THE STRATEGY HIVE

CLEARER DECISIONS
STRONGER SYSTEMS
BETTER OUTCOMES

ABA TECHNOLOGY BUYER'S GUIDE

2026 OWNER EDITION

INDUSTRY PREVIEW



A practical guide for ABA owners and leadership teams choosing technology with clarity and confidence.

INDUSTRY PREVIEW

For the People Building ABA Technology

Most writing about ABA software is aimed at the companies selling it. This guide is written for the people buying it: owners, operators, clinical directors, and billing leads who live with the software every day. If you build, sell, or invest in ABA technology, that is exactly why it is worth reading. It shows how your buyers think, what they will ask you to prove, and where today's products still leave staff doing the work.

The biggest issue isn't that ABA doesn't have technology. It's that humans are still acting as the connection between all of the technology.

Intake, scheduling, authorizations, clinical documentation, and billing should be one connected workflow. Too often, employees are still moving information from one step to the next by hand.

This industry preview shares a few pages of that buyer-side view. The full guide adds the platform-by-platform findings, the full demo script, pricing comparisons, and the decision tools owners use to choose.

THE BUYER'S VIEW

What Owners Say Is Still Not Working

These are the problems that come up again and again from the provider side. None of them is a missing feature list. Most are failures in the handoffs between features.

Area	Where it still breaks down
Scheduling	Callouts and cancellations force manual rebuilds. Credentials, payer restrictions, authorization hours, supervision, travel, and PTO all constrain who can see whom, and systems often show the problem without suggesting the best replacement.
Authorizations	Authorized, scheduled, and used units are tracked separately. Units are hard to translate into usable weekly schedules, hours go unused, and staff can schedule past the limit.
Billing and RCM	Preventable denials from modifiers, place of service, payer rules, and unit limits. Denial follow-up is still manual, and software may name a denial without saying how to fix it.
Documentation to billing	Late notes, missing signatures, wrong times, and overlapping sessions hold claims. Billing chases clinicians, and compliance problems surface after the service instead of before it.
Intake	Information is re-entered several times and families are chased for documents. Many intake tools collect information without moving the family forward.
Credentialing	Payer enrollment lives in spreadsheets and does not flow into scheduling automatically.
Reporting	Lots of data, little decision-ready information. Leadership finds problems after they have already cost money.
Integrations	"We integrate" can mean almost anything. Staff build spreadsheets to bridge systems that technically connect.
Implementation	Incomplete configuration, payer rules built wrong, and conflicting answers from implementation staff. A great product can perform badly because implementation was bad.
Adoption and support	RBTs need something simple. Support teams that do not understand ABA operations slow down cash flow when billing problems wait days.
True cost	Per-user and per-client pricing climbs with scale, add-ons and claim fees stack up, and administrative labor is the hidden cost.

If I need three people and five spreadsheets to compensate for what the software doesn't do, that's part of the cost of that platform.

