THIRD HORIZON

AUTISM LAW SUMMIT 2026

Network Adequacy in Health-Plan-Funded ABA

A data-driven approach: from Transparency in Coverage files to an Autism Services Opportunity Index for CASP members

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With the Council of Autism Service Providers (CASP)
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WHERE THIRD HORIZON STARTS

Payers now publish every in-network rate. The same files answer the network question.

✦ REAL DATA · OKLAHOMA CARRIER TRANSPARENCY FILES (AUG 2026)

CODE	DESCRIPTION	TIER	MEDICAID FFS (REAL)	COMMERCIAL MEDIAN	IN-NETWORK RANGE	RECORDS
97151	Behavior identification assessment	BCBA	$23.55	$155.21	$91–$319	5,800
97152	Supporting assessment by technician	Technician	—	$112.36	$63–$238	7,201
97153	Adaptive behavior treatment by protocol	Technician	$17.35	$287.30	$166–$455	5,789
97154	Group adaptive behavior treatment	Technician	—	$69.64	$15–$147	4,062
97155	Protocol modification by physician/QHP	BCBA	$23.55	$174.18	$105–$252	5,772
97156	Family adaptive behavior guidance	BCBA	$23.55	$84.42	$59–$141	5,823
97157	Multiple-family group guidance	BCBA	—	$66.90	$24–$97	6,516
97158	Group adaptive behavior treatment by QHP	BCBA	—	$20.77	$14–$167	6,379
0362T	Behavior identification supporting assessment (team)	Team	—	$127.62	$77–$298	9,410
0373T	Adaptive behavior treatment, two+ technicians	Team	—	$312.06	$64–$890	6,912

The rule

Since 2022, Transparency in Coverage requires plans to post machine-readable files of every negotiated rate, by provider and code.

The platform

Third Horizon has processed these files since 2023. The Starset platform covers about 270 payer networks nationally.

