Florida Association for Behavior Analysis

Recommendations to AHCA and the Behavior Analysis Task Force

Executive Summary

The Florida Association for Behavior Analysis (FABA) submits these recommendations to the Agency for Health Care Administration (AHCA) Behavior Analysis Task Force to strengthen the quality, accountability, and accessibility of applied behavior analysis (ABA) services for Florida Medicaid members. We thank Secretary Harris for her leadership of the Task Force.

ABA is a scientific discipline that uses principles of learning and behavior to produce socially meaningful behavior change. Its professional practice is an evidence-based, medically necessary treatment for a wide range of behavioral and developmental conditions. ABA is not a uniform service: treatment models differ in purpose, intensity, staffing, and clinical oversight, and one hour of ABA does not necessarily equal another.

This summary accompanies FABA's full recommendations, which follow the Task Force's six charges.

Recognize the Distinct Models of ABA Care

Focused, comprehensive, and caregiver-mediated models meet different clinical needs and require different settings, staffing, and oversight. Our primary recommendation is that AHCA formally recognize focused ABA and comprehensive ABA as distinct models of care.

- Focused ABA addresses a limited number of targets and may be intensive or non-intensive. Intensive focused care for severe challenging behavior or feeding concerns may require specialized settings and higher staffing ratios.
- Comprehensive ABA typically involves 25–40 hours per week over multiple years and prepares members, typically young children, for educational settings.
- Recognize caregiver training as a standalone treatment model when clinically indicated.
- Differentiate reimbursement for 97153 when it is delivered by a BCBA or BCaBA.

Preserve Behavior-Based Eligibility and Ensure Skill Deficits Independently Establish Eligibility

Florida Medicaid bases eligibility on functional impairment rather than diagnosis, consistent with EPSDT, but does not currently treat skill deficits alone as sufficient. Our primary recommendation is that AHCA retain behavior-based eligibility, without restricting access to individuals with an autism spectrum disorder (ASD) diagnosis, and recognize clinically significant skill deficits (e.g., in communication, social functioning, self-care, and safety) as independently sufficient to establish functional impairment.

Ensure Planned and Coordinated Transitions of Care

As members progress, care typically moves from comprehensive to focused, from higher to lower intensity, and from therapist-implemented to caregiver-implemented treatment. Our primary recommendation is that every treatment plan include a transition plan with defined criteria for discharge. For members with profound autism or other intellectual disabilities who may need lifelong care, for the least intensive level of ongoing support that maintains their skills and safety.

- Create a direct referral pathway from Early Steps to early intensive behavior therapy. For children under 3, an Early Steps referral should be equivalent to a physician referral for the first 6 months of care.

- Require clear criteria for school-based ABA, including fading plans for private instructional personnel (PIP) and alignment with high-risk behavior or transfer-of-care goals.
- Refer eligible members to the Agency for Persons with Disabilities (APD) as early as age 3, given long waitlists.

Ensure Young Children Receive Intervention and Maintain Flexibility in Treatment Duration Limits

Outcomes are strongest when intensive intervention begins early, yet Florida lags the national average in serving children under age 5. Our primary recommendation is that AHCA remove the barriers that delay intensive services for children under age 7.

- Apply heightened medical-necessity scrutiny to requests for intensive hours for school-aged children over age 7, including intensive services delivered in schools.
- Raise unit limits for initial assessments and reassessments so providers are paid for time to complete high-quality assessments.
- Any caps on services should be soft caps with exceptions based on individual need, consistent with EPSDT. Research supports 24 to 36 months of comprehensive treatment, with continuation based on medical necessity.

Strengthen clinical oversight and measure meaningful outcomes.

RBT supervision and clinical oversight are often conflated but are governed by different authorities. Our primary recommendation is that AHCA distinguish RBT supervision, a BACB credentialing standard, from clinical oversight of cases, which AHCA governs.

