



NC Department of Health and Human Services

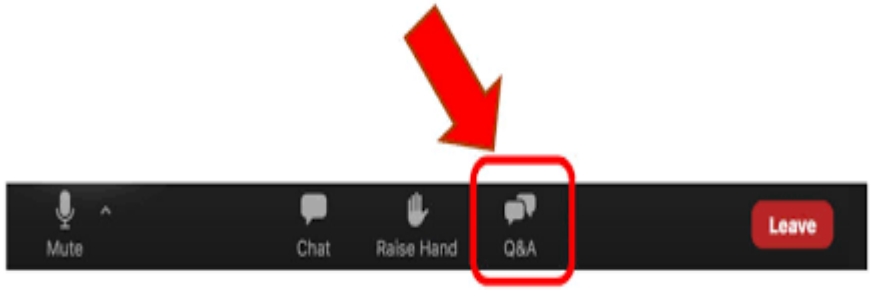
Division of Mental Health, Developmental Disabilities, and Substance Use Services

Ensuring Person-Centered Care for Children with Autism in NC Medicaid

May 12, 2026

Housekeeping

- Reminders about the webinar technology:
  - Please make sure you are using a computer or smart phone connected to the internet, and the audio function is on, and the volume is turned up.
  - Please make sure your microphone is muted for the duration of the call unless you are speaking or asking questions.
  - Questions can be submitted any time during the presentation using the “Q&A” box located on your control panel, and we will answer as many questions as time allows after the presentation.

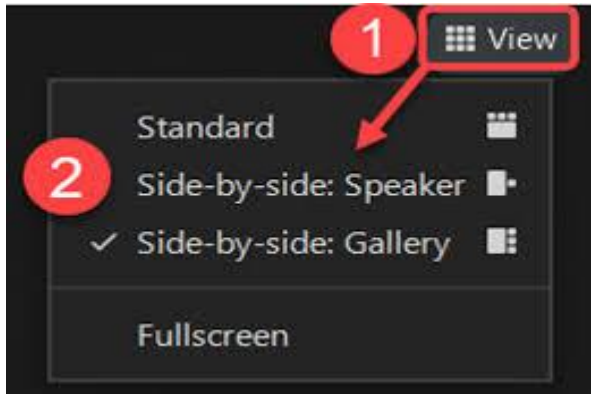


Housekeeping

- American Sign Language (ASL) Interpreters and Closed-Captioning
  - ASL Interpreters and Closed-Captioning options will be available for today's event.
  - For closed-captioning options select the "Closed Caption" feature located on your control panel.

Intérpretes en lengua de signos americana (ASL) y subtítulos:

Habrá intérpretes de ASL y opciones de subtítulos disponibles para el evento de hoy. Para opciones de subtítulos, seleccione la función "Subtítulos" ubicada en su panel de control.



- Adjusting Video Layout and Screen View
  - Select the "View" feature located in the top-right hand corner of your screen.

Agenda

1. Introductions
2. Background
3. For Review: Proposed Research-based Behavioral Health Treatment (RB-BHT) Clinical Coverage Policy Updates for August 2026
4. HB 696: Statutory Changes to RB-BHT Coverage
5. Looking Ahead: Additional Changes Being Considered or Explored
6. Q&A

Guest Speakers

Angela B. Smith, PharmD, DHA

Chief Clinical Officer, NC Medicaid

LaCosta Parker

I/DD-TBI Program Manager
NC Medicaid

Keith McCoy, MD

Chief Medical Officer
(DMH/DD/SUS)
Associate Medical Director
(NC Medicaid)

