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REGION 10 PIHP

SUBJECT		CHAPTER	SECTION	SUBJECT
Autism Program		05	03	10
CHAPTER	**SECTION**			
Clinical Practice Guidelines	Care Delivery			
WRITTEN BY	**REVIEWED BY**	**AUTHORIZED BY**		
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I. APPLICATION:

☐ PIHP Board ☒ CMH Providers ☐ SUD Providers
☒ PIHP Staff ☒ CMH Subcontractors

II. POLICY STATEMENT:

It shall be the policy of Region 10 PIHP to manage services of the Autism Program, including Applied Behavior Analysis, through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Benefit, according to all applicable Michigan Department of Health and Human Services (MDHHS) and federal (CMS) standards and requirements.

III. DEFINITIONS:

Autism Spectrum Disorder (ASD): A developmental disability affecting social skills, communication, and behavior. Abilities in these areas range depending on the individual. Signs of these impairments usually occur before a child turns three years old, although children are often diagnosed between ages three and five.

Applied Behavior Analysis (ABA): A process of systematically applying a variety of evidenced-based practices to improve socially significant behavior (e.g., those important for successful functioning in a variety of environments). ABA is founded in the scientific principles of behavior and learning and includes, but is not limited to, functional communication training, discrete trial training, reinforcement, prompting, incidental teaching, schedules, naturalistic teaching, shaping, and pivotal response training.

IV. STANDARDS:

A. PIHP responsibilities shall include:
   1. Liaison with MDHHS on Autism Program issues/concerns
   2. Monitor that the CMHSPs maintain clinical capacity to deliver ABA services to individuals as they present
   3. Analyze utilization data on a regional level

B. CMHSP responsibilities shall include:

1. Process and complete referrals, evaluations, re-evaluations, and disenrollment's from the Autism Program
2. Ensure compliance with all Autism Program requirements set by State and Federal guidance as they are defined in the Medicaid Provider Manual
3. Submit the Autism Monthly tracking sheet by the fifteenth (15^{th}) of each month, or the next business day, to the PIHP Autism Coordinator
4. Provide performance measurement and data in a timely matter upon the request of Region 10 PIHP

C. Screening:
   1. Screening for ASD may occur during an EPSDT well-child visit with the child's primary care provider. The well-child evaluation is designed to rule out medical or behavioral conditions other than ASD, and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.
   2. Screening for ASD may also occur as part of an assessment being conducted by the Region 10 PIHP Access Department, a CMHSP Department during an encounter with an assigned clinician from the CMHSP or other contracted provider, or through another community partner (such as providers/programs within the education system).
   3. The approved screening tools are:
      a) Modified Checklist for Autism in Toddlers Revised (M-CHAT-R) is a brief, initial screening tool validated for toddlers 16 through 30 months of age.
      b) Social Communication Questionnaire (SCQ) is a brief, initial screening tool for individuals older than four years of age with a mental age greater than two years of age.

D. Referral:
   1. Region 10 PIHP has identified multiple access points for ease of referral for ABA services. Initial referrals may be made to the Region 10 PIHP Access Center for individuals not yet engaged in behavioral health services. Additionally, specific points of access within each CMHSP must be identified to receive and process referrals for individuals already in services who are being referred for diagnostic evaluation of ASD. The referral date is the date the individual was referred for further evaluation (e.g., referred by primary care provider during well-visit) or the date the family inquired about services (e.g., through Region 10 Access Center or existing CMHSP provider).

E. Comprehensive Diagnostic Evaluation:
   1. Before the individual receives ABA services, a qualified licensed practitioner will complete a comprehensive diagnostic evaluation to determine the individual's diagnosis, and if appropriate, make recommendation for the individual to receive ASD

services. A comprehensive diagnostic evaluation will be completed within 30 days of the referral date.