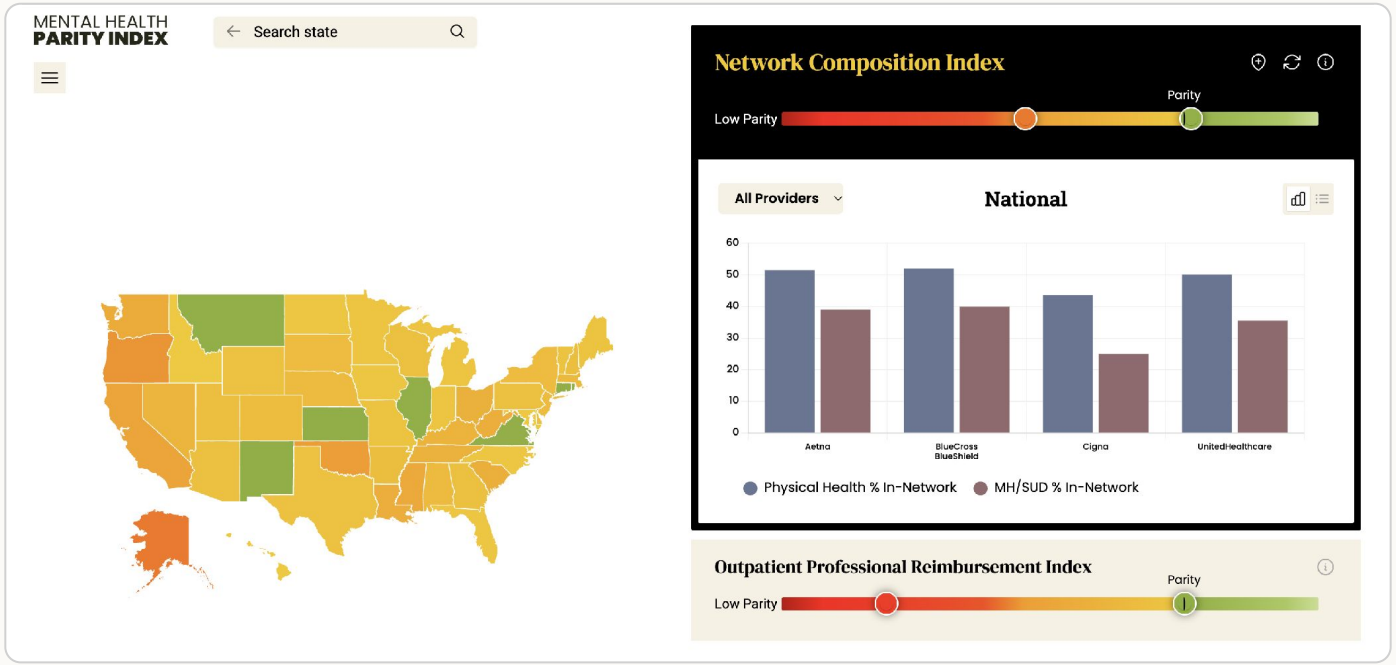
The network signal

A contracted rate exists only when a provider is in-network. 409,134 Oklahoma records show who is in-network, their rates, where they practice, and with which carrier.

Sources: CMS Transparency in Coverage final rule (effective July 1, 2022); Third Horizon TiC extract, Oklahoma, six commercial carriers (August 2026). Screenshot from the Index concept demonstration.

THE MENTAL HEALTH PARITY INITIATIVE

With The Kennedy Forum and the American Medical Association, Third Horizon turned those files into a national Mental Health Parity Index



Two Parity Index measures

Reimbursement
Negotiated rates normalized using RVUs for outpatient medical versus behavioral health rates

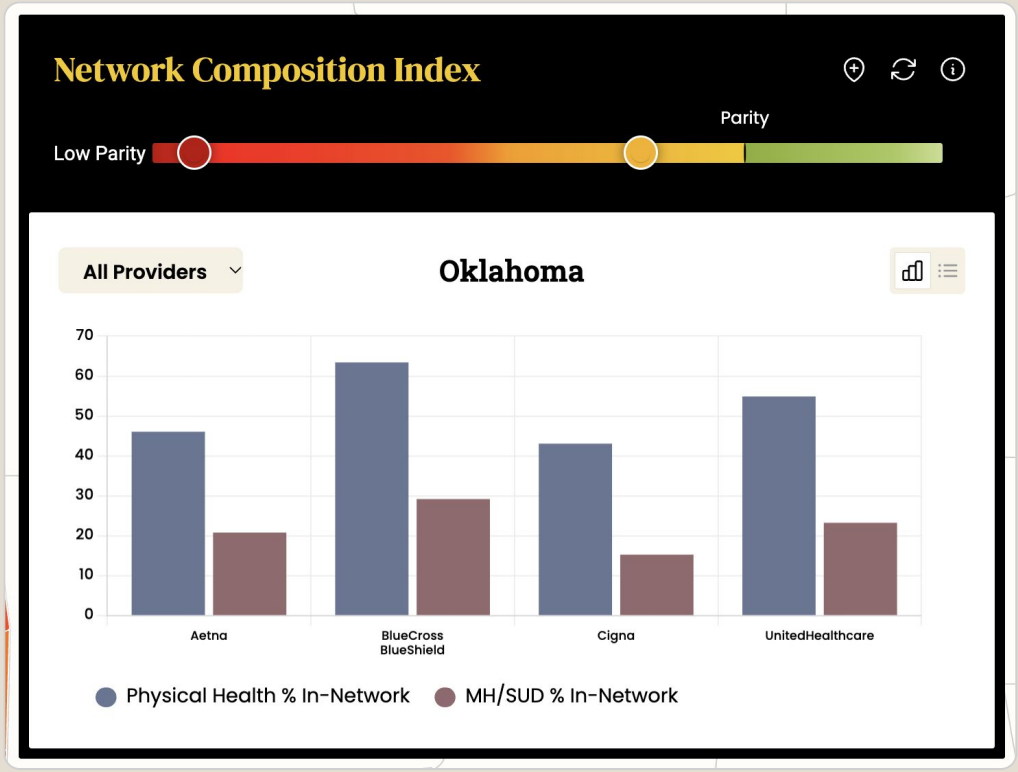
Network composition
In-network clinicians as a share of the licensed workforce, behavioral versus physical

www.ParityIndex.org

Sources: Mental Health Parity Index, The Kennedy Forum and Third Horizon (2026); U.S. Department of Labor, Field Assistance Bulletin 2026-03 (September 8, 2026)

