WHITEPAPER

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ABCs of Autism 2.0: Provider Considerations For An Increasingly Scrutinized Sector

By Nayab Mahmood, Scott Silberberg

The autism therapy sector remains one of the fastest-growing areas in healthcare, but operators are having to face new challenges as scrutiny around cost, utilization, and billing practices continues to intensify. Medicaid has become a major growth engine for Applied Behavior Analysis (ABA), supported by federal and state coverage mandates. As spending rises, regulators and payors are escalating their response through audits and tighter utilization management, while several states are cracking down on reimbursement levels, eligibility criteria, and benefit administration to better control growth. This scrutiny has increasingly centered on large, private equity-backed platforms, where rapid expansion and scale have increased utilization but also exposure to compliance risk. This whitepaper updates our prior analysis by summarizing these shifting dynamics, and concludes with best practices for providers navigating heightened scrutiny and evolving reimbursement dynamics.

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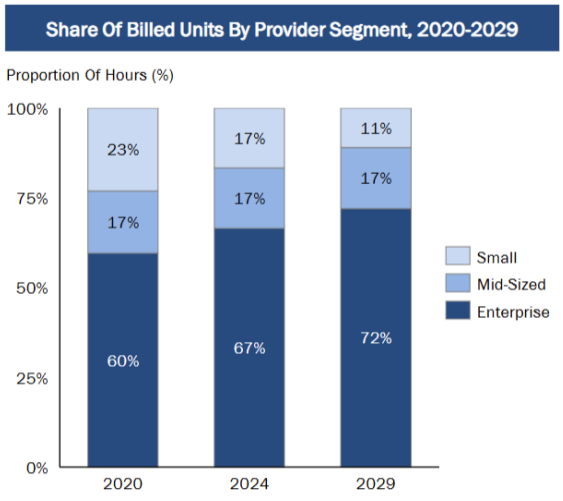
I. Background of Benefit

ABA has transitioned over the last decade from a niche autism therapy to a widely covered Medicaid service, driven largely by federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements. In 2014, the Centers for Medicare & Medicaid Services (CMS) began requiring states to cover medically necessary ABA under EPSDT, which obligates Medicaid programs to provide any service needed to correct or ameliorate physical or behavioral conditions for children up to age 21. As a result, Medicaid agencies have increasingly formalized ABA coverage, and every state also has some form of insurance coverage mandate for autism-related services across commercial payors.

These policy dynamics have created a broad and durable coverage foundation, accelerating provider expansion, investment, and utilization growth. However, the same forces that normalized access have also produced uneven eligibility criteria and reimbursement rates across states—setting the stage for today's heightened scrutiny around utilization and cost growth, particularly within Medicaid, as enrollment and autism diagnoses continue to increase. According to Marwood research, the vast majority of billed ABA units today are billed by large enterprise organizations, as opposed to small and mid-sized organizations. These larger organizations, typically backed by private equity investors, have been highlighted as a key area of concern from payors and regulators seeking to better manage the sector.

Despite these challenges, demand for services is expected to continue, as labor supply trends are improving, but have not yet caught up with need. From Marwood analysis, the US supply of BCBAs is expected to grow ~11% annually over the next 5 years, down slightly from a historical increase of ~14%, and RBTs are expected to grow around ~20%, down from ~25%. The southwest and southeast regions of the country have exhibited above average supply growth, which is likely to continue. Wages are also expected to increase 5-6% per year, as a slightly lower pace than historically. Turnover rates in the sector however remain high due to low wages difficult working conditions, and this is not expected to change significantly.



II. Increasing Spend, Increasing Scrutiny

As utilization of ABA therapy has exploded over the last two decades, so has spending on the sector. According to data from Marwood's proprietary claims database, when applying the national average

Medicaid rates to relevant ABA codes, Medicaid spend on ABA increased over 860% from 2019 to 2023.

With this increase in spend comes increase in payor concerns on how to reign in this rapidly growing sector. This has manifested in a number of ways in the last year. As evidenced in earnings calls, large national health plans such as Centene and Elevance have highlighted ABA as a top spend category, particularly for government business lines. Centene announced the creation of an enterprise-wide taskforce to review the benefit and develop new strategies and Optum has reportedly been closing and refining provider networks and reducing outlier rates in several key states of concern.

