AMA
AMERICAN MEDICAL ASSOCIATION

# Behavioral health opportunities in value-based care

Guidance for physician practices

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# Introduction

Timely access to behavioral health treatment is an important part of the U.S. health care system. One in five adults currently receives treatment for a behavioral health condition.[1] Many more patients have untreated or inadequately treated needs.[2] The incidence and severity of behavioral health conditions among children and teens have also increased sharply.[3] These challenges cannot be separated from the larger health care delivery system. Patients with behavioral health conditions – especially if untreated – often struggle with comorbid conditions, which can result in poorer health outcomes and higher costs of care.[4] Behavioral health conditions may also contribute to or exacerbate drivers of health access and outcomes, such as access to safe housing, education, and transportation.

Simply put, behavioral health cannot be separated from a patient's overall health status. Yet, for a variety of reasons, behavioral health care has not always been well integrated into other aspects of the U.S. health care delivery system. This has important implications for physicians participating in value-based care arrangements, most of which hold providers accountable for patients' overall health care costs and the quality of patient care (often including outcomes). Failure to properly manage behavioral health needs in a patient population can seriously harm a physician practice's efforts under value-based care (VBC) arrangements. Conversely, participants are more likely to succeed under these arrangements with an intentional, well-operated strategy to address behavioral health.

Furthermore, behavioral health clinicians have their own impetus to participate in value-based care arrangements. While demand has skyrocketed, they continue to face difficulty receiving adequate payment despite state "parity" laws requiring equivalent coverage and payment for behavioral and physical health services. Value-based care arrangements can create opportunities for behavioral health clinicians to not only ensure patients can access their services in a timely manner, but also to receive sustainable payment for those services.

Integrating behavioral health and value-based care is often easier said than done. Behavioral health services can differ from other medical care in many ways, including the settings of care, types of professionals involved, treatment timelines, patient engagement strategies, regulatory requirements, and payer relationships. As a result, while the need to better integrate behavioral health care services is clear, it can be challenging for physician practices to implement such strategies as part of their overall value-based care efforts.

**Key consideration**

Behavioral health services can be delivered through "traditional" health care delivery models like physicians providing care in offices or emergency departments. But also involved, are services provided by subspecialty physicians or various non-physician providers in settings like specialized hospital units, community settings, or even patient homes. Behavioral health service providers and facilities also may be subject to distinct licensure, regulatory, and other rules, and may have different payment arrangements. Finally, behavioral health services can increasingly be delivered through technological means, including via telehealth and through a variety of digital tools facilitating either access to clinicians or improved self-management by patients.

Although integration of behavioral health care with physical health care can be challenging, it also represents an exciting opportunity. By encouraging joint accountability for patient care, value-based care arrangements can create aligned incentives and enhanced care delivery tools to promote greater coordination between behavioral health clinicians and other medical providers, which have often been fragmented in the past. In doing so, physicians can improve patient satisfaction and outcomes while realizing additional revenue. This document is intended to help physicians understand and develop actionable, sustainable strategies around these opportunities.

# Defining behavioral health services

Behavioral health services have several unique features and defined legal concepts. In some cases, these are well-understood terms within behavioral health agreements, but may be undefined, ambiguous, or confusing outside that context. In any integrated relationship, it is important for the partners to align expectations around these defined terms. The following examples represent common definitions from legal sources, but note that these terms can and often should be negotiated to reflect the parties' actual intent.

Behavioral health generally refers to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms.[5] **Behavioral health care** refers to the prevention, diagnosis, and treatment of those conditions.[6] Value-based care arrangements may encompass this full definition or a subset (such as a focus only on substance use or a focus on certain clinically diagnosed mental health disorders). Clarifying this definition is vitally important for any value-based care arrangement. Arrangements will sometimes identify broad clinical categories (e.g., "major depression") or a series of Current Procedural Terminology (**CPT ®**) codes. It is generally more advantageous for physicians for this definition to be as specific as possible to avoid potential disputes and uncertainty in calculating performance under any VBC arrangement. However, the most important consideration is that the parties should share the same understanding of the services and/or conditions to be managed.

### Defining scope of service

- ***Mental health disorder:*** a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior.[7]
- ***Substance use disorder (SUD):*** the cluster of cognitive, behavioral, and physiological symptoms indicative of a recurrent use of alcohol and/or illicit substances that leads to impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal.[8]

Behavioral health services may be provided in a variety of practice settings, including hospital settings (inpatient, outpatient, and emergency department), physician offices, and in the community (such as through community mental health centers (CMHCs)[9]). In many cases, a patient may present in multiple settings over the course of treatment. A value-based care arrangement may focus on the overall longitudinal management of patient costs and health status, or be focused on interventions related to the highest-cost settings of care, often hospital-based care.

VBC arrangements may also focus on improving the efficiency of patients accessing care in the appropriate setting (for example, by quickly identifying patients with behavioral health needs in the emergency department and helping them access care in alternative or additional settings).

Interventions may also involve helping patients access care through technological means. For example, patients may benefit from in-home care options (either in-person or via telehealth), which allow them to access care quickly without the need to present in a typical clinical setting.[10] Certain digital self-management solutions and digital therapeutics also show promise in controlling conditions like depression and anxiety.[11] Developers have also marketed tools intended to help patients manage conditions like attention deficit hyperactivity disorder and substance use disorder. Such technological tools may help patients access needed care in efficient, timely, patient-centered ways that reduce costs while improving patient satisfaction and outcomes.

