Illinois Autism Insurance Coalition
BUILDING PARITY, ACCESS AND CAPACITY

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Department of Healthcare and Family Services
Steffanie Garrett, General Counsel
201 S. Grand Ave East, 3rd Floor
Springfield, IL 62763-0002
Submission by Email: HFS.Rules@illinois.gov

Re: DHFS Proposed Amendments to Medical Payments 89 IAC 140; Section 140.457 and proposed new Section 140.465 for Adaptive Behavior Support (ABS) Services including applied behavior analysis (ABA) therapy.

Dear Ms. Garrett,

Thank you for the opportunity to provide public comment on DHFS' proposed amendments to Sections 140.457 and 140.465 Adaptive Behavior Support Services. Our Coalition has greatly appreciated the collaborative working relationship with DHFS and the Office of Medicaid Innovation over the past few years. We hope to continue this collaboration as we move forward with the implementation of final amendments to this much-needed service for individuals throughout the state with autism spectrum disorder (ASD).

The Illinois Autism Insurance Coalition's provider network consists of 28 autism service providers that offer applied behavior analysis (ABA) therapy, speech and occupational therapy, diagnostics, counseling, school consultation, and adult support services. Our Coalition brings together the collective strength of like-minded organizations to improve the landscape of private and public reimbursable insurance services for autism spectrum disorder to those served in the state of Illinois.

We are pleased to see DHFS address and correct an access barrier by including board-certified behavior analysts (BCBA) in delivering ABS services without supervision. After reviewing the proposed rules, our Coalition has the following concerns and recommendations to address barriers to accessing services for Medicaid-eligible children and obstacles in service delivery impeding providers:

(1) Restrictive Treatment Limitations - Concerns 1, 5A, 5B, and 5C
(2) Overburdensome Certification Requirements for Center-Based Services - Concerns 2A and 2B
(3) Narrowing of an already depleted workforce - Concerns 3, 6A, and 6B

Issues of Concern & Recommendations

***Concern 1: (a)(3)(A) Recommended by a licensed physician operating within their scope of practice*.**

Issue: This language limits who can recommend treatment and does not include a licensed psychologist which is the most common practitioner type we see every day in the field diagnosing and recommending treatment modalities. A prescription from a physician should not be needed but was listed in the DHFS provider notice[1] dated September 2021, as a requirement to access care.

The DHFS provider notice also lists licensed clinical psychologists as practitioners who can diagnose ASD and recommend treatments. Under Illinois state law, a diagnosis of ASD can be made by a "physician licensed to practice medicine in all its branches" or "a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders."[2]

Family Impact: Subjecting families to yet another medical appointment that offers no real help to their child is time-consuming and costly to the family. The wait time for such appointments is often long. Those diagnosed with autism should be able to access ABS services, including ABA therapy, without delay. We are not aware of HFS requiring all children in Medicaid seeking treatment for mental health disorders, to be required to have a prescription from a physician on and above a completed psychological testing, diagnosis, and recommendations obtained by a psychologist. For families accessing Medicaid's community-based behavioral services (CBS) system, an independent practitioner is defined as a licensed clinical psychologist, licensed clinical social worker, or psychiatrist, and their treatment recommendation does not require a prescription from a physician to access services.[3]

Recommendation 1: Amend the requirement to enable a licensed psychologist and/or any other licensed professional operating within the scope of their license to recommend ABS services for the treatment of ASD without the requirement of a formal prescription from a physician.

A) Recommended by a licensed physician, *licensed psychologist, or any other licensed professional* operating within the scope of their license.

[1] DHFS *Provider Notice 9.2021*. https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/prn210930b.aspx
[2] Illinois General Assembly. Public Act 097-0972, *INS CD-Autism Spectrum Disorder*. 2013. https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=097-0972.
[3] IDHFS Community-based Behavioral Services (CBS) Provider Handbook, page 19, https://www2.illinois.gov/hfs/SiteCollectionDocuments/07062022CommunityBasedBehavSvcsHdbkFor07012022Final.pdf and IDHFS Section 140.452 Individual Practitioner Definition, page 1, https://www.ilga.gov/commission/jcar/admincode/089/089001400D04520R.html

Concern 2: (a)(3)(C) Delivered in a home or community setting, or at the office of a BHC enrolled to deliver ABS services.

