

BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

Bulletin Number: MMP 26-18

Distribution: Community Mental Health Services Programs (CMHSP), Prepaid Inpatient Health Plans (PIHP)

Issued: October 1, 2026

Subject: Updates to Behavioral Health Treatment (BHT) Requirements for Autism Services

Effective: As Indicated

Programs Affected: Medicaid

The purpose of this policy is to update Behavioral Health Treatment (BHT) requirements for Autism services that are currently outlined in the Behavioral Health Treatment Services/Applied Behavior Analysis section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter within the [Michigan Department of Health and Human Services \(MDHHS\) Medicaid Provider Manual](#). Updates include removing the requirement that a child has to receive a physical examination prior to accessing BHT services, updating diagnostic re-evaluation language, and clarifying applied behavior analysis (ABA) standards to align with generally accepted standards of care.

Language in this policy update is consistent with recommendations from the Behavior Analyst Certification Board (BACB), Association of Professional Behavior Analysts (APBA), Autism Speaks, and Council of Autism Service Providers (CASP) for policy language and best practice standards in the provision of ABA for autism spectrum disorder (ASD).

Lastly, this policy updates BHT provider qualifications to include licensure requirements as approved by the Michigan Legislature in 2018 (Public Act 403 of 2016, MCL - Section 333-18251) and diagnostic re-evaluation requirements as approved by the Michigan Legislature in 2021 (Public Act 111 of 2021, MCL - Section 400.109n).

I. Behavioral Health Treatment Services/Applied Behavior Analysis

The Centers for Medicare & Medicaid Services (CMS) defines medical necessity as healthcare services or supplies that are needed to diagnose or treat an illness or injury, condition, disease or its symptoms. The Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides a comprehensive array of prevention, diagnostic, and treatment services for eligible infants, children, and adolescents under age 21, as specified in Section 1905(a) and 1905(r) [42 USC 1396d] of the Social Security Act

(1967), to correct or ameliorate defects and physical and mental illnesses and conditions discovered whether or not such services are covered under the State Plan. The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to ensure early detection and care so that a child's health problems are averted or diagnosed and treated as early as possible.

A. Screening

Screening for potential ASD is a critical component and first step in the treatment of ASD.

The primary care provider (PCP) performs initial screening in EPSDT visits or any time concerns are raised in any type of visit. If screening indicates that the beneficiary needs further specialized evaluation, the PCP will either perform the diagnostic evaluation, refer to a diagnosing provider, or refer to the beneficiary's Prepaid Inpatient Health Plan (PIHP). Screening can also occur at the PIHP or Community Mental Health Services Program (CMHSP) or when concerns are noted by a parent/legal guardian, caregiver or teacher.

No prior authorization is required for screening.

B. Referral

If a child's screen requires further evaluation, the PCP or parent/legal guardian may contact the beneficiary's PIHP in coordinating a referral to:

- a qualified practitioner for a comprehensive diagnostic evaluation; and/or
- an initial behavior assessment and treatment plan development by a qualified licensed practitioner.

The PIHP is responsible for the comprehensive diagnostic evaluation (if ASD is not already diagnosed), behavioral assessment, BHT services (including ABA), and for the related EPSDT medically necessary Mental Health Specialty services. Beneficiaries deemed ineligible for PIHP enrollment can be referred to the Medicaid Health Plan (MHP) or Medicaid Fee-For-Service (FFS).

C. Comprehensive Diagnostic Evaluations

Diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified practitioner includes:

- A physician with a specialty in psychiatry or neurology;
- A physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics, or a related discipline;

- A physician with a specialty in pediatrics or other appropriate specialty with training, experience, or expertise in ASD and/or behavioral health;
- A psychologist with training, experience, or expertise in ASD and/or behavioral health;
- An advanced practice registered nurse (APRN) with training, experience, or expertise in ASD and/or behavioral health;
- A physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
- A master's level, fully licensed clinical social worker working within their scope of practice, and qualified and experienced in diagnosing ASD.

Qualified and experienced in diagnosing ASD is defined by:

- A minimum of two years diagnosing developmental disorders, such as ASD; and
- A minimum of one year of didactic learning under the supervision of a practitioner specializing in diagnosis and treatment of children with complex neurological conditions; and/or
- Participation in a collaborative team model with a neuropsychologist or other qualified and experienced providers.

The diagnosing provider will perform a diagnostic evaluation of the beneficiary's behavior and development. Diverse presentations of ASD require that each evaluation be individualized and address the variations from one beneficiary to another. Practitioners are expected to use evidence-based assessments to evaluate the beneficiary's specific needs.

If behavioral supports are recommended, the diagnosing provider will refer beneficiaries diagnosed with ASD to the PIHP for a referral to a licensed behavior analyst for behavioral assessment and treatment plan development.

If the beneficiary does not meet any of the current diagnostic criteria for ASD and does not qualify for PIHP enrollment, the diagnosing provider shall refer the beneficiary to the MHP to assist with medically necessary treatment as needed.