### Common settings for behavioral health treatment

- ***Inpatient acute care:*** intensive 24-hour per-day care provided through hospitals and other behavioral health care facilities.[12] This level of care is typically intended to stabilize a behavioral health crisis.
- ***Residential treatment:*** 24-hour-per-day group living environment that offers room or board and specialized treatment, behavior modification, rehabilitation, discipline, emotional growth, or habilitation services for persons with emotional, psychological, developmental, or behavioral dysfunctions, impairments, or chemical dependencies.[13] Patients in residential care are medically stable and often receive this level of care for an average of 30 – 90 days.
- ***Partial hospitalization program ("PHP"):*** an intensive outpatient treatment program for patients who have an active behavioral health condition that typically requires a commitment of 20 hours or more of treatment per week. PHP typically incorporates an individualized treatment plan that includes the coordination of services wrapped around the particular needs of the patient and includes a physician-led multidisciplinary team approach to patient care. A PHP furnishes treatment at a level more intense than IOP, but less intense than inpatient acute care.[14]
- ***Intensive outpatient program ("IOP"):*** an intensive outpatient treatment program for patients who have an active behavioral health condition that typically requires a commitment of 9 hours or more of treatment per week. IOP typically incorporates an individualized treatment plan that includes the coordination of services wrapped around the particular needs of the patient and includes a physician-led multidisciplinary team approach to patient care. An IOP furnishes treatment at a level more intense than outpatient therapy but less intense than PHP.[15]
- ***Group therapy:*** the treatment of multiple patients who have a common therapeutic purpose at once by one or more behavioral health care providers.[16] Group therapy may be rendered at any level of care, whether inpatient, residential, or outpatient.
- ***Individual therapy:*** the treatment of a single patient by a behavioral health care provider.[17] Individual therapy may be rendered at any level of care, whether inpatient, residential, or outpatient.

Behavioral health strategies also often involve improving access to substance use disorder therapy. These interventions often focus on identifying patients with care needs in "traditional" medical settings like the emergency department or physician offices and helping them access dedicated substance use disorder care. They may also involve improved integration between substance use disorder services and other kinds of care.

### Defining scope of service

- ***Medication management:*** a structured approach to prescribing, administering, and evaluating behavioral health medications to ensure optimal therapeutic outcomes and patient safety.[18]
- ***Opioid treatment program (OTP):*** a program or practitioner engaged in the treatment of individuals through the dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological or physical effects incident to opioid addiction.[19]
- ***Sober living*** *or* ***Recovery residence:*** refers to a residential facility designed for individuals with a primary diagnosis of substance use disorder that is free from alcohol and nonprescribed/illicit substance, promotes independent living and life skill development, and provides structured activities and recovery support services that are primarily intended to promote recovery from substance use disorders.[20] Typically, patients may come and go from such facilities while abiding by program rules, which provide structure, accountability, and encouragement through early recovery.

Finally, behavioral health services may be furnished by a variety of providers, including but not limited to physicians. Among others, specialized behavioral health practitioners can include psychiatrists, doctors of psychology, psychiatric or mental health nurse practitioners or physician assistants, psychotherapists, social workers, community mental health workers, and peer support specialists. Various professions have their own credentialing and licensing requirements. One common value-based behavioral health care intervention involves expanding access by improving the integration of non-physician behavioral health practitioners into other care settings.

However, patients often receive substantial behavioral health services from other kinds of physicians who may not be considered traditional "behavioral health" clinicians.[21] For example, family practice physicians, pediatricians, internal medicine physicians, obstetrician gynecologists, and gerontologists often encounter behavioral health conditions and play an important role in managing them. Similarly, emergency department physicians frequently encounter patients with behavioral health conditions. These conditions may be the primary reason for the emergency department visit, a contributing or exacerbating factor, or entirely unrelated to the purpose of the visit. They may involve long-term management of low-acuity, well-controlled symptoms or may present in a new-onset or acute state. Behavioral health conditions also play an important role in other specialty care such as oncology and cardiology; for example, alcohol dependence directly impacts the severity and outcomes of many chronic conditions. As a result, value-based care interventions may also involve efforts to support these practitioners to help them identify patients with behavioral health needs and improve their management of these conditions.

# Behavioral health integration

## General integration strategies

As indicated above, behavioral health services may be delivered by a diverse array of individuals in a variety of settings. However, while these conditions often present in or impact traditional physical health care delivery settings, they are not always well-integrated into such settings. A robust body of evidence demonstrates that patients benefit from greater integration between behavioral and physical health services.[22] Such benefits include statistically significant improvements in both depression and anxiety outcomes across short-, medium-, and long-term care.[23] Further, patients generally report higher satisfaction, better coping skills, decreased stigma, and increased adherence to behavioral health treatment protocols.[24] Providers also indicate reduced stress, increased confidence in managing behavioral health conditions, and improved care delivery as a result of integrating behavioral health care and primary care.[25] Accordingly, there is increasing support for promoting such integration.[26]

Payment incentives can promote this integration as well. The Medicare program provides fee-for-service payment for care management under the psychiatric collaborative care management ("**CoCM**") program, involving collaboration between a treating physician (often a primary care physician), a behavioral health care manager, and a psychiatric consultant, as well as certain behavioral health care management services outside that model.[27]

## Types of integration

There is no one-size-fits-all model for behavioral health integration. In one common strategy, a health care provider introduces new types of care into an existing care setting. For example, this might involve a physician practice hiring a mental health nurse practitioner, or a hospital establishing a new substance use disorder service line, which could include opening new or expanded intensive outpatient and partial hospitalization programs, as well as developing a new relationship with a psychiatry practice to enhance emergency department coverage. In this arrangement, a provider is expanding its capacity to provide additional services, which are usually billable. The downside of this structure is that it requires substantial initial investment, including hiring additional licensed professionals who are often in short supply. This costly investment may not be justifiable if an entity only sees patients with behavioral health needs on an unpredictable or intermittent basis.

