Episode Intelligence Authorization and Payment (EIA) Compensation Model (Revised Version)

Environmental Scan

October 22, 2026

I. Overview

The purpose of this environmental scan is to provide members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) with background information and context for the proposed physician-focused payment model (PFPM) *Episode Intelligence Authorization and Payment (EIA) Compensation Model (Revised Version)*. This revised proposal was submitted by Joanne Bayouk, MBA, MSN, RN, and was determined to have met the administrative requirements for a PFPM on September 28, 2026.

The scan focuses on three topics:

1. Problems in Care Delivery and Payment Related to Behavioral Health Services
2. Medicare Payment Policy Related to Behavioral Health Services
3. Results From Related Alternative Payment Models (APMs)

Appendix A provides the guiding Research Questions used to conduct this scan. Appendix B includes an Annotated Bibliography. Appendix C provides References.

II. Information on the Submitter

Joanne Bayouk is a registered nurse, psychiatric mental health nurse practitioner candidate, and clinical informaticist. Ms. Bayouk has over 20 years of experience across multiple sectors, including payer operations, pharmacy benefit management, health plans, hospital systems, and revenue cycle management. She is completing psychiatric mental health nurse practitioner training in December 2026.

III. Problems in Care Delivery and Payment Related to Behavioral Health Services

Mental health and substance use disorders, referred to collectively as behavioral health conditions, impact millions of people in the United States each year.[1] Major depressive disorder (MDD) is one of the most significant behavioral health conditions in the United States. This condition impacts individuals' daily lives and contributes to health care utilization and spending. For example, among people with chronic diseases, those with mental health disorders had greater resources use (e.g., hospitalizations, hospital length of stay, emergency department [ED] visits) and costs relative to those without a mental health disorder.[2]

Background on Major Depressive Disorder in the Medicare Population

This section first provides an overview of MDD, including its symptoms, recommended treatments, and prevalence. This section also includes an overview of the use of behavioral health services and associated costs.

Major Depressive Disorder. MDD causes an individual to experience feelings of sadness, hopelessness, or emptiness for two weeks or more.[3] While the main symptoms of MDD are depressed mood and a loss of interest or pleasure in activities, individuals may also experiences changes in appetite, fatigue, feelings of worthlessness or guilt, slowed movements, sleep problems, trouble concentrating, and thoughts of suicide or self-harm.[4] To be diagnosed with MDD, an individual must experience at least five of the previously listed symptoms for the majority of the day, nearly every day, for at least two weeks, and one symptom must be either depressed mood or loss of interest or pleasure in most activities.[5] Symptoms must cause distress or disrupt everyday life and cannot be due to a different medical condition, medication side effect, or substance use.[6]

MDD frequently occurs in episodes, or periods where an individual's symptoms of depression are increased.[7] For example, major depressive episodes can occur for several weeks, months, or even years if left untreated.[8,9] MDD episodes can involve a single episode, recurrent episodes, partial remission (where symptoms are still present but improve), or full remission (where there are no symptoms).[10] The severity of MDD can be mild, moderate, or severe.[11]

Treatment for MDD often lasts for several months or more, depending on whether symptoms return.[12] Treatment typically includes psychotherapy, such as cognitive behavioral therapy (CBT) or interpersonal therapy (IPT), and/or medications, such as selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs). Therapy often takes several sessions before individuals experience an improvement in symptoms, and medications may begin to improve symptoms within two to four weeks but take up to 12 weeks to provide full benefits.[13] Additional forms of treatment for MDD can include brain stimulation therapies (e.g., electroconvulsive therapy, repetitive transcranial magnetic stimulation), light therapy, or alternative medicine such as exercising or taking folate.[14]

Approximately 15.5 percent of adults in the United States experience MDD annually.[15] In 2023, approximately 19 percent of Medicare beneficiaries were diagnosed with depression.[16] Medicare beneficiaries under the age of 65 were more likely to report having ever been diagnosed with depression (56 percent) compared with Medicare beneficiaries over the age of 65 (22 percent) in 2023.[17] The prevalence of depression in Medicare beneficiaries was higher among dual-eligible beneficiaries (31.3 percent) relative to non-dual-eligible beneficiaries (15.2 percent) and among females (22.6 percent) relative to males (13.4 percent) in 2018.[18] Relative to the general population, people with depression have a 40 percent greater risk of developing physical health conditions, including cardiac disease, hypertension, stroke, diabetes, metabolic syndrome, and obesity.[19]

Use of Behavioral Health Services. Different factors can determine the length of recommended treatment for individuals with behavioral health conditions, such as the severity of symptoms. For example, although the recommended number of sessions depends on a patient's responsiveness to treatment, individuals with mild depression may receive 8 to 12 sessions of CBT for depression, while individuals with severe depression may receive 16 or more sessions of CBT. Booster sessions for up to one to two years following the completion of treatment may be useful for some individuals with recurrent depression.[20] A nationally representative study of adults conducted between 2001 and 2003 showed that patients with a behavioral health condition received a median of three visits for behavioral health treatment annually, with an interquartile range of 1 to 10 visits.[21]

A Medicare claims analysis conducted by the Medicare Payment Advisory Commission (MedPAC) in 2021 showed that psychotherapy constitutes the majority of behavioral health services, as 1.2 million Medicare FFS beneficiaries accounted for 14.8 million psychotherapy services, averaging to 11.9 services

per beneficiary who received the service.[22] Approximately 3.1 million Medicare fee-for-service (FFS) beneficiaries received 13.3 million evaluation and management (E&M) visits for behavioral health, averaging to 4.2 services per beneficiary who used the service.[23] The analysis showed similar use of behavioral health services among Medicare FFS and Medicare Advantage (MA) beneficiaries in 2019.[24] Between 2016 and 2021, there was a shift in Part B where the volume of behavioral health services moved from being provided by psychiatrists to being provided by nurse practitioners and physician assistants.

Dropout from behavioral health treatment is relatively common. Over one in five (22.4 percent) patients drop out before completing the recommended course of treatment each year.[25] Among patients who dropped out of treatment, the median number of visits until dropout was four to six visits within the specialty mental health sector (including psychologists or other non-psychiatrist mental health professionals in any setting or social workers/counselors in a mental health specialty setting, or use of a mental health hotline) and three visits in the general medical sector (including primary care physicians, other general medical physicians, nurses, other health professionals) and human services sector (religious or spiritual advisors or social workers/counselors in any setting other than a specialty mental health setting).[26] Over 70 percent of all dropouts occurred following the first or second visit.[27] The general medical sector accounted for the majority of treatment episodes and had the highest dropout rates (31.6 percent) relative to the other sectors.[28] Psychiatrists experienced the lowest dropout rates (15.1 percent) compared with the specialty and general medical sectors. People who had a substance use disorder or had a psychiatric comorbidity (i.e., two or more classes of psychiatric disorders) were at increased risk of dropping out after the third visit.[29] Across patients with a variety of behavioral health conditions, there are multiple reasons for treatment dropout, including:

- No or low perceived need for treatment, such as the patient believing that they did not need help anymore or that they recovered;

- Structural barriers, such as financial reasons, poor availability of treatment, or transportation barriers; and

- Attitudinal barriers, such as the stigma associated with mental health, perceived ineffectiveness of treatment, having a negative experience with treatment, or believing that they could handle the condition on their own.[30]

Medicare Spending on Behavioral Health Conditions. In 2015, approximately 12.7 percent of total Medicare spending was associated with mental health disorders.[31] Of the 12.7 percent, 4.2 percent ($2.7 billion) was spent on mental health services, and 8.5 percent ($5.5 billion) was associated with additional medical spending due to having mental illness.

An analysis conducted by MedPAC in 2021 showed that beneficiaries receiving Part B behavioral health services cost Medicare $4.8 billion in total spending on Part B services, translating to $981 per beneficiary receiving the services.[32] The analysis showed that treatment for depression accounted for the largest share of Part B behavioral health spending (31 percent) in 2021. The majority of behavioral health spending was for psychotherapy ($1.5 billion, or 38 percent of physician fee schedule behavioral health spending) and E&M visits ($1.3 billion, or 33 percent of physician fee schedule behavioral health spending).[33]

Quality/Performance Measures Used to Assess Patient Outcomes Associated with MDD

This section provides a summary of quality/performance measures used to assess quality of care and patient outcomes associated with MDD. This section also provides examples of core measure sets in behavioral health care.

