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Common Reimbursement Mechanisms in Team-Based Behavioral Health Care: Final Report

Prepared for
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by
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Office of the Assistant Secretary for Planning and Evaluation

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COMMON REIMBURSEMENT MECHANISMS IN TEAM-BASED BEHAVIORAL HEALTH CARE: FINAL REPORT

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Acronyms

The following acronyms are mentioned in this report and/or appendix.

ACT	Assertive Community Treatment
APM	Alternative Payment Model
ARMH	Addiction Recovery Medical Home
BH	Behavioral Health
BHH	Behavioral Health Home
CCBHC	Certified Community Behavioral Health Clinic
CMA	Care Management Agency
CMS	Centers for Medicare & Medicaid Services
CoCM	Collaborative Care Model
COE	Center of Excellence
COVID-19	Novel Coronavirus
CPT	Current Procedural Terminology
CSC	Coordinated Specialty Care
ED	Emergency Department
EHR	Electronic Health Record
FFS	Fee-For-Service
HH+	Health Home Plus
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HRSA	Health Resources and Services Administration
MAT	Medication-Assisted Treatment
MCO	Managed Care Organization
MCT	Mobile Crisis Team
MH	Mental Health
MOUD	Medication for Opioid Use Disorder
OBOT	Office-Based Opioid Treatment
OHH	Opioid Health Home
OMH	New York Office of Mental Health
OMHSAS	Pennsylvania Office of Mental Health and Substance Abuse Services
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PCP	Primary Care Provider
PMPM	Per Member Per Month
PPS	Prospective Payment System
PSYCKES	Psychiatric Services and Clinical Knowledge Enhancement System

SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	Serious Mental Illness
SPA	State Plan Amendment
SUD	Substance Use Disorder
TCM	Targeted Case Management

Executive Summary

ES.1 Why is team-based care vital for behavioral health?

The high prevalence of mental health conditions and substance use disorder in the United States is exacerbated by high levels of unmet service needs. Behavioral health workforce shortages contribute to challenges in accessing behavioral health care. Team-based care is a service approach that typically involves two or more individuals of varying disciplines and backgrounds who work collaboratively to provide coordinated behavioral health care. Team-based care can help alleviate behavioral health workforce shortages by utilizing peers and non-licensed professionals. The additional team members facilitate licensed professionals practicing at the top of their license, thereby increasing capacity and the ability to deliver additional services. However, team-based behavioral health care is often not adequately reimbursed, making it difficult to sustain. The Office of the Assistant Secretary for Planning and Evaluation supported this study to better understand: (1) existing reimbursement mechanisms for team-based behavioral health care models; and (2) strategies that support reimbursement of team-based behavioral health services.

ES.2 How did we conduct this study?

We conducted an environmental scan to identify common team-based behavioral health care models and their reimbursement mechanisms. We supplemented the environmental scan with interviews with subject matter experts in behavioral health care reimbursement and policies related to reimbursement. Through the environmental scan and interviews, we narrowed our focus to 11 team-based care models. We developed a catalog to compare reimbursement mechanisms and strategies within and across team-based models. The catalog includes publicly available information identifying payer types reimbursing for each model, typical funding sources, and common reimbursement mechanisms.

Following the environmental scan and expert interviews, we conducted case studies of five exemplary models of team-based behavioral health, utilizing different reimbursement mechanisms. We interviewed service providers, health department and other program administrative staff. Our interviews were designed to solicit information on the development and implementation of reimbursement mechanisms to support the models.

ES.3 What did we find?

Team-based behavioral health models are funded through various mechanisms, often requiring grant funding to make up the short falls in billable services relative to the total service costs. Reimbursement rates often do not cover billable providers' total costs of team-based care, and vital team members, like peer support specialists and care coordinators can be difficult to bill for. Successfully funded team-based care models (i.e., costs for the team were fully reimbursed) often included a flexible reimbursement mechanism that allowed providers to include components that would otherwise be difficult to reimburse in a fee-for-service (FFS) payment system. Team-based behavioral health care

continues to face barriers--some components remain unreimbursed or under-reimbursed; uptake of novel billing codes specific to team-based care is low; and some novel reimbursement mechanisms are associated with a single payer while the teams serve a broader patient mix.

ES.4 What strategies promote team-based care?

State and federal grant funding play a vital role in the development and implementation of novel reimbursement mechanisms. Medicaid waivers and state plan amendments can be used to expand Medicaid service coverage, supporting the flexible inclusion of team-based care components. The establishment and uptake of novel FFS billing codes with service definitions that included team-based activities is a strategy with potential to increase needed reimbursement across all payers, though to date that uptake is often low. Finally, incorporating the financing for team-based care into the payment structure, as for example with bundled rates or per member per month payments, can create the necessary flexibility to support team-based care.

ES.5 Conclusions

Team-based care is an established approach for addressing gaps in health care service delivery and has the potential to alleviate workforce shortage challenges by allowing clinicians to practice at the top of their license. But for these approaches to be sustainable, they need reimbursement mechanisms that cover all team members and team-based activities, often not covered by traditional FFS mechanisms. Bundled payments or FFS billing codes that have been enhanced to include team-based activities have been designed to cover the costs of team-based care but are not widespread. Strategies to promote coverage and detailed case studies may provide federal and state administrators with guidelines for how to successfully expand and sustain team-based behavioral health care.

1. Background

According to the 2019 National Survey on Drug Use and Health, the prevalence of behavioral health (BH) conditions, including substance use disorders (SUDs) and mental health conditions, have remained stable, or increased, in recent years. Among adults aged 18 or older in 2019, 25% (61 million people) had either a mental health condition or an SUD in the past year. Unmet need for behavioral health services is also substantial.[1] The unmet need for mental health services is especially striking in the population of adults with serious mental illness (SMI), where 48% of individuals reported experiencing an unmet need for mental health services. Among adults with co-occurring SUD and SMI, that need is even greater: only 13% received SUD treatment at a specialty facility and mental health services.

Widespread behavioral health workforce shortages and unequal distribution of providers contribute to the high levels of unmet need in behavioral health care.[2,3] Additionally, the current workforce shortage is projected to worsen over the next decade. A recent Health Resources and Services Administration (HRSA) report provides national-level supply and demand projections for behavioral health professionals from 2017 through 2030. Current behavioral health workforce shortages (e.g., adult and child psychiatrists) are apparent in the 2017 data, and HRSA projects further reductions in the supply of psychiatrists and addiction counselors by 2030.[4]

The HRSA report on workforce projections emphasizes the importance of health care delivery models that increase the use of peers, paraprofessionals, and non-licensed behavioral health workers to expand the workforce. Team-based care models typically involve two or more individuals of varying disciplines and backgrounds who work collaboratively to provide coordinated behavioral health care. A team-based approach can help address behavioral health workforce shortages by allowing peers and non-licensed behavioral health workers to work alongside licensed professional providers, in turn allowing licensed professionals to practice at the top of their license. Team-based care can provide other advantages as well: through increased care coordination and improved care integration, it can reduce burnout for providers and enhance comprehensive care for patients.[5,6] In addition, recent studies have shown that team-based care helps to improve patient satisfaction[7] and the quality, utilization, and cost of care.[8]

Despite these potential benefits, experts have noted that many reimbursement mechanisms do not adequately support team-based care models. They may not account for the time spent coordinating and meeting as team.[9] 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.[10] Several evidence-based services, service delivery mechanisms, and promising practices, such as Assertive Community Treatment (ACT), the Collaborative Care Model (CoCM), and mobile crisis teams (MCTs), require multidisciplinary teams that include peer support specialists and non-licensed counselors. Some established reimbursement mechanisms support these team-based models, but reimbursement approaches vary widely.

The goal of this study is to better understand the adoption and implementation of team-based care and existing reimbursement mechanisms across Medicaid, Medicare, and commercial payers. Specifically, this study aims to answer the following research questions:

1. What reimbursement mechanisms exist for common evidence-based behavioral health models that use teams of providers, especially peers and counselors?

