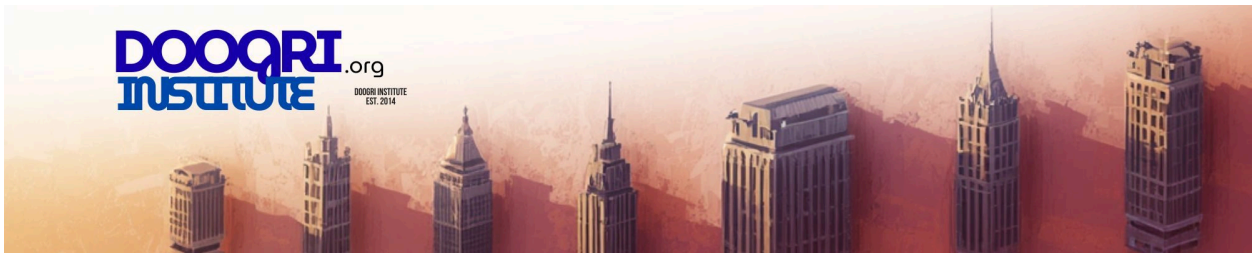


TO:	**Dr. T. March Bell** Inspector General Office of Inspector General (OIG) U.S. Department of Health and Human Services (HHS) Washington, DC **CC:** **Dr. Mehmet Oz** Administrator Centers for Medicare & Medicaid Services (CMS) U.S. Department of Health and Human Services (HHS) **The Honorable Robert F. Kennedy, Jr.** Secretary U.S. Department of Health and Human Services (HHS)
FROM:	**Dr. Henny Kupferstein, Policy Analyst, Doogri Institute**
DATE:	**March 17, 2026**
SUBJECT:	**Audit Findings: Medicaid Applied Behavior Analysis Billing Patterns in Texas**
RE:	**Request for Federal Scrutiny of Texas Public and Private ABA Service**

The Armadillo Effect: How Managed Care Shields Texas Medicaid Autism Billing from Public and Federal Scrutiny

CMS Audit: March 17, 2026

This audit evaluates selected Applied Behavior Analysis (ABA) services delivered under Texas Medicaid, with a focus on **billing practices, service delivery structures, and patient experience indicators**. The findings are hereby formally submitted to the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) for federal review. We are requesting that Texas be federally scrutinized under the **HHS-OIG Work Plan SRS-A-25-029 audit project**.

Texas operates one of the largest Medicaid programs in the United States. Recent federal enrollment data place **California first, New York second, and Texas third in Medicaid and Children's Health Insurance Program (CHIP) enrollment**, with approximately **4.1**

million beneficiaries enrolled in Texas as of late 2025. Because of the scale of the program, even relatively small levels of improper billing can expose federal and state governments to substantial financial losses.

This report presents findings from a systematic analysis of publicly available federal datasets examining billing patterns associated with **Applied Behavior Analysis (ABA)** services provided to Medicaid beneficiaries and linked to providers registered in the State of Texas. The analysis integrates information from the **CMS National Plan and Provider Enumeration System (NPPES) National Provider Identifier Registry** and the **U.S. Department of Health and Human Services Medicaid Provider Utilization and Spending dataset (CY2018–CY2024)**.

The analysis reviewed **24,554 behavior technician and behavior analyst NPIs registered in Texas** and examined associated Medicaid billing activity conducted through their affiliated billing entities. Screening procedures were designed to identify utilization patterns inconsistent with the operational realities of ABA service delivery or with regulatory supervision requirements governing behavior technicians.

Across the datasets examined, multiple billing entities and rendering providers displayed patterns that may be indicative of **fraudulent or improper billing**, including:

- **Claims reflecting service volumes exceeding physically possible daily working hours**
- **High concentrations of technician-delivered services with minimal or absent supervisory billing by licensed behavior analysts**
- **Billing networks sharing addresses, phone numbers, or rendering providers across nominally independent entities**
- **Templated or uniform billing patterns inconsistent with individualized treatment plans**
- **Rapid activation and deactivation of rendering providers associated with high billing volumes**

In total, **$201,673,118.81 in Medicaid payments** were identified as linked to services rendered by **Texas-registered individual providers** within the national dataset examined.

These findings are consistent with a broader national pattern identified in recent **HHS Office of Inspector General audits**, which have documented substantial improper payments associated with ABA services in multiple state Medicaid programs. Recent audits have identified:

- **Colorado:** $77.8 million in improper payments and $207.4 million in potentially improper payments
- **Indiana:** $56 million in improper payments and $76.7 million in potentially improper payments

- **Wisconsin:** $18.5 million in improper payments
- **Maine:** $45.6 million in improper payments

Despite the size of its Medicaid program and its substantial ABA service utilization, **Texas has not yet been the subject of a comprehensive federal audit focused specifically on ABA billing practices**.

Given the scale of Medicaid expenditures involved and the patterns identified in the data analysis, the findings presented in this report suggest the need for **further federal and state investigation** to determine whether services billed were actually rendered, whether required supervision occurred, and whether billing practices comply with applicable Medicaid regulations and federal healthcare fraud statutes.