Alternatively, behavioral health integration may involve enhancing or strengthening relationships between distinct entities that provide physical and behavioral health services. For example, a primary care practice might develop a relationship with a behavioral health specialty practice and a hospital system to ensure efficient care coordination for patients requiring substance use disorder intervention. The latter style of integration may be supported through care coordination personnel, such as a dedicated individual who maintains ongoing communication with the patient to help address any barriers to care. Care coordinators may also help organize follow-up visits, monitor health status and adherence to treatment protocols, and direct patients to additional resources.

As still another alternative, an existing primary care or multi-specialty practice may improve the behavioral health services provided by existing staff. As discussed in more detail below, many practices can improve the quality of their behavioral health care through additional screening and improved processes of coordinating with outside partners.

Parties may also integrate by developing more targeted joint strategies. For example, they may develop interventions to address social barriers to accessing care, such as a lack of transportation or challenges accessing prescription medication. Integration may also take the form of joint communication between a behavioral health and a physical health clinician, including shared access to data on an electronic health record or data collected through patient self-management tools.

## Integrated Care Spectrum

From the BHI Collaborative's BHI Compendium

| | |
|---|---|
| Level 1: **Minimal Collaboration** | Care is delivered in separate facilities with separate systems; communication is infrequent and typically initiated only under compelling circumstances driven by physician and other clinician needs; understanding of the others' roles is limited. |
| Level 2: **Basic Collaboration at a Distance** | Behavioral and non-behavioral health clinicians practice in separate facilities with separate systems; periodic communication about shared patients is driven by patient issues; there is appreciation of other physicians' and other clinicians' roles as resources. |
| Level 3: **Basic Collaboration On-site** | Physicians and other clinicians practice in the same facility but not necessarily in the same offices. Although they have separate systems, they communicate regularly about shared patients due to the need for each other's services and referrals. |
| Level 4: **Close Collaboration On-site** | Physicians and other clinicians practice in the same facility with some shared systems, such as scheduling and medical records. They collaborate through consultation, co-create coordinated care plans for patients, and interact face-to- face about shared patients on a regular basis. |
| Level 5: **Close Collaboration** | Physicians and other clinicians are in the same facility with some shared space and identify delivery system challenges and implement system solutions together. They collaborate via frequent in-person team meetings to discuss patient care and specific patient issues and have an in-depth understanding of others' roles and culture. |
| Level 6: **Full Collaboration** | Physicians and other clinicians are in the same facility and share all practice space, functioning as one integrated team. There is consistent communication at the team and individual levels, and collaboration is due to a shared concept of optimal health care. The roles and cultures of care team members blur or blend together. |

## Integration into primary care and other physician practices

Although there are many categories of specialized behavioral health providers, a significant amount of behavioral health care occurs in primary care settings.[28] Many national professional organizations, as well as the U.S. Preventive Services Task Force ("**USPSTF**"), have released recommendations for behavioral health screening in primary care.[29] The USPSTF recommends that adults be screened for depression, anxiety, unhealthy alcohol use, and drug use.[30] Primary care practices may also employ or contract with behavioral health professionals to offer screening and treatment services for a broader set of conditions, including autism and ADD/ADHD. As a result, behavioral health conditions are often first identified and treated in ambulatory primary care settings. Primary care physicians (and physicians in certain other specialties) may also collaborate with behavioral health professionals in medication management.

Physician payment policies may also encourage screening and behavioral health treatment services. The Merit-based Incentive Payment System ("**MIPS**") adjusts Medicare payments to physicians and other practitioners based on a variety of performance factors. Providers and physician groups can report a set of quality measures, organized as "**MIPS Value Pathways**" or "**MVPs**." The Centers for Medicare and Medicaid Services ("**CMS**") has released an MVP set dedicated to "Quality Care in Mental Health and Substance Use Disorders."[31] These pathways include measures related to screening and developing a plan of care, medication management and outcomes.

Integration can also occur as an ancillary service line to other physician practices, by adding specialized personnel including community health workers and peer support specialists. One common strategy for this integration is the GATHER framework used in the Primary Care Behavioral Health model, which creates a set of principles to help organize behavioral health personnel support for a "generalist" practitioner.[32] While the GATHER model was developed for primary care practices, it is adaptable to specialty practices, particularly multi-specialty practices that can integrate both primary care and behavioral health care with other specialties. For example, in a single shift, a behavioral health professional employed by a multi-specialty practice could potentially visit with a pulmonology patient who wishes to quit smoking, an oncology patient to discuss anxiety, and an OB/GYN patient struggling with post-partum depression.

Finally, practices can explore leveraging technology and self-management tools to begin integrating behavioral health services into the physician practice setting. Mood trackers, alcohol intake diaries, and stress management apps are examples of the tools available to physicians. There are certain legal flexibilities available to physicians who participate in a value-based care enterprise who provide free access to technology and/or these tools to their patients. If exploring this avenue, it is important to ensure compliance with state and federal health information privacy and security laws.

# Behavioral health treatment in value-based care

## Challenges of behavioral health in value-based care arrangements

Behavioral health care poses some unique considerations for value-based care arrangements. The AMA has published other resources related to general value-based care arrangement considerations. But in general, VBC arrangements give practice entities an opportunity to earn additional payment by successfully improving the costs and quality of care for certain patients when compared to a historical baseline or benchmark.