Issue 2A: Requiring all office and center-based service locations to become DHFS-certified Behavioral Health Clinics (BHC) is an overburdensome business certification not utilized in commercial insurance. Excluding the robust commercial insurance network of center-based ABA service providers from around the state, would negatively impact Medicaid consumers.

We commend DHFS for its creation of BHCs which are considered a smaller and lighter version of HFS-certified Community Behavioral Health Centers (CBHC). The BHCs provide mobile crisis response, crisis stabilization, medication management, counseling, and case management. With the newly signed state licensure Act for board-certified behavior analysts, we cannot see a center-based provider needing an overburdensome BHC certification requiring the expense for a full-time licensed practitioner of the healing arts (LPHA), which is hard to find and hire, to provide oversight only for the provider's Medicaid consumers receiving ABA therapy.

Currently, DHFS is reimbursing claims for ABA therapy delivered in homes, community, and center-based settings without a requirement of a BHC certification within Phase 2 of the coverage rollout. At present, HFS allows non-BHC center-based providers to deliver ABS services but because of workforce shortages and the inability to hire licensed practitioners, only a few providers are delivering services today.

For years now, commercial insurance has reimbursed ABA therapy delivered in an office or center-based locations without a requirement to obtain a facility or clinic certification, and without safety concerns arising to a level of discussion of the need for oversight.

Family Impact: Families will have fewer location options compared to families with commercial insurance and compared to some Medicaid families seeking services for other types of disorders within the state's array of services. This could lead to further travel to BHC service locations and for many, those locations will most likely be outside their communities. Within the proposed rules, families would not have a center-based location option that is not required to be certified as a BHC.

Issue 2B: Limiting service delivery locations and not including natural environments where we find children such as in schools, pre-schools, and daycares limits access to these vital services.

The behaviors and deficits commonly associated with ASD may occur across all of a child's natural environments and must be addressed in the environments in which they occur as noted in the industry's three generally accepted standards[4] of care (GASC) guidelines relied upon for ethical service delivery and medical necessity criteria for ABA therapy in the treatment of ASD.

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[4] Standards (GASC): (1) Behavior Analyst Certification Board (BACB), *Clarifications Regarding Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers 2nd Edition*, (2019). https://www.bacb.com/wp-content/uploads/2020/05/Clarifications_ASD_Practice_Guidelines_2nd_ed.pdf. (2) Council for Autism Service Providers (CASP), *Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Manager*. (2020). https://casproviders.org/asd-guidelines/. (3) ABA Coding Coalition, *The Model Coverage Policy.* (2022). https://abacodes.org/wp-content/uploads/2022/01/Model-Coverage-Policy-for-ABA-01.25.2022.pdf

We commend HFS for recognizing the need for ABA in schools and submitting a currently pending state plan amendment with CMS regarding Medicaid school-based health services (SBHS). Per HFS in October 2021, "school-based practitioners who have been submitting claims for physical and behavioral health services for special education students through an IEP/IFSP are able to provide those services for students in the general population without an IEP/IFSP… The following services and practitioners are being added: Applied Behavioral Analysis services,…"[5]

Within the EPSDT (early, periodic, screening, diagnostic, and treatment) guidance to states, the Centers for Medicare & Medicaid Services (CMS) maintains that "Schools are particularly appropriate places to provide medical, vision, and hearing screenings; vaccinations; some dental care; and behavioral health services."[6] According to CMS, "The goal of EPSDT is to assure that individual 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."[7] Under the EPSDT mandate, state Medicaid agencies are responsible for ensuring that all medically necessary ABA and behavioral health treatments to correct or ameliorate a child's ASD deficits and conditions are provided based on individualized determinations of medical necessity. In additional guidance to states, CMS has said that regardless of any services provided by schools pursuant to IDEA or otherwise, the state Medicaid program retains primary responsibility for covering and ensuring delivery of all medically necessary healthcare services in school settings for Medicaid-eligible children.[8]

Excluding or limiting Medicaid coverage in school settings not only violates the federal EPSDT mandate and medical necessity, but it also runs contrary to the Americans with Disabilities Act's (ADA) integration mandate. The ADA's integration mandate requires delivery of care "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[9]

Family Impact: Families need service options that work for their families. They want to have services delivered in their communities and in the right environments that will provide the best impact on their child's progress. They want treatment decisions to be made by their family and treatment team.

Recommendation 2: Amend the language to include offices and center-based services without a certified BHC requirement. Also, amend the language to include schools, pre-schools, and daycares.