Background

Medicaid Coverage for Applied Behavior Analysis

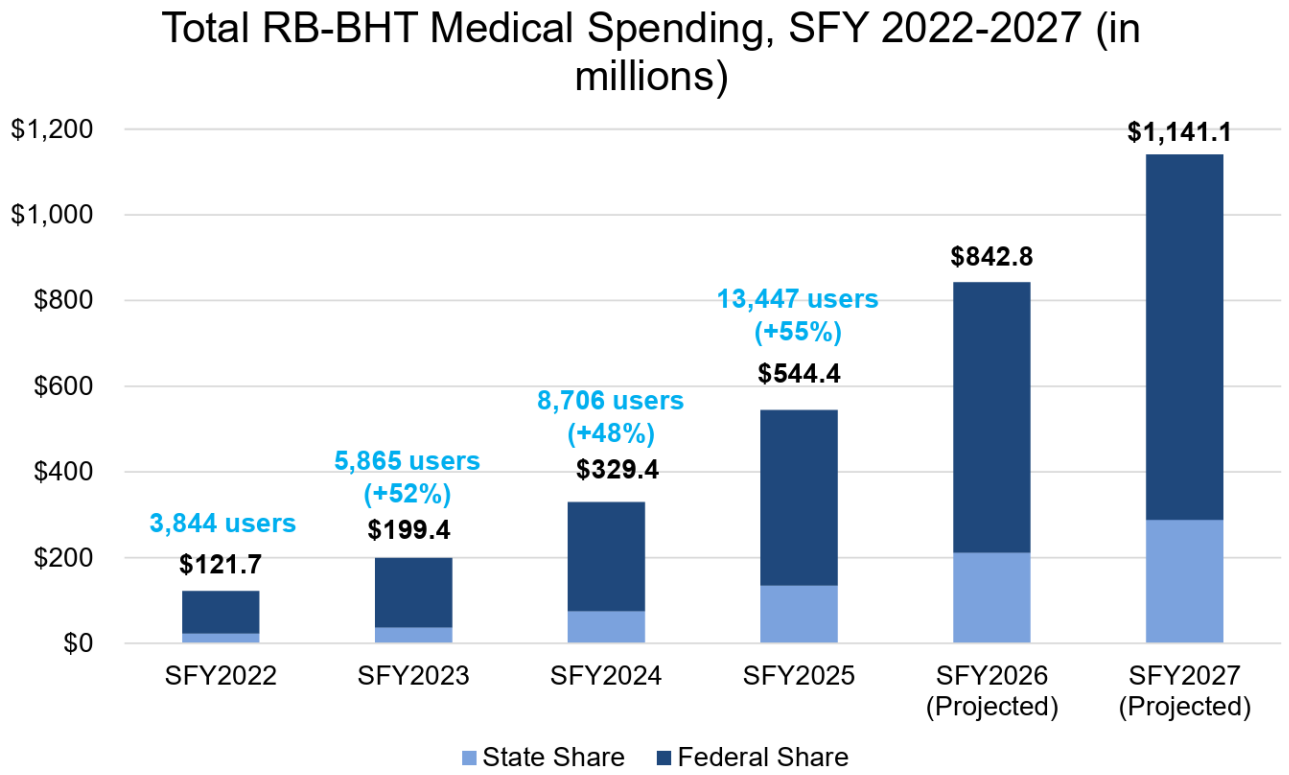
- The prevalence of autism diagnoses among children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) is higher compared to the national average, and Medicaid is a crucial source of coverage for Applied Behavior Analysis (ABA) and other autism and autism-related services and supports.
- In 2014, Centers for Medicare & Medicaid Services (CMS) issued guidance clarifying that Medicaid must cover autism diagnosing and treatment under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).
- The 2014 guidance doesn't explicitly require coverage for ABA, however, all states cover ABA for children under age 21 either through EPSDT or as a State Plan benefit.

Medicaid Coverage for Applied Behavior Analysis

- NC Medicaid covers ABA under its RB-BHT service, which includes other treatment modalities “supported by credible scientific evidence” for both children and adults.
- In recent years, states across the country—including NC—have experienced rapid increases in ABA spending and utilization.
  - Federal and state Offices of Inspector General are increasing oversight over the delivery and billing of ABA services.
  - States are also grappling with defining quality and utilization standards as ABA clinical standards and guidelines continue evolving.

NC Has Experienced Exponential Increases in RB-BHT Spending in Recent Years

A sharp increase in RB-BHT utilization and spending in such a short timeframe has raised concerns about the quality and appropriateness of the services being delivered, as well as the long-term impact on NC Medicaid's budget.