2. What strategies allow, encourage, or require coverage of team-based services in Medicaid, Medicare, and commercial payers?

This report presents findings from an environmental scan, subject matter expert interviews, a catalog of reimbursement mechanisms used in team-based behavioral health care, and case studies of five selected service models with varying approaches to team-based reimbursement. The first section of this report presents methods and findings of the environmental scan and reimbursement catalog, followed by a section dedicated to the case study findings. Finally, the results from both sections are synthesized to outline key strategies to support reimbursement of team-based behavioral health care.

2. Methods

To identify team-based care models 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) as well as in searches of scholarly literature (Google Scholar). Detailed search terms and logic can be found in **Appendix A**. In addition to these searches, we conducted scans within government and other stakeholder websites that are relevant to team-based care (e.g., Centers for Medicare & Medicaid Services [CMS] and Substance Abuse and Mental Health Services Administration [SAMHSA]).

We supplemented our scan with information from interviews with subject matter experts in behavioral health care delivery models and reimbursement mechanisms. We conducted six interviews with nine stakeholders who represented commercial and public sector mental health and substance use service delivery systems, as well as experts knowledgeable in the inclusion and reimbursement of peer support in team-based care. Three interviews focused on national policy related to health care financing, two interviews focused on team-based care within commercial plans, and one interview focused on peer support specialists. Interviews were approximately 60 minutes long and were conducted over Zoom. We recorded and used Temi to transcribe each interview. We then reviewed the transcripts for key takeaways and common themes. Next, we compared the interview findings to the environmental scan results to identify similar and contrasting trends.

Based on the environmental scan, we identified 11 types of team-based care models. We developed a catalog to compare reimbursement mechanisms and strategies within and across models. The catalog includes salient information that was publicly available about the payer, funding sources, and reimbursement mechanisms (i.e., how providers are paid). We included billing codes and rates when possible, and we provided notable information about provider teams, common or required components of service depending on the model, billing or service restrictions, characteristics of the model, and whether peers were involved in service provision. Within models that were widely implemented, we documented variation across states. For each model, we compiled information on treatment approach, population served, and common composition of provider teams by state. Where we noted sufficient consistency in treatment approach and patient population across states, we summarized those characteristics at the model level instead of breaking them out by state. In all models, we noted variation in specific services covered, which often is due to state-level variation in implementation and coverage.

Based on the environmental scan and reimbursement catalog, we selected five models of team-based behavioral health care with innovative provider reimbursement approaches to explore in detail as case studies. Within each case study, we recruited interviewees by contacting health department or other program administrative staff as well as providers for each case study organization. We identified administrative contacts that were formally affiliated with each program. Administrative contacts, in turn, identified provider contacts who were successful in receiving reimbursement. The Aware program was the exception; that case study was limited to an administrative contact.

We developed one interview guide for administrative interviewees and another for providers, focused on details of the reimbursement mechanism, including the development of the mechanism, types of providers eligible to bill, and strengths and challenges of the mechanism. We then tailored each guide to the individual interviewee. Interviewees received a list of the discussion questions based on the interview guide in advance of the interview date. We conducted nine interview sessions with a total of 14 individuals, where several interviews included multiple interviewees. Interviews generally lasted 60 minutes and were conducted over Zoom. We recorded each interview and transcribed each using Temi. We reviewed the transcripts for key takeaways and common themes.

3. Findings: Environmental Scan and Case Studies

3.1 Team-Based Models of Care and Reimbursement Mechanisms

We identified 11 models of team-based care, based either on novelty or widespread implementation. For a summary description of each model, see ***Table 3-1***. Models had varying degrees of homogeneity in implementation. Some follow a well-defined structure of team members and service composition while others share a patient population and general team and treatment approach. This section also covers each model's most common reimbursement mechanism, funding sources, the payer or payers that reimburse for the model's services, and common funding gaps. A summary of the primary payer and common reimbursement mechanism for each model can be found in ***Table 3-2***.

Table 3-1. Team-Based BH Model Descriptions

Model	Model description
Coordinated Specialty Care (CSC)	Recovery-oriented treatment program for people with first episode of psychosis.
Mobile Crisis Teams (MCTs)	Community-based service in which teams travel to provide services to an individual in crisis.
Pediatric-Child Psychiatry Teleconsult	Pediatric MH specialists provide teleconsultation, training, and care coordination to pediatric PCPs.
Sustained Addiction Recovery	Sustained Addiction Recovery models provide comprehensive care specific to addiction treatment with an emphasis on long-term recovery and relapse prevention.
Emergency Department-based Treatment and Support	Includes programs that connect individuals presenting with SUD at EDs with SUD treatment services, often including trained peer advocates who offer recovery supports.
Opioid Treatment Programs (OTPs)	Includes programs that provide outpatient treatment for patients with OUD. This model emphasizes care that is primarily focused on OUD treatment for both Medicare and Medicaid beneficiaries.
Opioid Health Home (OHH)	These OUD treatment models provide comprehensive and integrated outpatient treatment services, including care management and coordination, and focus on the Medicaid population.
Behavioral Health Homes (BHH)	These comprehensive care teams serve Medicaid beneficiaries suffering from SMI. BHHs integrate community supports, often including social workers and peer specialists.
Psychiatric Collaborative Care Model (CoCM)	The CoCM is characterized by a treatment team that includes a PCP, a psychiatric consultant, and a BH care manager. Originally designed for the Medicare population, state Medicaid programs have the option to include CoCMs billing codes, and the codes have been adopted and adapted by some commercial plans.

Table 3-1 (*continued*)	
Model	**Model Description**
Assertive Community Treatment (ACT)	ACT provides multidisciplinary treatment to support those with SMIs. ACT team members help patients with medication, therapy, physical health, social support, employment, or housing. ACT has several client populations, focusing on individuals who are transitioning between care settings (e.g., acute inpatient to community care).
Certified Community Behavioral Health Clinic (CCBHC)	CCBHCs provide 9 essential services and care coordination, including 24-hour MCTs, screening and assessment, patient-centered treatment, outpatient MH and substance use services, outpatient primary care screening, TCM, psychiatric rehabilitation services, peer supports, and community-based MH care.

Coordinated Specialty Care (CSC) Model

CSC models focus on treating mental health conditions in young adult and adult populations suffering first episode of psychosis.[11] CSC models are recovery-oriented treatment programs implemented by a multidisciplinary team that generally includes a Master's level clinician as team leader,[12] responsible for team coordination and non-billable interactions (e.g., team meetings), a psychiatrist, and an educational or vocational specialist. Teams also often include a licensed clinical social worker or certified alcohol and drug counselor to lead group or individual psychotherapy, and a nurse or peer responsible for case management.[13] In addition to services provided directly to clients, CSC programs prioritize community outreach because of the model's emphasis on identifying individuals in early stages of psychosis.

These models commonly rely on fee-for-service (FFS) reimbursement through Medicaid and private insurance. However, even for covered services such as medication management and individual therapy, there are indications that the standard billing rates may not align with the intensity of services provided.[14] In addition, specific CSC services, such as supported employment and education services or outreach activities, are difficult to bill for under Medicaid or commercial FFS systems, leading to a patchwork approach to financing. Providers rely on grant funding, including SAMHSA's Community Mental Health Services Block Grant program, and state funds to fill the gaps.[14] Some CSC programs draw on alternative reimbursement mechanisms to cover the costs of otherwise non-covered services, and our scan yielded examples of providers being paid by a cost-based bundled monthly payment from Medicaid managed care organizations (MCOs).[11] In these examples, the monthly rate was determined by actuarial studies of bundled CSC services, though the bundled payment often excluded supported education and employment services. Lack of coverage for specific services, variable coverage across payers, and reliance on other funding sources remain key issues.