OPPORTUNITY

Where the Market Still Falls Short

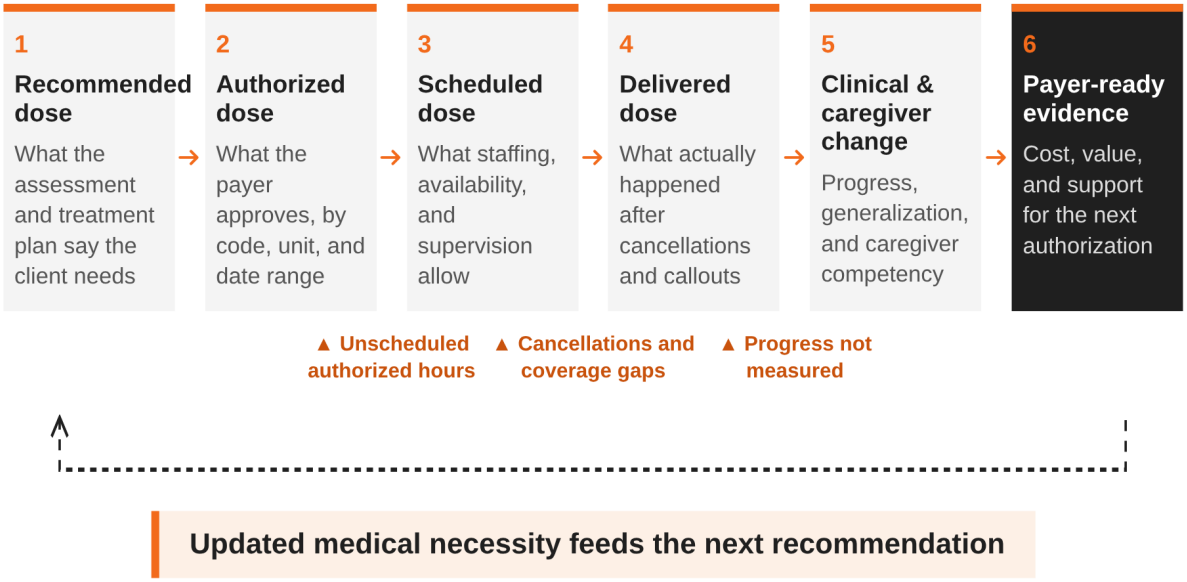
A sample from the buyer-side gap analysis. Each area shows what exists today, the real problem underneath, and what is still missing.

Area	What exists today	The real problem	What is still missing
Authorization management	Storage of dates, codes, and units; expiration alerts.	Storage is not management. Providers need to know whether authorized treatment will be used appropriately before it expires.	Continuous authorization intelligence tied to clinical dose and outcomes.
Scheduling	Calendars, availability filters, staff matching, early optimization tools.	ABA scheduling is a multi-constraint optimization problem, not calendar management.	Closed-loop scheduling that understands clinical priority and the utilization or financial consequence.
Documentation AI	Drafting, summarization, templates, and note auditing.	Generating more text can create compliance risk rather than reduce the burden.	Cross-document reasoning: does the note match the plan, authorization, schedule, and clinical data?
RCM and claims AI	Scrubbing, work queues, payment posting, AI-assisted denials.	The hard work happens after the happy path fails.	Clinical-to-financial reasoning: where upstream a service became financially invalid, and why.
Interoperability	APIs, integrations, exports, data warehouses.	Staff often become the reconciliation layer.	Vendor-neutral clinical, operational, and financial intelligence with clear source-of-truth rules.

THE BIG STRATEGIC GAP

From recommended care to payer-ready evidence

Recommended, authorized, scheduled, and delivered dose are not the same number. Each handoff can leak hours, revenue, or evidence.



No single provider-facing system in this guide universally closes this full loop today. Vendors own different pieces.

In the full guide: the problem-by-problem capability map across intake, scheduling, clinical data, billing, authorizations, credentialing, caregiver training, AI notes, documentation QA, medical necessity, and outcomes, with what buyers should test in each.

STRAIGHT ANSWERS

Questions Investors and Builders Ask

Where is the greatest near-term AI ROI?

High-volume administrative work where people currently search, calculate, compare, or audit: eligibility, authorizations, note QA, claim validation, denial classification, scheduling exceptions, and RCM prioritization. These workflows have measurable labor and revenue consequences and carry less clinical risk than autonomous treatment decisions.

What would make a provider switch platforms?

Not a prettier interface. A meaningful reduction in administrative labor, fewer disconnected systems, reliable complex RCM, better authorization and utilization control, better data visibility, strong clinical usability, and an economic case that still holds after migration cost and risk.

What would make a provider add a point solution?

The bar is much lower. It must integrate with the current stack, solve a measurable expensive problem, avoid creating another major workflow, and show ROI without a core-platform migration.

What worries buyers about AI vendors?

AI theater: impressive demos without workflow depth, generic payer rules, weak exception handling, poor traceability, excessive false positives, brittle integrations, unproven ROI, and products that shift work rather than remove it.

How do you tell real agentic AI from marketing?

Look for work completed, not recommendations displayed. Measure the share of the workflow completed without a person, the exception rate, human touches, escalation quality, auditability, reversibility, and the downstream result. A chatbot or a generated draft alone is not an agentic operating model.