> (a)(1)*(c) an office and center-based location not certified as a BHC.*
>
> (a)(3)(C) Delivered in a home, community setting, *school, pre-school, daycare, an office-based or center-based setting* delivered by an ABS professional within their scope of practice, or at the office of a BHC enrolled to deliver ABS services.

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[5] HFS. *Expanded Medicaid Reimbursement For School Districts Providing Physical And Behavioral Health Services For Students.* October 2021. https://iaase.org/documents/1635259235Programannouncement10.2021FINAL.pdf

[6] Centers for Medicare & Medicaid Services (CMS). *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents.* CMS, June 2014, 21, https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.

[7] Centers for Medicare & Medicaid Services. *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents.* CMS, June 2014, 21, https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf

[8] U.S. HHS, Centers for Medicare and Medicaid Services*, State Medicaid Director Letter #14-006,* December 15, 2014, p. 3. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

[9] 28 C.F.R. § 35.130(d) *Olmstead v. L.C.*,527 U.S. 581. 1999 https://www.ecfr.gov/current/title-28/chapter-I/part-35/subpart-B/section-35.130

Concern 3: (b)(2)(B) An individual who is 21 years of age or older, has a high school diploma or GED, and has received technical training in developmental interventions from a Department-approved training entity as detailed in the applicable Department-issued provider handbook.

Issue: We are not clear if the staff age requirement impacts the ABS service called Developmental Interventions only. The umbrella service of Adaptive Behavior Support services includes two distinct services: ABA therapy and Developmental Interventions.

If this language applies to ABA services, our concern here is the requirement for ABS staff to be at least 21 years or older. The age and training requirements proposed above exceed the requirements for commercial plans. We believe the age requirement for direct treatment staff (technicians) delivering ABA therapy is 18 in all other state plan amendments, state autism insurance mandates, and on the commercial insurance side.

We would also request ABA therapy services be delivered by an additional direct treatment staff called a technician who has the equivalent training of a registered behavior technician (RBT) certificate[10] and is deemed competent by the supervising behavior analyst (BCBA) to deliver treatment services.

Family Impact: Imposing these requirements would increase the likelihood that Medicaid beneficiaries will encounter limited access to ABS services compared to their commercially insured counterparts. Requiring direct care staff, who work under the supervision of a practitioner, to be 21 years or older will dramatically decrease the workforce needed to meet the currently stretched workforce demands for delivering autism services. This leaves children with autism sitting on long waitlists to start ABA therapy.

The IDHS-DDD 56U Behavioral Intervention and Treatment service offers behavioral strategies to be developed by a Level 1 provider such as a psychologist or behavior analyst and delivered by a Medicaid waiver direct care staff that is 18 years or older, not required to obtain an RBT certification, and with the current staffing shortage, may be under the age of 18 and without a high school diploma in some settings.[11]

Recommendation 3: If (b)(2)(B) does not impact ABA therapy, make that clearer in the language.

> <u>(b)(2)(B) An individual who is 21 years of age or older, has a high school diploma or GED, and has received technical training in developmental interventions from a Department-approved training entity as detailed in the applicable Department-issued provider handbook *before delivering Developmental Intervention Services.*</u>

If (b)(2)(B) does impact ABA therapy include the following language.

> <u>(b)(2)(B) An individual who is *18* years of age or older, has a high school diploma or GED, and has *received technical training equivalent to the training required for the Registered Behavior Technician and shows competency to deliver treatment or is a Registered Behavior Technician.*</u>

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[10] Behavior Analyst Certification Board (BACB), https://www.bacb.com/wp-content/uploads/2020/05/RBTHandbook_210513.pdf

[11] IDHS-DDD, *Staffing Crisis Flexibility Q & A*, https://www.dhs.state.il.us/pag.e.aspx?item=137994

Concern 4: (c)(1) Behavior Assessment and Treatment Planning (BATP). BATP is the formal process of assessing an individual's current maladaptive or disruptive behaviors and developing or updating individualized treatment goals, objectives and service recommendations based upon the assessment findings…

Issue: The language above needs to include assessments of current functional skills and skill deficits, including skill acquisition, maintenance of skills, and/or the prevention of the condition worsening.

The Medicaid Act prohibits discrimination of benefits based on diagnosis[12] therefore, "treatment of ASD cannot be limited to maladaptive and disruptive behaviors." Pursuant to Medicaid's EPSDT mandate, all deficits and conditions arising from a child's diagnosis of ASD must be treated.[13] Other states have considered and rejected nearly identical language. We urge our state to reject language that limits access to autism treatment.

