that have emerged that require attention.

For example, it is important to note that an ABA program *should* include training and support to enable parents and other caregivers to participate in treatment planning and treatment plan implementation. This participation is not in lieu of the provision of medically necessary care, but rather compliments it. The current COMAR ABA Regulations[3] take participation requirements a step further, unfortunately, stating the following:

> *D. The participant's parent or caregiver shall:*
>
> *(1) Be trained to reinforce ABA services for the participant in a clinically effective manner; and*
>
> ***(2) Be present or available in the setting where services are being provided at all times, even if not directly participating in the services.***

Requirement 2 conflicts directly with the previously referenced CMS bulletin[4], which states:

> ***All children****, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. …EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis and treatment* ***without delay****. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting.*

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[3] COMAR ABA Regulations 10.09.28.05. 05 Limitations
[4] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf

In addition to the EPSDT violations this arbitrary requirement presents, it also contributes to ongoing access issues for the many families relying on the Medical Assistance Program, particularly when parents or guardians are employed or have other caregiving responsibilities.

With 1 in 54 children diagnosed with ASD according to the Centers for Disease Control[5] and an estimated incremental lifetime cost of $3.2 million according to the Harvard School of Public Health[6], it is fiscally prudent that children access evidence-based care, including ABA, whether or not their parents are able to be present for the provision of therapy at all times.

Senate Bill 469 remedies this disparity by simply removing the arbitrary parental participation requirement. We strongly support its passage and ask that you move quickly to ensure it. Thank you for your consideration. Should you need additional information, please do not hesitate to contact me at jursitti@casproviders.org or (682) 225-7146.

Sincerely,

Judith Ursitti

Judith Ursitti
Vice President of Community Affairs

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[5] https://www.cdc.gov/ncbddd/autism/data.html

[6] https://jamanetwork.com/journals/jamapediatrics/fullarticle/570087

4 - FIN - SB 469 -MD Medical Assistance Progam - A

Uploaded by: Bennardi, Maryland Department of Health /Office of Governmen
Position: INFO

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

February 10, 2021

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401–1991

RE: Senate Bill 469 - Maryland Medical Assistance Program – Applied Behavior Analysis Services – Reimbursement - Letter of Information

Dear Chair Pendergrass and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of information for Senate Bill (SB) 468 Maryland Medical Assistance Program – Applied Behavior Analysis Services – Reimbursement.

This bill would prohibit MDH from requiring a parent or caretaker's presence or availability at the setting in which a child receives applied behavioral analysis (ABA) services as an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.

MDH covers ABA services for children under the age of 21 as part of its ESPDT benefit. To qualify for services, a child must have a diagnosis of autism spectrum disorder (ASD) and exhibit the presence of maladaptive behavior or developmental skills deficits that significantly interferes with home, school, or community activities, amongst other requirements. A licensed psychologist, or a licensed behavioral analyst is responsible for developing an ABA treatment plan. The ABA treatment plan must identify certain long-term goals for treatment and must address care coordination and support. The participant's parent or caregiver must (1) be trained to reinforce ABA services in a clinically effective manner; and (2) be present or available in the setting where services are being provided at all times, even if not directly participating in the services. SB 469 would require MDH to eliminate the second requirement.

In CY 2019, 945 children aged 0-20 used 98,473 ABA services. The total cost of services was $18.3 million. Nearly half of these children were aged 5 or younger. Removing the requirement that a parent or caretaker is present or available would have a fiscal impact because of expected increase in service utilization. Expenditures would be subject to a 52% FMAP. Assuming a conservative 10% increase in service utilization, the fiscal impact would be $1.8 million ($952,967 Federal funds, $879,662 General Funds).

The current policy was implemented to enhance the quality of services received and to improve outcomes for vulnerable children with ASD. Involvement of parents/caregivers in treatment, particularly for younger children with ASD, has long been recognized as a vital component to the development of communication, social, and academic skills, thus improving treatment outcomes.

Parents have more opportunities to teach their children than an ABA practitioner so their involvement is critical. If the parent/caretaker is not present, this critical training component is missing. There is also a risk of ABA services being misused as a substitute for other types of care while a parent/caretaker is unavailable to care for the child themselves.

Lastly, this bill may impact school-based applied ABA services funded under individualized education plan (IEP). Traditionally these services do not require a parent or caregiver's presence. However, SB 469 may cause a shift from school-based ABA services, funded separately under an IEP, to community-based ABA services reimbursed by Medicaid. The shift from school-based ABA services to community-based ABA services will increase Medicaid reimbursement funds and may cause duplication in services.

I hope this information is useful. If you would like to discuss this further, please do not hesitate to contact me at webster.ye@maryland.gov /(410) 260-3190 or Heather Shek, Deputy Director of Governmental Affairs at heather.shek@maryland.gov and at the same phone number.

Sincerely,

Webster Ye

Webster Ye
Assistant Secretary