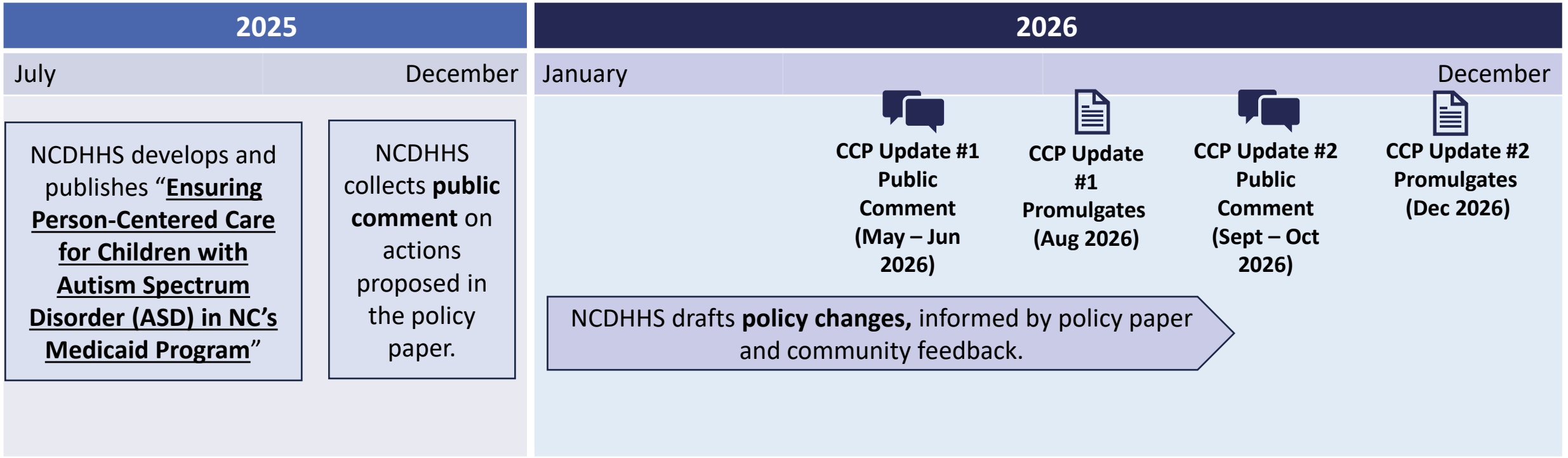


Source: NCDHHS Update on Autism Benefit to JLOC

NC Is Responding to RB-BHT Utilization and Spending Trends

- North Carolina Department of Health and Human Services (NCDHHS) worked with community partners to identify key drivers of utilization and spending. NCDHHS will release two updates to the RB-BHT CCP 8F in 2026 to effect policy changes.

- In October 2025, NCDHHS published "Ensuring Person-Centered Care for Children with Autism Spectrum Disorder (ASD) in NC's Medicaid Program.



Proposed Research-Based Behavioral Health Treatment (RB-BHT) Clinical Coverage Policy Updates for August 2026

Key Drivers of Utilization and Spending

- NCDHHS has examined RB-BHT claims data; reviewed health plan, provider and family feedback; and researched best practice clinical standards to identify likely drivers of utilization and spending trends. These drivers inform a broad range of updates to the CCP.*
  - Treatment may not consistently align with evidence-based standards, and treatment plans may not be sufficiently individualized. The RB-BHT CCP can clarify billing requirements to reduce provider confusion.
  - Overuse of telehealth services may contribute to inappropriate utilization.
  - RB-BHT may be used as the primary treatment after an ASD diagnosis, even when less intensive services are appropriate.
  - A significant number of new providers have entered the NC market.

*CCP updates will also include minor revisions to clarify areas of confusion identified by community partners but may not be direct drivers of utilizations.