There has been limited uptake of behavioral health clinicians in value-based care arrangements.[33] There are several reasons for this, including administrative differences in operating behavioral health and physical health practices and a lack of arrangements tailored specifically to behavioral health clinicians. Behavioral health conditions also differ from physical health conditions with respect to provider availability and the types of providers responsible for care, and the target population may differ as well.

For example, behavioral health physicians have different payer participation patterns than other kinds of physicians. Behavioral health providers are more likely to provide care on an out-of-network or cash pay-only basis.[34] Behavioral health conditions can also impact patients' employment status and income levels, which are directly tied to insurance coverage. This is important because value-based care arrangements are generally embedded within payer arrangements. Therefore, when a provider exits a network or a patient's eligibility for coverage changes, the terms of that VBC arrangement may no longer apply to provider or patient.

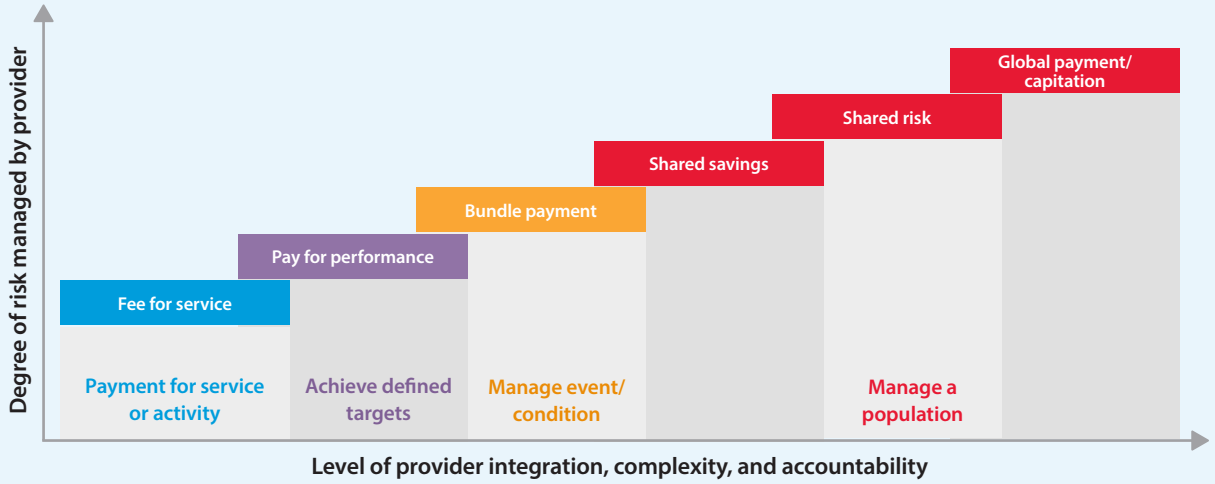
Further, as described above, the behavioral health landscape can be highly fragmented, with care delivered in a multitude of settings and by many different kinds of practitioners, who may provide related or overlapping services. As a result, it can be challenging to integrate behavioral health into more holistic strategies (for example, accountable care organization ("**ACO**") strategies centered on managing acute inpatient hospital care). These more general value-based care arrangements may occasionally reward certain activities related to behavioral health (like depression screening in the context of a primary care visit); however, they rarely create or directly incentivize specific behavioral health interventions. Because of these unique characteristics, there are few available VBC models explicitly focused on behavioral health.

Perhaps most importantly, the most common types of value-based care arrangements focus on the management of total cost of care through primary care clinicians. Although behavioral health conditions directly impact the total cost of care, the operational focus on primary care can effectively discourage behavioral health specialists from full participation in these arrangements. On the other hand, specialty arrangements tend to focus on tightly defined episodes of care, which may not align with the long-term support provided by many behavioral health providers.

## Value-based care degrees of risk

The AMA has produced substantial guidance about participating in value-based care arrangements. However, such arrangements typically involve a combination of several payment concepts:

- Performance-based bonus payments that involve an additional payment above and beyond fee-for-service reimbursement if the provider meets certain defined quality or efficiency goals.
- A reserved payment, often referred to as a "**withhold**" or "**holdback**," in which a payer retains a portion of payment for all services provided by the provider(s), which will be paid out if the provider(s) achieve certain cost and quality goals.
- A reconciliation model, in which the provider(s) bill on a fee-for-service basis over a performance year, but the costs of patient care for a specific condition or service are reconciled against expected costs at the end of year, resulting in a bonus or penalty, or a positive or negative adjustment to fee-for-service reimbursement in the following year.
- A "**shared savings**" bonus or "**shared loss**" penalty, in which the costs of care for a population over a performance period are compared to a historical benchmark, resulting in a lump sum bonus paid to, or obligation owed by, the provider(s).
- A capitated payment, in which the provider(s) receive a fixed per-member payment over a period of time during the performance year (commonly a "**per-member per-month**" or "**PMPM**" payment). This payment may also be reconciled against the patients' expected costs of care, resulting in an additional bonus or payment obligation.




Under any of these models, payment is often adjusted based on metrics of care quality (typically measured based on a mix of process and patient outcome measures). Payment may also be adjusted for other factors including the relative health of the patient population ("**risk adjustment**"), geography, settings of care, and health equity measures. VBC arrangements vary widely in their focus. Many of the most popular (including Accountable Care Organizations under the Medicare Shared Savings Program) focus on the total cost of care for all attributed patients. However, some arrangements are more focused and involve management of a specific condition (for example, bundled payments or episode-based payments focused on joint replacements or coronary artery bypass grafts).

