ABAI
Association for Behavior Analysis International

June 23, 2026

To the Editors:

The nonprofit Association for Behavior Analysis International (ABAI) is the primary international membership organization for those interested in the philosophy, science, application, and teaching of behavior analysis. (Behavior analysis is a natural science approach to behavior, focusing on the effect of environmental events on behavior, especially the results of behavior.) ABAI appreciates the sustained attention that *The New York Times* and *The Wall Street Journal* have devoted to concerns about applied behavior analysis (ABA) billing and provider conduct. Accountability reporting serves a vital public function, and ABAI heartily supports all efforts to ensure that every dollar spent on ABA delivers safe, scientifically grounded, medically necessary treatment to the individuals who depend on it. Bad actors who exploit vulnerable families or defraud Medicaid deserve every bit of the scrutiny and repercussions they receive.

At the same time, we urge policymakers, payors, regulators, journalists, and the public to resist a dangerous conflation: the conduct of the worst actors in any field is not an accurate measure of the field itself, and misconduct by a few cannot be permitted to justify cutting off medically necessary services to the hundreds of thousands of children who receive responsible, evidence-based ABA every day. ABA is unique in that it can require 25 or more hours a week to optimize outcomes in some children. Thousands of peer-reviewed journal articles support that treatment intensity, and investigations into ABA providers—whether by regulators or journalists—should not mischaracterize evidence-based intensity of 25-40 hours of ABA per week as an indication of overtreatment or fraudulent behavior. Rather, this is the access to treatment that families have fought for decades to secure, having seen the thousands of success stories of autistic children who receive intensive ABA and then close the developmental gap between them and their neurotypical peers, learning communication and socials skills that were not acquired without ABA.

Documentation Failures Are Not Fraud

The series of Office of Inspector General (OIG) audits published since 2024—covering Indiana, Wisconsin, Maine, and Colorado—identified hundreds of millions of dollars in "improper payments." We take those findings seriously. But the OIG itself is clear: improper payment estimates are not fraud rate estimates. None of the four published reports used the word "fraud." The findings describe documentation deficiencies, credentialing gaps, and supervision-record failures—real problems that the field must fix through compliance infrastructure, provider

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education, and clearer billing standards. They are not evidence of a profession systematically deceiving the government.

This distinction matters because the remedies are entirely different. Documentation and supervision failures are corrected through audits, provider training, and a field-wide documentation standard—work that ABAI and its partners are actively pursuing, including through the 2027 revision of the CPT adaptive behavior billing codes. Access restrictions, hour caps, and coverage limitations do not address the root of utilization concerns; they simply ensure that children who need treatment cannot get it.

Rising ABA Spending Reflects Growing Access and Need, Not a Field Out of Control

Recent coverage has highlighted the rapid growth of Medicaid ABA spending—now approximately $14.5 billion annually—as though the number itself was evidence of abuse. Context is essential. In 2000, autism affected an estimated one in 150 children. Today, CDC data place prevalence at one in 31—a nearly fivefold increase. The workforce needed to deliver ABA has also grown significantly—with a 28% increase in Board Certified Behavior Analysts just from 2024 to 2025—building capacity to provide ABA. Until 2014, most Medicaid-enrolled children with autism had no access to ABA at all, but clarification from the Centers for Medicare and Medicaid Services (CMS) prompted state Medicaid agencies to add the benefit for its pediatric enrollees. Consequently, the growth in spending is largely the story of low-income families finally accessing services for their children. Put another way: if every Medicaid-enrolled child with autism received just 15 hours per week of ABA, the cost would approach $85 billion annually. Current spending of $14.5 billion serves an estimated 17 percent of that population. We are not looking at a system out of control. We are looking at a system that has only begun to close an access gap that has existed for decades.

For perspective, annual spending on cardiovascular disease exceeds $400 billion; diabetes, $413 billion; Alzheimer's and dementia, $360 billion. No one proposes capping insulin prescriptions or cardiac catheterizations because some providers have committed fraud. In fiscal year 2023 alone, the Department of Justice resolved $3.83 billion in *proven* health-care fraud in cardiology, hospital systems, and kidney dialysis, among others. A single cardiology company paid more in one False Claims Act settlement than what the OIG found improper across four ABA-audited states combined. Yet findings in other health care fields prompted compliance reforms and enforcement action, not calls to deny heart surgery to patients.

