

Camber

Practical Guide

PE-grade underwriting for modern ABA scrutiny

Claims integrity as a portfolio risk

For investors and operating partners in ABA and behavioral health

THE SCRUTINY

ABA is under active federal scrutiny. Four states are still to report.

Since CMS clarified Medicaid's obligation to cover ABA services in 2014, ABA has been one of the fastest-growing segments in healthcare services. After 2019, that growth accelerated sharply, with the number of Medicaid-funded ABA sessions delivered annually expanding by 298% to 2024.

Private equity investment increased alongside this growth. Previously, diligence focused on revenue growth rather than its defensibility. This focus has now shifted.

As of January 2022, the HHS Office of Inspector General (OIG) has been running a structured, multi-year audit series targeting Medicaid-funded ABA services across eight states.

Four states have reported, and four are still to come:

\$198M

Confirmed improper payments identified across audited states.

Source: OIG, Series SRS-A-25-029

95 of 100

Sampled enrollee-months in Indiana with at least one documentation issue.

Source: OIG A-09-22-02002, December 2024

\$410M

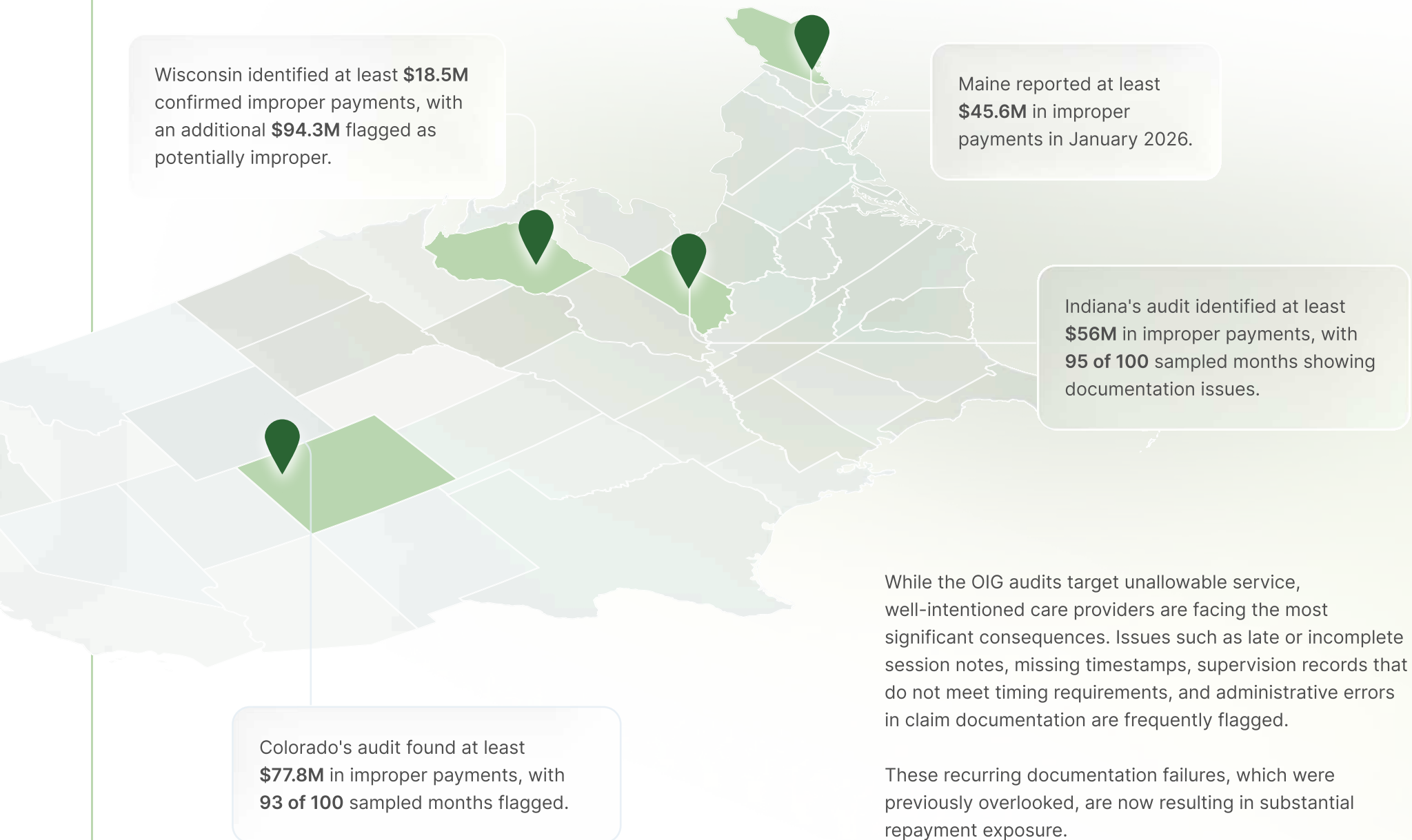
Additional payments flagged as potentially improper and under review.

