

POSITION STATEMENT

Authority Without Authorization Governance and Accountability in Applied Behavior Analysis

Position Statement Issued by ABA Accountability Project

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*Intended Recipients: Insurance Companies and Payers • State Insurance Commissioners •
Professional Bodies (BACB, ABAI, APBA) • ABA Provider Community*

All factual claims in this document are drawn from publicly available materials on CASP's official website (casproviders.org), CASP's own published materials, and peer-reviewed research. Sources are cited in full at the end of this document.

Executive Summary

Every profession eventually confronts a foundational question: Who has the authority to speak for the field — and on what basis is that authority granted? In applied behavior analysis, that question has never been formally answered. Over the past fifteen years, the Council of Autism Service Providers (CASP) has increasingly presented itself to payers, regulators, and federal agencies as representing the autism provider community. The central question addressed in this statement is whether that authority was ever granted by the field it claims to represent.

The Council of Autism Service Providers (CASP) describes itself on its public website as representing “the autism provider community to the nation at large including government, payers, and the general public.” It does not. No election was held. No field-wide process occurred. No credentialed behavior analysts outside the founding group were consulted.

Here is what is documented in CASP’s own publicly available materials:

- **CASP began in 2009** when leaders from ten provider agencies convened privately in Las Vegas. No election was held. No field-wide process occurred. No credentialed behavior analyst outside the founding group was consulted. Yet CASP now lobbies federal agencies, sets standards, and speaks for the entire field — a field that never chose it.
- **CASP’s board is composed entirely of executives of large, multi-state provider companies** — every standard set for the field, every policy lobbied on the field’s behalf, decided by people whose organizations directly benefit from those decisions.
- **CASP created the Autism Commission on Quality (ACQ) as a wholly-owned subsidiary** and subsequently acquired the Behavioral Health Center of Excellence (BHCOE) — giving one trade association ownership of the two primary accreditation bodies in the field. It has successfully lobbied more than a dozen payer entities to require accreditation from one of these bodies as a condition of network participation. CASP’s own CEO has publicly acknowledged that ACQ “wouldn’t have been able to make ends meet” without CASP’s financial support — directly contradicting CASP’s claim that ACQ operates independently.
- **CASP received the BACB’s ABA Practice Guidelines in 2020** and now monetizes them — requiring payers to pay for commercial access and mandating CASP-sponsored training to use them. The organization that stewards the field’s clinical guidelines actively works to prevent the requirement that the people delivering services under those guidelines hold the field’s own credential.
- **CASP has published practice parameters governing the use of artificial intelligence in ABA** — the next frontier of clinical practice — developed by a working group composed entirely of its own member organizations. Every new frontier CASP enters follows the same pattern: write the standard, sell the training, lobby payers to require it.
- **The accreditation requirements, compliance systems, and operational standards CASP lobbies payers to mandate are built for large national organizations** with entire departments dedicated to administrative overhead. For an independent BCBA or small community-based practice, meeting those requirements means diverting clinical time away from patients — or absorbing costs the practice cannot survive. This is not a side effect. It is

a predictable outcome of standards written by executives of large corporations, for the operational realities of large corporations.

This is not a statement against quality standards or appropriate regulations. The field needs both. This is a statement about who is setting them, under what governance structure, and in whose financial interest — and about what practitioners, professional bodies, payers, and regulators can do to ensure that those standards serve the field rather than the organizations that profit from them.

The research on how professions govern themselves is clear: fields that fail to build independent governance structures before significant outside capital enters do not get a second chance to do it easily. Private equity completed 85 percent of all mergers and acquisitions in the autism services sector between 2017 and 2022. The window for the field's legitimate professional bodies — the BACB, APBA, and ABAI — to assert independent governance authority is narrowing with every payer contract signed, every state mandate passed, and every standard CASP embeds into federal policy.

This statement documents what has happened, why it matters, and what the field must do — and do now — to ensure that the future of autism services is determined by the clinicians who deliver it, the families who depend on it, and the science that should govern it. Not by a trade association that appointed itself to speak for all of them.

Section I: What Every Mature Profession Answers First

Every profession, at some point in its development, faces a foundational question: who speaks for us, and on what authority?

The answer to that question — how it is answered, when it is answered, and by whom — determines nearly everything that follows. It determines whether clinical standards are written by clinicians or by the financial beneficiaries of those standards. It determines whether credentialing requirements are set to protect patients or calibrated to protect margins. It determines whether, when outside capital arrives looking for a return, it enters a field with rules already in place — or a field still deciding what it is.

Mature professions answer this question before the money arrives. They build governance infrastructure — independent credentialing bodies, multi-stakeholder standards organizations, ethics codes with enforcement, ownership structures that keep financial interests subordinate to clinical ones — not because they anticipated any particular threat, but because that infrastructure is what transforms a collection of practitioners with shared knowledge into a profession with legitimate authority. It is the difference between an occupation and a profession. And it is the difference, as the history of American healthcare demonstrates repeatedly, between a field that shapes its own future and one that wakes up to find its future has been shaped for it.

The sociology of professions literature is unambiguous on this point. Andrew Abbott's foundational 1988 work, *The System of Professions*, established that professional authority is not granted — it is claimed, defended, and institutionalized. Abbott's central argument is that professions exist in a competitive ecology where jurisdiction over expert knowledge is perpetually contested. A profession that fails to institutionalize its jurisdictional claims — through recognized governance structures, enforceable standards, and legitimate representative bodies — does not simply stagnate. It leaves its jurisdiction open to capture by other actors who are less encumbered by the question of whether they are entitled to claim it. Abbott notes explicitly that “organization of a profession into a single, identifiable national association is clearly a prerequisite of public or legal claims.” Without that organization, the claim goes to whoever shows up first.

Talcott Parsons, whose framework remains the foundational checklist of professional maturity, identified seven characteristics that distinguish a fully institutionalized profession: a specialist body of knowledge; recognized authority to which clients defer; self-governing professional associations capable of making and enforcing standards; a distinct ethics code; control over credentialing and entry; a commitment to public service over private gain; and structural protections for patients against exploitation. A field that possesses the first five but lacks the last two — self-governing representative associations and patient protection structures — has the intellectual infrastructure of a profession without the governance infrastructure that makes it defensible.

Applied behavior analysis, as this statement will document, has built an impressive and legitimate version of the first five. It has a rigorous peer-reviewed science base accumulated over six decades. It has a credentialing body — the Behavior Analyst Certification Board — whose certification is recognized by federal agencies, state Medicaid programs, and insurance companies across the country. It has an ethics code with real enforcement. It has state licensure in most jurisdictions. It has the intellectual and credentialing architecture of a mature profession.

What it has not built — and what every other healthcare profession that successfully defended its clinical integrity built before significant capital entered its market — is the governance layer: an independent, multi-stakeholder body with legitimate democratic authority to speak for the field's standards, represent its practitioners' interests, and protect the patients it serves from the structural conflict of interest that arises when financial incentives and clinical obligations point in different directions.

That gap is not a minor administrative oversight. It is the vulnerability that the history of American healthcare tells us, with remarkable consistency, produces the same outcome every time: when the governance layer is missing, something fills it. In emergency medicine it was large staffing corporations. In dermatology it was private equity rollups. In ABA it was a trade association of large provider executives that convened privately in a Las Vegas hotel in 2009, decided it would speak for the field, and has been building the institutional infrastructure to make that claim stick ever since.

This statement is not primarily about that organization's intentions or the good faith of the individuals within it. It is about what happens structurally, and predictably, when a profession leaves its most important question unanswered — and about what answering it, at long last, would actually require.

