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ISSUE BRIEF

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REIMBURSEMENT MECHANISMS AND CHALLENGES IN TEAM-BASED BEHAVIORAL HEALTH CARE

KEY POINTS

- Although team-based models of behavioral health care are widespread, reimbursement gaps remain common, making sustainable funding difficult; federal and state funding remain critical to many team-based models.
- Fee-for-service generally limits reimbursement to direct care provision and is a commonly cited barrier to reimbursement for team-based behavioral health care, which often includes activities outside of direct care.
- Many team-based models use alternative reimbursement mechanisms to sustainably reimburse for team-based care.

INTRODUCTION

Team-based care models typically involve two or more individuals of varying disciplines and backgrounds who work collaboratively to provide coordinated care.[1] Behavioral health care, specifically, can necessitate a team-based approach due to patients' complex care needs, characterized by co-morbidities, specialty care, and frequent transitions between health care professionals or teams.[1] Team-based care can also help address behavioral health workforce shortages by including peers and non-licensed behavioral health workers in teams of licensed providers, thereby facilitating professional providers' ability to practice at the top of their license. In addition to mitigating workforce shortages, team-based care is associated with increased well-being and reduced burnout for providers and increased care coordination and integration of care for patients.[2,3]

Despite the demonstrated benefits of team-based care models, experts in the fields of behavioral health workforce and network adequacy have noted that existing reimbursement models do not adequately support team-based care.[4,5] Fee-for-service (FFS) billing, the dominant reimbursement mechanism in the United States,[6] is generally tied to volume of procedures provided directly to the patient. By contrast, team-based care often combines direct services with activities that are conducted between visits (e.g., outreach, referrals, documentation) and between team-members (care coordination, team meetings, consultations). Because of the emphasis on direct service provision, it can be difficult for providers to bill for team-based activities in a FFS context. Additionally, many existing licensing, credentialing, and payment policies limit the ability of peers and non-licensed behavioral health workers to independently bill for services rendered, creating a reimbursement gap for team-based models of care that involve peers and paraprofessionals.[1] In response to barriers to sustainable reimbursement linked to traditional FFS billing, team-based models are turning to alternative reimbursement mechanisms, such as enhanced FFS, bundled rates, and per member per month (PMPM) payments.[7]

This issue brief outlines: (1) the reimbursement challenges of several team-based behavioral health care models; and (2) the approaches different models take to sustainably bill for team-based care. This study seeks to address the following research questions:

1. What are common reimbursement gaps across team-based behavioral health models?
2. How have reimbursement gaps been mitigated by alternative reimbursement mechanisms?
3. What challenges remain for models implementing alternative reimbursement approaches?

METHODS

To identify models of team-based care and associated reimbursement strategies, we conducted a scan of peer-reviewed articles, gray literature, industry reports, presentations, and website content. We used key search terms in general Internet searches (Google) and in searches of scholarly literature (Google Scholar). In addition to these searches, we conducted scans within government and other stakeholder websites that are relevant to team-based care (e.g., the Centers for Medicare & Medicaid Services [CMS] and the Substance Abuse and Mental Health Services Administration [SAMHSA]). The scan was supplemented by interviews with subject matter experts in behavioral health care delivery models and reimbursement mechanisms. We conducted six interviews with nine stakeholders across commercial and public sector behavioral health care, including individuals with expertise in how peer specialists are included and reimbursed in team-based care models.

Eleven team-based behavioral health models were identified in the environmental scan: Coordinated Specialty Care (CSC), Mobile Crisis Teams (MCTs), Pediatric-Child Psychiatry Teleconsult, Sustained Addiction Recovery, Emergency Department–Based Treatment and Support, Opioid Treatment Programs (OTPs), Opioid Health Homes (OHHs), Behavioral Health Homes (BHHs), Psychiatric Collaborative Care Models (CoCMs), Assertive Community Treatment (ACT), and Certified Community Behavioral Health Clinics (CCBHCs). A subset of these models is discussed in this brief, which focuses on models that highlight common reimbursement gaps and promising alternatives to FFS billing.

For each model, we identified publicly available information about the payer (e.g., which agency or payer administers reimbursement), funding sources, and reimbursement mechanisms (i.e., how providers are paid). Where possible, we also identified billing codes and payment rates associated with the model. Other notable information collected on team-based models included provider team structure, service components, billing or service restrictions, characteristics of the model, and whether peers were involved.