Children with ASD often present skill deficits that must be addressed to improve their developmental trajectory. Additionally, treatment may be medically necessary to maintain skills and functioning and prevent regression, and this care must also be covered under EPSDT. Such treatment goals are clearly covered under the industry's standards of care (GASC) and EPSDTs broad "correct or ameliorate" standard.

Family Impact: It is important for families to have an understanding of their child's current level of functioning prior to treatment starting. The BATP service needs to ensure skills and behaviors are assessed and included in the developed treatment plan. As treatment progresses and future evaluations or assessments are completed, families will be able to the treatment progress by comparing testing results throughout the child's treatment.

Recommendation 4: Amend this section to add skills assessment as part of the BATP.

> (c)(1) Behavior Assessment and Treatment Planning (BATP…is the formal process of assessing an individual's current maladaptive or disruptive behaviors, *functional skills, skill deficits, skill acquisition and maintenance of skills,* and developing or updating individualized treatment goals, objectives, and service recommendations based upon the assessment findings…

[12] 42 C.F.R. §440.230 (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition.

[13] 42 USC §1396(r)(5), https://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim.

Concern 5: 2(A)BAI services must be delivered consistent with HFS-approved evidence-based practice guidelines using one of the following treatment modalities

(c)(2)(A)(i) Comprehensive Applied Behavior Analysis (ABA). Comprehensive ABA addresses development gains in individuals aged six years and under exhibiting adaptive living skill deficits, impairments in social skill or communication skill acquisition, or severe behaviors (harm to self, others, or property);

(c)(2)(A)(ii) Focused ABA. Focused ABA functions as an adjunct service supporting the delivery of a broad array of therapeutic support services for individuals aged seven through 20 years exhibiting severe behaviors (harm to self, others, or property);

Issue 5A: HFS-approved evidence-based practice guidelines in 2(A) is vague and the state has already established guidelines by enacting PA 102-953[14] which created the Licensed Behavior Analyst Act. Also, there are the recognized three standards of care guidelines explained below.

Issue 5B: Age limits in the Comprehensive and Focused ABA are improper and violate federal law.

Pursuant to Medicaid's EPSDT mandate, the state Medicaid agency is responsible for ensuring that all medically necessary ABA therapy to correct or ameliorate a child's ASD deficits and conditions is provided based on individualized determinations of medical necessity.[15] Managed care organizations administering Medicaid benefits are prohibited from using medical management criteria that are more restrictive than allowed by EPSDT or the federal Mental Health Parity and Addiction Equity Act[16]. Age limits are quantitative treatment limitations prohibited by Act, and managed care organizations are prohibited from imposing them.[17]

Issue 5C: Requiring an individual to exhibit severe symptoms before they can access Focused ABA intervention is ignoring the need for preventative treatments and allows symptoms to go untreated.

The established accepted standards (GASC) clearly define ABA therapy as being delivered through Comprehensive and Focused interventions and maintain Focused ABA should not be restricted by age, cognitive level, or co-occurring conditions.[18] Focused ABA targets treatment toward a limited number of key functional skills or challenging behaviors, and any definition should be inclusive of both.[19] The proposed language in would prevent children aged seven through 20 years of age, who are not "exhibiting severe behaviors," from receiving Focused ABA interventions.

Family Impact: Medicaid-eligible children with ASD most likely have never received behavioral intervention treatment services other than medication management and for those that could benefit, counseling. Some children with ASD have self-injurious, aggressive, and property destruction behaviors and many are now adolescents still without treatment. HFS first announced access to ABA

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[14] Illinois General Assembly, *Professions, Occupations, And Business Operations, (225 ILCS 6/) Behavior Analyst Licensing Act* (2022). https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=4308&ChapterID=24

[15] 42 U.S.C. §1396d(r)(5), https://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim.

[16] CMS. *The Mental Health Parity and Addiction Equity Act (MHPAEA). 2023. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet*

[17] 42 CFR 438.910(d)(1), https://www.law.cornell.edu/cfr/text/42/438.910.

[18] The Council of Autism Service Providers (CASP). *Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers. GASC,* Second Edition. 2020, 12, https://casproviders.org/asd-guidelines/.