An environmental scan conducted by the National Committee for Quality Assurance (NCQA) assessed the current state of behavioral health measurement across the health care system.[34] Findings showed that federal programs, particularly programs focused on behavioral health care, rely on metrics and non-standardized quality measures. When federal programs use standardized measures, the measures are generally focused on specific conditions or processes and used inconsistently across programs. The environmental scan found that only 35 unique standardized behavioral health quality measures were implemented across all federal programs, 16 of which were used in only one program. The most commonly used measures were follow-up after hospitalization for mental illness; screening for depression and follow-up plan; initiation and engagement of alcohol and other drug abuse and dependence treatment; and preventive care and screening: tobacco use—screening and cessation intervention. The environmental scan also showed that current standardized measures inadequately and inconsistently assess behavioral health integration.[35]

For patients diagnosed with MDD, Medicare focuses on measures that evaluate screening, timely treatment, and symptom improvement. For example, measures include screening for depression and follow-up plan, depression remission at 12 months, antidepressant medication management, and reduction in suicidal ideation or behavior symptoms.[36]

One component of the Centers for Medicare & Medicaid Services' (CMS') Behavioral Health Strategy—a comprehensive CMS strategy for promoting high-value behavioral health care—includes increasing screening for high-impact conditions, including depression.[37,38] Annual depression screenings are fully covered by Medicare Part B; however, only 6 percent of Medicare beneficiaries used this benefit in 2018.[39]

Patient-reported outcome measures can be used to help define symptom burden and assess change over time during the course of treatment.[40] One commonly used patient-reported outcome measure to screen for depressive symptoms is the Patient Health Questionnaire-9 (PHQ-9), a nine-item patient self-report measure that asks patients to reflect over the past two weeks on how often they have been bothered by problems associated with depression (e.g., little interest or pleasure in activities, poor appetite or overeating).[41,42,43] Each item is rated on a scale from 0 (not at all) to 3 (nearly every day), and patients can obtain a score of 0 to 27 on the measure. Higher scores reflect more severe symptoms of depression.

The CMS Innovation Center's Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model uses Outcome Aligned Payments (OAPs), a new type of payment that rewards health outcomes rather than activities. In the model, payments are based on the overall proportion of patients who meet a defined outcome compared with a minimum threshold that increases with each participation year. The PHQ-9 is used to track and reward behavioral health outcomes for depression in the behavioral health track of the model. More information about the ACCESS Model can be found in *Section V. Results From Related Alternative Payment Models (APMs)*.

Core Measure Sets in Behavioral Health Care. Efforts are currently underway to develop and implement core measure sets in behavioral health care. The Care Quality Measures Collaborative (CQMC), founded by America's Health Insurance Providers (AHIP) and CMS, aims to develop core measure sets that align

high-value, evidence-based measures across payers. One core set is focused on behavioral health and includes measures for depression; serious mental illness (SMI); and tobacco, alcohol, and other use.[44,45] Areas for future measure development in the set include measures focused on coordination of care (e.g., bidirectional integrated behavioral health care and primary care); patient-reported measures (e.g., patient experience with psychiatric care); and measures on access to a prescriber, therapy, and peer services.[46]

CMS' Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) aim to reduce reporting burden by providing consistency across CMS programs and include subsets of measures related to specialties or medical conditions. One MVP is the Quality Care in Mental Health and Substance Use Disorders MVP, a specialty-specific reporting option that aims to streamline reporting of behavioral health data. While MVP reporting is not currently required, CMS proposes to sunset traditional MIPS after the 2028 performance year and fully implement MVP reporting in the 2029 performance year.[47]

IV. Medicare Payment Policy Related to Behavioral Health Services

This section summarizes Medicare payment policy related to behavioral health services, including current reimbursement approaches and payment issues for behavioral health services, background information and challenges with current claims adjudication practices, an overview of Fast Healthcare Interoperability Resources (FHIR), and use of episode-based payments and outcome-based holdback payment structures to reimburse for behavioral health services.

Current Reimbursement Approaches and Payment Issues for Behavioral Health Services

This section provides an overview of how behavioral health services are typically reimbursed in Medicare FFS.

Medicare FFS provides health insurance to 20 percent of the U.S. population.[48] Under Parts A, B, and D, Medicare covers a range of behavioral health services, including screening, evaluation, counseling/psychotherapy, behavioral and physical health integration, early intervention for non-dependent substance use, opioid treatment, partial and psychiatric hospitalizations, and prescription medications.[49] Under Medicare FFS, health care providers bill Medicare on a per-service basis using services codes (e.g., Current Procedural Terminology [CPT] and Healthcare Common Procedure Coding System [HCPCS] codes).[50] Payments are set through fee schedules, primarily the Medicare Physician Fee Schedule (PFS), which assigns standardized payment rates for health care services using relative value units (RVUs). Health care professionals and facilities must bill Medicare for each individual behavioral health service provided.

The FFS model can be associated with several challenges. By rewarding the volume of services provided, services are reimbursed regardless of the quality of care, and providers may be incentivized to treat healthier patients who reliably present for visits.[51] In addition, FFS models can lead to fragmented care because provider coordination within and outside the system is not reimbursed. These challenges can have consequences for individuals with behavioral health conditions. For example, gaps in behavioral health care can lead to increased ED visits and hospitalizations.[52]

Behavioral health providers typically accept payment from public and private payers at lower rates compared with non-behavioral health providers who bill for medical services. One study showed that between 2007 and 2016, psychiatrists accepted all sources of payment, including payment from Medicare, Medicaid, capitated private insurance, and non-capitated private insurance, at lower rates

compared with physicians of other specialties.[53] This difference in insurance acceptance rates between psychiatrists and non-psychiatrist physicians was greater for public insurance compared with private insurance.[54] One reason for this difference could be low reimbursement. Original Medicare generally pays mental health providers more than commercial insurers for in-network mental health services, but less than commercial insurers for out-of-network mental health services. Patients go out of network more frequently for mental health services compared with other medical services, potentially leading mental health providers to choose to not participate in insurance networks.[55] Additionally, psychiatrists commonly rely on self-pay, or visits paid entirely by the patient, as the supply of psychiatrists is low, while mental health service demand is high.[56]

Another potential reason for lower insurance acceptance rates among psychiatrists compared with physicians of other specialties includes greater administrative burden associated with documentation and billing for behavioral health services compared with medical services.[57,58] Relative to standard medical documentation and billing practices, the documentation and billing practices for behavioral health services can be more complex due to the nature and variability of behavioral health services.[59] While medical billing commonly involves the delivery of repeated services such as the same procedures, tests, labs, and exams, behavioral health billing typically has less standardization. There are many codes for psychotherapy services (e.g., time-based codes for psychotherapy sessions, codes for individual versus group therapy, codes for crisis situations) that have specific criteria for when and how to bill. For example, psychotherapy sessions vary in their length, and billing for these sessions relies on time-based CPT codes that require clinicians to track the actual start and stop times of psychotherapy sessions (not solely session length or appointment time) and accurately report the correct time-based billing code associated with the start and stop times. The highest individual psychotherapy code covers sessions of 53 minutes or longer and cannot be billed twice to cover long sessions.[60] In addition, only face-to-face time with patients can be counted in psychotherapy codes; time spent on documentation, phone calls, and record reviews that occur outside of sessions cannot be counted.[61] These time-based psychotherapy codes are among the most audited codes in behavioral health.[62] Medical billing also uses time-based codes, such as E&M codes; however, E&M codes are billed based on cumulative time spent with patients on the date of the visit, which can include face-to-face and non-face-to-face activities (e.g., reviewing notes, documentation in the medical record).[63]

Behavioral health providers also face challenges with demonstrating that mental health services are medically necessary. Behavioral health conditions are not confirmed in the same way that physical health conditions are confirmed (e.g., through lab tests or imaging scans). As a result, it is recommended that behavioral health providers provide sufficient documentation that allows each billed service to stand on its own.[64] Payers often require documentation of medical necessity for each claim because a treatment plan at intake does not sufficiently document ongoing medical necessity.[65] For example, documentation for each psychotherapy session may include the patient's diagnosis, current symptoms, functional status, treatment goals, and prognosis, as well as the interventions delivered, face-to-face time of the session, service modality, frequency, results of any clinical tests administered, medication monitoring, progress updates, and plan for ongoing treatment.[66]

By providing comprehensive documentation for each billed service, behavioral health providers can avoid common documentation failures that result in claim denials for delivered behavioral health services, such as failure to demonstrate medical necessity, broken treatment plan continuity, and errors in time-based CPT documentation (e.g., billing a 60-minute code for providing 40 minutes of psychotherapy).[67,68]

Psychiatric Care Management. Patients can benefit from the integration of behavioral and physical health care services, including reporting higher satisfaction, reduced stigma, and greater adherence to behavioral health treatment plans.[69] Examples of this integration can include hiring a mental health nurse practitioner in a physician practice or establishing a relationship between a primary care practice and a behavioral health practice to promote care coordination.[70] One program offered by Medicare that promotes behavioral health integration is the Psychiatric Collaborative Care Management (CoCM) program, which promotes collaboration between physicians and behavioral health care providers under Medicare FFS. Medicare uses CoCM billing codes to reimburse providers for using team-based behavioral health care in primary care settings.[71] The team delivering psychiatric CoCM services includes the billing practitioner (physician, physician assistant, or nurse practitioner), a behavioral health care manager, and a psychiatric consultant (e.g., psychiatrist).[72] Key services under the CoCM codes include joint care planning, where the primary care team works with the patient to discuss treatment options; ongoing follow-up by the care manager, where the care manager assesses clinical response using validated rating scales (e.g., PHQ-9), delivers evidence-based psychosocial interventions, and uses a patient registry to track patient treatment plans, outcome measures, progress, and follow-up; and systematic case reviews, where the care manager and psychiatric consultant review cases in the registry, and the primary care team continues or adjusts the patient's treatment.[73]