Source: OIG, Series SRS-A-25-029

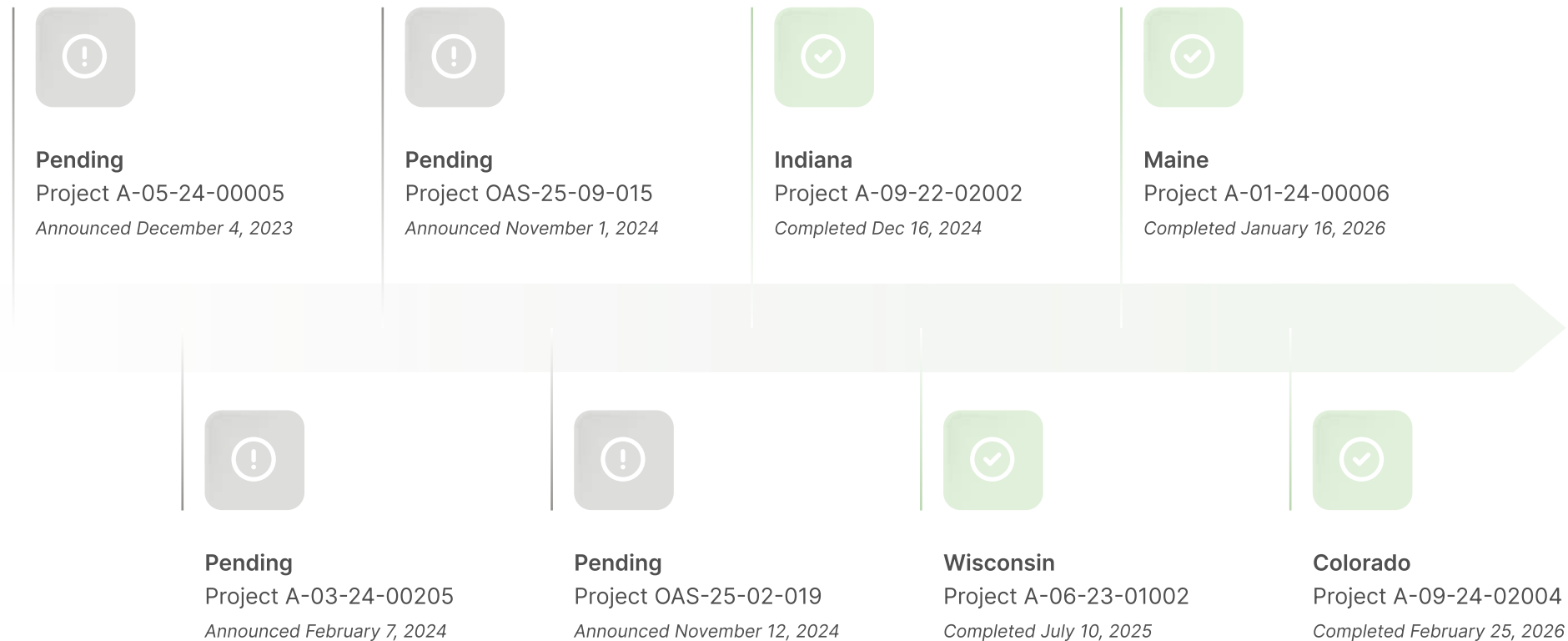
93 of 100

Sampled months in Colorado with documentation issues identified.

Source: OIG A-09-24-02004



The audit series is ongoing, with four states still to report. The OIG withholds the names of states until the audit is complete and published.



Regulatory oversight of ABA billing is also increasing

In February 2026, CMS sought stakeholder input on a possible future rule under its Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative.

The announcement marked a shift from retrospective pay-and-chase enforcement to real-time, AI-driven fraud detection across Medicare and Medicaid. HHS Secretary Kennedy described this as a transition to a "detect and deploy" strategy to prevent improper payments before disbursement.