Section II: What Other Professions Built, and When

The pattern is not subtle, and it is not new. Every healthcare profession that successfully defended its clinical integrity from investor capture built independent governance structures before the capital arrived. The timeline is instructive — not because the fields that got it right were far-sighted visionaries, but because the sequence of what they built, and when, is consistent enough to function as a blueprint. And the sequence of what happened to the fields that built it late is consistent enough to function as a warning.

Medicine established the American Medical Association in 1847 — a professionally governed membership body representing individual physicians, not the hospitals or corporations that employed them. The Corporate Practice of Medicine doctrine emerged in case law by the early twentieth century, reserving clinical ownership for licensed professionals. The Joint Commission on Accreditation of Hospitals was established in 1951 as a genuinely independent multi-stakeholder body — not as a subsidiary of a trade association, not as a product of self-appointment, but as a body with board representation from physicians, consumers, and public members specifically to prevent the kind of industry capture that results when the financial beneficiaries of standards control the governance of those standards. When private equity entered medicine, it entered a field with rules already in place.

Dentistry followed a similar path. The American Dental Association was founded in 1859. The Commission on Dental Accreditation developed as an independent accreditation body — not owned by the ADA, not a subsidiary of a trade association. Most states extended Corporate Practice of Medicine protections to dentistry by the mid-twentieth century, requiring dentist ownership of dental practices. The governance architecture preceded the investment wave.

Psychology built its governance layer over several decades. The American Psychological Association was established in 1892. A formal ethics code emerged in 1953, developed through a field-wide democratic process. State licensing boards proliferated through the 1950s and 1960s, creating independent regulatory authority separate from the professional association. Evidence-based practice guidelines began developing through a peer-reviewed process with broad clinician input. By the time corporate interests attempted to reshape psychology's practice environment, the profession had institutional structures capable of pushing back.

Emergency medicine is the closest analog to the situation ABA now faces, and the most instructive. Emergency medicine established the American College of Emergency Physicians in 1968 and the American Board of Emergency Medicine — an independent credentialing board — in 1976. Both structures predated private equity's entry into the specialty by decades. When PE firms began acquiring emergency staffing groups at scale in the late 2010s, there was an existing professional infrastructure to sound the alarm. Legislative response arrived within approximately four years. Emergency medicine did not have to build its governance structures while fighting investor capture simultaneously. Applied behavior analysis does.

The timeline comparison is the point. Medicine took several decades from the AMA's founding to build its full governance architecture. Dentistry took a comparable arc. Emergency medicine, moving faster, built its independent credentialing body in roughly eight years from the field's formal establishment. Applied behavior analysis has had twenty-eight years since the BACB was founded in 1998 — the equivalent of emergency medicine's full governance build window, times

three — and has not yet assembled the independent, multi-stakeholder standards body that every comparison field had in place before investor capital arrived.

The lesson is not that ABA has been negligent. The lesson is that the window to build independent governance structures is not infinite, and the cost of missing it is high. Every field that has faced this situation has learned that lesson. Applied behavior analysis should not have to learn it again from scratch.

Section III: What ABA Built Instead

Applied behavior analysis did not fail to professionalize. It is important to say that clearly, because the argument of this statement is not that the field is undisciplined or that its practitioners are unprofessional. The argument is more specific and more uncomfortable than that: the field built the right foundations and then stopped one layer short of completion — and that missing layer is the one that matters most when capital arrives looking for a return.

The foundation is genuine and should be recognized as such. Florida issued the first state certification for behavior analysts in 1983, establishing early that this was a credentialed practice, not an unlicensed trade. The Behavior Analyst Certification Board was established in 1998 — a legitimate, independent, nonprofit credentialing body whose certification is recognized by federal agencies, state Medicaid programs, and insurance companies across the country. The BACB's certification programs are accredited by the National Commission for Certifying Agencies, the same body that accredits credentialing programs across American healthcare. The ethics code the BACB established has real enforcement mechanisms — certification can be suspended or revoked for violations, which creates genuine professional accountability. The Registered Behavior Technician credential, introduced in 2013, extended that accountability to the frontline practitioners delivering the majority of direct service hours. State licensure laws, which began proliferating in earnest after 2009, now govern behavior analyst practice in the majority of U.S. states. The Association for Behavior Analysis International has maintained a rigorous scientific community for decades. The Association of Professional Behavior Analysts, founded in 2007 specifically to represent credentialed individual practitioners, established the right institutional form two years before CASP existed.

By any reasonable measure, this is the record of a field that was actively and sincerely working toward professional maturity. The BACB in particular built something the field should be proud of — an independent credentialing body, not owned by any trade association, not subject to lobbying pressure, designed explicitly to protect consumers rather than advance member financial interests.

What the field did not build — and what the comparative history of other healthcare professions suggests was the necessary next step — was the governance layer that sits above credentialing and below regulation. The independent, multi-stakeholder body with democratic legitimacy to develop clinical standards, speak for the field's practitioners to payers and regulators, and protect the profession's jurisdictional claims from capture by actors whose interests are not aligned with the profession's public obligations. The body that, in medicine, looks like the Joint Commission. In psychology, like a democratically governed APA with transparent standards development. In emergency medicine, like ABEM and ACEP working in concert to define what the specialty is and who speaks for it.

The absence of that body was not negligence. It was timing — and timing, in this case, was everything.

Between 2012 and 2019, state autism insurance mandates proliferated across the country, creating overnight demand for ABA services at a scale the existing provider base could not meet. Demand that outpaces supply at that velocity does not wait for governance infrastructure to catch up. It attracts capital. Between 2017 and 2022, private equity firms completed 85 percent of all mergers and acquisitions in the autism services sector — a rate not found in any other segment of American

healthcare. The field went from a collection of predominantly clinician-owned independent practices to a consolidating, investor-driven industry in approximately five years.

The governance layer the field had not yet built would have been the structural answer to that transformation — the set of rules already in place, the ownership protections already encoded in law, the independent standards body already recognized by payers and regulators, that would have told incoming capital: this is what ABA is, these are its rules, and you are operating within them. Without it, the field had no institutional answer to the question the insurance mandate wave and the PE acquisition surge were both implicitly asking: who speaks for this profession, and on what authority?

Into that silence, in 2009 — before the mandate wave, before the PE surge, but early enough to be positioned when both arrived — leaders from ten provider agencies convened privately and began constructing an answer. Not because they were acting in bad faith, but because the question was real and unanswered and someone was going to answer it. The problem was not that they showed up. The problem was what they were, and what they were not.

What they were: a group of large provider organization leaders with the organizational resources, institutional ambition, and financial incentive to claim jurisdictional authority over the field's standards, accreditation, and regulatory representation.

What they were not: elected, credentialed as a representative body, structurally independent of the financial interests their decisions would govern, or accountable to anyone outside their own membership.

Abbott's framework for understanding professional development is precise about what happens in this situation. Jurisdictions — the recognized authority to control expert knowledge and its application — do not remain unclaimed. When a profession fails to institutionalize its own jurisdictional claims, those claims migrate to whatever actor is organized enough, resourced enough, and motivated enough to make them. The question Abbott's framework asks of ABA is not whether CASP should have filled the vacuum. It is why the profession left the vacuum for CASP to fill — and whether it is prepared, now, to fill it itself.

Section IV: A Predictable Consequence

To understand what CASP is, it helps to understand what it is not — and to resist the instinct to explain its growth through any single person's intentions. The more accurate and more useful explanation is structural. CASP did not manufacture a problem and exploit it. It identified a genuine vacuum, had the organizational resources to fill it, and filled it — in the legal form most convenient to its founding members, with the governance structure most advantageous to their financial interests, and under a banner of field-wide representation it was never democratically authorized to carry.