The team delivers psychiatric CoCM services for an episode of care that bundles all services. The episode of care ends when the patient meets the treatment goals; the patient does not meet the treatment goals, and the team refers the patient to direct psychiatric care; or the patient has a lapse in care without CoCM services for six consecutive months.[74] The codes reimburse the billing practitioner for the cumulative time the team spent delivering CoCM services each month (up to a maximum time threshold for the initial month and subsequent months). Payer coverage of CoCM services varies; while some payers cover CoCM services as preventive primary care services, other payers may cover CoCM services as specialty services.[75]

CoCM codes are part of Medicare's broader behavioral health integration (BHI) strategy. BHI is a monthly, time-based care management service that integrates behavioral health care with primary care.[76] The CoCM codes are intended to enhance primary care by adding two additional services: 1) care management support for patients receiving behavioral health treatment; and 2) regular psychiatric inter-specialty consultation. These additional services may be particularly beneficial for patients whose behavioral health conditions do not improve.

Uptake of CoCM codes has been relatively low. In 2018, 56,579 CoCM services totaling $6,253,377 in payments were delivered to Medicare beneficiaries.[77] Despite low uptake, research evidence shows that CoCM codes can increase access to behavioral health care in primary care settings, can improve patient experience by allowing patients to receive behavioral and physical health care within one setting, and may be more cost-effective than current standard treatments for behavioral health conditions.[78]

Although CoCM services can be used to treat patients with co-occurring behavioral health and medical conditions, as well as substance use disorders, CoCM services have the strongest evidence base for treating patients with depression.[79] Research evidence indicates that psychiatric CoCM may be effective in achieving a treatment response for patients with both moderate and severe MDD; however, the odds of achieving treatment response and remission for patients with MDD differed by case complexity. Patients with MDD who had more complex conditions (presence of anxiety, heightened risk of suicide) had lower odds of improvement compared with patients who did not have these additional conditions. Additionally, the odds of achieving treatment response and remission differed by insurance type;

patients with Medicare, MA, and Medicaid had lower odds of improvement compared with patients with commercial insurance. The authors recommended that clinicians provide more specialized care to patients with greater complexities and those on Medicare and Medicaid.

Background on Current Claims Adjudication Practices and Challenges

This section provides background information on current claims adjudication practices and the challenges behavioral health providers may face with claims adjudication delays and denials. Claim adjudication in medical billing is the review process payers use to determine whether reimbursement for a medical claim should be paid, denied, or adjusted.[80] This process is conducted following the delivery of services by checking patient eligibility, verifying medical necessity, and evaluating medical codes. The purpose of this process is to ensure that each claim meets coverage rules and payer requirements.

Claim adjudication can be done manually, where a human leads the review of each claim.[81] This approach can be time-intensive but highly accurate and is best suited for complex claims. Claim adjudication can also be automated using technology.[82] This approach has increased risk of errors but is fast, scalable, and best suited for routine, low-complexity claims. Hybrid claim adjudication approaches are also used, which leverage a combination of both human review and automation.[83] This approach can balance accuracy and speed and is best suited for medium-to-complex claims.

Payments are made after a claim is adjudicated. When claims are denied, no amount is reimbursed for the service, and providers may choose to dispute the adjudication decision through an appeal.[84] Appeals generally require providers to submit appeal letters, corrected claims, additional documentation, and/or coding clarification.[85] Common reasons for denials for behavioral health claims include a lack of or expired prior authorization, services provided that were not covered under the patient's plan, insufficient documentation of medical necessity, a mismatch between the start and stop times of psychotherapy compared with the billed time-based code, and duplicate claim submissions.[86,87]

There is limited publicly available information on claim denial rates, including differences in claim denial rates between mental health services and medical/surgical services. The State of Oregon has released two behavioral health parity reports of commercial insurers that provide some information on claim denial rates. In 2021, the average claim denial rates were nearly identical for behavioral health and medical/surgical services, at 8.76 percent and 8.77 percent, respectively. By 2022, however, a notable difference emerged with the average denial rate declining to 6.59 percent for behavioral health services while increasing to 12.53 percent for medical/surgical services.[88] Additionally, Oregon insurers reported that behavioral health and substance use disorder services experienced a higher prior authorization denial rate (10.2 percent) compared with medical/surgical services (6.9 percent), a pattern that was consistent from 2021 through 2023.[89] Within the state, appeals for behavioral health and substance use disorder services were submitted less frequently and had lower overturn rates compared with appeals for medical/surgical services.[90]

A study using 2017 and 2018 Medicare claims data found that Medicare denied approximately 6 percent of all CoCM services in 2017 (representing $26,842 in potential payments) and 43 percent in 2018 (representing $2,942,257 in potential payments).[91] Common reasons for claim denials for psychiatric CoCM codes include insufficient documentation regarding the initiating visit, the team structure, or psychiatric consultant involvement; failure to show use of a patient registry; incomplete or missing

outcome measures; not meeting the specified thresholds for clinical staff time; and a lack of negotiated CoCM code rates with the payer.[92,93]

Providers face challenges with current claims adjudication practices in behavioral health care. There are financial impacts to claims adjudication delays and denials. Providers cannot necessarily bill the patient directly when claims are denied.[94] Not only do behavioral health providers lose revenue if a claim denial is not appealed or overturned, but there are also administrative costs to correcting and resubmitting denied claims.[95] The average cost of correcting and resubmitting a denied behavioral health claim can range from $25 to $30 per claim.[96] Some sources suggest that billing errors can cost behavioral health practices an average of $25,000 to $45,000 annually.[97] Delays in payment due to claim denials can be particularly impactful for small and medium-sized practices, which tend to rely on timely reimbursements to cover operational costs.[98]

FHIR Resources

Developed by Health Level Seven (HL7), FHIR uses Application Programming Interfaces (APIs) to securely and electronically exchange health care information. It uses a modular design that breaks down health care data into smaller parts called resources, establishing a common framework for representing and exchanging health care information across different health care organizations and systems, independent of how the data are structured or stored within local electronic health records (EHRs).[99] The latest version of HL7 FHIR (Release 5, version 5.0.0) comprises 157 resources, with each resource reflecting a specific type of data and serving a different purpose (e.g., lab results, patient records, appointments).[100] Each resource includes structured data and a narrative, allowing resources to be used by both machines and people.[101]

Health care organizations select which FHIR resources to implement within their EHRs based on their operations and clinical workflows.[102] Once an organization selects which FHIR resources to implement, it will create rules for the resource data (e.g., fields, codes) and then map the organization's existing data in the EHR to the FHIR resources. Commonly implemented FHIR resources among health care organizations include patient, practitioner, encounter, observation, condition, medication request, medication, allergy intolerance, procedure, diagnostic report, care plan, appointment/schedule, and immunization resources.[103]

Two other examples of HL7 FHIR resources are the Communication resource and the CareTeam resource. The Communication resource provides a standardized way to record information that was transmitted or shared between a sender and recipient, such as communication between clinicians or between a clinician and a patient.[104] This resource can be particularly useful for care coordination as it documents who communicated what, to whom, and when.

The CareTeam resource provides a standardized way to record the people and organizations involved in delivering care to patients.[105] This resource identifies participants on the care team (e.g., clinicians, patients, caregivers), their specific roles on the team, the period during which the care team is active, and the organization responsible for managing the care team. This resource can be particularly useful for supporting care coordination across different health care providers and settings.

Use of Episode-Based Payments and Outcome-Based Holdback Payment Structures to Reimburse for Behavioral Health Services

Behavioral health providers have had limited participation in value-based care arrangements. Several factors contribute to low levels of participation, including operational and administrative differences between behavioral health and physical health practices, a lack of value-based care arrangements designed specifically for behavioral health providers, and differences between behavioral health conditions and physical health conditions in terms of workforce availability, the types of clinicians delivering care, and the characteristics of the populations served.[106] Despite these challenges, different organizations use episode-based payment models and outcome-based holdback payments to shift provider reimbursement away from traditional FFS payment and toward accountability for the cost and quality of care delivered. This section provides an overview of these two approaches and describes examples of how Medicare FFS, MA plans, commercial plans, and Medicaid organizations use such payment structures.