Mobile Crisis Team (MCT)

MCTs provide emergency behavioral health services to individuals in crisis.[15] These teams generally include both licensed or credentialed behavioral health professionals, who are capable of assessing the individual in crisis, and a paraprofessional, often a peer support

specialist or psychiatric technician. Although MCTs are often able to draw on Medicaid reimbursement, state Medicaid programs vary widely in coverage and rates,[16] and the majority of MCT programs remain reliant on state and local funds. Most MCTs bill Medicaid FFS, though commercial coverage exists in some states as well. The level of funding for the teams varies heavily by state and county and can also vary year-to-year, depending on local budgets, leaving providers to navigate an inconsistent funding landscape. The development and sustainable financing of MCTs is a national priority and under the American Rescue Plan, additional federal funds are allocated to states interested in developing their mobile crisis intervention services. States are able to apply for this option under Medicaid and to develop crisis services tailored to their state's needs.[17]

Pediatrician-Child Psychiatry Teleconsult Model

This model gives primary care providers (PCPs) access to multidisciplinary teams that can provide pediatric psychiatry consultations.[18] Psychiatric teleconsultation is designed to increase provider capacity by connecting PCPs with specialty providers and other psychiatric resources. This model is distinct from other models discussed in that it describes a system in which providers consult with other providers, instead of providing services directly to patients. This model provides PCPs with access to teams that can include a behavioral health specialist (such as a child or adolescent psychiatrist), a care coordinator, and a referral specialist. These teleconsult services frequently rely on grant funding over traditional reimbursement mechanisms, though there are examples of teleconsultation programs being paid through Medicaid MCOs.[19] Grants and state funds directly pay for the psychiatrist (or other specialty providers), who provide on-call consultations to PCPs who are providing direct services to their patients. Although this model is reliant on grant funding, the direct payments to providers ensure that consultations and referral support are consistently compensated and available as-needed. As with other models that rely on grant funding, sustainable financing is a key issue for psychiatric teleconsultation.

Sustained Addiction Recovery

Sustained addiction recovery encompasses two distinct models developed to treat SUD in adults. The two models are Addiction Recovery Medical Home-Alternative Payment Model (ARMH-APM)[20] and Aware Recovery Care.[21] ARMH-APM is an alternative payment model designed to provide patients with a long-term, comprehensive, and integrated pathway to addiction treatment and recovery over a 5-year program encompassing three treatment phases. The first phase focuses on pre-recovery and stabilization efforts across the variety of initial settings for patients seeking treatment for SUD (i.e., general emergency or acute care settings). The second phase involves a closely managed course of treatment for up to 12 months in an institutional setting. The final phase lasts up to 4 years, following the patient in a variety of community-based non-institutional settings. Across the phases, ARMH-APM includes a recovery coach, care coordinator, PCP, and an addiction or behavioral health specialist.

Aware Recovery Care is characterized by its in-home SUD treatment approach, for individuals with commercial insurance coverage. The program is designed to last 52 weeks and includes psychotherapy and psychoeducation components, both for the individual and for the family. In addition to psychotherapy, the Aware treatment approach includes

medication-assisted treatment (MAT), occupational therapy, life skills coaching, and legal assistance. Some of the regional Aware programs offer in-home withdrawal management in addition to SUD treatment and related therapies. Aware teams include a PCP, individual therapist, family therapist, and a psychiatrist.

Aware is offered in eight states and reimbursed as a bundled rate by commercial payers, while ARMH-APM has been implemented within Medicaid MCOs. ARMH-APM applies a specific reimbursement strategy to each phase of recovery, beginning with FFS for pre-recovery and stabilization services, and bundled payments tailored to the institutional and subsequently non-institutional settings in the last two phases. These bundled payments apply across care settings as part an integrated and centralized design to combine acute, outpatient, and behavioral health providers as part of a continuous treatment process. While ARMH-APM necessarily takes place across many treatment settings, Aware Recovery Care is home-based, and it includes family members in the therapeutic process. The Aware team splits a monthly bundled payment for at-home addiction recovery treatment.

Emergency Department-Based Treatment and Support Models

These models connect adults presenting with SUD in emergency departments (EDs) with SUD treatment services and peer recovery supports.[22] Emergency department care teams generally consist of nurses, physicians, pharmacists, social workers/case managers, and peer support specialists.[23] Peer support specialists assess and engage patients and provide education on overdose prevention, while the medical team ensures medical stability, diagnosis, and treatment initiation. Peer coaches also play a crucial role in facilitating referrals to community resources and treatment, and in some cases facilitate the transfer of electronic health records (EHRs) to community treatment programs. Although Medicaid covers peer services, grant funding and local funds are often necessary to compensate for coverage gaps for team-based communications and care coordination activities. These models face additional reimbursement challenges because, outside of Medicaid, peer support services are generally not covered by commercial insurance or Medicare.

Opioid Treatment Program (OTP)

OTPs are certified and accredited facilities that can dispense medication for OUD (MOUD), including methadone, in addition to providing other support services such as individual counseling and group therapy. In several states, OTPs play a pivotal role in larger opioid use disorder (OUD) care teams, through the "hub and spoke" model[24-26] and other collaborative care models.[27] Originally developed in Vermont, the OTP forms the "hub" of specialized OUD care for patients with more severe care needs, and primary care practices function as "spokes," offering OUD treatment for stabilized patients. OUD treatment by OTPs is reimbursable through Medicare as a bundled payment[28] and the SUPPORT Act recently mandated that all state Medicaid programs cover OTP services.[29]

Opioid Health Home (OHH)

OHHs are paid for by Medicaid programs and provide more holistic care compared to OTPs.[30] OHH teams offer an extensive set of services organized by comprehensive care management of services, medications, and tests. Care coordination includes assistance and support related to social determinants of health (legal, housing, and employment

assistance). Specific services are provided to promote a healthy lifestyle including nutritional counseling, exercise plans, relapse prevention plans, and supports for managing chronic pain. OHHs also offer comprehensive assessment and transitional care, as well as referral to community, social support, and recovery services. OHH staffing is uniform across programs, generally including a Health Home director, PCP, case manager, registered nurse, certified peer recovery coach, community health worker, and a Health Home coordinator. OHHs are generally reimbursed on a per member per month (PMPM) basis for home health services, while payments for medications are generally handled on a FFS basis.[31]

Behavioral Health Home (BHH)

BHHs serve Medicaid beneficiaries with SMI and require a Medicaid state plan amendment (SPA) to implement. As is standard with health homes, BHH offers comprehensive care management, as well as care coordination for physical and behavioral health treatments, and community-based long-term services and supports. BHHs also offer health promotion and individual and family support, comprehensive transitional care and referral to community and social support services, including housing. BHH staff generally include physicians, nurse care coordinators, social workers, and other behavioral health professionals such as counselors. The reimbursement scheme for BHHs is dependent on the state Medicaid system. States are free to develop innovative reimbursement mechanisms, but most reimburse using PMPM payments.[32]

Psychiatric Collaborative Care Model (CoCM)

The psychiatric CoCM (henceforth, CoCM) provides integrated behavioral health care for individuals with less complex conditions such as depression or anxiety. The CoCM is delivered by a team of PCPs, psychiatrists, and behavioral health care managers. The model offers an initial behavioral health assessment followed by monthly meetings with a behavioral health care manager and consultations and treatment from a psychiatric consultant qualified to prescribe a full range of medications. Monthly rates covering these services were first adopted by Medicare in 2017.[33] The time-based charge code for CoCM allows for a wider range of services and coordination between providers than is typical in FFS arrangements. Medicare's CoCM reimbursement model has been adopted and adapted by some state Medicaid programs and by some commercial payers. However, there are indications that commercial payers have lagged behind Medicare in the adoption of CoCM payment approaches.[34]

Assertive Community Treatment (ACT)