Separately, the House Committee on Energy and Commerce requested information from ten states regarding Medicaid fraud, waste, and abuse, specifically identifying ABA services as high-risk.

Several states, including Colorado, Indiana, Nebraska, New York, North Carolina, and Idaho, have implemented measures ranging from rate reductions and service caps to full service reclassifications. Collectively, these developments indicate a structural shift within the industry.

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We are replacing the old 'pay and chase' model with a real-time 'detect and deploy' strategy, using advanced AI tools to identify fraud instantly.

HHS Secretary Robert F. Kennedy Jr., February 2026

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THE CONTEXT

How a 298% growth spike put ABA in the crosshairs

Understanding the reasons for increased ABA scrutiny is essential, as it clarifies which assets are most exposed.

Industry growth was demand-driven. Autism diagnoses were rising, coverage mandates followed, and providers scaled to meet them.

The CDC now reports 1 in 31 children in the U.S. have been identified with Autism Spectrum Disorder.



Medicaid-funded ABA visits in 2019



Medicaid-funded ABA visits in 2024

Spending exceeded original estimates by up to 2,800% in some states.

The workforce scaled alongside it. The BACB reports 253,397 RBT certificants as of April 2026, up from 89,122 in 2020. Over half of the current workforce has entered the field within the past five years.

However, billing and documentation infrastructure did not keep pace. Many Medicaid policies and revenue cycle frameworks were established prior to the expansion and have not been updated to accommodate current volumes, workforce composition, or heightened scrutiny.

That gap is where auditors are finding the problems.

The claims being audited now largely date back to 2019-2022, the same period when most PE consolidation in ABA occurred.

Revenue that was recognized, counted, and in many cases used to underpin acquisition valuations during that window is now subject to retrospective review.

FINANCIAL EXPOSURE

How a session note gap becomes a balance sheet problem

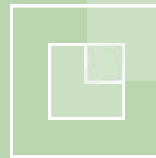
While OIG findings may initially appear to be a compliance issue, a more comprehensive perspective recognizes them as an EBITDA risk.

Post-payment audit findings often extend beyond what most deal models anticipate. While repayment obligations are visible, the retroactive impairment of revenue already factored into valuations poses a greater challenge.

Consider what Camber found at a PE-backed behavioral health platform spanning nine states with \$100M in contracted revenue. Entering 2024, the platform had no visibility into where revenue was leaking. Manual workflows, fragmented tools, and limited denial visibility were creating losses across sites that did not show up on the P&L.

Camber's diagnostic identified nearly a year of unpaid Medicaid claims sitting unrecovered after a credentialing issue that nobody had caught. First-pass paid rates were running at a level that looked acceptable on the surface.

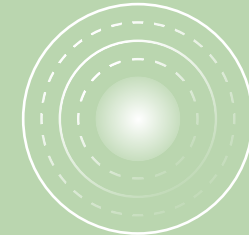
The underlying denial trend told a different story



>\$4 million
In EBITDA
recovered



+50%
Improvement in
first-pass paid rates,
reaching 94%



14 - 21
days DSO
reduction

At a 6-8x EBITDA multiple, the value implication of that recovery runs well beyond the claims themselves. For a \$100M platform, unaddressed RCM leakage of this kind typically represents \$3-8M in recoverable EBITDA.

Operational burdens further increase financial exposure

Audit responses require substantial administrative effort, including documentation reconstruction across fragmented systems, diversion of clinical leadership, and prolonged compliance remediation.

For a scaled enterprise provider, audit response responsibilities often fall on the same leadership team managing daily operations, meeting quarterly targets, and preparing for transactions.



Direct repayment liability

The claim fails documentation standards. Your clinic repays the payer.



EBITDA impairment

The revenue underpinning the original valuation was overstated.



Operational drag

Audit response absorbs leadership capacity and inflates cost during remediation.

THE DILIGENCE GAP

The blind spot in standard diligence

Standard ABA diligence effectively identifies risks related to revenue concentration, payer mix, staffing models, margin profile, and retention. However, claims integrity is often not examined at the depth required by current industry conditions.

Most acquisition processes do not evaluate:

- Historical claims compliance rates against documentation standards
- The strength of pre-submission validation workflows
- Whether historical claims already paid could be subject to repayment demands
- What the operational recovery process looks like if audit findings land during ownership



This diligence gap matters for two reasons.

