



# KEENE PERSPECTIVES

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**To:** House Health Care Committee  
**From:** Cortney Keene, BCBA, LBA  
**Date:** 02/09/2026  
**RE:** Written Testimony Regarding DHVA ABA Coding Changes follow up to Verbal Testimony provided 02/05/2026

Dear Chair Black and Members of the Committee,

Thank you for the opportunity to provide testimony regarding the DVHA ABA Coding Changes that went into effect on 1/1/2026. My name is Cortney Keene; I am a clinician co-owner of Keene Perspectives in White River Junction, a resident of Hartland, Vermont, and currently serve as the Chair of the Vermont Association of Applied Behavior Analysis (VTABA). I am providing testimony as a small business owner and employer in Vermont, a clinician supporting children with autism as a healthcare provider, and as the Chair of VTABA. I am writing to follow up on my verbal testimony to the committee on 02/05/2026 to ensure my position is accurately reflected in the public record and easily accessible for your committee to reference.

Our organization, Keene Perspectives, is a dually accredited organization by the Autism Commission on Quality and as a Behavioral Health Center of Excellence. These are the *only two* nationally recognized accreditations in the field of ABA at this time. Additionally, I was recognized as the SBA's Vermont Small Co-Business Persons of the Year in 2023 along with my husband and co-founder of Keene Perspectives (Dr. Christopher Keene, PhD, BCBA-D). I share this not to gloat, but to stress our commitment to owning and operating a business in Vermont, developing and maintaining a highly trained workforce, providing high quality services with strong clinical outcomes, our commitment to best clinical and operational practices, and to our community. Due to the gravity of the situation and the critical nature of this advocacy, I will state more bluntly than I normally would in suggesting that we are *exactly* the kind of providers Vermont and its families want and need.

I provided my verbal testimony alongside Brian Marrier, BCBA from AAI and Melinda Neff, BCBA from Green Mountain Behavior Consulting. Combined, our three organizations estimate we served around 40% of the 320 unique Vermont Medicaid members who received ABA services in 2025. At our organization, Keene Perspectives, we support primarily children with level 3 profound autism, who require comprehensive care in the form of daily, year round, 1:1 intensive services.

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**What is ABA?** Applied behavior analysis is a treatment and teaching methodology often prescribed for children with autism, and I am speaking today about a model based on medical necessity, often considered outpatient, specialist services. As a treatment, ABA is individualized around each patient's presentation of symptoms of autism, strengths, and specific barriers to learning. Provided across settings in single or tiered delivery models, with treatment overseen by a BCBA. Services are often categorized as focused or comprehensive (less or more than 25 hours a week of services), which also roughly correspond to intensity of services and support needed to ameliorate their symptoms and make socially meaningful and significant change in their lives and the lives of their families.

**My testimony will focus on two main issues: concurrent billing and telehealth.** The changes that went into effect on 1/1/2026 are having a sweeping impact on ABA services across Vermont and the impact on medicaid members and providers is already being felt. The DVHA reported in their testimony they have heard from 3 providers who are no longer accepting Medicaid members. At Keene Perspectives, we are evaluating the changes that we need to make to be a viable business and service provider in Vermont.

**The DHVA has made these policy change decisions based primarily on unofficial information that is NOT considered official coding advice,** it is not widely available, and only accessible with a subscription. It **does not** constitute official direction from the AMA and there have been no changes to this ABA coding guidance since the codes became permanent in 2019.

The two resources that are considered official coding advice are the 2026 American Medical Association CPT coding book and the 2019 CPT Assist Article. All ABA codes and code descriptors are clearly defined in both documents. If something is not allowed, it would be specifically outlined in the parentheticals in those resources. Neither indicate that 97153 and 97155 cannot be billed concurrently. Nothing else would be considered official guidance. The AMA would not approve or publish multiple codes unless they were separate and distinct services. The CPT codes for a technician and a QHP are separate and distinct services that are client-centric.

I was able to gain access to the 2024 Knowledge Base Article 7744 that Vermont Medicaid cited as the basis for these policy changes and have included a screenshot below. Please take note of the fine print at the bottom where it clearly states the parameters under which this knowledge base should and should not be considered.

[Return to search results](#)

KB #: 7744

Date: 06/17/2024

**Medicine****Adaptive Behavior Services**Tags: **KB Exclusive****Question:**

Is it appropriate to report code 97155 concurrently with 97153? In this case, a technician and a BCBA/MD are treating the same patient during the same time interval. Can the tech report code 97153 and the BCBA report code 97155 for the same time?