The ACT model provides care to patients with SMI who have recently been transferred out of inpatient settings. They provide a low client-to-staff ratio, 24-hour staff availability, and community-based and directly provided services. ACT interventions might include psychopharmacologic treatments such as atypical antidepressant or antipsychotic medications, mobile crisis intervention, or group therapy.[35] In addition, ACT offers behavioral training for activities of daily living, support for resuming education and employment, and other support services including education for families as well as financial, housing, and transportation support. ACT teams include a psychiatrist, supervisor, care managers, peer support specialists and nurses.[35] ACT models are funded by state Medicaid

agencies with additional support from state funds. Services for Medicaid FFS beneficiaries are billed using a unified billing code. However, there are limitations to billing for ACT services: the vocational and education services in the ACT models are often not covered by state Medicaid programs, and Medicare does not currently reimburse for ACT services.[36]

Certified Community Behavioral Health Clinic (CCBHC)

CCBHCs provide at least nine essential services along with care coordination, including 24-hour MCTs, screening and assessment, patient-centered treatment, outpatient mental health and substance use services, outpatient primary care screening, targeted case management (TCM), psychiatric rehabilitation services, peer supports, and community-based mental health care for veterans.[37] There is a general requirement for teams to include a psychiatrist as a medical director and a chief executive officer or project director. Additional team member requirements vary by state but generally include a medically trained behavioral health provider able to prescribe and manage medication, credentialed substance use specialists, and individuals with trauma expertise able to promote recovery of children with serious emotional disturbance, adults with SMI, and those with SUD.

CCBHCs are Medicaid-funded models that began as demonstrations but have since expanded. The original demonstration CCBHCs have nine specified services that are core to the model for which the teams are reimbursed with a prospectively determined bundled rate through its Prospective Payment System (PPS) for either a daily visit, or a monthly rate for individuals who have received services in the month (depending on the state). The PPS is paid even if the service provided is not normally covered by the state's Medicaid program. While the CCBHCs are expected to serve an all-payer patient-mix, they receive the PPS rate only for Medicaid beneficiaries. Outside of the demonstration CCBHCs, the "expansion" CCBHCs, by contrast, receive reimbursement using their regular billing mechanisms. Expansion CCBHCs can charge all payers for services and must do so before accessing reserve grant funds that pay for non-reimbursable services and for services provided to underinsured or uninsured individuals.

3.2 Common Reimbursement Mechanisms

Team-based models rely on a variety of reimbursement mechanisms, some including multiple mechanisms within the same model. Traditional FFS is the most common form of reimbursement, where providers bill for discrete services priced on a fee schedule based on labor and material inputs. Traditional FFS has several limitations, including an incentive for overtreatment and the inability to reimburse certain team members and activities that are not associated with a specific billing code. In addition to traditional FFS, some models were able to use enhanced FFS billing, where the Current Procedural Terminology (CPT) code rate is set to account for team-based activities. An example of this is the billing code for the CoCM model. Enhanced FFS arrangements have minimal barriers to entry for participating providers and payers, because of providers' familiarity and widespread use of the codes. In addition to adjusting the rates for existing codes, some team-based models leverage novel billing codes to bill for services not currently covered under an existing CPT.

Alternative reimbursement mechanisms, such as bundled payments[38] and PMPM payments,[39] are in use in some team-based care models. Bundled payments are a payment to providers based on an expected bundle of services; the bundled rate may be set based on an average FFS cost for treating a given diagnosis, or, more comprehensively, based on estimated cost of providing a bundle of team-based services. These bundled payments may include incentive payments for achieving savings or meeting goals based on quality measures. Often set at as weekly or monthly intervals, bundled payments allow for a more flexible suite of services, where services provided are driven by individual patient need, and are less prone to incentivizing overuse of high-cost, unnecessary services.

PMPM payment is another alternative to FFS. PMPM budgets a set payment for care for a given beneficiary, often requiring at least one service to trigger the monthly payment. PMPM payments also address FFS issues related to overtreatment and coverage gaps. It does this by capping the reimbursement amount, incentivizing necessary care while still allowing for more treatment variety and flexibility because reimbursement is not tied to specific CPT codes. For a summary of the reimbursement models used in each model and the primary payer using that mechanism, see ***Table 3-2*****.**

The reimbursement mechanisms described above each address some of the common issues in sustainably funding team-based behavioral health care. As noted above, FFS mechanisms can present barriers to billing for some team-based services and team members, but also for billing for indirect care such as team meetings, care coordination, and community or patient outreach, all key components of many team-based models. Enhanced FFS partly addresses the issue of indirect care by setting higher reimbursement rates, to reflect indirect care costs, while bundled payments and PMPM are better suited to ensure that the whole team is covered and providing greater flexibility for the range of services that providers can offer.

Another common hurdle for team-based models is the lack of reimbursement for time spent on-call. Models such as MCTs are designed to reach patients at the location where the crisis is occurring and are designed to respond quickly. However, neither travel time nor time spent on-call can be reimbursed under FFS. MCTs compensate for these reimbursement gaps with local and state grant funding, or when those financing approaches fall short, by increasing response times or reducing hours of operations. Models that face similar barriers include psychiatric teleconsultation and emergency department-based treatment and peer support.

Models that serve a patient-mix distributed across multiple payers contend with the challenge of a fragmented payer environment, in which not all payers cover the same services, and, when they do, often do not reimburse at the same rates. Because payers are not required to cover identical services, "payer-agnostic" models, in other words, models in which all patients are treated using a team-based approach, regardless of payer, will be reimbursed for team activities only by a subset of patients.

Table 3-2. Primary Payer and Common Reimbursement Mechanism, by Model		
Model	**Primary Payer**	**Common Reimbursement Mechanism**
Coordinated Specialty Care (CSC)	Medicaid	**FFS** for billable individual services in the model. Grant funding is used to cover providers and services not reimbursable by payer, or those services are omitted from the model.
Mobile Crisis Team (MCT)	Medicaid	Although state and local funds are the most common source of financing, Medicaid **FFS billing** is the most common reimbursement mechanism. Some **commercial payers** cover MCTs.
Pediatric-Child Psychiatry Teleconsult	Direct Funds	Providers receive **direct payments** from state governments for participating in grant-funded services rather than through a reimbursement-based payment. Some examples of reimbursement through **Medicaid MCOs**.
Sustained Addiction Recovery	Commercial	Sustained addiction recovery models rely on **bundled payments**, In the case of ARMH, the program combines a **brief FFS** during the stabilization phase, followed by **tiered bundled payments**, in addition to incentivizing performance on recovery-linked quality measures. A second model, Aware Recovery Care, reimburses through monthly, **bundled payments**.
Emergency Department-based Treatment and Support	Medicaid	Medicaid **FFS billing**. Some states have added **enhanced FFS** to cover long-term services provided by peer support specialists while others cover peers with **grant funding**.
Opioid Treatment Program (OTP)	Medicaid, Medicare	Weekly **bundled payment** under Medicare and, more recently, a daily bundled payment under Medicaid.
Opioid Health Home (OHH)	Medicaid	Medicaid **PMPM** payments for Health Home services, while medication is generally billed **FFS**.[31]
Behavioral Health Home (BHH)	Medicaid	Medicaid **PMPM** payments for Health Home services, often tiered by disease severity.[32]
Collaborative Care Model (CoCM)	Medicare, commercial	Time-based **enhanced FFS** billing codes that allow for reimbursement of patient care performed outside of face-to-face encounters, including consultation services and patient outreach.[40]
Assertive Community Treatment (ACT)	Medicaid	**Enhanced FFS** where the FFS billing code is a unified billing code covering a range of services by the ACT team.
Certified community Behavioral Health Clinic (CCBHC)	Medicaid	**Demonstration CCBHCs:** a **bundled rate** for Medicaid enrollees for any of 9 covered services.[41] **Expansion CCBHCs: FFS billing**, where FFS must be applied before grant funding can be used.