Key Context for the Changes Discussed Today

- In addition to updates to the CCP, the state is exploring additional pathways to ensure access to high-quality and appropriate RB-BHT services.
- NCDHHS is collaborating with health plans and the NC Department of Justice on evaluating and strengthening existing program integrity protocols, including the monitoring plan, for RB-BHT services.
- The NC Legislature has passed new RB-BHT legislation to address provider standards, use of telehealth, and enforce service quality standards (among other areas). Policy changes included in this presentation are subject to change based on new statutory requirements.
- The changes discussed today are summaries. Additional detail on each of these requirements will be included in the CCP when it is released for public comment.

Strengthening Treatment Planning and Service Delivery Standards

- New treatment plan requirements will ensure service delivery reflects the individual needs and goals of the member and their caregiver(s) and considers the full continuum of the members' services and supports.
- Driver: Treatment may not consistently align with national guidelines and treatment plans may not be sufficiently individualized.

Strengthening Treatment Planning and Service Delivery Standards (cont.)

8F CCP Changes	Rationale
Require the treatment plan be informed by an assessment conducted using a scientifically validated assessment instrument; and **require the treatment plan be updated regularly.**	Promotes individualized treatment in alignment with clinical best practices and national guidelines; and ensures treatment scope/intensity aligns and evolves with member needs.
Standardize treatment plan requirements (e.g., require providers to include clinical justification for requested treatment hours and whether treatment is focused or comprehensive; require a service intensity titration plan).	
Require that treatment plans include a weekly service schedule outlining all of the member's Medicaid-covered and non–Medicaid-covered services (e.g., RB-BHT, school-based services, respite, occupational, physical, and speech-language therapy, social skills training, etc.).	Facilitates care coordination across providers, prevents duplication of services and ensures intensity of services is developmentally appropriate.
Observation and direction hours provided by licensed providers (Current Procedural Terminology (CPT) code 97155) **must account for at least 10% and no more than 20% of total direct treatment hours** provided by technicians. Providers will be required to submit clinical justification in the treatment plan for a ratio outside this range.	Aligns case supervision policy with clinical best practices and encourages licensed providers to work at the top of their credentials.
Standardize required session note elements.	Supports enhanced program integrity and monitoring.

Strengthening Caregiver Engagement Requirements

- Caregiver engagement supports a child achieving their treatment goals and, ultimately, service discharge. NCDHHS plans to establish minimum standards for caregiver involvement, including requiring inclusion of caregiver-focused goals in the treatment plan.
- Driver: Treatment may not consistently align with evidence-based standards and treatment plans may not be sufficiently individualized.

Strengthening Caregiver Engagement Requirements (cont.)

8F CCP Changes	Rationale
Require treatment plans include **at least two specific and measurable goals for caregivers**.	• Reinforces the critical role of caregivers in achieving and sustaining meaningful outcomes for children receiving RB-BHT. • Promotes continuity of care, supports skill generalization beyond formal treatment, and helps ensure ongoing progress after RB-BHT services conclude.
Require a minimum of **six parent training sessions per six-month** authorization period.	
Require **transition/titration planning to include caregiver training hours.**	
Require providers to submit **written justification if caregiver training is not incorporated** into the treatment plan or the number of training hours and/or goals are below the required minimum.	Provides flexibility for circumstances when the caregiver(s) are unable to participate in training or treatment.

Strengthening Provider Standards

- Virtually all RB-BHT service hours are provided by paraprofessionals called technicians; technicians are not currently required to obtain certification prior to delivering services.
- Driver: Treatment may not consistently align with national guidelines and treatment plans may not be sufficiently individualized.

Strengthening Provider Standards (cont.)

- **Additional CCP Updates to Provider Standards**
  - Community partners have requested clarification regarding the provider types that may make an autism diagnosis (a requirement for RB-BHT eligibility). The CCP will be updated to specifying the following:
  - Provisional diagnoses for members under age 3 may be made by Physicians (Medical Doctor, Doctor of Osteopathy), Licensed Psychologists, Licensed Psychological Associates or Clinicians with a master's degree (with appropriate training). Provisional diagnoses are valid for 6 months.
  - Non-provisional diagnoses may be made by Physicians (Medical Doctor, Doctor of Osteopathy), Licensed Psychologists and Licensed Psychological Associates.
    - Non-Provisional Diagnosis must be made using one of the following scientifically validated tools: Brief Observation of Symptoms of Autism (BOSA), Tele-ASD-Peds (TAP), or Autsim Diagnostic Observation Schedule, Second Edition (ADOS-2).