That is not a story about individual actors. It is a story about what happens when a profession leaves its most important question unanswered long enough for someone else to answer it.

What CASP has become is best understood not through the intentions of the people within it — which this statement addresses directly — but through the logic of the structure itself. That structure was not inherited by its current leadership. It was built by them, expanded by them, and continues to operate under the governance of the same executives who designed it. What it has produced is worth examining on those terms.

CASP's current leadership includes both the executives who designed this structure from the beginning and those who joined it later. It is worth acknowledging that distinction honestly, because it matters for how we understand accountability. Lorri Unumb, CASP's CEO since 2019, is a parent of autistic children, a trained attorney, the author of Ryan's Law — the landmark 2007 South Carolina autism insurance legislation — and a decade-long veteran of Autism Speaks. She founded a small, single-location nonprofit ABA center, not a national corporate chain. She did not design the governance structure she now leads. Creditable personal histories and structurally compromised governance are not mutually exclusive. The argument of this statement is not that any individual within CASP is acting with cynical intent. It is that the structure itself is constitutionally incapable of providing what the field needs — regardless of the intentions of the people operating within it.

What CASP has built, over the following fifteen years from its founding, was not a professional association. It was something more strategically coherent and more commercially self-reinforcing: a closed-loop system in which the same organization writes the standards, accredits compliance with those standards, lobbies payers to require that accreditation, owns the data infrastructure used to evaluate network adequacy, and is now developing guidelines for the next generation of clinical technology. At every step there is a product for sale. At every step the rules being written are written by the organizations that profit from them. And at every step the claim of field-wide representation provides the political cover that makes the commercial machinery defensible.

This is not a coincidence of institutional design. It is the predictable consequence of a 501(c)(6) trade association — a legal structure whose explicit purpose is to advance the business interests of its dues-paying members — being allowed to occupy a governance role that demands precisely the opposite orientation. A trade association's legal obligation runs to its members. A clinical standards body's obligation runs to the patients its standards are meant to protect. Those are not the same obligation. In a well-governed field they are held by separate institutions specifically to prevent the conflict of interest that results when they are not. In ABA, they have been collapsed into one.

The BACB understood this distinction when it was established in 1998. Its own published materials state explicitly that BACB certification “cannot be influenced by special-interest lobbying” — that protection was a design choice, not an accident. The BACB built its independence into its structure deliberately, because its founders understood that a credentialing body captured by the financial interests of the organizations it credentialed would not be a credentialing body at all. That same logic applies, with equal force, to clinical standards bodies, accreditation programs, and the organizations that lobby payers on the field’s behalf. CASP’s structure fails that test at every level — not because of the intentions of the individuals within it, but because a 501(c)(6) trade association governed entirely by the executives of its own member organizations is constitutionally incapable of passing it.

What CASP has built is real. Its institutional footprint — guidelines, accreditation programs, a national patient data registry, federal lobbying infrastructure, payer relationships, state advocacy networks — is extensive and increasingly difficult to dislodge. Standards, once embedded in federal and state policy, calcify. Accreditation requirements, once written into network contracts, become baseline assumptions. The time for the field’s legitimate actors to contest CASP’s jurisdictional claims is now.

Section V: What the Structure Has Produced — The Documented Record

The preceding sections have established the structural argument: a trade association self-appointed to represent a field it was never authorized to speak for, governed by the financial beneficiaries of its own decisions, operating without the independent checks that every comparable healthcare profession built before significant outside capital entered its market. What follows is the documented record of what that structure has produced — documented in CASP’s own public materials, its leadership’s own public statements, and peer-reviewed research.

The pattern is consistent across every domain CASP has entered. Write the standard. Sell the tools required to meet it. Lobby payers to require it. Expand. Each step deepens the financial dependency of the field on CASP’s products and services, and each step is defended under the banner of clinical quality. Understanding the full scope of what has been built requires examining not just CASP’s own subsidiaries, but the broader ecosystem of partnerships, coalitions, and institutional entanglements through which its influence operates.

The Accreditation Loop

CASP created the Autism Commission on Quality in 2022 as a wholly-owned subsidiary. It then successfully lobbied more than a dozen payer entities to require ACQ accreditation — or accreditation from the Behavioral Health Center of Excellence — as a condition of network participation. In December 2025, CASP acquired Jade Health, the parent company of BHCQE, consolidating both accreditation programs and the National Autism Data Registry under a single trade association. Every provider organization that seeks accreditation from either body pays fees to a subsidiary of the same trade association whose member organizations compete for the same payer contracts.

CASP’s own CEO has stated publicly that ACQ “wouldn’t have been able to make ends meet” without CASP’s direct financial support. This acknowledgment is significant beyond what it reveals about ACQ’s finances. It directly contradicts CASP’s repeated characterization of ACQ as an independent accreditation body. A subsidiary that cannot sustain itself without its parent organization’s financial support is not independent of that parent — regardless of what its governance documents say, regardless of the good faith of its committee members, and regardless of how it is described in materials presented to payers and regulators.

The claim of independence becomes harder still to sustain when the composition of ACQ’s own committees is examined. ACQ’s Standards Committee was, by CASP’s own founding press release, “originally founded through CASP” before being transferred to ACQ at launch — meaning the body that wrote ACQ’s standards did not emerge independently of CASP but was built within it. The current Vice Chair of ACQ’s Accreditation Committee — the body empowered to make accreditation determinations — is the Chief Clinical and Administrative Officer of BlueSprig Pediatrics, the KKR-backed private equity platform that acquired a CASP founding board member’s company in 2023. A past president of APBA and a current APBA board member each serve as subject matter experts on ACQ’s Standards Committee. The accreditation body CASP describes as independent of any single organization is, at the committee level, populated by executives of CASP’s own member organizations, affiliates of PE-backed companies whose founders sit on CASP’s board, and board members of the professional association CASP has co-published guidelines with. Structural independence is not achieved by forming independent

committees. It requires that the people serving on those committees are themselves independent of the financial interests at stake. By that standard, ACQ’s independence claim does not hold.

The accreditation per-location reapplication requirement deserves specific attention. ACQ requires each clinic location — not each organization — to reapply for accreditation every two years. For a national chain with one hundred locations, this is an administrative process manageable by a dedicated compliance team. For an independent BCBA running a single clinic, it is a recurring burden of time, documentation, and fees that the practice can barely absorb. The requirement is identical on paper. The burden is not.

The Data Infrastructure Conflict

In December 2024, CentralReach — a major ABA software company subsequently acquired by Roper Technologies for \$1.65 billion — announced a formal partnership with CASP. Under this arrangement, CASP uses CentralReach’s dataset of more than four billion anonymized data points to build what the joint press release describes as a “proprietary network adequacy model” that CASP presents to payers.

The conflict embedded in this arrangement is structural and compounding. CentralReach’s software is used by more than half of the largest ABA providers in the United States — the same organizations that constitute CASP’s membership and whose executives govern its board. The data flowing through CentralReach from those organizations is the data CASP uses to define what network adequacy looks like. Providers using CentralReach generate more robust, more standardized data that performs well in network adequacy assessments built on CentralReach’s own dataset. Providers using different or simpler systems may appear less adequate by comparison — not because their clinical work is inferior, but because their data does not flow through the same platform.

CASP simultaneously partners with Juniper — a CASP Business Affiliate that provides proprietary payer rate data exclusively to CASP member organizations as a membership benefit. Juniper also partnered with CASP on California Medi-Cal network adequacy analysis. Non-member providers and independent practices do not have access to this rate intelligence. The competitive information advantage flows to the organizations already advantaged by scale.

The result is a data infrastructure in which the trade association that writes the standards also controls the data used to evaluate compliance with those standards — and that data flows primarily from the software platforms used by its own member organizations.

