Science Over Cynicism:
The Race to Preserve Best-Practice Applied Behavior Analysis

TOOLKIT

CARD™
CENTER FOR AUTISM
& RELATED DISORDERS

Julie Kornack

Center for Autism and Related Disorders

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This toolkit does not constitute legal advice. Examples may not be appropriate for all circumstances.
Inquiries may be directed to Julie Kornack at J.Kornack@centerforautism.com.

Insurance Appeals & Peer Review

First Things First – Keep Current Services in Place Pending an Appeal
Both patient and provider should ask the funding source to comply with the following federal regulation.

Federal Regulations § 147.136(iii)

Requirement to provide continued coverage pending the outcome of an appeal. A plan and issuer subject to the requirements of this paragraph (b)(2) are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that **benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review**.

Issue	Informational Response	Patient-Specific Information
Age-Based Concerns *Your patient is too old for ABA.*	The **Affordable Care Act** prohibits discriminatory treatment of a patient based on age. Research shows that older patients, including adults, derive a benefit from ABA. In *W.P. v. Anthem* (S.D. Ind. 2018), Anthem agreed to cease the use of guidelines relating to coverage for ABA based on an individual's age, as such guidelines are inconsistent with federal law. The lead plaintiff in that case was a 13-year-old for whom Anthem refused to authorize 40 hours and, rather, limited its authorization to 20 hours.	Describe patient's deficits and link treatment goals to diagnostic criteria. Emphasize the need to promote functionality in the community and minimize the potential need for services provided in more restrictive settings. Reference research that supports ABA for older children, adolescents, and adults.[1]
Quantitative Treatment Limits *ABA is limited to ____ hours per week.* *Medically Unlikely Edits (MUEs) limit ABA to 8 hours per day.*	The federal **Mental Health Parity and Addiction Equity Act** prohibits quantitative treatment limits, such as limiting ABA to a certain number of hours per week. **For Medicaid Patients Only**: **Medicaid EPSDT** (under 21) requires all medically necessary treatment to be authorized and prohibits arbitrary limits, such as those you reference. **When MUEs Are Basis for Denial**: MUEs are intended to alert you to possible billing errors or fraud but are not intended to limit medically necessary treatment. Any arbitrary limit on medically necessary treatment violates the federal **Mental Health Parity and Addiction Equity Act**'s prohibition on quantitative treatment limits. If asked to provide evidence of the medical necessity	For intensive ABA treatment (usually 30 hours or more), describe the role of intensity in ensuring optimal outcomes and provide research that supports the intensity requested.[2] Note: While the number of goals may justify increased hours, intensity itself is an important variable in predicting optimal outcomes. For that reason, behavior analysts should not be required to increase the number of treatment goals in order to justify treatment hours. MUEs are intended to alert payors to potentially improper billing and are not intended to be used to

	for exceeding MUEs, clarify that treatment hours are preauthorized (if applicable) and, therefore, already deemed medically necessary by the funding source. Essentially, a denial based on MUE is objecting to the *pace* at which medically necessary treatment is being delivered, which is a determination that should be left to the treating clinician who has observed the patient in person.	limit medically necessary treatment. Regardless of MUEs, MHPAEA prohibits quantitative treatment limits (QTLs), and the insurer's duty is to individualize treatment decisions based on medical necessity.
Caregiver Participation *Parents/caregivers must participate in ABA treatment.*	A decision about medically necessary treatment cannot be based on or limited because of the behavior or actions of a person who is not the patient. At a minimum, a requirement of parent/caregiver participation as a *condition* of treatment authorization violates the federal **Mental Health Parity and Addiction Equity Act.** Such a requirement also violates the nondiscrimination provision of the **Affordable Care Act, Section 1557**, which prohibits discrimination on the basis of – among other elements – a patient's disability. Given that no other medically necessary treatment is withheld if a parent/caregiver fails to participate, such a policy discriminates against an individual with ASD on the basis of his/her disability.	Caregiver participation may be viewed as a best practice when the caregivers are physically and mentally available to participate in treatment. Whether a patient can derive a benefit from ABA without caregiver participation is a clinical decision made by the behavior analyst, not a determination to be made by the funding source. If caregiver participation would benefit the patient, the behavior analyst should describe efforts to involve the caregivers, including offering appointments during outside of traditional work hours, using telehealth, and/or increasing the caregiver's awareness of the benefits of caregiver participation. Lack of caregiver participation is not a proper basis for denial or titration of medically necessary treatment. For additional language, see ***Parent/Caregiver Participation in ABA Treatment*.**
Location Exclusions *We don't authorize services in school [because they are educational, not medically necessary].*	The proposed treatment does not address goals in an IEP or advance the goals of a teacher's classroom curriculum. Rather, the proposed treatment addresses goals in a treatment plan, which are linked to the core diagnostic criteria of autism spectrum disorder. Medically necessary treatment in school is warranted when the behavior occurs in the school setting and/or when a skill learned in one setting is not generalizing to the school	If the location at issue is a school, assure the funding source that you agree that educational services are not its responsibility. For each location at issue, Identify the treatment goals in each location, link each goal to the core diagnostic criteria of ASD and, if possible, explain the role of the environment in attaining each goal.

