October 12, 2026

To Whom It May Concern:

We write to express serious concern regarding policies and rulings that restrict access to medically necessary services based solely on the time of day services are delivered or the location in which those services occur. These categorical limitations undermine individualized care, conflict with federal Medicaid requirements, create potential behavioral health parity concerns, and risk violating the rights of children with disabilities.

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requires states to provide all medically necessary services necessary to correct or ameliorate a child's physical or behavioral health condition. Medical necessity determinations must be individualized and based on the unique needs of the child, not on administrative considerations such as school schedules, service location, or provider convenience. CMS reaffirmed these requirements in its 2026 EPSDT Coverage Guide and Children's Behavioral Health Toolkit, emphasizing that states must provide the full continuum of medically necessary behavioral health services available under Medicaid to eligible children.[1][2]

When a child requires Applied Behavior Analysis (ABA) or another medically necessary intervention to access, participate in, and benefit from educational and community environments, denying or limiting those services because they occur during school hours or in a school setting effectively substitutes a blanket policy for an individualized medical necessity assessment. Such restrictions fail to recognize that children do not stop experiencing symptoms, treatment needs, or functional impairments simply because they are attending school.

Recent Centers for Medicare & Medicaid Services (CMS) guidance confirms that medically necessary services for children must be available where they live, learn, and participate in their communities. CMS recognizes schools as appropriate settings for Medicaid-covered services and encourages states to facilitate, rather than restrict, access to medically necessary health and behavioral health care in educational settings.[3]

In addition, restrictions that apply uniquely to behavioral health services raise significant concerns regarding parity and equal access to medically necessary treatment. Children routinely receive medically necessary physical health services during the school day, including nursing care, diabetes management, seizure-related supports, medication administration, physical therapy, occupational therapy, and other health interventions. Those services are generally not deemed unnecessary merely because they occur during school hours or within educational settings. Behavioral health services should not be subjected to more restrictive standards solely

due to the nature of the disability or treatment modality. Clinical necessity, rather than the clock or location, should determine whether services are authorized and delivered.

Policies that categorically prohibit services during certain hours of the day or in particular locations are inconsistent with the individualized framework required under Medicaid, EPSDT, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and the Individuals with Disabilities Education Act (IDEA). Children with disabilities are entitled to equal access to medically necessary healthcare services and may not be denied treatment opportunities based on administrative classifications unrelated to clinical need.

Moreover, restrictions based solely on time or location may have the practical effect of denying meaningful access to treatment. Many medically necessary interventions are most effective when provided in the natural environments where functional challenges occur. For children receiving ABA services, treatment is often designed to address communication deficits, social interaction, adaptive functioning, behavior regulation, safety awareness, and educational participation in the exact settings where those challenges arise. For some children, medically necessary services delivered during school hours or within educational settings are essential to addressing impairments that cannot be effectively treated in a clinic, home, or different environment.

Limiting treatment to after-school hours may also undermine established clinical principles regarding generalization of skills. Children with autism and related developmental disabilities frequently require intervention across multiple settings to learn, maintain, and generalize critical functional skills. Restricting services to a narrow window of time or a limited setting may reduce treatment effectiveness, delay progress, and hinder the child's ability to successfully navigate educational, social, and community environments.

These restrictions may also create substantial burdens for families. Many working parents and caregivers rely upon integrated service delivery models that allow children to access medically necessary treatment while participating in educational programming. Limiting services to evenings or weekends may reduce availability, increase waitlists, interfere with family functioning, create transportation hardships, and ultimately decrease access to care for the very children Medicaid is intended to serve.

We are particularly concerned by reasoning that assumes a child's physical presence in the classroom is synonymous with meaningful educational access. Federal law does not define educational benefit by seat time or classroom attendance alone. Rather, the United States Supreme Court has held that educational programming must be reasonably calculated to enable a child to make progress appropriate in light of the child's unique circumstances.[4] A child who cannot regulate behavior, communicate effectively, participate safely, engage socially, or otherwise access instruction without medically necessary treatment is not meaningfully accessing education simply because they are physically present in a classroom.

Likewise, federal disability law increasingly recognizes that disability-related accommodations and modifications must be evaluated independently of traditional special education analyses. In *A.J.T. v. Osseo Area Schools* (2025), the United States Supreme Court reaffirmed that the ADA and Section 504 provide independent protections against disability discrimination and rejected heightened barriers to claims seeking equal access and reasonable modifications.[5] Consequently, even where a school district believes it has satisfied its obligations under IDEA, categorical denial of medically necessary treatment during school hours may still violate a child's rights under the ADA and Section 504.