## Challenges of using traditional value-based care frameworks for behavioral health

Behavioral health poses some challenges under common VBC frameworks. Most arrangements involving management of the total cost of care are heavily focused on primary care management. Patients are usually attributed to the physician who furnishes the plurality of primary care services to a patient. Distribution of any value-based care bonus payment is often allocated based on this attribution. As a result, specialists like behavioral health professionals may not receive bonus payment commensurate with their significant value to patient care and improved efficiency.

### Key consideration

For example, if a behavioral health physician in an ACO successfully controls a patient's substance use disorder, that may substantially improve the patient's health status and also make it more likely for the patient to pursue other health-seeking behavior (such as participating in annual wellness visits or adhering more effectively to a treatment regime) that helps to improve the ACO's performance. This can increase the likelihood, and the amount, of any shared savings bonus. However, if the behavioral health clinician is not responsible for the patient's attribution to the ACO, they may not receive a portion of that shared savings bonus under a traditional attribution-based distribution methodology.

Specialists often perform better under capitated or reconciliation-based models, in which payment is linked to management of a clinical condition or episode. In episode-based models, a "**convener**" entity can receive a bonus for managing a defined episode of care, which typically occurs across multiple providers. The episode begins with a certain trigger, often an inpatient admission or outpatient procedure. The convener is then responsible for distributing any bonus payments to incentivize and align the various providers who contribute to improved efficiency and quality throughout the care episode. In a capitated model, providers (who may include individual clinicians or entities like hospitals) are paid a fixed amount for each attributed patient, often on a PMPM basis. The capitated payment is intended to reimburse the provider for all services (or for certain defined services) delivered to a patient. Capitation may be combined with a reconciliation process, in which the total capitated payments are compared to an expected amount at the end of a performance year, resulting in a bonus or penalty. Episodes and PMPM models are attractive for specialists because they tend to be more focused on services and expenses that the particular specialists can realistically control. These arrangements also usually involve payments earmarked for specialists, either in the form of a capitated payment from a payer or a negotiated rate paid by a convener. Finally, the arrangements may allow providers flexibility to use parts of the capitated funding to incentivize or improve integration with other kinds of clinicians or providers.

**Key consideration**

One example of a behavioral health bundled payment model is the AMA and American Society for Addiction Medicine ("**ASAM**")'s Patient-Centered Opioid Addiction Treatment ("**P-COAT**"), which contemplates bundled payments for the initiation and maintenance of medication-assisted treatment ("**MAT**") for opioid addiction disorders (respectively, "**IMAT**" and "**MMAT**").[35] Under this model, clinicians who assembled an appropriate care team could offer patients diagnosed with an opioid addiction disorder the ability to opt-in to integrated management of their MAT. The physicians would receive a bundled payment for IMAT and ongoing monthly payments for MMAT, which would vary in value based on the stage of treatment. Payments could increase or decrease based on the care team's performance of certain expected activities. A physician would have the option to take on upside or downside risk based on their attributed patients' Actual Average PMPM Opioid Use-Related Spending compared to a payer's Target PMPM Opioid Use-Related Spending.

However, behavioral health models also pose challenges for episode-based and capitated models. These models are often most attractive for services that involve an identifiable triggering event that can be used for attribution purposes as well as a fairly predictable course of care that can be used to establish cost targets. Although some behavioral health services fit these criteria, others do not. For example, under the Medicare TEAM initiative, a hospital will be evaluated by assessing Medicare expenditures during the 30 days following an inpatient admission for coronary artery bypass graft surgery (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip/femur fracture treatment (SHFFT), and spinal fusion.[36] CMS used data collected from prior bundled payment initiatives to identify cost targets and appropriate clinically-based exclusions for each bundle (for example, CMS will not count costs associated with hospital admissions for unrelated oncology care toward the TEAM cost calculations). Behavioral health works differently. While some patients with behavioral health needs present in the emergency department or otherwise receive hospital care, many others present in a physician office or community setting. There often is no single therapeutic intervention (like surgery) marking the start of an episode and it is not always possible to identify the "end" of an episode either clinically or based on a period of time. Costs can vary greatly based on the severity of the condition, the nature of the necessary intervention, and the circumstances of the presentation. Behavioral health clinicians may be more likely than some physicians to have long-term relationships with their patients. In many cases, care is much more intense and costly at the time of diagnosis and initial establishment of a treatment plan, but less expensive during later management stages. As a result, bundled and capitated payments for behavioral health tend to be highly targeted to specific kinds of conditions and interventions.

Bonus models, including a performance-based bonus or withhold, raise some of the same issues. This structure can be appealing because a practice's performance is evaluated based on its own performance, rather than combined with others in an ACO or bundled payment. Performance-based bonuses also are more often based on process measures like the frequency of screening for depression or other conditions. Further, established quality metrics are available to measure performance of this type. However, they tend to offer less significant bonuses than population health models. In particular, practices should carefully consider the economics of any bonus involving a withhold, holdback, or other amount at risk, as these may effectively function as *reductions* of payment over the course of a participation period that will only be offset by adequate quality performance.

## Federal behavioral health models

Despite the challenges described here, there has been some success integrating behavioral health concepts into existing value-based care arrangements. For example, the Medicare Shared Savings Program ("**MSSP**") requires reporting on depression screening and depression remission at 12 months.[37] There is some evidence that the MSSP interventions have had small but significant impacts on inpatient and outpatient mental health and substance use disorder visits.[38] The Center for Medicare and Medicaid Innovation ("**CMMI**") has also developed a small number of models with a behavioral health focus.