- Require 10–20% clinical oversight by lead analysts, individualized to case complexity, and permit concurrent billing of 97153 and 97155.
- Require SMMC plans, as a condition of network participation, to audit 10% of RBTs to verify an active credential.
- Pair individualized goal data with standardized, multi-domain outcome measures to guide authorization, step-down, and discharge.
- Reimburse coordination of care, consistent with other health professions.

Link Every ABA claim to the Responsible Clinician

Florida Medicaid billing systems do not connect RBT claims to the lead analyst, so AHCA cannot detect billing that exceeds plausible oversight. Our primary recommendation is that all ABA claims require both the rendering provider and the responsible clinician.

- Close billing pathways that allow RBTs to bill without a linked lead analyst, and use linked data to detect impossible service patterns.
- Implement electronic visit verification (EVV) designed to work with common EMR systems and ABA service models.
- Adopt the 2027 CPT codes to reimburse intensive focused care, caregiver-mediated models, and indirect clinical oversight.

Establish Licensure and Best-Practice Standards for ABA

Forty states and the District of Columbia license behavior analysts. Florida does not license behavior analysts, leaving the state without authority over unlicensed practice. Our primary recommendation is that Florida adopt a state license for behavior analysts based on the Association of Professional Behavior Analysts (APBA) Model Licensure Act and tied to BACB certification. Additionally, AHCA should develop principle-based standards for ABA organizations covering facility licensing, accreditation, and labor practices such as 1099 misclassification of clinical staff.

In closing, Florida has a strong foundation for ABA services. These recommendations would match care to clinical need, start intervention when it is most effective, link every billed hour to an accountable clinician, and hold ABA to the standards of other licensed health professions. FABA welcomes the opportunity to continue working with AHCA and the Task Force to put them into practice.

Florida Association for Behavior Analysis

The Florida Association for Behavior Analysis (FABA) submits these recommendations to the AHCA Behavior Analysis (BA) Task Force to strengthen the quality, accountability, and accessibility of Applied Behavior Analysis (ABA) services for Florida Medicaid members. FABA is thankful for the leadership provided by Secretary Harris which has resulted in multiple task force meetings with thoughtful agendas and meaningful content. Our recommendations are outlined following the six charges to the Task Force.

1. Examine Clinical Care Models

Defining Applied Behavior Analysis. Applied behavior analysis (ABA) refers to an applied science, which uses principles of learning and behavior to produce socially meaningful behavior change, and to its professional practice, which translates research-based procedures into evidence-based services (Carr & Sellers, 2026). Although ABA is most widely recognized for its role in autism services (CASP, 2024), its application extends to a broad range of behavioral concerns across many conditions like severe feeding disorders (e.g., Ibañez et al., 2020), encopresis (Call et al., 2017), attention-deficit hyperactivity disorder (LaRue et al., 2026), among others described by the Behavior Analyst Certification Board (BACB, 2023)https://www.bacb.com/wp-content/uploads/2022/01/Executive-Summary_230412-a.pdf. Presently, Florida Medicaid reflects this breadth: eligibility rests on maladaptive behavior that impairs a major life activity rather than on diagnostic criteria (AHCA, 2026).

From a treatment standpoint, ABA also encompasses several service models, each guided by assessment to determine medically necessary care individualized to factors such as age, abilities, and clinical needs (CASP, 2024). Across models, ABA relies on direct, repeated measurement of observable behavior and ongoing data analysis to guide clinical decisions (CASP, 2024). Because socially meaningful changes often require a transfer of treatment to other change agents (e.g., caregivers, relatives, teachers) and settings (e.g., clinic to home), the clinical course of ABA services also includes planning for generalization and service titration. Finally, given the complex, multifactorial nature of members' clinical needs, effective coordination of care across providers and disciplines is critical.