The Legislative Loop

CASP is actively lobbying for the inclusion of behavior analysts in the Behavioral Health Information Technology Coordination Act — legislation that, if passed, would create electronic health record and documentation requirements for behavior analysts at the federal level. CASP’s advocacy page confirms meetings with the bill’s sponsors, Congresswoman Doris Matsui and Senator Markwayne Mullen, on this specific legislation.

Read in the context of CASP’s partnerships with CentralReach and Juniper, this lobbying completes a loop: CASP writes documentation standards and session note templates explicitly designed for “broad payer adoption.” CASP lobbies for federal legislation that would create EHR requirements making those documentation standards effectively mandatory. CentralReach sells the

EHR platform that most efficiently meets those standards — and is used by more than half of CASP’s largest member organizations. CentralReach’s data then informs the network adequacy models CASP presents to payers. None of these relationships require public disclosure. But in every case, the financial interests of CASP’s member organizations and technology partners are structurally served.

The Lobbying Ecosystem

CASP’s federal advocacy does not operate through CASP alone. Since 2024, CASP has led what its own advocacy page describes as “a coalition of applied behavior analysis and early intervention service providers, organizations, and professional associations.” This coalition operates alongside — and in coordination with — the National Coalition for Access to Autism Services, a separate nonprofit whose membership substantially overlaps with CASP’s and which spent \$180,000 on federal lobbying in 2025.

The practical effect is that when Congress and federal agencies receive advocacy on ABA policy, they may be hearing from CASP through its own lobbying operation, from NCAAS through its separate lobbying operation, and from individual large provider organizations directly — all representing substantially the same financial interests, arriving under different organizational names, and collectively creating the appearance of broader consensus than the underlying constituency warrants.

CASP employs named federal lobbyists — Bob Okun and Christina Hamilton — who, by CASP’s own membership materials, maintain “strong bipartisan congressional connections.” CASP conducted Capitol Hill Fly-In events in April 2025 and March 2026, directly lobbying congressional offices on its priority legislation.

The Personnel Pipeline

The boundaries between CASP and the corporate provider organizations that govern it are not merely structural — they are biographical. CASP’s Vice President of Government Affairs, Mariel Fernandez, joined CASP directly from BlueSprig Pediatrics — a KKR-backed private equity platform that is among the largest ABA provider companies in the country, and that acquired a CASP founding board member’s company in 2023. The founding board member in question spent fifteen years in logistics and technology at Lockheed Martin’s Savi Group before co-founding an ABA company in 2009 — the same year CASP was formed — and remains on CASP’s board through June 2028.

The person running CASP’s government affairs operation came from one of the largest PE-backed ABA corporations in the country, whose founder sits on CASP’s board. This is not a conflict that arose accidentally. It is the predictable consequence of an organization whose governance has been, from its founding, composed of executives of the corporate providers it claims to represent.

The Professional Body Entanglement

Perhaps the most significant development in CASP’s institutional expansion is its deepening entanglement with the field’s legitimate professional bodies — an entanglement that is simultaneously voluntary on those bodies’ part and structurally advantageous to CASP.

CASP sits alongside APBA, the BACB, and Autism Speaks on the ABA Coding Coalition — the body that works with the American Medical Association’s CPT Editorial Panel on billing codes for ABA services. These are the codes that every ABA provider bills under. CASP’s presence at that table alongside the field’s credentialing and professional membership bodies creates the institutional appearance of co-equal standing that CASP’s governance structure does not warrant.

A current APBA board member simultaneously serves on CASP’s Documentation Special Interest Group and the ACQ Standards Committee. A past APBA board president is embedded in three CASP Special Interest Groups and co-chairs CASP’s Client Outcomes SIG. APBA has co-published professional guidelines with CASP. And at APBA’s 2026 annual convention, the organization gave its advocacy award to CASP’s Vice President of Government Affairs — who joined CASP from a KKR-backed PE-owned ABA corporation.

ABAI, for its part, has not publicly clarified that CASP’s standards and accreditation programs do not carry its scientific endorsement — a silence that payers and regulators reasonably interpret as implicit validation.

The consequence of this entanglement is that CASP’s authority is continuously laundered through the credibility of organizations whose legitimacy it does not share. When CASP lobbies CMS, TRICARE, the Department of Labor, and the Department of Defense, it does so carrying the implicit imprimatur of institutions — the BACB, APBA, ABAI — that have not formally endorsed its authority but whose institutional proximity creates the impression of endorsement.

The Systematic Exclusion of Independent Providers

At every step of this expansion, the costs fall disproportionately on the providers least able to absorb them. Accreditation fees and per-location reapplication requirements that represent a rounding error in the operating budget of a national chain represent an existential burden for an independent practice. Documentation standards designed around the infrastructure of large organizations assume compliance departments that community-based practices do not have. Data partnerships that give CASP member organizations exclusive access to payer rate intelligence create competitive advantages unavailable to non-members. Network adequacy models built on data flowing primarily from large-platform software systems disadvantage providers using different tools. Lobbying positions that preserve billing flexibility for large organizations — opposing RBT enrollment requirements, advocating for broad uncredentialed staffing classifications — serve the labor cost models of corporations, not the clinical integrity standards of independent clinicians.

The independent BCBA running a community-based practice serving thirty families did not vote for any of this. She was not consulted when the standards were written, not represented when the accreditation requirements were designed, not included when the lobbying priorities were set. She simply woke up one day to find that an organization she did not choose was systematically constructing a compliance ecosystem calibrated to the operational scale of its largest members — and that her survival in payer networks increasingly depends on her ability to purchase compliance from the same organization that wrote the rules requiring it. That is not an accident of institutional design. It is the predictable outcome of standards written by people who will never have to live under them.

Section VI: The Credentialing Double Standard

If the pattern documented in Section V establishes that CASP’s structure systematically advantages large provider organizations at the expense of independent practitioners and the field’s clinical integrity, one example illustrates that pattern with a clarity that requires no inference. CASP’s relationship to the Registered Behavior Technician credential — the BACB’s frontline certification for the practitioners who deliver the majority of direct ABA service hours to autistic individuals — is not a peripheral policy disagreement. It is the sharpest available illustration of what CASP’s governance structure produces when financial interests and clinical obligations point in different directions.

What the RBT Credential Is and Why It Exists

The Registered Behavior Technician credential was developed by the BACB in 2013 to protect consumers. It establishes a minimum standard of training, competency verification, and ongoing supervision for the frontline practitioners sitting with autistic children and adults and delivering behavior-analytic intervention. It is not a burdensome or obscure requirement. It is the BACB’s foundational answer to the question: who is qualified to deliver ABA services directly to a client?

The credential requires a high school diploma, forty hours of training, a competency assessment, and ongoing supervision by a credentialed behavior analyst. It is among the most accessible professional certifications in healthcare. It exists for one reason: because the people delivering direct services to a vulnerable population should be demonstrably trained and accountable to a professional standard.

What CASP Does With It

CASP promotes and monetizes the BACB’s ABA Practice Guidelines as the clinical foundation of its authority to payers, regulators, and federal agencies including CMS, TRICARE, the Department of Labor, and the Department of Defense. The scientific and professional legitimacy those guidelines carry derives from the BACB’s credentialing rigor and the peer-reviewed research base of applied behavior analysis. CASP did not generate that legitimacy. It received it when the BACB transferred the guidelines in 2020, and it has been trading on it ever since.

