Autism, Advocacy, and Intervention

Achieving Milestones

Document Navigation Guide

This document presents clinical evidence, utilization data, family impact, and policy analysis related to Vermont Medicaid's 2026 Applied Behavior Analysis (ABA) policy changes.

Readers may reference the sections below based on area of interest:

Statement of Concern

The policy changes implemented by the Department of Vermont Health Access (DVHA) on January 1, 2026 raise serious concerns regarding the rigor, quality, and integrity of the interpretive process that led to their adoption. The DIVA review and resulting policy outcome reflect selective interpretation, insufficient engagement with established clinical guidance, and a failure to meaningfully incorporate outcome data, provider expertise, and family impact into decision-making.

These changes were enacted despite extensive, well-documented guidance from national professional organizations—including the Council of Autism Service Providers (CASP)—and despite a substantial body of peer-reviewed literature supporting both telehealth service delivery and concurrent clinician program modification as best practice when applied with appropriate safeguards.

In the weeks following implementation, agencies across Vermont have already reported destabilization, service disruption, and early program failure. The speed and severity of these impacts strongly suggest the policy was not stress-tested against real-world delivery models, workforce structures, or continuity-of-care requirements. The consequences are not theoretical; they are occurring in real time.

Most critically, autistic children and their families are bearing the impact. Families who were receiving authorized, clinically appropriate, and demonstrably effective services are now facing abrupt disruption through no fault of their own. For many, telehealth and real-time clinician involvement during treatment were not conveniences, but essential components of effective care. The removal of these options places families at risk of losing meaningful access altogether.

The prohibition on concurrent billing of CPT codes 97153 (direct treatment) and 97155 (clinician program modification) reflects a fundamental misunderstanding of Applied Behavior Analysis (ABA) service delivery and established best practice. These services represent distinct, medically necessary roles performed by different providers. Treating them as duplicative contradicts the CPT framework, CASP guidance, and ABA Coding Coalition standards.

Taken together, the telehealth restrictions and concurrency prohibition reflect a pattern of decision-making driven more by fear of external scrutiny than by evidence-based policy. The selective citation of guidance, disregard for comprehensive professional standards, and lack of post-implementation review suggest a process conducted without sufficient transparency, collaboration, or quality assurance.

We respectfully urge Vermont's policymakers to recognize the urgency of this moment. Agencies are destabilizing, workforces are at risk, and families are losing access to care that was demonstrably effective. A pause, reassessment, and collaborative correction are necessary to restore evidence-based practice, protect the workforce, and ensure that autistic children and their families are not collateral damage of a flawed and inadequately vetted policy decision.

Introduction to Autism, Advocacy, and Intervention (AAI)

Autism, Advocacy, and Intervention (AAI) is a Vermont-based provider of Applied Behavior Analysis (ABA) services, delivering care through in-home, clinic-based, and telehealth models. We have served Vermont families for over six years and have provided ABA services nationally for more than a decade. Currently, AAI supports more than 70 Medicaid-funded autistic children and their families in Vermont.

AAI has implemented ABA via telehealth (in addition to our clinics, in-person service and school contracts) with rigor and accountability for over ten years. As early as 2015, AAI presented objective telehealth outcomes to public funding sources outside Vermont, including California Medicaid and Regional Centers. When COVID-era restrictions emerged, AAI did not need to rapidly construct telehealth infrastructure; we were already operating under established clinical guardrails, quality controls, and outcome-tracking systems.

For the past six years, AAI intentionally developed a Vermont-specific telehealth division (in addition to our clinic in Rutland and in-person services throughout the state) in direct compliance with Vermont Medicaid policy as it existed at the time. This infrastructure expanded access, supported workforce stability, and ensured continuity of care for families across Vermont's rural and underserved regions. Telehealth, when used appropriately, is not a shortcut—it is a structured, evidence-supported modality that can strengthen outcomes for many children.

AAI submits this statement to provide objective data, clinical context, and family-reported impact regarding DVHA's 2026 ABA policy changes. Our intent is not only to describe organizational impact, but to document system-level consequences affecting access, workforce sustainability, and continuity of care for autistic children and families across Vermont.

Key Concerns at a Glance

1. Telehealth is a Valid and Essential Modality: Telehealth should not be treated as a "less-than" or inherently inferior service model. When used appropriately, ABA therapy delivered via live videoconferencing can be just as effective as in-person services. Outcomes data from AAI and others show strong skill gains and goal mastery via telehealth, with many children meeting or exceeding expected benchmarks. Telehealth should remain an available option in Vermont's ABA program – especially given our rural geography – rather than being categorically restricted.

2. Family Choice and Clinical Appropriateness: For many autistic individuals, the telehealth format is not just a convenience – it can be integral to their engagement and learning. Some families explicitly prefer telehealth over in-home or clinic sessions for reasons including privacy, comfort, past negative experiences in other settings, scheduling flexibility, or the child's unique sensory needs. When a child is clearly thriving with tele-ABA (with data showing progress), it is not in the family's or child's interest to force a change to in-person only. Policy should avoid a one-size-fits-all mandate that ignores individual circumstances and informed family choice. Vermont should adopt a readiness-based approach: telehealth

should be used only when the family and child demonstrate the necessary baseline skills, technology access, safety supports, and caregiver capacity to make it clinically appropriate.