3.3 Examples of Models Using Various Reimbursement Mechanisms

More Inclusive or Flexible FFS Billing Codes

Several models and states use adjusted or enhanced FFS billing codes. For well-established models, such as ACT, most state Medicaid programs have adopted a billing code specific to the ACT services (H0040)--this code is a per diem charge covering all potential ACT services, rather than a single discrete service. By comparison, reimbursement for CSC generally occurs service-by-service, leaving components of the model such as outreach and supported employment as unreimbursed, depending on state Medicaid coverage.[11] Although CSC programs generally bill using traditional FFS billing, there are several notable exceptions, such as Philadelphia and Delaware counties in Pennsylvania using the T1024 billing code ("evaluation and treatment by an integrated specialty team"), reimbursing for CSC as a bundled payment. Similarly, emergency department-based peer support models are often able to bill for peer support specialists using FFS billing, and some states have broadened those billing codes to cover more sustained contact. For example, New Jersey's peer support services billing code (H0038 HF X3) corresponds to 8 weeks of Recovery Specialists and Patient Navigators services, easing the coding burden and guiding clinical practice towards sustained follow-up and support through the stabilization phase.

There are several adjustments to Medicare billing codes that can support team-based care. Beginning in calendar year 2018, Medicare began making payments for CoCM, using CPT codes 99492, 99493, and 99494. These CoCM billing codes are intended to enhance primary care through the addition of behavioral health care managers and psychiatric consultation. However, adoption of the CoCM within Medicare lags behind other novel care management codes, and fewer than 0.1% of individuals with behavioral health conditions received services through the novel code type in 2017 and 2018.[42] In addition, despite rollout under Medicare, state Medicaid authorities may elect not to implement the novel billing codes. As of August 2020, only 17 states were reimbursing for CoCM codes in their state Medicaid programs. Further, state-specific differences in implementation allow for state Medicaid programs to exclude beneficiaries based on diagnoses, set prior authorization requirements, as well as specify team credentials and set billing provider limitations.[33]

Alternatives to FFS

The environmental scan identified several instances of especially innovative departures from traditional FFS. ARMH is a particularly salient example of a model that offers: (1) a departure from FFS billing; and (2) flexibility within the model to draw on different reimbursement mechanisms and rates depending on recovery stage (stabilization, active treatment, and recovery management).[20] Similarly, in a move toward more flexible reimbursement, Pennsylvania's ACT program incorporates pay-for-performance components within a Medicaid MCO, which can incentivize team-based care. Finally, the PPS reimbursement mechanism used by the demonstration CCBHCs allows for more flexible provision of team-based services. The flexibility provided by PPS supports team-based behavioral health care within the CCBHC, and serves as a vehicle for other team-based care models such as ACT, CSC, and MCTs.[37]

4. Findings: Case Studies

Based on the environmental scan and reimbursement catalog, we selected five models of team-based behavioral health care as case studies, focusing on programs and providers with innovative approaches to reimbursing for team-based care. **Table 4-1** outlines the selected case studies and their reimbursement mechanisms.

Table 4-1. Model Description and Reimbursement Mechanisms, by Case Study

Service Model	Service Model Description	Reimbursement Mechanism
New York's Mobile Crisis Teams (MCTs)	MCTs of 1 licensed provider, 1 licensed and 1 unlicensed provider, or 2 licensed providers	**Enhanced FFS** billing under Medicaid MCOs; rates are established by New York's OMH and are adjusted by team composition (team size, licensing), length of time of service, and region
Montana's coverage of Medication for OUD (MOUD)	Services related to OUD treatment include provider visits, medication prescription, lab testing, medication distribution, and BH integration management	**Bundled payment** under Medicaid, reimbursable by OTPs and OBOT
Aware in-home SUD recovery	Services comparable to residential treatment that are provided in-home, including MAT management, peer support, individual and family therapy, and care coordination	**Bundled payment** through several commercial insurers in multiple states
New York Health Home Plus (HH+) Program	Integrated, coordinated, and transitional care for high-need clients with SMI	OMH reimburses HH+ services using **PMPM rates**
Pennsylvania Centers of Excellence (COEs)	Outpatient care that integrates OUD treatment with physical health treatment using care management	Pennsylvania's OMHSAS passes funding to MCOs, which must then direct the funds to a specified list of COEs providers using **PMPM rates**

4.1 New York's Mobile Crisis Team (MCT)

Through its state Medicaid managed care program, New York provides: (1) telephonic triage and crisis response; (2) mobile crisis response; (3) telephonic follow-up; and (4) mobile follow-up for adults and children. Of these four services, this case study focused on the mobile crisis response teams. New York's Office of Mental Health (OMH) supported the development of enhanced FFS Medicaid codes specific to MCTs. In collaboration with New York's MCOs, OMH set tiered reimbursement rates for MCTs. There are seven rates, customized by team composition (one licensed provider, two licensed providers, or the most common arrangement: one licensed and one unlicensed provider), location (downstate or upstate), and length of time of service (<90 minutes, 90-180 minutes, >180 minutes).[43]

The seven rates are based on two national procedure codes, H2011 and S9485, which OMH customized to be specific to New York's needs. Before the development of the enhanced Medicaid FFS codes, most MCTs in New York were entirely dependent on local funding. Billable service flexibility is a strength of the MCT reimbursement through Medicaid. The seven distinct rates allow for context-specific reimbursement. Further, interviewees indicated that New York's digital infrastructure facilitated the provision of the appropriate MCT, in addition to determining a patient's insurance coverage. Provider teams use a health information technology (HIT) system called the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), a HIPAA-compliant web-based application that supports team decision-making and care coordination, to determine which team composition is best suited to each crisis call. However, shortages of licensed staff have complicated the process, and the variety of EHR systems has created difficulty in obtaining clients' demographics and billing information. MCT providers reported difficulty billing commercial insurers, either because providers cannot obtain insurance information from the client, the services exceed the allowable number of units, or the commercial plan does not reimburse MCT services at all. In addition, although OMH successfully negotiated reimbursement for MCTs through Medicaid MCOs, Medicaid FFS does not reimburse for MCTs, resulting in a reimbursement gap for the minority of Medicaid clients enrolled in FFS Medicaid.

Encouraging providers to bill for services is also challenging. Despite limited budgets that MCT providers generally operate under, some providers decline to bill for a variety of reasons, including believing their funding is sufficient or the billing system is too complex. New York's OMH offers technical assistance to providers in how to successfully bill and encourages billing MCOs, when possible, because the additional funding stream could be used to expand services, such as operating around the clock or hiring additional staff. The relationship between OMH and providers was characterized as bi-directional, as OMH supports providers through technical assistance, and provider organizations send OMH feedback that shapes licensing requirements and billing rates. OMH currently is working on a SPA to expand MCT coverage from Medicaid managed care beneficiaries to all Medicaid enrollees.

4.2 Montana's Coverage of Medication for Opioid Use Disorder (MOUD)

In Montana, MOUD services (provider visits, medication prescription, lab testing, medication distribution, and integrated behavioral health management) can be reimbursed through a bundled payment. Counseling services are billed separately, a notable exclusion from the bundled payment. To qualify for reimbursement through the weekly Medicaid MOUD bundled payment, the client must have had a visit with a medical provider in the past month. Medicaid MCOs reimburse at separate bundled rates for OTPs and office-based opioid treatment (OBOT), and two types of MOUD service bundles are reimbursable: MOUD intake (billed during the first week of treatment) and MOUD established care (billed after the first week of treatment).