NETWORK COMPOSITION

A network is measured as a relative percent of the clinicians who are licensed against the percent in-network



NUMERATOR

Clinicians with a contracted rate in a carrier's Transparency in Coverage file

DENOMINATOR

Clinicians licensed or credentialed to deliver the service in a given geography

Oklahoma: for every major carrier, the in-network share of mental health and substance use clinicians is well below the share of physical health clinicians. Provider counts and time-and-distance tests never surface that gap.

Source: Mental Health Parity Index, Network Composition Index, Oklahoma (The Kennedy Forum and Third Horizon, 2026)

WHY AUTISM, WHY NOW

Every state mandates ABA coverage. No one measures whether the networks deliver it adequately.

A head count is insufficient

New York defines an adequate network as two in-network providers per county.

Rules built for other care

Most standards are general behavioral health time-and-distance tests, often loosened in rural counties.

Ghost networks

Directories often list providers who are full, out-of-network, or unreachable.

Families carry the proof

Providers and parents face access gaps as they wait to receive services.

421 percent

Growth in Medicaid and CHIP ABA spending from 2021 to 2025, against 67 percent growth in children served. The policy conversation has moved from coverage to cost, and several states have cut rates or added limits this year. The field needs its own evidence on access before the policy conversation is settled without this data.

Sources: New York network adequacy standard; HHS ASPE, Network Adequacy for Behavioral Health (2021); CMS State Medicaid and CHIP ABA Toolkit (August 4, 2026)

THE VISION

The Autism Services Opportunity Index: advocacy tools and intelligence for CASP members to drive network adequacy and industry response to cost growth dialogues

01

Policy

Mandates, caps, parity, and Medicaid changes, kept current

02

Need

Autism prevalence and children by state and community

03

Workforce

Certified and licensed analysts; shortage areas

04

Rates

Medicaid schedules; aggregate commercial benchmarks

05

Networks

County access map and network composition from TiC files

THE OUTPUT

A one-page state or county profile any provider, BCBA, family, or attorney can take to a legislator, regulator, or plan.