	setting. Arbitrary location exclusions violate the federal **Mental Health Parity and Addiction Equity Act**'s prohibition on non-quantitative treatment limits. All medically necessary hours should be authorized, regardless of location.	
Insufficient Progress *Your patient hasn't made enough progress to warrant continued treatment.*	[If patient has made progress, provide examples of progress.] Lack of progress is not a proper basis for denial of medically necessary treatment. It is not unusual for a patient to plateau or even regress temporarily during ABA treatment. Sometimes, lack of regression and maintenance of skills are, in fact, progress. Would you deny kidney dialysis to a patient because s/he continued to require it to *maintain* function? The fact that you would not indicates that such a policy violates the federal **Mental Health Parity and Addiction Equity Act**. ABA is medically necessary as long as the patient derives a benefit from it. Note: The Medicare benefit policy manual issued by the Centers for Medicare and Medicaid Services states: *It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions,* ***control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement****. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met* (Emphasis added.)	If appropriate: • Provide examples of how the patient might regress if services are not maintained; • Share patient-specific events that may have hindered progress (e.g., medication change, family challenges, treatment gaps, etc.); • Describe treatment plateaus specific to this patient and how they might be managed; and/or • Describe how treatment goals have been modified to facilitate progress.
Duration of Treatment *Your patient has received ABA for ___ years, so it's time to fade treatment and discharge.*	The federal **Mental Health Parity and Addiction Equity Act** prohibits quantitative treatment limits, such as limiting ABA to a certain number of weeks or years. Depending on the denial language, a denial based on prior access to ABA could be	Share peer-reviewed research that supports duration or demonstrates that benefits are derived across the lifespan (e.g., Linstead et al., 2017 showed longer duration of treatment

	viewed as denying treatment because patient has a pre-existing condition, an improper basis for denial prohibited by the **Affordable Care Act**. **For Medicaid Patients Only**: **Medicaid EPSDT** (under 21) requires all medically necessary treatment to be authorized and prohibits arbitrary limits, such as those you reference.	produced better outcome). If appropriate, describe the progress the patient has made, including prevention of worsening/maintenance of skills, and explain the anticipated consequence of decreasing or withdrawing treatment.
Symptom Severity *Your patient needs to exhibit at-risk behavior to be eligible for comprehensive treatment.*	A diagnosis of autism spectrum disorder is sufficient to access medically necessary ABA. A patient's delays or age may warrant a comprehensive program, whether at-risk behavior is evident. A guideline that conditions access to ABA on specific severity or symptoms violates the **Mental Health Parity and Addiction Equity Act**, as well as **Section 1557** of the **Affordable Care Act**.	Share peer-reviewed research that supports treatment intensity, and underscore that children in the study did not necessarily exhibit at-risk behaviors. Give patient-specific examples of deficits and behaviors to be overcome. If appropriate, explain that patient is likely to make more progress with more treatment hours and is less likely to require care in a more restrictive setting.
Fail-First Protocols *Let's first see how your patient does with 10 hours per week of ABA.*	Research has demonstrated that intensity of ABA (e.g., the number of hours per week) is a critical variable in achieving optimal outcomes. The number of hours requested are based on research, best practices, clinical expertise, and patient observation. The suggestion to try a smaller dose first is considered a ***fail-first* protocol**, which is prohibited by the **Affordable Care Act**.	Share peer-reviewed research that supports treatment intensity. Give patient-specific examples of deficits and behaviors to be overcome. If appropriate, explain that patient is likely to make more progress with more treatment hours and is less likely to require care in a more restrictive setting.
Comorbidity *Patient has other diagnoses that require treatment.*	While we facilitate coordination of care with other members of our patient's treatment team, that question should be directed to the patient's physician. ABA is the gold standard of treatment for the patient's diagnosis of autism spectrum disorder. To deny ABA on the basis of comorbid diagnoses would be discriminatory and would violate a host of federal laws, including the **Mental Health Parity and Addiction Equity Act**, the **Affordable Care Act**, and the **Americans with Disabilities Act**.	Describe your efforts to coordinate care with other members of the patient's treatment team. Use patient-specific examples to explain the medical necessity of ABA treatment, regardless of other symptomatic diagnoses, and provide assurances that the patient's other health care providers have not expressed concerns that ABA is interfering in patient's other treatment.