In summary, ABA is not a one size fits all formula. One hour of ABA does not necessarily equal another hour of ABA across children, providers, or treatment models. Consistent with Dr. Weatherby's (2026) recommendation to the Task Force, **we recommend that** AHCA and the SMMC health plans strive to ensure that children with behavioral needs are identified as early as possible so they may have access to care in order to benefit from therapy. Moreover, despite evidence that early intervention can reduce educational and intervention-related costs later in life (Chasson et al., 2007; Green et al., 2002; Jacobson et al., 1998; Motiwala et al., 2006), AHCA's own data indicate that Florida continues to lag behind the national average in service delivery to children under age five. (AHCA, 2026b).

Focused ABA. Focused ABA services target a limited set of behaviors associated with the development of critical skills (e.g., toileting or sleeping) or that pose a significant risk to health or safety (e.g., self-injury, aggression, food refusal, fluid refusal, elopement). Focused intervention may be intensive (i.e., 20 or more hours per week), or it may be non-intensive (e.g., 10 hours per week). Focused intervention that is intensive in nature is more likely to target severe challenging behavior, severe feeding concerns, or severe sleep issues (CASP, 2024). These presentations often require specialized settings such as therapy rooms with padding or adaptive seating for swallow safety. The specialized settings may also include 2 or more RBTs to safely support each patient's care, with onsite direction by the lead behavior analyst. This service also comes with a higher ratio of case oversight to direct treatment, particularly during assessment and early treatment (CASP, 2024). Florida Medicaid policy does not currently address higher intensity services, and the fee schedule omits the current AMA CPT codes (2019) developed for severe behavior requiring this level of staffing (AHCA, 2026).

We recommend that AHCA recognize focused intervention as one model of therapy that members may require, and that focused intervention may be intensive or non-intensive depending on the member's age and needs. **We also recommend** that AHCA adopt the 2027 CPT codes (AMA, 2027) in their entirety so that intensive focused care may be appropriately treated and reimbursed.

Comprehensive ABA. Comprehensive ABA addresses multiple developmental domains simultaneously, such as communication, social, adaptive, cognitive, play, and behavioral skills. Comprehensive ABA includes 25 to 40 hours of direct treatment (CASP, 2024) and may be medically necessary for three years or more (Odom et al., 2010, 2014). This treatment model is intended to occur for a time-limited window (24 to 36 months or more) followed by transition of care into school and/or to a focused model of treatment. The goal of intensive comprehensive intervention is to prepare members for entry into educational services which are often delivered in a group with less 1:1 instructional time. This requires treatment planning that includes a transition from 1:1 services to group services as the member learns to learn. The treatment planning should also include ABA in the form of discrete trial training (DTT; Wolf et al., 1963), natural environment training (NET; Hart & Risley, 1975; Sundberg & Partington, 1998), and therapy implemented by others such as teachers, day care staff, and parents. Note that the style of implementation is prescribed by the lead analyst in response to the member's progression as they learn to learn with and from others. During comprehensive therapy, children should be making progress. Failure to make progress or regressions in progress should be documented with clear modifications to the treatment protocol, staff training, or other environmental change (CASP, 2024). These modifications are noted in the member's performance graphs with clear phase change lines. It should be noted that adjustments to intensity should be directly related to the member's response to treatment rather than chronological age or duration of time in services. CASP (2024) also describes planned transitions across levels of care, such as movement from comprehensive to focused treatment or from high to lower intensity of services to maintain acquired skills.

The 2025 AHCA coverage policy recognizes that functional impairment may involve maladaptive behavior as well as deficits in communication, safety awareness, self-care, and other areas of functioning (AHCA, 2025). **We recommend that** AHCA clarify that clinically significant skill deficits that result in functional impairment are independently sufficient to establish eligibility for ABA services and do not require the presence of maladaptive behavior. Such deficits may include, but are not limited to, impairments in communication, social functioning, self-care, safety, and other adaptive skills. Moreover, **we further recommend that** continued authorization rest on standardized outcome measures with a planned step-down as the child meets treatment goals which may include skill acquisition or behavioral decreases.