There is also growing regulatory concern about inappropriate billing of services. In 2024, the Office of the Inspector General began investigating ABA billing in a number of states, and they have since published the results of their audits in Indiana, Wisconsin, and Maine. The reports found evidence of inappropriate billing of $56M, $18.5M and $45.6M respectively, with the federal government seeking repayments from the states. Audits are ongoing in at least six other states and further publication of findings, expected to be similar to those already published, will only underscore these concerns. In addition, news reports out of Minnesota around alleged fraudulent activity across a number of healthcare sectors, including autism, exacerbates scrutiny in the space. These types of concerns are also leading to more states seeking to establish new licensing standards for ABA providers as a means of oversight.

III. Realignment of Rates in Outlier States

After several years of Medicaid rate increases for ABA services driven by workforce shortages and member access concerns, a subset of states have entered a correction phase. In these outlier states, reimbursement rates or utilization growth diverged significantly from national norms, drawing heightened attention from Medicaid agencies and managed care plans. While these actions remain concentrated rather than systemic, they illustrate how states are recalibrating coverage, reimbursement, and utilization oversight in response to sustained growth in Medicaid ABA spending.

In Nebraska, Medicaid ABA rates had historically been highest in the nation, but the state announced significant fee schedule reductions effective August 2025. Cuts to core treatment and supervision codes were explicitly framed as an effort to bring reimbursement more in line with peer states following rapid spend growth. The state has also established a 30-hour weekly cap on ABA treatment, which may be exceeded if medically necessary. Nebraska was the first state to pursue this type of restriction and others may follow.

Other state responses have combined rate pressure with broader policy tightening. Facing a mid-year budget shortfall, Colorado implemented across-the-board Medicaid reductions in late 2025 and reset

pediatric behavioral therapy rates to 95% of a new benchmark based on neighboring states, resulting in rate decreases effective October 2025. However, industry groups and advocates filed suit in November 2025 challenging the changes. In Indiana, Medicaid officials announced a 10% cut across most ABA codes effective April 2026, though group therapy rates are set to increase 15%. Rate pressure is likely to be paired with new recommendations establishing hourly guidelines based on age and severity.

Florida and Idaho highlight how delivery system and benefit changes can also be used to manage ABA spending without cutting state fee schedules directly. In Florida, ABA was carved into Medicaid managed care in February 2025, shifting rate negotiation authority to MCOs; while the state fee schedule remained largely stable, at least one major plan reduced reimbursement by ~20% after continuity-of-care protections expired. Idaho took the opposite approach, carving autism therapy out of managed care and into fee-for-service under the Children's Habilitation Intervention Services (CHIS) program with limited notice, issuing a memo on October 31 and making the change effective December 1. The shift is expected to introduce new operational and reimbursement constraints, including a transition from CPT-based billing to HCPCS codes and restrictions on concurrent billing.

Lastly, North Carolina demonstrates the political limits of provider rate reductions and the strength of the autism advocacy community in protecting pediatric access. The 10% cut to ABA rates implemented in October 2025 was quickly challenged by families and advocates and ultimately reversed, underscoring how organized disability rights stakeholders can still exert meaningful political influence when programs serving disabled children are targeted. The state also faces ongoing legal challenges alleging discriminatory impact, reinforcing that ABA policy changes can trigger not only public pressure but also litigation risk.

Select State Medicaid ABA Spend Over Time

State	Time Period	Medicaid ABA Spend ABA Increase Over Time Period
WI	2018-2022	35%
NC	2022-2026(E)	424%
IN	2019-2026(E)	438%
NE	2020-2024	1,761%

IV. Value-Based Care Progress

Value-based care (VBC) in ABA is progressing, but it remains early-stage and concentrated in pilot-style arrangements rather than broadly adopted, full-risk models. Most activity to date is structured as pay-for-performance or shared-savings "upside" incentives, with payors testing whether tighter treatment planning, clearer medical necessity documentation, and standardized outcomes tracking can reduce intensity or length of care without restricting access.

Several industry groups are working to define what "value" means in ABA. The Council of Autism Service Providers (CASP) emphasizes evaluating progress using

multiple measures and cautions against simplistic proxies that can misrepresent functional improvement. In late December 2025, CASP agreed to acquire Jade Health's Behavioral Health Center of Excellence (BHCOE), one of the field's most established accreditation bodies, bringing it under the same umbrella as CASP's Autism Commission on Quality (ACQ) and unifying two organizations advancing quality standards across autism services. CentralReach, a leading ABA-focused electronic health record (EHR) and practice management platform, has also published materials on value-based quality measure dashboards and increased integration of AI, reflecting growing demand for operational reporting to support VBC contracting.