Request for Federal Scrutiny of Medicaid-Funded Autism Service Industry in Texas

This complaint presents evidence of suspected Medicaid fraud involving **Applied Behavior Analysis (ABA)** providers operating in Texas and through Texas-linked multi-state billing networks. Using publicly available federal provider-registration and Medicaid-utilization datasets, the analysis identified patterns consistent with claims for services that were not rendered as billed, technician services lacking adequate supervisory support, rendering activity that exceeded physical possibility, and cross-state billing structures that may conceal responsibility for false claims. The Texas-specific exposure identified in this analysis exceeds **$201.7 million** in payments tied to Texas-registered individual NPIs, with additional exposure flowing through **out-of-state entities using Texas renderers as a major revenue source**. A federal investigation is best suited to evaluate whether out-of-state ABA billing entities deriving **substantial revenue** from Texas-registered rendering providers are using **interstate corporate structures, shared infrastructure, or cross-jurisdictional credentialing arrangements** to submit false or inflated Medicaid claims.

The Structural Oversight Gap

When federal Medicaid funding follows the enrollee through capitation payments, services are no longer visible through traditional fee-for-service claims data. Detailed service records exist primarily as encounter data within managed care systems, while financial responsibility for compliance shifts toward private insurers and provider organizations. In this structure, federal oversight is often able to verify that payments were made and that documentation meets contractual requirements, but it becomes significantly harder to determine whether services are being delivered consistently with national coverage standards. The result is a structural oversight gap: federal funds continue to support autism therapy coverage, yet the underlying service delivery; treatment intensity, supervision quality, continuity of care, and patient outcomes, may remain difficult to independently evaluate. When both the visibility of service

data and the locus of liability shift away from the public claims system, ensuring that beneficiaries actually receive the care contemplated by federal policy requires oversight mechanisms that incorporate encounter-data analysis and patient-experience evidence alongside traditional billing audits.

Audit Findings: Texas Medicaid ABA Billing

Local Findings: ZIP Code 75068 (Little Elm, Denton County)

After our statewide review, one zip code in particular warranted further pattern detection testing. The initial point of inquiry for this meta analysis was **ZIP code 75068 in Little Elm, Texas**, a suburban area north of Dallas. Examination of the National Provider Identifier (NPI) registry revealed an unusually dense concentration of behavior technician registrations in this ZIP code relative to population size.

A total of **64 behavior technician NPIs** were registered in ZIP code 75068. Of these:

- **48 individual NPIs (75%) were registered at a single address**
  2831 W Eldorado Pkwy, Little Elm, Texas

The concentration of provider registrations at one address is notable because each NPI represents an individual healthcare provider credentialed to deliver services under federal healthcare programs.

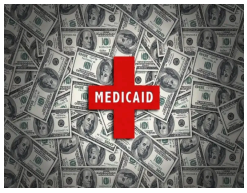
Enumeration Pattern

The registration timeline for the 48 providers at this single address shows a pattern of accelerating registrations:

Year	Number of NPIs
2021	4
2022	7
2023	7
2024	1
2025	28

The **28 new registrations in 2025 alone** represent a sharp increase compared with prior years. The 2025 registration increase closely correlates with the 2025 surge of Medicaid providers in the state. These registrations occurred across **nine consecutive months**, suggesting a systematic onboarding process rather than sporadic individual provider registrations.

Medicaid Billing Visibility



Despite the large number of provider registrations, **none of the 48 technicians appear in the publicly available Medicaid Provider Utilization and Spending dataset**. This discrepancy can occur for several reasons:

- the providers may not yet have begun billing
- billing may fall below reporting thresholds
- services may be billed through **managed-care encounter systems rather than fee-for-service claims**

Nobody wants to take medicaid rates because the legislated reimbursement is offensively low. Essentially, a provider needs to be registered to accept Medicaid to be a part of the managed care plans. Conversely, in Texas, where most Medicaid services are delivered through managed-care organizations rather than direct fee-for-service reimbursement, we see this business model overtly manifesting.

Local Organizational Structure

Two ABA service organizations are registered within the ZIP code:

- **Brilliant Stars ABA, LLC**
- **Spark Behavioral Solutions & Consulting Services, LLC**

Both entities operate within the same geographic area as the technician registration cluster. 🚩The relationship between these organizations and the large concentration of technician NPIs warrants further examination to determine whether the registrations reflect legitimate workforce expansion or the creation of billing infrastructure ahead of service delivery. An increase of technicians without an increase of medicaid billing is a red flag that is actively waving in the breeze.

Statewide Findings and Analysis: Texas Medicaid ABA Billing

Broader structural patterns across Texas were evaluated using publicly available federal datasets. A total of **24,554 behavior technician and behavior analyst NPIs** were identified as registered in the state, including **23,268 individual providers** and **1,286 organizational NPIs**. These providers were linked to **343,626 Medicaid claim-month records** in the national Medicaid Provider Utilization dataset, of which **12,483 records involved Texas-registered individual rendering providers**, representing approximately **$201.7 million in Medicaid payments**.