3. Misinterpretation of ABA Guidelines: DVHA's justification for these changes appears to rest on a misreading of professional guidelines and coding standards. In particular, DVHA has redefined the term "face-to-face" to mean physical presence, and on that basis disallowed telehealth for core ABA treatment codes (97151, 97153, 97154, 97158, etc.). However, in ABA coding contexts "face-to-face" simply means the clinician and client are directly interacting (as opposed to doing paperwork) – it does not require physical co-location. The very source DVHA cites – the Council of Autism Service Providers (CASP) Telehealth Practice Parameters (2nd Edition) – explicitly includes synchronous videoconferencing as an appropriate service delivery modality for codes 97151 (assessment), 97153 (1:1 therapy), 97154 (group therapy), 97155 (program modification), and so on, when clinically appropriate. In other words, national ABA standards do not ban telehealth for these codes; on the contrary, they provide guidance on how to do it safely and effectively. We are concerned that DVHA's selective quoting of CASP guidance ignores the full context of the document and its extensive research citations supporting telehealth's clinical role. Similarly, DVHA's prohibition on concurrent billing of 97153 and 97155 relies on a narrowly interpreted AMA coding Q&A, whereas the AMA's own CPT codebook contains no such blanket prohibition – and an AMA CPT Assistant publication (Nov. 2018), CASP guidance, and ABA Coding Coalition guidance describe concurrent 97153/97155 as appropriate when two distinct providers are delivering two distinct medically necessary services.

4. Consequences of the Policy Changes: The telehealth restrictions and concurrent billing prohibition are already producing harm. Providers are being forced to cut off telehealth options that were working well, disrupting care for children who adapted to and thrived in structured virtual sessions. Families who cannot easily accommodate in-person care (due to work schedules, transportation barriers, housing barriers, or a child's comfort and safety needs) are experiencing service reductions or risk losing services altogether. The concurrent billing prohibition undermines efficient, high-quality care: providers will be forced into unacceptable choices where either the technician's direct treatment time or the clinician's program modification time goes unbilled. This creates serious downstream risk: agencies may reduce clinician program modification contact, stretch caseloads beyond clinical best practice to manage revenue loss, or exit Vermont Medicaid entirely.

We expand on these points and offer recommendations below, backed by clinical data and family input.

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Background: DVHA's 2026 Policy Changes
Effective January 1, 2026, DVHA changed how ABA services can be delivered and reimbursed under Vermont Medicaid. Two major changes are at issue:

1. Telehealth Restrictions: Under the policy, only three ABA billing codes (97155 – clinician protocol modification, 97156 – parent training, and 97157 – multi-family group training) remain eligible for telehealth reimbursement. Direct treatment codes like 97153 and group treatment (97154, 97158), as well as the initial behavior assessment (97151), are no longer allowed via telehealth. In practice, this eliminates live video ABA sessions for core treatment and assessment activities that families previously relied on. DVHA has stated in an FAQ that their "face-to-face policy for ABA is being physically in person" for these treatment codes – a major shift from the prior policy framework.

2. Prohibition on Concurrent Billing (97153/97155): DVHA also prohibits billing 97155 when 97153 is occurring at the same time. Yet these codes represent clinically different work performed by different providers. The technician implements treatment protocols with the child (97153). The clinician performs program modification and clinical decision-making (97155), which is often most effective when it occurs during active treatment.

DVHA has indicated these changes are intended to align with federal guidance and to preempt Medicaid audit findings. We acknowledge program integrity matters. However, our position is that these restrictions go beyond federal requirements, conflict with established clinical practice guidelines, and—based on what we are seeing in the field—are already undermining quality and access.

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Telehealth in ABA: Clinical Rationale and Outcomes

Telehealth ABA services involve delivering therapy through live videoconferencing, the behavior technician or behavior analyst engaging the child via camera and microphone, and a caregiver or another adult present with the child to assist as needed. Telehealth is not appropriate for every child or situation—we carefully evaluate each case for readiness—but when it is a good fit, telehealth can improve access, maintain treatment fidelity, and offer unique clinical advantages.

• Engagement and Comfort: Some children on the autism spectrum respond better in a telehealth format. Being in their own environment, without the intrusion of a physically present therapist, can reduce anxiety and challenging behaviors for certain learners. Families should have the dignity of choosing the setting where their child learns best, rather than being forced into a blanket mandate. CASP and the ABA Coding Coalition recognize telehealth, when clinically appropriate and delivered with guardrails, as compatible with the ABA code set, including assessment, direct treatment, group treatment, program modification, and caregiver training codes. Vermont should align with the full body of guidance rather than selectively quoting isolated phrases.

• Group Services and Peer Access: Telehealth is also an exceptional tool for group-based ABA services when clinically appropriate. Many autistic individuals in Vermont lack access to structured peer interaction due to geography and transportation barriers. Group treatment codes exist because social learning often requires peer contexts. Telehealth can create structured, clinician-led group environments for learners who otherwise have no access to such experiences. Removing telehealth from group treatment codes unnecessarily reduces access and clinical options.

• Clinical Effectiveness: AAI tracks objective outcomes for all clients, allowing comparison across service modalities. Our data show telehealth can achieve outcomes on par with in-person therapy when implemented under the right conditions. Internal data mapping monthly goal mastery percentages showed averages in the 80%+ range of objectives met at 6-month review points, with telehealth clients achieving comparable progress to in-person (attached).