Yet on CASP’s own publicly available advocacy page, under Indiana state updates, CASP explicitly identifies “high risk provider enrollment requirements, including RBTs, by April 1, 2025” as a named policy barrier — one it deployed lobbyists to defeat. At the federal level, CASP advocates for Department of Labor employment classifications that include broad categories such as “Direct Service Professionals” and “Behavior Technicians” — deliberately broader than RBT-specific language — preserving maximum billing flexibility for large provider organizations staffing direct service roles without BACB certification.

This is not a coherent clinical position. It is a financial one. RBT certification requires training investment, examination fees, and ongoing supervision costs that reduce margins. Uncredentialed technicians are cheaper to hire, faster to onboard, and generate the same billing codes under sufficiently flexible regulatory language. CASP supports the RBT credential as a workforce development pipeline when it serves its members’ growth models. It opposes mandatory RBT credentialing when that credentialing creates billing friction, enrollment overhead, or limitations on who can be placed in front of a client.

The BACB’s guidelines — which CASP now stewards and monetizes — are invoked when they confer authority. They are set aside when they impose cost.

What This Means in Practice

Provider enrollment requirements for RBTs exist to create accountability. When a credential must be formally enrolled in a state Medicaid program, the state can verify that the person billing for services holds the required training and supervision. Opposing this requirement means opposing the mechanism by which states confirm that the people delivering care to autistic children are actually qualified to do so. It means preserving the ability of provider organizations to place less-credentialed or unverified staff in front of clients and bill for those services under looser supervision structures.

Dr. Jon Bailey — the BACB’s founding director and one of the field’s most prominent ethics voices — has described this exact dynamic as the most damaging consequence of private equity’s dominance in ABA: a systematic shift from closely supervised, clinician-led care to therapies delivered by less-supervised, less-credentialed technicians. His characterization — “an erosion of the foundation” of applied behavior analysis — describes precisely the workforce model that CASP’s advocacy actively protects.

The families receiving services delivered by uncredentialed frontline practitioners in states where CASP has successfully opposed RBT enrollment requirements are not represented in this calculation. They are not represented on CASP’s board. They are not the constituency whose financial interests CASP’s governance structure is designed to serve. They are the people bearing the cost of decisions made entirely without them.

The Question This Raises for the BACB

The BACB transferred its ABA Practice Guidelines to CASP in March 2020 in good faith. Nothing in that transfer anticipated that the receiving organization would use those guidelines as a lobbying credential while simultaneously opposing the mandatory enforcement of the BACB’s own frontline certification in state Medicaid programs.

The BACB is the only organization with both the standing and the obligation to address this contradiction directly. It is the origin source of the guidelines’ legitimacy. It created the RBT credential the guidelines depend on. And it is the body whose stated mission — protecting consumers of behavior analytic services — is most directly compromised by the documented gap between what CASP claims the guidelines authorize and what CASP’s advocacy actually produces.

Payers and regulators considering CASP’s standards as clinical benchmarks should understand what CASP’s selective credentialism means in practice: the organization stewarding the field’s clinical guidelines lobbied against requiring that the people delivering services under those guidelines hold the field’s own credential for that role. The children receiving those services are not a consideration in that calculation. They are not CASP’s constituency. Their parents are its leverage.

Section VII: The Democratic Legitimacy Problem — Who Authorized Them, and Who Pays the Price

Every concern documented in this statement — the accreditation frameworks, the clinical guidelines, the federal lobbying priorities, the state-level advocacy positions, the data infrastructure, the credentialing policy positions, the professional body entanglements — is being done in the name of the autism services field. None of it was authorized by that field.

This is not a procedural complaint. It is a fundamental question about who holds legitimate authority to shape the standards, policies, and regulatory environment of a profession that serves one of the most vulnerable populations in American healthcare. Authority of this kind requires a source. It requires a process by which those governed by authority have consented to be governed. CASP has never provided that process, and has never been asked to.

The applied behavior analysis field has legitimate governance structures. The BACB credentials its practitioners. ABAI convenes its science. APBA represents its professional membership. State licensure boards regulate its practice. None of these bodies appointed CASP to speak for the field. None of them endorsed CASP's accreditation subsidiary as the quality standard for autism services. None of them voted to transfer authority over clinical practice guidelines to a trade association governed by large-provider executives. The credentialing and scientific bodies that constitute the field's actual governance infrastructure did not create CASP's authority. They have simply not yet formally contested it — and CASP has moved quickly to make that contestation progressively more difficult with each passing year.

What CASP did have, from the beginning, was organizational resources, executive ambition, and a vacuum that the field's legitimate governance bodies had not yet filled. Abbott's framework is instructive here: jurisdictional vacuums are filled by whoever shows up with the organizational capacity to fill them. CASP showed up. The field's credentialing and professional bodies, focused on their own legitimate functions, did not move quickly enough to establish governance over the standards and policy space that CASP was simultaneously occupying. By the time the occupation was visible, it was institutionally entrenched — embedded in payer contracts, federal lobbying relationships, state advocacy infrastructure, and professional body co-publications that create the appearance of legitimacy without its substance.

The Exclusion of Independent Providers From Governance

The absence of democratic authorization is not merely a philosophical concern. It has direct, practical consequences for the practitioners and organizations that constitute the majority of the field.

CASP's governance structure has never included meaningful representation from independent clinicians, small practice owners, or community-based providers. Its board has been, from its founding, composed of executives of large, multi-state provider organizations. The result is a compliance ecosystem calibrated to the operational scale of large national providers rather than the independent clinicians and small practices that constitute the majority of the field.

This matters not as an abstraction but as a documented pattern with measurable consequences. The ABA market is highly fragmented — even the nine largest providers account for less than thirty percent of industry revenue, meaning the remainder is distributed across a large number of

independent, community-based, and small-to-mid-size organizations. These are the practices most likely to be owned by clinicians rather than investors. They are the practices most likely to serve underserved communities and maintain the individualized, relationship-based care that the science of behavior analysis actually supports. They are the practices least able to absorb compounding compliance costs — and the most likely to be systematically priced out of payer networks as those costs accumulate.

No independent provider representative sits on CASP's board. No community-based practice owner has a formal voice in ACQ's standards development. No clinician running a two-person practice was consulted when CASP's documentation templates, organizational guidelines, and accreditation criteria were designed. The people who will spend the most time and money attempting to meet those requirements had no seat at the table where they were written. And the organization writing them has a direct financial interest in their adoption — because every new compliance requirement CASP creates is simultaneously a new product CASP can sell to help providers meet it.

The Use of Families as Leverage

There is a final dimension of CASP's democratic legitimacy problem that deserves explicit attention because it implicates not only independent providers but the families CASP claims to serve.

CASP's advocacy infrastructure actively mobilizes families of autistic individuals to contact legislators and regulators on providers' behalf. Its state advocacy pages solicit families to share their stories with legislators and contact Medicaid regulators to advocate for rate increases, network adequacy requirements, and policy positions that align with CASP's lobbying priorities. Its caregiver surveys are distributed through member organizations to generate political pressure on policymakers.

Family engagement in healthcare advocacy is legitimate and important. Families of autistic individuals have genuine and substantial stakes in ABA reimbursement rates, network access, and service quality. The concern is not that families are being engaged. The concern is what they are not being told when they are.

Families participating in CASP's advocacy efforts are doing so through an infrastructure controlled by a trade association whose primary legal obligation is to its dues-paying member organizations — organizations that are not structurally required to align their financial interests with those families' clinical needs. The families donating their voices to CASP's advocacy campaigns are not informed that the organization coordinating that advocacy is governed entirely by large-provider executives, that it actively opposes state credentialing requirements designed to protect the quality of their children's services, or that the standards it is lobbying payers to adopt were developed without any structural family representation in its governance — a parent who is also the organization's chief executive officer is not the same as the independent family voice that formal governance representation requires.