BCBAs Providing Direct Services. In some cases, the BCBA delivers treatment directly to the member rather than the RBT directly implementing. This occurs based on clinical complexity, safety risks, when the need for rapid protocol modification exceeds the scope of technician-delivered care, when fading the child out of services, or when the local RBT workforce is limited. CASP (2024) recognizes that although most ABA services use a tiered model, a behavior analyst may provide all services, including direct treatment and protocol modification, based on the member's needs. Florida Medicaid currently reimburses 97153 at the same rate whether implemented by a Lead Analyst, BCaBA, or RBT (AHCA, 2025). However, **this should be** differentiated. Additionally, the 2027 CPT Codes also include a code 97173 for adaptive behavior treatment with analysis, administered face-to-face by a physician or other qualified health care professional further substantiating the need for AHCA to adopt the 2027 CPT Codes.

Caregiver Training in ABA. Caregiver training in ABA may include educating the parents about their child's treatment plan or helping the parents understand their child's challenging behaviors. But caregiver training may also include a parent who chooses to be the intervention implementer. At no point should a member's relative serve as the member's RBT (BACB, 2026). In a caregiver-mediated model, the BCBA trains parents or caregivers to implement behavioral procedures within daily routines, without ongoing technician-delivered treatment. This model may be chosen for very young children with emerging concerns, individuals with circumscribed needs, families in rural or underserved areas, and individuals stepping down from more intensive services. CASP (2024) describes effective caregiver training as active and skills-based, including modeling, practice, and in-vivo coaching. CASP notes that a caregiver's presence during technician-delivered sessions does not constitute training. It should be noted that when a caregiver-mediated model is delivered, protocol modification by the lead analyst will be needed. Furthermore, in this model, the lead analyst may also need to provide direct therapy as clinically indicated and described above.

One goal in parent training is to equip caregivers with targeted strategies that fit naturally into daily life, so parents maintain their parenting role rather than serve as their child's primary interventionist. CASP (2024) affirms that caregiver participation enhances treatment but is neither a substitute for professionally directed treatment nor a condition for access to services. AHCA has identified improved caregiver involvement as a quality goal for the BA program (Grantham, 2026c). **We recommend** that AHCA and SMMC plans recognize caregiver training as a standalone treatment model when clinically indicated, individualize caregiver participation expectations within each treatment plan, and distinguish active, skills-based caregiver training from parent education. **We also recommend** that AHCA adopt the 2027 CPT Codes (AMA, 2027) so that caregiver training includes a broader definition of caregiver and includes others such as teachers, grandparents, and respite providers.

Services in schools. School-based ABA supports members whose target behaviors occur primarily at school or interfere with their ability to benefit from and participate in education. FABA (2025) created recommendations for the use of ABA practitioners as private instructional personnel (PIP) in educational systems. We recommend that AHCA and the Department of Education (DOE) review that document and collaborate to ensure that Florida's resources are used appropriately to meet the needs of its children.

CASP (2024) states that clinical need, rather than a priori restriction, should determine treatment settings. CASP further distinguishes medically necessary ABA delivered in schools from educational services provided under IDEA. CASP also excludes hours spent in educational settings and receiving IEP services from the calculation of ABA treatment intensity. Florida Medicaid does not restrict place of service, and schools accounted for $620.7 million in paid BA expenditures in SFY 2025–26, second only to the home (Grantham, 2026b). Section 1003.572, F.S., as amended by HB 795 (2023), permits parent-selected RBTs to provide services in the educational setting. **We recommend that** AHCA preserve access to school-based ABA when documentation shows (FABA, 2025) that:

- The lead analyst recommended service intensity and the locations of services based on best practice guidelines
- The school defined the roles, procedures, and expectations of a PIP providing ABA services based on the needs of the students, teachers, and school team members
- The lead analyst engaged in the collaboration process with the school team members, parents/caregivers, and other related professionals
- The lead analyst complied with the BACB Code of Ethics (BACB, 2020)
- The lead analyst provided appropriate amounts of case oversight and RBT supervision (BACB, 2026a; BACB, 2026b)
- The lead analyst planned for fading of ABA services and programmed for maintenance and generalization
- Services met medical necessity criteria and active treatment was provided for the entirety of the billed session

