OFFICE OF THE INSPECTOR GENERAL
MASSACHUSETTS

# MassHealth and Health Safety Net: 2024 Annual Report

## MassHealth's Applied Behavior Analysis Program – Service Providers

March 1, 2024

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**Inspector General**
**Office of the Inspector General**
**Commonwealth of Massachusetts**

OFFICE OF THE INSPECTOR GENERAL MASSACHUSETTS

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Inspector General

March 1, 2024

*Via Electronic Mail*

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**Re: MassHealth's Applied Behavior Analysis Program – Service Providers**

Dear Governor Healey and Commonwealth Leaders:

Pursuant to Chapter 12A of the Massachusetts General Laws and Section 96 of Chapter 28 of the Acts of 2023, enclosed please find the Office of the Inspector General's (OIG) 2024 Annual Report, *MassHealth's Applied Behavior Analysis Program – Service Providers*.

In 2023, I created the OIG's Healthcare Division (HCD) to conduct the annual OIG studies of Massachusetts Medicaid (MassHealth) and the Health Safety Net (HSN), as well as to review a wide variety of public healthcare policy, delivery and access issues. The HCD's oversight work seeks to identify programmatic vulnerabilities within MassHealth and the HSN and develop recommendations for improving internal controls and practices to prevent fraud, waste and abuse of public funds in these public healthcare systems.

This year the HCD reviewed MassHealth's Applied Behavioral Analysis (ABA) Program, which provides treatment to MassHealth-eligible children diagnosed with autism spectrum disorder through MassHealth-managed care entities (MCEs) like managed care organizations and accountable care organizations. Specifically, the OIG reviewed whether service providers deliver ABA treatment in a manner consistent with MassHealth's performance specifications.

The HCD determined that despite provisions in contracts with MassHealth, the MCEs did not employ robust program integrity measures to ensure (1) that children on MassHealth received properly supervised treatment, and (2) that overpayments to providers that submitted claims for unsupervised services were identified, reported to MassHealth and ultimately recouped.

I want to thank the many contributors to this report, especially Gregory Matthews, Director of the Healthcare Division. I also extend my appreciation to Susanne O'Neil, Acting Deputy Inspector General and General Counsel; Alyssa Tasha and Stephen Gerry of the Data Analytics Division; Joshua Giles, Director of the Policy and Government Division; senior executive assistant Nataliya Urciuoli; and the OIG's communications and publications teams.

Please contact me if you have any questions about this report or the OIG's Healthcare Division. I hope that you, too, find this report to provide meaningful and important insight.

Sincerely,

Jeffrey S. Shapiro, Esq., CIG
Inspector General

cc (via email):

Jane Ryder, Commissioner, Department of Developmental Services
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# EXECUTIVE SUMMARY

The Office of the Inspector General's Healthcare Division (HCD) has completed an analysis of MassHealth's Applied Behavior Analysis (ABA) Program, which provides treatment to MassHealth-eligible children diagnosed with autism spectrum disorder (ASD) through MassHealth-managed care entities (MCEs) like managed care organizations and accountable care organizations.[1] The HCD sought to determine whether service providers deliver ABA treatment in a manner consistent with MassHealth ABA performance specifications. Those specifications require ABA providers within the MCE healthcare networks to ensure that licensed applied behavior analyst (LABA) staff provide adequate supervision to all paraprofessional staff, including behavioral technicians (BT) and interns, who administer adaptive behavior treatment plans developed by the LABA and provide direct services to children with ASD. LABAs provide BTs with a minimum of one hour of supervision for every 10 hours of direct ABA services. In Massachusetts, to satisfy the licensure requirements for an LABA, a clinician must pass the Board Certified Behavior Analyst (BCBA) examination issued by the Behavior Analyst Certification Board.[2]

As outlined in this report, the HCD conducted an outlier analysis that identified MassHealth ABA providers that did not give access to adequately supervised ABA services for MassHealth members with autism. As a result of gaps in program integrity reviews, MassHealth:

(1) overpaid MCEs' ABA providers for service claims over the 10:1 supervision ratio in the amount of **$16,761,445**;

(2) paid 627 ABA claims submitted by MassHealth providers that "impossibly billed" more than 24 hours of service for a member on a given date, resulting in overpayments of **$439,632**; and

(3) paid 561 ABA service claims purportedly provided to 311 members on holidays, amounting to **$162,535**.

[1] The OIG is aware that some members of the ASD community prefer to use terms such as "person with autism," "person with ASD," "autistic person" or "person on the autism spectrum," while others favor the use of other terms or embrace the concept of neurodiversity to recognize that conditions like autism are neurological variations that are simply part of human differences. The OIG seeks to not only promote person-first language but also an awareness that language changes with time and individuals within groups sometimes have different opinions about the preferred language or terms used to describe themselves. For the purposes of this report, the terms "autism spectrum disorder" and "ASD" are used when referring to the condition defined by the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The terms "children with ASD" or "children identified with ASD" are also often used throughout this report in accordance with Center for Disease Control and Prevention guidance on person-first language. *See* https://www.cdc.gov/ncbddd/disabilityandhealth/materials/factsheets/fs-communicating-with-people.html (last visited February 22, 2024).

[2] To satisfy LABA licensure requirements, a clinician, pursuant to Section 165 of Chapter 112 of the Massachusetts General Laws, must demonstrate good moral character; complete a doctoral or master's degree program related to the study of behavior analysis or a related field of human services; complete a practicum or supervised experience in the practice of behavior analysis; and complete board-approved examinations, including the BCBA examination issued by the Behavior Analyst Certification Board. *See* 262 CMR 10.03 and 10.04.

These findings represent an opportunity for MassHealth and its ABA provider networks to conduct program integrity audits to determine if services were actually rendered or accurately documented for claims processing.

The HCD also determined that despite provisions in contracts with MassHealth, the MCEs did not employ robust program integrity measures to ensure (1) that children on MassHealth received properly supervised treatment, and (2) that overpayments to providers that submitted claims for unsupervised services were identified, reported to MassHealth and ultimately recouped.

OFFICE OF THE INSPECTOR GENERAL MASSACHUSETTS

JEFFREY S. SHAPIRO
Inspector General

**REPORT IN BRIEF**
**MassHealth Applied Behavior Analysis Provider Review**

## Why the OIG Conducted a Review of MassHealth Applied Behavior Analysis Providers

Autism spectrum disorder (ASD) is a developmental disorder that affects people's ability to process information, causing (1) obstacles with social and communication skills, (2) restrictions in interests, (3) repetitive behaviors, and (4) sensitivity to, or discomfort from, sensory stimulation.[3]

Applied behavior analysis (ABA) focuses on the analysis, design and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. ABA services provide behavioral assessments, behavior-analytic data interpretation, highly specific treatment plans, supervision and coordination of interventions, and training for other interveners to address objectives or performance goals that support the acquisition of socially significant adaptive skills and reduction of behaviors that interfere with a young person's successful functioning.[4]

A review of ABA providers was necessary because over the past several years, the Office of the Attorney General's Medicaid Fraud Division investigated and resolved numerous cases alleging ABA providers submitted fraudulent claims to MassHealth for services not rendered and inadequate supervision. Access to quality MassHealth ABA treatment for children is a priority requiring that ABA services be provided by properly credentialed licensed applied behavior analysts and behavior technicians or paraprofessionals meeting minimum supervision standards.

## Key Findings

The OIG's outlier analyses determined that:

- 1,831 MassHealth members received inadequately supervised ABA services;
- 108 providers provided inadequately supervised ABA services and MassHealth overpaid for these ABA services in an amount exceeding $16.7 million. The top 10 providers in this category account for $7,301,341 in overpayments;
- MassHealth paid for 627 ABA claims representing more than 24 hours of service billed for a person with ASD on a given service date ("impossible billing"). MassHealth's payments for impossible billing totaled $439,632; and
- MassHealth paid 561 ABA claims for 311 members for services purportedly delivered on holidays, amounting to $162,535. This finding represents an opportunity for MassHealth and its ABA provider networks to conduct program integrity audits to determine if services were actually rendered on holidays or accurately documented for claims processing.

## OIG Methodology

The OIG reviewed ABA encounter data related to ABA provider current protocol terminology (CPT) codes 97153 and 97155 and conducted a series of analyses to identify the top 10 ABA providers whose supervision fell below performance specifications. Those specifications require a minimum of one hour of supervision from a licensed applied behavior analyst (LABA) for every 10 hours of direct ABA services. The OIG also evaluated encounter data to identify instances in which ABA providers submitted claims for "impossible billing," *i.e.*, instances when a provider billed for more than 24 hours in a day for services provided to individual MassHealth members, and claims submitted by providers for services provided on major holidays (New Year's Day, the Fourth of July, Thanksgiving and Christmas).

## Conclusions

- MassHealth managed care entities (MCEs) may be providing inadequately supervised ABA services to children with autism. These services are critical to successful early intervention for the development of adaptive skills.
- Oversight controls are needed to screen for improper billing.
- MassHealth should review processes for improved coordination with MCEs to better prevent and detect fraud, waste and abuse in its ABA program.
- Opportunities may exist for improvement of MCEs' recovery of overpayments and reporting fraud, waste and abuse to MassHealth and the Office of the Attorney General's Medicaid Fraud Division.
- Stakeholders urgently need to address the shortage of licensed applied behavior analysts to improve access to properly supervised services.

[3] AM. PSYCHIATRIC ASS'N, *WHAT IS AUTISM SPECTRUM DISORDER?* https://www.psychiatry.org/patients-families/autism/what-is-autism-spectrum-disorder (last visited February 22, 2024).

[4] CTR. FOR DISEASE CONTROL AND PREVENTION (CDC), *TREATMENT AND INTERVENTION SERVICES FOR AUTISM SPECTRUM DISORDER*, https://www.cdc.gov/ncbddd/autism/treatment.html#Behavioral (last visited February 22, 2024).

# BACKGROUND

## I. The Office of the Inspector General's Healthcare Division

The Office of the Inspector General for the Commonwealth of Massachusetts (OIG) is an independent state agency charged with preventing and detecting fraud, waste and abuse in the use of public funds and assets. The OIG investigates allegations of fraud and waste at all levels of government, assists the public in preventing the misuse of public funds, and reviews programs and practices in state agencies and municipalities to identify systemic vulnerabilities and opportunities for improvement.