First, this is not a future risk but a current liability embedded in claims that have already been submitted, paid, and recorded. While the revenue from these claims is recognized, the associated liability from documentation errors is not.

Second, this issue affects not only existing assets but also new acquisitions. Any ABA acquisition underwritten without assessing claims integrity carries similar exposure.

Behavioral health M&A deal volume increased 42% year-over-year in 2025, reaching 104 publicly announced transactions according to [Irving Levin Associates](#). Buyers who address these questions early can avoid overpaying for unseen liabilities.

Valuations are starting to reflect the difference.

For operating partners, this is an exit pricing consideration. For deal teams, it is an entry pricing factor. An enterprise provider with a clean claims history and robust documentation workflows represents a lower-risk, higher-value asset.

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Premium multiples in ABA are now concentrated among platforms with strong clinical governance.

FOCUS Investment Banking, December 2025

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EXIT IMPLICATIONS

How unresolved claims exposure moves through to exit

Unresolved claims exposure remains with the asset, impacting exit timing, exit multiples, and buyer willingness to proceed.

Audit findings that emerge near exit create two challenges: the repayment liability itself and the need for remediation before closing, which extends timelines and introduces uncertainty when financial performance must be clear and transparent.

CMS's shift to real-time enforcement under the CRUSH initiative is likely to reduce the lag between claim submission and enforcement action. Assets acquired during the 2019-2022 expansion remain exposed to retrospective review, while new assets face a much shorter window.

Investors are already responding. According to M&A Healthcare Advisors, the most successful ABA deals close when buyers have confidence in the sellers' financial data. This trust is difficult to establish when data is incomplete or unreliable. Well-governed platforms attract stronger buyer interest, while those with unresolved exposure often face price renegotiations or escrow requirements to address contingent liabilities.

Audit finding surfaces at exit

Repayment liability emerges during sale process

Transaction timeline extends

Buyer re-trades on price or adds escrow provisions

EBITDA for prior periods subject to restatement

Claim integrity addressed pre-exit

Clean financial history with documented validation controls

Diligence moves faster

No escrow provisions for claims liability

Premium multiple supported by compliance infrastructure

For operating partners, the priority is to assess whether compliance infrastructure across portfolio companies can ensure a clean claims record before exit

OPERATIONAL PRIORITIES

Prevention costs significantly less than remediation

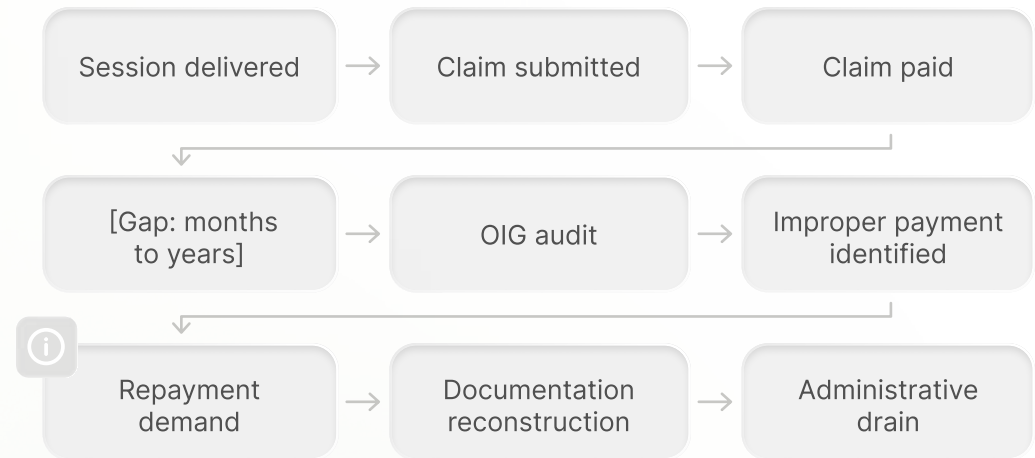
Most improper payments identified in the OIG's audit series could have been prevented before reaching a payer. Claims missing timestamps should be intercepted prior to submission. Supervision notes outside the required window should be flagged during documentation, not discovered years later during audits.

The difference between a defensible claims record and an exposed one comes down to when the check happens.