They are not CASP's constituency. They are its leverage. And the legislators and regulators receiving that advocacy — seeing family voices alongside institutional lobbying — reasonably interpret the combination as evidence of alignment between CASP's positions and the interests of the people being served. That interpretation may not be warranted. The families speaking on

CASP's behalf deserve to know the full picture of the organization whose cause they are advancing.

The Window

The democratic legitimacy problem is not static. Each year that passes without a formal challenge to CASP's self-appointed authority makes that authority harder to contest. Payer contracts that reference ACQ accreditation become baseline expectations. Federal agencies that have received CASP's lobbying for years begin treating its guidelines as settled standards. State regulators who have heard only CASP's voice on ABA policy have no framework for understanding that a different voice exists. The window to establish that a different voice does exist — and that it has something important to say — is open now. It will not remain so indefinitely.

The question this section returns to is the one that runs through the entire document: on whose authority is CASP acting, and who was ever asked to grant it? The answer, documented throughout this statement in CASP's own words and its leadership's own public statements, is no one. Leaders from ten provider agencies met privately in 2009 and decided to represent a field. They were not chosen. They were not elected. They were not ratified by the practitioners, researchers, credentialing bodies, or families whose interests they now claim to advance.

That act of self-authorization has had real consequences. It will continue to have real consequences — for the independent providers being priced out of the compliance ecosystem CASP is constructing, for the families mobilized as leverage by an organization that does not include them in its governance, and for a profession that deserves the same independent, multi-stakeholder governance infrastructure that every comparable healthcare field built before the financial interests arrived.

Section VIII: What the Field Needs to Build

The preceding sections have documented what happens when a profession fails to build its own governance infrastructure before significant financial interests arrive. The vacuum gets filled — not by the field’s legitimate scientific and credentialing bodies, not by a democratic process, and not by the practitioners who deliver the majority of its services — but by whoever has the organizational resources and institutional ambition to occupy the space first. Applied behavior analysis has now lived with the consequences of that failure for more than a decade. The question this section addresses is not how to undo what CASP has built — that is a separate and longer project — but what the field needs to build in its place, and what legitimate governance in a mature profession actually looks like.

This is not a theoretical exercise. Every profession that has successfully navigated the arrival of corporate capital and outside financial interests has done so by constructing specific institutional structures before or during that arrival — structures that preserved clinical authority, established democratic accountability, and created independent checks on the financial interests that would otherwise reshape the profession in their own image. Applied behavior analysis is not unique in facing this challenge. It is unique in how little it has built to meet it.

Phase One: Credentialing Defense

The most immediate and achievable governance priority is the defense and expansion of the BACB’s credentialing infrastructure as the non-negotiable floor of clinical practice in ABA. This means two things in practice.

First, the BACB should formally and publicly affirm — to payers, regulators, and federal agencies — that mandatory RBT enrollment in Medicaid and other payer programs represents the minimum professional standard for frontline ABA service delivery. This affirmation should be issued as a formal policy statement, not as a response to CASP’s lobbying positions, but as a proactive clarification of what the BACB’s own credentialing mission requires.

Second, state licensure boards and professional associations should actively support — not merely permit — mandatory RBT enrollment requirements wherever they are proposed. The documented opposition to these requirements by a trade association whose member organizations benefit financially from uncredentialed staffing is not a neutral policy disagreement. It is an attempt to preserve a workforce model that the field’s own science does not support. The field’s legitimate governance bodies should say so.

Phase Two: Independent Standards Development

The authority to develop clinical practice standards in applied behavior analysis belongs to a process that CASP’s current structure cannot provide: one that is transparent, multi-stakeholder, and independent of the financial beneficiaries of the standards being developed.

What this looks like in practice is a formal standards development process convened by the field’s legitimate scientific and credentialing bodies — the BACB, ABAI, and genuinely independent clinical researchers — using the procedural requirements established by the American National Standards Institute or an equivalent independent standards governance body. ANSI-accredited standards processes require balanced representation across stakeholder groups, documented

consensus procedures, transparent public comment periods, and governance structures that explicitly prevent any single financial interest from controlling the outcome.

This is not an impossible standard. It is the standard applied to clinical practice guidelines in medicine, nursing, physical therapy, and every other healthcare profession that has successfully defended its clinical authority against financial capture. The ABA field has the scientific foundation to support this process. What it has lacked is the institutional will to convene it — and the urgency created by recognizing that every year the process is delayed is another year in which CASP's self-developed standards become more deeply embedded in payer contracts and federal policy.

Phase Three: A Legitimate Multi-Stakeholder Professional Authority

The field currently has no organization that combines the following three characteristics: governance by democratically accountable representatives of the field's practitioner constituency, structural independence from the financial interests of large corporate providers, and the organizational capacity to engage payers, regulators, and federal agencies with the sustained advocacy those relationships require.

APBA was founded to be that organization. As documented in this statement, it has drifted from that founding purpose in ways that its own board should examine urgently. Whether APBA can reclaim that role — through genuine disentanglement from CASP's institutional ecosystem and a recommitment to practitioner-independent governance — is a question only APBA's board and membership can answer.

If APBA cannot or will not fill that role, the field needs an organization that will. The model exists in other professions: the American College of Physicians speaks for internists independently of the hospital systems that employ them. The American Academy of Family Physicians represents family practitioners independently of the insurance companies and health systems that shape their practice environment. In each case, the professional membership organization's independence from employer financial interests is not incidental to its function — it is its function. Applied behavior analysis needs the equivalent, and needs it now.

Phase Four: Anti-Capture Standards for Standards Bodies

The field should establish, through its legitimate scientific and credentialing bodies, explicit governance standards that any organization seeking authority over clinical practice guidelines, accreditation criteria, or policy positions in ABA must meet. These standards should include at minimum:

- A board composed of representatives from multiple stakeholder groups — active clinicians, researchers, family representatives, and public members — with no single group holding majority control.
- Explicit prohibitions on board members holding financial interests in organizations that directly benefit from the standards being developed.
- Transparent public comment processes for all proposed standards before adoption.
- Structural separation between any standards body and any accreditation body operating in the same field.

- Prohibition on any organization simultaneously developing standards, accrediting compliance with those standards, and lobbying payers to require that accreditation — the precise configuration CASP has constructed.

These are not novel requirements. They are the baseline governance standards that ANSI, the National Committee for Quality Assurance, and The Joint Commission apply to standards bodies in every other corner of American healthcare.

Phase Five: Corporate Practice Protections

The legislative movement toward CPOM-equivalent protections for ABA is already underway in analogous fields. As of early 2026, at least fifteen states have enacted healthcare transaction review laws specifically targeting private equity acquisitions, and bills are actively moving in more than twenty additional states. The language driving this movement — that corporate ownership creates structural conflicts between investor financial obligations and practitioner clinical obligations, and that patients bear the cost when financial interests override clinical judgment — applies directly and urgently to applied behavior analysis.

The field's scientific and professional bodies should actively engage the growing legislative movement toward healthcare ownership protections, providing scientific testimony on the documented clinical consequences of non-credentialed corporate ownership of ABA service organizations. They should advocate for ownership and operational control protections that ensure clinical decisions in ABA — staffing levels, supervision ratios, treatment intensity, service duration — remain in the hands of credentialed professionals rather than investors. And they should do so with the urgency the moment requires, because the legislative window that is currently open in other healthcare fields will not last indefinitely.