Under the authority of the OIG as enumerated in Chapter 12A of the Massachusetts General Laws and other statutes, and through a separate annual authorization (*see* Section 96 of Chapter 28 of the Acts of 2023), the OIG's newly established Healthcare Division (HCD) is authorized to review, analyze and comment, report and otherwise opine on a variety of issues related to healthcare policy, delivery and access. The HCD's oversight mandate also includes the authority to audit the Commonwealth's Health Safety Net (HSN) program and examine practices in hospitals concerning the care that uninsured patients receive and the resulting free charges. Moreover, the HCD's oversight mandate includes the authority to assess the Massachusetts Medicaid program's (MassHealth) eligibility requirements, utilization, claims administration and compliance with federal mandates.

The HCD's oversight work seeks to identify programmatic vulnerabilities within the HSN and MassHealth and develop recommendations for improving internal controls and practices to prevent the misuse of public funds in these public healthcare systems. The HCD may also investigate potential or actual instances of provider fraud, waste and abuse when appropriate.

## II. The Medicaid Program

The federal government created the national Medicaid program in 1965 to provide medical assistance to low-income individuals, particularly children, through a shared state-federal commitment. Today, the national Medicaid program pays for medical care, as well as long-term nursing and other care, for tens of millions of individuals. At the federal level, the Centers for Medicare and Medicaid Services (CMS) manages the program. Each state administers its own version of Medicaid in accordance with a CMS-approved plan. Although the states have considerable flexibility in designing and operating their Medicaid programs, they must comply with applicable federal guidelines.

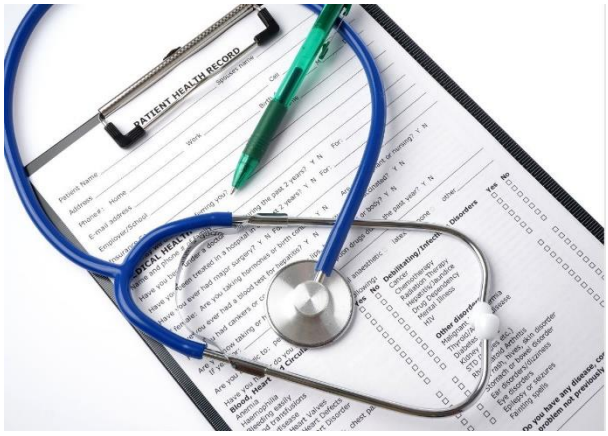
The Executive Office of Health and Human Services (EOHHS) administers the Massachusetts Medicaid program, known as MassHealth, through its Office of Medicaid and its constituent agencies. MassHealth provides and pays for medically necessary healthcare services for eligible individuals, including qualifying children, families, seniors and people with disabilities living in Massachusetts.

## III. The Health Safety Net Program

The Legislature created the Health Safety Net (HSN) program in 2006, funded by the Health Safety Net Trust Fund. The purpose of the HSN program, set forth in Chapter 118E of the Massachusetts General Laws, is to "maintain a healthcare safety net by reimbursing hospitals and community health centers for a portion of the cost of reimbursable health services provided to low-income, uninsured or underinsured residents" of the Commonwealth.[5] The Legislature charged MassHealth with management of the HSN program in 2012.

## IV. Autism Spectrum Disorder

The American Psychiatric Association defines "Autism Spectrum Disorder" (ASD) as "a complex developmental condition involving persistent challenges with social communication, restricted interests and repetitive behavior."[6] People living with autism may also experience sensitivity or discomfort from sensory stimulation, like lights or sounds. Clinicians use the term "spectrum" to reflect the wide range of symptoms and severity that children diagnosed with autism experience. As explained by the Centers for Disease Control and Prevention (CDC), "Autism Spectrum Disorder (ASD) is a developmental disability caused by differences in the brain. Some people with ASD have a known difference, such as a genetic condition. Other causes are not yet known. Scientists believe there are multiple causes of ASD that act together to change the most common ways people develop."[7]




In 2022, the American Psychiatric Association released a revised version of the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR).[8] It is now the standard reference used by psychiatrists and other clinicians to diagnose mental and behavioral conditions, including ASD. The DSM-5-TR definition recognizes two main diagnostic criteria for ASD:

> A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of the following illustrative examples:

[5] M.G.L. c. 118E, § 66(a).

[6] AM. PSYCHIATRIC ASS'N, *WHAT IS AUTISM SPECTRUM DISORDER?* https://www.psychiatry.org/patients-families/autism/what-is-autism-spectrum-disorder (last visited February 22, 2024).

[7] CDC, *WHAT IS AUTISM SPECTRUM DISORDER*? https://www.cdc.gov/ncbddd/autism/facts.html (last visited February 22, 2024).

[8] AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (5th ed., Text Rev. 2022) (DSM-5-TR).

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language, or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or making friends to the absence of interest in peers.

B. Restricted, repetitive behaviors, interests or activities, as manifested by at least two of four symptoms:

1. Stereotyped or repetitive motor movements, use of objects or speech (e.g., simple motor stereotypes, lining up toys, or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take the same route, or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).[9]

[9] *Id.* at 56-57 (numbering in original).

Symptoms of ASD often appear early in a child's development, while a clinical ASD diagnosis may not occur until later "when symptoms cause developmental challenges that are not better explained by other conditions."[10] That is, ASD can sometimes be recognized around 18 months or younger; however, a reliable diagnosis by an experienced clinician can be made by age two.[11] ASD is diagnosed four times more frequently in boys than in girls.[12]

Children living with ASD may behave, speak, interact and learn in ways that are different from other children. The level of abilities can differ significantly in children diagnosed with ASD.[13] That is, some people with ASD can engage in conversation and have advanced communication skills; conversely, others may be nonverbal.[14] Some people on the ASD spectrum need a lot of help in their daily routines, while others work and live independently with little to no assistance or support.[15]

Developing and maintaining friendships, communicating with others, or understanding acceptable behaviors in a variety of social and school settings may be difficult for children with ASD as they become adolescents and young adults.[16] Children living with ASD may come to the attention of healthcare providers when they are diagnosed with other co-occurring medical conditions like anxiety, depression or attention-deficit/hyperactivity disorder.[17] These conditions frequently occur in combination with an ASD diagnosis and more often in people diagnosed with ASD than people without ASD.[18]

## V. Evolution of ASD Insurance Coverage in Massachusetts

In 2011, Massachusetts passed "An Act Relative to Insurance Coverage for Autism" (ARICA), which mandated that private health insurers in Massachusetts provide coverage for diagnosing and treating people with ASD.[19] The private insurance industry also extended coverage to applied behavior analysis (ABA) therapy. Conversely, from 2011 to 2015, MassHealth did not provide coverage for the diagnosis or treatment of ASD. However, in 2015, following the 2014 passage of the Autism Omnibus Bill[20] and an amendment to M.G.L. c. 118E, § 10H, MassHealth began to cover medically necessary ABA treatment

[10] AUTISM RSCH. INST., *WHAT IS AUTISM*? https://autism.org/what-is-autism/ (last visited February 22, 2024).

[11] CDC, *WHAT IS AUTISM SPECTRUM DISORDER?* https://www.cdc.gov/ncbddd/autism/facts.html (last visited February 22, 2024).

[12] *Id*.

[13] *Id*.

[14] *Id*.

[15] *Id*.

[16] *Id*.

[17] *Id*.

[18] *Id*.

[19] 2010 Mass. Acts, c. 207.

[20] 2014 Mass. Acts, c. 226.

through MassHealth Standard, MassHealth CommonHealth[21] and the Family Assistance Program for children under age 21 diagnosed with ASD, with supervision by Board Certified Behavior Analysts (BCBAs). By Fiscal Year (FY) 2019, MassHealth spent almost $109.2 million on ABA services.[22] As reflected in Table 1, the number of MassHealth members and dollars spent on ABA services continued to grow. MassHealth spent over $141 million on ABA services for 8,031 members in FY 2021. In FY 2022, MassHealth ABA utilization costs were almost $170 million for 8,747 members, and in FY 2023 MassHealth spent almost $192 million for 9,328 MassHealth members receiving ABA services. *See also* Appendixes B and C.[23]

**Table 1: MassHealth ABA Coverage, FY 2021-2023**

| Fiscal Year | Number of MassHealth Members Served | Number of Units Billed | Amount Paid |
|---|---|---|---|
| 2021 | 8,031 | 8,414,751 | $141,063,782 |
| 2022 | 8,747 | 9,415,026 | $169,651,185 |
| 2023 | 9,328 | 10,628,005 | $191,804,776 |

[21] People with disabilities who are ineligible for MassHealth Standard because of income or asset thresholds are eligible for MassHealth CommonHealth, a program available for individuals with disabilities and whose income is greater than 133% of the federal poverty level. Unlike MassHealth Standard, CommonHealth is an option for healthcare coverage through progressively priced monthly premiums based on a household's aggregate income.

For people who have private insurance coverage through their employer, CommonHealth will pay for any medically necessary Medicaid-covered services that the employer health plan does not cover, including co-pays, co-insurance and deductibles, as long as the provider accepts MassHealth. The sole exception is for applied behavior analysis: the ABA provider does not have to be a MassHealth provider for co-pays to be covered. In addition, people with CommonHealth can obtain premium assistance, which may cover some, and sometimes all, of the cost of the premium/payroll deduction for the private insurance.

[22] MASSACHUSETTS AUTISM COMM'N, *2022 ANNUAL REPORT* at 8-9 (May 2023).

[23] MassHealth provided the OIG with the information contained in Table 1 and Appendixes B and C.

## I. Applied Behavior Analysis

Treatment of children living with ASD is often behavior-focused, with an emphasis on altering or modifying the child's behaviors by understanding what happens before and after the child exhibits unwanted behaviors. According to the CDC, behavior-centric treatments "have the most evidence for treating symptoms of ASD."[24] Behavioral approaches to treatment have become widely accepted among healthcare professionals, educators, schools and ASD treatment clinics.[25]

Because ABA therapy is highly individualized, treatment care plans are developed based on the specific developmental needs of each child, and a course of therapy typically spans two or more years.