Post-payment audit responses often require reconstructing records from memory, across fragmented systems, with staff turnover and outdated documentation. Pre-submission validation identifies these errors before they become liabilities. The operational cost difference is significant, and the financial impact, as demonstrated by OIG findings, can be substantial.

POST-PAYMENT RESPONSE

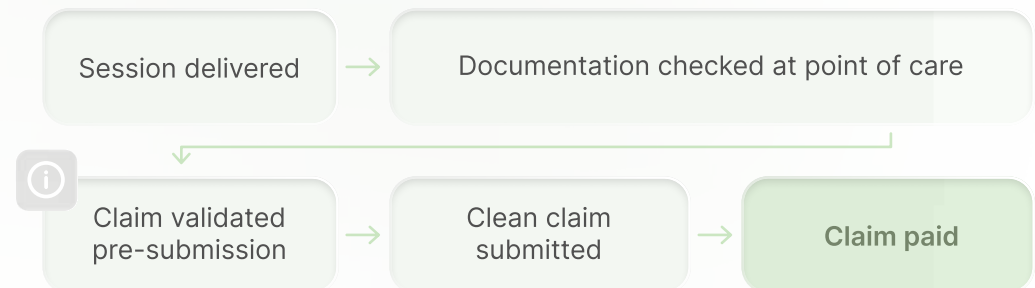
This reflects the current state for most ABA organizations.



i Exposure Window

PRE-SUBMISSION VALIDATION

This represents the target revenue cycle process.



i Catches what an audit would find

A starting point for ABA portfolio review

For investors and operating partners, the following three operational questions can quickly assess a portfolio company's position:



Does the ABA provider validate claims before submission, or only after denial?

Pre-submission validation serves as the primary control to prevent documentation errors from resulting in repayment liabilities. Denial management is a recovery measure, not a preventive one.



Does leadership have real-time visibility into denial trends and their root causes?

Lagging indicators mean problems are discovered weeks after they could have been addressed. Real-time visibility means patterns get caught at the source.



Is the documentation workflow integrated into clinical operations, or does it sit alongside them?

Documentation standards that exist in manuals but not in workflows will fail under audit. The standard needs to be enforced at the point of care, not reviewed after the fact.

Camber's approach to ABA claims integrity at portfolio scale

Camber is an RCM partner specializing in ABA and behavioral health. The practices outlined in this guide reflect Camber's daily work with some of the largest providers nationwide.

Camber currently partners with portfolio companies of KKR and General Atlantic, managing \$2.5 billion in claims. Across supported organizations, Camber has achieved a 12.3% year-over-year improvement in first-pass paid rates and an average 50% reduction in traditional billing headcount.

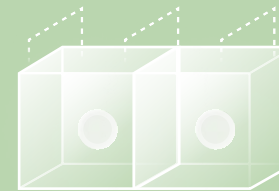
- \$2.5B claims covered
- +12.3% YoY improvement in FPPR
- ~50% average decrease in traditional billing headcount
- 700+ automation rules built in 2025
- 99.9% average platform uptime across 12 months

For PE-backed platforms, Camber begins with a diagnostic assessment. This process typically takes three to four weeks, is provided at no cost, and requires only EHR data access and approximately two hours with your billing lead.

The underlying denial trend told a different story



Top denial categories by volume and dollar value with root cause



Collection rate benchmarked against peer operators by payer and service line



A revenue recovery opportunity with timeline and confidence range

To date, our diagnostics have identified an average opportunity of 3-4x ROI per provider.

For a \$100 million specialty platform, unaddressed RCM leakage typically represents \$3-8 million in recoverable EBITDA. A 2 to 4 point NCR improvement and a 10 to 20 day DSO reduction can yield a 200-500 basis point annual EBITDA impact.

Case study FY2025

Camber delivered over \$4M in EBITDA impact for a PE-backed behavioral health platform.

Camber partnered with a PE-backed behavioral health enterprise operating in nine states with \$100 million in contracted revenue. At the start of 2024, the organization lacked the revenue cycle foundation necessary to support its growth.

Manual workflows, fragmented tools, and limited denial visibility contributed to revenue leakage across sites.

By partnering with Camber:



First-pass paid rates improved by more than 50%, reaching 94%



DSO was reduced by 14-21 days



Nearly a year of unpaid Medicaid claims were recovered after a credentialing issue was identified and resolved



Leadership now has daily AR visibility across all nine states

See where revenue is leaking across your portfolio.
Request a complimentary Camber diagnostic.

Run a diagnostic