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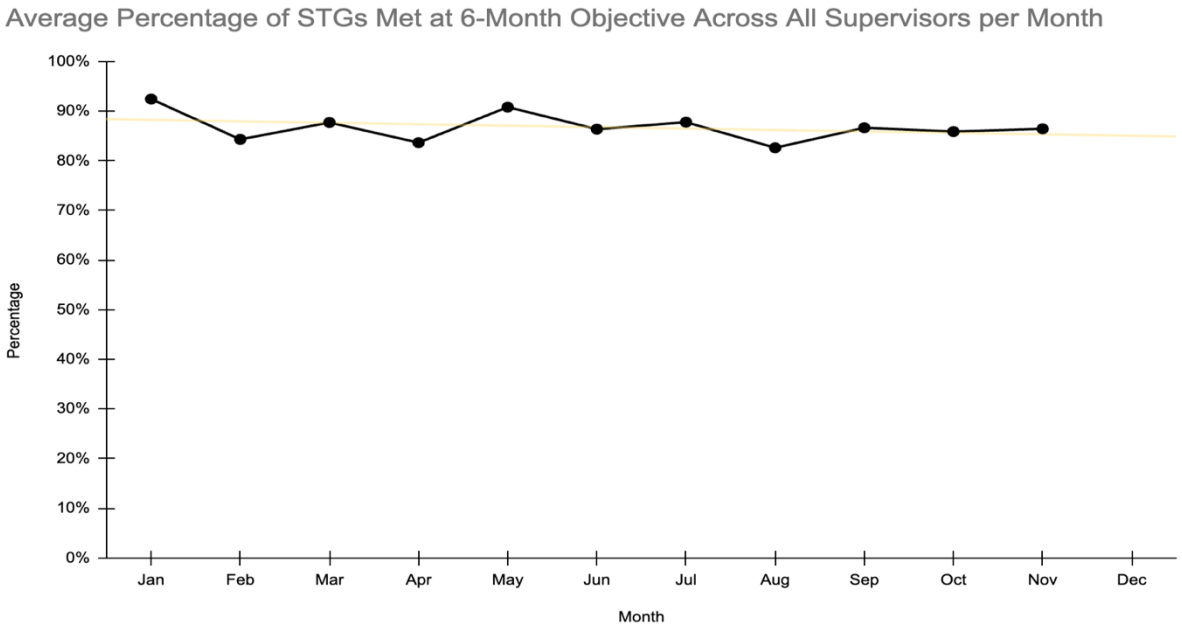
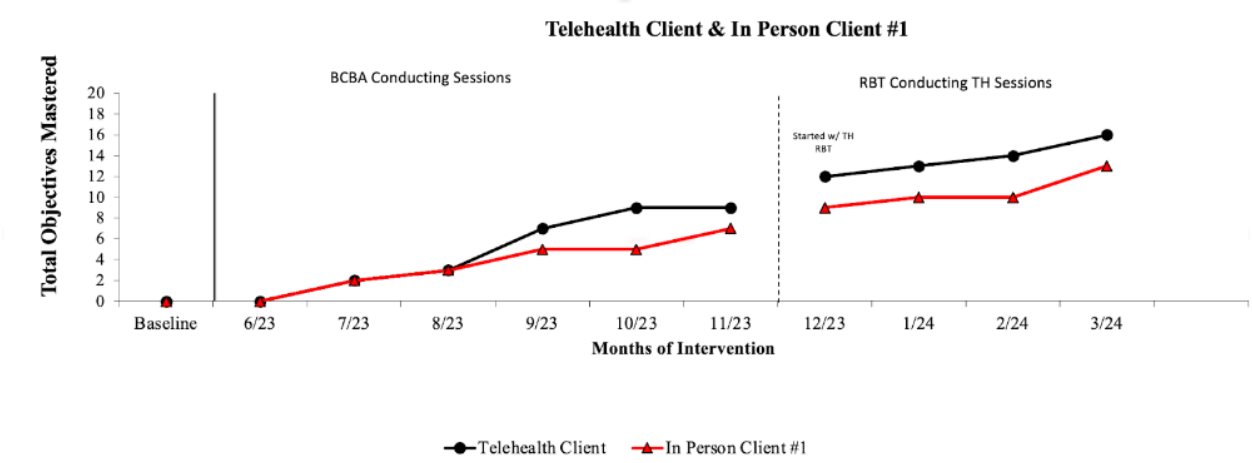
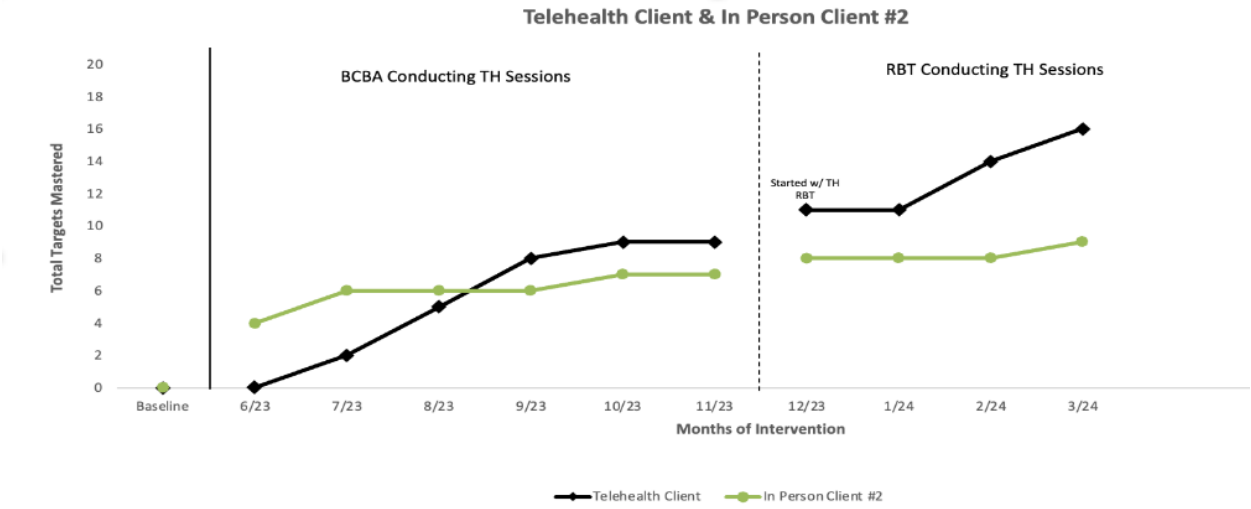