Applied behavior analysis (ABA) "uses behavioral learning principles to help children with ASD decrease maladaptive behaviors and increase positive social interactions. It is supported by more than 30 years of research and is the treatment of choice for children with ASD. Research suggests that ABA should be delivered from early childhood and for 20-40 hours per week to yield the best outcomes."[26] During ABA sessions, qualified clinicians encourage desired behaviors and limit certain autism traits to improve a variety of tracked and measured skills.[27] Because ABA therapy is highly individualized, treatment care plans are developed based on the specific developmental needs of each child, and a course of therapy typically spans two or more years.[28] There are multiple ABA teaching styles or strategies. For example, the CDC highlights two ABA teaching styles:

1. *Discrete trial training* "uses step-by-step instructions to teach a desired behavior or response. Lessons are broken down into their simplest parts, and desired answers and behaviors are rewarded. Undesired answers and behaviors are ignored."[29]

[24] CDC, *Treatment and Intervention Services for Autism Spectrum Disorder*, https://www.cdc.gov/ncbddd/autism/treatment.html#Behavioral (last visited February 22, 2024).

[25] *Id*.

[26] Am. Psychiatric Ass'n, *Supply of Certified Applied Behavior Analysts in the United States: Implications for Service Delivery for Children with Autism*, https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201900058?journalCode=ps (last visited February 25, 2024).

[27] CDC, *Treatment and Intervention Services for Autism Spectrum Disorder*, ttps://www.cdc.gov/ncbddd/autism/treatment.html#Behavioral (last visited February 22, 2024).

[28] *Id.*; Assoc. for Behavioral Analysis Int'l, *Applied Behavior Analysis in Children and Youth with Autism Spectrum Disorders: A Scoping Review*, at 522-523, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9458805/pdf/40614_2022_Article_338.pdf (last visited February 25, 2024).

[29] CDC, *Treatment and Intervention Services for Autism Spectrum Disorder*, ttps://www.cdc.gov/ncbddd/autism/treatment.html#Behavioral (last visited February 22, 2024).

2. *Pivotal response training* "takes place in a natural setting rather than clinic setting. The goal . . . is to improve a few 'pivotal skills' that will help the person learn many other skills. One example of a pivotal skill is to initiate communication with others."[30]

In both ABA teaching styles, a behavior technician (BT) captures and tracks progress data that is evaluated by a licensed supervisor for continued assessment of the adequacy of interventions and progression of skill development.

The objective of ABA services is to help children diagnosed with ASD develop the skills needed to understand socially appropriate behavior and, eventually, to live independently. ABA services can be provided in-home or in community-based settings like schools or clinics. Services revolve around individualized care plans developed by a licensed applied behavior analyst (LABA) or Board Certified Behavior Analyst (BCBA) to address a child's needs. ABA clinicians help children with ASD develop and improve a variety of functional abilities such as social skills, communication, academic and learning skills, motor dexterity, hygiene and grooming.[31]

## II. Recent Growth in the Applied Behavior Analysis Industry

ASD is recognized as one of the fastest-growing developmental disorders in the United States, more common than childhood cancer, diabetes and AIDS combined.[32] As prevalence rates of children diagnosed with ASD continue to rise, the need for ABA services has experienced similar exponential growth. The employment of substance abuse, behavioral disorder and mental health counselors is expected to grow 18% from 2022 to 2032, much faster than the average for all occupations.[33] Specifically, the ABA services industry experienced significant growth following the "passage of state health insurance mandates, the Affordable Care Act (ACA) mandate for coverage in its marketplace health plans, and the 2014 Medicaid coverage mandate for medically necessary services in behavioral health, including people with autism."[34] Accordingly, because ABA services comprise one of the fastest growing healthcare industries in the United States, there is an increased need for vigilance in program integrity to keep pace with the growing number of ABA providers entering the public healthcare environment.

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[30] *Id.*

[31] PSYCHOLOGY TODAY, *APPLIED BEHAVIOR ANALYSIS*, https://www.psychologytoday.com/us/therapy-types/applied-behavior-analysis (last visited February 22, 2024).

[32] MASS. GEN. HOSP., *30 FACTS TO KNOW ABOUT AUTISM SPECTRUM DISORDER,* March 20, 2023, https://www.massgeneral.org/children/autism/lurie-center/30-facts-to-know-about-autism-spectrum-disorder#:~:text=Autism%20spectrum%20disorder%20is%20one,all%20races%20and%20both%20sexes (last visited February 22, 2024).

[33] U.S. BUREAU OF LAB. STAT., *OCCUPATIONAL OUTLOOK HANDBOOK, SUBSTANCE ABUSE, BEHAVIORAL DISORDER, AND MENTAL HEALTH COUNSELORS*, https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm#:~:text=Employment%20of%20substance%20abuse%2C%20behavioral%20disorder%2C%20and%20mental,projected%20each%20year%2C%20on%20average%2C%20over%20the%20decade (last visited February 22, 2024).

[34] CTR. FOR ECON. AND POL'Y RSCH., *POCKETING MONEY MEANT FOR SPECIAL NEEDS KIDS: PRIVATE EQUITY IN AUTISM SERVICES*, https://cepr.net/report/pocketing-money-meant-for-kids-private-equity-in-autism-services (last visited February 22, 2024).

Recent data shows that the demand for applied behavior analysts is growing substantially. For example, the annual nationwide demand for individuals holding Board Certified Behavior Analysts (BCBA) or Board Certified Behavior Analyst-Doctoral® (BCBA-D®) certification has increased each year since 2010, with a 23% increase from 2021 to 2022.[35] Demand for credentialed BCBAs was highest in five states in 2022: California, Massachusetts, Texas, Florida and New Jersey, which account for 48% of the recent demand for behavior analysts.[36] The CDC determined that the five states with the highest estimated rates of ASD are Massachusetts (2.42%), Virginia (2.41%), Connecticut (2.37%), California (2.36%) and Minnesota (2.35%).[37]

Because ABA services comprise one of the fastest growing healthcare industries in the United States, there is an increased need for vigilance in program integrity to keep pace with the growing number of ABA providers entering the public healthcare environment.

Table 2 and Figure 1 demonstrate that Massachusetts experienced a 52% increase in employment of BCBAs and a 129% increase in employment of behavioral technicians (BTs) between 2018 and 2022.[38]

**Table 2: Rising BCBA and BT Employment[39]**

| Year | BCBAs[40] | BT | Total Employed in Massachusetts |
|---|---|---|---|
| 2018 | 2,276 | 956 | 3,232 |
| 2019 | 2,618 | 1,332 | 3,950 |
| 2020 | 2,891 | 1,473 | 4,364 |
| 2021 | 3,236 | 1,788 | 5,034 |
| 2022 | 3,430 | 2,186 | 5,616 |

[35] Clinicians holding the BCBA-D® designation are BCBAs with doctoral or postdoctoral training in behavior analysis. The BCBA-D® designation is not a separate certification and does not grant any privileges beyond BCBA certification. BEHAVIOR ANALYST CERTIFICATION BOARD, https://www.bacb.com/bcba/#:~:text=Board%20Certified%20Behavior%20Analyst%20%E2%80%93%20Doctoral,any%20privileges%20beyond%20BCBA%20certification (last visited February 22, 2024).

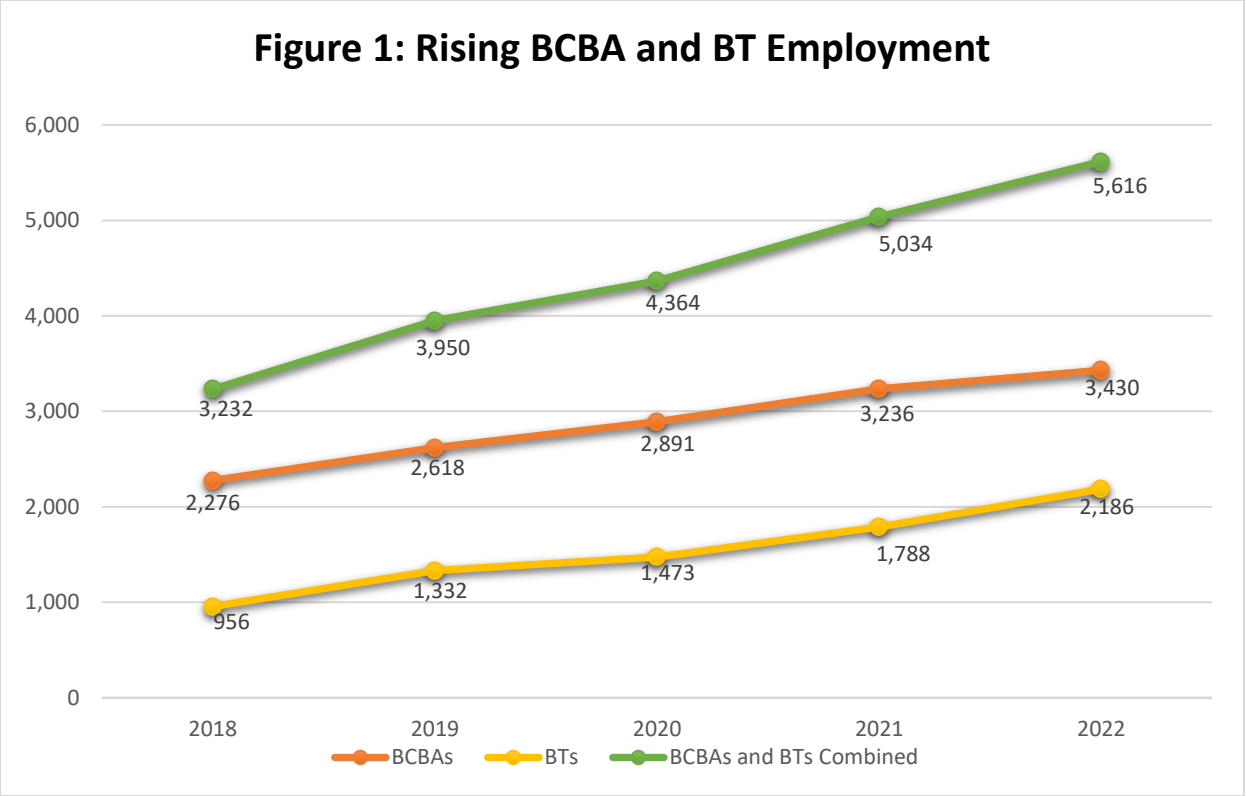
[36] BEHAVIOR ANALYST CERTIFICATION BD., https://www.bacb.com/wp-content/uploads/2023/01/Lightcast2023_230206-a.pdf (last visited February 22, 2024).