How to Appeal an Insurance Denial

Federal law requires insurers, health plans, and managed care organizations to have an appeals process in place and to make enrollees aware of that process when an adverse decision is made. If a funding source declines to authorize all or part of the ABA treatment recommended by the behavior analyst, both the ABA provider and patient have the option to appeal the decision. This guidance focuses on the steps to take when a patient/guardian appeals the decision.

MHPAEA Disclosure Request Form: In addition to the appeal, a patient may submit a MHPAEA Disclosure Request form to the health plan, to request information about a plan's treatment limitations (e.g., location exclusion, parent participation requirement). Find the form and additional information here.

Event	Actions	Additional Information
Provider or patient is alerted by telephone, traditional mail, or email that ABA services will be wholly or partially denied.	Patient/guardian follows instructions in the denial letter to initiate the appeal. If denial letter has not been received, patient/guardian contacts member services to initiate the internal appeal. (This process must be completed prior to requesting an external appeal, sometimes called an Independent Medical Review.) [For continuing patients] Both patient and provider request insurer to keep services in place at current level during the appeals process in accordance with Sec. 147.136 of the Federal Regulations. Provider submits letter in support of original treatment recommendations with relevant research.	• It is not necessary to wait for the denial letter before initiating the internal appeal. Sometimes, the patient/guardian will need to elevate the call to a supervisor to obtain guidance on how to initiate the appeal prior to receiving written notice. Don't wait to initiate the appeal. • Each funding source has its own process for initiating the internal appeal, ranging from making a phone call to submitting a formal request in writing. • If the patient is at risk of immediate harm, parent/guardian may request an expedited appeal on this basis. Expedited reviews are completed within 72 hours. • Internal appeals must be completed within a specified time period, usually 30-45 days.
Denial is upheld.	Patient/guardian follows instructions in denial letter to request 2nd level review or external appeal. Provider submits letter in support of initial recommendations with relevant research.	• For state-regulated insurance, patient should be able to request an independent medical review (sometimes called an *external review*) after the initial appeal fails. Some self-funded plans require a second internal appeal prior to exhausting the internal appeals process.

Provider Letter Template in Support of Recommended ABA Hours

Date

Patient Name:
Patient Date of Birth:
Funding Source ID #:

Dear *Funding Source:*

I am the clinician overseeing the treatment of [patient]'s symptoms associated with his/her diagnosis of autism spectrum disorder (ASD).

[For ongoing patients only]

On behalf of [patient], [ABA Provider] seeks to ensure that services remain in place in accordance with the current authorization pursuant to Sec. 147.136 of the Federal Regulations, which provides:

> **(iii)** ***Requirement to provide continued coverage pending the outcome of an appeal.*** A plan and issuer subject to the requirements of this paragraph (b) (2) are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that **benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review**. (Emphasis added.)

[Patient-Specific Information]

Patient exhibits extensive behaviors and developmental delays as a result of her diagnosis of ASD, including [insert some key patient deficits and behaviors; include concerns about safety or self-injurious behavior, if applicable].

