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DEVELOPMENT OF INNOVATIVE REIMBURSEMENT MECHANISMS FOR TEAM-BASED BEHAVIORAL HEALTH CARE: RESULTS FROM CASE STUDIES

KEY POINTS

- Development of novel reimbursement mechanisms for team-based care often involve state-initiated negotiations and guidance in addition to state or federal funding.
- Rate-setting, development of regulations and contract requirements, and technical assistance to providers are key state activities to develop and implement novel reimbursement approaches.
- Close relationships and iterative feedback between providers and administrators are instrumental in designing and successfully adopting sustainable reimbursement mechanisms.

INTRODUCTION

Team-based behavioral health (BH) care can effectively address clinical needs and mitigate behavioral health workforce shortages. Team-based care models typically involve two or more individuals of varying disciplines and backgrounds who work collaboratively to provide coordinated care. A team-based approach can help address behavioral health workforce shortages by allowing peers and non-licensed behavioral health workers to work alongside licensed professional providers and, in turn, allowing licensed professionals to practice at the top of their license.[1] Team-based care can also increase care coordination, improve care integration, enhance comprehensive care for patients, and reduce provider burnout.[2,3] In addition, recent studies indicate that team-based care improves patient satisfaction[4] as well as the quality and cost of care.[5] However, reimbursement through traditional fee-for-service (FFS) billing is often insufficient and can result in uncompensated team-based activities.[6] When reimbursement does not compensate providers for the full cost of care, providers may be disincentivized from implementing a team-based service model because they are financially unsustainable.

The barriers to sustaining team-based behavioral health care through traditional FFS billing have encouraged the use of novel reimbursement mechanisms, such as enhanced FFS, bundled rates, and per member per month (PMPM) payments.[7] Enhanced FFS departs from traditional FFS through enhanced rates that cover components of team-based care that would have been difficult to reimburse for under traditional FFS. A bundled rate, wherein a set of services are all covered under a single code covering an episode of care shared over a care team, presents another alternative to traditional FFS.[8] Finally, PMPM payments allot providers a fixed monthly fee for each eligible beneficiary in their care.[9] We conducted case studies of several innovative team-based behavioral health service models and reimbursement mechanisms. The focus of each case study is on the rationale for the transition to the novel reimbursement mechanism, how the reimbursement mechanism was developed and implemented, and plans for future refinements of the reimbursement mechanism. Across case studies, we examined the role of state and local funding in developing the reimbursement mechanisms, as well as the roles of iterative feedback and continuous improvement in the development and implementation of novel reimbursement mechanisms.

APPROACH

Case Study Selection. Case studies were conducted for five team-based service delivery models that used innovative or complex reimbursement mechanisms, including enhanced FFS, bundled payments and PMPM payments.

Recruitment and Interviews. By reaching out to relevant health department or other program administrative staff, we identified administrative contacts who were formally affiliated with each service delivery model and, where possible, we prioritized individuals who were the most knowledgeable about the reimbursement mechanism's development and implementation. Throughout this issue brief, we refer to these individuals as program administrators or state administrators, depending on whether the service model is considered a program and whether the administrative contacts are embedded within the state Medicaid program. Our administrative contacts, in turn, identified provider contacts based on providers' success billing for team-based care under the novel mechanism. The Aware model was the exception in that the case study was limited to an administrative contact, who indicated that providers have limited contact with the reimbursement mechanism. Interview guides were developed to solicit information related to the reimbursement mechanism of interest, including the development of the mechanism, types of providers eligible to bill, and strengths and challenges of the mechanism. We developed an interview guide for state or program administrators and a separate interview guide for providers; both guides were tailored to the case study's reimbursement mechanism and service delivery characteristics.

The combination of interviewing program administrators and providers allowed us to triangulate findings across the administrative and the provider perspectives on the development and implementation of the same reimbursement mechanism. Interviewees received a list of the discussion questions several days in advance of the interview. We conducted nine interview sessions with 14 individuals--several interviews included multiple interviewees. Interviews generally lasted 60 minutes and were conducted over Zoom. Each interview was recorded and transcribed using Temi. We reviewed the transcripts for key findings and common themes.

RESULTS

Case Study Reimbursement History and Current Reimbursement Mechanism

Our case studies included service delivery models that focused specifically on substance use disorder (SUD; Montana's opioid use disorder [OUD] treatment, Pennsylvania's Centers of Excellence (COEs), Aware Recovery Care) or on mental health (New York's Health Home Plus [HH+]), as well as models that were more generally behavioral health-focused (New York's Mobile Crisis Teams [MCTs]). **Table 1** describes the service delivery models and their associated reimbursement mechanism. Our case study findings are focused on the history and rationale for developing and implementing an innovative reimbursement mechanism, iterative refinements of the mechanism, and future development plans.