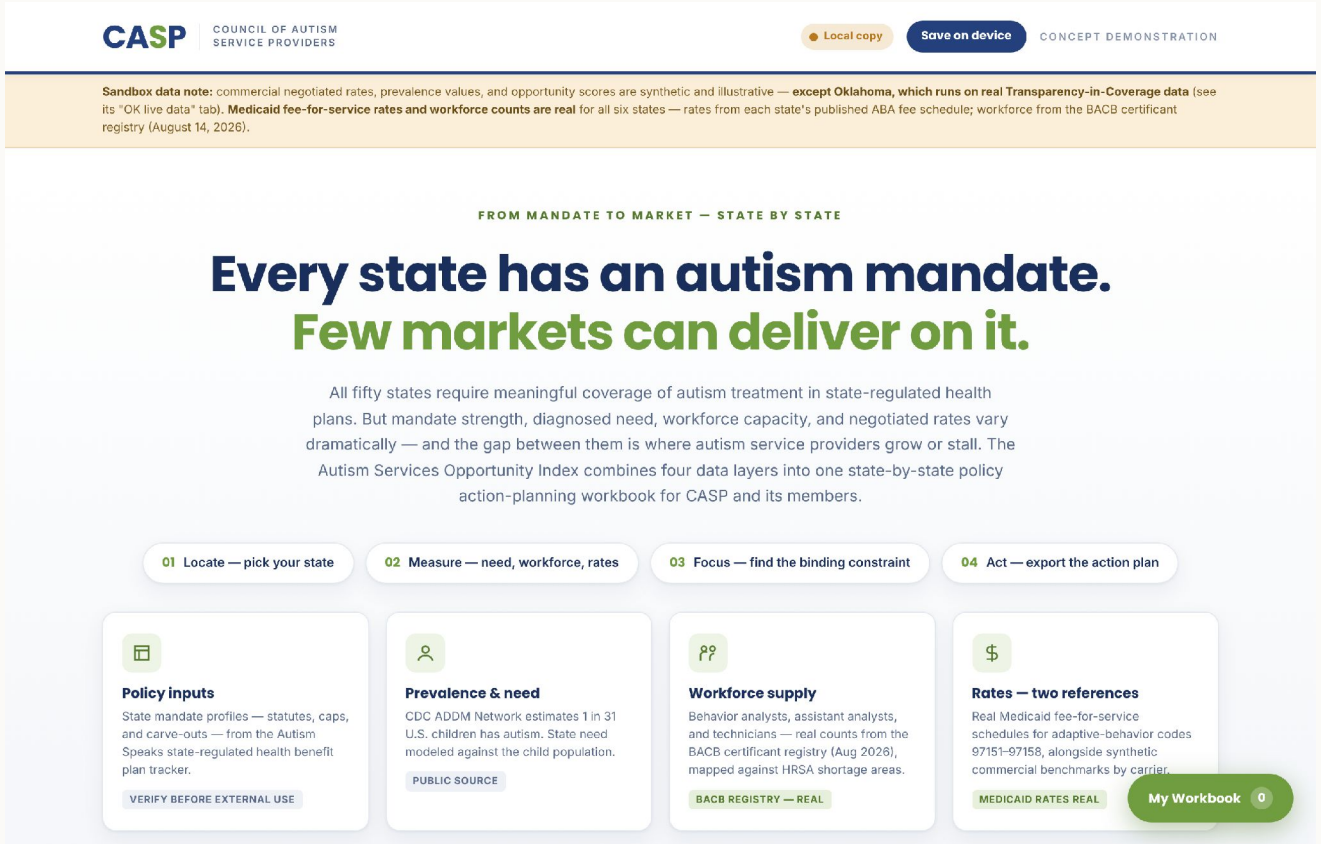
INDEPENDENT BY DESIGN

CASP leads and a member workgroup sets and publishes the method. Third Horizon builds and runs the data. Only public carrier and Medicaid data; CASP never collects member contract rates.

Model: The Kennedy Forum Mental Health Parity Index. Sources: CDC ADDM; BACB registry; HRSA; state Medicaid fee schedules; payer TiC files; Autism Speaks tracker

THE WORKING PROTOTYPE

A state-by-state workbook: locate, measure, focus, act





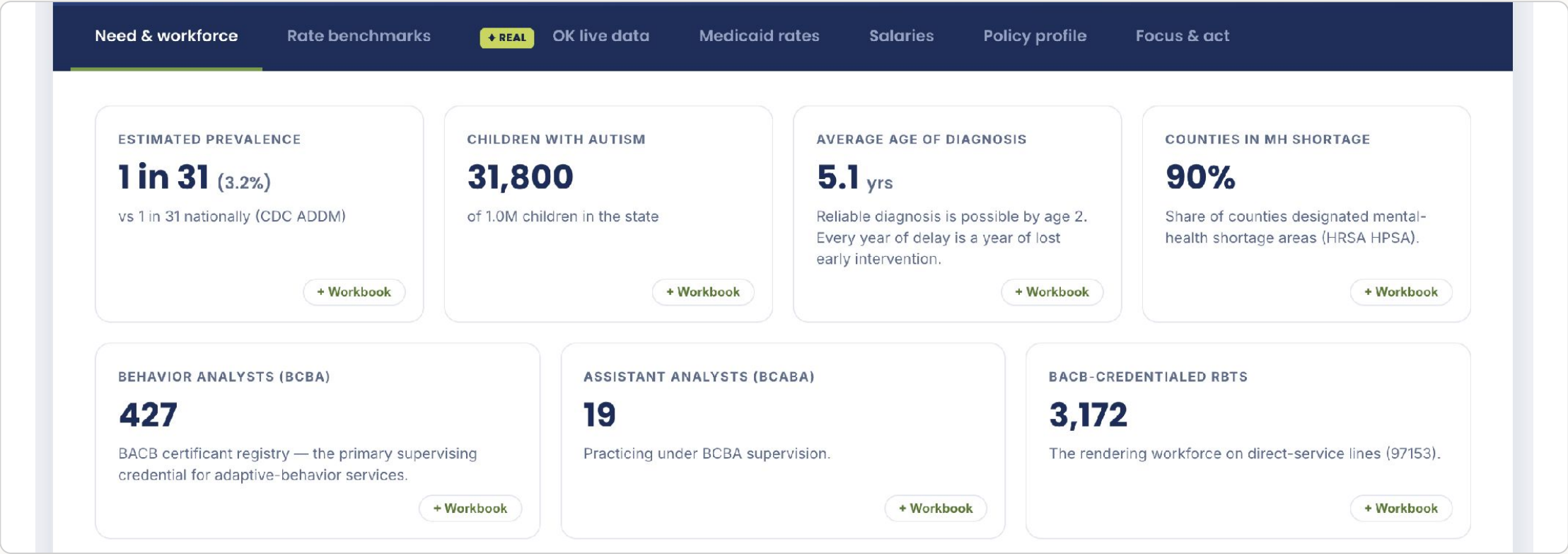
Four scored components point each state to its binding constraint and an action plan a member can export.