The Common Thread

Each of these five phases shares a common logic: the structural protections that preserve clinical integrity in a profession do not build themselves. They must be built, defended, and actively maintained by the people who have the most at stake in their preservation — the credentialed practitioners, independent researchers, and families whose interests are not served by the financial capture of a field they helped create. Applied behavior analysis has an extraordinary scientific foundation, a credentialing infrastructure that is the envy of comparable behavioral health professions, and a practitioner community whose commitment to the populations they serve is genuine and deep. What it needs now is governance that matches the quality of its science — independent, accountable, democratic, and structurally protected from the financial interests that have been reshaping it from the outside for more than a decade.

That governance will not be built by CASP. It was never going to be. It can only be built by the field itself — and the time to build it is now, while that choice still belongs to the field

Section IX: What We Are Asking

The concerns documented in this statement are not abstract. They have produced, and will continue to produce, concrete consequences for the practitioners who deliver ABA services, the families who depend on them, and the autistic individuals whose quality of care is shaped by the governance decisions made in their name. What follows is a specific set of requests — differentiated by audience, grounded in the documented record, and calibrated to what each recipient has both the standing and the obligation to do.

To Insurance Companies and Third-Party Payers

Payers occupy a unique position in this ecosystem: they are simultaneously CASP's primary lobbying target and the most powerful check on CASP's authority that currently exists. Every network requirement that references ACQ accreditation, every coverage policy that defers to CASP's clinical guidelines, and every medical necessity determination that treats CASP's standards as authoritative is a decision payers made — and a decision payers can revisit.

Before granting any organization's accreditation or standards the status of a coverage condition, network requirement, or quality benchmark, we urge payers to apply the following governance tests to the body proposing them: Is the standards-setting body governed by a board that is independent of the financial beneficiaries of those standards? Were the standards developed through a transparent, multi-stakeholder process that included active clinicians, families of individuals receiving services, and independent researchers? Is the accreditation body structurally independent from the trade association whose members it accredits? Has the organization disclosed its 501(c)(6) trade association status and the legal obligations that status imposes?

Specifically, we ask payers to: require independent governance verification before renewing or expanding any contract provision that references ACQ or BHCOE accreditation as a network condition; request a formal accounting of the financial relationships between CASP, ACQ, BHCOE, their respective boards, and the payer contracts those relationships influence; and consider what it means for network adequacy assessments when the data informing those assessments flows primarily from a software platform used by the trade association's own member organizations.

To State Insurance Commissioners and Regulators

State regulators have both the authority and the obligation to examine whether the organizations shaping clinical standards for services delivered to vulnerable populations in their states meet the governance requirements those standards demand. CASP's documented opposition to RBT enrollment requirements — the mechanism by which states verify that frontline ABA practitioners hold the training and supervision the field's own credentialing body requires — is a documented lobbying position that directly undermines state consumer protection mechanisms.

We urge state insurance commissioners and managed care regulators to: apply rigorous scrutiny to any lobbying by CASP for mandated or preferred recognition of ACQ or BHCOE accreditation; require that any organization seeking regulatory authority over clinical standards in autism services demonstrate governance structures consistent with accepted standards for independent standards bodies; request a formal accounting of the financial relationships between CASP, its accreditation subsidiaries, and their respective board members; consider whether IRS private benefit rules for

501(c)(6) organizations are being appropriately applied; and examine whether ABA service organizations in their states would benefit from ownership and operational control protections analogous to those other healthcare fields have constructed to preserve clinical integrity against investor control.

To the BACB

The BACB occupies a singular position in this situation: it is the origin source of both the guidelines CASP is using as a lobbying credential and the frontline credential CASP is simultaneously lobbying against. No other organization has the BACB's standing to address the contradiction that this statement has documented.

We ask the BACB to: conduct a formal review of how the ABA Practice Guidelines are currently being used by CASP — specifically whether CASP's documented opposition to mandatory RBT enrollment is consistent with the consumer protection purpose for which those guidelines were developed and transferred; publicly affirm that mandatory RBT enrollment in Medicaid and other payer programs is consistent with the BACB's professional and consumer protection standards; issue a clarifying statement regarding the limits of CASP's authority to invoke BACB-derived guidelines as the basis for policy positions that directly conflict with the BACB's own credentialing standards; formally recommend to payers and regulators that mandatory RBT credentialing represents the minimum professional standard for frontline ABA service delivery; establish an ongoing mechanism to ensure that guidelines transferred to any external entity continue to be applied in ways consistent with their consumer protection purpose — and formally reconsider whether CASP's stewardship of the ABA Practice Guidelines remains appropriate given the documented pattern of invoking those guidelines' authority while actively opposing their frontline enforcement. The transfer was made in good faith. The record since 2020 raises a legitimate question about whether that good faith has been reciprocated.

To ABAI

ABAI's silence on the questions raised in this statement is not neutral. When the field's preeminent scientific organization does not clarify that CASP's standards and accreditation programs do not carry its scientific endorsement, payers, regulators, and federal agencies reasonably interpret that silence as implicit validation. The lobbying at CMS, TRICARE, the Department of Labor, and the Department of Defense is happening now. Standards, once codified in federal policy, are significantly harder to reverse.

We ask ABAI to: publicly clarify that CASP's accreditation programs and self-developed standards do not carry ABAI's scientific endorsement; affirm that the ABA Practice Guidelines, in their original form as developed under BACB stewardship, reflect the field's scientific consensus — and that CASP's documented lobbying against mandatory RBT enforcement is inconsistent with that consensus and does not represent the scientific community's position; make clear to payers and federal agencies that CASP's advocacy positions should not be interpreted as reflecting the scientific consensus of the field; articulate what governance standards should apply to any organization seeking to translate the science of behavior analysis into clinical practice standards or payer policy; and engage with the growing legislative movement toward CPOM-equivalent protections for ABA, providing scientific guidance on the clinical consequences of non-credentialed ownership and investor control of ABA service delivery.

To APBA

APBA was founded to give professional behavior analysts a voice distinct from the organizations that employ them. That founding purpose has never been more urgently needed than it is right now — and has never been more at risk of being quietly abandoned. The institutional entanglements documented in this statement are not incidental to APBA’s current trajectory. They are its trajectory, and the direction of travel is toward deeper alignment with the corporate interests its founders created it to be independent from.

This matters acutely because APBA is, at this moment, the only organization structurally positioned to speak for individual credentialed practitioners independently of the financial interests that now dominate the field’s governance. The BACB credentials practitioners but cannot advocate. ABAI convenes science but does not represent practitioners. State licensure boards regulate but do not organize. CASP claims to speak for the field but serves its dues-paying corporate members. If APBA does not fill the role it was built to fill, that role goes unfilled — and the field’s individual practitioners are left without an institutional voice at the precise moment when having one matters most.

Whether APBA is currently capable of being that organization — given the entanglements documented here — is a question only its board and membership can answer. We ask them to answer it honestly, publicly, and with the urgency the moment demands. The practitioners who founded APBA built something important. The practitioners who need it today are asking whether it still exists.

To Fellow Independent ABA Providers

You are not adequately represented by CASP. The standards being developed and lobbied for in your name were written by executives of large organizations, for the operational realities of large organizations. The accreditation requirements being lobbied for in your name will disproportionately burden your practices. The data partnerships informing network adequacy models flow primarily from software platforms your largest competitors use. The lobbying positions being advanced in your name protect the workforce models of corporations, not the clinical integrity standards of independent clinicians.

The easiest response to all of this is to do nothing — to absorb the compliance costs, navigate the accreditation requirements, adapt to the lobbying outcomes, and hope the trajectory changes on its own. Many providers will make that choice, and it is understandable. Inaction requires nothing. But inaction has consequences too, and they are not abstract: the compliance ecosystem will grow more expensive, the accreditation requirements more burdensome, the network adequacy models more tilted toward large-platform providers, and the window for the field to reclaim its own governance progressively narrower. The independent providers who say nothing today are the ones who will find themselves priced out of payer networks tomorrow — not because their clinical work is inferior, but because they let someone else speak for them.