### Key consideration

CMMI was created by the Affordable Care Act to test various models of care. In 2024, it announced an innovation model to test the opportunity to provide holistic, integrated care to beneficiaries with moderate to severe behavioral health conditions: the Innovation in Behavioral Health ("**IBH**") Model.[39] Participating entities will include specialty behavioral health practices, OTPs, and outpatient provider practices; these entities will receive health information technology infrastructure support to help them lead interdisciplinary care teams to comprehensively address a patient's behavioral and physical health needs as well as health-related social needs, such as housing, food, and transportation.[40] Under IBH, the participants will begin to transition from traditional fee-for-service to value-based payments and will be compensated based on enhanced quality and delivery of whole-person care, increased access to health care services, improved health and equity outcomes, and reduced emergency department and inpatient utilization.[41] CMMI selected four state Medicaid agencies (MI, NY, OK, SC) to participate in an eight-year model performance period beginning January 1, 2025. [42]

### Key consideration

Also in 2024, CMMI announced the Guiding an Improved Dementia Experience ("**GUIDE**") Model, which focuses on comprehensive, coordinated dementia care, and aims to improve quality of life, reduce strain on unpaid caregivers, and enable dementia patients to remain in their homes and communities.[43] Medicare Part B providers and suppliers, excluding durable medical equipment and laboratories, may participate in GUIDE.[44] Participants will assign individuals with dementia to a care navigator who will help them access services and support, encompassing clinical services (including behavioral health services) and non-clinical services such as meals, transportation, and respite care.[45] GUIDE utilizes a PMPM payment methodology plus the potential for a performance-based adjustment to incentivize high-quality care that improves quality of life, reduces the burden on unpaid caregivers, and prevents/delays long-term nursing care as clinically appropriate.[46]

# Business strategies for behavioral health in value-based care

While there are certain initial and ongoing costs of integrating behavioral health into value-based care, these expenses may be offset by the significant opportunity to improve performance and earn bonus payments. Despite the inherent challenges, there are many reasons to seek improved management of behavioral health conditions in the VBC context. These conditions can have significant implications for cost and quality, so VBC entities who improve their management can have an enormous impact. These are some examples of successful VBC strategies incorporating behavioral health.

**Example 1:**
**An independent behavioral health provider included in an ACO / population health network**

One very common value-based care structure is an ACO or a clinically integrated network ("**CIN**"). These arrangements include participation in various Medicare, Medicaid, and commercial population health models. In most cases, ACOs and CINs are involved in arrangements with payers to manage the total cost of care of an identified patient population.

Behavioral health care can be effectively incorporated into ACO or CIN strategies in several ways. Most straightforwardly, the ACO may include a behavioral health provider as a formal "participant." To the extent the behavioral health practice provides primary care services, these patients could be attributed to the ACO. However, patients of a behavioral health practice usually are also served by other primary care practitioners. Under most ACO arrangements, patients are attributed to primary care practitioners before specialty providers. Therefore, under the most common attribution-based shared savings distribution models, a behavioral health practice would not be financially rewarded for its participation in the ACO, even if it provides a very substantial contribution to the ACO's overall performance. To address this concern, behavioral health practices often consider alternative models of compensation.

For example, behavioral health practitioners often negotiate alternative distribution models. These models may include a "priority" shared savings distribution (i.e., a payment of a fixed amount deducted from the ACO's overall shared savings, often contingent on the behavioral health practice meeting certain cost and quality goals). Additionally, or alternatively, the practice may be paid some form of fixed PMPM fee, or a fixed bonus based on performance. These funds are supplied from the ACO's shared savings, but they are not based on attribution.

ACOs may also engage behavioral health providers in less direct economic ways. For example, an ACO may establish a relationship with a psychiatric hospital facility to maintain certain bed capacity for ACO patients. The facility would agree to participate in the ACO's care coordination and quality improvement efforts and the ACO would identify the facility as a preferred partner. There might be limited formal financial exchanges, but the ACO would benefit through improved management of these (often high-cost) patients, while the facility would bill for its services as normal.

**Example 2:**
**A multi-specialty practice leveraging integrated behavioral health functions**

An existing multi-specialty practice may benefit from adding capacity to serve patients' behavioral health needs. This may mean adding behavioral health specialty personnel, but it may also mean modifying the practice's typical processes to improve both screening and treatment services.

This strategy can be particularly attractive for multi-specialty practices with a record of success in value-based care models. Behavioral health is not always a priority for integration into fee-for-service practices because there are often significant fixed costs associated with building out a service line of this nature. Differences in practice management, credentialing, and payment terms heighten the challenges for integrating a full-scale behavioral health function into a multi-specialty practice. Despite these new, necessary costs, practices often experience challenges negotiating adequate fee-for-service reimbursement for these behavioral health services.

Value-based care changes the context in ways that may make it more attractive to address behavioral health issues. Under VBC arrangements, a practice is paid in part based on the savings it generates, rather than fixed per-procedure (or per-visit) payments. Behavioral health interventions may create savings that far exceed the value of payment available for each component service. At the same time, multi-specialty practices often employ many primary care practitioners, who are often the source of patient attribution, which in turn means they often realize the benefits of the savings they generate. These additional savings can be divided internally in various ways, including by directing additional incentive payments to behavioral health physicians.

**Example 3:**
**A population health entity paying for non-physician behavioral health support / "wraparound" services to address unmet needs in a managed patient population**

A population health strategy does not necessarily entail building out a full behavioral health service line. It can also mean investment in supportive services to assist a network of practices jointly operating under a value-based strategy.

For example, ACOs often invest in care coordination staff who are not physicians or advanced practice professionals. These individuals provide supportive services to help attributed patients access care, identify and address barriers, improve adherence to treatment regimens and promote healthy behaviors. An ACO might hire (or contract with) social workers, community health workers, and other supportive service providers to help manage specific behavioral health needs.