Behavior-based eligibility. Florida Medicaid determines eligibility for BA services by functional impairment rather than diagnosis, consistent with several other states, including California, Colorado, and Missouri (Grantham, 2026b). This approach reflects the scope of ABA as a treatment for clinically significant behavior across a variety of conditions. CASP (2024) states that access to focused and comprehensive ABA should not be restricted by age, cognitive level, diagnosis, or co-occurring conditions. Approximately one in four Florida Medicaid BA recipients had no ASD diagnosis identified in encounter data (Grantham, 2026a), a population that included children with intellectual and developmental disabilities, ADHD, pediatric feeding disorders, and other conditions for which ABA is an evidence-based treatment. Under Federal Early Periodic Screening Diagnosis, and Treatment (EPSDT; SSA), requirements mandate coverage of medically necessary services within the scope of § 1905(a) that are needed to correct or ameliorate identified conditions (Social Security Act § 1905(a), (r), 42 U.S.C. § 1396d(a), (r)). This specifies that Medicaid-enrolled children under 21 are entitled to medically necessary services that correct or ameliorate a condition, regardless of diagnosis. **We recommend that** AHCA retain behavior-based eligibility which should include substantial skill deficits and/or challenging behavior excess.

While two speech and language pathologists presented to the Task Force advocating for the use of naturalistic developmental behavioral interventions (NDBI), it should be noted that a recent umbrella review by Reichow et al (2026) concluded that across multiple systematic reviews and meta-analyses, ABA-based comprehensive early interventions reliably produced superior outcomes in IQ and adaptive behavior compared to treatment-as-usual or eclectic services.

2. Care transitions

Effective care transitions must account not only for shifts in the intensity of intervention (from comprehensive to focused) but also for changes in service settings such as home, school, and community environments. Effective care transitions also include predictable developmental transitions children experience as they move from early-childhood programs to school-age services and ultimately to adult living.

Services in schools. Given that services in schools may be funded in a variety of ways (e.g., through IDEA, school billing Medicaid, or Private Instructional Personnel [PIP]), our recommendation will focus on the latter: services in schools where a PIP delivers the care which is reimbursed through Medicaid or commercial insurance. As such, **we recommend that** Medicaid-funded, school-based ABA be a process that includes a medically-necessary treatment plan documenting the need for services in school and describing fading the PIP services and transitioning services to the school team. In addition to the stipulations above, **we recommend that** services in school should be aligned with goals that address high-risk behaviors and/or transferring care to the school team. Specific goals should include targeted behaviors in school with a clear fading and transition plan. The treatment plan should specify if services are consultative (i.e., training school staff) or provided directly to the member in school.

Transition from Early Steps. We recommend that a direct referral pathway be created from early steps to early intensive behavior therapy. AHCA should collaborate with Florida Department of Health and the SMMC Health Plans to ensure that any child who exhibits red-flags of autism are immediately screened and referred for a comprehensive diagnostic evaluation. For children under 3, an Early Steps referral should be equivalent to a physician referral for the first 6 months of care.

Transition to adulthood. Not every member will need to be transferred to the Association for Persons with Disabilities (APD). However, for members who are eligible, this referral should happen as soon as possible (i.e., age 3) to ensure that appropriate services are available when they are needed. **We recommend that** this be addressed in every treatment plan for eligible members.

Transition and discharge. Every treatment plan should include a transition and discharge plan. The lead analyst should identify the planned end of services, including which goals will be utilized to measure the end of care and the criteria with which those goals will be met.

3. Quality metrics

High-quality ABA services depend on seamless coordination of care across providers, clear and defensible case supervision practices, robust RBT supervision that ensures treatment integrity, and a licensure framework that protects families while supporting a competent, sustainable behavior analyst workforce. It is also essential that outcome measures show members making sufficient progress in treatment. Failure to make progress or regressions in progress should be documented with clear modifications to the treatment protocol, staff training, or other environmental change (CASP, 2024). These modifications are noted in the member's performance graphs with clear phase change lines.