RESULTS

Models of team-based behavioral health care face two challenges specific to traditional FFS reimbursement: (1) lack of reimbursement for team-based activities; and (2) lack of sustainable reimbursement for certain provider types, especially peer support. More generally, because several models provide team-based care across multiple payers, navigating the fragmented payer system was another common challenge to sustainable reimbursement. Models that provide team-based care for all patients while billing multiple, siloed payers were often faced with rate and coverage variability, with payers covering different sets of services and reimbursing for those services at different rates. By extension, when models achieved sustainable billing for team-based services within one payer, the team-based care provided might remain unreimbursed or under-reimbursed by other payers. For a summary of how those challenges manifested in several models, see **Table 1**. An overview of all the models identified in the scan, in addition to a summary of major reimbursement issues, are provided in a related ASPE brief.[8] Throughout this issue brief, we distinguish between traditional FFS and alternative reimbursement mechanisms, a term used to refer to a range of reimbursement approaches that deviate from traditional FFS.

Table 1. Barriers to Reimbursement in Team-Based Behavioral Health Models	
Model	**Barriers to Adequate Reimbursement**
Coordinated Specialty Care (CSC)	• No reimbursement for supported employment, education services, and community-based outreach services under many Medicaid state plans. • Difficult to sustainably fund care coordination, team oversight, and training. • FFS billing rates not aligned with high-intensity services.
Mobile Crisis Teams (MCTs)	• Reliance on local funding reduces need for FFS billing. • Crisis context can be a barrier to assessing insurance coverage. • On-call time is not billable time. • Payer-agnostic design results in service provision to commercial and Medicare beneficiaries, with limited or no reimbursement, respectively.
Psychiatric Teleconsult	• Consultation services remain dependent on grant funding. • Variable billing volume makes FFS billing difficult to sustain.

Across the team-based models of behavioral health care, we found that some models were more embedded in traditional funding approaches and less likely to leverage alternative reimbursement mechanisms. In other words, these models were almost uniformly reliant on traditional FFS billing, grant funding, or a combination of the two. We cite several of the models in our environmental scan to illustrate the range of reimbursement issues that affect models using traditional reimbursement. We distinguished between models that rely on traditional FFS and models using an alternative reimbursement mechanism, either by design or because they were adapted to bill using an alternative reimbursement mechanism. This second group of models illustrates common alternative reimbursement mechanisms used by team-based behavioral health models, how those mechanisms alleviate reimbursement gaps, the specific advantages of the alternative reimbursement mechanism to team-based care, and what challenges remain.

Reimbursement Issues Affecting Team-Based Behavioral Health Models

We found that several models face consistent barriers to sustainable reimbursement for their team-based activities and consequently, rely on grant or local funding, either as a primary funding source or to supplement reimbursement gaps left by FFS billing. These three models, CSC, MCTs, and Psychiatric Teleconsult, differed in how much their funding streams relied on FFS billing. CSC is generally billed for service-by-service under traditional FFS billing, where certain services provided by the model may not be billable to all-payer types across all states. MCTs are predominantly funded through state or local funds to maintain on-call availability even when MCTs are not engaged in direct care provision. MCTs are often reimbursable through Medicaid; however, the combination of providing an on-call service and team-based services across payers results in reimbursement gaps. Finally, the Psychiatric Teleconsult model was identified as rarely sustained through FFS reimbursement alone, although several states indicated that they were billing teleconsult services through Medicaid. These models are predominantly grant-funded and consequently do not incur reimbursement gaps as in the CSC and MCT models.

Unreimbursed Care: Team-Based Activities, Peer Support Services, and Coverage Limitations

The CSC model, which provides recovery-oriented treatment for people with first episode psychosis, is generally reimbursed, service-by-service, through FFS billing. The provider teams can vary by state but are generally composed of a psychiatrist, an occupational therapist or other support specialists such as social workers, and peer support specialists. Key components of the model, including team coordination, training, patient outreach, and team meetings, are not billable services under Medicaid FFS. Further, peer support specialist services are variably supported across payers and states. In 2018, 37 states covered peer support services through Medicaid, either through the Medicaid state plan, a state plan amendment (SPA), or Medicaid waivers.[9] The CSC model also includes supported education and employment services, emphasizing engagement in work and school as part of the treatment process. However, these services are generally not

covered by commercial insurers or by standard Medicaid benefits. Finally, for CSC services that are covered by payers, the rates are generally too low to support the intensive level of care provided through CSC.[10] To fill these gaps, states rely on block grants and appropriated funds for training support staff and implementing non-covered services.[11] Similar to CSC models, MCTs face barriers to sustainable reimbursement under FFS billing in that team supervision, training, transportation, and outreach are both integral to the model and difficult to bill for.