2. A qualified licensed practitioner works within their scope of practice and is qualified and experienced in diagnosing ASD:
    a) A physician with a specialty in psychiatry or neurology
    b) A physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics, or a related discipline
    c) A physician with a specialty in pediatrics or other appropriate specialty with training, experience, or expertise in ASD and/or behavioral health
    d) A psychologist
    e) An advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health
    f) A physician assistant with training, experience, or expertise in ASD and/or behavioral health
    g) A masters level, fully licensed clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD
3. To determine a diagnosis, the qualified licensed practitioner will use valid evaluation tools that may include but are not limited to:
    a) Direct observation
    b) The Autism Diagnostic Observation Schedule-Second Edition (ADOS-2)
    c) A comprehensive clinical interview such as the Autism Diagnostic Interview-Revised (ADI-R), or equivalent
    d) The Developmental Disabilities Children's Global Assessment Scale (DD-CGAS).
4. Other valid evaluation tools may be utilized to determine a diagnosis and medical necessity service recommendations, such as cognitive/developmental tests, adaptive behavior tests, and/or symptom monitoring.
5. A Re-Evaluation will be completed no more than three years from the date of the most recent evaluation, unless medically necessary, to assess individual's eligibility criteria utilizing valid evaluation tools as necessary to determine medical necessity and recommended services.
6. Results of evaluation will be appropriately delivered to the individual and parent(s)/ guardian(s). It is strongly preferred that feedback sessions will be provided face-to-face. The evaluation report will be submitted to the appropriate CMHSP Autism Coordinator.

F. Medical Necessity Criteria:
    1. Medical necessity and recommendation for ABA services are determined by a physician or other licensed practitioner working within their scope of practice under state law. Comprehensive diagnostic re-evaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. The

recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms, and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers. The individual must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B:

a) The individual currently demonstrates substantial functional impairment in social communication and social interactions across multiple contexts, and is manifested by all three of the following:
    i. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interest, emotions, or affect, to failure to initiate or respond to social interactions.
    ii. 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.
    iii. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficult adjusting behavior to suit various social contexts, too difficult in sharing imaginative play or in making friends, to absence of interest in peers.
b) The child currently demonstrates substantial restricted, repetitive, and stereotyped patterns of behavior, interest, and activities, as manifested by a least two of the following:
    i. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys, or flipping objects, echolalia, and/or idiosyncratic phases).
    ii. 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, and/or need to take same route or eat the same food every day).
    iii. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).
    iv. Hyper-or hypo-reactivity to sensory input or unusual interest 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, and/or visual fascination with lights or movement).

G. Determination of Eligibility for ABA services:
The following requirements must be met:
1. Child is under 21 years of age.
2. Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.
3. Child is medically able to benefit from the Behavioral Health Treatment (BHT)
4. Treatment outcomes are expected to develop, maintain, or restore, to the maximum extent practicable, the functioning of a child with ASD. Measurable variables may include increased social-communication skills, increased interactive play/age-appropriate leisure skills, increased reciprocal and functional communication, etc.
5. Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individualized Education Plan/Individualized Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.)
6. Services are able to be provided in the child's home and community, including centers and clinics.
7. Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities or may be masked by learned strategies later in life).
8. Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.
9. Medical necessity and recommendation for BHT services are determined by a qualified licensed practitioner.
10. Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.

H. Behavioral Assessment:
1. A developmentally appropriate behavioral applied behavior analysis (ABA) assessment must identify strengths and weaknesses across domains and potential barriers to progress. The information from this process is the basis for developing the individualized behavioral plan of care with the individual, family, and treatment planning team. Behavioral assessments can include direct observational assessments, record review, rating scales, data collection, functional or adaptive assessments, structured interviews, and analysis by a qualified behavioral health professional. Behavioral assessment tools must describe specific levels of behavior at baseline to

inform the individual's response to treatment through ongoing collection, quantification, and analysis of the individual's data on all goals as monitored by a qualified behavioral health professional. The comprehensive, individualized behavioral assessment that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement will accompany the IPOS. Board Certified Behavior Analysts (BCBA) and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the individual's response to treatment and skill acquisition. Ongoing determination of the level of services must be completed every six months, minimally. This ongoing determination requires evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated with the use of reliable and valid assessment instruments and other appropriate documentation of analysis. This may include graphs, assessment reports, records of services, progress reports etc.

I. Behavioral Observation and Direction:
    1. A qualified provider will provide clinical direction and oversight to the delivery of ABA services to a lower-level provider in the provision of services to an individual. The provider delivers face-to-face observation and direction regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for the individual. Observation and direction will be delivered real-time to maximize the benefit for the individual and will be provided minimally one hour for every 10 hours of ABA services delivered.
    2. Behavioral observation and direction may be provided using tele practice services. The MDHHS Medicaid Provider Manual outlines the specific requirements to meet compliance and regulations to participate in tele practice services.