D. Medical Necessity Criteria

CMS defines medical necessity as healthcare services or supplies that are needed to diagnose or treat an illness or injury, condition, disease, or its symptoms. Medical necessity and recommendation for BHT services are determined by a physician or other qualified licensed practitioner working within their scope of practice under state law and based on individual need.

Diagnostic re-evaluations for ASD are not required unless determined medically necessary by a physician, other qualified licensed practitioner or when requested by the beneficiary's family or legal guardian (Public Act 111 of 2021, MCL - Section 400.109n).

E. Determination of Eligibility for BHT

To be eligible for BHT services, the following criteria must be met:

- Medicaid beneficiary;
- Under 21 years of age;
- Diagnosis of ASD (i.e., all levels of severity) by a qualified licensed practitioner;
- Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning;
- BHT services are recommended by a qualified licensed practitioner;
- Services are medically necessary to ameliorate symptoms, build adaptive behaviors, and/or reduce maladaptive behaviors to enhance the beneficiary's health, safety, and overall functioning and/or to prevent deterioration or regression;
- Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services; and
- Services can be provided in the beneficiary's home, community (i.e., centers or clinics), or school.

II. BHT Services

A. BHT Services Provider Qualifications

Licensed behavioral health practitioners are available within PIHP provider networks and include:

- Board-certified and licensed behavior analyst (BCBA/LBA or BCBA-D/LBA)
- Board-certified and licensed assistant behavior analyst (BCaBA/LABA) under the supervision of a LBA
- Licensed psychologist (LP/LLP) with extensive knowledge, experience and training in applied behavior analysis. Extensive knowledge, experience and training is defined as:
 - A minimum of two years working directly with individuals diagnosed with ASD;
 - Completion of a minimum of three of the Behavior Analyst Certification Board (BACB) required academic courses; and
 - One year experience developing behavior treatment plans (BTPs) based on ABA.
- Registered behavior technician (RBT) or behavior technician (BT) under the supervision of an LBA or LABA

BHT services must be provided under the direction of an LBA. These services must be provided directly to, or on behalf of, the beneficiary by training their parents/legal guardians, BTs, and LABAs to deliver the behavioral interventions. The LBA is also responsible for communicating progress on goals to parents/legal guardians minimally

every three to six months; clinical skill development and supervision of LABAs and BTs; and collaborating with support coordinators/case managers and the parents/legal guardians on goals and objectives with participating in development of the individual plan of service (IPOS) that includes the behavioral plan of care.

B. Behavioral Assessment

The initial behavioral assessment and development of the behavioral plan of care shall be performed by any one of the following licensed behavioral health providers:

- Board-certified and licensed behavior analyst (BCBA/LBA or BCBA-D/LBA)
- Board-certified and licensed assistant behavior analyst (BCaBA/LABA) under the supervision of an LBA
- Licensed psychologist (LP/LLP) with extensive knowledge, experience and training in ABA working in conjunction with an LBA

Assessment and formulation of behavior treatment goals will be consistent with current, evidence-based, generally accepted standards of ABA. The assessment will include, but not be limited to, gathering information from the following sources:

- Record review
- Interviews with multiple family members, including siblings, and other community caregivers;
- Rating scales (adaptive-behavior assessments, functional assessments, etc.);
- Direct assessment and observation in different settings and situations; and
- Assessment from other professionals, as needed.

The behavioral health provider will submit the assessment and behavioral plan of care to the PIHP or CMHSP for prior authorization before treatment begins. All behavior plans will:

- a. Follow current, evidence-based, generally accepted standards for ABA;
- b. Measure each plan goal using a standardized measurement system that may include Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) or Assessment of Basic Language and Learning Skills, Revised (ABLLS-R);
- c. Provide an anticipated timeline and treatment hours needed to achieve each goal based on both the initial assessment and subsequent re-evaluations over the duration of the intervention; and
- d. Document that services will be delivered by a behavioral health provider who is licensed to provide ABA services in Michigan.

C. Behavioral Intervention

The PIHP will issue a prior authorization for ABA when it determines ABA is medically necessary and recommended by a licensed behavioral health provider. All behavior plans shall include the goals and associated settings/locations where services will be delivered. Beneficiaries may receive ABA services in settings/locations that address areas of need and maximize treatment outcomes. Locations include, but are not limited to, a clinic, beneficiary's home, school, residential or other community settings. Behavioral health providers and their treatment team can include:

- BCBA/LBA;
- LABA (supervised by an LBA);
- LP/LLP; or
- RBT/BT (supervised by a LABA or LBA).

Individual-specific behavioral plan of care and interim progress assessments follow current, evidence-based, generally accepted standards for ABA. The PIHP shall require documented progress as follows:

- a. Interim progress assessment is submitted at least every six months based on clinical progress toward treatment plan goals;
- b. Measure progress towards each BTP goal using a standardized measurement system that may include VB-MAPP or ABLLS-R;
- c. Provide an anticipated timeline and treatment hours needed for achievement of the goal based on both the initial assessment and subsequent re-evaluations over the duration of the intervention; and
- d. Document that services are delivered by a qualified behavioral health provider who is licensed to practice ABA in Michigan.