[37] The percentages are estimates of adults living in the state with ASD, both diagnosed and undiagnosed. WORLD POPULATION REVIEW, https://worldpopulationreview.com/state-rankings/autism-rates-by-state (last visited February 22, 2024).

[38] BEHAVIOR ANALYST CERTIFICATION BD., *REGION-SPECIFIC CERTIFICANT DATA*, https://www.bacb.com/services/o.php?page=101134 (last visited February 22, 2024).

[39] *Id.*

[40] The term "BCBA" in Table 2 and Figure 1 includes all BCBA designation levels: Board Certified Behavior Analyst, Board Certified Behavior Analyst-Doctoral® (BCBA-D®), and Board Certified Assistant Behavior Analyst® (BCaBA®). BCBAs with doctoral or postdoctoral training in behavior analysis can seek the designation of BCBA-D®, which neither confers a separate certification nor grants any privileges beyond BCBA certification. Holders of a BCBA-D® designation function in the same capacity as a BCBA. The BCaBA® is an undergraduate-level certification in behavior analysis. Professionals certified at the BCaBA level provide behavior-analytic services under the supervision of a BCBA. BEHAVIOR ANALYST CERTIFICATION BOARD, *BOARD CERTIFIED BEHAVIOR ANALYST HANDBOOK* (2023), https://www.bacb.com/wp-content/uploads/2022/01/BCBAHandbook_231227-a.pdf (last visited February 22, 2024).




The Massachusetts Autism Commission (commission) and its subcommittees have recognized a growing shortage of qualified BCBA clinicians with LABA credentials and has instituted a number of studies and recommendations to address the issue through training, recruitment and retention initiatives.[41] For example, in 2017, the commission's Birth to Fourteen Subcommittee discussed the shortage of LABAs in Massachusetts. With approximately 1,800 LABAs in the state, the committee identified a need to incentivize people to obtain master's degrees despite the lack of competitive salaries in the field.[42] The commission also recognized that the LABA and BCBA shortage is reflective of similar struggles in the mental health field in terms of the adequacy of the workforce to provide services to eligible patients.[43]

From 2018 to 2020, the commission's Birth to Fourteen Subcommittee directly addressed the shortage of ABA providers in Massachusetts. The subcommittee focused on efforts to encourage people to enter the ABA field through incentives like tuition reimbursement programs. The subcommittee took steps to collect data on ABA clinicians and their demographics and reached out to MassHealth to obtain

[41] The Secretary of EOHHS is the chair of the Autism Commission, and representatives from DDS, DCF, DPH, MRC, MassHealth, DESE, DHCD and EOLWD are members of the Autism Commission and its subcommittees. The Secretariat incorporates the recommendations of the commission, as appropriate, into operational policies within EOHHS and discusses them with other cabinet-level state agencies. *See* MASS. AUTISM COMM'N, *THE MASSACHUSETTS AUTISM COMMISSION ANNUAL REPORT* 16 (2018), available at https://www.mass.gov/doc/2017-annual-report-of-the-autism-commission/download (last visited February 26, 2024).

[42] MASS. AUTISM COMM'N, Meeting Minutes at 2 (January 11, 2017).

[43] *Id*.

additional data from MassHealth agency providers.[44] In 2020, the subcommittee planned to coordinate an approach to this issue with MassHealth and other agencies.[45] In August 2021, the subcommittee outlined its recommendations and priorities for 2021 to 2022, including ABA staffing shortages and the oversight of ABA center-based agencies.[46] In June 2022, the subcommittee revisited the issue of LABA recruitment, staffing and retention, and recognized that the availability of LABA staffing to supervise BTs was a significant and identifiable concern.[47]

[44] MASS. AUTISM COMM'N, Meeting Minutes at 2-3 (June 21, 2018).

[45] MASS. AUTISM COMM'N, Meeting Minutes at 2 (December 4, 2020).

[46] MASS. AUTISM COMM'N, Meeting Minutes at 1-2 (August 27,2021).

[47] MASS. AUTISM COMM'N, Meeting Minutes at 2 (June 17, 2022).

As defined in state regulations, Applied Behavior Analysis (ABA) is

> [a] MassHealth service that focuses on the analysis, design, implementation and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. This service provides for the performance of behavioral assessments; interpretation of behavior analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training of other interveners to address specific objectives or performance goals in order to support the acquisition of socially significant adaptive skills and reduction of challenging behaviors that interfere with a youth's successful functioning.[48]

## I. ABA Services Provided by MCEs and Their Provider Networks

MassHealth currently provides ABA services to MassHealth members through three types of MassHealth MCE plan options. MassHealth members can choose to enroll in health plans from the following options:

1. Accountable Care Organizations (ACOs), consisting of:

   (a) 15 Accountable Care Partnership Plans (ACPPs), and

   (b) two Primary Care ACOs (PCACOs);

2. Managed Care Organizations (MCOs), consisting of two plans; and
3. The Primary Care Clinician (PCC) Plan.[49]

Under ACPPs, the MassHealth member's primary care provider (PCP) works with one health plan. The ACPP provider network includes PCPs, specialists, behavioral health providers and hospitals.

In PCACO plans, PCPs join to form an ACO to provide care to MassHealth members. The ACO contracts directly with MassHealth to coordinate the full range of services for MassHealth members. PCACOs work with the MassHealth provider network of specialists and hospitals and, in some cases, can

[48] 101 CMR 358.02.

[49] MassHealth's 15 ACPP plans are offered through Fallon Health Atrius Health Care Collaborative; Berkshire Fallon Health Collaborative; Fallon 356 Care; BeHealthy Partnership Plan; WellSense Beth Israel Lahey Health Performance Network ACO; WellSense Community Alliance; WellSense Boston Children's ACO; East Boston Neighborhood Health WellSense Alliance; WellSense Mercy Alliance; WellSense Signature Alliance; WellSense Southcoast Alliance; WellSense Care Alliance; Mass General Brigham Health Plan with Mass General Brigham ACO; Tufts Health Together with Cambridge Health Alliance; and Tufts Health Together with UMass Memorial Health. MassHealth's two PCACO plans are offered through Community Care Cooperative and Steward Health Choice. MassHealth's two MCO plans are offered through WellSense Essential MCO and Tufts Health Together.

provide members with direct access to additional healthcare providers in their "referral circle." The Massachusetts Behavioral Health Partnership (MBHP) provides behavioral health services.

MassHealth MCO health plans are run by insurance companies that provide healthcare services through their provider network, which includes PCPs, specialists, behavioral health providers and hospitals.

The MassHealth PCC Plan consists of a network of primary care clinicians, specialists and hospitals that provide services to MassHealth members. MBHP provides behavioral health services in this plan.

## II. MCE Staffing Requirements

MCEs require that ABA services be provided by teams that include LABAs, BTs and paraprofessionals (unless clinically indicated otherwise). To become a LABA, applicants must satisfy educational requirements (doctoral or master's programs) and pass the Board Certified Behavior Analyst examination issued by the Behavior Analyst Certification Board (BACB).50

BTs provide direct ABA services to children with ASD and work under the direct supervision of LABAs. All MCEs have MassHealth-approved ABA program performance specifications that establish the minimum qualifications for BTs. Specifically, BTs must be 18 years old and must have:

1. A high school diploma or general education development (GED) and 12 months of experience working with people with developmental disabilities, children, adolescents, transition-age youth or families;
2. An associate's degree related to human, social or education service disciplines, or a degree or certification related to behavior management, from an accredited community college and six months of employment experience working with persons with developmental disabilities, children, adolescents, transition age youth or families; or
3. A certification as a registered behavioral technician (RBT) by the BACB and three months of experience working with persons with developmental disabilities, children, adolescents, transition-age youth or families.

In Massachusetts, ABA providers are required to ensure that their LABA staff are trained in the principles of ABA. MCE performance specifications also require providers to ensure that all ABA staff complete training upon employment and annually thereafter on the following topics:

1. Overview of clinical and psychosocial needs of the target population;
2. Systems of care, principles and philosophy;
3. Ethnic, cultural and linguistic considerations of the community;

[50] *See* 262 CMR 10.00.

4. Community resources and services;
5. Family-centered practice;
6. Behavior management coaching;
7. Social skills training;
8. Psychotropic medications and possible side effects;
9. Risk management and safety plans;
10. Crisis management;
11. Introduction to child-serving systems and processes (such as DCF, DYS, DMH, DDS and DESE);
12. Basic IEP in special education information;
13. Managed care entities, performance specifications and medical necessity criteria;
14. Child and adolescent development, including sexuality; and
15. Conflict resolution.

## III. MCE Performance Specifications

The MassHealth program does not issue ABA regulations; instead, MassHealth approves each MCE's promulgated performance specifications outlining all the requirements of an ABA provider. Performance specifications are expectations imposed on entities that contract to provide specific ABA services and are intended to enhance MassHealth enrollees' experiences and outcomes by promoting transparency and consistency across plans and providers.

## IV. Supervision Requirements

MassHealth MCEs require that ABA providers within their networks ensure that LABAs adequately supervise all paraprofessional staff and BTs. MCE performance specifications require a minimum of one hour of case supervision for every 10 hours of direct service.[51] MCE performance specifications also require that ABA providers within an MCE network develop and maintain policies and procedures for all components of ABA services. The ABA agency is responsible for ensuring that all new and existing staff members are trained in these policies and procedures.

MassHealth MCEs require that ABA providers within their networks ensure that LABAs adequately supervise all paraprofessional staff and BTs.

[51] For example, *see* Optum Applied Behavior Analysis performance specification, https://public.providerexpress.com/content/dam/ope-provexpr/us/pdfs/ourNetworkMain/welcomeNtwk/ma/ma-perform-specs/3855hh.pdf (last visited February 22, 2024).