When MOUD was first introduced in Montana, it was funded by SAMHSA's State Opioid Response and State Targeted Response grants. MOUD then transitioned to being

reimbursed through Medicaid FFS, and in July 2020, Medicaid bundled rates became available. To create the bundled rates, state Medicaid administrators examined the FFS codes that were being billed, spoke to subject matter experts about what is clinically appropriate for treatment of OUD, consulted with Montana providers about team-based workflow and associated costs, and reviewed commercial insurer's rates for MOUD services. Administrative interviewees reported that the bundled rates were developed because of concerns over billing inconsistencies across MOUD providers. Administrators and providers emphasized that, compared to FFS, the bundled rate de-incentivized overutilization of profitable but unnecessary and invasive services such as urinalysis. Bundled payments gave providers the flexibility to develop a protocol for care and testing that centered around patient needs and clinical appropriateness. Montana plans to further develop MOUD bundled rates: the state has submitted a SPA proposing to establish a readmission rate, to augment the existing two bundled rates for intake and established care. The SPA also adds care coordination to the list of services that trigger bundled payments.

According to the providers, bundled rates simplified their billing process. Providers reported that billing MOUD under FFS could be burdensome because clients often require frequent encounters, with variable clinical needs, and under FFS, each service within an encounter is billed individually. Providers also emphasized how critical bundled rates were to maintaining and expanding their service provision, citing the more predictable nature of the bundled payment and the consistency of payment over time, compared to FFS billing. The bundled rates also directly support team-based care; the consistent and predictable payment supported the hiring of peer support specialists, intra-team communication, and client outreach, services that are not reimbursable under FFS. Furthermore, the bundled rates have given state administrators clearer data about how frequently MOUD is being provided and by whom. While Montana's FFS billing system does not distinguish claims for MOUD from claims for other treatment for clients with OUD, state administrators can be certain that providers who receive bundled payments are providing MOUD. The ability to identify MOUD providers through claims data supports the state Medicaid program's efforts to identify geographic areas of need as well as to target providers for technical assistance on bundled payment through Medicaid.

At the time of our interviews, only four programs in Montana were billing for MOUD at the bundled rate; most providers still bill Medicaid FFS for MOUD. Limited provider uptake of the bundled billing approach was attributed in part due to a lack of outreach and education directed at providers on the new billing mechanism. Our administrative interviewees theorized that early providers of MOUD may not be aware of Medicaid bundled reimbursement and that providers may be hesitant to move away from the FFS billing approach that they are familiar with. Administrative interviewees also reported that more outreach and technical assistance by Medicaid is needed, especially toward smaller OBOTs, to increase awareness of the bundled payment. Digital infrastructure also presents a challenge to uptake of the reimbursement mechanism. Many behavioral health providers in Montana do not have EHRs or have only recently developed them, an issue that is compounded by limited broadband access in parts of the state. Lack of digital infrastructure presents a barrier to team-based care because it can facilitate service documentation and billing.

4.3 Aware In-Home Substance Use Disorder Recovery

Aware is a service delivery model of SUD treatment that brings residential-style treatment into the home. Aware was founded on the principle that the most effective SUD care takes place in the home and requires more than a 3-month tenure; the model considers 12 months a more reasonable timeline for stabilization than more common short-term stabilization services. After a pilot study demonstrated Aware's effectiveness,[44] Anthem collaborated with Aware to develop a bundled rate for holistic, in-home SUD treatment. The bundled rates are intended to de-incentivize unnecessary but profitable services, like urinalysis, and to provide the flexibility to support the high-touch nature of SUD services. Bundled service billing also simplifies the payment process for commercial patients because there is only one co-pay per month, limiting patient cost-sharing for high-touch care. The model has expanded to multiple commercial payers since inception.

Complications remain in the billing process: codes for this service vary by insurance plan, although some codes are similar across payers. Payers are working toward greater uniformity in coding. The interviewee also emphasized the importance of EHR in tracking patient encounters and facilitating billing within a treatment model as intensive and complex as Aware.

Providing this model of care and reimbursement faces additional challenges related to staffing and program expansion. In-home addiction treatment is labor-intensive, and given current shortages in the behavioral health labor market, particularly during the COVID-19 Public Health Emergency, consistent staffing remains a barrier for this service delivery model. Participating commercial payers also vary in the types of paraprofessionals they employ. Certified Recovery Advisors, a key feature of the model, were reported as being increasingly accepted by commercial insurers, but other paraprofessionals that were integral to Aware, such as Family Education Facilitators, have not yet experienced this rise in acceptance. Aware is advocating for a nationally recognized billing code for their service bundle, citing the advantages to expanding across commercial payers and states under a recognized billing code.

In its expansion to new states and payers, Aware representatives emphasized that preexisting contracts with commercial payers in one state facilitated the development of contracts with those payers in other states. However, program expansion is a labor-intensive process, requiring legal, compliance, project management, and accounting staff. Aware is also weighing expansion to serve Medicaid enrollees. However, expansion under Medicaid brings challenges: both CMS reporting and the treatment model itself are labor-intensive and thus costly, and Medicaid's fee schedules are generally less than those of commercial payers.

4.4 New York Health Home Plus (HH+) Program

HH+ is a component of New York's state Health Home program, which is focused on Medicaid enrollees living with SMI. Health Home is a treatment modality that uses integrated care, coordinated care, and transitional care to holistically address physical health and social determinants of health. HH+ incorporates Health Home services, but at a

higher level of intensity (e.g., more face-to-face contacts, low caseload sizes), specifically for patients who have SMI and who meet other qualifications (e.g., court order to undergo treatment, recent discharge from a state psychiatric center, recent release from prison). New York has 200 OMH-designated Care Management Agencies (CMAs) that provide HH+ services to about 25,000 individuals.

HH+ developed from New York's existing care management system, TCM. Whereas TCM focused solely on mental health, HH+ uses an integrated care model to address both behavioral and physical health. The PMPM rate is set to factor in the high-intensity integrated care needed by the HH+ population; thus, rates for HH+ are higher than rates for Health Home. New York state selected PMPM as the reimbursement mechanism for HH+ to allow providers the flexibility to develop innovative service delivery approaches.

Both provider and administrative interviewees noted that New York's HH+ system's robust HIT system facilitated team-based care and reimbursement. Like New York's MCTs, HH+ has access to PSYCKES for care coordination. The provider interviewee reported high administrative and information technology knowledge requirements, and that the requisite staff training was time-intensive, but that digitizing the CMA's record-keeping allowed for more rapid communication between team members and more comprehensive care for patients.

The formalized communication between OMH and HH+ providers was linked to the iterative development of the HH+ rate over time, as well as to the subpopulations that were gradually added to the service definition. In keeping with the iterative development process, the administrative interviewees indicated their interest in building on the reimbursement mechanism to include pay-for-performance elements.

4.5 Pennsylvania Centers of Excellence (COEs)

In Pennsylvania's COEs, care managers integrate outpatient OUD treatment with physical health treatment. To reimburse COEs, Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) passes funding to MCOs, which must then direct the funds to a specified list of COE providers at a current rate of $277.22 PMPM. COE services are covered for Medicaid MCO beneficiaries. Before transitioning to PMPM via MCOs, Pennsylvania COEs were originally funded by a state demonstration grant. This start-up grant funding allowed COEs time and financial freedom to develop systems to deliver the most appropriate care and to recruit and train qualified staff. The COEs then transitioned to MCO reimbursement as a more sustainable funding source, compared to time-limited grant funding. OMHSAS used grant expenditure data when calculating the PMPM rates.

Administrator interviewees emphasized the importance of technical assistance for providers in gaining support among MCOs for the reimbursement method. State administrators and their university partners provided individualized technical assistance to COEs and open channels for MCO feedback, which encouraged MCOs' buy-in. Both administrator and provider interviews indicated that incentivizing providers to retain patients in care is a key strength of the PMPM mechanism. Although both administrator and provider interviewees agreed that the PMPM rate of $277.22 generally did not cover the cost of the high-intensity

care needed in the first month of treatment, program administrators emphasized that they intended the rate to "pay off" over the course of 6-12 months of treatment. An administrative interviewee highlighted that the bundled payment allowed COEs additional flexibility in how best to address their clients' needs. For example, some COEs have taken on the role of whole-person care, by intervening on social determinants of health and partnering with community-based housing, transportation, childcare, or food security organizations. Interviewees also noted adaptations in the bundled rate: two MCOs have increased the PMPM to include physical and behavioral health care in the same bundled rate.