Coordination of care. Seamless coordination of care is an essential element of behavior analysis services and it is required in the BACB Code of Ethics (2020). As such, **we recommend that** behavior analysts be reimbursed for coordination of care because it is a clinically necessary component of effective treatment,

particularly for children with complex needs. Medicaid already reimburses care coordination for professions such as speech and language pathology, occupational therapy, physical therapy, and nursing. Behavior analysts face the same requirements to align treatment plans, communicate progress, and ensure consistency across home, school, and medical environments. Without reimbursement, BCBAs are forced to absorb uncompensated services adding to the existing administrative burden.

Supervision of RBT. Per the RBT Handbook (BACB, 2026), a minimum 5% supervision is required of all behavior analytic service hours provided by RBT across employers, clients, and setting. Only a BCaBA and BCBA/BCBA-D may provide RBT supervision. Currently, the BACB monitors and audits RBT supervision. **We recommend that** the SMMC health plans audit 10% of RBTs to ensure required documentation is available at all times.

Clinical oversight. As Dr. Olive (2026) discussed in her presentation to the Task Force, clinical oversight is a separate and distinct service for members. Consistent with the CASP (2024) recommendations, **we recommend that** AHCA require lead analysts to provide 10% to 20% clinical oversight of cases based on the RBT hours being provided to the member. This should be an individualized recommendation based on the skills of the RBT, skills of the lead analyst, complexities of the member, and any other relevant factors (CASP, 2024). **We recommend that** concurrent billing for 97153 and 97155 be allowed based on the fact that they are two separate and distinct services as described by the ABA Coding Coalition (2022) and the CPT Coding Manual (AMA, 2019), and further clarified in the 2027 CPT Codes.

Assessment. We recommend that AHCA require initial and continued-authorization assessments to meet the standards for high-quality, individualized assessment described in the CASP ABA Practice Guidelines (CASP, 2024). However, expectations for assessment quality must be accompanied by reimbursement policies that provide clinicians with sufficient time to meet those expectations. High-quality assessment is necessary to identify individualized treatment needs and goals, evaluate meaningful progress, and determine whether treatment should be continued or modified. The current six-hour limit for initial behavior assessment and 4.5 hour limit for reassessments should therefore be reevaluated to ensure that reimbursement does not create a barrier to comprehensive, clinically appropriate assessment (Webb, 2026).

Licensure for Behavior Analysis. As of September 2026, 40 states and the District of Columbia (DC) license behavior analysts. Fourteen states have a stand-alone behavior analyst board, thirteen states have licensing housed within a department or agency with no licensing board, and twelve states and DC are housed under another profession's board or under an omnibus board. The state of Colorado has yet to determine where their licensing board will be housed. **We recommend that** Florida establish a state licensure law for behavior analysts based on the Association for Professional Behavior Analysts Model Licensure Act (Association for Professional Behavior Analysts [APBA], 2018). The license should be both a practice act and a title act. The licensing board should license behavior analysts (BCBA and BCBA-D) and Assistant Behavior Analysts (BCaBA). The license would define the scope of practice in statute and prohibit unlicensed practice and misuse of titles.

There are several advantages of a state license. First, it gives the state authority to investigate complaints and sanction licensed and unlicensed providers. The BACB can only act against its own certificants and has no authority of individuals who are not BCBAs, BCaBAs, or RBTs. The license would set an enforceable floor for qualifications, ethics and scope. The license may include requirements above and beyond the BACB clinical competencies (e.g., jurisprudence, state law compliance, other relevant proficiencies) and it could give Medicaid a verifiable state credential for provider enrollment and billing. Finally, it puts behavior analysis on par with other licensed health professions, as 40 states have already done.