Participants in VBC arrangements also have greater flexibility to provide valuable, non-monetary items and services to support patient care. Through various regulatory flexibilities, VBC participants can often provide patient transport, guaranteed or preferential placement in treatment facilities, and access to non-covered cash pay services.

**Example 4:**
**Integrating self-management technology into a population health arrangement**

A variety of technological tools have shown progress with the self-management of behavioral health conditions. The Food and Drug Administration ("**FDA**") has approved several software medical devices to address conditions like depression, ADHD, and substance use disorder. Other tools include wellness devices that are not sufficient to treat behavioral health conditions, but may help patients develop skills to manage and reduce the severity of their conditions. Digital behavioral health therapeutics ("**DTx**") may be provided on a prescribed or over-the-counter basis, and payers vary widely in their coverage of these tools.[47]

Coverage for DTx varies greatly. Starting in 2025, CMS now pays for certain kinds of DTx (also called "**Digital Mental Health Therapeutics**" or "**DMHT**"). DMHT is only covered if the FDA has cleared or granted De Novo authorization for the device as a computerized behavioral therapy device for psychiatric disorders, and the device is used to support the services of an eligible professional implementing a behavioral health plan of care.[48] Payment is also only available if the device is furnished "incident to" the professional service; that is, if the practice incurs an expense like a license for the DMHT and makes it available to the patient.[49] In addition, payment for certain kinds of health management tools may be available under certain other Medicare categories like remote patient monitoring and remote therapeutic monitoring.

These new payment opportunities will likely increase the uptake of digital tools both inside and outside value-based care arrangements. But they have certain limitations. Payment is not available for software or devices that have not been cleared by the FDA for certain narrow behavioral health purposes. CMS also declined to extend payment for devices (including software as a medical device) approved, cleared, or authorized for use under categories other than "computerized behavioral therapy devices for psychiatric disorders." Even if payment is technically available, these devices face important patient and provider learning curves in terms of understanding the availability of the device, its integration into treatment pathways, and the collection and management of any data provided by the device.

Value-based care arrangements provide excellent opportunities to promote the adoption of novel technologies of this kind. First, VBC arrangements often have access to funds like shared savings or population-based payments, which can be used to support the cost of provider or patient licenses for self-management tools even if the payer does not directly cover them. Second, because participants in these models are accountable for overall cost and quality performance goals that are tightly linked to a patient's self-management and adherence to treatment plans, they may be more incentivized to explore new tools to help promote patients' success in these goals.

Self-management tools may also integrate with other population health strategies, such as overall care coordination and patient communication tools. For example, a patient's self-assessed mood may trigger a consult with a mental health specialist, or a patient's sleep tracking may trigger outreach from a care coordinator who ultimately connects the patient to a sleep specialist. These tools therefore may help patients access care in a seamless way based on clinical needs, without requiring patients to proactively seek care.

# Unique regulatory issues for behavioral health

Integrating behavioral health providers can raise new kinds of legal considerations. In fact, behavioral health services present several novel issues that providers and population health entities will need to be cognizant of as they enter this space.

1. **State law considerations**

   Just as states take diverse approaches to regulating the practice of medicine broadly, they also vary in their approach to behavioral health specifically. State laws cover an enormous array of behavioral health issues, including clinician and facility licensure, informed consent, emergency/involuntary commitment for treatment, corporate practice prohibitions, medication management restrictions, zoning limitations for residential facilities, and many other matters. States are often particularly concerned about fraud and abuse in behavioral health, especially the risk of inappropriate financial arrangements related to patient recruitment and treatment of vulnerable populations. Gaining familiarity with your state's laws and regulations around behavioral health providers, services, and facilities is paramount. The diversity of state laws can create unique challenges for value-based care arrangements attempting to scale national or regional strategies, or for applying best practices that may have been implemented successfully elsewhere.

### Key consideration

Some common questions about state behavioral health services are:

- What kinds of licenses or certifications are practice clinicians required to hold, and what are the ongoing requirements to maintain those licenses?
- Are there unique rules applicable to the behavioral health services provided in terms of location, ownership, integration with other kinds of care, etc.?
- Are there limitations on paying personnel, including clinicians and marketing staff?
- Does the state specify rules for ancillary or supportive therapy provided by your practice, especially related to the administration or prescription of controlled substances?
- Are any physical locations operated compliant with state and local land use and zoning requirements, especially if residential services are provided?
- Are any digital or telehealth services operated consistent with state rules for such services, including any rules about licensure, data security, use of out-of-state personnel, and prescribing?

**2. Disclosure of substance use disorder records**

Substance use disorder treatment records are subject to more stringent privacy restrictions than other kinds of health data. The regulation known as 42 CFR Part 2 ("**Part 2**") requires that records of SUD treatment, diagnosis, or referral managed by federally assisted SUD programs must be kept confidential. Due to the sensitive nature of SUD treatment records, Part 2 historically placed far stricter controls on disclosure than the Health Insurance Portability and Accountability Act ("**HIPAA**"); it generally required patients to explicitly consent to *each* disclosure of their SUD records with very limited exceptions. Following the COVID-19 pandemic, Congress and the Department of Health and Human Service ("**HHS**") modified Part 2 to align more closely with HIPAA by allowing patients to provide a single consent for all future uses and disclosures for treatment, payment, and health care operations. This allows HIPAA-covered entities and business associates that receive records under this consent to use and redisclose the records in accordance with the HIPAA regulations, and aligns penalties and breach notification standards with the HIPAA requirements.[50] The modified rule also clarified that SUD records do not need to be segregated from other health care records. However, SUD data is still subject to certain heightened requirements; for example, it cannot be used in legal proceedings against the patient without a court order or patient consent.