Episode-Based Payment Models. Episode-based payments are single, fixed-price payments (known as target prices) that cover all services provided for a pre-defined clinical episode over a fixed period.[107] Total spending is evaluated across all services involved in the episode. Providers can receive bonus payments if spending is below the target price or penalties if spending is above the target price. This type of payment model aims to improve care coordination, reward outcomes rather than volume of services, create accountability across settings, and control medical costs.[108] This type of payment can give providers flexibility in the services they offer for different behavioral health conditions.[109]

Episode-based payments can be designed as retrospective or prospective. Retrospective episode-based payment structures pay providers FFS throughout the episode of care.[110] Following the episode, the payer retrospectively calculates the total spending for the episode and compares that spending to the pre-defined target price. If the provider meets the quality standards and their spending was below the target price, the provider may receive a shared savings payment in addition to the FFS payments received throughout the episode of care. If the provider's spending was above the target price, the provider may need to pay a portion of the excess costs to the payer. This payment approach allows providers to continue receiving regular FFS payments during care delivery while creating incentives to coordinate care, improve quality, and reduce unnecessary spending.

Prospective episode-based payment structures give providers a single, pre-determined payment to cover eligible services for an entire episode of care at the beginning of the episode.[111] The payment amount is based on a pre-determined target price for the episode. Because the payment amount is established in advance, providers assume greater financial accountability for the cost of care. Providers may receive shared savings if total costs for the episode are below the episode-based payment. Providers may be financially responsible—and absorb a financial loss—if spending exceeds the episode-based payment. Rather than paying the provider separately for each service delivered, the prospective episode-based payment is intended to cover all or most services associated with the episode, and providers must manage resources within the fixed budget.

A report by the American Medical Association indicated that episode-based payment models in behavioral health tend to be targeted for select behavioral health conditions that have a predictable course of care.[112] Certain behavioral health conditions may be less compatible with episode-based payment models for several reasons.[113] First, many behavioral health conditions require ongoing, longitudinal care and support. Second, many behavioral health conditions do not have a single intervention (e.g., surgery) that clearly defines the start of an episode. It can also be difficult to identify the end of an episode clinically and based on time. Third, costs of care can depend on the severity of the behavioral health condition and the nature of the treatment provided.[114]

Generally, most payers are still paying for the majority of services using FFS as the underlying payment mechanism. Across different types of payers, the use of episode-based payments has primarily been in the context of testing APMs and value-based contracting.

Medicare FFS. CMS commonly tests episode-based payment models under Medicare FFS. The models have varied in the types of services, clinical conditions, and providers targeted but have generally focused on covering the costs of surgical procedures, joint replacement, and oncological care.[115] Historically, the majority of CMS episode-based payment models have been voluntary rather than mandatory and have implemented retrospective payment arrangements rather than prospective payment arrangements. Relative to prospective payment designs, retrospective payment designs more easily operate in an FFS environment as expenditures can be billed separately.[116] A 2018 report by the U.S. Government Accountability Office (GAO) demonstrated that providers participating in CMS episode-based payment models were typically larger organizations, had higher episode volume, were teaching hospitals or affiliated with teaching hospitals, and were more commonly located in urban areas compared with providers nationally that participated in Medicare FFS and were eligible to participate in the episode-based models.[117]

Opioid Treatment Programs. Medicare pays enrolled Opioid Treatment Programs (OTPs)—Substance Abuse and Mental Health Services Administration (SAMHSA)-certified programs or practitioners that provide opioid treatment using opioid agonist treatment medication—using episode-based payments that cover weekly episodes of care for Medicare Part B beneficiaries receiving opioid use disorder (OUD) treatment services.[118] CMS developed episode-based payment rates for drug- and non-drug components of OUD treatment services, requiring that at least one OUD treatment service be provided to an enrollee during a seven-day episode of care. Covered services include but are not limited to U.S. Food and Drug Administration-approved opioid agonist and antagonist OUD medications, substance use counseling, individual and group therapy, and periodic assessments.

An audit conducted by the U.S. Department of Health and Human Services' (HHS') Office of the Inspector General (OIG) in 2025 compared CMS' episode-based payment amounts for OUD treatment services with OIG-calculated payment amounts for the individual OUD treatment services that were provided to enrollees.[119] Findings showed that episode-based payments were generally higher than the individual payment amounts calculated based on the services that were actually provided to enrollees. Medicare could have saved $301.5 million, equating to 53 percent of $564.6 million in total payments, if episode-based payment rates for OUD treatment services had reflected the services provided to enrollees. OIG indicated that the episode-based payment amounts exceeded the individual service payments because CMS' approach for setting episode-based rates did not adequately account for the specific mix of OUD treatment services delivered by OTPs or the frequency with which those services were provided during a treatment episode.

***MA Plans*.** Medicare Advantage Organizations (MAOs) have implemented episode-based payment models for in-network providers who care for beneficiaries enrolled in their MA plans.[120] Provider participation in these payment arrangements is generally voluntary. Given the comparable demographic characteristics of beneficiaries in Medicare FFS and MA plans, MAOs often look to CMS episode definitions as a foundation when establishing how episodes of care are structured within their episode-based payment arrangements.[121]

***Commercial Health Plans*.** Common value-based payment models used in the commercial sector are population-based payments and capitation, Accountable Care Organizations (ACOs), and episode-based

payments. Commercial payers use episode-based payment models for in-network providers who treat members covered under their commercial insurance offerings, including individual and group, fully insured, and self-insured plans.[122] Provider participation in these payment arrangements is generally voluntary. Because the demographic characteristics of members enrolled in commercial plans differ from those served by Medicare FFS and MA, commercial payers often dedicate significant resources to define episodes of care that are applicable to their members. The variation in reimbursement rates within the commercial market creates both complexities and opportunities for commercial payers and providers. For example, health plans may adjust member cost-sharing requirements to encourage patients to receive services from providers who participate in episode-based payment models.[123]

Medicaid Organizations. Several state Medicaid agencies have adopted episode-based payment models for providers serving Medicaid beneficiaries, including those enrolled through Medicaid Managed Care Organizations (MCOs).[124] In some states, such as Arkansas, Ohio, and Tennessee, for example, providers are required to participate in episode-based payment models that cover a range of clinical specialties. Colorado has established a voluntary episode-based payment model focused on episodes for maternity care. Medicaid programs often design episodes to reflect the unique needs and characteristics of the populations they serve.

Outcome-Based Holdback Payments. Outcome-based holdback payments aim to shift from paying for the volume of services to rewarding providers based on the quality and effectiveness of care they provide. These types of payments align financial incentives with patient outcomes, where payers withhold a portion of performance-based incentive payments from providers until specific health outcomes are met. For example, 10 percent of provider incentive payments may be tied to patient outcomes.[125]

One study reviewed findings from 88 articles that evaluated 12 outcome-based payment models.[126] The majority of the outcome-based payment models included in the study were implemented in the United States among public and private payers, such as CMS (e.g., Pioneer ACO Model), the State of Maryland (Maryland Hospital-Acquired Condition Program), and Blue Cross Blue Shield (Alternative Quality Contract). Two models included in the study were implemented in the United Kingdom, and one model was implemented in Korea. The authors classified the models into two categories based on the models' design features:

- Narrow outcome-based payment models, where financial incentives were based on quality indicators. This approach generally applies to single provider groups (e.g., hospitals, primary care practices) and focuses on specific clinical conditions (e.g., acute myocardial infarction).

- Broad outcome-based payment models, which used a comprehensive approach that combined global budgets, shared savings incentives, and financial incentives based on quality indicators. This approach generally applies to multidisciplinary provider organizations responsible for delivering a wide range of services to a patient population.

While over half (five out of nine) of the narrow models were associated with improved quality of care, the narrow models generally were associated with higher utilization and costs.[127] All three broad models in the study were associated with improved quality of care and lower utilization and costs. Positive impacts of broad outcome-based payment models on quality of care increased over time, while the impacts of narrow models generally were not sustainable.[128] Although there were limited studies focused on outcome-based payments in behavioral health care, one study found no improvement in

outcome indicators for substance use disorder.[129] Outcome-based payment models can have unintended consequences, such as encouraging providers to neglect non-measured aspects of care.[130]

Outcome-based holdback payments are commonly used in Medicare FFS, MA, and Medicaid managed care. Examples of how outcome-based holdback payments are used in APMs under Medicare FFS can be found in *Section V. Results From Related Alternative Payment Models (APMs)*.

***MA Plans*.** Although the MA quality bonus program does not use outcome-based holdback payments, the program rewards MA plans with higher Medicare payments for achieving a quality rating of 4 stars or higher on a 5-star scale. Star ratings are based on MA contracts' performance on approximately 40 measures (e.g., proportion of enrollees that received a specific cancer screening, annual flu vaccinations). CMS develops cut points for each measure to assign the measure a 1-to-5-star rating. The measures' ratings are then aggregated into an overall rating for the MA contract. In 2026, over two-thirds of MA enrollees (68 percent) are in MA plans that qualify for higher payments in the quality bonus program.[131] Federal spending for the quality bonus program will be approximately $13.4 billion in 2026.