Concept demonstration. Weights are illustrative until the CASP workgroup sets them. Medicaid rates and workforce counts are real for all six states; Oklahoma runs on live Transparency in Coverage data.

Source: Autism Services Opportunity Index concept demonstration (Third Horizon for CASP, October 2026)

OKLAHOMA, IN THE ACTUAL DATA

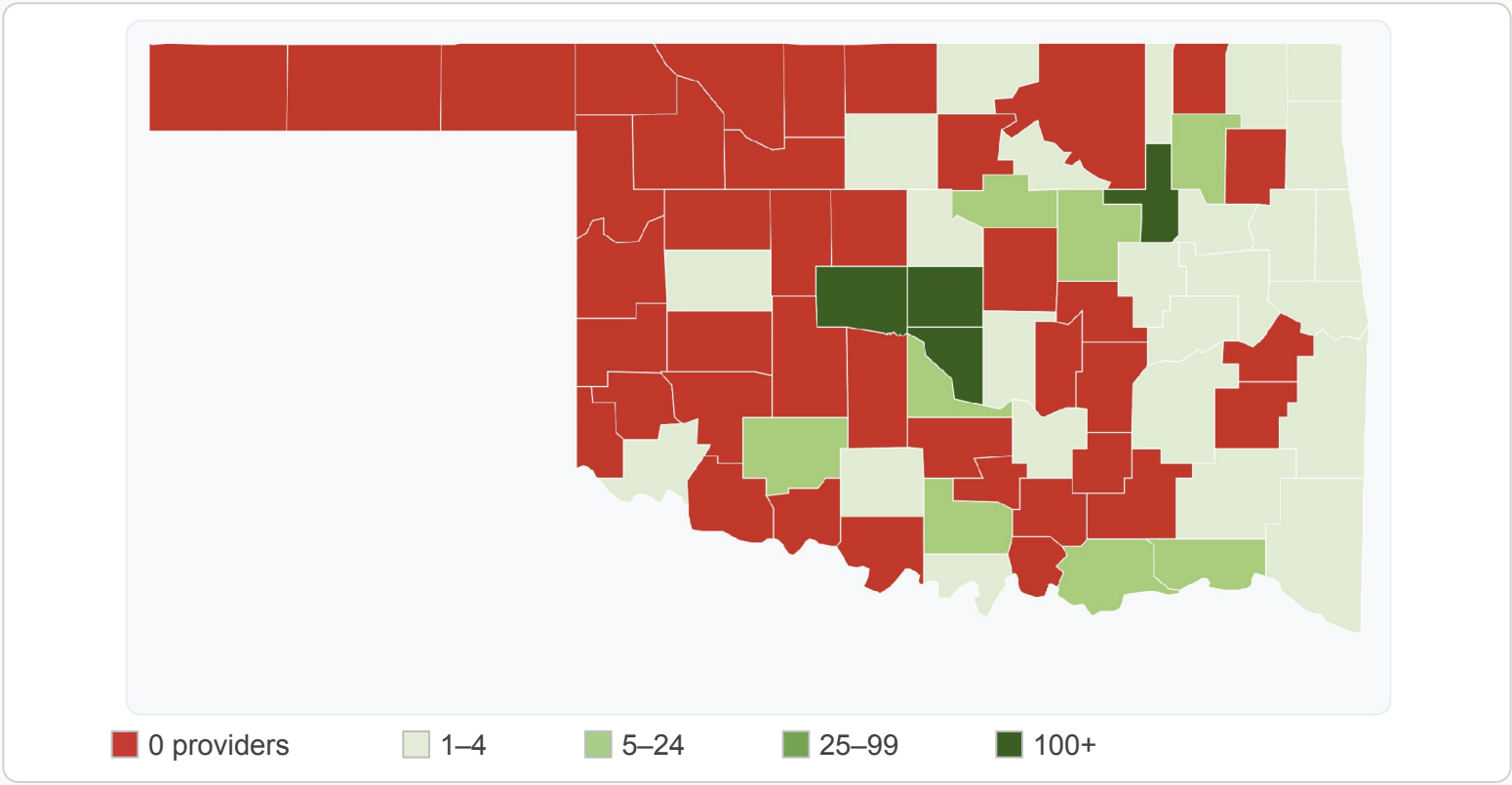
Need and workforce first: 31,800 children with autism and 427 behavior analysts