Strengthening Provider Standards (cont.)

8F CCP Changes	Rationale
Require behavior technicians to **obtain and maintain certification** from one of two national accreditation entities: • Behavior Analyst Certification Board (BACB) (the largest ABA credentialing organization). • Qualified Applied Behavior Analysis Credentialing Board (QABA).	NC will join a growing number of states that are requiring certification of behavior technicians as a tool to enforcing and monitoring clinical best practices.
This policy will have a **phase-in period** and new hires will have **120 days from the date of hire** to obtain certification going forward.	Avoid unnecessary disruptions to care.

Clarifying Billing Requirements

- NCDHHS plans to implement several changes to promote standardized billing practices across RB-BHT CPT codes, with the goal of improving program oversight and understanding drivers of utilization/spending.
- Driver: The RB-BHT CCP can clarify billing requirements to reduce provider confusion.

Clarifying Billing Requirements (cont.)

- Note: The American Medical Association plans to update ABA coding guidelines effective Jan. 1, 2027. Details on these changes are expected in fall 2026. NCDHHS will update its billing guidance accordingly.

8F CCP Changes	Rationale
Clarify that billable activities under CPT code 97155 (adaptive behavior treatment with protocol modification) are limited to: • Providing real-time corrective feedback. • Demonstrating new or modified protocols for a technician or caregiver to observe.	Ensures providers bill only for activities that are eligible for Medicaid reimbursement and supports monitoring of billing practices.
Clarify that the following activities under CPT code 97155 are not billable: • Ensuring the technician practices in a competent, professional, and ethical manner in accordance with the standards of the profession/licensure standards. • Ensuring that the technician continues to develop their knowledge and skills.	
Clarify when concurrent billing is and is not permitted for adaptive behavior treatment (97153/4) paired with modification of the treatment protocol (97155).	
Clarify which ABA providers can bill each RB-BHT CPT code.	Ensures providers are delivering services within their scope of practice and training and supports monitoring of billing practices.

Reenforcing Allowable Billing Under RB-BHT

- The substantial increases RB-BHT utilization in recent years increases the risk that the service may be used in ways that are not clinically appropriate, or when other less intensive clinically appropriate services are available. Clarified billing requirements from NCDHHS aim to address that.
- Driver: The RB-BHT CCP can clarify billing requirements to reduce provider confusion.

Reenforcing Allowable Billing Under RB-BHT (cont.)

8F CCP Changes	Rationale
Clarify language that explicitly prohibits duplication/supplantation of non-Medicaid services (e.g., Individuals with Disabilities Education Act services).	Ensures providers bill only for activities that are eligible for Medicaid reimbursement and supports monitoring of billing practices.
Specify that RB-BHT may not be used for custodial, respite or habilitative services.	
Strengthen language clarifying circumstances when RB-BHT may not be billed (e.g., naps, lunch, transportation, unstructured time and other non-therapeutic time).	

Establishing Limits on Use of Telehealth

- The percentage of RB-BHT claims delivered via telehealth nearly doubled from 2024 to 2025, which points to a risk that telehealth may be used when not clinically indicated or appropriate.
- Driver: Overuse of telehealth services may contribute to inappropriate utilization and inadequate supervision.

Establishing Limits on Use of Telehealth (cont.)

- Note: CPT codes 97156 and 97157 (family and multi-family adaptive behavior treatment guidance) may continue to be delivered via telehealth.