## V. Tech-to-LABA Time Ratio for Supervision

For ABA providers to receive payment for services provided to children with ASD, they must submit service claims using current protocol terminology codes (CPT codes) for the services provided. Massachusetts regulations govern the rate of pay used by governmental entities in making payments to eligible ABA providers.[52] Payment rates are for each unit of ABA service measured in 15-minute increments. As shown in Table 3, for face-to-face ABA treatment provided to one patient by a BT under the direct supervision of a physician or other qualified healthcare professional (QHP), the ABA provider submits a claim under CPT Code 97153.[53] The MassHealth rate for CPT 97153 is **$16.37** for every unit (or 15 minutes) of service. When the ABA provider submits claims for the required supervision of BTs administered by a physician or other qualified healthcare professional like a LABA, the provider submits a supervision claim under CPT Code 97155. This supervision may include simultaneous direction given to the BT and face-to-face interaction with one patient and is reimbursed at **$30.73** for every unit submitted.

**Table 3: ABA Treatment and Supervision Rates**

| Service | CPT Code | Rate per Unit |
|---|---|---|
| Treatment by BT | 97153 | $16.37 |
| Supervision by QHP | 97155 | $30.73 |

According to the ABA Coding Coalition, comprised of organizational representatives and consultants who participated in developing the code set for ABA services, CPT code 97155 is used "(1) when a QHP conducts 1:1 direct treatment with the patient to observe changes in behavior or troubleshoot treatment protocols; or (2) when the QHP joins the patient and the technician during a treatment session to direct the technician in implementing a new or modified treatment protocol."[54]

The term "direction" as used in CPT code 97155:

> [R]efers to the QHP directly monitoring the delivery of treatment to a patient by a behavior technician. The focus is on ensuring that treatment protocols are implemented correctly in order to maximize benefit to that patient. Direction of a technician includes, but is not limited to, the QHP frequently observing the technician implementing the patient's protocols with the patient, providing instructions and confirming or corrective

[52] *See* 101 CMR 358.00.

[53] The American Medical Association (AMA) established a definition for a Qualified Health Care Professional (QHP) in terms of which providers may report services: "A 'physician or other qualified health care professional' is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service." AMERICAN MEDICAL ASSOCIATION, *CURRENT PROCEDURAL TERMINOLOGY CPT 2020 PROFESSIONAL EDITION* (4th ed. 2020).

[54] ABA CODING COALITION, *FREQUENTLY ASKED QUESTIONS*, https://abacodes.org/frequently-asked-questions/#:~:text=In%202013%2C%20the%20American%20Medical,training%2C%20licensure%2Fregulation%20(when, (last visited February 22, 2024).

> feedback as needed, and/or demonstrating correct implementation of a new or modified treatment protocol with the patient while the technician observes, followed by the technician implementing the protocol with the patient while the QHP observes and provides feedback.[55]

The "supervision" of a BT or other employee by a QHP includes the methods through which the QHP ensures that the BT or other employee:

> (a) practices in a competent, professional, and ethical manner in accordance with the standards of the profession; (b) engages with and follows the employer's policies and procedures; (c) continues to develop their knowledge and skills; and (d) receives the personal support needed to cope with the stressors and demands of their position. "Supervision" may also involve activities to enable the supervisor and supervisee to comply with specific requirements for obtaining or maintaining a paraprofessional or professional credential, such as a certification or license, or to fulfill ethical responsibilities.[56]

## VI. Methodology

To identify ABA providers that did not ensure that MassHealth members received appropriately supervised ABA care, the OIG worked to verify that for every 10 hours (40 units) of ABA services provided by a BT, a LABA provided supervision for at least one hour (4 units). To conduct this study, the OIG reviewed units and encounter data submitted by MassHealth MCE ABA providers for BT services under CPT Code 97153 and LABA supervision under CPT Code 97155.[57] The OIG reviewed the data to determine if the minimum 10:1 ratio was satisfied by ABA providers within the various MCE networks.

The OIG conducted an analysis to identify ABA providers that did not ensure that MassHealth members received appropriately supervised ABA care. The OIG identified 108 ABA providers with claims submitted for at least five MassHealth members with BT-to-LABA ratios exceeding the 10:1 requirement.

Based on a review of MassHealth encounter data for the period from January 1, 2022, to October 30, 2023 (the review period), the OIG determined that the average ratio of hours for supervision of BTs by LABAs is one hour of supervision for every 7.78 hours of ABA services provided. However, the OIG identified 108 ABA providers with claims submitted for at least five MassHealth members with BT-to-LABA ratios exceeding the 10:1 requirement. The

[55] *Id*.

[56] *Id*.

[57] An encounter is a professional contact between a patient and a provider who delivers healthcare services. Encounter data is a data set provided by the MCE that records every service provided to a MassHealth MCE's member derived from claims that providers submit to the MCE for the services they provide.

OIG calculated an overpayment amount for each ABA provider based on the percent share of their gross amount paid for claims over the 10:1 ratio. The combined estimated overpayment is **$16,761,445**.

## VII. Outlier Review Findings

The OIG's outlier analysis included only those MassHealth ABA providers who provided services to at least five MassHealth members during the review period, which consisted of a universe of 562 total providers. Out of the 562 providers, the OIG identified 108 ABA providers with claims submitted for at least five MassHealth members who had BT-to-LABA time ratios exceeding the 10:1 ratio. From the 108 ABA providers with claims indicating excessive unsupervised time, the OIG identified the top 10 ABA providers, listed in Table 4 below, who have the highest BT service-to-LABA supervision ratios, meaning the providers that failed to ensure MassHealth children treated for ASD had access to appropriately supervised ABA treatments.

**Table 4: Highest Supervision Ratios by Provider[58]**

| Provider Name | Tech-to-LABA Ratio | Gross Paid for ABA Claims |
|---|---|---|
| Provider ABA00024 | 38.4 : 1 | $556,843 |
| Provider ABA00021 | 30.0 : 1 | $78,209 |
| Provider ABA00017 | 28.9 : 1 | $134,418 |
| Provider ABA00029 | 28.1 : 1 | $307,153 |
| Provider ABA00013 | 25.6 : 1 | $67,468 |
| Provider ABA00019 | 23.6 : 1 | $5,546,549 |
| Provider ABA00032 | 22.8 : 1 | $81,884 |
| Provider ABA00023 | 22.6 : 1 | $289,080 |
| Provider ABA00008 | 21.1 : 1 | $570,206 |
| Provider ABA00022 | 21.1 : 1 | $49,625 |
| **Top 10 Total** | | **$7,681,435** |

[58] Provider names are not identified in this report, but will be provided to oversight agencies as appropriate. Pseudonyms repeated across Tables 4 through 9 indicate the same provider.

To contextualize the dollar amount of the claims paid for unsupervised ABA services in Table 4, the OIG calculated an overpayment amount for each provider based on the percent share of their gross paid amount for claims over the 10:1 ratio.[59] The total estimated overpayment for the 10 providers with the highest ratio of unsupervised ABA care is **$7,301,341**, as reflected below in Table 5**.**

**Table 5: Largest Estimated Overpayments by Provider**

| Provider Name | Estimated Overpayment | % of Provider's Total ABA Payment |
|---|---|---|
| Provider ABA00019 | $3,057,886 | 55% |
| Provider ABA00002 | $708,730 | 12% |
| Provider ABA00006 | $706,171 | 9% |
| Provider ABA00007 | $703,739 | 17% |
| Provider ABA00009 | $496,053 | 9% |
| Provider ABA00012 | $419,482 | 49% |
| Provider ABA00024 | $392,241 | 70% |
| Provider ABA00008 | $276,650 | 49% |
| Provider ABA00010 | $276,325 | 34% |
| Provider ABA00004 | $264,064 | 29% |
| **Estimated Overpayment Total** | **$7,301,341** | |

[59] For example, if a provider had a ratio of 20.0:1 and was paid $100,000, the overpayment was calculated as (1-10/20 x $100,000 = $50,000).

The OIG identified providers who submitted claims exceeding the 10:1 tech-to-LABA ratio across all MassHealth ABA providers. In the aggregate, ABA providers exceeded the supervision ratio for 1,831 MassHealth members.

Table 6 identifies the top 10 members and their providers who exceeded the required BT-to-LABA supervision ratio.

**Table 6: Highest Supervision Ratios by Member**

| De-Identified Member ID | Tech-to-LABA Ratio | Gross Paid for Member's ABA Claims | Member's Top Provider - Name | Provider's % of Member's ABA Claims |
|---|---|---|---|---|
| Member A | 1,285.0 : 1 | $84,265 | Provider ABA00019 | 100.0% |
| Member B | 543.0 : 1 | $35,679 | Provider ABA00015 | 88.1% |
| Member C | 533.9 : 1 | $70,162 | Provider ABA00025 | 91.4% |
| Member D | 403.5 : 1 | $26,544 | Provider ABA00025 | 100.0% |
| Member E | 340.5 : 1 | $44,838 | Provider ABA00013 | 32.9% |
| Member F | 319.5 : 1 | $21,044 | Provider ABA00034 | 87.5% |
| Member G | 276.0 : 1 | $18,195 | Provider ABA00019 | 97.2% |
| Member H | 269.8 : 1 | $16,270 | Provider ABA00018 | 100.0% |
| Member I | 239.6 : 1 | $55,335 | Provider ABA00019 | 100.0% |
| Member J | 217.0 : 1 | $3,579 | Provider ABA00016 | 100.0% |

Table 7 reflects the OIG's outlier analysis, based on average hours per claim for CPT codes 97153 and 97155, the number of paid ABA claims, supervision ratios and gross paid ABA claims taken together. The OIG considers a provider as an outlier if any of these metrics differ substantially from the averages in the table's bottom row.[60] These providers are the most unusual because their metrics differ the most from these averages.