**Answer:**

No, while the work performed by the physician directly and the work supervising a technician are different, it is the patient's time face-to-face in the service that is reported under these CPT codes, not the clinician's time. Both clinicians cannot report for the same unit of time spent with the patient. Therefore, codes 97153, *Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes*, and 97155, *Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes*, may not be reported together for the same time period.

Information provided by the American Medical Association ("AMA") through CPT® Network, also referred to as CPT® Knowledge Base, is for medical coding guidance purposes only. It (i) does not supersede or replace the AMA's Current Procedural Terminology® manual ("CPT Manual") or other coding authority, (ii) does not constitute clinical advice, (iii) does not dictate payer reimbursement policy, and (iv) does not substitute for the professional judgement of the practitioner performing a procedure, who remains responsible for correct coding. In issuing this guidance, the AMA has relied upon the facts as presented. The guidance is intended only for the requestor, and it may be later rescinded, modified or clarified. The AMA is not responsible for updating guidance that is provided to a requestor, and requestor acknowledges and agrees that guidance may cease to be accurate or complete based on subsequent guidance published in the CPT Manual. The AMA expressly disclaims and in no event shall the AMA be liable for any loss or damage based on reliance on or use of the information herein.

Content Provided By: CPT Knowledge Base

**Figure 1.** AMA Knowledge Base Article #7744 question, answer, and context for appropriate application.

*Additionally, there is a pending code change application where there will be new ABA codes and new guidance effective 1.1.2027. Until that information is made publicly available by the AMA sometime later this year, there have been NO updates to the ABA code set since it was introduced in 2019 and the codes went permanent.*

The two code definitions in question include:

**97153.** Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes

**97155.** Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional, **which may include simultaneous direction of technician**, face-to-face with one patient, each 15 minutes

Anytime that 97153 is being delivered by a technician, our generally accepted standards of care - the ABA Practice Guidelines, require that protocol modification (97155) occurs for a specific percentage of time, while a technician is delivering services (97153) that are client-centric. Both the 97155 and 97153 activities are client focused. In response to these changes, Vermont provider and the VTABA Board have all provided DVHA with extensive resources countering the change to concurrent billing practices, as well as the immensely negative impact providers expected it to have on critical services across the state.

97155 is a direct service being provided while another direct service is being provided and both have to be compensated as a practical matter. They should be compensated under the formula

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that the DVHA operates under within the case rate model (more on this below). They are treatment hours being delivered, and there is no question that this value is being delivered and providers need to be paid for services rendered. Otherwise, the DVHA would be forcing providers to provide services for free or not provide medically necessary services in line with standards of care.

**Regarding changing telehealth practices**, I wanted to share that the 2026 Medicare physician fee schedule effective 1/1/2026, includes all of ABA treatment codes approved on a permanent basis. In both the proposed and final rule, CMS said they were making this change because they wanted to respect each clinician's professional judgment in evaluating the most appropriate methodology for their individual patients to receive care. CMS has said they can be delivered via telehealth and encouraging clinician decision making and family choice. It would be reasonable and appropriate for the DVHA to ask for clinical rationale from providers. We aren't saying everyone gets it, but we are saying there can't be a blanket rule that no one can receive the services the DVHA removed from the approved list. **The changes adopted 1/1/2026 have completely removed families and clinicians from the decision making process with a vital resource for accessing life changing, high quality ABA care through a mechanism ideal for rural communities.**

With regards to the ABA case rate model (specific to Vermont), where providers are reimbursed for total hours provided and not a fee-for-service, the ABA Case Rate model should not exclude these hours when determining tiers for payment. Those hours should still be accounted for in how services are billed. Nothing in the cited ABA Knowledge Base Q&A serves as sufficient justification for excluding 97155 from the tier payments, and **risks compromising the network of service providers in Vermont rapidly based on the severely negative impact of these changes when Medicaid rates have already fallen substantially behind other private insurance providers, as reported by The DVHA with the loss of 3 providers in the first month of the changes.**

For Keene Perspectives, our January impact was 14.4% in decreased reimbursement for services rendered, and we consider this a low baseline impact with holiday and snowday closures, and a large number of client cancellations due to illness. In other words, when we have less disruption of services, we expect even worse outcomes month to month. We currently service 10 Medicaid members receiving comprehensive ABA services (each requiring upwards of 30 hours per week on average), with 10 children with Vermont Medicaid on our waitlist (ages 2-4). In addition, Vermont diagnosing physicians have been calling us to find out if we are still taking Vermont Medicaid because other providers in Vermont are no longer taking these clients, and they are trying to determine where to send referrals for newly diagnosed children. This doesn't take into account those seeking services who are school-aged into early adulthood and the need is there and growing.