Table 1. Service Model Description and Reimbursement Mechanisms, by Case Study		
Service Model	**Service Model Description**	**Reimbursement Mechanism**
New York's Mobile Crisis Teams (MCTs)	MCTs comprised of either 1 licensed provider, 1 licensed and 1 unlicensed provider, or 2 licensed providers for adults.	**Enhanced FFS** billing under Medicaid MCOs--7 reimbursement rates are established by New York's OMH and are adjusted by team composition (team size, licensing), length of time of service delivered, and region.
Montana's Coverage of Medications for Opioid Use Disorder Treatment (MOUD)	Services include provider visits, medication prescription, lab testing, medication distribution, and BH integration management.	**Bundled rate** reimbursable under Medicaid, billable by opioid treatment programs and office-based opioid treatment providers.
Aware In-home Substance Use Disorder (SUD) Recovery	Services comparable to residential treatment that are provided within the client's home, including MAT management, peer support, individual and family therapy, and care coordination.	**Bundled rate** through several commercial insurers in multiple states.
New York's Health Home Plus (HH+)	Intensive health home care management service in which care management agencies provide comprehensive care management and assessment, along with physical and behavioral health promotion, as well as support services for high-need clients with SMI.	New York OMH reimburses HH+ services using **PMPM rates**.
Pennsylvania's Centers of Excellences (COEs)	COEs focus on integrating physical and behavioral health care, providing recovery support services, and increasing access to MAT. COEs' care management services include accepting warm hand-offs, integrating and coordinating patient care, referring clients to necessary resources, and helping clients navigate the care continuum.	Pennsylvania's OMHSAS passes funding to MCOs, which must direct the funds to a specified list of COE providers using **PMPM rates**. COEs receive PMPM payments for any care management services provided in the month.

New York's Mobile Crisis Teams

New York's Office of Mental Health (OMH) spearheaded the development of enhanced FFS Medicaid rates specific to MCTs. In collaboration with New York's managed care organizations (MCOs), OMH set tiered reimbursement rates for MCTs. There are seven rates, customized by team composition (one licensed provider, two licensed providers, or the most common arrangement: one licensed and one unlicensed provider), location (downstate or upstate), and length of time of service (< 90 minutes, 90-180 minutes, > 180 minutes). The seven rates are based on two national HCPCS codes, H2011 and S9485, which OMH customized to be specific to New York's needs. OMH offers technical assistance to providers on how to successfully bill these codes. Despite the creation of tailored rates to support New York's MCTs, many MCT providers continue to rely primarily on other funding sources to supplement Medicaid, including local funds and state revenue. State administrators indicated that providers remained hesitant to bill for MCT services, often because of difficulties confirming insurance coverage type in crisis situations, but uptake of the novel billing process was variable across MCT providers. Providers indicated that obtaining accurate client information could be a limiting factor for billing

> *"We decided to create a mobile crisis benefit that had four elements that could be billed separately. In the past, if you did a mobile crisis [service], it was just one rate, and it contained multiple services. We thought if we broke it up into four different services, it would give more flexibility for reimbursement among different providers."*
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> —State administrator, New York MCTs

Medicaid for MCT services, citing the need for accurate client details necessary to link clients to their Medicaid coverage. Building on the development of an enhanced FFS rate, OMH is working on a state plan amendment (SPA) to expand MCT coverage from Medicaid managed care beneficiaries to include beneficiaries enrolled in the state Medicaid program.

Montana's Coverage of Medication for Opioid Use Disorder

In Montana, medication for opioid use disorder (MOUD services) (provider visits, medication prescription, lab testing, medication distribution, and integrated behavioral health management) can be reimbursed through a Medicaid bundled payment. When the MOUD service delivery model was first introduced in Montana, it was funded by the Substance Abuse and Mental Health Services Administration's State Opioid Response and State Targeted Response grants. The MOUD model then transitioned to being reimbursed through Medicaid FFS, and in July 2020, Medicaid bundled rates became available. To create the bundled rates, state Medicaid administrators examined the FFS codes that were being billed, spoke to subject matter experts to define clinically appropriate OUD treatment, consulted with Montana providers about team-based workflow and associated costs, and reviewed commercial insurer's rates for MOUD services. Administrators reported that the Medicaid bundled rate was developed in response to the range of approaches that Montana providers were using to bill for MOUD, with the goal that a bundled rate would standardize billing across providers. Provider uptake of the bundled rate has an additional advantage for state administrators in that it identifies providers who deliver MOUD services, a more difficult process under traditional FFS billing. Moving forward, Montana has submitted a Medicaid SPA proposing an additional rate for readmitted beneficiaries to augment the existing two bundled rates for intake and established care, allowing for more flexible and treatment-aligned billing. The SPA also adds care coordination to the list of services that can trigger bundled payments. Finally, the state Medicaid program is prioritizing outreach to providers who are eligible to bill using the bundled rate but have yet to transition to the novel reimbursement mechanism.