We also conducted controlled case comparisons in 2023/2024 matching clients by age and baseline skill level; after nine months, both telehealth and in-person clients demonstrated desirable objective mastery. This aligns with broader literature: clinical appropriateness and guardrails—not modality alone—drive outcomes. (attached)




Telehealth Client & In Person Client #2
BCBA Conducting TH Sessions
RBT Conducting TH Sessions
Started w/ TH RBT
Total Targets Mastered
20
18
16
14
12
10
8
6
4
2
0
Baseline
6/23
7/23
8/23
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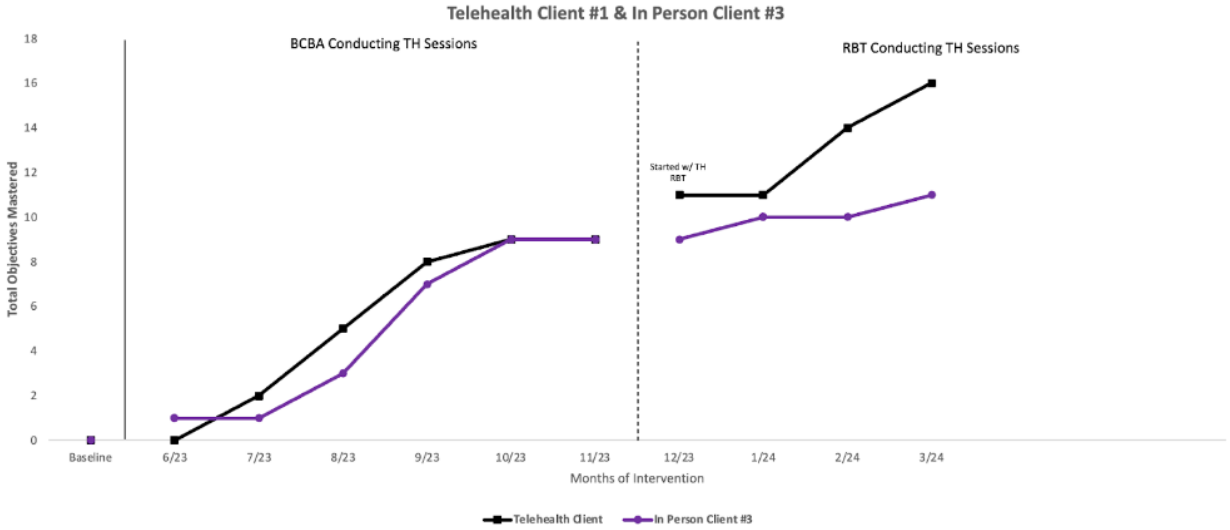
11/23
12/23
1/24
2/24
3/24
Months of Intervention
Telehealth Client
In Person Client #2


Telehealth Client #1 & In Person Client #3
BCBA Conducting TH Sessions
RBT Conducting TH Sessions
Started w/ TH RBT
Total Objectives Mastered
18
16
14
12
10
8
6
4
2
0
Baseline
6/23
7/23
8/23
9/23
10/23
11/23
12/23
1/24
2/24
3/24
Months of Intervention
Telehealth Client
In Person Client #3

Concurrent Billing of 97153 and 97155: Why It's Clinically Important

The prohibition on billing 97155 when 97153 is occurring misunderstands how ABA is delivered and what these codes represent.

A typical ABA session involves a behavior technician implementing protocols with a child (97153) while a BCBA is observing and performing clinician-level program modification and clinical decision-making (97155). The BCBA's role includes adjusting teaching procedures, modifying behavior plans based on real-time responding, ensuring treatment fidelity, and coaching the technician. These are distinct, medically necessary services delivered by different providers. They are complementary, not duplicative.

The AMA's CPT framework was built to reflect this model. The November 2018 CPT Assistant describes 97155 as intended to be reported when a qualified health care professional is directing a technician implementing the protocol. CASP guidance similarly describes concurrent reporting when a clinician is engaged in active program modification during technician-led treatment.

DVHA's position relies in part on a CPT Knowledge Base entry (#7744). It is important to note that the CPT Knowledge Base itself is interpretive guidance and is not the controlling authority over the CPT codebook and official AMA publications. DVHA should not treat a single interpretive entry as higher authority than the published materials and full-body guidance supporting clinically appropriate concurrency.