On-Call Services and Indirect Service Provision

Lack of reimbursement for on-call time is another barrier to sustainable reimbursement for models that are limited to traditional FFS billing. For MCTs, this includes team activities and services that are outside of direct care provision, including 24/7 availability, transportation time, and care coordination.[12] The MCTs' ability to reach people in remote areas increases access to care; however, this is a financial liability under a FFS scheme because travel time is not reimbursable. MCTs are further disadvantaged within traditional FFS billing because services must be available at all hours of operations, whereas actual need for MCT services fluctuates. In other words, MCTs must be staffed during their hours of operations but only receive reimbursement when their services are used directly, leading to instability and potential insolvency for provider teams. Teleconsult models face similar issues as a model providing on-call services. These models fund a team of psychiatric specialists to act as an available resource to pediatric primary care providers (PCPs) who require specialist guidance to treat patients facing mental health issues. However, the nature of teleconsult models, providing consultative services to PCPs, means that these models rarely provide services directly to patients, making reimbursement through traditional FFS more challenging.[13] As a consequence, a combination of appropriated state dollars and grant funding pays for psychiatric specialists to consult with PCPs.

Variable Coverage for Team-Based Services Across Multiple Payers

In addition to issues with or a lack of FFS reimbursement, team-based models also contend with a fragmented payer system. As a crisis service, the MCT model is an especially striking example of the effects of a fragmented system on team-based care. MCTs are intended to be payer-agnostic; in other words, they provide crisis care irrespective of insurance coverage or type. Insurance coverage for MCTs is not uniform across payers; whereas Medicaid often includes coverage for MCTs, Medicare does not cover their services and commercial insurance coverage is variable. As a result, when Medicaid is the primary payer type for a team-based care model, patients enrolled in Medicare and non-covering commercial insurers can receive the same level of care through MCTs without contributing to sustainable reimbursement. Variable coverage across payer types leaves MCT billing tied to its patient-mix, specifically to the proportion of clients who are enrolled in Medicaid. The combination of crisis service and an unreliable reimbursement landscape results in MCTs primarily relying on local funding and Mental Health Block Grant (MHBG) funding, despite the effects that variations in local budgets and grant funding can have on MCT operations. Although historically, MCTs could be supported through MHBG funding, legislative action in 2021 requires states to set-aside not less than 5% of their MHBG funding each year to fund crisis services specifically, representing an additional $35 million in MHBG funding annually.[14] Another payer-agnostic service delivery model, the pediatric psychiatric teleconsult model is occasionally covered through Medicaid but generally not reimbursed by other payers. These programs pay for psychiatrists to provide on-call consultations to PCPs that require specialist support in diagnosing and treating mental illness. The vast majority of pediatric psychiatric teleconsult programs are grant-funded. In both cases, the lack of a comprehensive, all-payer reimbursement scheme leaves provider teams supporting a larger pool of beneficiaries than those that can be billed for, and the insufficient funding leaves programs reliant on grant funding and fluctuating appropriations in state and local budgets.

Reimbursement Mechanisms that Alleviate Reimbursement Gaps for Team-Based Behavioral Health Care

Based on the limitations of traditional FFS billing to sustainably reimburse for team-based services, several team-based models bill for team-based services using alternative approaches: enhanced FFS, bundled payments, and PMPM payments. These reimbursement mechanisms have advantages specific to successful reimbursement of team-based care, ranging from codes that encompass team-based activities, to bundled rates that allow for flexible service provision by a range of team members, to PMPM rates that are intended to cover the cost of comprehensive care for each patient in the provider's care. A summary of these models, their payment approaches, and corresponding advantages for team-based care are presented in **Table 2**.