Within this dataset, multiple patterns emerged that are inconsistent with the operational realities of Applied Behavior Analysis (ABA) service delivery and warrant regulatory review.

Taken together, these findings suggest that Texas represents a **large and rapidly expanding market for Medicaid-funded autism therapy services**, but one that is difficult to evaluate through publicly available data alone. Because Texas Medicaid operates primarily through **managed-care organizations**, a substantial portion of service activity may occur within **encounter-data systems that are not visible in federal public claims datasets**.

As a result, the findings presented here likely reflect **only the subset of billing activity that remains observable through fee-for-service data sources**, rather than the full scope of service delivery.

A comprehensive evaluation of Medicaid-funded autism services in Texas would therefore require integration of additional data sources, including:

- managed-care encounter datasets
- state program-integrity investigations
- provider licensing and oversight records

Without access to these sources, significant portions of service delivery remain **outside the analytical visibility of public datasets**, limiting the ability to fully assess whether services are delivered in accordance with federal standards.

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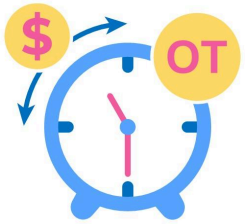
1. Impossible Service Volumes



Across the dataset, **76 individual providers registered in Texas billed more than 16 hours of therapy in a single day**. ABA therapy billed under CPT code **97153** represents one-to-one treatment delivered by a technician. Service volumes

exceeding standard working hours raise questions about whether the services billed could have been physically delivered. In some cases, the estimated daily service volumes were far higher, including:

- **60–80 hours per day**
- **more than 100 hours in a single day**

These figures were derived using two independent estimation methods based on:

- reimbursement amounts
- claim frequency

Such volumes require verification through underlying treatment documentation and scheduling records.

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2. Technician Billing Without Supervision

Multiple billing entities showed **very low ratios of supervision codes relative to technician-delivered treatment hours**, despite Texas regulatory requirements that behavior technicians operate under the supervision of licensed behavior analysts. In several cases, entities billed:

- **100% technician-delivered services with zero supervision codes**
- **Supervision rates representing less than 20% of total treatment activity**

This pattern is inconsistent with expected clinical practice and raises questions about whether required supervisory activities were performed or appropriately documented. It may reflect either **incomplete supervision documentation** or **delivery of technician services without adequate clinical oversight**.

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3. Concentrated Billing Through Single Rendering Providers

Several organizations generated substantial Medicaid revenue through **a single rendering provider**. Examples included:

- organizations where **100% of revenue flowed through one provider**
- providers billing hundreds of thousands of dollars in therapy services within short operational periods.

This level of concentration is inconsistent with typical clinical staffing models for ABA services and raises questions about the operational structure of the clinics involved. When combined with implausible service volumes, these patterns suggest the need for further review of **service documentation, staffing configurations, and the accuracy of reported service delivery**.

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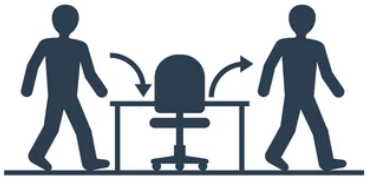
4. High Renderer Turnover



Some entities showed extremely high provider turnover. In certain cases:

- **over 80% of technicians were active for fewer than three months**

Taken together, the observed combination of **short provider tenure, rapid billing activity, and subsequent loss of claims visibility** warrants further examination to determine whether these patterns reflect normal operational transitions or structural limitations in how service delivery is captured in public datasets.

💡 High turnover may reflect normal workforce dynamics in some settings, but it can also complicate supervision, training, and compliance oversight. It must be noted that once services are provided through managed care, a provider's fee-for-service no longer appears in the medicaid database. Essentially, the pipeline for circumventing federal scrutiny is to register as a medicaid provider, and transition to managed care as soon as the private equity investors have a proven reimbursement portfolio. **Assuming the state reimbursement cycle is 45 days, a provider does not need to continue to seek Medicaid clients to continue their earning streams.** Here we see a surge of providers that correlate with cessation of Medicaid billing **within one controller billing cycle**.

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5. Multi-State Rendering

The dataset identifies a substantial cohort of **out-of-state billing entities** that nevertheless derive a large share of their Medicaid payments from services rendered by **Texas-registered behavior technicians and behavior analysts**. This pattern is significant for program-integrity purposes because it suggests that Texas is functioning not merely as a local service market, but as a **high-volume labor and billing base within broader multi-state ABA reimbursement networks**.

In multiple instances, entities headquartered in other states received **majority-Texas revenue**, meaning that more than half of all Medicaid payments attributed to the billing entity were generated through Texas-registered rendering NPIs. This is not inherently unlawful.

However, when combined with the other indicators identified in this complaint—impossible individual service hours, weak supervisory ratios, shared infrastructure, enumeration clustering, and multi-state rendering by the same individuals—the out-of-state pattern is consistent with **centralized billing arrangements that may obscure operational accountability and frustrate state-level oversight**.