Federal Law Protects These Children—and Should Not Be Bypassed in the Name of Compliance

The impulse to respond to audit findings by imposing ABA service hour caps, lifetime limits, age cutoffs, burdensome administrative rules, and location exclusions—as several states have already proposed or enacted—is understandable but unlawful. Two federal statutes stand as explicit guardrails.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, enacted in 1967 as part of Medicaid, requires states to cover all medically necessary services for children under 21, including ABA, even when those services are not otherwise included in a state's Medicaid plan. EPSDT does not permit states to cap hours, impose lifetime limits, or deny services on the basis of cost containment.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) separately prohibit insurers and Medicaid managed care organizations from imposing treatment limitations on mental health benefits—including ABA—that are more restrictive than those applied to medical and surgical benefits. Hour caps, age limits, location exclusions, caregiver participation requirements, and fail-first protocols are precisely the kinds of quantitative and nonquantitative treatment limitations MHPAEA was enacted to prohibit. The federal government's own MHPAEA Reports to Congress have repeatedly identified limitations on ABA as among the most common violations, with preauthorization requirements found noncompliant 100 percent of the time in federal enforcement reviews.

ABAI applauds regulators and legislators who are serious about rooting out fraud. We urge them with equal seriousness not to use audit findings as a pretext for restrictions that federal law prohibits. Indiana's proposed 30-hour-per-week cap and 3-year lifetime limit, California's proposed 25-hour soft cap, and North Carolina's monthly-authorization requirements for children receiving more than 16 hours per week are among the state actions that appear to violate EPSDT and MHPAEA and will undoubtedly be challenged accordingly. Such illegal restrictions will harm autistic people by preventing or delaying access to medically necessary services.

Out-of-Network Excess Is a Payor Failure

Recent reporting has highlighted a New York provider billing Aetna at rates far exceeding the norm under an out-of-network arrangement. ABAI agrees that such arrangements are problematic, but the responsibility for that problem lies squarely with the payor, not with the ABA field. When payors permit out-of-network providers to charge and collect extraordinary rates, the damage ripples well beyond the insurer's balance sheet. Those out-of-network rates function as a recruiting tool. Providers who operate outside payor networks—free from the rate constraints that govern in-network contracts—can offer wages and signing bonuses that responsible, in-network providers cannot match. The result is a talent drain that deprives in-network practices of the behavior analysts and technicians that they need to serve their patients, producing the inadequate networks that cause families to seek services from out-of-network providers like those profiled by NYT.

If major payors are paying out-of-network ABA claims at multiples of their in-network rates, the solution is not to condemn the ABA field—it is to enforce the managed-care tools every payor already possesses: network adequacy standards that ensure there are sufficient in-network providers to meet demand, reasonable and appropriately benchmarked reimbursement rates that incentivize qualified providers to participate in networks, and meaningful utilization review of out-of-network claims that applies the same scrutiny to extraordinary rates that it applies to everything else. MHPAEA's comparative analysis requirements, which mandate that payors evaluate their own rate-setting methodologies against medical and surgical equivalents, provide exactly the framework for this accountability.

In short, a payor that has failed to build an adequate in-network ABA infrastructure and then points to the resulting out-of-network costs as evidence of a field out of control should be clear about what it can do better.

The Path Forward: Compliance and Access Are Not in Conflict

ABAI and its members take compliance seriously. We are committed to identifying and disseminating field-wide documentation standards, ensuring that the 2027 CPT code revisions are implemented in ways that reduce audit vulnerability, and educating behavior analysts about their legal and ethical obligations in billing and documentation. We support strong enforcement against providers who knowingly defraud Medicaid or exploit families.

What we cannot accept and what federal law does not permit is a response to compliance that sacrifices the children whom we all seek to protect. The path forward runs through better compliance infrastructure and more informed regulators, not through access restrictions that punish families for the misconduct of a small minority of providers and the failure of payors to maintain adequate networks and safeguard claims payment processes.

ABAI notes that the vast majority of behavior analysts comply with applicable laws, regulations, professional standards, and contracts and do not engage in fraudulent activities. One behavior analyst fraudulently billing is too many, but the number of behavior analysts accused of fraudulent billing is a very small percentage of the behavior analysts providing ABA services in the United States. The majority are providing ethical, effective services that contribute to enhanced quality of life for autistic individuals and their families. Efforts to address fraud must not undermine the hard-won access to medically necessary ABA services.

We welcome the opportunity to work with journalists, regulators, legislators, and payors to build a system in which every ABA claim reflects medically necessary, well-documented, evidence-based treatment and every child who needs that treatment can access it.

We would be happy to provide references to works supporting these comments.

Respectfully,

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