

ABA ACCOUNTABILITY PROJECT

Executive Brief

Governance, Accountability, and Authority in Applied Behavior Analysis

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The Core Issue

The Council of Autism Service Providers (CASP) presents itself to payers, regulators, and federal agencies as the representative voice of the autism service provider community. It is not — and it was never authorized to be.

CASP was formed in 2009 when executives from ten provider organizations convened privately. No election was held. No field-wide process occurred. No credentialed behavior analysts outside the founding group were consulted. Over the following fifteen years, CASP built an institutional infrastructure — accreditation subsidiaries, federal lobbying operations, clinical guidelines, data partnerships, and a national patient registry — that it now deploys with the claim of field-wide authority it was never granted.

This brief summarizes the documented governance conflicts embedded in that infrastructure and what payers, regulators, and professional bodies should ask before acting on CASP's advocacy.

What CASP Is

CASP is a **501(c)(6) trade association** — a legal structure whose explicit purpose is to advance the business interests of its dues-paying member organizations. Its board is composed entirely of CEOs and Executive Directors of those member organizations. Every standard CASP sets, every policy it lobbies for, every accreditation criterion it establishes: all of it is decided by people whose organizations directly benefit from those decisions.

This is not a technicality. In fields where standards bodies carry the authority CASP is seeking — healthcare, financial services, food safety — a board composed entirely of the financial beneficiaries of its own decisions would not be considered independent by any serious regulatory standard. CASP operates with no such requirement and no such balance.

The Closed Loop

What CASP has built over fifteen years is a self-reinforcing commercial system:

- CASP received the BACB's ABA Practice Guidelines in 2020 and monetizes them — requiring payers to pay for commercial access and mandating CASP-sponsored training to use them.
- In 2022, CASP created the Autism Commission on Quality (ACQ) as a wholly-owned subsidiary. It has since lobbied more than a dozen payer entities to require ACQ accreditation 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 — a direct admission that ACQ is not financially independent of the trade association whose members it accredits.
- In December 2025, CASP acquired Jade Health — the parent company of the Behavioral Health Center of Excellence (BHCOE) and the National Autism Data Registry — consolidating both major ABA accreditation programs and a national patient-level data repository under a single trade association.
- CASP holds a BACB-Authorized Continuing Education (ACE) provider designation and sells over 75 events worth more than 100 BACB CEUs — including training positioned as required to use the guidelines it controls. The organization that stewards the field's clinical guidelines also charges the credentialed practitioners who must understand them for the continuing education required to maintain their own credentials.
- CASP partnered with CentralReach — a Platinum Sponsor of the Autism Investor Summit, a longtime CASP annual conference sponsor, and CASP's formal data partner since 2024, acquired by Roper Technologies for \$1.65 billion — to build a proprietary network adequacy model presented to payers. The data underlying that model flows primarily from software used by CASP's own member organizations.

The result: the same organization writes the standards, accredits compliance with those standards, lobbies payers to require that accreditation, charges practitioners for the training to use those standards, and controls the data used to evaluate network adequacy. At every step, there is a product for sale. At every step, the organizations that profit from the rules are the organizations writing them.

The Credentialing Contradiction

The clearest illustration of how CASP's governance structure produces outcomes that serve member financial interests over field clinical integrity is its relationship to the Registered Behavior Technician (RBT) credential — the BACB's frontline certification for the practitioners who deliver the majority of direct ABA service hours.

CASP promotes the BACB's ABA Practice Guidelines as the clinical foundation of its authority to payers and federal agencies. Yet on its own public advocacy page, CASP explicitly identifies mandatory RBT enrollment requirements as a named policy barrier it deployed lobbyists to defeat in Indiana Medicaid. At the federal level, it advocates for staffing classifications deliberately broader than RBT-specific language, preserving billing flexibility for large provider organizations staffing direct service roles without BACB certification.

This is not a coherent clinical position. RBT certification requires training investment and ongoing supervision costs that reduce margins. Uncredentialed technicians are cheaper to hire and generate the same billing codes under sufficiently flexible regulatory language. CASP invokes the BACB's credibility when it confers authority. It works against the BACB's credentialing standards when those standards create cost friction for its largest member organizations.

Who Bears the Cost

The ABA market is highly fragmented — even the nine largest providers account for less than 30 percent of industry revenue. The majority of organizations in the field are independent, community-based, and small-to-mid-size practices. These are the providers least represented in CASP's governance and most burdened by the compliance ecosystem CASP is constructing.

ACQ accreditation requires administrative infrastructure — documentation systems, quality assurance processes, internal audit capacity — that large national organizations maintain as standard operations. For an independent BCBA running a community-based practice, achieving and maintaining accreditation means diverting clinical time to administrative compliance or hiring dedicated administrative staff the practice cannot afford. The per-location reapplication requirement (every two years, per clinic) compounds this burden. For a national chain with a hundred locations, it is a manageable administrative cycle. For an independent single-site practice, it is an existential recurring cost.

The independent providers being priced out of payer networks by this compliance ecosystem are the organizations most likely to be clinician-owned, most likely to serve underserved communities, and most likely to provide the individualized care that the science of behavior analysis actually supports. That is not a side effect of the standards CASP is building. It is a predictable consequence of standards written by large-provider executives for large-provider operational realities.

What Stakeholders Should Ask

Payers and regulators considering CASP's accreditation or standards:

- Is the standards-setting body governed independently of the organizations that financially benefit from those standards?
- Were the standards developed through a transparent, multi-stakeholder process that included active clinicians, independent researchers, and family representatives?
- Is the accreditation body structurally and financially independent from the trade association whose members it accredits — or has its own leadership acknowledged it could not sustain itself without that trade association's support?
- When the organization promoting accreditation requirements simultaneously opposes the credential verification mechanisms that confirm frontline practitioners are trained — whose quality is actually being protected?

Professional bodies (BACB, ABAI, APBA):

- CASP's authority is continuously reinforced by its institutional proximity to the field's legitimate scientific and credentialing bodies. That proximity creates the appearance of endorsement that CASP's governance structure does not warrant. The field's legitimate bodies have not formally contested CASP's self-appointed authority — and that silence is being read as validation.

Independent providers:

- 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 window to contest CASP's authority is open now. It will not remain open indefinitely.

The Window

Each year that passes without a formal challenge to CASP's self-appointed authority makes that authority harder to contest. Payer contracts referencing ACQ accreditation become baseline expectations. Federal agencies that have received only CASP's voice on ABA policy begin treating its positions as settled consensus. Standards, once embedded in federal and state policy, calcify.

The field's legitimate governance bodies — the BACB, ABAI, and APBA — have the standing to clarify that CASP does not represent the field's scientific or credentialing consensus. Payers have the power to require independent governance verification before accepting any organization's accreditation as a quality benchmark. Regulators have the authority to examine whether the organizations shaping clinical standards in their states meet the governance requirements those standards demand.

The full position statement — documenting all claims in CASP's own public materials, its leadership's own public statements, and peer-reviewed research — is available at [**abaaccountabilityproject.org**](http://abaaccountabilityproject.org).