The concern is heightened where out-of-state entities show the same structural features observed among Texas-headquartered entities: high technician-code volume, low supervision intensity, renderer concentration, or rendering patterns inconsistent with the physical realities of one-to-one treatment. In such circumstances, the cross-state structure may function as a mechanism for scaling claims volume while diffusing responsibility across jurisdictions, payors, addresses, and credentialing systems.

The following out-of-state entities were identified as having **substantial Texas-rendered Medicaid exposure**:

- **Behavior Frontiers, LLC (CA; NPI 1245539394)** received **$33,067,222** total, of which **$22,336,639 (67.5%)** was rendered by Texas-registered NPIs; composite score **75/210**; **46 renderers**.
- **Bluegrass Behavioral Health Group, LLC (KY; NPI 1952840860)** received **$23,691,900** total, of which **$14,784,934 (62.4%)** was Texas-rendered; score **60/210**; **26 renderers**.
- **Behavior Health & Wellness Center, LLC (VA; NPI 1962736595)** received **$15,800,121** total, of which **$9,211,540 (58.3%)** was Texas-rendered; score **60/210**; **7 renderers**.
- **Applied Behavior Autism Center LLC (CA; NPI 1821623018)** received **$7,362,493**, and **100.0%** of that amount was Texas-rendered; score **25/210**; **1 renderer**.
- **Behavior Management Foundation (CA; NPI 1861850653)** received **$7,340,230** total, of which **$5,663,328 (77.2%)** was Texas-rendered; score **60/210**; **10 renderers**.
- **Therapy Center of Acadiana (LA; NPI 1982983870)** received **$6,324,518** total, of which **$3,617,569 (57.2%)** was Texas-rendered; score **60/210**; **9 renderers**.
- **Red River Therapeutic Solutions LLC (LA; NPI 1003279654)** received **$11,914,083** total, of which **$2,824,194 (23.7%)** was Texas-rendered; score **35/210**; **36 renderers**.
- **Behavioral Developmental Services (LA; NPI 1023454451)** received **$16,360,915** total, of which **$2,368,757 (14.5%)** was Texas-rendered; score **75/210**; **14 renderers**.
- **ABA Across Environments (CO; NPI 1427556281)** received **$2,288,432**, and **100.0%** was Texas-rendered; score **60/210**; **1 renderer**.

- **Behavior Change Institute, LLC (NM; NPI 1730517889)** received **$2,423,010** total, of which **$2,025,015 (83.6%)** was Texas-rendered; score **60/210**; **28 renderers**.

Taken together, these figures show that **Texas-registered renderers generated tens of millions of dollars for non-Texas billing entities**. This cross-jurisdictional structure warrants federal scrutiny because it raises at least three investigative questions: First, whether the billed services were **actually rendered in Texas by the identified individuals**. Second, whether those individuals were **properly supervised under Texas law and Medicaid requirements**. Third, whether the use of out-of-state billing entities has the practical effect of **shielding high-volume claim generation from meaningful in-state oversight**.

Where an out-of-state billing entity derives a majority of its Medicaid revenue from Texas-registered renderers, federal investigators should verify the underlying claims, treatment plans, supervision records, service logs, and payroll relationships to determine whether the Texas NPIs were functioning as genuine treatment personnel or as **billing conduits within a larger coordinated scheme**.

The data analysis identifies not only suspicious activity among Texas-headquartered ABA billing entities, but also a broader **multi-state pattern** in which out-of-state organizations rely heavily on Texas-registered rendering providers to generate Medicaid revenue. Several non-Texas billing entities received a majority of their Medicaid payments through Texas renderers, including entities headquartered in California, Kentucky, Virginia, Louisiana, Colorado, and New Mexico. In addition, individual renderers were identified billing under entities in **multiple states during the same month**, a pattern incompatible with ordinary in-person one-to-one ABA treatment. These findings suggest that the Texas market may be embedded in **regional or national billing networks** whose structure requires investigation beyond any single provider or county.

From an enforcement perspective, the significance of these multi-state patterns is not merely geographic. The data indicates a system in which **rendering providers, billing entities, business addresses, and claim streams are dispersed across state lines**, while the actual services billed remain subject to state-specific supervision and Medicaid program rules. That structure can impede routine oversight, complicate jurisdictional accountability, and facilitate the submission of false or inflated claims at scale. The presence of repeated impossible-hours billing, weak supervision ratios, high renderer churn, and cross-state billing by the same individuals provides a reasonable basis to investigate whether some of these entities are participating in **coordinated healthcare-fraud activity affecting federally funded Medicaid programs**.

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6. Large Clusters of Newly Registered Providers at Single Addresses

The National Provider Identifier registry showed **large numbers of behavior technicians registered at single commercial addresses**. One example involved:

- **48 individual technician NPIs registered at one address in Little Elm, Texas**
- **28 of those NPIs enumerated in a single year**

Bulk registration patterns may reflect legitimate hiring expansion, but they can also signal rapid scaling of technician labor structures associated with high-volume therapy models. Consistent with our findings in **San Diego, a single zip code in California**, registered addresses are often shell corporations in office suites that cannot possibly house more than 5 people, as well as the use of UPS and P.O. boxes as registered clinical settings.