Table 2. Advantages of Reimbursement Mechanisms for Team-Based Care Models

Model(s)	Reimbursement Method	Advantages Over Traditional FFS for Team-Based Care
Assertive Community Treatment (ACT) Psychiatric Collaborative Care Model (CoCM)	Enhanced FFS	Specific billing codes to reimburse for team-based activities in addition to direct care provision, reduced burden on providers compared to billing for individual services using traditional FFS.
Certified Community Behavioral Health Clinic (CCBHC)	Bundled Rate	PPS allows for investments in infrastructure that supports team-based care, in addition to hiring staff or providing services that would be difficult to reimburse through FFS billing.
Sustained Addiction Recovery (ARMH)	Bundled Rate	Combines traditional FFS and bundled rates. In addition to adjusting bundled payment by condition severity, the model uses FFS reimbursement for pre-stabilization emergency services to reach patients in a variety of emergent settings. After stabilization, the model uses a static bundled payment during recovery initiation and active treatment, followed by a declining bundled payment during community-based recovery, corresponding to the lower acuity in that treatment phase.
Behavioral Health Homes (BHH) Opioid Health Homes (OHH)	PMPM	Monthly payment for patients receiving care through the health home to cover any of services provided by the health home.

Enhanced Fee-For-Service

Enhanced FFS departs from traditional FFS by defining billing codes that cover previously unreimbursed team-based care as well as indirect care. ACT models are often reimbursed using enhanced FFS billing that allows provider teams to bill for a range of ACT services under a single code, which can include services beyond individually reimbursable services in state Medicaid fee schedules. ACT models provide a suite of services, combining medication provision and therapeutic services with social, employment, and housing supports to individuals living with serious mental illness (SMI).[15] CoCM refers to the combination of several team-based activities and is billed for using a novel FFS billing code that accounts for services that are often unreimbursable through traditional FFS, such as outreach and care engagement efforts, registry documentation, psychiatric consultation, team collaboration, and care coordination (both internal and cross-team).[16] In CoCM, teams consist of a PCP, a care manager, and a psychiatric consultant, often a psychiatrist. The model is designed to expand the treatment capacity of primary care teams to address common behavioral

health issues such as depression and anxiety. The CoCM model was initially designed for Medicare and has since been expanded to Medicaid and replicated by private insurers.

Although enhanced FFS mitigates some of the financial strain and coding burden of traditional FFS, especially regarding coverage of indirect care, some reimbursement gaps remain. State by state, Medicaid programs may selectively include ACT components in the ACT billing code, often leading to a lack of reimbursement for provision of other care elements such as vocational services. Additionally, enhanced FFS retains the incentive inherent in traditional FFS to favor volume over quality of care. Further, enhanced FFS does not solve the issue of a fragmented payment system; for example, ACT codes are not covered by Medicare.[17] Within CoCM, we noted that, although the novel billing code was specifically designed to reimburse for team-based care, uptake has been low, and barriers to applying novel billing codes, such as documentation requirements, persist.[16,18]

Bundled Rates

A bundled rate, wherein a set of services are all covered under a single code covering an episode of care shared over a care team, presents another alternative to traditional FFS.[19] CCBHCs receive bundled payments from CMS to cover any CCBHC services that patients can receive during encounters. It should be noted that while CCBHCs outside of those participating in the demonstration do not use the same bundled payment system, this section is focused on demonstration CCBHCs, which do. CCBHCs provide coordinated essential services, including integrated addiction and mental health services, medication-assisted treatment, and 24/7 crisis response. Crucially, the bundled payments for CCBHCs are calculated specifically for the CCBHC and include care coordination, establishment and maintenance of a health information technology system, and crisis and referral services, rather than aggregating FFS reimbursement rates.[20] Additionally, under an innovative model of sustained addiction recovery, the Addiction Recovery Medical Home Alternative Payment Model (ARMH-APM), providers receive bundled payments from some commercial payers and Medicaid managed care organizations (MCOs) to provide long-term substance use disorder (SUD) stabilization and treatment services. ARMH is designed to coordinate and reimburse for long-term addiction treatment and coordinating acute, outpatient, and behavioral health care with a central team. ARMH includes three phases (stabilization, recovery, and active treatment) that stretch over 5 years. ARMH's initial stabilization phase, localized to emergency departments delivering acute and pre-stabilization services, is reimbursed using traditional FFS billing. Following the acute phase, providers are paid through monthly bundled payments during the recovery and active treatment phases of the ARMH model, where the two phases differ in bundled rate to reflect care intensity.