There continues to be overall network inadequacy especially in rural parts of the state supporting across the age span (birth to 21) for ABA services. Rates are one of the main things that attract providers to network. Reevaluating the overall fee schedule (**which hasn't had an**

**update since shifting to case rate in 2019)** in addition to fixing these clinical and administrative barriers that have now been implemented would help to ensure more access to care for many Vermont children and families unable to access services, from birth to 21.

Noting our Governor's three main priorities this year:

- **Growing the economy:** we need more ABA providers, not less - 2025 CDC reports 1 in 31 children have been identified with autism spectrum disorder (ASD), which means the need for medically necessary supports are *growing*, not shrinking. The only way to meet this need is to have highly skilled clinicians and front line staff to support this need.
- **Make Vermont more affordable:** ABA organizations employ hundreds of Vermonters combined across the state. By the nature of the intensive services, they increase the Vermont workforce, provide high quality training, and keep young people working in Vermont while building careers and supporting our most vulnerable. Every child or adult with autism receiving comprehensive ABA services also means approximately 1.3-1.5 full time equivalent workers in the workforce in our state, with positive impacts both through direct support and enabling caregivers to join or rejoin the workforce with the benefit of reliable, effective services.
- **Protect our most vulnerable:** these changes are immediately doing the opposite of protecting our most vulnerable and only shifts the overall cost down the road and spreads it across supportive agencies. If ABA organizations have to make the decision to cut services or close their doors, now supports shift to families and schools, many of which will be untrained, underequipped, and understaffed to meet this need. This means families may have to leave their employment and schools are already overloaded with special education services. These ABA coding changes have far reaching ramifications. By committing to effectively supporting ABA services, all 3 of these priorities would be strongly aligned.

Chair Black asked at the end of the verbal testimony about private insurance rates. Rates with ABA providers are individually and privately negotiated at the contracting phase when joining as a group or individual provider. The [Blue Cross Blue Shield of Vermont ABA Policy](#) is publicly available on their website, and their policy follows concurrent billing as outlined by the official guidance from the AMA. This is just one example of a private commercial insurance company.

I have done my best to provide a breakdown (detailed in table below) to share a comparison of the percentage difference between DVHA Case Rates, DVHA Fee-for-service (FFS) rates, and commercial rates. It is very difficult to compare head-to-head due to the complexity of the case rate model. **To not bury the lede, I can share that Case Rate reimbursement is 38-42% lower than private insurance rates for identical services when disallowing concurrent billing (1.1.2026 change).** Even with concurrent billing allowed, Case Rate reimbursement is 18-22% lower than private insurance rates. In order to present the House Healthcare Committee with essential information for comparison to answer their rate questions, I have also included ABA FFS comparisons to Case Rate and private insurance rates below.

Briefly, Case Rate reimbursement follows tier-based compensation. For example, a client receiving 15-24 hours of services (across all service codes provided) would fall into tier 3 and compensation would be provided accordingly. The lower the number of hours in the tier, the

higher hourly rate on average for all codes provided (the “floor” of hourly rates possible for each tier). The higher the number of hours in the tier, the lower the hourly rate on average for all codes provided (the “ceiling” of hourly rates possible for each tier. Please see the Case Rate tier levels below, all of this information is publicly available:

Tiers	Hours (Floor)	Payment	Floor Ave	Ceiling Ave
0	0	\$ -		
1	2	\$ 219.00	\$ 109.50	\$ 43.80
2	6	\$ 575.00	\$ 95.83	\$ 41.07
3	15	\$ 1,298.00	\$ 86.53	\$ 54.08
4	25	\$ 1,964.00	\$ 78.56	\$ 57.76
5	35	\$ 2,777.00	\$ 79.34	\$ 56.67
6	50	\$ 3,779.00	\$ 75.58	\$ 59.00
7	65	\$ 4,833.00	\$ 74.35	\$ 61.17
8	80	\$ 5,939.00	\$ 74.23	\$ 63.18
9	95	\$ 7,097.00	\$ 74.70	\$ 65.11
10	110	\$ 8,307.00	\$ 75.51	\$ 66.99
11	125	\$ 9,569.00	\$ 76.55	\$ 68.84
12	140	\$ 10,883.00	\$ 77.73	\$ 70.66
13	155	\$ 12,249.00	\$ 79.02	\$ 72.48
14	170	\$ 13,667.00	\$ 80.39	\$ 74.27