Site inspections in California revealed lack of signage, no handicap parking to indicate a health service is being rendered. When querying the neighbors, asking what time the children arrive for therapy in the morning, the answer is, "what children?" or "I haven't seen the owners in about 8 months. Did you come to pick up their mail?"

Structural Limitation of Public Oversight

These findings emerge primarily from **fee-for-service Medicaid datasets**, which remain one of the few publicly accessible sources for analyzing provider billing patterns.

However, Texas Medicaid operates largely through **managed care organizations (MCOs)**. Under managed care:

- states pay insurers **capitated payments per enrollee**
- individual service claims become **encounter records within insurer systems**
- those records are **not automatically visible in federal public datasets**

As a result, large portions of Medicaid service activity may occur **outside the analytical visibility of independent researchers and journalists**.

The services still occur. The billing records still exist. But the data reside within **restricted encounter systems** rather than publicly analyzable claims datasets. This structural shift significantly reduces the ability of outside observers to detect anomalous billing patterns.

We tested the entire state of Washington and found that

Implications for Federal Oversight

The findings from the Texas analysis highlight a **broader oversight challenge in modern Medicaid programs**. When services move into managed care systems:

- financial flows remain federally subsidized
- clinical services continue to be delivered to Medicaid beneficiaries
- but **public transparency around provider billing decreases**

This change increases reliance on internal oversight mechanisms, including:

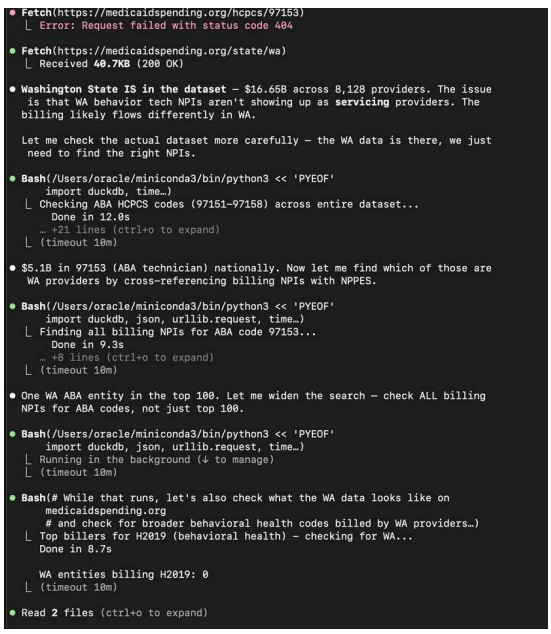
- managed care plan investigations
- state program-integrity units
- targeted federal audits

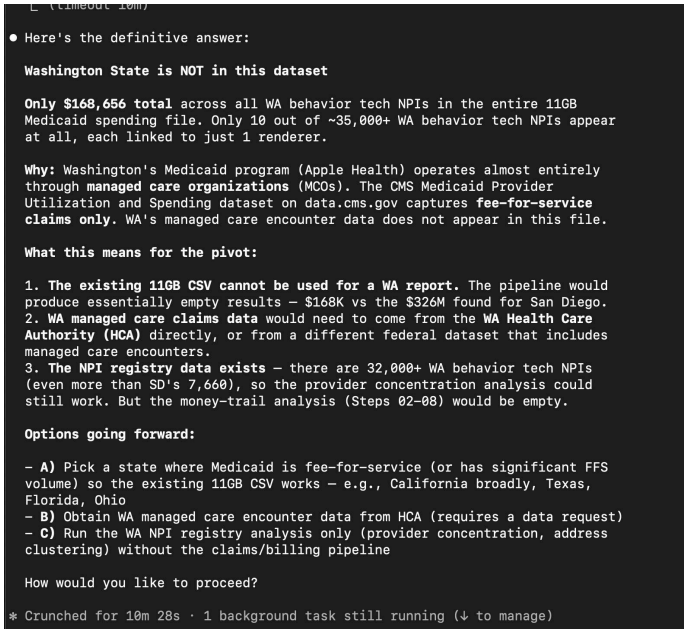
However, when these oversight systems are inconsistent or delayed, problematic billing patterns may persist without external scrutiny.

Washington State: Apple Health Strategy

Analysis of the national Medicaid Provider Utilization and Spending dataset shows that ABA service activity in **Washington State is largely absent from fee-for-service claims data**. Only **$168,656** in total Medicaid payments were identified across all Washington behavior technician NPIs, with approximately **10 out of more than 30,000–35,000 registered providers** appearing in the dataset at all, each linked to a single rendering provider. This minimal presence stands in stark contrast to national ABA technician billing totals exceeding **$5 billion**, indicating that the lack of observable data is not due to low service volume. Instead, it reflects Washington's Medicaid structure: the **Apple Health program operates almost entirely through managed care organizations**, and the federal dataset captures only fee-for-service claims, not managed-care encounter data. As a result, ABA services delivered in Washington are effectively invisible in publicly available claims datasets, preventing reconstruction of provider-level billing patterns and rendering the scale and structure of autism

service delivery largely opaque to independent analysis.