**Table 7: Largest Differentials from Average Provider Metrics**

| Provider Name | Average Hours Per Claim | Claims Paid Per Member | Gross Paid Per MassHealth Member | Tech-to-LABA Ratio | Gross Paid for ABA Claims |
|---|---|---|---|---|---|
| Provider ABA00009 | 2.4 | 60.2 | $10,318 | 7.5 : 1 | $5,644,176 |
| Provider ABA00004 | 8.9 | 146.1 | $90,208 | 12.9 : 1 | $902,079 |
| Provider ABA00006 | 3.2 | 79.6 | $17,892 | 9.2 : 1 | $7,639,774 |
| Provider ABA00011 | 14.4 | 9.0 | $9,114 | 10.9 : 1 | $63,799 |
| Provider ABA00020 | 15.1 | 30.0 | $31,890 | 10.2 : 1 | $159,448 |
| Provider ABA00001 | 15.7 | 29.8 | $32,886 | 10.3 : 1 | $295,972 |
| Provider ABA00002 | 3.2 | 71.2 | $16,076 | 9.2 : 1 | $6,141,129 |
| Provider ABA00008 | 18.1 | 33.0 | $40,729 | 21.1 : 1 | $570,206 |
| Provider ABA00026 | 2.1 | 167.0 | $7,146 | 18.8 : 1 | $57,168 |
| Provider ABA00024 | 5.7 | 106.6 | $39,774 | 38.4 : 1 | $556,843 |
| Provider ABA00019 | 3.6 | 144.0 | $31,877 | 23.6 : 1 | $5,546,549 |
| Provider ABA00021 | 2.4 | 55.3 | $8,690 | 30.0 : 1 | $78,209 |
| Provider ABA00017 | 4.0 | 56.4 | $14,935 | 28.9 : 1 | $134,418 |
| **Averages, All ABA Providers** | **3.2** | **65.9** | **$15,195** | **7.8 : 1** | **$271,369** |

[60] The OIG calculated the following thresholds to determine whether a provider differed substantially from the averages in the table's bottom row. Each provider listed in the outliers table met at least one of these criteria (relative to the averages for all ABA providers): (1) average hours per claim were 4.5 times (or more) greater; (2) gross paid per MassHealth member was 5.9 times (or more) greater; (3) the tech-to-LABA ratio was 3.7 times (or more) greater; (4) gross paid for ABA claims was 20.3 times (or more) greater; or (5) the number of claims paid per member was 2.5 times (or more) greater.

Additionally, the OIG identified 627 "impossible billing" claims with more than 24 hours of ABA services rendered to a member on a given service date, based on the units submitted. MassHealth paid $1,368,929 for these claims, with **$439,632** attributable to the share of claims that passed the 24-hour mark. Table 8 lists the 10 providers that submitted the most claims for more than 24 hours of ABA services on a given date for an individual MassHealth member. These claims comprise **$418,525** of the over-24-hour "impossible billing" total.

**Table 8: Providers with Most Impossible Billing Claims**

| Provider Name | # Claims Submitted Exceeding 24 Hours | Longest Service, in Hours | Total Paid for these Claims | Share of Payments for Service Past 24 Hours |
|---|---|---|---|---|
| Provider ABA00001 | 158 | 150.0 | $324,092 | $75,393 |
| Provider ABA00008 | 151 | 133.5 | $439,737 | $202,505 |
| Provider ABA00020 | 75 | 56.0 | $134,715 | $17,206 |
| Provider ABA00014 | 48 | 192.0 | $87,682 | $13,536 |
| Provider ABA00005 | 37 | 92.5 | $77,481 | $19,498 |
| Provider ABA00004 | 37 | 48.0 | $76,640 | $18,706 |
| Provider ABA00031 | 26 | 125.0 | $52,777 | $11,917 |
| Provider ABA00028 | 12 | 95.2 | $34,231 | $15,552 |
| Provider ABA00024 | 9 | 166.0 | $58,063 | $43,920 |
| Provider ABA00027 | 9 | 24.5 | $14,288 | $292 |
| **Top 10 Total** | | | | **$418,525** |

Finally, the OIG identified claims submitted by ABA providers on major holidays (New Year's Day, Memorial Day, the Fourth of July, Labor Day, Thanksgiving and Christmas). MassHealth paid a total of **$408,132** for 1,555 holiday claims. Table 9 lists the 10 ABA providers that submitted the most claims for services provided on holidays, amounting to questionable payments of **$162,535.**

**Table 9: Providers with Most Holiday Claims**

| Provider Name | # of Claims on Holidays | # of Members | Total Paid, Holiday Claims |
|---|---|---|---|
| Provider ABA00019 | 298 | 127 | $77,096 |
| Provider ABA00009 | 48 | 42 | $7,995 |
| Provider ABA00006 | 39 | 30 | $7,710 |
| Provider ABA00012 | 32 | 17 | $9,929 |
| Provider ABA00028 | 28 | 21 | $9,447 |
| Provider ABA00033 | 27 | 16 | $7,828 |
| Provider ABA00007 | 26 | 18 | $7,060 |
| Provider ABA00003 | 25 | 15 | $7,300 |
| Provider ABA00008 | 19 | 9 | $24,009 |
| Provider ABA00030 | 19 | 16 | $4,161 |
| **Top 10 Total** | | | **$162,535** |

## I. Importance of Program Integrity Measures

In light of the OIG's initial review of MassHealth's ABA program, which uncovered overpayments of more than $16.7 million for services that were inadequately supervised or indicative of impossible billing and holiday billing, the OIG conducted a secondary review assessing MassHealth's oversight of its MCEs' program integrity measures used to identify, prevent and recover improper payments.

A review of MassHealth's MCEs' program integrity issues is critical because it is estimated that millions of dollars are lost yearly to fraud, waste and abuse in the MassHealth program.[61] Such loss of public funds diverts necessary dollars from essential healthcare services. Unsupervised MassHealth ABA services may constitute fraud, waste or abuse and result in potentially inadequate ABA care for children with ASD and their families.

## II. Incentives for Preventing, Identifying and Reporting Fraud in Provider Networks

In 2018, the U.S. Department of Health and Human Services, Office of the Inspector General (HHS-OIG), noted that a number of states and MCOs were concerned about fraud, waste and abuse in managed care systems.[62] These concerns were aggravated by the lack of fraud, waste and abuse referrals from MCOs to single state agencies responsible for administering the Medicaid programs or to the Medicaid Fraud Control Units (MFCUs) in each state.[63]

HHS-OIG concluded that this lack of referrals arose from the fact that MCOs had no incentive to detect and refer potential fraud and abuse.[64] HHS-OIG observed in a previous annual report that (1) managed care entities can lose money if their contracts do not allow them to share in fraud-related recoveries, and (2) their contracts typically do not include negative consequences for a lack of fraud referrals.[65] As a result, a managed care entity may find it preferable to remove a provider suspected of fraud from its network rather than refer allegations of fraud to the single state agency's public integrity

[61] For example, in January 2022 the Attorney General's Office announced that the MFD recovered more than $55 million in calendar year 2021. *See* https://www.wwlp.com/news/crime/ags-office-recovers-over-55-million-in-medicaid-fraud-in-2021/ (last visited February 28, 2024).

[62] U.S. DEP'T OF HEALTH AND HUMAN SERV., OFF. OF INSPECTOR GENERAL, *WEAKNESSES EXIST IN MEDICAID MANAGED CARE ORGANIZATIONS' EFFORTS TO IDENTIFY AND ADDRESS FRAUD AND ABUSE* 2, OEI-02-15-00260 (July 2018), https://oig.hhs.gov/oei/reports/oei-02-15-00260.pdf (last visited February 28, 2024).

[63] *Id*.

[64] *Id.*

[65] U.S. DEP'T OF HEALTH AND HUMAN SERV., OFF. OF INSPECTOR GENERAL, *MEDICAID FRAUD CONTROL UNITS, FISCAL YEAR 2014 ANNUAL REPORT* 12, OEI-06-15-00010 (April 2015), https://oig.hhs.gov/oei/reports/oei-06-15-00010.pdf (last visited February 28, 2024).

unit or an MFCU for further investigation or prosecution.[66] HHS-OIG forecast that more fraud would go unreported as MCEs provided more Medicaid services.[67]

Program integrity efforts are usually the responsibility of the federal Centers for Medicare & Medicaid Services (CMS), the state Medicaid agency and MCOs.[68] In the fee-for-service system, the state Medicaid agency is responsible for processing, paying and monitoring claims and for identifying fraud, waste and abuse.[69] However, when MCOs provide covered healthcare services under state contracts, the MCOs are contractually obligated not only to process, pay and monitor network provider claims, but also to detect provider fraud, waste and abuse.[70]

To be paid through Medicaid's managed care program, MCOs are contractually obligated to establish internal controls to maintain provider integrity by identifying, investigating and reporting allegations of potential fraud and abuse.[71] MCOs typically establish special investigation units (SIUs) to detect fraudulent activity. When an SIU identifies potential wrongdoing, it "typically conducts an investigation, often reviewing claims, requesting medical records, or initiating audits of suspected providers."[72] If the investigation substantiates an allegation of fraud, the SIU typically refers the case either to the Medicaid agency or the state's MFCU for investigation and prosecution.[73] MCOs also have robust tools to conduct pre-payment and post-payment reviews of provider claims to ensure all claims are accurate, properly submitted and paid.[74] In addition, MCOs may take corrective action or implement a correction plan against the offending provider and identify and recover overpayments as a result of fraud, abuse or billing errors.[75] The MCO, in its discretion, may terminate or elect not to renew a provider's contract when the provider is suspected of wrongdoing.[76]

## III. MassHealth's 2023 Contracts with MCEs

The program integrity measures outlined above were codified in a final rule issued by CMS in 2016 and contain MCE responsibilities to maintain program integrity efforts as outlined in 42 C.F.R. 438.608. In

[66] *Id*.

[67] *Id*.

[68] U.S. DEP'T OF HEALTH AND HUMAN SERV., OFF. OF INSPECTOR GENERAL, *WEAKNESSES EXIST IN MEDICAID MANAGED CARE ORGANIZATIONS' EFFORTS TO IDENTIFY AND ADDRESS FRAUD AND ABUSE* 3, OEI-02-15-00260 (July 2018), https://oig.hhs.gov/oei/reports/oei-02-15-00260.pdf (last visited February 28, 2024).

[69] *Id*.

[70] *Id*.

[71] *Id.*

[72] *Id*. at 3.

[73] *Id*. at 4.

[74] *Id*.

[75] *Id*.