One primary purpose of the quality bonus program is to encourage MA plans to improve quality. However, experts have expressed concerns with the program. First, experts have suggested that there are too many measures included in the program and that the measures do not appropriately account for social risk factors.[132] Second, the measures included in the program may not be adequate indicators of quality.[133] Star ratings are reported at the MA contract level rather than the MA plan level, and MA plans within a single contract can vary by benefits, costs, service areas, and enrollee populations.

***Medicaid Organizations*.** Medicaid managed care uses quality withholds, or risk arrangements where a state agency can hold a share of capitation payments from Medicaid managed care plans.[134] The plans can earn the withheld payments by meeting specific pre-defined performance targets. Although states vary in their approach, states generally withhold approximately 1 to 3 percent of total monthly or annual capitation payments as part of these quality withholds.[135] Plans are assessed using clinical metrics, behavioral health outcomes, or preventive care goals.

The purpose of quality withholds is to encourage Medicaid managed care plans to improve patient outcomes. States can design these withholds to focus on improving quality in specific Medicaid-covered services, such as certain behavioral health services.[136] For example, a state that wishes to decrease readmissions and ED visits for dually eligible individuals with mental health conditions could design a quality withhold that encourages Medicaid managed care plans to use outpatient services for enrollees with mental health conditions. Select Healthcare Effectiveness Data and Information Set (HEDIS) measures could be used to assess performance.[137]

The Medicare-Medicaid Plan (MMP) program was a CMS Financial Alignment Initiative capitated model demonstration designed to integrate Medicare and Medicaid coverage for dual-eligible beneficiaries, a population with complex medical, behavioral health, and long-term care needs. Demonstrations under the CMS Financial Alignment Initiative began in 2013. Nine states participated in the capitated model, with some demonstrations running through the end of 2025 if the state submitted plans to transition the MMP populations to integrated dual-eligible special needs plans (D-SNPs).[138,139] The overarching goal of the program was to enhance care coordination for dual-eligible beneficiaries by improving financial alignment between Medicare and Medicaid services through a three-way contract between CMS, a state, and a health plan, referred to as MMPs.[140] Each demonstration developed a person-

centered care delivery model that integrated medical, behavioral health, and long-term services and supports for dual-eligible beneficiaries.

Under the capitated program, participating plans received prospective capitation payments from CMS and the state to provide and coordinate covered services.[141] To promote accountability for outcomes under the CMS Financial Alignment Initiative, Medicare and the respective state Medicaid agency applied a prospective quality withhold methodology under which a portion of the plan's capitation payment was withheld up front and could be earned back if the plan achieved quality performance benchmarks. The quality withhold measures included a combination of core performance measures that were standard across all demonstrations, as well as state-determined measures that were applicable to the target population in each demonstration.[142] Generally, quality withhold amounts began at 1 percent of payment in the first year and increased over time. For each quality withhold measure, MMPs would earn a "met" or "not met" designation depending on their performance relative to the benchmark.[143] Quality withhold payment amounts were based on the percentage of measures with a "met" designation:

- 0 percent of the withhold would be paid if an MMP received a designation of "met" on 0 to 19 percent of the quality measures;
- 25 percent of the withhold would be paid if an MMP received a designation of "met" on 20 to 39 percent of the quality measures;
- 50 percent of the withhold would be paid if an MMP received a designation of "met" on 40 to 59 percent of the quality measures;
- 75 percent of the withhold would be paid if an MMP received a designation of "met" on 60 to 79 percent of the quality measures; and
- 100 percent of the withhold would be paid if an MMP received a designation of "met" on 80 to 100 percent of the quality measures.[144]

Each demonstration's impact on beneficiary experience, quality of care, utilization, and costs was evaluated separately.[145] Generally, beneficiaries reported improved care coordination and high-quality care. Participating states implemented new care coordination strategies, offered additional benefits, and increased access to social services.[146] Although the demonstrations had mixed impacts on utilization, the demonstrations generally reduced inpatient admissions, reduced long-term nursing facility placement, and increased physician E&M visits. The demonstrations had mixed and relatively small impacts on Medicare spending.

V. Results From Related Alternative Payment Models (APMs)

This section describes selected CMS APMs that have focused on or included behavioral health services or have used episode-based accountability approaches.

Medicare Alternative Payment Models (APMs) that Focus on or Included Behavioral Health Services

Innovation in Behavioral Health (IBH) Model (2025–2032). CMS' IBH Model is a state-based CMS Innovation Center model that aims to improve care for Medicaid, Medicare, and dually eligible beneficiaries with moderate to severe behavioral health conditions, including mental health conditions,

substance use disorders, or both. The model supports specialty behavioral health practices in delivering integrated, whole-person care that addresses behavioral health, physical health, and health-related social needs.[147] IBH tests separate but aligned Medicaid and Medicare payment approaches. Participating state Medicaid agencies receive cooperative agreement funding and are responsible for designing or adapting Medicaid payment approaches for IBH services during the pre-implementation period. Practice participants in selected states are eligible to participate in both the Medicaid and Medicare payment approaches.[148] On the Medicare side, participating practices may receive infrastructure funding, Integration Support Payments (ISP) paid on a per-beneficiary-per-month (PMPM) basis, and pay-for-reporting and pay-for-performance incentives calculated as a percentage of the ISP. The Medicare performance-based payment begins as pay-for-reporting and phases in performance-based accountability over time, including upside bonuses and later withholds tied to quality performance. Participating states' Medicaid payment approaches must align with the Medicare payment approach and include a performance-based payment component, including an upside bonus and a performance-based withhold, unless CMS approves another accountability feature for certain provider types.[149]

Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model (2026–2036). CMS' ACCESS Model is a 10-year voluntary model in Original Medicare that began on July 5, 2026.[150] The model tests OAPs for technology-supported chronic care across four clinical tracks, including a behavioral health track focused on depression and anxiety.[151,152] ACCESS participants receive fixed, predictable payments for managing beneficiaries' qualifying conditions over 12-month periods, with full payment contingent on achieving track-specific clinical outcome targets. In the behavioral health track, those targets are based on validated patient-reported outcome measures, including the PHQ-9 for depression and Generalized Anxiety Disorder Assessment-7 (GAD-7) for anxiety.[153] Payment amounts vary by clinical track and include a higher rate for initial care and clinical improvement and a lower rate for continued management or clinical maintenance. ACCESS participants may use technology-supported care services, such as lifestyle and behavioral support, therapy, patient education, medication management, and other supports that may be delivered in person, virtually, or asynchronously, to help beneficiaries meet outcome targets.[154,155] ACCESS is structured around longitudinal condition management rather than a discrete treatment episode.

Medicare APMs That Have Used Episode-Based Accountability Approaches

Across the episode-based payment models reviewed, CMS generally retained Medicare FFS claims submission and payment during the episode while using retrospective accountability mechanisms that linked payment to episode spending and quality performance. Providers typically continued to bill Medicare FFS during the episode, and CMS later assessed performance using target prices, spending benchmarks, reconciliation payments, performance-based payments, recoupments, and quality-adjusted financial incentives. Across these models, quality measures influenced payment, but accountability was generally implemented through retrospective reconciliation, performance-based payments, or recoupments rather than through an episode-level outcome holdback.

The specific accountability mechanisms varied across models. The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model, Comprehensive Care for Joint Replacement (CJR) Model, and Transforming Episode Accountability Model (TEAM) generally used target prices and quality-adjusted reconciliation payments or repayments. The Oncology Care Model (OCM) and Enhancing Oncology Model (EOM) similarly retained Medicare FFS billing during episodes but combined care

management payments (Monthly Enhanced Oncology Services) with retrospective performance-based payments or recoupments tied to episode spending and quality performance.

Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model (2018–2025). CMS' BPCI Advanced Model was a voluntary episode-based payment model that held hospitals and physician group practices financially accountable for the cost and quality of care during 90-day clinical episodes.[156] The model included 29 inpatient and 3 outpatient clinical episodes.[157] Participants continued to bill Medicare FFS during the episode; after the episode, CMS compared actual episode spending to a target price and incorporated quality performance in determining whether participants received a reconciliation payment or owed a repayment.[158,159] Evaluation findings indicate that the model achieved Medicare savings in Model Years 4 and 5 after earlier losses, largely through reductions in post-acute care use, without effects on readmission or mortality rates.[160] Evaluation reports suggest that participants used discharge planning, post-acute care management, data analytics, and coordination with primary care and post-acute providers as key care redesign strategies.[161] Beginning in Model Year 4, CMS changed the model to require participants to select broader clinical episode service line groups and modified the target-pricing methodology. Participation declined after these changes, suggesting that the broader accountability and revised pricing approach may have made the model less attractive to some participants; however, participants that remained were accountable for more episodes on average.[162]

Oncology Care Model (OCM) (2016–2022). CMS' OCM was a voluntary episode-based payment model for oncology practices treating Medicare FFS beneficiaries receiving chemotherapy.[163] The model centered on six-month episodes of care triggered by receipt of a qualifying cancer therapy. Participating practices continued to bill Medicare FFS during the episode and received Monthly Enhanced Oncology Services (MEOS) payments to support care management and coordination. CMS retrospectively assessed episode spending relative to a target price and determined performance-based payments or recoupments, adjusted based on quality performance.[164,165] Quality performance was incorporated through an Aggregate Quality Score translated into a performance multiplier and based on claims-based measures, patient-reported experience, and practice-reported measures submitted through the OCM Data Registry.[166,167] Evaluation findings indicate that OCM reduced average total episode payments, particularly in later performance periods and among higher-risk cancer types, but MEOS and performance-based payments offset those reductions, resulting in net losses to Medicare over the full model period.[168,169]

Enhancing Oncology Model (EOM) (2023–2030). CMS' EOM is a voluntary episode-based payment model for oncology practices treating Medicare FFS beneficiaries receiving systemic chemotherapy for seven cancer types.[170] The model began on July 1, 2023, and builds on OCM by focusing on cancer types where prior model experience suggested opportunities for savings, requiring electronic patient-reported outcomes, and encouraging shared decision-making.[171] EOM participants are accountable for the total cost and quality of six-month oncology episodes while continuing to bill Medicare FFS during the episode. Medicare retrospectively compares episode spending to benchmarks and determines whether participants receive performance-based payments or owe recoupments, based on spending and quality performance.[172,173] Participants may receive MEOS payments to support enhanced services such as patient navigation, care planning, 24/7 access to clinicians, and care coordination.[174,175] Early evaluation findings from the first performance period suggest reductions in total episode payments, driven largely by lower Part B systemic therapy drug spending; however, after accounting for MEOS and performance-based payments, the model likely resulted in a net loss to Medicare in its first six months.[176]

Comprehensive Care for Joint Replacement (CJR) Model (2016–2024). CMS' CJR Model was a mandatory episode-based payment model for acute care hospitals in selected geographic areas that held hospitals financially accountable for the cost and quality of lower extremity joint replacement episodes.[177] Episodes included the anchor hospitalization or outpatient procedure and related Medicare Part A and Part B services during the 90 days after discharge.[178,179] Participant hospitals continued to be paid under existing Medicare FFS payment systems during the episode, while CMS retrospectively compared actual episode spending to a target price and determined whether hospitals received reconciliation payments or owed repayments, with amounts adjusted based on quality performance.[180,181] CMS extended and modified CJR for Performance Years 6–8, reflecting continued use of the model and changes to episode definitions, target pricing, and reconciliation policy.[182,183] Evaluation findings indicate that the CJR Model produced Medicare savings while maintaining quality; Performance Years 6 and 7 generated an estimated $112.7 million in net Medicare savings, largely driven by reductions in post-acute care spending, particularly inpatient rehabilitation facility use.[184] Safety-net hospitals were more likely than non-safety-net hospitals to owe repayments under the model.[185] CMS subsequently launched Comprehensive Care for Joint Replacement Expanded (CJR-X), which continues the model's mandatory episode-based payment approach for lower extremity joint replacement while incorporating additional policy and operational refinements.[186]

Transforming Episode Accountability Model (TEAM) (2026–2030). CMS' TEAM is a five-year, mandatory episode-based payment model for selected acute care hospitals in Original Medicare.[187] The model holds hospitals accountable for the cost and quality of care for five high-expenditure, high-volume surgical episode categories.[188,189] Episodes begin with the anchor surgery or procedure and extend through 30 days after hospital discharge.[190,191] TEAM participants continue to bill Medicare FFS, while CMS retrospectively compares episode spending to target prices and determines whether the hospital receives a reconciliation payment or owes a repayment, with the amount adjusted based on quality performance and participation track.[192,193] TEAM includes graduated risk tracks, including a no-downside-risk track for the first year for all participants and longer transition periods for some safety-net hospitals.[194,195] TEAM continues CMS' use of mandatory episode-based accountability, target pricing, quality adjustment, and reconciliation for defined surgical episodes. [196,197]

Medicare Shared Savings Program (2012–Present). CMS' Medicare Shared Savings Program, one of the largest value-based payment programs in the United States, is a permanent Medicare ACO program that promotes accountability for an assigned Medicare FFS beneficiary population, care coordination, and investment in infrastructure and redesigned care processes.[198] Although the program does not use any form of episode-based payment, it uses quality-gated shared savings. ACOs may participate under the BASIC track, which includes a glide path from one-sided shared savings to increasing levels of two-sided risk, or the ENHANCED track, which offers the highest level of risk and potential reward.[199] CMS compares an ACO's Medicare Parts A and B FFS expenditures for its assigned beneficiary population to an updated benchmark to determine whether the ACO is eligible to receive shared savings or responsible for shared losses.[200] ACOs must also meet quality reporting and performance requirements; the quality performance standard is used to determine eligibility for shared savings at the maximum rate available under the ACO's track and, for ENHANCED track ACOs, to avoid maximum shared losses.[201]

Appendix A. Research Questions

The environmental scan involved a targeted search of information from existing peer-reviewed and non-peer-reviewed publications to address the research questions provided in Table A.1. Sources reviewed included major medical and health services research journals, grey literature, and websites of professional associations/societies and CMS that include relevant evaluation reports and program documentation.

Table A.1. Research Questions

Research Questions
Problems in Care Delivery and Payment Related to Behavioral Health Services
1. What quality/performance measures have been used to assess patient outcomes associated with major depressive disorder? 2. What are existing care delivery and payment challenges in behavioral health services?
Medicare Payment Policy Related to Behavioral Health Services
3. What are current reimbursement approaches and payment issues for behavioral health care services? 4. What challenges do providers face with current claims adjudication practices in behavioral health care? 5. What billing, coding, and documentation complexities contribute to claim denials and delayed payments for behavioral health care services? 6. What are FHIR resources? How do health care organizations implement this technology? 7. How have other payers (e.g., Medicare Advantage plans and Medicaid managed care) used episode-based payments and outcome-based holdback payment structures to reimburse for behavioral health services?
Results From Related Alternative Payment Models (APMs)
8. What existing Alternative Payment Models (APMs) have focused on or included behavioral health services? 9. What existing APMs have used episode-based prospective payment and/or outcome-based holdback payment structures? What has been learned from the implementation and evaluation of these models?

Appendix B. Annotated Bibliography

Bishop TF, Press MJ, Keyhani S, Pincus HA. Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA Psychiatry*. 2014;71(2):176-81. doi:10.1001/jamapsychiatry.2013.2862

Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To understand differences in acceptance of insurance by psychiatrists and physicians of other specialties.
Main Findings: The share of psychiatrists who accepted private fee-for-service (FFS) insurance, Medicare, and Medicaid was lower than physicians of other specialties. This low rate of acceptance among psychiatrists may be associated with barriers to accessing mental health services.
Strengths/Limitations: The survey did not ask physicians why they did not accept insurance nor did it collect information on insurance acceptance from physicians practicing in hospital outpatient departments.
Generalizability to the Medicare Population: Strong; this study focused specifically on physicians' insurance acceptance rates for patients with Medicare.
Methods: Data from the National Ambulatory Medical Care Survey (NAMCS), a nationally representative survey of office-based physicians, were used to assess physicians' insurance acceptance rates of new patients with private FFS insurance, Medicare, or Medicaid.

Carlo AD, Basu A, Unützer J, Jordan N. Acceptance of insurance by psychiatrists and other physicians, 2007-2016. *Psychiatr Serv*. 2024;75(1):25-31. doi:10.1176/appi.ps.202100669

Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To understand differences in insurance acceptance rates by psychiatrists and non-psychiatrist physicians.
Main Findings: Non-psychiatrist physicians participated in all insurance networks to a greater extent than psychiatrists. The acceptance gap was greater for public (Medicare, Medicaid) than private (non-capitated private, capitated private) insurance.
Strengths/Limitations: The survey did not ask why physicians did or did not accept insurance nor did it sample physicians practicing in hospitals, federal medical facilities, or community health centers.
Generalizability to the Medicare Population: Strong; this study focused specifically on physicians' insurance acceptance rates for patients with Medicare.
Methods: Data from the NAMCS, a nationally representative survey of office-based physicians, were used to compare insurance acceptance rates among psychiatrists with non-psychiatrist physicians.

Department of Consumer and Business Services. Report on Behavioral Health Parity: As required by House Bill 3046 (2021). September 15, 2023. https://dfr.oregon.gov/business/reg/health/Documents/mental-health-parity/20230915-mental-health-parity-report.pdf

Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Report
Objective: To assess parity between behavioral health/substance use disorder services and medical/surgical services among commercial insurers in Oregon.