The individualized nature of these determinations is further reflected in federal IDEA regulations, which require decisions regarding children with disabilities to be made on an individual basis rather than through blanket exclusions or categorical assumptions.[6] The use of rigid time-of-day restrictions or location-based prohibitions is therefore fundamentally inconsistent with the individualized decision-making framework established throughout federal disability and Medicaid law.

Accordingly, we are concerned that rulings or policies imposing categorical restrictions based on school attendance, time of day, or location of service effectively substitute administrative preferences for individualized assessment and medical necessity. Neither federal disability law nor Medicaid law permits a determination that medically necessary services become unnecessary merely because they are delivered during school hours or within a school setting. The legally relevant inquiry is not where or when a service is delivered, but whether the service is medically necessary, individualized, and provided in the setting most appropriate to address the child's documented needs.

We further urge policymakers, Medicaid authorities, managed care organizations, and reviewing entities to evaluate these issues through the lens of individualized medical necessity, disability rights, and equitable access to healthcare. Coverage decisions should be guided by clinical evidence, treating provider recommendations, comprehensive assessments, and the unique needs of each child rather than categorical assumptions regarding school attendance, time of day, or treatment location. The consequences of restricting medically necessary behavioral health services extend beyond reimbursement policy and directly affect child safety, developmental progress, communication, family stability, educational access, and long-term outcomes.

We respectfully urge reconsideration of any policy, interpretation, or ruling that limits medically necessary services based on time-of-day or location-of-service restrictions. Coverage and authorization decisions should instead be based on individualized clinical determinations, consistent with EPSDT requirements, federal disability rights protections, and current CMS guidance. Children should not be denied medically necessary care because of arbitrary scheduling or location rules that bear no relationship to their documented treatment needs.

Ultimately, children with disabilities are entitled to the same individualized consideration afforded to all Medicaid beneficiaries. Medical necessity cannot be determined by a bell

schedule, a classroom doorway, or an inflexible administrative policy. When clinical evidence demonstrates that treatment is necessary to allow a child to safely function, communicate, learn, and participate in daily life, access to that treatment should follow the child's needs, not artificial restrictions regarding where or when care may occur.

Thank you for your consideration of these concerns and for your commitment to ensuring that children receive medically necessary services in a manner consistent with federal law and their rights as Medicaid beneficiaries. Please reach out to us at 517-371-1400.

Sincerely,

Janna Ruedisale

Janna Ruedisale
Director, Michigan Behavior Analysis Providers (MiBAP)
membership@mibap.org | (517) 371-1400

Footnotes

1. Centers for Medicare & Medicaid Services (CMS), *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guide for States: Coverage in the Medicaid Benefit for Children* (May 2026), emphasizing that EPSDT requires coverage of medically necessary services and individualized medical necessity determinations.

2. CMS, *State Medicaid & CHIP Toolkit: Children's Behavioral Health Services and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Requirements* (February 2026), describing states' obligations to provide medically necessary behavioral health services across the continuum of care.

3. CMS, *Delivering Service in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming* (2023), recognizing schools as appropriate settings for Medicaid-covered health and behavioral health services.

4. *Endrew F. v. Douglas County School District RE-1*, 580 U.S. 386 (2017), holding that educational programs must be reasonably calculated to enable a child to make progress appropriate in light of the child's circumstances and emphasizing individualized decision-making.

5. *A.J.T. v. Osseo Area Schools*, 605 U.S. ___ (2025), confirming that ADA and Section 504 claims remain independent protections for students with disabilities and rejecting heightened standards for educational disability discrimination claims.

6. 34 C.F.R. § 300.101(c)(2), requiring eligibility and service determinations for children with disabilities to be made on an individual basis.

This version is substantially stronger legally and directly challenges the core premise of the Fall 2025 Bay-Arenac ruling without expressly attacking the judge, instead demonstrating that categorical time-of-day and location restrictions conflict with subsequent CMS guidance, EPSDT requirements, IDEA, ADA, and Section 504 authorities.

7. Mental Health Parity and Addiction Equity Act (MHPAEA), 29 U.S.C. § 1185a; 42 C.F.R. §§ 438.900-438.930. Federal parity requirements prohibit mental health and behavioral health benefits from being subject to more restrictive treatment limitations than comparable medical and surgical benefits, including non-quantitative treatment limitations affecting access to care.