Two prominent VBC examples highlight how payors are testing outcomes-based models in ABA. Magellan's collaboration with California-based provider Kyo (launched October 2022) reported improvements in Vineland-3 Adaptive Behavior outcomes after six months across domains such as communication, daily living skills, and socialization, alongside reduced caregiver burden as measured by the Parental Stress Scale. In the commercial market, Aetna and California-based provider ACES launched an "Institute of Quality for Autism" relationship in 2021 that expands access to ACES providers under a value-based arrangement, positioning ACES as Aetna's first ABA-focused quality network. [SS4.1]

Despite momentum, providers remain skeptical about scalable metric design. Unlike hospitals, where quality can be measured through readmission rates or avoidable emergency department use, ABA outcomes vary widely across a highly heterogeneous population, making standardized quality benchmarks difficult to define and apply consistently.[NM5.1] Nevertheless, as payors sharpen cost-management strategies, VBC in ABA is likely to advance incrementally through the use of provider-established outcomes tracking and quality reporting over time.

VI. State Changes and Best Practices

In this environment of renewed focus on utilization management in the sector, those providers with strong clinical programs, robust documentation standards, and an innovative approach to outcomes tracking are those that are likely to be most successful.

While historically it has been well-established that the younger the child is, higher intensity treatment yields the most impact, some recent research has started to question intensity of treatment as being the main variable, which may be reflected in some of the recent payor pushback for plans of care 30+ hours a week. This scrutiny is primarily focused on providers that are perceived as providing blanket treatment plans for all their patients, and are not taking care to individualize therapy for each child's specific needs. There has also been more of an emphasis as of late on therapy that regularly involves parents, is comprehensive and multidisciplinary, and provided by appropriately-trained providers.

Strong documentation practices and a focus on compliance will be a cornerstone of strong operators. Providers have to take to care to ensure their records are meticulously maintained to reflect who is providing services and when. Clinical documentation should be detailed - as ABA codes are time based and typically 1:1, notes need to document the time spent and include what actually transpired during the session and tie in to the treatment plan, as well as including a narrative summary outlining the child's progress level towards outlined treatment goals.

In Marwood's compliance practice, common issues reviewed include inadequate documentation to support the time spent, issues with time spent and units billed, the billing provider on the claim form being different from the rendering provider who signed the note, group therapy being provided but 1:1 therapy being billed, and concurrent therapy (ABA plus OT/PT/SLP) being billed during the same time interval. All of these issues can result in claim denial or recoupment in the event of a payor audit. In addition, there have been some recent concerns around providers that offer both therapy as well as ASD diagnostic services, and potential conflict of care and incentive to over-diagnose, though that is not a widespread concern today.

Providers Marwood has spoken to also emphasized new strategies and tools they are utilizing to continue to have high authorizations approval. One provider noted the importance of ensuring their authorization requests do not exceed what can reasonably be delivered by their organization (reducing the differential between authorized hours by the payor and delivered hours by the provider), as a significant mismatch will only invite further payor scrutiny. Providers also note they are taking care to individualize treatment and have variation in the hours being requested to reflect this, and requiring increased levels of supervision. Some are pursuing accreditation by national organizations, and requiring all front-line therapists be registered BTs (which is increasingly becoming a requirement of payors to ensure some standard level of training of front-line staff, including notably Optum).

New industry tools are also being developed to help bring some level of standardization in the sector. Some providers are utilizing new research-based tools being piloted such as the Patient Outcome Planning Calculator (POP-C) which is question-assessment designed to help providers determine service intensity and place clients into high (30-40 hours), medium (20-30), or low tiers (<20) of care. As some payors pursue more frequent authorization periods, this can help streamline the process from the provider side.

VII. Concluding Thoughts

With more payor and regulatory scrutiny on care provided for children with Autism Spectrum Disorder, providers must take care to improve their documentation standards, training of staff and treatment programs to make sure compliance standards are met and treatment is appropriately tailored to each child's

needs. Increased utilization management and in some geographies, rate pressure, may impact margins particularly for smaller providers, however market factors such as unmet demand and need for care will continue to drive growth and consolidation in the sector. As practices grow, it will be important to spend time evaluating the regulatory and payor market of new geographies to determine attractiveness and any long-term risk.

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