The disadvantages of licensure include the need for legislation which could draw opposition from other professions. Another disadvantage is the costs associated with creating and maintaining a licensing board. While licensing fees may help offset some of the expenses, given the number of FL ethics concerns

documented on the BACB website, a licensing board may occur additional expenses should the ethical patterns in Florida continue. Finally, licensure increases expenses and administrative burden for practitioners and business owners.

If Florida were to recommend licensure, **we recommend that** licensure be tied to BACB certification. The benefits of this model include verification through the BACB without the need for curriculum development, exam development, or continuing education requirements. **We advise against** writing education, exam, or continuing education requirements into the statute. **We also advise against** limiting scope of practice based on client population, diagnosis, or setting. The advantage of this approach is that the licensing law remains current, even with BACB updates. One disadvantage of this model is that it relies on the BACB, a private body.

We recommend that the licensing bill exempt RBTs, BACB trainees (those in process of obtaining BCaBA or BCBA), and other licensed professionals acting within their scope. The licensed practitioner should be accountable for the RBT professional work. The advantage to this recommendation is that it avoids the needs to license a large RBT workforce which adds additional costs and access barriers. The disadvantage of this approach is that technicians would only be overseen by their supervisors.

If Florida were to recommend licensure, another option would be to establish a profession-led board. This stand-alone board would be composed of behavior analysts and assist behavior analysts, if available. Other states have reported challenges filling board seats with BCaBAs. At least one member of the public should be included. This approach could include reciprocity with other states as well as temporary-license provisions. The advantage of a profession-led board is that it brings subject matter expertise. However, this approach is more costly than an agency-based model.

Healthcare models. Applied behavior analysis is a medically necessary health care service, and Florida should recognize and regulate it that way. The state has comparable licensed allied health professions (e.g., speech-language pathology, physical therapy, occupational therapy, psychology). Those professions operate within established state frameworks that set expectations for practitioner qualifications, organizational accountability, and business conduct. ABA should be held to standards in line with those professions. As a foundational step, **we recommend that** the State establish licensure for behavior analysts as described above. Licensure would set a legal standard for who may practice, define scope of practice, and give the State oversight and enforcement authority, as it does for other licensed health care professionals. **We further recommend that** the State develop guidelines, guardrails, and standards for organizations delivering ABA services. These should address: (a) facility and organizational licensing, (b) accreditation expectations, and (c) labor practices such as the appropriate classification of clinical staff. These standards should be consistent with those already in place for other allied health professions in Florida, and they should be phased in over a reasonable period so providers can comply without undue disruption to their operations or to patient care. The standards should also stay principle and process based (i.e., adaptable) rather than prescriptive, so they remain relevant as clinical practice, workforce conditions, and the health care landscape change.

Outcome measures. Consistent with the Autism Commission on Quality standard 8.03 (ACQ; 2022), **we recommend that** evidence-based and developmentally-appropriate assessments be utilized to evaluate clinical outcomes for members receiving these services.

4. Service-authorization limits

Given the extensive research on the effectiveness of early and intensive behavior intervention (e.g., Eikeseth et al., 2007; McEachin, Smith, & Lovaas,1993; Peters-Scheffer et al., 2011; Reichow, 2026; Sallows & Graupner, 2005), **we recommend that** all barriers to access care for members under age 7 be removed. Intervention intensity should reflect developmentally appropriate recommendations. For example, 40 hours of therapy per week is developmentally appropriate for a three-year old if therapy is provided over 7 days in the week. Daily time must be allotted for naps, meals, and breaks. **We recommend that** requests for intensive

hours for children over age 7 be reviewed carefully for medical necessity. **We recommend that** intensive hours for children in schools be reviewed carefully for medical necessity as described above.

5. Potential caps on service duration

Consistent with EPSDT (CMS, 2024; Giardino et al., 2022), **we recommend that** any caps on hours or service duration would need to be soft caps with room for exceptions based on individual member needs. It should be noted that for children who receive ABA before age 7, multiple years of intervention were required. Specifically, Sallows & Graupner (2005), Eikeseth et al. (2007), Peters-Scheffer et al. (2011), and long-term follow-up work by McEachin, Smith, & Lovaas (1993) reported this. Odom et al (2010, 2014) also noted that two to three years of intervention were necessary. Furthermore, Reichow et al. (2026) conducted an umbrella review and noted ABA therapy was delivered for 24 to 36 months in the studies they reviewed suggesting that at least 3 years of therapy be allowed.

