Episode Intelligence Authorization and Payment (EIA) Compensation Model Environmental Scan

September 10, 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*. This proposal was submitted by Joanne Bayouk, MBA, MSN, RN, PMHNP-c, and was determined to have met the administrative requirements for a PFPM on July 22, 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 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.

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), serious mental illness (SMI), and opioid use disorder (OUD) are among the most significant behavioral health conditions in the United States. These conditions impact individuals' daily lives and contribute 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, Serious Mental Illness, and Opioid Use Disorder in the Medicare Population

This section first provides an overview of MDD, SMI, and OUD, including their 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]

Serious Mental Illness. SMI is a mental, behavioral, or emotional disorder that substantially interferes with an individual's life and ability to function.[20] The definition of SMI comprises multiple mental health conditions and commonly includes MDD, schizophrenia, and bipolar disorder.[21,22] As a result, MDD, schizophrenia, and bipolar disorder are included in the definition of SMI in this environmental scan; however, the proposed payment model submitted by Joanne Bayouk defined SMI as only schizophrenia and bipolar disorder.

Schizophrenia is a mental illness that interferes with an individual's ability to manage their emotions, think clearly, make decisions, and relate to others.[23] The annual prevalence of schizophrenia among U.S. adults is less than 1 percent.[24] Symptoms include hallucinations, delusions, disorganized speech or thinking, disorganized or catatonic behavior, reduced emotional expression, and a lack of interest or motivation.[25] To be diagnosed with schizophrenia, an individual must have two or more symptoms, and each symptom must be present for a substantial period of time within a one-month period coupled with signs of limited functioning in daily life for at least six months. Many individuals with schizophrenia also

experience cognitive difficulties, such as challenges with attention or memory, but these symptoms are not among the core diagnostic criteria.

A large proportion of U.S. adults with SMI receive treatment (approximately 70.8 percent of adults in 2024).[26] Treatment for schizophrenia can include psychotherapy (e.g., CBT, supportive psychotherapy, cognitive enhancement therapy), medication (e.g., antipsychotic medications such as clozapine and long-acting injectables), psychosocial interventions (e.g., assertive community treatment, peer support groups, individual placement and support), and physical health management (e.g., meditations, nutrition interventions).[27] Often, treatment for schizophrenia requires collaboration among multiple providers, such as psychiatrists, therapists, peer specialists, and primary care providers.[28] Schizophrenia is often considered a complex, long-term illness.[29]

Bipolar disorder is a mental illness that causes shifts in an individual's mood, energy, and ability to think clearly.[30] The annual prevalence of bipolar disorder among U.S. adults is 2.8 percent.[31] People with bipolar disorder may experience states of mania or depression and can have extended periods (e.g., years) with no symptoms. Severe cases of bipolar disorder can include psychotic symptoms (e.g., hallucinations, delusions).[32] To be diagnosed with bipolar disorder, an individual must have experienced at least one episode of mania or hypomania (a milder form of mania without psychotic episodes).[33]

Treatment for bipolar disorder can include psychotherapy (e.g., CBT, family-focused therapy), medications (e.g., lithium, anticonvulsants, second-generation antipsychotics, antidepressants), self-management strategies (e.g., education to recognize an episode's early symptoms), and complementary approaches (e.g., exercise, meditation).[34]

Among 4.4 million Medicare fee-for-service (FFS) beneficiaries in 2015, 22.7 percent (987,379) had an SMI diagnosis (defined as bipolar disorder, schizophrenia or related psychotic disorders, or MDD).[35] Compared with Medicare beneficiaries with no known mental illness, Medicare beneficiaries with SMI tend to be younger, female, Black or Hispanic, and have dual eligibility.[36]

Patients with SMI tend to have greater utilization of health care services relative to patients without a known mental health condition. Relative to Medicare beneficiaries with no known mental illness, those with SMI had more hospitalizations in general acute care hospitals, days in the hospital, inpatient rehabilitation days, ED visits, observation stays, nursing care facility days, and home health service days. Additionally, beneficiaries with SMI were prescribed more unique drugs compared with beneficiaries with no known mental illness.[37]

Opioid Use Disorder. Prescription opioids are typically used to treat pain. OUD is a chronic illness involving a pattern of opioid use that causes problems or distress.[38] To be diagnosed with opioid use disorder, an individual must experience at least two of the following symptoms during a one-year period: taking the drug in a larger amount or over a longer period than intended; having a desire to reduce opioid use; spending a substantial amount of time obtaining, using, or recovering from the drug; having a strong desire to use the drug; experiencing problems fulfilling responsibilities in daily life; experiencing continued drug use despite recurring social or interpersonal problems; limiting activities because of drug use; using the drug in physically dangerous situations; continuing to use the drug despite physical or psychological problems that are likely caused or exacerbated by the drug; developing a tolerance to the drug; and experiencing withdrawal from the drug.[39]