The time for organized, sustained advocacy from independent practitioners is not approaching. It is now. The professional bodies, payers, and regulators who shape this field need to hear from the providers who deliver most of its services — in numbers large enough to make clear that CASP does not speak for them, and with documentation thorough enough to make clear why that matters.

Your endorsement of this statement is one concrete action available to you now. Every verified signature is evidence that CASP does not speak for the entire field. Every colleague you share this with is one more practitioner who understands what has been done in their name — and who can decide for themselves whether to let it continue.

Section X: Conclusion

The question at the center of this statement is simple enough to fit in a single sentence: who authorized CASP to do what it is doing?

The answer, documented throughout this statement in CASP's own words and its leadership's own public statements, is no one. Leaders from ten provider agencies met privately in 2009 and decided to represent a field. They were not chosen by that field. They were not elected by its practitioners. They were not ratified by its credentialing bodies, its scientific community, or the families of the children whose care their decisions now shape. They had organizational resources, institutional ambition, and a governance vacuum the field had not yet filled. They filled it. And they have been expanding what they built in that vacuum — systematically, deliberately, and profitably — for the fifteen years since.

This statement has documented what that expansion has produced: a wholly-owned accreditation subsidiary lobbied into payer contracts as a network requirement; a second accreditation program and a national patient data registry consolidated under the same trade association roof; a data partnership with a billion-dollar software company whose largest customers are CASP's own member organizations; a legislative lobbying operation working in parallel with a separate coalition to create the appearance of field-wide consensus where none exists; a personnel pipeline running directly from PE-backed corporate ABA providers into CASP's government affairs operation; and an accreditation committee whose claimed independence is undermined by the presence of executives from those same PE-backed providers in its governance.

None of this required secrecy. None of it was hidden.

What This Is Not

We have said this before and we say it again here, at the close, because it matters: this statement is not an argument that CASP should not exist. It is not a claim that everyone involved in CASP has acted with cynical intent. It is not a competitive grievance dressed in the language of governance. It is not opposition to quality standards in autism services — the field needs them desperately, and their absence is part of what made the current situation possible.

What this statement is, and has been from its first page, is a governance argument. The question of whether an organization has legitimate authority to do what it is doing is not answered by whether its intentions are good, whether its members work hard, or whether some of its products have value. It is answered by asking who authorized it, how its decisions are made, whose interests its governance structure serves, and whether the checks on its authority are adequate to the power it is exercising. Applied to CASP, those questions produce the answers documented throughout this statement. They are not comfortable answers. They are, however, accurate ones.

What the Field Deserves

Applied behavior analysis has earned its place in American healthcare. Its scientific foundation is rigorous, its outcomes are documented, and its practitioners are, overwhelmingly, people who entered the field because they are committed to the children and families they serve. The field deserves governance that matches the quality of its science — independent, accountable,

democratic, and structurally protected from the financial interests that have been reshaping it from the outside for more than a decade.

Every other healthcare field that has faced the arrival of significant outside capital has learned, some more painfully than others, that clinical integrity does not survive without structural protection. Medicine learned it. Dentistry learned it. Emergency care learned it. In each case, the protection came from professional bodies willing to assert their authority, legislative bodies willing to enforce it, and credentialing bodies willing to define and defend the standards that financial interests could not be permitted to override. The lesson is available. Applied behavior analysis simply has not yet applied it.

The structural protections that preserve clinical integrity in a profession do not build themselves. They are built by the people who understand what is at stake — practitioners who recognize that the governance decisions being made today will determine the conditions under which they practice tomorrow, families who understand that the standards shaping their children's care should be set by people accountable to clinical outcomes rather than quarterly returns, researchers who recognize that the science they have built deserves stewardship by institutions whose independence is genuine rather than performed, and credentialing bodies that understand that the authority they have spent decades earning cannot be borrowed indefinitely by organizations whose governance structures are incompatible with the independence that authority requires.

The Window

The window to act is open. It will not remain so indefinitely.

Each year that passes without a formal challenge to CASP's self-appointed authority makes that authority harder to contest. Payer contracts that reference ACQ accreditation become baseline expectations that feel too entrenched to revisit. Federal agencies that have received only CASP's voice on ABA policy for years begin treating its positions as settled field consensus. State regulators who have heard CASP's lobbyists without hearing the field's independent practitioners have no framework for understanding that a different view exists. Independent providers who absorb each new compliance cost in silence find the next one already waiting. The compounding works in CASP's favor — not because CASP is powerful, but because the field has not yet organized to say, clearly and collectively, that CASP does not speak for it.

This statement is the beginning of that organization. It is not the end.

To every payer who reads this and asks whether the standards they have adopted meet the governance requirements they apply in every other corner of healthcare: the answer is in the record we have documented. To every regulator who reads this and asks whether the lobbying they have received represents the field's genuine consensus: the answer is no, and here is why. To every professional body that reads this and recognizes in it the question its own constituency has been waiting for someone to ask: the field needs you to answer it. To every independent BCBA who reads this and recognizes their own practice in the pattern we have described: the field will not reclaim its governance through institutional action alone. It will reclaim it because enough individual practitioners decided that silence was no longer acceptable.

No election was held. No field-wide process occurred. No credentialed behavior analyst outside of CASP's founding membership was asked whether they consented to be governed.

They simply let someone else speak for them.

| *That can change. It starts here.*

Signatories

The individuals and organizations listed below have endorsed this statement. Signatories are listed at the level of disclosure they have chosen. All signatures have been verified by the coordinating author. The decision to sign publicly, by credential only, or anonymously reflects each signatory's assessment of their own professional circumstances — not the strength of their conviction.

Full Signatories (Name, Credentials, Organization, State)

[Name], [Credentials] — [Organization], [State]

Credential Signatories (Name and Credentials Only)

These individuals have endorsed this statement and consented to disclosure of their name and professional credentials only.

[Name], [Credentials]

Anonymous Signatories (Verified, Withheld by Request)

These individuals have verified their identity and professional standing to the coordinating author, and have endorsed this statement in full. They have requested that their names not be published due to professional concerns about retaliation.

BCBA-D — Independent Provider, [State]

BCBA, LBA — Independent Provider, [State]

+ [N] additional verified signatories, names withheld by request

To endorse this statement, visit: abaaccountabilityproject.org

Sources

All factual claims in this document are drawn from publicly available information on CASP’s official website (casproviders.org) or from CASP’s own published materials, peer-reviewed research, and CASP leadership’s own public statements. Specific pages referenced include:

- CASP Mission & History — casproviders.org/history-and-mission
- CASP Staff & Board of Directors — casproviders.org/staff-and-board
- CASP Membership Information — casproviders.org/casp-member-organization
- Autism Commission on Quality (ACQ) — autismcommission.org
- CASP Advocacy Page (Indiana, Federal priorities) — casproviders.org/advocacy
- ABA Coding Coalition — abacodes.org/about/
- CentralReach / CASP Partnership Press Release — globenewswire.com, December 16, 2024
- CASP / Jade Health Acquisition — bhbusiness.com, January 13, 2026
- APBA 2026 Awards — apbahome.net/2026-apba-awards

Additional peer-reviewed and published sources:

- Batt, R. & Appelbaum, E. (2023). Pocketing Money Meant for Kids: Private Equity in Autism Services. Center for Economic and Policy Research (CEPR).
- Singh, Y. et al. (2026). Private equity acquisition of autism therapy centers. *JAMA Pediatrics*, January 5, 2026.
- CASP / ABA Centers NYSE Closing Bell Press Release, December 24, 2024.

All URLs verified as of March 2026.