If concurrency remains prohibited, providers will be forced into harmful operational choices: reduce real-time program modification during sessions, ask clinicians to work unpaid, fragment services into less efficient formats, or exit Medicaid. The early impact after January 1, 2026 suggests this is already destabilizing workforce capacity and agency viability.

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Concerns with DVHA's Approach

We have deep concerns not only with the policy content, but with DVHA's process and lack of responsiveness to real-world impacts since implementation.

• Lack of Collaboration: **Providers and families were not** engaged prior to implementation. On February 6, 2026, DVHA stated publicly that they collaborated with agencies in developing these changes; however, no providers nor any families, to our knowledge, have not been able to confirm that any collaboration occurred.

• Lack of Transparency and Justification: DVHA has not publicly shared a Vermont-specific analysis justifying the breadth of restrictions. If the concern is program integrity or federal scrutiny, Vermont

can address that directly through stronger documentation standards and more rigorous clinical audits—without eliminating effective modalities.

• Lack of Follow-Up Since Implementation: It has been just over one month since these changes took effect, and agencies are already reporting severe harm, including program closures, Medicaid exits, and workforce instability. Yet DVHA has not reached out to providers to evaluate impact, ask how service delivery has been affected, or collaborate on mitigation. At this point, the evidence providers have observed is that DVHA is not interested in listening. That is why many of us have not attempted to re-engage through informal outreach; the policy was implemented despite extensive professional feedback, and providers reasonably believe additional data and concerns will be dismissed.

• Federal Pressure and the Big Beautiful Bill: Providers are concerned DVHA is reacting to heightened federal Medicaid scrutiny connected to the Big Beautiful Bill and attempting to "solve" scrutiny by restricting best practice. If federal pressure is a driver, that should be addressed transparently and collaboratively—rather than through interpretations that contradict published ABA practice guidance and destabilize care. AAI asked DVHA frontline rep twice, "Is there any concern that this bill will impact ABA proved?" Anwser, "No". AAI is not the only agency reporting that they too asked the same question and received the same response.

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AAI Telehealth Utilization Data Demonstrating Historical Reliance and Policy Impact

To provide historical context regarding the real-world use of telehealth ABA services in Vermont, Autism, Advocacy, and Intervention (AAI) submits the following utilization data from calendar year 2025.

In 2025, AAI delivered a total of 9,923.25 ABA service hours to Vermont Medicaid members. Of these:

• 761.72 hours were provided via telehealth for ABA assessment services (CPT 97151). These services are no longer permitted via telehealth as of January 1, 2026.

• 324.77 hours were delivered as direct ABA therapy (CPT 97153) via telehealth. These services are no longer permitted via telehealth as of January 1, 2026.

• 1,896.44 hours were provided as clinician program modification (CPT 97155) via telehealth, delivered concurrently with active treatment. These hours reflect only telehealth-based program modification and were provided either to clients receiving telehealth direct treatment or to clients receiving in-home direct treatment (97153). Concurrent billing is now restricted under the new policy.

• 1,100.36 hours were delivered as caregiver/parent training via telehealth. These services remain permitted.

Total telehealth-delivered ABA services in 2025 equaled 4,083.29 hours, representing 41.15% of all ABA services delivered by AAI to Vermont Medicaid members that year.

Of those telehealth hours, 2,982.93 hours—including telehealth assessment (97151), telehealth direct treatment (97153), and telehealth-delivered concurrent program modification (97155)—are restricted or eliminated under the policy effective January 1, 2026. This represents 73.05% of all telehealth ABA services and 30.05% of AAI's total annual ABA service delivery.

As a result, 41.15% of all ABA services historically delivered by AAI are now at severe risk. Over the past ten years, AAI intentionally developed a dedicated telehealth division to expand access, maintain clinical quality, and comply with evolving Medicaid requirements. For the past six years, this infrastructure has been specifically designed to support the Vermont autistic community in compliance with Vermont Medicaid policies in effect at the time.

With the January 1, 2026 policy changes, this telehealth infrastructure has effectively been removed. The loss of these services equates to an estimated 41.15% reduction in annual revenue, creating immediate and significant risk to organizational stability. This includes the potential loss of employment for clinicians, technicians, and administrative staff; the loss of sustained professional development opportunities within the state; and the destabilization of a workforce that AAI has intentionally built, trained, and retained in Vermont over many years.

The impact extends directly to families. AAI currently serves more than 70 autistic individuals across Vermont. Based on historical service utilization, approximately 41.15% of those individuals and

families are now at severe risk of losing services that were previously authorized, effective, and compliant with Medicaid policy. Families have already been informed that their current service models may be disrupted or discontinued due to policy changes beyond the provider's control.

This level of disruption is not gradual or theoretical. It represents an immediate and measurable destabilization of care delivery, workforce sustainability, and family support systems across the state.

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Recommendations and Path Forward

We respectfully offer the following recommendations to preserve effective ABA practices while meeting oversight needs:

1. Allow Telehealth for ABA Codes with Clear Criteria: Vermont Medicaid should recognize telehealth (synchronous videoconference) as eligible for core ABA service codes when clinically appropriate, including 97151, 97153, 97154, 97155, 97156, 97157, and 97158. Telehealth should be permitted when readiness criteria are met: clinical appropriateness, informed consent, safety planning, and reliable technology, with a caregiver present when required. DVHA has repeatedly stated it trusts provider clinical judgment; that trust must be reflected in policy.