The majority of drug overdose-related deaths in the United States are associated with opioid use. In 2022, 81,000 of 110,000 drug overdose-related deaths in the United States were from either

prescription or illicit opioids.[40] In 2023, 8.6 million Americans reported misusing prescription opioids.[41] In 2020, over one million Medicare beneficiaries had a diagnosis of OUD.[42] Among Medicare FFS beneficiaries aged 65 and older, those with OUD but not taking a medication for OUD were more likely to be female and dually eligible relative to those without OUD.[43] People with OUD are at increased risk of developing depression and anxiety, infectious diseases (from injection opioid use), liver disease, cardiovascular conditions (e.g., myocardial infarction, cardiac arrhythmia, stroke, cardiac arrest), bone fractures, and osteoporosis.[44]

Growth in the treatment of substance use disorders among Medicare FFS beneficiaries is largely driven by OUDs.[45] Treatment for OUD is considered highly effective, potentially reducing the use of illicit opioids by 90 percent.[46] However, few people in need of OUD treatment receive treatment. Treatment for OUD can include counseling and behavioral therapies (e.g., motivational interviewing, education about treatment and relapse prevention, peer support) and medications for OUD (e.g., methadone, buprenorphine, naloxone).[47] Depending on the level of treatment needed, individuals may receive treatment in outpatient clinics, intensive outpatient treatment, inpatient treatment, or long-term therapeutic communities.[48] Medicare covers buprenorphine, methadone, and naltrexone to help stop or reduce the use of opioids, and nalmefene and naloxone to help reverse the effects of opioid overdose.[49] However, less than 16 percent of Medicare beneficiaries diagnosed with OUD received medication to treat the disorder through Medicare, and less than half of beneficiaries who received medication to treat the disorder also received behavioral therapy.[50]

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.[51] 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.[52]

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.[53] Approximately 3.1 million Medicare 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.[54] The analysis showed similar use of behavioral health services among Medicare FFS and Medicare Advantage (MA) beneficiaries in 2019.[55] Between 2016 to 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.[56] 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).[57] Over 70 percent of all dropouts occurred following the first or second visit.[58] 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.[59] 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 psychiatric comorbidity (i.e., two or more classes of psychiatric disorders) were at increased risk of dropping out after the third visit.[60] 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.[61]

Medicare Spending on Behavioral Health Conditions. In 2015, approximately 12.7 percent of total Medicare spending was associated with mental health disorders.[62] 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.[63] The analysis showed that treatment for depression accounted for the largest share of Part B behavioral health spending (31 percent) in 2021. Beneficiaries with schizophrenia spectrum disorders accounted for 14 percent of Part B behavioral health spending, while beneficiaries with bipolar disorder accounted for 9 percent of Part B behavioral health spending, and beneficiaries with substance use disorders accounted for 12 percent of Part B behavioral health spending.[64] 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).[65]

Patients with mental illness tend to have greater mental and medical health care spending compared with those who do not have mental illness. Medicare beneficiaries with bipolar disorder or schizophrenia tend to have greater mean total Medicare spending on mental health services ($22,025) compared with beneficiaries with MDD only ($18,535).[66]

Although Medicare covers different OUD treatments, Medicare coverage excludes some settings and provider types for substance use disorders (SUDs), such as intensive outpatient clinics and residential treatment programs. Evidence suggests that expanding Medicare coverage of levels of care needed by those with OUD could not only increase access to treatment but also reduce cost associated with untreated OUD, ultimately resulting in Medicare cost savings.[67] Among beneficiaries aged 65 years or older, those diagnosed with OUD but not taking a medication for OUD had an average Medicare spending of $3,320 per-beneficiary-per-month (PBPM)—approximately $1,565 PBPM higher than those without OUD ($1,755 PBPM). Additionally, among beneficiaries aged 65 years or older, those with OUD

and taking medications for OUD had an average Medicare spending of $2,109 PBPM—approximately $1,211 PBPM less than those with OUD and not taking medications for OUD.[68]

Quality/Performance Measures Used to Assess Patient Outcomes Associated with MDD, SMI, and OUD

This section provides a summary of quality/performance measures used to assess quality of care and patient outcomes associated with MDD, SMI, and OUD. 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.[69] 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.[70]

Major Depressive Disorder. 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, depression remission at 12 months, and reduction in suicidal ideation or behavior symptoms.[71]

One component of the Centers for Medicare & Medicaid Services' (CMS') Behavioral Health Strategy—a comprehensive CMS strategy for promoting high-value behavioral health care[i]—includes increasing screening for high-impact conditions, including depression.[72,73] Annual depression screenings are fully covered by Medicare Part B; however, only 6 percent of Medicare beneficiaries used this benefit in 2018.[74]

One commonly used 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 doing activities, poor appetite or overeating).[75,76,77] 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.