Consumer Safety and the Data Gap

One consequence of the current data architecture is that **patient and family experience often becomes the earliest indicator of system failures**.

Families receiving autism services frequently observe problems that may not immediately appear in claims data, including:

- services authorized but not delivered
- frequent staff turnover disrupting treatment
- inadequate supervision of technicians
- billing practices inconsistent with actual therapy sessions

These experiences constitute **important evidence about how services function in practice**. Yet consumer experience data rarely enters formal program-integrity analysis.

Policy Implication

For federally funded healthcare programs, oversight cannot rely exclusively on billing records any longer. A comprehensive evaluation of program integrity should incorporate multiple data sources, including:

- claims and encounter datasets
- audit findings
- provider licensing oversight
- **consumer safety and patient-experience evidence**

Without these additional signals, large managed-care systems may operate with **limited public visibility into the quality and integrity of services being delivered.**

Conclusion: The Managed-Care Blind Spot

The findings from the Texas analysis highlight a structural oversight gap in modern Medicaid programs.

Federal and state investigators increasingly rely on **statistical analysis of billing data** to identify fraud, waste, and abuse. These methods depend on the visibility of claims. When services are delivered through fee-for-service Medicaid, those claims appear in administrative datasets that allow analysts to detect abnormal billing patterns.

Managed care changes that visibility. Under managed care financing, detailed service records exist primarily as **encounter data inside insurer systems**, not as publicly visible claims. Those records are transmitted to regulators but are rarely accessible for independent analysis. As a result, a large share of Medicaid service activity can occur outside the datasets that researchers, journalists, and watchdog organizations traditionally use to detect billing anomalies.

This creates a structural blind spot. If program-integrity systems rely primarily on managed-care oversight while public claims visibility declines, the ability to detect large-scale billing irregularities may be delayed or weakened. Oversight becomes dependent on internal compliance programs, insurer investigations, and targeted regulatory audits rather than broad statistical scrutiny.

For sectors experiencing rapid expansion such as Medicaid-funded autism therapy, this shift in data architecture has significant implications. The analysis presented here identifies patterns within the portion of Texas billing that remains visible in public datasets. However, because most Texas Medicaid services are delivered through managed care, these findings likely represent only a **partial view of the system's overall billing activity**.

Effective oversight therefore requires more than claims analysis alone. Federal and state regulators should ensure that program-integrity reviews incorporate **encounter-data analysis, provider-licensing oversight, and consumer-experience evidence** when evaluating rapidly expanding Medicaid service sectors. Without these additional sources of information, significant portions of Medicaid service delivery may remain analytically opaque.

The question facing regulators is therefore not simply whether individual claims are compliant. It is whether the **structure of the payment system itself allows sufficient transparency to safeguard both public funds and patient welfare.**

[end of audit]

This audit was conducted by autistic professionals trained by the Doogri Institute. As a consumer-directed organization, our intent is to collaborate with lawmakers to ensure that public policy is informed by patient experience. We the consumers of public programs hold the record of what is meaningful or harmful to us. Public dollars should not systematically function as a blank check to underwrite harm, waste, abuse, and neglect. The fraud ends today.

Appendix: The Managed-Care Payment Structure and the Visibility Problem

Under Medicaid managed care, the federal government does not reimburse individual services directly. Instead, the federal government provides its share of funding to states based on a **capitated payment structure tied to the number of enrolled beneficiaries**. In practical terms, federal financial participation follows the enrollee: a fixed payment is made for each person covered by the program.

Once those federal funds reach the state, the state typically pays **managed care organizations (MCOs)** a per-member monthly payment to administer care for those enrollees. The managed care plans then pay providers for individual services.

This payment architecture changes how services appear in public data. In traditional **fee-for-service Medicaid**, each service generates a claim that is processed by the state and reflected in federal administrative datasets. Those datasets allow analysts to track which providers delivered services, how often they billed, and the volume of treatment delivered.

Managed care alters that transparency. Individual services are recorded primarily as **encounter data inside insurer systems**, rather than as fee-for-service claims processed directly through the state Medicaid program. While encounter records are transmitted to regulators, they do not appear consistently in the public claims datasets that historically allowed independent analysis of provider billing patterns.

The result is a structural gap in visibility. Federal funding continues to flow for each enrolled child, but the detailed service records that would normally allow analysts to evaluate treatment intensity, provider behavior, and billing patterns are often inaccessible outside of state agencies and managed care plans.

For rapidly expanding service sectors such as Medicaid-funded autism therapy, this architecture creates a challenge for oversight. Without accessible service-level data, it becomes difficult to determine whether children receiving coverage under federal autism-related insurance mandates are consistently receiving the services those policies are intended to guarantee.