Note: Interim progress assessments may be required by the PIHP more often than every six months when warranted by individual circumstances.

III. BHT Service Level

1. **Focused ABA treatment.** This refers to treatment provided directly to the beneficiary for a limited number of behavioral targets. It is not restricted by age, cognitive level, diagnosis, or co-occurring conditions. Focused ABA treatment may aim primarily to increase adaptive behaviors (e.g., communication, social initiations), reduce problem behaviors (e.g., elopement, aggression), or both. When reduction of problem behaviors is the primary goal, it is critical to also target increases in alternative adaptive behavior because the absence of adaptive behavior is often the precursor to serious behavior disorders. Therefore, focused ABA treatments are also appropriate for beneficiaries who need to acquire adaptive skills (e.g., communication, tolerating change in environments and activities, self-help, social). Focused ABA treatment plans are appropriate for beneficiaries who (a) need treatment only to develop a limited number of key functional

skills, or (b) have such risky problem behavior that its treatment should be the priority. In prioritizing treatment targets, the following should be considered:

- Behavior that threatens the health or safety of the beneficiary or others or that constitutes a barrier to quality of life (e.g., severe aggression, self-injury, property destruction, or elopement).
- Absence of adaptive, social, or functional skills that are fundamental to health, safety, social inclusion, and independence (e.g., toileting, dressing, feeding, and compliance with medical procedures).

2. Comprehensive ABA treatment. In this model, behaviors in multiple affected domains (cognitive, communicative, social, self-care, leisure, etc.) are targeted for treatment, often along with maladaptive behaviors such as tantrums, elopement, pica, self-injury, and stereotypy. Comprehensive treatment may also be appropriate for beneficiaries who engage in harmful and risky behaviors and/or have substantial deficits in adaptive skills that jeopardize their health and safety. Treatment may be 1:1 initially, with gradual transitions to small group formats as appropriate. Initially, treatment may be provided primarily in structured sessions, but more naturalistic methods are also used as appropriate. As the beneficiary progresses and meets criteria, treatments may be provided in multiple different settings.

3. Variations in treatment models. ABA treatment programs vary along several dimensions, including intensity and duration. Other variations include the extent to which peers or caregivers are involved in the delivery of treatment. Decisions about how those and other dimensions are incorporated within individual treatment plans must reflect many variables, including the research evidence, beneficiary age and functional levels, characteristics of target behaviors, the beneficiary's rate of progress, caregiver circumstances and skills, and resources required to implement the treatment plan across settings.

IV. BHT Service Evaluation

As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement. BCBAs/LBAs and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the beneficiary's response to treatment and skill acquisition.

V. Transition and Discharge Criteria

The desired BHT goals and outcomes and criteria for discharge should be specified at the initiation of services, monitored throughout the duration of service implementation, and refined when appropriate. Discharge and transition planning should involve family members, other caregivers, and other professionals who serve the beneficiary in development of a behavioral plan of care that specifies monitoring and follow-up procedures as appropriate for the beneficiary and their caregivers. The behavior plan should also include clear descriptions of the roles and responsibilities of all providers and

caregivers, as well as criteria and target dates for treatment goals that must be achieved prior to the next phase. Discharge should generally involve a gradual step-down in services and cannot be based on a set timeline (e.g., one year, three years, etc.).

Treatment might occur in multiple settings (e.g., home, community, and school) on the same day. Treatment should not be denied or withheld based on caregiver availability. To ensure continuity of care and maintenance of gains after discharge from formal treatment, ABA services should not be delivered in subsequent settings (e.g., residence to school, clinic to home).

Discharge from BHT services should be reviewed and evaluated by the LBA, in consultation with the treatment team, for beneficiaries who meet any of the following criteria:

- The beneficiary is either no longer eligible for Medicaid or a state of Michigan resident;
- The beneficiary, parent/legal guardian is interested in discontinuing services;
- The beneficiary has not demonstrated measurable improvement and progress toward goals as documented by the LBA;
- The parent/legal guardian and provider are unable to reconcile differences regarding treatment planning and delivery; or
- Treatment goals have been achieved, and less intensive modes of services are appropriate (i.e., peer-delivered or –operated support services, wraparound services, parent education, home-based services, targeted case management/support and service coordination, Community Living Supports, BHT, home and community-based services, family support and training, skill building assistance, supported/integrated employment services, dental).

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 800-292-2550. Atypical Providers may phone toll-free 800-979-4662.

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >>
Policy, Letters & Forms.

Approved

A handwritten signature in dark ink, reading "Meghan E. Groen". The signature is fluid and cursive, with the first name "Meghan" and last name "Groen" clearly legible.

Meghan E. Groen, Chief Deputy Director
Health Services