[i] The CMS Behavioral Health Strategy aims to improve access to high-value behavioral health care by promoting early prevention, person-centered care, and the integration of physical and behavioral health services. The strategy focuses on mental health and wellness; substance use disorders prevention, treatment, and recovery; pain treatment and management; care delivery improvements; and the needs of special populations (e.g., older adults and long-term care residents, persons living in rural areas) through the promotion of evidence-based practices, technology, workforce expansion, and stronger coordination and engagement among providers, communities, states, and federal partners.

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)*.

Serious Mental Illness. Medicare quality measures for SMI focus on medication adherence, symptom improvement, and physical health. Examples of measures include adherence to antipsychotic medications for individuals with schizophrenia, diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications, and hemoglobin A1C poor control.[78,79] There are also follow-up measures commonly used for this population, including follow-up after hospitalization for mental illness (FUH) and follow-up after ED visit for mental illness (FUM).[80]

Opioid Use Disorder. Medicare quality measures for OUD emphasize access to evidence-based treatments and continuity of care. For example, measures include initiation and engagement of substance use disorder treatment, continuity of pharmacotherapy for OUD, improvement or maintenance of functioning for individuals with a mental and/or substance use disorder, reduction in suicidal ideation or behavior symptoms, and follow-up after an ED visit for substance use (FUA).[81,82]

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; SMI; and tobacco, alcohol, and other use.[83,84] 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.[85]

CMS' Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) are an alternative way for providers to meet MIPS reporting requirements.[86] 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.[87]

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 prior authorization and claims adjudication practices, challenges with adopting and implementing electronic health record (EHR) systems that are capable of generating Fast Healthcare Interoperability Resources (FHIR)-based prior authorization requests, 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.

Medicare Fee-For-Service. Medicare FFS provides health insurance to 20 percent of the U.S. population.[88] 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.[89] 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).[90] 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.

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 OUD treatment services.[91] 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.[92] 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.

Medicare Advantage. MA covers over half of eligible Medicare beneficiaries.[93] CMS typically pays MA plans a capitated, risk-adjusted monthly payment per enrollee to provide Medicare-covered services, including mental health and substance use disorder services.[94] CMS adjusts payments to MA plans for certain demographic characteristics and the health status of enrollees.

Funds received from CMS are generally sufficient for MA plans to offer supplemental benefits without an additional premium. Data from 2022 showed that a small proportion of MA plans provide additional benefits for behavioral health conditions.[95] For example, 12 percent of enrollees were in MA plans that offered access to additional inpatient hospital psychiatric services, and 6 percent of enrollees with mood disorders or OUD were in MA plans that provided tailored benefits (e.g., reduced cost sharing).

Medicaid Managed Care. Medicaid is the single largest payer for mental health services in the United States and has an increasing role in the reimbursement of services for substance use disorders.[96] States typically use a combination of FFS and managed care arrangements to provide behavioral health care to Medicaid beneficiaries.[97] These behavioral health services are increasingly being provided by managed care organizations (MCOs), which deliver care to three-quarters of all Medicaid enrollees across the nation.[98,99]

Payment structures and provider reimbursement rates differ by state and MCO contract. In some states, behavioral health services are carved into capitated MCO contracts or contract with risk-based limited benefit prepaid health plans (PHPs).[100] Other states continue to use FFS but contract with public or private Administrative Service Organizations (ASOs) to provide behavioral health services on a non-risk basis.[101] Although less common, states may also carve out certain behavioral health services (e.g., mental health residential stays) from MCO contracts to FFS or PHPs.[102]

Psychiatric Care Management. Medicare, commercial payers, and over half of state Medicaid agencies use Psychiatric Collaborative Care Management (CoCM) billing codes to reimburse providers for using team-based behavioral health care in primary care settings.[103] 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).[104] 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.[105]

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.[106] 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.[107]

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.[108] 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.[109] Despite low uptake, research evidence shows that CoCM codes can increase access to behavioral health care in primary care settings, 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.[110]

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.[111] 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 remission were lower among patients with severe MDD relative to patients with moderate MDD.[112] 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 Prior Authorization and Claims Adjudication Practices

This section provides background information on current prior authorization and claims adjudication practices. These practices differ between Medicare FFS and other payers.