8F CCP Changes	Rationale
Prohibit telehealth use for CPT code 97152 (behavior identification-supporting assessment); and **CPT codes 97153-97154** (delivery of adaptive behavior treatment at the individual or group level).	• Promotes high quality supervision and delivery of treatment services according to clinical best practices. • Delivering services in person enables providers to identify critical environmental factors that may impact behavior and to physically or manually demonstrate clinical techniques. • In-person observation allows for hands-on instruction and timely feedback between the clinician and paraprofessional. • Helps build the relationship between providers and members.
DHB will define circumstances when CPT code 97151 (behavior identification assessment) **can be delivered via telehealth**, **though providers must submit clinical justification**.	
Disallow out-of-state providers (i.e., located outside of a 40-mile radius of North Carolina's border).	

House Bill 696: Statutory Changes to RB-BHT Coverage

HB 696: Medicaid Coverage for ABA Therapy

- The North Carolina Legislature has passed new statutory requirements for RB-BHT services that largely align with planned CCP updates, with a few exceptions:

	HB 696 Policy	August 2026 CCP Update
Supervision, Observation and Direction of Paraprofessionals	No more than **50% of LQASP observation and direction** of a paraprofessional may be conducted via telehealth unless certain exceptions to-be-developed by DHHS are met.	Restricts observation and direction of paraprofessionals via telehealth to **20%,** unless clinical justification is provided.
	For members who receive over 200 hours of service from paraprofessionals in a six-month period: • The percentage of services provided by LQASPs to a beneficiary must be at least 10% but no more than 20% of services provided by paraprofessionals to that same beneficiary. • Services that exceed 20% threshold may be reimbursed with documented medical necessity.	Requirement applies to **all members**, agnostic of amount of service hours received.
Prior Authorization	For any treatment plan providing more than 16 hours of services per week, the treatment plan must be approved by a PHP or DHHS and **reapproved monthly**.	Requires all treatment plans be authorized by health plans and reauthorized **no less than every six months**. Health plans maintain the option to require more frequent reauthorization.
Out-of-State Providers (i.e., providers outside 40 miles of the state border)	Out-of-state BCBAs and Qualified Autism Services Practitioner Supervisors **cannot enroll** in the North Carolina Medicaid program.	Prohibits **all** out-of-state providers from delivering RB-BHT services in North Carolina (e.g., LQASP, BCBA/QBA, C-QP).

Looking Ahead: Additional Changes Being Considered or Explored

Possible Future Policy Changes

- NCDHHS also plans to explore additional policy changes based on feedback from community partners, including through future CCP revisions (in 2026), as well as contracting, state guidance and training/technical assistance.
- NCDHHS welcomes any input from the community as we work through these additional policy changes

Key Driver	Policy Changes Under Consideration (*Planned for December 2026 CCP)
Treatment may not consistently align with evidence-based standards and treatment plans may not be sufficiently individualized.	• Strengthen minimum assessment and/or diagnostic standards* • Explore options and approaches for provider accreditation • Collaborate with plans and providers to enhance provider monitoring and oversight • Explore options for aligning rate structure to quality (e.g., paying differential rates to providers based on quality metrics/performance)
RB-BHT may be used as the primary or sole treatment after an ASD diagnosis, even when less intensive services are appropriate.	• Institute new requirements for whole-person care planning (e.g., assessment and referral checklist to all autism services the child/caregiver(s) may need).* • Establish standards and guidelines for other treatment models* • Increase community awareness of non-RB-BHT services • Provider capacity building and technical assistance
A significant number of new providers have entered the NC market.	• Establish informed consent standards and other provider self-referral guardrails* • Allow plans to close the provider network (included in draft legislation)

Wrap Up - Thank You!

- Reminder: Upcoming Public Comment Period
  - You will have the opportunity to provide public comment on August 2026 CCP changes beginning in May. NCDHHS is looking forward to your feedback.

Question and Answer Session

Questions and feedback are welcome at BHIDD.HelpCenter@dhhs.nc.gov.

The presentation slides for this webinar will be posted to DMH/DD/SUS Webinars webpage.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Mental Health,
Developmental Disabilities and
Substance Use Services

Stay Connected with DMH/DD/SUS

Join our monthly Side by Side Webinars

Join our Mailing List