Concerns surrounding the PMPM mechanism included its potential to incentivize client volume and preferential retention of low complexity patients, who garner the same PMPM as high complexity patients. Interviewees reported that some providers perceive the reimbursement rate as failing to cover the full cost of care during the early months of treatment. For the next development phase of the COE reimbursement mechanism, interviewees expressed interest in tying reimbursement to key performance measures, and in tiered reimbursement that is more aligned with treatment stage and intensity.

4.6 Findings Across Case Studies

We focused on a range of programs that are successfully reimbursing for team-based behavioral health care. Consequently, case study findings are responsive to this report's second research question focusing on barriers and facilitators to implementation and maintenance of reimbursement practices that support team-based behavioral health care. The design of the case studies, in which four of the five case studies included both administrative and provider interviews, allowed us to identify and triangulate barriers and facilitators of team-based care reimbursement, on both the administrative and the provider sides. Several key themes emerged in multiple case studies, ranging from the importance of grant funding in developing novel reimbursement mechanisms, iterative development of reimbursement mechanisms, and collaborative relationships between administration and providers.

State or federal grant funds were instrumental in developing and adopting novel reimbursement mechanisms or rates. Although interviewees consistently emphasized the importance of sustainable reimbursement mechanisms, most interviewees reported depending on grant funding playing a temporary but key role in the development and adoption of their current reimbursement mechanism. Interviewees used early-stage funding to support collaboration with local universities to design evidence-based bundles of services, develop technical assistance partnerships with universities, solicit current service utilization and associated costs from providers, and build relationships with providers for iterative feedback on the mechanism. Grants incentivized providers to appropriately implement the evidence-based services, ensuring the processes and staff were ready for the bundled payment rates. Case studies focused on Pennsylvania's COE and Montana's MOUD bundled rate are both striking examples of state and federal grant funding, respectively, playing a key role in the development and implementation of novel reimbursement mechanisms. In addition, in the case of New York's MCTs, provider interviewees emphasized the importance of combining funding streams from reimbursement and state or local funds, or "braided funding," to bridge the gaps between FFS and the actual cost of care.

Iterative communication and feedback between administrators and providers were key facilitators of both the reimbursement mechanism development process and successful implementation and maintenance. Multiple interviewees reported that close relationships between the administrators and providers led to more clinically appropriate reimbursement rates, a more responsive refinement cycle of the reimbursement mechanism, and better-informed providers.

On the administrative side, several programs emphasized the importance of technical assistance in helping providers successfully transition to new billing requirements. In the Pennsylvania COEs, state funding allowed the COEs to collaborate with local universities in their technical assistance efforts, which allowed providers to have their reimbursement questions answered rapidly and allowed administrative contacts to reinforce the effectiveness of the bundled rate through data summaries back to providers. Interviews also captured the value of the technical assistance relationship to providers as a conduit for incorporating provider feedback into the development and evolution of bundled case rates. Interviewees in Montana, Pennsylvania's COE, and New York's HH+ program reported that they considered a combination of documented practice costs and qualitative descriptions of workflow in the development of their reimbursement mechanisms. In the case study on Montana's OUD bundled rate, providers emphasized the personal and informal connection to the state administrators, given the size of the state, whereas the case study on New York's HH+ program emphasized a more formal relationship between providers and state administrators. Over the years, HH+ has also expanded the populations eligible for HH+ based on stakeholder and provider feedback. Stakeholder and provider feedback also guided the development of the HH+ rate, determined by caseload, staffing qualifications, and contact requirements.

Models serving clients covered by a single type of payer were more successful in covering the costs of care. Both Aware and New York's HH+ program are linked to their payer type: Aware serves beneficiaries enrolled in commercial health plans, and the HH+ program serves Medicaid enrollees. Within models that were designed for reimbursement by a single payer type, interviewees reported advantages of specialization: Aware and HH+ interviews referenced efficiencies gained by focusing on a specific population in terms of providing tailored care. In the case of HH+, interviewees emphasized that reimbursement rates had been iteratively tailored to complex and high-need populations, often based on provider feedback. Aware representatives, in turn, focused on the advantages conferred by the ability to leverage connections with a commercial payer across multiple states in which that payer was active. By contrast, in the case study of New York's mobile crisis program, characterized by serving clients regardless of insurance status, the range in client payer mix was cited as a barrier to consistent FFS billing, as reimbursement practices for mobile crisis vary widely across payers.

Across the case studies, we also identified several key barriers to successful and sustainable reimbursement of team-based behavioral care. First, provider perceptions of underfunding remained an issue across mechanisms. Second, in case studies in which services were provided to a broad client mix, regardless of payer, interviewees noted that the primary reimbursement mechanism (generally Medicaid) was effectively

subsidizing the care received by clients enrolled in other payers. In the case of the Pennsylvania COEs and Montana's MOUD treatment, both reimbursement mechanisms were tied to the Medicaid beneficiaries being served, despite providers serving a broader mix of beneficiaries. Third, geographic challenges remain for reimbursement where outreach and transportation costs are more substantial due to rurality (e.g., Montana), though programs such as New York's HH+ mitigates geographic barriers through distinct reimbursement rates for different regions. Finally, where states invested in digital infrastructure, we saw those investments support both successful team-based care and the reimbursement process. By contrast, where digital infrastructure was absent or when providers referred to times preceding its implementation, the absence highlighted its importance in: (1) intra-team communication through electronic visit notes and visit follow-up reminders; (2) the identification of both patients and providers; and (3) communication between provider teams and larger organizations, such as MCOs, state Medicaid programs, and health homes.

5. Strategies to Promote Reimbursement of Team-Based Care

Inadequate reimbursement is a barrier to sustained implementation of team-based care. For reimbursement to be sustainable, reimbursement rates should be derived from the actual cost of team-based care accounting for both services provided and team activities. We have seen accurate rate-setting require both up-front investment to collect these rate-setting data, often in the form of grant-funded demonstration projects, as well as collaborative relationships with providers, as provider feedback was instrumental in accurate rate-setting and iterative rate development. Further, sustainable reimbursement depends on availability and standardization of rates across payers. Using the environmental scan, expert interviews, and case studies, we synthesized a range of strategies that promoted the successful and sustained reimbursement of team-based behavioral health care. In this context, a strategy is a step or series of steps that states or programs may take to support reimbursement of team-based behavioral health care.

State and federal grant funding are instrumental in the development of reimbursement rates and the successful implementation of novel reimbursement mechanisms that support team-based behavioral health care. In the environmental scan and catalog, we noted the contribution of state and federal grant funding to the maintenance of MCTs, CCBHCs, psychiatric teleconsult and CSC programs by covering services that are difficult to reimburse for through FFS. Moving beyond maintenance, the case studies indicated that for most reimbursement mechanisms, successful development and implementation depended on grant funding to support start-up and transition. In these cases, funding towards the iterative development of reimbursement rates was associated with rates that aligned more closely with the cost of team-based care provided, and we noted instances where the funding allowed for provider input to be incorporated in rate development.

In pursuit of sustainable reimbursement, states may draw on Medicaid waivers or SPAs as a strategy to expand on services covered by Medicaid state programs. 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. Medicaid 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.[45] Across models, waivers and SPAs were common strategies to allow for reimbursement of certain elements of team-based care, such as peer support specialists.