Prior Authorization. Prior authorization is a utilization management tool used across payers (e.g., Medicare, Medicaid, and commercial payers). Providers or suppliers must submit a prior authorization request with supporting medical documentation to the patient's health insurance company or managed care organization to obtain provisional affirmation of coverage for the service before providing the service.[113] Prior authorization decisions are preliminary assessments that a future claim for a health care service will meet or not meet the payer's coverage, payment, and coding requirements.[114] Standards for reviewing prior authorization requests are typically developed by insurance plans.[115] Utilization management tools such as prior authorization are generally used to reduce improper billing and payments by ensuring that services are necessary and clinically appropriate. This process can also help providers and suppliers ensure that any coverage, payment, or coding issues are addressed before a service is provided, potentially reducing claim denials and appeals.[116]

Under Medicare FFS, providers or suppliers submit prior authorization requests to their Medicare Administrator Contractor (MAC).[117] The use of prior authorization in Medicare FFS is limited to a specific set of services: outpatient hospital services, non-emergency ambulance transport, and durable medical equipment.[118] Approximately 628,243 prior authorization reviews were completed by CMS under Medicare FFS in 2024, translating to approximately two prior authorization reviews per 100 Medicare FFS beneficiaries.[119] Less than one-quarter (22.9 percent) of the prior authorization requests in Medicare FFS were denied in 2024.[120] See *Section V. Results From Related Alternative Payment Models* for more information on a new CMS Innovation Center model, the Wasteful and Inappropriate Service Reduction (WISeR) Model, that uses artificial intelligence (AI) to facilitate prior authorizations in Medicare FFS for certain services in six states.

While Medicare FFS does not require prior authorization for behavioral health services, MA plans frequently do.[121,122] Most (84 percent) of MA enrollees are in plans that require prior authorization for mental health services.[123] Approximately 93 percent of MA enrollees are required to receive prior authorization for psychiatric inpatient hospital stays. Additionally, nearly 80 percent of enrollees are required to receive prior authorization for opioid treatment services, outpatient substance abuse services, mental health specialty services, and psychiatric services.[124] While MA insurers are required to

share data on timeliness and use of prior authorization, CMS does not collect information on how prior authorization requests, denials, and appeals vary by service types, plans, or enrollee characteristics.[125]

Evidence suggests that 53 million total prior authorization requests were submitted to MA insurers in 2024, and 4.1 million (nearly 8 percent) of those requests were denied.[126] This number translates to approximately 1.7 prior authorization requests submitted per enrollee.[127] Approximately 11.5 percent of the denied prior authorization requests were appealed, and most appeals (80.7 percent) were partially or fully overturned.[128]

A 2022 report from OIG showed that 13 percent of prior authorization denials by MA plans met Medicare coverage rules and likely would have been covered under Medicare FFS.[129] OIG described two potential causes for the denials. First, MA organizations (MAOs) used clinical criteria that are not used in Medicare coverage rules, leading to the denial of services that independent reviewers determined medically necessary. Second, MAOs indicated that the prior authorization requests had insufficient documentation to support approval; however, independent reviewers determined that the records were sufficient to support the services.

There is limited evidence on prior authorization requirements for psychiatric CoCM codes. The codes do not require prior authorization in Medicare FFS but may require prior authorization in commercial health plans, MA, and Medicaid. For example, after the initial 12 months of treatment, Medicaid plans may require prior authorization to use the codes for an additional 12 months.[130,131] Some Medicaid plans require an attestation form for providers or provider groups to be reimbursed for the codes.[132] The form requires the providers and provider groups to attest that they are actively providing care consistent with the core principles and requirements of CoCM.

Claim Adjudication. 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.[133] 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, when a human leads the review of each claim.[134] This approach can be time-intensive but highly accurate and is best suited for complex claims. Claim adjudication can also be automated using technology.[135] 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.[136] This approach can balance accuracy and speed and is best suited for medium-to-complex claims.