> *"There are areas in Montana where it would be difficult to go, because you don't know if you're going to be able to sustain a program. Then you have these bundles, this is just a reasonable cost, enough to help you get through. It's made it so we're looking at […] places where they don't have services yet. Whereas before it was tough to advocate [for expanding services] if they don't at least pay for themselves. Now you can afford to expand."*
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> —Provider, Montana MOUD

Aware In-Home SUD Recovery

Aware is a service delivery model of SUD treatment that brings residential-style treatment into the home. Aware was founded on the principle that the most effective SUD care takes place in the home and requires more than a 3-month tenure; the model considers 12 months a more clinically appropriate timeline for stabilization than more common short-term stabilization services. In a unique collaboration for our case studies, developing the bundled rate for in-home SUD treatment was a collaborative effort between Aware and Anthem, a commercial insurer. The model uses a monthly bundled payment and has expanded to multiple commercial payers and across multiple states since inception. While the bundle rates and services vary by commercial payer, they generally include care coordination, physical and behavioral health assessments, medication provision and management, coaching and counseling services, individual therapy, family systems therapy, and Certified Recovery Advisors. As part of the model's iterative refinement, Aware is collaborating with commercial payers toward greater uniformity in coding, as billing codes for

> *"The idea behind the bundle was Anthem's. The program is flexible in nature because the disease is chronic and changes over time. You have to be flexible in how often and which set of services you're going to provide on any given day."*
>
> —Program administrator, Aware

Aware's services currently vary by insurance plan. In addition, Aware is advocating for a nationally recognized billing code for bundles that include paraprofessionals, citing the advantages to expanding across commercial payers and states under a recognized billing code.

New York HH+

HH+ is primarily a care management service, intended to address physical, behavioral, and social determinants of health for clients who have serious mental illness (SMI) and meet additional eligibility criteria (e.g., court order to undergo behavioral health treatment, recent discharge from a state psychiatric center, recent release from prison). OMH reimburses HH+ using PMPM rates. Administrators indicated that PMPM was chosen as the reimbursement mechanism for HH+ to allow providers the flexibility to implement innovative service delivery approaches. Communication between OMH and HH+ providers is formalized through a working group made up of HH+ providers, in addition to technical assistance provided by OMH. These formal lines of communication facilitated the iterative development of the rates and the broadening of HH+ eligibility criteria. In 2013-2014, New York pivoted from Targeted Case Management (TCM) to the HH+ model for care management in high-need clients with SMI. This shift was based on findings from New York's Medicaid Redesign Team, specifically those indicating that 20% of Medicaid enrollees account for 75% of Medicaid spending. While both TCM and HH+ focus on clients with SMI, TCM limited care management services to mental health care. By contrast, the transition to HH+ allowed for more flexible provision of case management services for both behavioral and physical health care, in addition to services related to client engagement (e.g., motivational interviewing, suicide prevention, risk screening, trauma-informed care). In considering future refinement of PMPM reimbursement for HH+, administrators indicated their interest in expanding the reimbursement mechanism to include elements of pay-for-performance, emphasizing the importance of New York's robust health information technology (HIT) in outcome performance tracking.

> *"Establishing a PMPM, the vision was that it allowed for flexibility. Here's the rate and what we want. Here are the standards, show us how you can serve people well. Within this structure, we want to learn from you. We don't want… the restrictions of the TCM approach. We want to have the flexibility for innovation."*
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> —Health department administrator, New York HH+

Pennsylvania Centers of Excellence

Pennsylvania's COEs receive a PMPM payment for each patient that the COE has assumed care management responsibilities for. A state demonstration grant funded the initial 3 years of Pennsylvania COEs to alleviate the start-up costs of adjusting their service delivery process. In a move toward sustainable reimbursement, the COEs transitioned to billing Medicaid MCOs in 2019. The PMPM reimbursement mechanism was selected by the Pennsylvania Department of Human Services for its simplicity, and because the PMPM rate could be calculated based on provider expenditures acquired during the years of grant funding. In addition, program administrators consulted with the Centers for Medicare & Medicaid Services in the development of the payment model. To reimburse COEs, Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) passed funding to MCOs, which must then direct the funds to a specified list of COE providers at the PMPM rate of $277.22. Administrators emphasized the importance of technical assistance for providers in gaining support among MCOs for the reimbursement method: state administrators and their university partners provided individualized technical assistance to COEs and open channels for MCO feedback, which encouraged MCOs' buy-in. For the next development phase of the COE

> *"When we considered the options, PMPM seemed cleanest. It seemed like something that we could develop a rate for and clearly communicate to people why the rate is what it is, which is something that people always want to know, especially in Medicaid where we know our rates are notoriously low."*
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> —State administrator, Pennsylvania COEs

reimbursement mechanism, interviewees expressed interest in tying reimbursement to key performance measures and in tiered reimbursement that is more aligned with treatment stage and intensity.