In this environment, evaluating whether national coverage standards are being met requires access not only to financial flows but also to **encounter-level treatment data and patient experience information**. Without those sources of information, independent verification of service delivery becomes significantly more difficult.

Liability, Oversight, and the Managed-Care Incentive Structure

The transition from fee-for-service Medicaid to managed-care financing alters not only how services are paid but also how responsibility for program integrity is distributed.

Under a traditional **fee-for-service model**, providers submit claims directly to the state Medicaid program for each service delivered. The state reviews those claims and, when improper billing is identified, the state itself may be considered financially responsible for federal overpayments. As a result, state program-integrity systems tend to focus heavily on detecting improper claims and recovering funds from providers.

This structure frames the state as the immediate financial victim of improper billing. When fraud or overutilization occurs, enforcement actions are typically directed at individual providers who submitted the claims.

Managed care redistributes that responsibility.

When services are delivered through managed-care organizations, the state pays insurers a **capitated amount per enrollee** rather than reimbursing individual services. Managed care plans then pay providers and assume contractual responsibility for claims review, utilization management, and fraud detection.

In practice, this structure shifts a significant portion of operational liability away from the state and toward **managed care organizations and provider businesses**. If improper billing or compliance failures occur, investigations frequently focus on whether the plan and the provider adhered to contractual requirements.

While this arrangement can improve administrative efficiency, it also changes the incentives surrounding oversight.

Program-integrity systems under managed care tend to concentrate on **financial compliance signals**—whether claims documentation meets contractual requirements and whether billing patterns trigger fraud-detection algorithms. Oversight systems are therefore often optimized to detect anomalies in claims data rather than to evaluate the broader quality of services delivered.

In sectors such as Medicaid-funded autism therapy, where services are delivered primarily through technician labor under supervisory structures, the distinction between **billing compliance** and **clinical quality** becomes significant.

A provider organization may satisfy billing documentation standards while still delivering services that vary widely in quality, supervision intensity, or continuity of care. Because managed-care oversight systems focus primarily on claims compliance, these clinical dimensions can receive less systematic scrutiny.

For families and patients, this dynamic can create a regulatory gap. The formal oversight framework prioritizes ensuring that claims submitted to federal programs appear compliant,

while the lived experience of service delivery—staff turnover, supervision adequacy, treatment continuity, and therapeutic effectiveness—may be addressed primarily through complaint processes rather than proactive monitoring.

In effect, the regulatory architecture prioritizes **financial accountability for claims** over **systematic evaluation of care quality in high-volume service sectors**.

This dynamic does not imply that managed-care oversight systems are ineffective. Rather, it reflects a structural feature of how oversight responsibilities are distributed across states, insurers, and providers.

When large sectors of Medicaid services move into managed care, effective oversight requires mechanisms that evaluate both **financial integrity and patient safety outcomes**. Without integrating these dimensions, oversight systems may detect improper claims while remaining less sensitive to systemic issues affecting the quality and continuity of care experienced by beneficiaries.

Federal Rights to Individualized Autism Care

Children enrolled in Medicaid have federally protected rights to medically necessary services for developmental and behavioral conditions, including autism. These protections arise primarily from the **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** benefit under **42 U.S.C. §1396d(r)**.

EPSDT establishes a federal floor for pediatric care in Medicaid. The statute requires states to provide services that are necessary to **"correct or ameliorate" physical and mental conditions discovered through screening**. For children with autism spectrum disorder, this requirement means that services must be based on individualized clinical assessments rather than predetermined service packages or generalized program models.

Under EPSDT, several specific protections apply:

1. Individualized Assessment

Federal Medicaid policy requires that treatment decisions be based on a **comprehensive diagnostic and functional evaluation** conducted by qualified professionals. Services must be authorized according to the child's specific needs rather than standardized program templates.

2. Individualized Treatment Planning

Once a condition is identified, Medicaid programs must provide medically necessary services through **individualized treatment plans**. These plans must specify the types, intensity, and duration of services required to address the child's condition.

3. Ongoing Reassessment

EPSDT requires periodic reassessment of treatment effectiveness and continued medical necessity. Services must be adjusted when a child's needs change.

4. Qualified Provider Supervision

When services are delivered by paraprofessional staff, such as behavior technicians in Applied Behavior Analysis (ABA) therapy, federal guidance requires that services be **directed and supervised by qualified clinicians**.

These principles establish a federal expectation that autism therapy funded through Medicaid must be **individualized, clinically supervised, and regularly evaluated**.

The Role of Claims Data in Federal Oversight

Federal investigators frequently rely on administrative claims data to evaluate whether these requirements are being implemented in practice.

Claims datasets allow regulators to identify patterns such as:

- unusually high service volumes
- identical treatment intensity across large groups of patients
- minimal supervision relative to technician-delivered therapy
- unusually concentrated billing among providers.

These statistical signals often trigger formal audits by the **HHS Office of Inspector General** and other program-integrity units.