In Medicare FFS, claims are submitted directly to Medicare through MACs and are typically processed within 14 to 30 days.[137,138] Unlike Medicare FFS, MA plans process all claims through their own claims and payment procedures.[139] Commercial payers typically process claims within 15 to 30 days. Although Medicaid programs differ by state, states can take more than 45 days to adjudicate 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.[140] Appeals generally require providers to submit appeal letters, corrected claims, additional documentation, and/or coding clarification.[141]

Common issues during claim adjudication include coding errors, formatting and data entry errors, eligibility and policy issues (e.g., expired benefits), missing or insufficient documentation, failure to show prior authorization, and provider credentialing issues.[142] Common reasons for denials for behavioral health claims includes a lack of prior authorization, services provided that were not covered under the patient's plan, insufficient documentation of medical necessity, and duplicate claim submissions.[143]

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).[144] 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.[145,146]

Provider Challenges with Current Prior Authorization and Claims Adjudication Practices in Behavioral Health Care

Providers face challenges with current prior authorization and claims adjudication practices in behavioral health care. Many payers require prior authorization for the initial course of treatment, as well as ongoing sessions for behavioral health services.[147] This can create a large volume and frequency of per-service authorization transactions in behavioral health care. Given the large volume of transactions, prior authorization is associated with substantial administrative burden for providers. On average, practices complete 40 prior authorizations per physician per week, equating to approximately 13 hours per week.[148] About 40 percent of physicians report having staff who work exclusively on prior authorizations.[149] Given the administrative burden, the majority of physicians (94 percent) have reported that prior authorization somewhat or significantly increases burnout.[150]

Physicians' perception of the burden of prior authorization requirements varies by lines of business. Sixty-nine percent of physicians reported high or extremely high burden associated with prior authorization requirements in MA, while 63 percent of physicians reported the same for commercial insurers, 62 percent for Medicaid, and 47 percent for Medicare FFS.[151]

More than one in three (35 percent) physicians reported that prior authorization criteria are rarely or never evidence-based.[152] Only one in five physicians (21 percent) report that they always appeal adverse prior authorization decisions. Reasons for not appealing adverse prior authorization decisions include not believing that the appeal will be successful based on prior experience (59 percent), having insufficient resources and time (52 percent), and believing that patient care cannot wait for the health plan to approve the prior authorization (49 percent).[153] While technology aims to automate the prior authorization process, 60 percent of physicians report concerns that AI increases or will increase prior authorization denial rates.[154]

There are financial impacts to prior authorization requirements and claims adjudication delays and denials. Providers cannot necessarily bill the patient directly when claims are denied.[155] Not only do providers lose revenue if a claim denial is not appealed or overturned, but there are also administrative costs to correcting and resubmitting prior authorizations and denied claims.[156] The average cost of correcting and resubmitting a denied claim can range from $25 to $30 per claim.[157] Other sources indicate that the cost burden for physician practices ranges from $2,200 to $80,000 annually per physician (in 2010 dollars).[158]

Patient Challenges with Current Prior Authorization and Claims Adjudication Delays and Denials

Patients face challenges with current prior authorization and claim adjudication practices in behavioral health care. Prior authorization requirements may impact patient outcomes, delays in care, abandonment of care, adverse events, and increased utilization.

Ninety-two percent of physicians reported that prior authorization has a somewhat or significant negative impact on patient clinical outcomes.[159] Prior authorization requirements can impact outcomes by delaying care, interrupting treatment, or causing the abandonment of treatment.[160] Ninety-five percent of providers reported that prior authorization can delay care, and 80 percent reported that prior authorization can at least sometimes lead patients to abandon their recommended course of treatment.[161] Many patients whose prior authorizations are denied are not offered alternative treatment options.[162] Additionally, 26 percent of physicians reported that prior authorization has led to a serious adverse event for a patient (e.g., hospitalization or life-threatening event) or has required interventions to prevent damage, disability, birth defects, or death.[163]

Prior authorization requirements and delays can also lead to patient frustration, cause patients to try ineffective treatments, influence patients to schedule additional office visits, and cause patients to use more expensive forms of care (e.g., ED use).[164,165] Eighty-eight percent of physicians reported that prior authorization requirements led to higher overall utilization of health care resources, such as ineffective initial treatment, additional office visits, ED visits, and hospitalizations.[166]

Challenges to Adopting and Implementing EHR Systems Capable of Generating FHIR-Based Prior Authorization Requests

Finalized in January 2024, the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) requires certain payers to process prior authorization requests electronically for non-drug items and services, embedded within providers' EHRs, using Health Level 7 (HL7) FHIR application programming interfaces (APIs).[167] FHIR-based electronic prior authorization APIs aim to improve transparency and efficiency of prior authorization processes and reduce administrative burden.[168] Under the rule, providers submit and track prior authorization requests electronically. The rule aims to:

- Improve the exchange of data and prior authorization information among patients, providers, and health plans;
- Shorten prior authorization decision timeframes (seven calendar days for standard/non-urgent requests and 72 hours for expedited/urgent requests);
- Increase transparency in prior authorization decisions by requiring payers to provide specific reasons for prior authorization denials; and
- Promote public reporting of prior authorization metrics (approvals, denials, processing times).[169]

The rule does not regulate how prior authorization decisions are made. The rule applies to MAOs, state Medicaid and Children's Health Insurance Program (CHIP) FFS programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs). Medicare FFS is not impacted by these CMS interoperability regulations. Compliance deadlines under the final rule are staggered by plan type. but all plans must be in compliance by January 1, 2027.

In addition, as part of the final rule, an attestation measure called *Electronic Prior Authorization* was added to the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program.[170] This new measure will require eligible clinicians to attest "yes" to requesting a prior authorization electronically via a prior authorization API using data from certified EHR technology for at least one medical item or service ordered during the 2027 calendar year performance period, or report an exclusion, if applicable. Eligible hospitals and critical access hospitals will attest "yes" to requesting a prior authorization request electronically via a prior authorization API using data from certified EHR technology for at least one hospital discharge and medical item or service ordered during the 2027 EHR reporting period, or report an exclusion, if applicable.[171] CMS aims to reduce administrative burden by implementing this attestation measure as the measure does not require a numerator/denominator calculation.

CMS-0057-F requires payers to modernize their data infrastructure, including integrating prior authorization systems, claims platforms, clinical data repositories, and provider-facing portals.[172] As a result, many payers are encountering challenges with implementing the FHIR-based APIs for prior authorization, particularly organizations with fragmented legacy systems.[173] One challenge is related to operational readiness.[174,175] As implementation efforts progress beyond planning stages, many payers have encountered unexpected complexities, such as governance approvals that influence architecture, security rules that impact partnerships, and workflow updates that require coordination across multiple teams.[176] Another challenge is related to expanding the capabilities of Patient Access APIs, or APIs that allow patients to view their medical records, claims, and health data on third-party mobile applications (apps) or websites.[177] While many payers have already adopted technologies that allow patients to access their data (e.g., through earlier rules such as CMS-9115-F), building on top of the existing technologies to meet the requirements of the final rule (CMS-0057-F) can be more complex and costly than anticipated because the original technologies were not necessarily developed for workflow integration.

As of March 2026, only 20 percent of providers had begun implementing FHIR-based APIs for electronic prior authorizations.[178] This relatively low percentage of use among providers may be due to a general lack of awareness of the new requirements.

The April 2026 Interoperability Standards and Prior Authorization for Drugs proposed rule (CMS-0062-P) is built around the same key provisions as the 2024 final rule (CMS-0057-F) but includes prescription drugs.[179] The proposed rule would require payers to use the same electronic prior authorization API established for non-drug items and services under the 2024 final rule for drugs covered under the payer's medical benefit.

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

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.[180]

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.[181]

Episode-based payments can be designed as retrospective or prospective. Retrospective episode-based payment structures pay providers FFS throughout the episode of care.[182] 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.[183] 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.

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.[184] 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 a FFS environment as expenditures can be billed separately.[185] A 2018 report by the U.S. Government Accountability Office (GAO) demonstrated that participants in CMS episode-based payment models were typically larger, 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.[186]

As previously described, episode-based payments for Medicare OTPs—programs designed to provide OUD treatment to Medicare Part B beneficiaries—were generally higher than individual payment amounts calculated based on the services that were actually provided to enrollees.[187] Medicare could have saved $301.5 million if the episode-based payment rates for OUD treatment services reflected the services provided to enrollees. CMS' approach for setting episode-based payment rates may not have

sufficiently accounted for the OUD treatment services delivered by OTPs or the frequency with which the services were provided during treatment episodes.