Based on patient observation, clinical judgment, and extensive support in the peer-reviewed literature, I have made a determination that the behaviors and deficits associated with [patient]'s diagnosis of ASD warrant a treatment program of [INSERT NUMBER OF HOURS OF 1:1 ABA] hours per week of 1:1 applied behavior analysis (ABA); [INSERT NUMBER OF HOURS OF BCBA] hours per week of protocol modification and direction of the technician; and [INSERT NUMBER OF HOURS OF FAMILY GUIDANCE/CAREGIVER TRAINING] hours per week of parent/caregiver training. [INSERT INSURER NAME] has denied this treatment request, saying [INSERT RATIONALE PROVIDED BY INSURER].

[Clinical Argument]

Please note that [INSERT INSURER'S AUTHORIZED HOURS] hours per week of ABA is not a sufficient dosage to meet the definition of intensity that has been demonstrated to achieve optimal outcomes. A substantial body of peer-reviewed literature repeatedly concludes that optimal ABA hours for a child this age range from 30-40 hours per week. I have attached some studies for your reference in this regard. While we would expect a patient to demonstrate some amount of progress with even a minimal number of hours of ABA, the rate of progress in the proposed program would, of course, be limited and insufficient to maximize outcomes.

[Legal Argument]

[IF APPLICABLE, INSERT LEGAL AND PATIENT-SPECIFIC ARGUMENT BASED ON RELEVANT PORTIONS OF THE TABLE AT THE BEGINNING OF THE TOOLKIT.]

Research has demonstrated that the most critical variable in evidence-based autism treatment is the intensity (e.g., number of hours per week) of ABA. Without sufficient hours of ABA each week, [patient] may lose the opportunity to optimize treatment benefits, function independently, and fulfill [his/her] potential. Certainly, a delay in access to medically necessary treatment may cause irrevocable harm to the patient. We respectfully urge [INSERT INSURER NAME] to authorize the full treatment plan, and we welcome an opportunity to discuss this with you in greater detail.

Sincerely,

____

Enclosures:

[List Research]

Parent/Caregiver Participation in ABA

Parent/caregiver participation may be a *goal* of the behavior analyst, but parent/caregiver participation cannot be a prerequisite to treatment. Rather, the value of parent/caregiver participation to the individual patient is a determination to be made by the behavior analyst. While parent/caregiver participation in ABA treatment may optimize the benefits of treatment, treatment may still be extremely effective without parent/caregiver participation.

When clinically appropriate, behavior analysts should endeavor to train parents/caregivers in ABA and involve them in the treatment plan, but some parents/caregivers will not participate to the extent that funding sources hope. A parent/caregiver's ability to participate and support treatment, and the nature and degree of that support, may vary based on numerous factors. Most often, parents/caregivers who do not participate in treatment cannot get time off from work or have other children whose schedules interfere. Parent/caregivers may have mental or physical disabilities themselves that make participation in treatment extraordinarily challenging or even unhelpful. It is always improper to deprive children of medically necessary treatment because of a lack of parent/caregiver participation.

Parent/caregiver participation may be an *aspirational goal* but cannot be a *condition* of medically necessary treatment. Health plans, insurers, and administrators cannot deny medically necessary treatment because parents/caregivers do not participate. Some plans have stated – improperly – that the *goal* of treatment is to shift treatment delivery to the parents. Of course, the goal of treatment is to address the deficits and behaviors associated with the autism diagnosis, not to shift treatment from highly trained health care professionals to the parents/caregivers.

Behavior analysts should convey the usefulness of parent/caregiver participation whenever it is clinically appropriate and provide a wide array of options to facilitate parent/caregiver participation, including offering parent/caregiver training opportunities outside of traditional work hours and via the Internet.

To deprive a patient of medically necessary treatment because of a parent/caregiver's failure or inability to participate in the treatment violates EPSDT (Medicaid), the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Americans with Disabilities Act (ADA).

Insurance-Funded ABA Services in a School Setting

For behavioral health treatment services, the location, such as a school or community setting, may be an integral part of the treatment plan and may be necessary to ensure treatment goals are met, especially generalization of skills across settings. Medically necessary autism treatment may be provided in a school setting (a) to ensure that skills acquired in the home and community generalize to the school setting; (b) when the behavior occurs in the school setting; (c) or simply as a matter of logistics to ensure that a child's full treatment hours are delivered.