[19] The Council of Autism Service Providers (CASP). *Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers. GASC,* Second Edition. 2020, 12, https://casproviders.org/asd-guidelines/.

therapy in October 2020 and through the three phases of the rollout of the coverage, very few families have received services.

Living without access to care is very isolating, and increases the chance of emergency room visits and out-of-home placements. This has been devastating for these Medicaid families. In the proposed rules, adolescents that have waited to access services for years and need intensive treatment could only access the less intensive Focused treatment option because of their age. And most likely, the less intensive intervention would not result in a significant reduction in challenging behaviors.

Recommendation 5: Remove HFS approved from 2(A), the reference to age in Sections (c)(2)(A)(i) and (ii), and the reference to severe behaviors in (c)(2)(A)(ii).

> 2(A)BAI services must be delivered consistent with evidence-based practice guidelines using one of the following treatment modalities
>
> (c)(2)(A)(i) Comprehensive Applied Behavior Analysis (ABA). Comprehensive ABA addresses development gains in individuals exhibiting adaptive living skill deficits, impairments in social skill or communication skill acquisition, *and maladaptive and/or severe behaviors* (harm to self, others, or property).
>
> (c)(2)(A)(ii) Focused ABA. Focused ABA functions as an adjunct service supporting the delivery of a broad array of therapeutic support services *that target a limited number of key functional skills or maladaptive and/or severe behaviors.*

Concern 6: (c)(2)(B) BAI services delivered using the Comprehensive or Focused ABA modality must be rendered by ABS Clinicians credentialed as a BCBA or by ABS Technicians credentialed as an RBT.

Issue A: Limiting the types of practitioners who can design, implement, and supervise treatment to only board-certified behavior analysts (BCBA) would likely also preclude other licensed professionals delineated in Section (b)(1)(B) from supervising comprehensive or focused ABA when it is within their scope of practice.

Issue B: Limiting the direct treatment staff to only registered behavior technicians (RBTs) exceeds the requirement in commercial insurance and would likely hinder access to treatment services by Medicaid beneficiaries

As discussed in concern 3, we would request an additional type of direct treatment staff called a technician. Technicians would have the equivalent training of an RBT and have been deemed competent by the supervising BCBA to deliver treatment services. Labor shortages are pervasive throughout the healthcare industry, and such limits should not be imposed when they have no direct benefit to the patient, as is the case here.

Family Impact: Workforce requirements that slow the start of treatment and leave children on the waitlist for services for longer periods of time, are devasting for families. Most families would prefer to start treatment once the supervising practitioner deems the direct care staff or technician has completed the proper training and has been assessed as competent to deliver treatment services. This would allow treatment services to be delivered more timely and without waiting on certification

exams and testing results, which is similar to families with private and employer-based insurance who may not require the RBT certification at all.

Recommendation 6: We recommend two changes (c)(2)(B):

For the supervising treatment practitioner requirements, reference the American Medical Association[20] CPT codes for Adaptive Behavior Services as a physician or qualified care professional (QHP) and the new Illinois Behavior Analyst Licensing Act.[21]

For the technician requirements, use the RBT certification and a technician with technical training equivalent to the training required for the RBT and deemed competent to deliver treatment services by the supervising BCBA or other licensed practitioners.

> (c)(2)(B) BAI services delivered using the Comprehensive or Focused ABA modality must be rendered by ABS Clinicians credentialed as a BCBA *or other licensed practitioners (LP) with ABA within their scope of practice* or by ABS Technicians credentialed as an RBT *or technician with training and supervision equivalent to a RBT and deemed competency to delivery services by the supervising BCBA or LP.*

On behalf of our Coalition, thank you again for the opportunity to provide public comment and recommendations on the proposed rules. As in the past, our Coalition is willing to support DHFS in the continued development of accessible ABS Services that aligns with generally accepted standards of care for treating ASD.

We welcome an opportunity for further discussions and would invite DHFS to come and observe the ABA services our participants provide. The Coalition's network of providers greatly appreciates the collaborative working relationship with DHFS and we look forward to working collaboratively in the future.

Sincerely,

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[20] American Medical Association *CPT Assistant November 2018 volume 28 issue 11*. https://www.ama-assn.org/practice-management/cpt/need-coding-resources

[21] Illinois General Assembly, *Professions, Occupations, And Business Operations, (225 ILCS 6/) Behavior Analyst Licensing Act* (2022). https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=4308&ChapterID=24