Despite the increased alignment with HIPAA, Part 2 can still create barriers for entities desiring to incorporate SUD care into a population health strategy. Providers should ensure they have appropriate patient consents in place to facilitate the use and disclosure of all necessary data among all necessary parties (including participants in the arrangement, ACO or CIN entities, and outside managers or analytic contractors). Parties should also note that some state laws around SUD data privacy are more stringent than Part 2.

**3. Eliminating Kickbacks in Recovery Act**

Behavioral health services also face unique requirements under the Eliminating Kickbacks in Recovery Act ("**EKRA**"). EKRA, passed by Congress in 2018, prohibits kickbacks for patient referrals in relation to recovery homes, clinical laboratories, and "clinical treatment facilities," meaning a licensed or certified medical setting other than a hospital that provides detoxification, risk reduction, outpatient treatment and care, residential treatment, or rehabilitation for SUD. As such, EKRA substantially changes the relationship between clinical facilities and their marketing and sales personnel. The text of EKRA appears to prohibit certain commonly accepted business practices, such as paying sales commissions to marketing personnel (including employees) or giving free equipment to physician clients. This conduct was not prohibited under the federal anti-kickback statute ("**AKS**"), though it is now prohibited under EKRA. EKRA has fewer safe harbors (or exceptions) than the similar AKS and Stark law and, unlike those statutes, can apply even where government funds are not implicated, including commercial plan reimbursements. Violations of EKRA are punishable by up to 10 years imprisonment and/or up to $200,000 in fines per occurrence.

**4. Telehealth**

Behavioral health care clinicians and patients have been particularly keen to embrace telehealth. During the height of the pandemic (March-August 2020), telehealth visits represented 40% of behavioral health outpatient visits, compared with only 11% of other visit types.[51] Now that in-person care has resumed, non-behavioral health telemedicine claims have dropped to around 5% of outpatient visits, but telehealth use for behavioral health treatment still represents 36% of these outpatient visits.[52]

Telehealth presents a number of state law-specific issues, including matters related to establishing a physician-patient relationship, informed consent, professional licensing, and prescribing. Additionally, at the federal level, there are grey areas around reimbursement, and regulatory and policy questions that continue to present uncertainty over the use of telehealth. As of the date of publication, telehealth clinicians participating in Medicare (and some Medicaid programs) continue to operate under Congress's temporary extension of flexibilities originally created in response to the COVID-19 Public Health Emergency. These flexibilities include delaying requirements for physicians to diagnose any new behavioral health condition in a face-to-face in-person visit.[53]

Since the height of the pandemic, telehealth has become highly integrated into behavioral health care. Many behavioral health interventions involve the use of synchronous face-to-face video communication to facilitate counseling and similar services in times and places convenient to patients. However, parties should be aware that the legal basis of telehealth coverage for federal program beneficiaries is still temporary and subject to Congressional reauthorization. Further, there is ongoing debate about whether telehealth-based behavioral health care should be paid using the same methodology, or at the same level, as in-person care.[54] As a result, despite the popularity of telehealth in this sector, strategies that rely heavily on these services may be vulnerable to regulatory disruption.

**5. Telehealth prescribing of controlled substances**

Relatedly, the ability to prescribe controlled substances over telehealth visits is also subject to regulatory uncertainty. The Drug Enforcement Agency ("**DEA**") initially allowed such prescribing on a temporary basis during the pandemic. It has since extended that flexibility several times, but has expressed a desire to shift to a more permanent policy, in part because the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 ("**Ryan Haight Act**") requires in-person prescribing with certain limited exceptions. As of 2025, the DEA flexibilities continue to allow clinicians to prescribe Schedule II-V controlled substances through telehealth encounters without requiring an in-person evaluation. The DEA has issued several proposals attempting to create a permanent framework for telehealth prescribing consistent with the Ryan Haight Act, including proposals issued in late 2024 and early 2025.[55] However, the DEA received substantial public comment expressing disagreement around the appropriate level of registration that should be required for prescribers and the necessity of particular limits on medications that could be prescribed via telehealth. As of the date of this document, the DEA has not published a final rule to create a permanent standard under the Ryan Haight Act. Notably, the DEA did expressly extend a clinician's ability to prescribe up to a 6-month supply of buprenorphine to treat opioid use disorder through a telephone consultation.[56]

**6. Behavioral health parity**

There are also ongoing efforts to support parity for behavioral health treatment. The federal Mental Health Parity and Addiction Equity Act ("MHPAEA") was enacted in 2008 to require health insurance plans to cover behavioral health services to the same degree as physical health services. MHPAEA generally dictates that financial requirements and treatment limitations imposed on behavioral health and SUD care cannot be more restrictive than comparable limits on medical/surgical benefits and it prohibits limitations that only apply to behavioral health and SUD benefits. The Affordable Care Act also established behavioral health and SUD as one of its "essential health benefits" that must be covered by certain kinds of commercial plans. These federal parity requirements have been refined over the years through

a series of federal rulemakings.[57] In addition, all fifty states have also enacted their own laws seeking to standardize the treatment of behavioral and physical health.[58] However, for a variety of reasons, there is still a substantial amount of unmet behavioral health need.[59]

While a full summary of laws around parity is beyond the scope of this summary, it is important for participants in value-based care arrangements to understand these requirements. Parity rules may constrain VBC strategies that preferentially focus on behavioral health/SUD conditions if they appear to create different quantitative or qualitative processes for patients with these conditions. Alternatively, they could create additional opportunities as payer sponsors of value-based care arrangements look for innovative care design models.

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