Moreover, services provided by a school under an IEP do not preclude medically necessary services that are being provided across all natural settings, including the school. Schools do not typically provide medically necessary treatment; they may provide supports pursuant to a different standard (some educational benefit), for different purposes (to access the educational curriculum) with differently credentialed providers (special education teachers and aides). Such services do not supplant medically necessary treatment.

Medically Necessary ABA	Educational Supports
Guided by a treatment plan developed by a behavior analyst	Guided by an Individualized Education Program (IEP)
Targets the deficits and behaviors associated with the DSM-5 diagnostic criteria	Targets academic goals associated with an educational curriculum
Delivered by a behavior technician under the direction of a behavior analyst	Delivered by a special education teacher or a teacher's aide

Mental Health Parity and Addiction Equity Act

Location exclusions violate the Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA applies to self-funded, large group, small group, and individual plans and to Medicaid managed care, alternative benefit plans, and CHIP plans. Where a state Medicaid agency uses managed care to deliver any benefit, all benefits must comply with MHPAEA.

According to the Department of Labor, "Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage [violate the federal Mental Health Parity and Addiction Equity Act]." When this issue has been litigated, the Court has consistently determined that insurance carriers are responsible for funding of medically necessary treatment, regardless of the location where it occurs, including school settings.

Medicaid Obligation to Cover Services in School (courtesy of Daniel R. Unumb, Esq., Autism Legal Resource Center)

Behavioral health treatment cannot be denied merely because it is being provided during school. Pursuant to Medicaid's EPSDT mandate, the state Medicaid agency is responsible for ensuring that *all* medically necessary ABA/BHT to correct or ameliorate a child's ASD deficits and conditions is provided based on individualized determinations of medical necessity. 42 U.S.C. §1396d(r)(5). This includes otherwise coverable care delivered in schools. *Id.*; 42 U.S.C. §1396b(c); *Detsel by Detsel v. Sullivan*, 895 F.2d 58, 66 (2d Cir. 1990).

As made clear by CMS EPSDT guidance to states, coverage of services in school settings is an important component of EPSDT services and "[s]chools are particularly appropriate places to provide . . . behavioral health services." EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (CMS June 2014) ("CMS EPSDT Guide"), p. 21.[1] CMS has also issued technical guidance to states stressing that regardless of any services provided by schools pursuant to IDEA or otherwise, **the state Medicaid program retains primary responsibility for covering and insuring delivery of all medically necessary healthcare service in school settings for Medicaid eligible children**. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, State Medicaid Director Letter #14-006, Re: Medicaid Payment for Services Provided without Charge, December 15, 2014, p. 3.[2]

Furthermore, for Medicaid enrollees, nothing in Medicaid restricts coverage for medical assistance for covered services included in a child's IEP [42 USC 1396b(c)], and nothing in IDEA permits a state to reduce medical or other assistance available under Medicaid with respect to provision of FAPE [20 USC 1412(e) and 1440 (c)].

Useful language to articulate some of these points may include:

- The location is often an integral part of the treatment and is necessary to ensure that treatment goals are met. That is, for treatment to be effective, it must be generalized across all natural environments, and the school is a natural environment for a school-age child.
- These services target goals in the treatment plan, which addresses the deficits and behaviors associated with your insured's autism diagnosis; school-*based* services do not address educational/academic goals.
- The location of services is part of the medically necessary treatment of the child's autism diagnosis.
- When this issue has been litigated, the Court has consistently determined that insurance carriers are responsible for funding of medically necessary treatment, regardless of the location where it occurs, including school settings.
- The duty as the insurance carrier to provide coverage for medically necessary treatment is a much higher standard than the duty of the school under IDEA to provide Free Appropriate Public Education.

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[1] Available at https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf. *See also* CMS EPSDT Guide, pp. 11-12, 20.