In fee-for-service Medicaid systems, each therapy session generates a claim processed directly by the state. Those claims become visible in federal administrative datasets used by investigators and researchers.

Managed Care and the Visibility of Autism Services

Texas Medicaid operates primarily through **managed care organizations (MCOs)**.

Under this structure:

- the federal government contributes funding based on the number of enrolled beneficiaries
- the state pays managed care plans a **capitated payment per enrollee**
- the plans then reimburse providers for individual services.

Individual therapy sessions therefore appear as **encounter records inside managed-care systems**, rather than as fee-for-service claims processed directly through the state Medicaid program.

While encounter data are reported to state and federal regulators, they are generally **not visible in the public datasets traditionally used to analyze provider billing patterns**.

This change in data architecture affects the ability of outside analysts to examine service delivery patterns.

Implications for Oversight and Patient Protection

When autism services move into managed care systems, the visibility of treatment activity changes.

Financial flows remain federally subsidized, but detailed information about **how services are delivered**—including treatment intensity, supervision patterns, and provider concentration—may be less accessible for independent analysis.

This does not eliminate oversight. Regulators still have access to encounter data and can conduct audits. However, the analytical barrier is higher, and independent monitoring by researchers, journalists, and patient advocates becomes more difficult.

For services subject to federal individualized-care requirements, such as autism therapy under EPSDT, this data limitation can complicate efforts to evaluate whether the statutory standards are being consistently implemented across programs.

Ensuring that children receive individualized treatment consistent with federal law therefore requires oversight systems capable of examining not only financial compliance but also **service-level treatment data and patient outcomes**.

Appendix II: Justification for Flagging ZIP Code for Highly Suspect "Services Not Rendered" Billing

This submission identifies a ZIP code area used as a sampling point in reviewing Applied Behavior Analysis (ABA) fee-for-service billing trends. In the year Medicaid fee-for-service coverage for ABA became available, the area saw a marked increase in provider registrations together with private equity investment in a provider newly entering the Medicaid fee-for-service market. Rapid provider growth and capital investment aligned with new reimbursement opportunities can create elevated risk environments for billing irregularities, including services billed but not rendered, and may warrant further program-integrity attention.

1. Structural Billing Model Creates a Single Point of Accountability

ABA services are frequently billed under the **National Provider Identifier (NPI) of a single supervising Board Certified Behavior Analyst (BCBA) / Licensed Behavior Analyst (LBA)**. In this model:

- Behavior technicians deliver most of the direct therapy hours.
- The supervising BCBA/LBA authorizes treatment plans and supervision.

- Claims are submitted under the BCBA/LBA's NPI as the rendering or supervising provider.

Because technicians are typically **not independently billable providers**, the supervising BCBA becomes the **legal and regulatory point of accountability for services delivered and billed**.

2. Documented Paper Trail Suggests Services Not Rendered

Within this ZIP code, there is a **consistent documentation pattern suggesting services were billed but not delivered**, including:

- service logs indicating therapy hours that conflict with documented attendance
- supervision requirements that appear not to have occurred
- billing records that do not match provider presence or service delivery
- discrepancies between scheduled sessions and actual staffing records

These records create a **clear administrative paper trail indicating possible "services not rendered."**

3. Regulatory Oversight Is Fragmented and Complaint-Driven

Oversight of ABA services in Texas is divided across multiple agencies:

- **Texas Department of Licensing and Regulation (TDLR)** – licenses behavior analysts and investigates licensure violations
- **Texas Health and Human Services Commission Office of Inspector General (HHSC-OIG)** – investigates Medicaid billing fraud
- **Child Protective Services / law enforcement** – investigates abuse or neglect allegations
- **Texas Education Agency (TEA)** – regulates public and charter school compliance when services occur in school settings

No single agency is responsible for **comprehensive oversight of ABA clinic operations**, and most enforcement actions are **complaint-driven rather than proactively audited**.

4. Evidence Indicates the Paper Trail Was Not Formally Investigated

Despite the existence of documentation indicating potential services-not-rendered billing, **no known formal investigation occurred** by:

- licensing authorities,
- Medicaid program integrity investigators, or
- law enforcement agencies.

Instead, responsibility for identifying the issue has effectively fallen to parents and families who observed discrepancies in service delivery and billing records.

5. Structural Incentive to Shift Investigations Away From Service Delivery

When allegations arise in therapy settings, investigations often focus on **administrative or billing compliance** rather than underlying service delivery failures. This occurs because administrative violations—such as billing discrepancies—are typically easier to prove than misconduct or abuse. As a result, clear service-delivery irregularities may remain unexamined when agencies do not initiate a formal inquiry.

6. Basis for Flagging the ZIP Code

Because of the combination of:

- a **centralized billing structure under a single BCBA/LBA NPI**,
- a **documented paper trail suggesting services not rendered**, and
- **lack of investigation by relevant authorities**,

this ZIP code should be flagged as **highly suspect for potential services-not-rendered billing practices** within ABA service delivery. Further review by appropriate regulatory or program integrity authorities is warranted to determine whether billed services accurately reflect services delivered to patients.