***MA Plans*.** MAOs have implemented episode-based payment models for in-network providers who care for beneficiaries enrolled in their MA plans.[188] 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.[189]

***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.[190] 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.[191]

***Medicaid Organizations*.** Several state Medicaid agencies have adopted episode-based payment models for providers serving Medicaid beneficiaries, including those enrolled through Medicaid MCOs.[192] 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.[193]

One study reviewed findings from 88 articles that evaluated 12 outcome-based payment models.[194] 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.[195] 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.[196] 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.[197] Outcome-based payment models can have unintended consequences, such as encouraging providers to neglect non-measured aspects of care.[198]

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 who 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.[199] 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.[200] Second, the measures included in the program may not be adequate indicators of quality.[201] 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.[202] 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.[203] 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.[204] 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.[205]

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).[206,207] 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.[208] 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.[209] 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.[210] 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.[211] 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.[212]

Each demonstration's impact on beneficiary experience, quality of care, utilization, and costs was evaluated separately.[213] 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.[214] 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 or pre-service coverage determinations.

Medicare 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.[215] 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.[216] On the Medicare side, participating practices may receive infrastructure funding, Integration Support Payments (ISP) paid on a PBPM 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.[217]

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.[218] The model tests OAPs for technology-supported chronic care across four clinical tracks, including a behavioral health track focused on depression and anxiety.[219,220] 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.[221] 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.[222,223] 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.[224] The model included 29 inpatient and 3 outpatient clinical episodes.[225] 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.[226,227] 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.[228] 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.[229] 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.[230]

Oncology Care Model (OCM) (2016–2022). CMS' OCM was a voluntary episode-based payment model for oncology practices treating Medicare FFS beneficiaries receiving chemotherapy.[231] 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.[232,233] 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.[234,235] 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.[236,237]

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.[238] 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.[239] 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.[240] Participants may receive MEOS payments to support enhanced services such as patient navigation, care planning, 24/7 access to clinicians, and care coordination.[241] 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.[242]

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.[243] Episodes included the anchor hospitalization or outpatient procedure and related Medicare Part A and Part B services during the 90 days after discharge.[244,245] 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.[246,247] 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.[248,249] 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.[250] Safety-net hospitals were more likely than non-safety-net hospitals to owe repayments under the model.[251] CMS subsequently launched CJR-X, which continues the model's mandatory episode-based payment approach for lower extremity joint replacement while incorporating additional policy and operational refinements.[252]

Transforming Episode Accountability (TEAM) Model (2026–2030). CMS' TEAM is a five-year, mandatory episode-based payment model for selected acute care hospitals in Original Medicare.[253] The model holds hospitals accountable for the cost and quality of care for five high-expenditure, high-volume surgical episode categories.[254,255] Episodes begin with the anchor surgery or procedure and extend through 30 days after hospital discharge.[256,257] 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.[258,259] 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.[260,261] TEAM continues CMS' use of mandatory episode-based accountability, target pricing, quality adjustment, and reconciliation for defined surgical episodes. [262,263]

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.[264] 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.[265] 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.[266] 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.[267]

Medicare APMs That Include Pre-Service Coverage Determinations

Wasteful and Inappropriate Service Reduction (WISeR) Model (2026–2031). CMS' WISeR Model is a six-year CMS Innovation Center model in Original Medicare that tests the use of enhanced technologies, including AI and machine learning, together with human clinical review, to support prior authorization or pre-payment medical review for selected items and services that may be vulnerable to fraud, waste, abuse, or inappropriate use.[268,269] The model operates in six states and applies to selected services with existing publicly available Medicare coverage criteria, such as national or local coverage determinations.[270,271] Selected services include examples such as skin and tissue substitutes, electrical nerve stimulators, and knee arthroscopy for knee osteoarthritis. Inpatient-only services, emergency services, and services that could pose substantial risk if significantly delayed are excluded. For selected services, providers and suppliers may submit a prior authorization request before furnishing the service. Model participants use enhanced technologies, including AI and machine learning, together with human clinical review, to assess whether the request meets existing Medicare coverage criteria and provide a pre-service coverage determination.[272,273] Under WISeR, providers and suppliers continue to be paid under existing Medicare FFS payment rules.[274] CMS pays WISeR Model participants—technology companies with clinical review capacity—based on a share of observed savings, with performance adjustments based on measures such as review accuracy, timeliness, beneficiary and provider experience, and downstream clinical outcomes.[275] Because WISeR is newly implemented, evaluation findings are not yet available on its effects on access, administrative burden, utilization, spending, or patient outcomes.[276]

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, opioid use disorder, and serious mental illness? 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, and how does this differ across payers? 4. What challenges do providers face with current prior authorization and claims adjudication practices in behavioral health care (e.g., how does the volume of per-service authorization transactions contribute to clinician administrative burden)? 5. What impact can prior authorization and claims adjudication delays and denials have on patients' access to behavioral health treatment, utilization of acute services, and outcomes? 6. Which behavioral health services are most frequently subject to prior authorization? How do prior authorization requirements differ across payers? 7. What billing, coding, and documentation complexities contribute to claim denials and delayed payments for behavioral health care services? 8. What are challenges to adopting and implementing electronic health record systems capable of generating FHIR-based prior authorization requests? Could these technological requirements impact certain providers such as small or independent practices to a greater extent than other providers? 9. 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)
10. What existing Alternative Payment Models (APMs) have focused on or included behavioral health services? 11. 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? 12. What existing models have implemented pre-service coverage determinations? What has been learned from the implementation and evaluation of these models?