Sources: CDC ADDM; BACB certificant registry (August 14, 2026); HRSA shortage areas. Screenshot from the Index concept demonstration, Oklahoma, Need and workforce tab.

THE MAP THE STATE CANNOT SHOW YOU

40 of 77 Oklahoma counties have no in-network commercial ABA provider



561,713

residents in those counties, about 14 percent of the state

~4,200

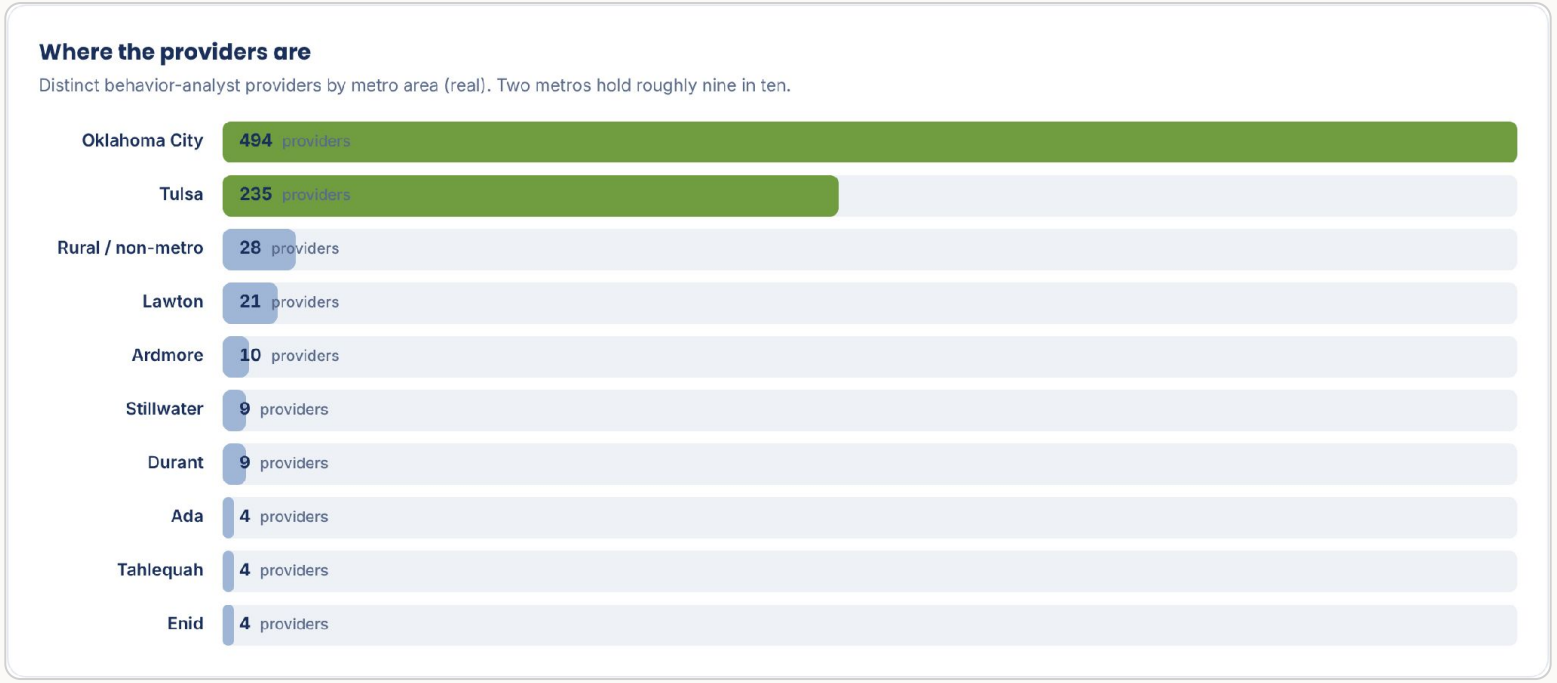
children with autism, estimated, with a benefit and no one in network to bill it