Main Findings: There were 4.1 medical/surgical claims for every one behavioral health claim, indicating higher utilization of medical/surgical services compared with behavioral health services. Although the majority of both types of claims were paid to in-network providers, behavioral health claims had a greater share of claims paid to out-of-network providers compared with medical/surgical claims. In 2022, 6.59 percent of behavioral health claims were partially or fully denied, while 12.53 percent of medical/surgical claims were denied.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; although this report was focused on commercial payers, issues with parity between behavioral health and medical/surgical services may be applicable to the Medicare population.
Methods: Data from multiple sources were considered in the analysis, including insurers' self-reported data, consumer complaints, and feedback from providers.

Department of Consumer and Business Services. Report on Behavioral Health Parity: As required by ORS 743B.427. September 15, 2025. https://dfr.oregon.gov/business/reg/health/Documents/mental-health-parity/20250915-behavioral-health-parity-report.pdf

Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Report
Objective: To assess parity between behavioral health/substance use disorder services and medical/surgical services among commercial insurers in Oregon.
Main Findings: Most commercial insurers demonstrated behavioral health parity compliance in their written policy documentation; however, many insurers could not provide sufficient operational evidence showing that behavioral health/substance use disorder services were managed in the same way as medical/surgical services. Behavioral health prior authorization requests were denied more frequently than medical/surgical requests (10.2 percent versus 6.9 percent in 2023), highlighting the need for stronger oversight.
Strengths/Limitations: The methods used in the report were influenced by statutory changes where quantitative reporting requirements had expired before the analysis was conducted. As a result, insurers were not required to report certain quantitative data, such as the number of denials and appeals for behavioral health/substance use disorder and medical/surgical services.
Generalizability to the Medicare Population: Moderate; although this report was focused on commercial payers, issues with parity between behavioral health/substance use disorder and medical/surgical services may be applicable to the Medicare population.
Methods: Insurers were asked to describe their policies and procedures for applying nonquantitative treatment limitations (NQTLs) to behavioral health/substance use disorder and medical/surgical services.

Figueroa JF, Phelan J, Orav EJ, Patel V, Jha AK. Association of mental health disorders with health care spending in the Medicare population. *JAMA Network Open*. 2020;3(3):e201210. doi:10.1001/jamanetworkopen.2020.1210

Subtopic: Problems in Care Delivery and Payment Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To understand health care spending associated with mental health disorders.
Main Findings: Substantial differences in spending were found among patients with a diagnosis of a serious mental illness (SMI) or common mental health disorder compared with patients who had no known mental illness. Medicare patients with mental health conditions accounted for 4.2 percent of total health care spending, while an additional 8.5 percent of total Medicare

spending was found to occur due to non-mental health conditions. Results suggested that those with mental health conditions are spending more on total health care than currently estimated.
Strengths/Limitations: The use of administrative claims data limited the authors' ability to determine whether any specific diseases were in remission, potentially biasing the results.
Generalizability to the Medicare Population: Strong; this study focused on the Medicare population.
Methods: The study assessed differences in patient characteristics across three groups: patients with SMI, patients with common mental health disorders, and patients with no known mental illness. Multivariable linear regression models were used to adjust for patient characteristics, examine total spending, and understand the differences in health care utilization.

Gautam M, Tripathi A, Deshmukh D, Gaur M. Cognitive Behavioral Therapy for depression. *Indian J Psychiatry*. 2020;62(Suppl 2):S223-S229. Doi:10.4103/psychiatry.IndianJPsychiatry_772_19

Subtopic: Problems in Care Delivery and Payment Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To describe the protocols for treating depression with Cognitive Behavioral Therapy (CBT).
Main Findings: This article provided a description and guidelines for CBT.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; guidelines for CBT can be used for the Medicare population.
Methods: N/A

Green JG, McLaughlin KA, Fillbrunn M, Fukuda M, Jackson JS, Kessler RC, et al. Barriers to mental health service use and predictors of treatment drop out: racial/ethnic variation in a population-based study. *Adm Policy Ment Health*. 2020;47(4):606-16. doi:10.1007/s10488-020-01021-6

Subtopic: Problems in Care Delivery and Payment Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To examine racial and ethnic differences in barriers to accessing mental health treatment and reasons for treatment dropout among adults with mental health disorders.
Main Findings: The authors found three key findings. First, the most common reason for not receiving treatment was no/low perceived need. This reason was significantly more common among Asian and Latino individuals compared with Black and white individuals. Second, attitudinal barriers were less likely to be reported by Asian and Latino individual. Third, structural barriers were associated with sociodemographic factors that varied by race and ethnicity.
Strengths/Limitations: Due to the retrospective nature of the surveys, respondents' reported treatment barriers and reasons for dropout could be vulnerable to recall bias.
Generalizability to the Medicare Population: Moderate; barriers for treatment and reasons for dropout may be broadly applicable to the Medicare population due to the inclusion of adults ages 60 and older in the study.
Methods: The authors used a pooled sample generated from three surveys. Multivariate logistic regression models were used to examine the association between race/ethnicity, sociodemographic, and county covariates with barriers to treatment.

Many Medicare Advantage and Medicaid Managed Care Plans Have Limited Behavioral Health Provider Networks and Inactive Providers. Office of Inspector General. OEI-02-23-00540. October 2025. https://oig.hhs.gov/documents/evaluation/11233/OEI-02-23-00540.pdf

Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Data Brief
Objective: To examine the extent to which Medicare Advantage (MA) and Medicaid managed care plan networks were limited and whether network directories accurately reflected which providers were actively providing services to the plan's enrollees.
Main Findings: MA and Medicaid managed care plans had limited networks of behavioral health providers. Network directories included inactive providers who were not providing services to enrollees. For example, directories would list providers who no longer worked at the location listed by the plan. Administrative burden and low payment rates impacted providers' willingness to work with managed care plans.
Strengths/Limitations: One strength of the analysis is that MA and Medicaid managed care plans were selected from a diverse group of both urban and rural counties from multiple states across the United States.
Generalizability to the Medicare Population: Strong; this data brief focuses on access to behavioral health care among enrollees of MA and Medicaid managed care plans.
Methods: The analysis included a review of provider network lists, data on behavioral health workforce, MA and Medicaid encounter data, and a survey of inactive providers.

Marcotte LM, Reddy A, Zhou L, Razliff A, Unützer J, Chang D, et al. Provision of Collaborative Care Model and general Behavioral Health Integration services in Medicare. *Psychiatr Serv*. 2021 Jul 1;72(7):822-825. doi:10.1176/appi.ps.202000265

Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To assess clinicians' use of the collaborative care model (CoCM) and general behavioral health integration (BHI) billing codes.
Main Findings: Although uptake of the billing codes remained low, there was an increase in the use of CoCM and BHI billing codes from 2017 to 2018. In 2017, 10,294 CoCM and BHI services were delivered (totaling $626,292 in payments). In 2018, 81,433 CoCM and BHI services were delivered (totaling $7,442,985 in payments). Approximately 5 percent of the services were denied in 2017, while 32 percent were denied in 2018.
Strengths/Limitations: The analysis was unable to identify reasons for claims denials.
Generalizability to the Medicare Population: Strong; the analysis focused on Medicare beneficiaries receiving CoCM and general BHI services.
Methods: Medicare claims data from 2017 and 2018 were analyzed to identify the number of CoCM and general BHI services delivered by clinicians across the United States.

Medicare: Voluntary and mandatory episode-based payment models and their participants. United States Government Accountability Office. GAO-19-156. December 2018. https://www.gao.gov/assets/gao-19-156.pdf

Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Report
Objective: To describe episode-based payment models and their participants and assess the advantages of voluntary versus mandatory models.
Main Findings: Voluntary payment models generally benefit providers as they have more favorable terms. Mandatory models generally benefit CMS and evaluation contractors because they provide more generalizable evaluation results. Voluntary payment models also enable CMS and evaluation contractors to test novel care redesign concepts, whereas mandatory models can encourage providers to transition to value-based care models, especially for those who

might be more reluctant to do so on their own. The choice to implement a voluntary model versus mandatory model may depend on CMS' needs.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Strong; this report explicitly reviewed CMS episode-based payment models.
Methods: The report included a review of current payment model data and reports supplemented by stakeholder interviews with participants, experts, and provider groups.

Medicare could have saved $301.5 million if bundled payment rates for opioid use disorder treatment services had reflected services provided to enrollees. Office of Inspector General. A-09-23-03002. October 2025. https://oig.hhs.gov/documents/audit/11237/A-09-23-03002.pdf
Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Report
Objective: To compare bundled payments for opioid use disorder (OUD) treatment with individual OUD treatment services and determine whether OUD treatment services provided to Medicare enrollees complied with certain Medicare requirements.
Main Findings: In general, bundled payments were found to be higher than the Office of Inspector General (OIG)-calculated payment amounts for individual treatment services provided. The audit found that 10 percent of bundled payments for episodes of care had no associated treatment plans or had a treatment plan that did not comply with certain Medicare requirements.
Strengths/Limitations: Data reliability assessments were performed to identify missing data and duplicate values in the Centers for Medicare & Medicaid Services (CMS) Integrated Data Repository.
Generalizability to the Medicare Population: Strong; the audit focused on Medicare enrollees.
Methods: The study included a random sampling review of Medicare Part B claim lines associated with different opioid treatment plans (OTP) and a questionnaire fielded to OTPs to understand their service protocol. Bundled payment amounts were compared to an OIG-calculated payment amount to determine the differences between the types and frequency of OUD treatment services.