6. Provider enrollment and billing standards

Consistent with Dr. Olive's presentation (2026), our primary recommendation for this charge is for AHCA to revise policy language to differentiate professional credentialing standards from clinical oversight standards. Effective billing accountability in ABA services requires a clear distinction between two oversight relationships that are often conflated but are governed by different authorities, serve different functions, and have different implications for billing policy.

Clinical Oversight. Clinical oversight is provided by the lead analyst and is anchored to the service recipient (i.e., member). This oversight should be governed by AHCA Medicaid standards (Rule 59G-4.125, F.A.C.) with the lead analyst as the responsible party. Clinical oversight encompasses treatment planning, protocol development and modification, medical necessity documentation, and progress monitoring. This is the oversight relationship that governs billing accountability and is subject to AHCA regulatory authority.

RBT Supervision. RBT Supervision is anchored to the Registered Behavior Technician (RBT) and governed by BACB credentialing standards (i.e., outside AHCA's regulatory authority). The responsible party for RBT supervision is a BCBA/BCBA-D or a BCaBA under the supervision of a BCBA/BCBA-D. RBT Supervision is required to maintain the RBT's credential. This is a professional credentialing standard, not a billing accountability mechanism (BACB, 2026b). Note: One BCBA may serve in both roles (RBT Supervisor and Clinical Oversight) simultaneously, but these remain legally and functionally distinct.

Billing Structure and Policy Language. Florida Medicaid billing portals (i.e., FLMMIS, most MCO portals) do not connect the lead analyst to the RBT at the level of the individual claim. This structural gap means that billing data do not identify the credentialed professional accountable for clinical oversight of billed hours. AHCA cannot detect mathematically impossible service patterns (e.g., RBT billing volumes that exceed what a lead analyst could plausibly direct and oversee). Currently, RBTs (who cannot practice independently) can effectively bill without a traceable link to clinical accountability/clinical oversight.

Link every ABA Claim to the lead analyst. We recommend that all ABA service claims (CPT codes 97151, 97152, 97153, 97155, 97156) require both the rendering provider and the responsible clinician as mandatory fields across all billing portals including FLMMIS and SMMC systems. **We recommend that** AHCA eliminate billing pathways that do not require a clinical oversight link. Systems that permit RBT billing without a linked lead analyst create exploitable gaps in accountability and should be closed. **We recommend that** AHCA use linked billing data to detect high-risk patterns. Linking clinical oversight at the claim level will allow AHCA to monitor RBT hour volumes per lead analyst that are mathematically inconsistent with available clinical oversight capacity. **We recommend that** AHCA allow concurrent billing of 97153 and 97155 so the agency may track direct clinical oversight. **We recommend that** AHCA adopt the 2027 CPT Codes (AMA, 2027) which will include indirect clinical oversight allowing for additional tracking of clinical oversight. **We further**

recommend that AHCA utilize the ABA Coding Coalition 2027 Supplemental Guidance on Interpreting and Applying the Revised 2027 CPT Codes for Adaptive Behavior Services.

Electronic visit verification. We support the recommendation made in the ABA Toolkit for AHCA to implement electronic visit verification. **We further recommend** that implementation include safeguards to ensure system reliability, compatibility across multiple devices, and seamless integration with commonly used electronic medical record (EMR) systems. The technology should also be designed to accommodate ABA clinical best practices and service delivery models. These considerations present an opportunity to reconsider electronic visit verification in conjunction with improvements in the billing structure described above. Together, billing structure updates, electronic visit verification, and concurrent billing will optimize the agency's ability to track clinical oversight activities and assess geographic clustering of implausible patterns consistent with prior fraud, waste, and abuse activity.

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