[2] Available at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf. Excluding or limiting Medicaid coverage in school settings is not only contrary to medical necessity and EPSDT, it runs afoul of the integration mandate of the Americans with Disabilities Act (ADA) which requires delivery of care "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) Depriving children with developmental disorders of medically necessary care also exposing them to the risk of unnecessary segregation and institutionalization in further violation of the ADA. *Olmstead v. L.C.*, 527 U.S. 581 (1999)

When Insurance Says Yes, but the School Says No

When an insurer authorizes services, but a school prohibits the ABA provider from providing the services on campus, it may be helpful for the parents/guardians to update the IEP to include an agreement to allow the ABA provider on campus and into the classroom to provide medically necessary treatment. Additionally, parents/guardians may want to make the school aware that the Americans with Disabilities Act (ADA) includes an integration mandate. That is, providing services in natural settings in which the child functions, such as a school, is not only considered best practice but is also required under the integration mandate of the ADA (Olmstead v. L.C., 527 U.S. 581, 1999). Finally, parents/guardians may want to raise Section 504 of the Rehabilitation Act which prohibits discrimination against students with disabilities. Since it is commonplace for schools to administer prescription drugs for students with medical ailments and to provide access to speech therapy on campus, a school that refuses to accommodate an ABA provider on campus is discriminating against a child who has a disability.

Schools that do not want to facilitate insurance-funded services should be aware that they may be responsible for funding the services. Most recently, the Supreme Court decision in *Endrew F. v. Douglas* makes it clear that the requirement for a school to provide a Free Appropriate Public Education (FAPE) is not a *de minimis* benefit and entitles a child with a disability to accommodations that address his/her functional and educational needs and enable a child to "make progress appropriate in light of the child's circumstances." In a regular education classroom:

> *"Regular examinations are administered, grades are awarded, and yearly advancement to higher grade levels is permitted for those children who attain an adequate knowledge of the course material." Id., at 203. Progress through this system is what our society generally means by an "education." And access to an "education" is what the IDEA promises.*

I. Free Appropriate Public Education must:

a) Be "specially designed" to meet a child's "unique needs"
b) Be the product of an agreement (IEP) between all members of the treatment team, including the parents/caregivers
c) Provide the child an opportunity to achieve his/her full potential
d) Address educational and functional needs
e) Be provided in the regular classroom "whenever possible" (§1412(a)(5)
f) Be reasonably calculated to enable the child to receive educational benefits
    1. In a regular classroom, this includes passing grades and moving from grade to grade.

II. Individualized Educational Program (IEP) must:

   a) Set out a plan for pursuing academic and functional advancement (§§1414(d)(1)(A)(i)(I)-(IV)
   b) Be “specially designed” to meet a child’s “unique needs” §§1401(29), (14)
   c) Involve the parents
   d) Have goals that change from year to year
   e) Ensure the child has the opportunity to meet challenging objectives reasonably calculated to enable the child to achieve passing marks and advance from grade to grade. (Rowley, 203-204)

Make the Most of My Favorite Law!

Whether you're a provider who sees a pattern of MHPAEA violations or you're a parent who has encountered MHPAEA violations when seeking access to care, everyone has a role to play to help increase awareness and enforcement of MHPAEA. Here are some ways to promote MHPAEA enforcement:

- Make trade organizations aware of the issue (**ABAI, Autism Speaks, BHCOE**, and **NCAAS**, and the public policy arms of state organizations, such as CalABA, TXABA, etc.).
- File a complaint with the state regulator (e.g., insurance commissioner) or with the **Department of Labor** for self-funded plans.
- Ask your state department of insurance what it is doing about the **newly required comparative analysis** that must be completed by health plans for non-quantitative treatment limitations.:
- Encourage patients to appeal, citing the MHPAEA violations. Increase awareness of the option for patients to use the **MHPAEA Disclosure Template** to request information from their health plan describing how an NQTL complies with MHPAEA.
- Register parity violations at the **Kennedy Forum's Parity Complaint Registry**.

Specific Actions for Behavior Analysts

- Make the plan's provider representative aware of the issue(s).
- Provide patients with a **letter in support of your recommendations**. (See **Toolkit** for example.)
- Raise the issue(s) in a **peer-to-peer review**.

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[1] National Autism Center. (2015). *Findings and conclusions: National standards project, phase 2*. Randolph, MA: Author

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