Establishing and promoting use of new or enhanced Medicare and Medicaid FFS billing codes with service definitions that support coordinated, team-based care are key to successful reimbursement. CMS and state Medicaid offices are increasingly developing new codes and service definitions that support multidisciplinary teams. Throughout the environmental scan and the case study, we see examples in the CoCM codes, which reimburse for team collaboration, and tailored billing codes for MCTs in New York. Case studies indicated that the development of new codes benefitted from iterative feedback from providers, and that barriers to uptake warrant additional study.

Bundled or PMPM rates more sustainably cover the cost of delivering team-based care. In addition to creating new billing codes that align with components of team-based care, the creation of bundled or augmented rates help to account for the cost of direct care as well as indirect and other team-based costs. The PPS rates applied at demonstration CCBHCs is a striking example for how financing for team-based care can be folded into a payment structure. Other examples include CMS's recent implementation of a Medicare bundled rate for OTP providers, expanding treatment opportunities for older and disabled adults with OUD.[28] Establishing bundled payments allows providers the flexibility to provide a set of team-based services under a single rate. In turn, this reimbursement allows providers to deliver services, such as peer support recovery services or client outreach, that would otherwise be difficult to sustain with a lack of coverage under the FFS mechanism. Our findings support the flexibility of bundled rates as a key facilitator of team-based care, especially in SUD treatment settings. In addition, in our case studies focused on bundled payment, there was some indication that bundled and PMPM reimbursement mechanisms were not only more closely aligned with the cost of team-based care, but that they encouraged more clinically appropriate services.

In addition to establishing bundled rates within Medicaid or Medicare to promote flexibility in service provision and team composition, we found that contracting mechanisms in MCOs were another strategy that could be leveraged toward team-based care. Commercial payers and states that have implemented Medicaid managed care can use contracting processes to incentivize the use of non-licensed counselors and peers as a part of team-based care.[46] Commercial payers and the state Medicaid authority can require providers and MCOs respectively to implement specific care models that rely on peer support and non-licensed counselors, such as ACT or assisted outpatient treatment. 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 also can use contracting processes to hold providers and MCOs accountable for team-based care practices by establishing targets, such as targets for the number of patients who receive peer support services. Commercial payers and states can align these targets to contract payment strategies, either through withhold or incentive arrangements. Payers can also incorporate team-based care elements into contract care management requirements, such as encouraging use of multidisciplinary care teams to support patient needs. Finally, contracts can tie team-based care requirements to performance improvement projects or value-based payment initiatives.

In some cases, state and lobbying efforts with commercial insurers or Medicaid MCOs negotiated coverage for team-based services, or when negotiations were unsuccessful, some states opted to mandate coverage for commercial insurers. Across models and states, there were several instances of providers or lobbying groups negotiating with commercial payers to encourage more inclusive reimbursement for components of team-based care. In addition, state officials were sometimes able to negotiate for coverage across all Medicaid MCOs in their state. In instances when negotiations were unsuccessful, some states elected to mandate program coverage. For example, after efforts to convince commercial insurers to cover ACT and CSC failed in

Illinois, the state legislature passed the Children and Young Adult Mental Health Crisis Act which mandates that both ACT and CSC must be covered by commercial insurers for youth under age 26. It further stipulates that both programs be reimbursed through bundled payments and that the team leader's credentials qualify all team members to be credentialed with the insurer.[11] Previous research on MCTs indicates that some states have successfully billed for mobile crisis services, though the process was often marred by certification requirements, coverage refusals and lengthy appeals processes, and variation in insurer definitions for what constituted crisis services.[47]

Digital infrastructure can ease the reimbursement process and simultaneously facilitate team-based care. The adoption of digital infrastructure in behavioral health care, such as EHR systems, has lagged behind general health care.[48] Digital infrastructure has the potential to play a strong role in enhancing team-based care through features like electronic consent, closed-loop electronic referrals toward warm hand-offs, and enhanced integration between behavioral health and other health care providers.[49] Case study findings also support the role of digital infrastructure in successful billing through integrated checks of billing requirements, in addition to increased connectedness among team members, and between teams and larger repositories of patient data.

6. Conclusions

Team-based behavioral health care occurs across a variety of service models and has the potential to mitigate behavioral health provider shortages while providing effective care. However, these models require innovative reimbursement approaches to address gaps in traditional FFS reimbursement. Many team-based care models lack sustainable reimbursement mechanisms to adequately cover care coordination, patient outreach, on-call availability, and specific providers such as peer support specialists or behavioral health care coordinators. Lack of sustainable reimbursement was especially common for MCTs and psychiatric teleconsult models, both of which must, by definition, be staffed even when not providing face-to-face services.

We identified several innovative strategies for successful reimbursement and explored important barriers and facilitators to implementing these mechanisms. Several key strategies are common in the promotion of successful team-based care and its reimbursement, and those range from high-level (e.g., federal, state) strategies to provider-level strategies. For high-level strategies, reimbursement of team-based behavioral health care is promoted through SPAs and state waivers and through the flexibility in service provision inherent in Medicaid MCOs. Both Medicaid and Medicare have developed billing codes specifically to support team-based care, although uptake and barriers to use remain. Many programs are dependent on braided funding to support elements of team-based care that were not reimbursed through FFS, for example drawing upon federal, state, and local grant funding. Although Medicaid was the primary payer in most of the models, provider and lobbyist groups in several states documented their negotiations with commercial payers to broaden coverage for services such as CSC and ACT, occasionally culminating in a legislative mandate for commercial insurers. When programs developed innovative reimbursement mechanisms, our findings showed the need for grant support in the development stages and the importance of close relationships between administration and providers, to closely map new reimbursement rates to the clinical reality of costs of care.

Team-based behavioral health care models have the potential to alleviate workforce shortage issues by allowing clinicians to practice at the top of their license. Team-based behavioral health care models also allow for different approaches to care that promise to better meet the needs of individuals with complex mental health and SUDs. But for team-based approaches to work and to be sustainable, they need reimbursement mechanisms that cover all team members and team-based activities that traditional FFS mechanisms do not cover. There are clear reimbursement mechanisms, such as bundled payments or team-based FFS billing codes, that cover the costs of team-based care but are not currently widespread. The outlined strategies to promote coverage and detailed case studies should provide federal and state administrators ideas for how to expand coverage for team-based behavioral health care in the future.

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Appendix A: Technical Details

Information gathered in our searches was organized into an Excel spreadsheet. The spreadsheet includes fields for team composition, services, reimbursement mechanisms, and other model details. The team composition field describes the types of providers typically involved in each model, including physicians, nurses, counselors and therapists, social workers, case managers or care coordinators, and peers. In parallel with team composition, the services field details the clinical, psychosocial, and coordinative components of care provided by each model. Reimbursement mechanisms (e.g., FFS, bundled payments) were tracked in reimbursement fields along with funding sources, which included payers (Medicaid, commercial insurance) and other sources like grants. Other fields categorized the models by their populations served (adult, youth, or child), most common setting (e.g., hospital, outpatient practice, telehealth, community, home), and focus (SUD, mental health, or general behavioral health). Models were also subjectively tagged as established or emergent based upon their date of inception and their prevalence.

We operationalized our search using the base terms "team-based care" OR "team-based care model" were combined with each of the following terms for a total of four searches: "behavioral health"; "substance-use disorder" OR SUD; "mental health"; and "behavioral health" AND "Peer." These four searches were applied to Google and Google Scholar. Four additional searches were conducted in each search engine using those terms plus the following reimbursement-focused phrases: "reimbursement mechanism"; "value-based payment" OR "value-based purchasing" OR "capitated payment"; Medicaid OR Medicare OR Commercial OR Private OR Payer; and "Coordinated Specialty Care (CSC)" OR "Assertive Community Treatment (ACT)" OR "Opioid Home Health" OR "Mobile Crisis." Each of these eight searches was conducted within two timeframes, 2010+ and anytime, for a total of 16 search combinations. Due to Google's word limit on queries, the terms for each reimbursement-focused search were divided into three separate searches, within the general Internet search.