Bundled payments provide an alternative to traditional FFS reimbursements but can have limited utility if designed poorly. Setting effective payment rates requires accurate cost estimates. Successful bundled payments have required models such as CCBHCs to analyze volumes of cost data to establish rates that accurately reflect the cost of team-based care.

Per Member Per Month

PMPM payment models allot providers a fixed monthly fee for each eligible beneficiary in their care.[21] Two Medicaid health home models, BHH and OHH, use PMPM reimbursements.[22,23] BHHs provide comprehensive care management and assessment, along with health promotion, and individual and family support to those suffering from SMI. OHHs implement a similar suite of services, in which the services are tailored to the population being treated for opioid use disorder (OUD). Generally, both BHHs and OHHs receive a monthly payment per beneficiary, where states have flexibility in determining the specifics of the payment mechanism, some electing to set tiered rates that account for condition severity.

Although PMPM payments can support flexible service provision, including indirect care, there are limitations to this payment approach. If a PMPM payment does not cover both the direct and indirect care, the outcome

is a shortfall between cost of care and payment for care, similar to the limitations of traditional FFS. In addition, PMPM payments are often uniform across an individual's treatment course and do not reflect intensity of services. In other words, the same PMPM rate applies to both the early stages of care, generally more time-intensive and resource-intensive, and the more stable, less resource-intensive stages. Consequently, although the PMPM may accurately reflect the average cost of team-based care over the full treatment course, providers may perceive a budget shortfall during the early stages of treatment. Misaligned costs and payment over the treatment phases may incentivize providers to preferentially treat patients who have stabilized in treatment over those in early treatment phases. This issue is especially salient to SUD treatment due to the potential for relapse and recurring need for high-acuity, early-phase care. Further, because of the uniform reimbursement rates, PMPM payment mechanisms may face resistance among Medicaid MCOs that historically set their own rates.[24]

DISCUSSION

Unsustainable reimbursement is a common barrier to team-based behavioral health care, especially under traditional FFS billing arrangements. In addressing our research questions, across models that rely on traditional FFS billing or grant funding, we found several common reimbursement gaps across models of team-based behavioral health care. Several models successfully incorporated alternative payment approaches, such as enhanced FFS, bundled payments, and PMPM payments, to sustainably fund team-based activities, mitigating some of the barriers under traditional FFS billing. Each alternative, however, included specific drawbacks, leaving models that successfully implemented alternative reimbursement mechanisms with their own challenges.

State and federal grant funding is crucial to the operations of MCTs, Psychiatric Teleconsults, and CSC programs. Funding sources vary widely; some models rely almost entirely on grant funding (e.g., psychiatric teleconsults), whereas others mostly receive local funding (e.g., MCTs). Even models using alternative reimbursement mechanisms such as demonstration CCBHCs rely on state and federal grants. Additionally, SAMHSA's MHBGs fund state Medicaid programs to implement many team-based behavioral health models. In addition to appropriations and grants, state Medicaid programs can apply for waivers to receive federal funds to cover team-based care. Section 1915(b) waivers allow a state to use savings it achieves through Medicaid managed care to provide additional services that are not already included in the state plan, whereas 1115 demonstrations permit the waiving of certain federal Medicaid requirements and allow reimbursement for costs that would not otherwise be eligible for federal funds for experimental, pilot, or demonstration projects that promote Medicaid objectives.[25] Within Medicare, which does not reimburse for key team-based services, (including ACT, peer services, or psychiatric rehabilitation) Medicare Advantage Special Needs Plans (SNPs) are able to tailor their benefits to the target population. To date, however, only one SNP exists specific to individuals with SMI, offering its enrollees case management, ACT, and supported employment, in addition to mental health services.[26] Across models, Medicaid waivers and SPAs are common strategies to allow for reimbursement of certain elements of team-based care, such as peer support specialists or supported education and employment services.