Grady County, 58,353 residents and a state mandate with no caps, has no in-network ABA provider with any of six carriers. Neither does Osage, the largest county by area.

Source: Third Horizon TiC extract, 409,134 records, 625 behavior-analyst NPIs, by practice county (August 2026). Commercial only; excludes telehealth. U.S. Census 2020; child estimate applies 1 in 31 to the under-18 share.

WHERE THE PROVIDERS ARE

Two metros hold roughly nine in ten of Oklahoma's in-network analysts



494 Oklahoma City

235 Tulsa

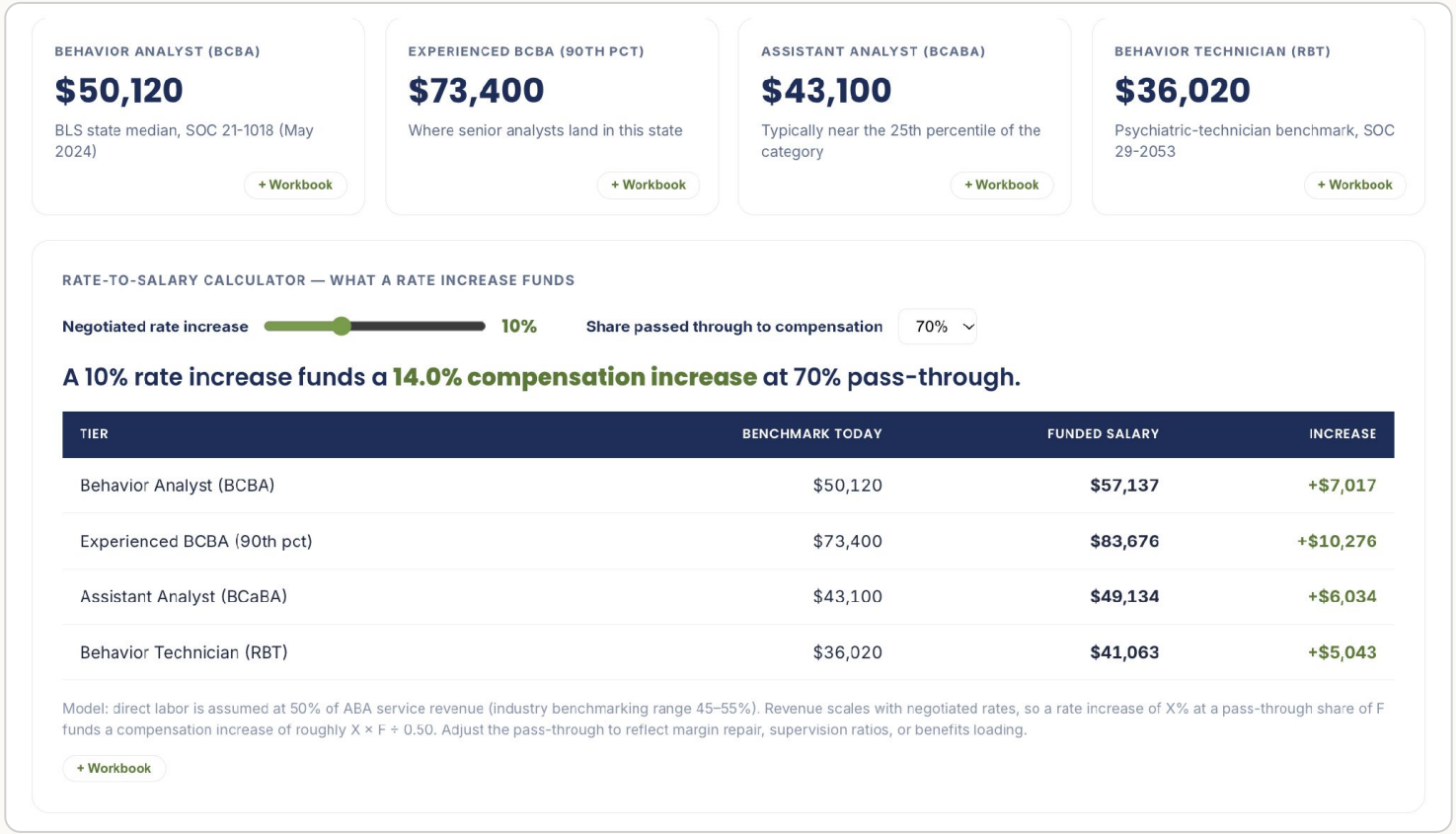
28 all rural and non-metro areas combined