2. Permit Concurrent 97153/97155 with Documentation Standards: Allow concurrent billing when a technician implements treatment and a clinician performs active program modification and clinical decision-making. Require documentation distinguishing each provider's role and audit for compliance. This protects integrity without undermining best practice.

3. Program Integrity through Clinical Quality Auditing: If DVHA's concern is fraud or compliance, the solution is audit rigor. Current audit practices often focus on limited paperwork checks (e.g., diagnosis, prescription, session note presence) rather than evaluating clinical rigor, individualization, outcome data, acquisition rates, medically necessary utilization patterns, or cookie-cutter program recommendations. Strengthen audits to evaluate quality and outcomes instead of removing clinically effective tools.

4. Center Family Choice and Continuity of Care: Policies must protect families from abrupt modality disruption when telehealth is clinically effective. Family choice, informed consent, and continuity of care should be explicit policy principles.

Parent Satisfaction Survey Summary

AAI conducted a parent satisfaction survey in July 2025 to assess family experience, service quality, communication, and overall satisfaction with ABA services.

Overall, the results demonstrate exceptionally high satisfaction across all measured domains, with consistent positive feedback regarding clinical quality, staff professionalism, communication, and service delivery models, including telehealth.

1. Overall Satisfaction

- 100% of respondents rated their overall satisfaction with AAI services at the highest level (5 out of 5).
- 100% of respondents indicated they would recommend AAI's services to another family in need.
    - Average score 4.96 out of 5.0

2. Service Delivery Preferences

- Families expressed satisfaction with their current ABA therapy hours, with a smaller subset requesting increased hours, indicating unmet demand rather than dissatisfaction.
- A substantial portion of families reported preference for:
    - Continued telehealth services, or
    - Hybrid models combining telehealth and in-person services

3. Clinical Quality & Staff Performance

Parents rated clinical staff extremely highly:

- Behavior Technicians (RBTs) were consistently rated as:
    - Knowledgeable
    - Well-prepared
    - Engaging and motivating
    - Able to make sessions fun, naturalistic, and effective
- Program Supervisors (BCBAs) received near-universal top ratings for:
    - Clinical knowledge
    - Teaching caregivers and technicians
    - Providing meaningful supervision
    - Being approachable and supportive
        - Average score 4.8 out of 5.0

4. Family Engagement & Communication

- Parents overwhelmingly agreed that:
    - Their input is considered in treatment planning
    - They receive regular updates on progress

    - Data and graphs are shared to demonstrate outcomes
        - Average score 4.88 out of 5.0

This reflects strong adherence to family-centered, data-driven ABA practices.

5. Administrative Support

- 100% of respondents indicated they:
    - Understand who to contact for scheduling and cancellations
    - Find schedulers accessible and responsive
    - Understand billing, insurance, and financial processes
    - Find administrative staff professional and ethical

6. Professionalism & Ethics

- 100% of respondents affirmed that AAI staff are professional and ethical, indicating high organizational trust and credibility.

7. Qualitative Feedback

Open-ended comments were limited but uniformly positive. One representative comment stated:

"I love our AAI TEAM! They have all been extremely supportive…"

Several respondents volunteered contact information for follow-up feedback, signaling strong engagement and willingness to collaborate.

Summary Conclusion

The July 2025 Parent Satisfaction Survey demonstrates that:

- Families report exceptional satisfaction with AAI services
- Telehealth and hybrid service models are highly valued
- Clinical quality, communication, and professionalism are organizational strengths
- Demand for services exceeds availability, with some families requesting increased hours

These findings provide strong, data-supported evidence that AAI's service delivery model—including telehealth—is effective, trusted by families, and aligned with best clinical practices.

Statements From Families Responding to DVAH 1/1/2026 Policy

1.

My name is X. I received an email from Brian Marrier, and he said you were interested in hearing from parents in regard to the changes that VT Medicaid is proposing to make to ABA therapy.

A little about us, I'm 35, I run a small business in Rutland, and I am the primary caregiver for my amazing five-year-old son, Al, who is nonverbal and diagnosed with Level 3 Autism Spectrum Disorder. He requires a high level of support in nearly every aspect of his daily life.

Al's father is chronically ill and is only able to participate in caregiver education sessions via Telehealth. If access to these appointments were restricted, he would not be able to participate in Al's treatment to the extent that he does now. ABA therapy is not only for the children—it is for the parents as well. While our children are learning how to navigate the world and live their best lives, parents are learning how to support, advocate for, and raise a child with autism.

Since beginning ABA therapy through AAI, Alex has made significant progress—reaching milestones that once felt unattainable. One of the most meaningful examples is potty training. Al was still in pull-ups at four and a half, and I didn't know what his toileting future would look like. However, after just five months of consistent ABA therapy and a cohesive care plan—one that would not have been possible without telehealth—Alex is now fully potty trained and continuing to gain independence in caring for himself.

These kinds of outcomes are exactly why ABA therapy is so critical. Restricting access to this therapy would have serious, long-term consequences for children like Al and for families across Vermont. Autism impacts the entire family, and the quality and consistency of therapy a child receives can fundamentally shape not only that child's quality of life, but the future of their entire household.

I would be more than happy to share more of our experience and how ABA therapy has fundamentally shaped my son's ability to communicate, learn, and care for himself. I'm open to writing something more detailed or scheduling a call—please let me know what would be most helpful, or if there are any specific questions you'd like me to address.