J. Person Centered Planning and Individual Plan of Service:
    1. The following will be determined through the pre-planning and Person-Centered Planning process with the individual:
        a) Strengths
        b) Needs
        c) Preferences
        d) Abilities
        e) Interests
        f) Goals
        g) Health status
    2. The IPOS is the fundamental tool for ensuring the individual's health and welfare. As such, it must be reviewed periodically to determine the ongoing appropriateness and adequacy of the services and supports identified in the plan. The IPOS must also ensure that the services furnished are consistent with the individual's stated goals,

continue to be responsive to the individual's needs and preferences and the nature and severity of their condition.

3. A formal review of the IPOS through the Person-Centered Planning Process, with the individual and their family or authorized representative, must occur not less than annually to review progress toward goals and objectives and to assess satisfaction with services.
4. The IPOS documents the following, specific to ABA services:
    a) The needs of the individual
    b) Desired outcomes through ABA goals and objectives
    c) Amount, scope, and duration of identified ABA interventions being provided at home or in the community, per behavioral plan of care and family input
    d) ABA services will include behavioral observation and direction by a qualified provider
    e) Contingency plan to address various risk factors including staff illness, vacation, etc.
    f) Risk factors of ABA
5. The IPOS and behavioral plan of care will also be developed for the unique individual. Individualization and integration between the IPOS and behavioral plan of care should be evident. The IPOS will be reviewed by the planning team, including BCBA or other qualified provider and parent(s)/guardian(s) annually, adjusting service level (which includes the specific number of hours of intervention to be provided to the individual weekly) to meet individual's needs, when clinically appropriate.

K. ABA Service Level:
    1. There are two levels of service intensity within the ABA model of ABA and can be provided for all levels of security of ASD to facilitate the individual's goal attainment:
        a) Focused Behavioral Intervention (FBI): provided at an average of 5-15 hours/week (actual hours needed are determined by the behavioral plan of care and interventions required).
        b) Comprehensive Behavioral Intervention (CBI): provided at an average of 16-25 hours/week (actual hours needed are determined by the behavioral plan of care and interventions required)
    2. Behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within the individual's community for an appropriate period of time, depending on the needs of the individual and their family or authorized representative(s). Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the individual's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant responsibilities of educational or other authorities. Each individual's IPOS must specify how identified supports and services will be provided as part of an overall, comprehensive set of supports and services that does not duplicate

services that are the responsibility of another entity, such as a private insurance or other funding authority, and do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the individual through a local education agency. The recommended service level, setting(s), and duration will be included in the individual's IPOS, with the planning team and the family or authorized representative(s) reviewing the IPOS no less than annually and, if indicated, adjusting the service level and setting(s) to meet the individual's changing needs. The service level includes the number of hours of intervention provided to the individual. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each individual and should reflect the goals of treatment, specific needs of the individual, and response to treatment. The PIHP's Utilization Management will authorize the level of services prior to the delivery of services.

L. Transition and Discharge Criteria:
   1. The desired ABA goals and outcomes for discharge should be specified at the initiation of services, monitored throughout the duration of service implementation, and refined through the behavioral service level evaluation process. Transition and discharge from all ABA services should involve a gradual step-down model and require careful planning. Transition and discharge planning from ABA services should include transition goal(s) within the behavioral plan of care or plan, or written plan, which specifies details of monitoring and follow-up as is appropriate for the individual and the family or authorized representative(s) utilizing the Person-Centered Planning process. Discharge from ABA services should be reviewed and evaluated by a qualified BHT professional for individuals who meet any of the following criteria:
      a) The individual has achieved treatment goals and less intensive modes of services are medically necessary and/or appropriate.
      b) The individual is either no longer eligible for Medicaid or is no longer a State of Michigan resident.
      c) The individual, family, or authorized representative(s) is interested in discontinuing services.
      d) The individual has not demonstrated measurable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the ABA interventions are not able to be maintained or they are not replicable beyond the ABA treatment sessions through successive authorization periods.
      e) Targeted behaviors and symptoms are becoming persistently worse with ABA treatment over time or with successive authorizations.

f) The services are no longer medically necessary, as evidenced by the use of valid evaluation tools administered by a qualified licensed practitioner.
g) The provider and/or individual/family/authorized representative(s) are unable to reconcile important issues in treatment planning and service delivery to a degree that compromises the potential effectiveness and outcome of the ABA service.