Niles L, Olin S. Behavioral Health Quality Framework: a roadmap for using measurement to promote joint accountability and whole-person care. The National Committee for Quality Assurance. May 2021. https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2021/07/20210701_Behavioral_Health_Quality_Framework_NCQA_White_Paper.pdf
Subtopic: Problems in Care Delivery and Payment Related to Behavioral Health Services
Type of Source: White Paper
Objective: To develop a behavioral health quality measurement framework that will guide and hold entities accountable for improving care access and outcomes for individuals with behavioral health conditions.
Main Findings: There is an overall lack of standardized quality measures used in federal programs focused on behavioral health. The delivery system for behavioral health is complex and fragmented, which leads to burdensome reporting efforts and inadequate funding. Behavioral health integration is needed to improve quality and address access and stigma, but it is inconsistently measured, and there is a lack of leadership for implementation.
Strengths/Limitations: N/A

Generalizability to the Medicare Population: Strong; programs reviewed in the white paper were identified as Federal Reporting Programs, which are national in scope and include standardized reporting requirements.
Methods: This study used a mixed-methods approach that included an environmental scan and key stakeholder interviews to evaluate the current behavioral health measurement landscape and the needs and challenges in the current system.

Olfson M, Mojtabai R, Sampson NA, Hwang I, Druss B, Wang PS, et al. Dropout from outpatient mental health care in the United States. *Psychiatr Serv*. 2009;60(7):898-907. doi:10.1176/ps.2009.60.7.898

Subtopic: Problems in Care Delivery and Payment Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To examine patterns and possible predictors of mental health treatment dropout among American adults.
Main Findings: Treatment in the mental health specialty sector was found to be associated with significantly reduced odds of dropout as compared with other sectors, such as the general medical sector. Those who dropped out of treatment after the first or second visit were significantly associated with psychiatric comorbidity, care in only one sector, treatment in the general medical sector, and complementary-alternative medicine. Those who dropped out after the third or later visit were associated with specific sociodemographic characteristics.
Strengths/Limitations: Results are vulnerable to recall bias as the study was conducted as a retrospective, self-report assessment.
Generalizability to the Medicare Population: Moderate; the study used a nationally representative sample of U.S. adults and may be generalizable to the Medicare population.
Methods: Data from the National Comorbidity Survey Replication were analyzed using cross-tabulation and discrete-time analysis to identify predictors of mental health treatment dropout.

Pelech D, Hayford T. Medicare Advantage and commercial prices for mental health services. *Health Affairs*. 2019;38(2):262-7. https://doi.org/10.1377/hlthaff.2018.05226

Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To identify differences in the amounts Medicare FFS, MA plans, and commercial plans pay providers for medical services and mental health services.
Main Findings: Medicare FFS generally pays providers more than MA plans and commercial plans for in-network mental health services. However, Medicare FFS pays providers less than commercial insurers for out-of-network mental health services. Patients go out-of-network more frequently for mental health services than for non-mental health services.
Strengths/Limitations: The analysis used data from 2014 instead of the most recently available data. Additionally, because the analysis used claims data, additional payments to physicians (e.g., insurers' quality bonuses) were not accounted for.
Generalizability to the Medicare Population: Strong; the study is focused on payments in Medicare FFS, MA plans, and commercial plans.
Methods: The study used 2014 claims data from the Health Care Cost Institute to examine commonly billed mental health services provided by behavioral health providers. The total service prices were compared with estimated Medicare FFS prices. Payments were compared for psychotherapy services, evaluation and management services delivered by mental health providers, and evaluation and management services delivered by any non-mental health physician specialty.

Reist C, Petiwala I, Latimer J, Raffaelli SB, Chiang M, Eisenberg D, et al. Collaborative mental health care: a narrative review. *Medicine*. 2022;101(52):e32554. http://dx.doi.org/10.1097/MD.0000000000032554

Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To summarize existing literature on the CoCM.
Main Findings: Previous research has shown that CoCM improves access to behavioral health care in primary care settings and may be more cost-effective than current standards of care for treating behavioral health conditions. CoCM can be adapted to specific patient populations (e.g., older adults, students, individuals with substance use disorder, women with perinatal depression).
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; although this narrative review did not focus specifically on the use of CoCM services in the Medicare population, findings are applicable to the Medicare population.
Methods: This narrative review synthesized existing literature on CoCM.

Sporinova B, Manns B, Tonelli M, Hemmelgarn B, MacMaster F, Mitchell N, et al. Association of mental health disorders with health care utilization and costs among adults with chronic disease. *JAMA Netw Open*. 2019;2(8):e199910. doi:10.1001/jamanetworkopen.2019.9910

Subtopic: Problems in Care Delivery and Payment Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To understand the association between mental health disorders and cost of care for Canadian adults 18 years or older with other chronic diseases.
Main Findings: Presence of a mental health disorder was associated with higher rates of hospitalization and emergency department visits. Higher costs were associated with age, male sex, low income, and an increasing number of comorbidities. Depression was associated with lower costs compared with other mental health disorders, but the higher prevalence of depression in the population made its impact on costs and utilization larger.
Strengths/Limitations: Using administrative data, the authors were unable to control for variables such as severity of disease.
Generalizability to the Medicare Population: Moderate; although the population of focus in this study was Canadians, the impact was measured on a public system and may be generalizable to the Medicare population.
Methods: The analysis was conducted on data from the Interdisciplinary Chronic Disease Collaboration Data Repository. Multivariable linear regression was used to predict total costs while controlling for sociodemographic characteristics.

Turner A, Miller G, Clark S. IMPACTS OF PRIOR AUTHORIZATION ON HEALTH CARE COSTS AND QUALITY. Altarum. November 2019.

Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Brief
Objective: To review the current state of evidence on the costs and benefits of prior authorization policies in health care.
Main Findings: Prior authorization can reduce utilization of targeted treatments but may not always translate to lower overall health spending. Burdens of prior authorization were found to include impacts on provider time and operating costs, as well as delays in care, frustration from providers and patients, and poor outcomes for patients who received delayed care or no care at all. Recommendations for improving prior authorization programs include reducing the number

of health care professionals subject to the requirements and regularly reviewing and updating prior authorization policies.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; prior authorization is regularly used in Medicare Advantage.
Methods: This brief included a systematic review of peer-reviewed and grey literature supplemented by interviews with experts in the insurance and pharmaceutical industry.

Vlaanderen FP, Tanke MA, Bloem BR, Faber MJ, Eijkenaar F, Schut FT, et al. Design and effects of outcome-based payment models in healthcare: a systematic review. *Eur J Health Econ*. 2019 Mar;20(2):217-232. doi:10.1007/s10198-018-0989-8
Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To review the evidence on pay-for-performance (P4P) models and determine their effects on quality of care, health care utilization, and health care costs.
Main Findings: Outcome-based payment models (OBPMs) generally showed larger improvements in process indicators than outcome indicators. Broader OBPMs (those with a combination of global budgets, risk sharing, and financial incentives based on quality measures) showed increasing improvements on quality indicators over time, while narrower OBPMs (those with only financial incentives based on quality indicators) showed improvements but effects were not sustained over time. Cost savings in broad OBPMs tended to increase over time.
Strengths/Limitations: This review was among the most comprehensive systematic reviews of OBPMs to date and used multiple data sources.
Generalizability to the Medicare Population: Moderate; the review included OBPMs where CMS was the health care purchaser.
Methods: The systematic review of the literature examined the effects of P4P models based on a definition of OBPMs developed for the study. Sources were pulled from scientific literature databases, websites of relevant governmental and scientific agencies, reference lists of included articles, and experts in the field.

Walker C, Little V, Lyons J. Collaborative care treatment for major depressive disorder. *Frontiers in Psychiatry*. 2026;17:1798572. doi:10.3389/fpsyt.2026.1798572
Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To assess whether the CoCM effectively treats individuals with moderate and severe major depressive disorder (MDD).
Main Findings: CoCM may be effective in treating patients with moderate and severe MDD. However, patients with severe MDD had a lower treatment response compared with patients with moderate MDD. Treatment response and remission varied by patient complexity and insurance type.
Strengths/Limitations: The study was conducted within a single behavioral health medical group that integrates mental health services into primary care settings; therefore, findings may have limited generalizability to other settings.
Generalizability to the Medicare Population: Strong; the analysis included patients with Medicare, Medicare Advantage, Medicaid, and commercial insurance.
Methods: The study analyzed 2018 to 2025 data from a single behavioral health medical group. Effect sizes for change in depression scores between baseline and final screener were assessed. Logistic regression was used to identify factors associated with treatment response and remission.

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