The shift from FFS to an alternative reimbursement mechanism requires establishing the necessary billing codes and payment structures so that team-based care providers can bill appropriately. CMS and State Medicaid agencies have developed new codes and service definitions that support multidisciplinary teams through enhanced FFS. CoCM codes allow for reimbursement of team activities, allowing providers to bill for the collaborative work between PCPs, psychiatrists, and behavioral health care managers. However, many of the novel billing codes are underutilized, and barriers to uptake warrant additional study. In addition to new billing codes, bundled and enhanced FFS rates can allow payment for indirect care and team-based care to be folded into a single rate. CCBHCs use a prospective payment system (PPS) rate for the bundled payments to fund their services, which include a range of team-based behavioral health services, and can include MCTs and

CSC services within the set of evidence-based practices that the CCBHCs offer.[27] Recently, CMS expanded coverage for OUD treatments in Medicare through a bundled payment to OTP providers.[28] Our findings support the flexibility of bundled rates and PMPM as a key facilitator of team-based care, especially in SUD treatment settings.

In addition to the different approaches to payment across the models, we saw a broad range of strategies that states and programs used to allow for reimbursement through alternative mechanisms. In managed care environments, contracting mechanisms can be used to require providers and MCOs respectively to implement team-based care models. Alternatively, commercial payers and states can establish more general guidelines for team-based care, allowing flexible and individualized programs that incentivize the use of teams. Commercial payers and states can align these guidelines to contract payment strategies, either through withholding or other incentive arrangements. Incorporating team-based care elements into contract care management requirements, such as encouraging use of multidisciplinary care teams to support patient needs, is another strategy to increase use of team-based care. Finally, contracts can tie team-based care requirements to performance improvement projects or value-based payment initiatives.

These strategies can help states and programs mitigate barriers associated with traditional FFS billing, transition to alternative reimbursement mechanisms, and collaborate with MCOs to cover and reimburse for team-based care. However, adjustments to reimbursement mechanisms are often limited within payer type, leaving team-based care models with sustainable reimbursement through one payer, while providing unreimbursed or under-reimbursed care to patients covered by other payers. The persistence of a fragmented payment system is particularly challenging, especially for payer-agnostic models, such as psychiatric teleconsults and MCTs, and contributes to those models' reliance on other funding sources.

LIMITATIONS

Information on reimbursement mechanisms associated with public payers (i.e., Medicaid, Medicare) was available in greater detail and in more states than information on commercial reimbursement mechanisms. Although we found general descriptions of team-based care covered by commercial insurers, the reimbursement details were often proprietary. Similarly, our examination of Medicaid MCOs across models indicated that the characteristic flexibility of Medicaid MCOs allowed them to tailor coverage and reimbursement to support team-based care. However, because states may have multiple MCOs, each with its own reimbursement policies, assessing both commonalities across MCOs and within-state differences was often difficult. Finally, for models that relied on local funding sources (e.g., county-level funding), these funding levels were difficult to quantify. In addition, local and state funds can vary from year to year, making it difficult to describe the effect of those funds, outside of the potential effects of year-to-year budget fluctuations. For example, we may be able to broadly identify that a model relies on local funding to sustain team-based behavioral health care, but year-to-year changes in local funding will generally be unavailable.

CONCLUSION

Traditional FFS billing reimburses for direct care provision, limiting its use for team-based care, which is generally predicated on team-based activities in addition to direct care. Some team-based behavioral health models have addressed these gaps in reimbursement by implementing alternative reimbursement mechanisms, including enhanced FFS, bundled payment, and PMPM. Enhanced FFS augments existing billing codes to support team-based care, either by creating tiered rates to reflect team composition or by adjusting rates to reflect the cost of team-based care. Bundled payments reflect the cost of services and labor that make up an episode of care, allowing providers flexibility in which services are included in that episode of care and to allow those services to vary over the course of treatment. In a variation on the bundled payment, the tiered bundled payment applies different bundled rates at different stages of care to align with the acuity of each

stage of care. PMPM models can also provide a single payment that includes indirect care costs. These reimbursement mechanisms can be developed with support from local, state, and federal grant and appropriations funding, by creating new billing codes and payment structures, and, in the case of managed care, by contracting requirements. Although these alternative reimbursement mechanisms address common issues with FFS billing, they do have limitations. For example, enhanced FFS rates may not include all team-based services, simply setting a bundled rate by combining the FFS rates of the bundled services may perpetuate the underpayment of team-based care inherent in traditional FFS, and PMPM rates, if set too low, can make early treatment phases, which are generally higher acuity, difficult to fund sustainably. Finally, reimbursement mechanisms are often tied to specific payers and, consequently, contribute to the challenge of team-based models operating in a fragmented payment system.

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