The Arc
Indiana

Statement Regarding Applied Behavior Analysis Therapy Services Proposed Rule LSA Document 14-337 405 IAC 5-22-12

Background: In 2000, The Indiana General Assembly passed a health insurance mandate for Pervasive Developmental Disorders, now commonly called "The Indiana Autism Insurance Mandate." The mandate was passed with bipartisan support, requiring HMOs, individual, small group and large group commercial insurance products to offer coverage for autism treatment (HEA 1122), including but not limited to Applied Behavior Analysis (ABA) Therapy Services with no age limits to treatment.

The Indiana Exchange ACA Plans require coverage for ASDs, and ABA under habilitative services, and their carriers must follow the terms of the Indiana Autism Mandate.

Fourteen years later, after 40 states followed Indiana in enacting insurance mandates for autism treatment, the Centers for Medicaid and Medicare (CMS) issues a guidance stating that state administered Medicaid programs had an existing obligation to cover autism treatment, including but not limited to ABA therapy, under Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. This guidance came after landmark court cases in Florida and Ohio required the state Medicaid plans to cover autism and ABA therapy.

The Arc applauds Indiana Medicaid for taking action on the CMS guidelines. Without access to clinical treatment under EPSDT, children on Medicaid do not have similar access to treatment as their counterparts who have private commercial or ACA based insurance plans, and they are much more likely than these children to require intensive special education services and lifelong support services. Several elements of the proposed rule raise concerns, and we request that they be addressed before the final rule is adopted in order to better reflect current standards of clinical care, standards of professional delivery of Behavior Analytic services, and equal access to treatment that Indiana law requires for non-Medicaid patients. We also encourage a revision of parts of the proposed rule so that it is consistent with federal law under the ACA and federal mental health parity laws, which include ASDs and DDs.

1. ABA is not included in the definition of habilitative services under this proposed rule. This is inconsistent with the BACB definition of ABA, the clinical standards for behavior analytic services beyond EIBI (Early Intensive Behavioral Intervention), and our own state's definition of habilitative services for ACA plans and coverage for ABA under on the Indiana ACA Marketplace.

2. ABA coverage does not start until age 3, our state First Steps program (0-3 intervention) does NOT provide EIBI; why make a child diagnosed at age 18mos-2.9 years old wait for treatment? Experts and research agree that early intervention is the key to prevent or reduce lifelong disability. ASDs can be reliably diagnosed as early as 12-18 months of age. Our state Medicaid rule should reflect known clinical standards and reflect the purpose of EPSDT – to reduce or eliminate potential disabling conditions.

3. The definition of "educational in nature" on page 2 seems overly broad and contradicts coverage for habilitative services. This could be misconstrued to limit ABA treatment to EIBI only, which is not the purpose of EPSDT, nor is it the clinical standard of ABA therapy service delivery. ABA services, in various forms, are a successful, evidenced based treatment for ASDs across the lifespan. All ages covered under EPSDT must have access to behavioral services when medically necessary.

4. RBT (Registered Behavioral Technician) services will only be covered if under the "supervision of a licensed psychologist holding a BCBA-D." This provision will greatly limit access and is not in keeping with BACB guidelines or standard clinical practice. There are only 12-14 BCBA-Ds, approximately, in the entire state and none are listed as being willing to supervise RBTs. Additionally, not all BCBA-Ds are psychologists and not all work in clinics. Some work in educational institutions. This requirement severely limits access to the point of denial of services in many if not most areas of the state.

5. The rule states that RBT services will not be covered in home or school – other states have done coordinated services in school in order to facilitate transition from EIBI to school. Not allowing home services has a host of issues as well. For example, how can a BCBA treat aggression that takes place in the home if he or she cannot observe it in the home and devise a plan that a RBT can assist to implement in the home? Will Medicaid pay for 15, 20, 25, 30 hours of BCBA time in the home in order to treat this type of behavior? Would that not lead to excessive costs where an effective RBT implemented program could address the issue in the home at lower cost with supervision and clinical direction from the BCBA, as is standard practice in ABA delivery?

6. The rule limits services to three years total. We cannot find any research or established clinical practice guidelines to support this limit. Even when looking at the EIBI research only, there is no research that supports limiting EIBI to only three years, let alone limiting all types of ABA clinical intervention to three years. We are not aware of other chronic conditions that face such limitations under EPSDT.

We look forward to working with clinical providers and Medicaid representatives to address the above concerns and look forward to the day when all children under Medicaid have access to the standard of care interventions that are available for ASDs to commercially insured and ACA insured children.

The Arc of Indiana
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