Thank you for covering this issue and for taking the time to hear from families directly affected.

Thanks for your time,

2.

Dear Brian,

I wanted to send this to you as this is what I've sent to both the Medicaid email that you gave last week but I'm also forwarding to WCAX and thought you deserved to see what you guys truly mean to me and my family and I truly hope we can get this reversed/stopped in its tracks I truly appreciate the transparency and effort you and everyone in the team is doing we see all that you do it is noticed

Dear Medicaid Policy Team,

I am the parent of a child with autism who has received ABA services since she was two years old. Before ABA became part of our lives, my daughter was unresponsive to her name, showed little affection, and did not react socially to anyone — including our family.

Through the skills gained from ABA, my daughter is now ten years old and has emerged as a multi-modal communicator. She has mastered toilet training, developed coping skills, and learned how to navigate a world that is not built for her or her sensory needs. She is one of the happiest children I know.

Without the guidance and consistent support we have received through ABA, I truly do not believe

I would have the same child I have today. I also would not have half of the knowledge, confidence, or skills I rely on as a parent to support her. ABA has not only supported my daughter — it has supported me.

This letter is directed specifically to Medicaid because Medicaid access is the reason families like mine are able to receive life-changing services. Removing access to ABA or placing additional restrictions on how families can obtain these services will only add another barrier to the lives of families who already battle daily challenges just to secure appropriate care and support.

One BCBA once told me that her job was to work so hard to teach both me and my daughter that she would eventually no longer be needed. That is exactly what our team is doing — building independence, confidence, and long-term success. Limiting or restricting ABA services undermines this goal and threatens the progress families have worked so hard to achieve.

ABA is not optional for our family. It is integral to my child's development and to my ability to support her safely and effectively. I urge Medicaid to protect continued, meaningful access to comprehensive ABA services for children and families like mine.

Thank you for taking the time to hear from parents whose lives are directly affected by these decisions.

2.

Medicaid Policy Team,

I am the mother of not one, but two children with autism & have frankly become quite concerned about the recent proposed changes to Vermont Medicaid coverage for autism and ABA services. These changes would significantly reduce access to (and clinical oversight of) medically necessary care for the children and families who already face various limitations due to geographical placement, transportation, financial instability and/or workforce shortages.

In more rural areas, where access to clinics, local staff, and BCBAs especially, is already extremely limited, telehealth has been an essential tool for my family. We have seen such meaningful progress through ABA services — I'm talking leaps and bounds & that wouldn't've happened without telehealth support. My son was completely nonverbal & now he's not (without an outside sourced speech program, mind you) & my daughter is such a social butterfly these days

I am worried these changes would take away options that are working for both of my children.

(Not to mention have you met an autistic who handles change well?? I haven't)

Please don't move forward with any policy that would limit ABA services, reduce access to telehealth care, or prevent my children's BCBA from being able to observe sessions and adjust their programs in real time. She's literally my eyes when I'm not there — a sense of security.

Changes like these would make it so much harder for my family to receive the support we need, as we are a homeschooling family. Their technicians & supervisor have been a god-send to us since we started with them. They say "it takes a village" and although I've never had one, the community at AAI has become my village.

I also think we should be taking into consideration that approximately 53% of autistic children come from low income households. Low income families are already financially struggling as is — how downright shameful it would be for our kids to lose a service they're federally entitled to because some parents realistically would not be able to afford the out of pocket costs.

Side bar to mention that autism is, in fact, genetic & we, as parents, have more than likely gone our entire lives undiagnosed ourselves; wishing we had answers, services, tools, & advocates growing up. That being said, please enjoy my latest infodump/one of my favorite hobbies & pastimes: Knowledge.

Even before Vermont-specific rules, federal Medicaid law requires states to cover medically necessary autism services for children:

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment
This is a federal mandate under 42 U.S.C. §1396d(r).
EPSDT requires all Medicaid programs to cover ANY medically necessary service for children under 21 (even if the service is not normally covered for adults)
In 2014, the federal CMS issued guidance clarifying that ABA is included when medically necessary for Autism Spectrum Disorder.

Vermont implemented both commercial insurance mandates and Medicaid coverage:

33 V.S.A. § 4303 — Coverage for diagnosis and treatment of autism spectrum disorder:
This law requires all health insurance plans in Vermont to cover:
Behavioral health treatment (Including ABA) for individuals diagnosed with autism.

While this is mainly for private insurance, Vermont Medicaid follows the same standard because of EPSDT + state alignment. MOST importantly, Vermont Medicaid explicitly covers ABA under its Clinical Coverage Guidelines.

Health Care Administrative Rules (HCAR) 4.230 – Applied Behavior Analysis Services

This is the official Vermont Medicaid rule.
It states:

Vermont Medicaid covers ABA services for members under age 21
Services must be for treatment of Autism Spectrum Disorder Coverage includes:

- Assessment
- Treatment planning

(done by telehealth in our case)

- Direct ABA sessions
- Supervision

(done by telehealth in our case)

- Parent training

(done by telehealth in our case)

- Skill-building
- Evidence-based behavioral interventions

These rules replaced the old Medicaid rule manual and are legally binding.

EPSDT Federal Mandate:

42 U.S.C. § 1396d(r) requires states to provide any medically necessary health care service to Medicaid-eligible children, regardless of whether the service is covered in the state Medicaid plan.