[76] *Id.*

April 2023, the *MassHealth Managed Care Organization Contract By and Between EOHHS and the Various MCOs and MassHealth Accountable Care Partnership Plan Contracts* incorporated these integrity provisions.[77] The contracts with the MCOs and ACOs require the entities to, among other things:

1. Comply with all applicable federal and state program integrity laws and regulations regarding fraud, waste and abuse;
2. Implement and maintain written internal controls, policies and procedures, and administrative and management arrangements or procedures designed to prevent, detect, reduce, investigate, correct and report known or suspected fraudulent activities consistent with 42 C.F.R. 438.608(a);
3. Meet with EOHHS regularly and upon request to discuss fraud, waste and abuse, audits, overpayment issues, reporting issues and best practices for program integrity requirements; and
4. Implement certain program integrity requirements for providers, as specified by EOHHS, including but not limited to implementing National Correct Coding Initiative edits or other CMS claims processing and provider reimbursement manuals and mutually agreed upon best practices for program integrity requirements.

Additionally, the 2023 contracts mandate that each MCO and ACO have a compliance plan requiring the MCO or ACO to take the following actions:

1. Develop written policies, procedures and standards of conduct articulating the entity's obligation to comply with federal and state law;
2. Designate a compliance officer and compliance committee accountable to senior management;
3. Maintain adequate Massachusetts-based staffing and resources (including personnel familiar with MassHealth rules and state and federal regulations) to investigate, develop and implement plans to prevent and detect fraud, waste and abuse within the organization;

[77] *See, e.g.*, the *Fifth Amended and Restated MassHealth Managed Care Organization Contracts By and Between The Executive Office of Health and Human Services and Boston Medical Center Health Plan, Inc*., https://www.mass.gov/doc/5th-amended-and-restated-mco-contract-bmchp-ar5/download and *Fifth Amended and Restated MassHealth Managed Care Organization Contract By and Between The Executive Office of Health and Human Services and Tufts Health Public Plans, Inc.*, https://www.mass.gov/doc/5th-amended-and-restated-mco-contract-tufts-ar5/download (last visited February 22, 2024).

The *Fifth Amended and Restated MassHealth Managed Care Organization Contracts* are agreements between EOHHS and Boston Medical Center Health Plan, Inc. and Tufts Health Public Plans, Inc. These contracts were first executed on October 2, 2017, and have been amended and restated four times before the fifth amendment and restatement effective April 1, 2023. The purpose of the contracts is to provide comprehensive healthcare coverage to eligible individuals under MassHealth and other health and human services programs designed to pay for medical services for eligible individuals pursuant to M.G.L. c. 118E; Title XIX of the Social Security Act (42 U.S.C. § 1396, *et seq.*); Title XXI of the Social Security Act (42 U.S.C. § 1397aa, *et seq.*); and other applicable laws and waivers.

4. Provide training to employees and maintain effective lines of communication among employees, compliance officers and EOHHS;
5. Enforce standards through clear disciplinary guidance;
6. Conduct internal monitoring and auditing as required by federal regulations; and
7. Respond promptly to fraud by developing corrective action plans and reporting to EOHHS.

The contracts further require that MCOs and ACOs provide EOHHS with their compliance plans annually and when requested. The entities must modify the plans as requested by EOHHS within 30 days of such request.

In addition to a compliance plan, MCOs and ACOs are also required to have an anti-fraud, waste and abuse plan with provisions pertaining to:

1. Mandatory reporting of suspected and confirmed fraud, waste and abuse;
2. Quarterly risk assessments of the entity's program integrity processes, including identification of the entity's three most vulnerable areas and an action plan to mitigate those risks;
3. Provider education on federal and state law related to Medicaid program integrity and fraud prevention, targeting providers with a pattern of incorrect billing practices or overpayments; and
4. Procedures designed to prevent and detect fraud, waste and abuse in the administration and delivery of contracted services, including specific controls (*e.g.*, lists of automated pre-payment and post-payment claims edits; descriptions of desk and onsite audits; surveillance and utilization management protocols used to aid program and payment integrity reviews).

The 2023 contracts include specific requirements for reporting overpayments to EOHHS. Managed care entities must share certain reports with EOHHS: (1) notification of provider overpayments reports (within five business days of the identification of the overpayment); (2) fraud and abuse notification reports; (3) summary of provider overpayments reports (including all overpayments during the contract year, all investigatory and recovery activity related to those overpayments, and any unrecovered overpayments from prior years); and (4) self-reported disclosure reports.

To address the issue that MassHealth MCEs lack incentive to detect and refer potential fraud, waste and abuse, the current contracts provide that if an MCO or ACO identifies an overpayment before EOHHS does, the MCO or ACO shall recover the overpayment and may retain the recovered amount. If an MCO or ACO identifies an overpayment but does not recover that amount within 180 days, the MCO or ACO must provide an explanation in the mandatory reporting outlined above. Under such circumstances,

EOHHS may exercise its discretion and apply a capitation payment deduction equal to the amount of overpayment identified but not collected.[78]

If EOHHS is the first to identify an overpayment, the MCO or ACO has 90 days from EOHHS's notification of the overpayment to investigate the related claims and notify EOHHS whether it agrees with or disputes EOHHS's overpayment findings. If an MCO or ACO disputes EOHHS's overpayment finding, they must provide a detailed description of the reasons for the dispute, identifying claims and the amounts of each overpayment in dispute.

If the MCO or ACO agrees with EOHHS's overpayment findings, the MCO or ACO must provide EOHHS notice of the agreed overpayment amount. The MCO or ACO must then collect the agreed-upon overpayments and provide a report to EOHHS within 90 days of issuing its notice.

If the MCO or ACO recovers the agreed-upon overpayment amount within 90 days, EOHHS may exercise its discretion and apply a capitation payment deduction equal to 80% of the overpayment amount. The MCO or ACO retains the remaining 20% of the overpayment amount collected. The capitation payment deduction is subject to modification when EOHHS determines there is a valid reason that the MCO or ACO could not collect the entire amount of the agreed-upon overpayment, such as a payment hold instituted by the Attorney General's Medicaid Fraud Division (MFD). In such cases, EOHHS calculates the capitation payment deduction based on the amount collected instead of the initially agreed-upon overpayment amount.

If the MCO or ACO is unable to recover the agreed-upon overpayment amount within 90 days of its response to EOHHS's notification of overpayment without providing sufficient justification, EOHHS may exercise its discretion to apply a capitation payment deduction equal to the uncollected overpayment amount.

The contracts also dictate that MCOs and ACOs require their providers to use a mechanism to report overpayment receipts, to return an overpayment within 60 days, and to notify the MCO or ACO in writing of the reason for the overpayment. The MCOs and ACOs, in turn, shall report any overpayment notifications by their providers to EOHHS.

The contracts contain additional program integrity provisions requiring MCOs and ACOs to:

1. Prior to initiating an audit, investigation, review, recoupment, withholding or involuntary termination of a network provider, request a confirmation from EOHHS that there are no

[78] Actuarially sound prospective capitation rates described in 42 C.F.R. § 438.6 are the primary mechanism through which MassHealth pays its MCEs. Capitation rates are in a fixed amount, usually expressed as a per-member, per-month rate paid by MassHealth, and are set based on variables such as the populations served and the services provided under the MCEs' MassHealth contract. MassHealth is obligated to ensure that prospective capitation rates and other revenue sources provide MCEs with a reasonable and appropriate payment for the MassHealth population served, as well as to adequately cover the MCEs' expenses and future unexpected expenses. *See* MASSACHUSETTS MEDICAID POLICY INSTITUTE, *A PRIMER ON MEDICAID MANAGED CARE CAPITATION RATES: UNDERSTANDING HOW MASSHEALTH PAYS MCOS* (October 2015).

oversight agency conflicts and cease all activity until receiving permission from EOHHS to proceed;[79]

2. Notify EOHHS within two business days after contact by the MFD, the Office of the State Auditor's Bureau of Special Investigations (BSI), or any other investigative authorities conducting fraud and abuse investigations, unless specifically directed by the investigative authorities not to notify EOHHS, and otherwise fully cooperate with the investigative authorities;
3. Report no later than five business days to EOHHS when the ACO or MCO receives information about a provider's circumstances that may affect its ability to participate in its network or MassHealth, including but not limited to termination of the provider's contract with the MCO or ACO;
4. Verify through sampling that MassHealth enrollees received services;
5. Designate a fraud and abuse prevention coordinator responsible for, among other things:
    a. Strengthening internal controls around claims and payments;
    b. Conducting regular reviews and audits of operations;
    c. Receiving all reports of suspected fraud, waste and abuse from employees, MassHealth enrollees and providers and developing protocols to triage such reports; and
    d. Establishing mechanisms to receive, process and effectively respond to complaints of suspected fraud and abuse from employees, providers and MassHealth enrollees and reporting such information to EOHHS;
6. Upon a complaint of fraud, waste or abuse from any source or upon identifying any questionable practices, report the matter in writing to EOHHS within five business days; and
7. Require providers to implement timely corrective actions related to program integrity matters as approved by EOHHS or terminate provider contracts as appropriate.

## IV. Program Integrity Review Conclusions

Although HHS-OIG recently identified inadequate program integrity measures in numerous states where MCEs are increasingly providing Medicaid services and taking the ultimate responsibility for combating fraud, waste and abuse by auditing and reviewing their network providers, EOHHS has mitigated those problems.

EOHHS developed an MCE contract with stringent provisions that provide financial incentives to the MCEs. The contract rewards robust program integrity initiatives that result in fraud referrals and recoveries of overpayments. These incentives also include a new finders' fee for high quality fraud

[79] This action ensures that the MCO or ACO does not interfere in law enforcement investigations or activities.

referrals that result in a judgment or settlement recovery under the False Claims Act. Conversely, EOHHS's contract contains provisions that enable EOHHS to sanction or adjust annual capitation amounts where MCEs fail to detect fraud, waste and abuse or recover resulting overpayments. These provisions are designed to incentivize MCEs to perform robust provider audits and identify and recover overpayments.