**Table 1.** Case Rate tiers, compensation, floor and ceiling ranges per service hour delivered.

The publicly available Vermont Medicaid ABA Fee-for-Service rates for our codes are as follows (they are billed in 15 minute units). ABA providers cannot bill these rates for children with ASD, instead use case rate:

CPT Code	DVHA Rate 2/9/26	Provider
97151	\$ 65.80	BCBA
97152	\$ 30.00	BCaBA or Tech
97153	\$ 15.00	BCaBA or Tech
97154	\$ 7.50	BCaBA or Tech
97155	\$ 49.35	BCBA or BCaBA (dvha removed bcaba, too)
97156	\$ 21.39	BCBA or BCaBA (dvha removed bcaba, too)
97157	\$ 21.39	BCBA or BCaBA (dvha removed bcaba, too)
97158	\$ 16.45	BCBA or BCaBA (dvha removed bcaba, too)

With the case rate model, providers provide services and then by the 15th of the following month submit a form with the total hours provided the previous month. Then the end of that second month is paid in a lump sum. Once we receive that payment, we can then send our claims

(March for January), submitted as fee for service shadow claims that pay 0.00. As the Committee identified, this process is incredibly administratively burdensome, makes maintaining books incredibly difficult, and also doesn't work in any EMR platforms for billing and reconciling) and clinical purposes.

- This model delays access to care by forcing assessments to be completed in the beginning of the month rather than in the last two weeks due to tier thresholds impacting reimbursement. For example, if you provide less than 2 hours of services in a month, they are free services, if 5 hours in that month it is \$43.80 per hour, or 2 hours in the month, \$109.50 per hour - for the same service provided. Assessing new clients and families is a labor intensive process that certainly does not benefit from this unnecessary barrier.
- This model also incentivizes clinicians and potentially bad actors to provide hours of service based on hitting the bottom of a tier rather than prioritizing medical necessity, as opposed to simply being paid for services rendered.
- Additionally, with the removal of concurrent billing, tiers 13 and 14 are no longer possible based on field standards for appropriate limits on medically necessary services, and what is reasonable for someone to access for services. We would be providing those hours of service for a client accessing comprehensive services but would not be compensated in the tier system for it without concurrent billing.
- It is also important to note that the Vermont ABA Policy outlines under their caseload recommendations section in the ABA Clinical Practice Guidelines that "total case supervision and clinical direction required by caseload (i.e., 2 hours of supervision/monitoring of direct service of the BT with the member by the BCBA for every 10 hours of direct service provided by the BT)." As a provider, we interpret this to mean that we must provide protocol modification for 20% of the 97153 direct services, despite no longer being reimbursed for the services. [This is on page 6 of the Clinical Practice Guidelines.](#)

In response to the Committee's questions about the Case Rate Model, Fee for Service, and private insurance rates, I put together a fee comparison case study. Private insurance rates are not disclosed, as they are provider-specific and contractually negotiated, so instead are indicated by percentage ranges.

#### **Fee Schedule Comparison Case Study:**

4 year old with autism receiving Comprehensive ABA services:

- 20 days of direct services (97153) in January 2026 at 6 hours a day
- 20% protocol modification (97155)
- 2 Adaptive Treatment Guidance (caregiver coaching) meetings (97156).

The breakdown of codes and hours/units is as follows:

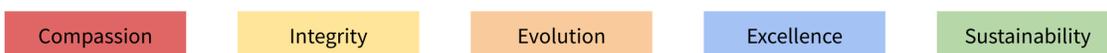
- 97153: 480 units (120 hours)
- 97155: 96 units (24 hours)
- 97156: 8 units (2 hours)