M. Qualified Service Providers:
1. ABA services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services. BHT services must be provided under the direction of a BCBA/Licensed Behavior Analyst (LBA), or a Master's prepared Qualified Behavioral Health Professional (QBHP), until September 30, 2025. These services must be provided directly to, or on behalf of, the child by training their parents/guardians, behavior technicians, and Board Certified Assistant Behavior Analysts (BCaBA) to deliver the behavioral interventions. The BCBA/LBA and other qualified providers are also responsible for communicating progress on goals to parents/guardians minimally every three to six months; clinical skill development and supervision of BCaBA, QBHP, and behavior technicians; and collaborating with support coordinators/case managers and the parents/guardians on goals and objectives with participation in development of the IPOS that includes the behavioral plan of care. ABA professionals (Registered Behavior Technicians [RBT], BCaBAs, and BCBAs) should follow guidance provided by the Behavior Analyst Certification Board to maintain their professional certification.

N. Adequate Workforce/ Provider Qualifications:
1. Region 10 PIHP and its affiliate CMHSPs adhere to all provider qualification requirements. Each CMHSP will maintain an adequate workforce to provide Autism Program services and support ongoing services as medically necessary and allow for adequate choice of provider.

O. A CMHSP policy/procedure will be developed, maintained and implemented by the CMHSP to assure ABA services through EPSDT benefit implementation.

V. PROCEDURES:

A. Referrals
1. CMH Autism Coordinator/Designee
a) Receives referral from Region 10 PIHP Access Center or a point of access within the CMHSP.
b) Ensures an individual is younger than 21 years of age with active Medicaid.

c) Documents screening tool utilized to prompt referral for evaluation, and ensures a comprehensive diagnostic evaluation is completed with independent evaluator within 30 days of referral date.

B. Initial Evaluations/Re-Evaluations
   1. Independent Evaluator
      a) Completes comprehensive diagnostic evaluation and prepares report of findings.
      b) Conducts a feedback session with parent(s)/guardians(s).
      c) Submits report to CMH Autism Coordinator/Designee.

C. ABA Service Level Approval
   1. CMH Autism Coordinator/Designee
      a) Identifies primary case holder and assigns case to ABA qualified provider to conduct behavioral assessment and develop a behavioral plan of care and will coordinate with primary case holder to develop inclusive IPOS.
      b) Reviews behavioral plan of care and IPOS for content and criteria, and ensures authorizations entered for ABA services are congruent with recommendations from ABA qualified provider.

D. Discharge/Disenrollment
   1. CMH Autism Coordinator/Designee
      a) Ensures individual completes an exit ADOS-2, if willing.
      b) Adherence to Adverse Benefit Determination Notice requirements as outlined in the PIHP's Grievance and Appeal System Policy.

E. Region 10 PIHP Reporting/Monitoring
   1. Autism Monthly Tracking form:
      a) Region 10 PIHP requires that the CMHSP Autism Lead submit the Autism Monthly tracking form to the PIHP Autism Coordinator by the fifteenth (15^{th}) of every month, to assist in monitoring the overall capacity of each CMHSP and provide Autism Program services within a reasonable timeframe. The Region 10 PIHP Autism Coordinator will review the data and offer consultation around any issues identified by the CMHSP.
   2. Quality Assurance:
      a) Region 10 PIHP monitors each CMHSP's compliance with MDHHS and Region 10 PIHP performance standards and requirements as well as their own policies and procedures annually during the contract monitoring process.
      b) Clinical Record Review
         i. The Region 10 PIHP Autism Coordinator conducts a full clinical record review on a random sample of records from each CMHSP to confirm

policy/procedure implementation is occurring regularly, confirm compliance with MDHHS/Region 10 performance standards, and ensure requirements are being met. Clinical case record reviews are conducted via desk audit and on-site review. Following all reviews, feedback, consultation, and any possible corrective action planning are facilitated by the PIHP with affected CMHSP(s).

c) Privileging/Credentialing and Training review:
   i. The Region 10 PIHP Autism Coordinator conducts a full staff qualifications and training review on a random sample of records from each CMHSP to confirm policy/procedure implementation is occurring regularly, confirm compliance with MDHHS/ Region 10 PIHP performance standards, and ensure requirements are being met. Staff qualifications and training reviews are conducted via on-site review. Following all reviews, feedback, consultation, and any possible corrective action planning are facilitated by the PIHP with the affected CMHSP(s).

VI. EXHIBITS:

None.

VII. REFERENCES:

A. MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Section 18-Behavioral Health Treatment Services/Applied Behavior Analysis
B. The Council of Autism Service Providers (CASP) (2024) *Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder. Guidance for Healthcare Funders, Regulatory Bodies, Service Providers, and Consumers.* Third Edition.
C. PIHP/CMH Medicaid Managed Specialty Supports and Services Program Contract-Attachment P.8.9.1