Oklahoma has 13 BCBAs per 1,000 affected children, the thinnest workforce of the six demonstration states.

Sources: Third Horizon TiC extract, Oklahoma (August 2026); BACB certificant registry (August 14, 2026). Screenshot from the Index concept demonstration, OK live data tab.

RATES AND WORKFORCE, ONE LEVER

The Index ties every rate ask to the workforce it would fund



$50,120

Oklahoma median for a behavior analyst (BLS, May 2024)

A rate increase becomes a recruiting argument when a member can show the legislature or the plan what it funds in analyst and technician pay.

Growth and adequacy are the same case: no network fills without a workforce that can afford to stay.

Sources: BLS OEWS, May 2024, SOC 21-1018 and SOC 29-2053, scaled to state wage level. Screenshot from the Index concept demonstration, Oklahoma, Salaries tab. Calculator assumes direct labor at 50 percent of ABA revenue.

FROM ONE STATE TO A STANDARD

What a data-driven network adequacy standard for ABA could measure zip code by zip code

Question	What most standards use today	What the data can measure now
Is anyone in network?	A provider count or a time-and-distance test written for general behavioral health	In-network ABA providers by county, by carrier, from the carriers' own TiC files
Is it a contracting gap or a supply gap?	Not asked	Network composition: in-network analysts as a share of the credentialed workforce
Do the rates sustain participation?	Not asked, though DOL now names reimbursement methods	Aggregate commercial benchmarks against Medicaid fee schedules, by code
Is the listed provider real and available?	Directory audits, usually after a complaint	Not yet. Payer files show contracts, not capacity. This is where we would leverage historical claims for utilization
How does the need compare?	Rarely tied to prevalence	Children with autism by county against the providers in reach

Sources: HHS ASPE (2021); DOL FAB 2026-03 (September 8, 2026); Third Horizon and The Kennedy Forum Parity Index method

FOR THE ROOM

How do we build a data-driven approach to network adequacy, state by state?

1. If you filed a network adequacy complaint tomorrow, what evidence would the regulator accept? Would a county map and a composition measure move them?

2. Where the map shows a county with no in-network provider, what should the field ask the carrier, the legislature, and the Medicaid agency for?

3. Which states have the widest gap between the standard on paper and what families find? Which state should the Index profile first?

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