What metric shows a product is working?

Not the number of AI generations. Measure human work eliminated and outcomes improved: staff touches per authorization, reviewer minutes per note, scheduler hours per staffed treatment hour, first-pass claim rate, unused authorized units, BCBA documentation time, and denial or recoupment reduction.

INSIDE THE DEMO

What Buyers Will Ask You to Prove

The full guide teaches owners to run the same real scenarios with every finalist and to give credit only for what is shown. A sample:

Scenario	What the vendor should show
Partial-week authorization	Approved units, weekly math, scheduled/rendered/billed/remaining, alerts, overuse prevention, expiration.
RBT callout	Qualified replacement using payer, credential, location, availability, continuity, client needs, supervision, and drive time.
Bad note before billing	System finds missing elements, time, signature, or payer issues, routes the correction, and holds or releases the claim.
Secondary insurance	Primary posts, the secondary claim is built with different requirements, and the balance stays traceable.

How findings are labeled

- **Shown:** the workflow was demonstrated during an evaluation.
- **Presenter described:** the vendor said it, but it was not demonstrated.
- **Not established:** the evaluation did not show it; more proof is needed.
- **Vendor-reported:** a published claim or statistic that has not been independently validated.

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What Is in the Full Guide

Profiles of AlohaABA, Motivity, RethinkBH, CentralReach, Theralytics, Office Puzzle, Raven Health, Hipp Health, Boost, Passage Health, ABA Engine, ABA Schedules, TheraDriver, Hi Rasmus, Lumary, and Camber, plus specialized tools: Brellium, Frontera Health, Operavo, Silna, and Solum Health. Each shows how the findings were gathered, what is still unproven, what buyers should test, and pricing with its basis and date.

- **137 pages**, updated through October 23, 2026
- A problem-by-problem capability map and sample screens of what good looks like
- The full 16-scenario demo script, vendor checklist, scorecard, and contract and migration checklists
- Market updates and an appendix of vendors on the radar

Get the Full Buyer's Guide
getwiththehive.com/aba-technology-buyer-guide

Want provider-side feedback on your product?

Brigitte offers a one-hour **ABA and Health Tech Vendor Product Review** ($350) to pressure-test a platform, feature, workflow, or product concept through an experienced ABA operations lens, and expert calls for investors and others interested in the ABA technology market.

Paid sessions are separate from the guide. They do not buy inclusion, placement, or a more favorable evaluation, and every vendor in the guide is held to the same evidence standard.

ABOUT THE AUTHOR



Brigitte LaFrance

Founder, The Strategy Hive · Founder, The Guardian Guide

Brigitte has spent more than 17 years in Applied Behavior Analysis, behavioral health, and healthcare operations, leading revenue cycle management, payer relations, prior authorizations, credentialing, compliance, workflow design, and organizational growth.

She serves as Chief Operating Officer of a growing ABA organization. Through The Strategy Hive, she partners with ABA providers across the United States, and through The Guardian Guide, she helps families and caregivers navigate complex systems with more clarity.

Her approach is grounded in organizational psychology and systems thinking: how leadership, culture, incentives, and change shape the way an organization performs. Her interest in technology grew naturally from that work: finding operational gaps, understanding the real burden on teams, and asking whether a system actually makes daily work easier.

This guide began with a question she kept hearing from providers: “What’s the best ABA platform?” After years of hands-on use, demonstrations, product testing, pricing reviews, and vendor conversations, she came to believe the better question is which technology fits a particular organization.

That belief shapes every page. Features and pricing matter, but so do growth plans, staffing, payer mix, operational capacity, implementation demands, and the cost of switching later. The guide also looks ahead to how payer expectations around quality, utilization, outcomes, and value may change what providers need from their technology.

Brigitte wrote this guide to share what she has learned, help buyers ask sharper questions, and connect technology decisions to the people, processes, and goals they are meant to support, today and as each organization grows.

> **“The strongest organizations are built at the intersection of people, leadership, systems, and execution.”**

Get the full ABA Technology Buyer's Guide www.getwiththehive.com