During its review of the ABA program's supervision requirements, the OIG determined that MassHealth, the MCEs and the MFD have developed a well-established and effective collaborative working relationship to combat fraud, waste and abuse. Through this innovative working relationship, representatives from MassHealth's program integrity, compliance and legal departments meet on a quarterly basis with MCEs and the MFD to share information; discuss risks related to fraud, waste and abuse; outline emerging fraud schemes; review program and provider audit results; evaluate referrals of credible allegations of provider fraud; and coordinate efforts for the MFD to investigate, prosecute or pursue civil recoveries as appropriate. As a result, in the aggregate, about 50% of MassHealth's referrals to the MFD originate with the MCEs. According to MassHealth, many of the MFD's successful ABA cases were developed from MCE referrals of network providers.

Although MassHealth has a good working relationship with the MCEs, additional opportunities exist to bolster ABA program integrity.

In combination, the new contract with financial incentives for improved program integrity and the collaborative work between MassHealth, MCEs and the MFD have been effective in avoiding issues HHS-OIG identified with MCEs lacking effective program integrity or oversight measures. Although MassHealth has a good working relationship with the MCEs, additional opportunities exist to bolster ABA program integrity. For example, MassHealth has not conducted an audit of ABA MCEs since MassHealth began covering ABA services in 2015. That is a cause for concern. Nevertheless, MassHealth indicates that the current contracts afford MassHealth the opportunity to evaluate and measure the MCEs' ABA program integrity measures and their adherence to performance specifications.

Without appropriate oversight, the exponential growth in the behavioral health industry could lead to greater numbers of providers delivering unsupervised services.

In addition to future holistic reviews of the MCEs' implementation of program integrity measures, EOHHS has the opportunity to require enhanced reviews of the adequacy of ABA supervision. Although the average ratio for supervision of BTs by LABAs was one hour of supervision for every 7.78 hours of direct services, the OIG found more than $16.7 million in overpayments made to providers who didn't meet the performance specifications' supervisory requirements. Based on the OIG's findings of outlier providers who inadequately supervise ABA services, EOHHS could mitigate future overpayments by exercising its discretion through the MCE contracts to require MCEs to conduct frequent CPT outlier reviews related to ABA supervision. Taking this action could help ensure that children with ASD receive quality ABA services. EOHHS could also establish a better understanding of the scope of potential overpayments to outlier providers with significant lapses in ABA supervision, and monitor the persistent problems associated with

LABA and BT shortages. Increasing the number of persons entering those fields is critically important given not only the projected growth in the numbers of children diagnosed with ASD, but also considering the exponential growth in the behavioral health industry that without appropriate oversight could lead to greater numbers of providers delivering unsupervised services.

# CONCLUSIONS AND RECOMMENDATIONS

This report demonstrates the OIG's commitment to safeguarding important public healthcare resources for the health and well-being of children and other MassHealth beneficiaries who receive ABA services. Such services are crucially important to our communities because they provide important skills development and care to some of the Commonwealth's most vulnerable individuals. Parents and families rely on MassHealth ABA service providers for needed therapeutic interventions for their children living with ASD. The failure to ensure that ABA services are properly supervised undermines the reliance that families place in MassHealth to deliver the highest quality of services to their children.

Fraud, waste and abuse in MassHealth's ABA program divert scarce public funds needed to provide behavioral health interventions to assist children with ASD in developing the needed skills to thrive and live as independently and successfully as possible. Outlier behavioral health service providers must not overlook the needs of children living with ASD and their families, nor should they enrich themselves with public funds by providing services without appropriate supervision. MassHealth, the MFD and MCEs have an innovative and collaborative working relationship that successfully identifies and addresses provider schemes that result in fraud, waste and abuse through a robust referral process. Nevertheless, opportunities still exist for MassHealth and its MCEs to better identify fraud, waste and abuse within the ABA program.

Specifically, MassHealth and its MCEs can:

1. Increase vigilance through ensuring adherence to established program integrity and auditing measures; and

2. Review encounter data to determine whether overpayment recoveries can or should be pursued for inadequately supervised ABA services, impossible billing and holiday billing.

While the OIG has identified nearly $17 million in potential overpayments to ABA providers for inadequately supervised ABA care, and while the shortage of qualified LABAs is real, failing to follow the supervisory standards is not an acceptable reality. Both things can be true, *i.e.*, inadequate supervision has occurred, which must be monitored and eliminated, and there is a significant need for professionals to enter this field. The LABA shortage is systemic, and more must be done to incentivize qualified candidates to bolster the number of LABAs and BTs available to provide services to the growing number of children diagnosed with ASD.

This staffing issue is certainly not MassHealth's problem to solve on its own and will require a collective effort from public, private and ABA program stakeholders to address. The OIG notes that opportunities exist to possibly expand the Massachusetts Loan Repayment Program for Health Professionals (MLRP) and the MA Repay Program to include LABAs in programs offering financial relief to individuals pursuing careers in applied behavior analysis. MLRP and MA Repay are both managed by the Massachusetts League of Community Health Centers, Inc. MLRP is a Massachusetts Department of Public Health loan repayment program that provides educational loan repayment as an incentive to health

professionals committed to practicing in communities with barriers to accessing care. MLRP's goal is to increase access to healthcare in underserved communities with a shortage of healthcare providers and to make funds available to individuals working in several healthcare professions; however, LABAs are not included in the program.

Similarly, MA Repay was created to address the impacts of the COVID-19 pandemic on healthcare professionals that resulted in shortages of clinicians and patient support staff across the healthcare environment. MA Repays utilizes state and federal funds to award millions in student loan repayments to eligible Massachusetts health and human services professionals in return for a commitment of four years of service. Unfortunately, MA Repays does not include LABAs in its list of eligible professions. Given the increasing need for ABA services for children diagnosed with ASD, access to a loan repayment program for LABAs may incentivize professionals to work in the ABA field and help alleviate the current shortage.

Meanwhile, MassHealth does have an immediate role to:

1. Ensure that sufficient supervision is in place to support services invoiced; and
2. Conduct reconciliations in order to identify and recoup overpayments due to practices such as impossible billing and holiday billing. As the spending for these services continues to increase, there is a need for a greater commitment to compliance, reconciliation and oversight work.

The OIG appreciates the cooperation of the leadership and staff from MassHealth and the Office of the Attorney General's Medicaid Fraud Division in responding to inquiries, providing the documents and information requested, and ensuring that the OIG staff had the necessary information to conduct its review and analysis and ultimately to report its conclusions.

## APPENDIX A: ABBREVIATIONS

ABA – applied behavioral analysis
ACA – Affordable Care Act
ACO – accountable care organization
ACPP – accountable care partnership plan
ADHD – attention-deficit/hyperactivity disorder
ASD – autism spectrum disorder
ARICA – An Act Relative to Insurance Coverage for Autism
BACB – Behavior Analyst Certification Board
BCaBA® – Board Certified Assistant Behavior Analyst®
BCBA – Board Certified Behavior Analyst
BCBA-D® – Board Certified Behavior Analyst-Doctoral®
BSI – Bureau of Special Investigations
BT – behavioral technician
CDC – Centers for Disease Control and Prevention
CMS – Centers for Medicare & Medicaid Services
CPT – current protocol terminology
DSM-5 – Diagnostic and Statistical Manual of Mental Disorders (fifth edition)
EOHHS – Executive Office for Health and Human Services
HCD – Healthcare Division
HHS-OIG – U.S. Department of Health and Human Services, Office of the Inspector General
HSN – Health Safety Net
GED – general education development
LABA – licensed applied behavior analyst
MassHealth – Massachusetts Office of Medicaid
MBHP – Massachusetts Behavioral Health Partnership
MCE – managed care entity
MCO – managed care organization
MFCU – Medicaid Fraud Control Unit
MFD – Medicaid Fraud Division
MLRP – Massachusetts Loan Repayment Program for Health Professionals
OIG – Office of the Inspector General
PCACO – primary care accountable care organization
PCC – primary care clinician
PCP – primary care provider
PRT – pivotal response training
QHP – qualified healthcare professional
RBT – registered behavioral technician
SIU – special investigation unit

## APPENDIX B: MASSHEALTH ASD INSURANCE COSTS FROM 2021 TO 2023

| Code | FY 2021 | | FY 2022 | | FY 2023 | |
|---|---|---|---|---|---|---|
| | # of Units Billed | Amount Paid | # of Units Billed | Amount Paid | # of Units Billed | Amount Paid |
| **MassHealth Managed Care Entities** | | | | | | |
| 97151 | 301 | $3,855 | 191 | $2,956 | 140,596 | $3,992,975 |
| 97153 | 2,720 | $13,609 | 1,695 | $20,055 | 6,169,033 | $94,850,982 |
| 97154 | - | - | - | - | 133,774 | $1,646,445 |
| 97155 | 404 | $3,526 | 236 | $4,140 | 841,388 | $24,454,290 |
| 97156 | 141,769 | $3,713,670 | 238,011 | $6,858,827 | 275,282 | $7,988,330 |
| 97157 | - | - | - | - | 478 | $11,572 |
| H0031-U2 | 616,108 | $16,775,016 | 662,379 | $19,578,269 | 545,825 | $16,433,469 |
| H0032-U2 | 848,189 | $22,804,594 | 951,039 | $27,348,095 | 271,089 | $7,826,259 |
| H2012-U2 | 42,431 | $4,023,068 | 20,420 | $1,828,879 | 2,489 | $233,029 |
| H2019-U2 | 6,762,829 | $93,726,444 | 7,541,055 | $114,009,964 | 2,248,051 | $34,367,424 |
| **MCE Total** | **8,414,751** | **$141,063,782** | **9,415,026** | **$169,651,185** | **10,628,005** | **$191,804,776** |

## APPENDIX C: MASSHEALTH MEMBERS RECEIVING ABA TREATMENT FROM 2021 TO 2023

| ASD Diagnosed MassHealth Members Served | Age 0-5 | Age 6-12 | Age 13-17 | Age 18-20 | Age 0-21 |
|---|---|---|---|---|---|
| **Fiscal Year** | **Distinct Members** | **Distinct Members** | **Distinct Members** | **Distinct Members** | **Total Distinct Members** |
| 2021 | 3,972 | 3,151 | 729 | 179 | 8,031 |
| 2022 | 4,265 | 3,463 | 810 | 209 | 8,747 |
| 2023 | 4,812 | 3,518 | 786 | 212 | 9,328 |