Vermont Rule HCAR 4.230
"Vermont Medicaid covers Applied Behavior Analysis (ABA) services for members under age 21 diagnosed with Autism Spectrum Disorder when medically necessary."

33 V.S.A. § 4303
"A health insurance plan shall provide coverage for the diagnosis and treatment of autism spectrum disorder, including evidence-based behavioral interventions."

I respectfully, but justifiably ask that you protect/preserve ALL access to ABA services for Vermont children and their families. We already have enough on our plate & we continue to show up & advocate day in and day out for these kids. Consider empathy, compassion, sympathy. Hell, we'll even take pity at this point

Please reconsider —

3.

DVHA,

Our direct therapist works hard and shows up consistently, but what keeps therapy effective is the BCBA who designs the plan and makes real-time clinical changes when my child's needs shift.

What scares me about DVHA's proposed changes is the idea that when the BCBA observes a session and adjusts the treatment plan, the state treats that clinician's work as if it "includes" the direct therapist's work at the same time—as though it's one combined activity. As a parent, that makes no sense. My child's therapist is actively teaching—prompting, reinforcing, collecting data, and responding to behavior. The BCBA is doing a different job: analyzing patterns, deciding what

needs to change, and updating the plan so my child can progress safely and effectively.

One person can't do both jobs at once for the same child. And the therapist cannot ethically rewrite a clinical plan without the BCBA. If Vermont removes funding for real-time clinical program modification while therapy is happening, families like mine will be forced into delayed plan changes,

reduced clinician involvement, or fewer therapy hours. That isn't improving integrity—it's reducing effective care.

Please don't eliminate the funding structure that allows BCBAs to make real-time treatment adjustments during a child's regularly scheduled and authorized session hours. That clinical work is not optional—it's what makes ABA medically appropriate and effective. They are two unique services.

4.

Telehealth is a necessary option for my child

I'm a parent of a child with autism, and telehealth ABA services have been essential for our family. My child does not function well in a clinic environment. The noise, transitions, unfamiliar people, and demands of a new setting can overwhelm him and reduce his ability to learn. Having providers come into our home can also be difficult—sometimes it increases anxiety and behavior, and it can feel intrusive and unsafe for our family.

Telehealth has been the one option that consistently works. In a familiar space, with fewer triggers, my child can engage and learn. He's made progress with communication, coping skills, daily routines, and early social interaction in a way that is calm and productive. And yes—we understand

that skills learned through telehealth must be generalized over time. A quality treatment plan starts where the child can succeed and then expands skills into real-world settings.

If DVHA restricts telehealth, our family won't simply "switch to in-person." We will lose access, lose continuity, and risk losing the progress we've worked so hard to build. Telehealth is not a convenience for us—it's a clinically solid, necessary option that makes treatment possible.

Please don't take effective intervention away from families like mine by removing telehealth as a viable service modality.

5.

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6.

Dear Medicaid Policy Team,

I am the parent of a child with autism who has received ABA services since she was two years old. Before ABA became part of our lives, my daughter was unresponsive to her name, showed little affection, and did not react socially to anyone — including our family.

Through the skills gained from ABA, my daughter is now ten years old and has emerged as a multi-modal communicator. She has mastered toilet training, developed coping skills, and learned how

to navigate a world that is not built for her or her sensory needs. She is one of the happiest children I know.

Without the guidance and consistent support, we have received through ABA, I truly do not believe I would have the same child I have today. I also would not have half of the knowledge, confidence, or skills I rely on as a parent to support her. ABA has not only supported my daughter — it has supported me.

This letter is directed specifically to Medicaid because Medicaid access is the reason families like mine are able to receive life-changing services. Removing access to ABA or placing additional restrictions on how families can obtain these services will only add another barrier to the lives of families who already battle daily challenges just to secure appropriate care and support.

One BCBA once told me that her job was to work so hard to teach both me and my daughter that she would eventually no longer be needed. That is exactly what our team is doing — building independence, confidence, and long-term success. Limiting or restricting ABA services undermines this goal and threatens the progress families have worked so hard to achieve.

ABA is not optional for our family. It is integral to my child's development and to my ability to support her safely and effectively. I urge Medicaid to protect continued, meaningful access to comprehensive ABA services for children and families like mine.

Thank you for taking the time to hear from parents whose lives are directly affected by these decisions.

7.

Hi Brian,

I wanted to let you know I emailed the DVHA Medicaid Policy team to share my feedback about the proposed ABA changes. I included both my perspective as a parent receiving parent training services through AAI and as a BCBA working in Vermont's public schools.

I also shared how positive our experience with AAI has been - Whitney has been absolutely wonderful to work with, and her coaching and support have made such a meaningful difference for our family.

Thank you for keeping everyone informed and for leading this effort. I appreciate all the work you're doing to advocate for families and providers across the state.

Best,

Conclusion

ABA providers and the families we serve share the same ultimate goal as DVHA: effective, medically necessary services delivered with integrity. The 2026 policy changes are already creating harm after only weeks in effect. They remove clinically effective tools, reduce access, destabilize the workforce, and conflict with published ABA practice guidance. We ask the Legislature to press DVHA to reverse or revise this policy and replace it with an outcomes-based, readiness-based approach that preserves telehealth when clinically appropriate, permits real-time clinician program modification during technician treatment, and addresses integrity through documentation standards and rigorous auditing rather than service elimination.

Respectfully,

Brian J Marrier, MA, MFA, BCBA, LBA
Team Founder