Appendix B. Annotated Bibliography

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.

Grimm CA. Some Medicare Advantage Organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care. U.S. Department of Health and Human Services Office of Inspector General. OEI-09-18-00260. April 2022.
https://oig.hhs.gov/documents/evaluation/3150/OEI-09-18-00260-Complete%20Report.pdf

Subtopic: Medicare Payment Policy Related to Behavioral Health Services
Type of Source: Report
Objective: To investigate and report on Medicare Advantage Organization (MAO) denials of prior authorization requests.
Main Findings: Thirteen percent of prior authorizations that were denied by MAOs met Medicare coverage rules and would have been otherwise approved. These prior authorizations were denied due to MAOs using clinical criteria not contained in Medicare coverage rules and mismanaging medical records in the patient's case file. Additionally, 18 percent of payment requests were denied due to human error during manual claims-processing review.
Strengths/Limitations: Case reviews were conducted using the medical records that had been submitted at the time of review; however, if additional records were submitted, they may have been missed.
Generalizability to the Medicare Population: Strong; this study focused on Medicare Advantage populations.
Methods: The study used a randomized sample of denials from 15 of the largest MAOs by enrollment. Case file reviews were conducted. Further analysis was conducted to generate population estimates of the rates of prior authorization denials and payment denials.

Many Medicare beneficiaries are not receiving medication to treat their opioid use disorder. Office of Inspector General. Data Brief OEI-02-20-00390. December 2021.
https://oig.hhs.gov/documents/evaluation/2697/OEI-02-20-00390-Complete%20Report.pdf

Subtopic: Problems in Care Delivery and Payment Related to Behavioral Health Services
Type of Source: Report
Objective: To understand whether beneficiaries diagnosed with opioid use disorder (OUD) received medication and behavioral therapy to appropriately treat the disorder.
Main Findings: Less than 16 percent of beneficiaries received medication to treat their OUD, and less than half of the beneficiaries who received medication for treatment also received behavioral therapy. Disparities in treatment patterns by race/ethnicity and location were observed.
Strengths/Limitations: It is possible that beneficiaries received treatment medications through payers other than Medicare.
Generalizability to the Medicare Population: Strong; this report focused on Medicare beneficiaries.
Methods: The study included an analysis of claims from Medicare Parts A and B and Part C encounter data.

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.

Mark TL, Parish WJ, Weber EM, Steinberg DG, Henretty K. The cost of opioid use disorder-related conditions in Medicare. *Drug and Alcohol Dependence*. 2023;244:109778. https://doi.org/10.1016/j.drugalcdep.2023.109778

Subtopic: Problems in Care Delivery and Payment Related to Behavioral Health Services
Type of Source: Journal Article
Objective: To estimate the potential cost savings resulting from expanding Medicare coverage of opioid use disorder (OUD) treatment and improving health outcomes.
Main Findings: This study found that the potential cost offsets of reducing the medical comorbidities associated with OUD ranged from $3 to 4.7 billion. The study also found that once Medicare OUD coverage is expanded, patients with OUD would take on spending patterns similar to Medicare beneficiaries without OUD of the same age, gender, and dual eligibility status. This could result in up to $15.8 billion in savings.
Strengths/Limitations: This study used 2019 data, prior to the Medicare expansion of coverage to opioid treatment programs.
Generalizability to the Medicare Population: Strong; this article focused on the costs of OUD treatments for Medicare beneficiaries.
Methods: Data from the 2019 Chronic Conditions Data Warehouse Master Beneficiary Summary files were analyzed to determine differences in spending between Medicare beneficiaries without an OUD diagnosis versus those with an OUD diagnosis and medication treatment controlling for demographic and eligibility differences. Additionally, the study estimated Medicare spending on comorbidities associated with OUD.

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.

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 the Centers for Medicare & Medicaid Services (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.

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.

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 collaborative care model (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 the Centers for Medicare & Medicaid Services (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 collaborative care model (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.

Appendix C. References

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