	<b>Case Rate w/ Concurrent 53 and 55</b>	<b>Case Rate w/o Concurrent 53 and 55</b>	<b>Medicaid Fee for Service w/ Concurrent 53 and 55</b>	<b>Medicaid Fee for Service w/o Concurrent 53 and 55</b>	<b>Private Insurance Comparison by %</b>
<b>Tier or Code Breakdown</b>	Tier 12	Tier 10	97153 - \$7,200 97155 - \$4,737.60 97156 - \$171.12	97153 - \$7,200 97155 - \$0 97156 - \$171.12	<b>Case Rate w/Concurrent: 18-22% lower than private insurance</b>  <b>Case Rate w/o Concurrent: 38-42% lower than private insurance</b>  <b>DVHA ABA FFS w/Concurrent: 9-13% less than private insurance</b>  <b>DVHA ABA FFS w/o Concurrent: 45-49% less than private insurance</b>
<b>Service Hours Provided</b>	146	146	146	146	
<b>Service Hours Compensated</b>	146	122	146	122	
<b>Total Compensation</b>	\$10,883.00	\$8,307.00	\$12,108.72	\$7,371.12	
<b>Average Hourly Across All Codes to Compare FFS to Case Rate</b>	\$74.54	\$56.89	\$82.93	\$50.48	

In addition to reversing the decision on concurrent billing based on unofficial information, considering a return to the FFS model to the case rate model to remove confusion, administrative burden (for providers and for DVHA), and remove the opportunity for bad actors to benefit at the hands of the vulnerable may be warranted. Additionally, the Vermont Medicaid ABA fee schedule has not been updated since 2019. The ABA fee for service schedule is not utilized for our services for children with autism, so comparing is a challenge, but with concurrent billing removed, ABA services for children with autism become not viable under either Case Rate or FFS models without a drastic adjustment to other rates.

**Recommendations**

I am incredibly appreciative of the Committee’s time and focus on this pressing issue for Vermont families and providers. In an effort to provide context and potential solutions that can



be incorporated on a fast timeline that preserves the provider network and services for our Vermont children and families, I have reviewed the Medicaid ABA FFS rates for all 50 states to present the recommendations below. Due to the recently enacted changes to concurrent billing and telehealth services, Case Rate vs FFS rate comparisons, and the lack of rate increases relative to many other states since the onset of Case Rate in 2019, these recommendations vary dramatically based on model determinations. I have also noted that many other Mental Health and Healthcare providers received rate increases announced in the Global Commitment Register for 2026, in contrast to ABA services receiving a 16-20% decrease in reimbursement. Please also note that the recommendations below are intended to help Vermont maintain an adequate provider network to serve our most vulnerable. The simplest, most straightforward and transparent model would be a switch to FFS and allowing concurrent billing of 97153 and 97155. In lieu of that, each option is also ranked below by order of administrative and clinical workload to maintain access of services for Medicaid members and adjusts rates based on the model and accounting for each separate and distinct service. For example, if Case Rate remains as the clinical service reimbursement model, then it would need to reflect rate adjustments to account for services rendered but not accounted for in the models with the removal of concurrent billing, which results in significant increases necessary to offset these changes.

1. If ABA services **switch to a FFS model** and **allow concurrent billing**, I would advocate for rate increases of 16.7-20% for 97153 specifically and 23-26% for 97156 specifically. All other code rates are reasonable based on analysis.
2. If ABA services **remain a Case Rate** model and **allow concurrent billing**, I would advocate for a rate increase of 15-17% per service hour provided. Since its introduction in 2019 when reimbursement rates were adequate, they have lagged behind severely over the past 7 years.

The remaining two options would impose significant administrative risk on monitoring compliance with the ABA policy making it very difficult to monitor for fraud, waste, and abuse.

3. If ABA services **remain a Case Rate** model and **do not allow concurrent billing**, I would advocate for a rate increase of 48-54% (due to removing direct reimbursement for QHP services via 97155).
4. If ABA services **switch to a FFS model** and **do not allow concurrent billing**, I would advocate for a rate increase of 25-27% for 97153 specifically and 23-26% for 97156 specifically.
  - a. This model would not be supported by ABA EMR systems and would be an immense administrative burden and impact daily operations.

In closing, on behalf of VTABA and my organization, we disagree with the basis for the removal of concurrent billing and fear this will have far reaching ramifications for families of children with autism spectrum disorder, birth to 21, who access ABA services in addition to maintaining an adequate provider network and keeping doors open for many small businesses in Vermont.

Thank you again for the opportunity to share my testimony. If I can answer any questions, please reach out to me directly at [cortneykeene@keeneperspectives.com](mailto:cortneykeene@keeneperspectives.com) or 802 232 2626.

*Cortney Keene*

# Audit trail

## Details

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 SENT	cortneykeene@keeneperspectives.com <b>sent</b> a signature request to: <ul style="list-style-type: none"><li>Cortney Keene (cortneykeene@keeneperspectives.com)</li></ul>	2026/02/10 15:41:48 UTC
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