LESSONS LEARNED AND CONSIDERATIONS

The design of the five case studies, four of which included both administrative and provider interviews, allowed us to identify and triangulate findings based on both the administrative and the provider perspectives on the development and implementation of the same reimbursement mechanism. In comparing case studies over stages of implementation (see **Figure 1**), we found that each site had identified gaps in service or payment ("Rationale for Development") and were attempting to mitigate those gaps by developing and implementing a novel reimbursement mechanism. At the implementation stage, reimbursement mechanisms were selected and refined to support more flexible service provision, allowing for a wider range of team-based services (e.g., HH+) or variable team composition (e.g., MCTs), while reducing burden on providers. We noted that, in addition to the iterative refinements to reimbursement, each site had outlined future developments, either targeting transition to a more value-based approach (e.g., COEs, HH+), broader service provision (e.g., Aware, MCTs), or increased provider uptake of the implemented reimbursement mechanism (e.g., MOUD, MCTs). **Figure 1** summarizes the pre-implementation, implementation, and future development stages across case studies, highlighting the rationale behind the development of the reimbursement mechanism, the reimbursement mechanism's implementation, as well as any plans referenced by case studies for future development.

Figure 1. Reimbursement Development, Implementation, and Future Development Goals, by Case Study

	Before Novel Reimbursement - Rationale for Development		Implementation of Novel Reimbursement Mechanism		Future Development of Reimbursement Mechanism
New York's Mobile Crisis Teams (MCTs)	MCTs depend on local funding, leading to county-by-county variation in service provision (hours of operations, geographic range).	→	New York mandates MCT coverage by Medicaid MCOs. State sets flexible reimbursement rates to allow for different types of team responses.	→	Increased uptake of enhanced FFS billing codes, expansion to commercial coverage, workforce expansion to include supervised student providers.
Montana's Medications for Opioid Use Disorder (MOUD) Treatment	Montana's coverage of MOUD is primarily through FFS billing. FFS billing is labor-intensive and variable.	→	Medicare and Medicaid allow a monthly bundled rate for MOUD. Uptake within opioid treatment program, many providers maintain FFS billing, difficulty tracking providers.	→	Stronger communication with providers to increase uptake of bundled rate billing, planned additional bundled rate for readmission.
Aware	Few options for long-term, at-home SUD recovery and treatment services. Commercial demand for new models of service delivery.	→	Aware offers monthly bundled rate within commercial payers to cover a range of services by a team of health professionals and paraprofessionals.	→	Expansion to additional states and commercial payers, advocacy for uniform billing codes across commercial payers.
New York's Home Health Plus (HH+)	TCM approach, services limited to connecting individuals to appropriate BH services.	→	New York HH+ program provides specialized, holistic care management to individuals at high risk for poor health outcomes.	→	Evaluation of cost reporting, move toward pay-for-performance structure.
Pennsylvania's Centers of Excellence (COEs)	Pennsylvania COEs were initially grant-funded, allowing the state to collect data and feedback on team-based care costs.	→	COEs reimbursed using a PMPM based on cost estimates over the course of treatment.	→	Move toward pay-for-performance components to incentivize quality over volume.

Several key themes emerged from the case studies, including: the flexibility and autonomy afforded by the mechanism, the role of grant funding in developing and implementing novel reimbursement mechanisms, the importance of close, collaborative relationships between state administrators and providers for iterative refinement of reimbursement mechanisms, and the role of state leadership in stakeholder engagement and successful implementation.

Developing Reimbursement Mechanisms Focused on Provider Autonomy and Treatment Flexibility

Across the study sites, administrators and providers emphasized that the development of the novel reimbursement mechanism was driven by the need for more flexible billing to sustainably reimburse for team-based services. For example, the Aware program cited the need for flexibility because of the changing and long-term treatment needs associated with SUD. Flexibility allows providers to change the frequency and types of services that are provided on any given day without the burden and risk of billing. The reimbursement was sustainable because the bundles were calculated based on costs of providing the evidence-based service. Program administrators also recognized that the simplicity of the mechanism would affect the uptake by providers. On the provider side, interviewees emphasized the advantages of billing flexibility, allowing them to tailor care in terms of services and team composition, without becoming mired in prescriptive programming or complex billing processes. New York MCT providers were able to reimburse at different rates by team composition and voiced appreciation for the combination of state guidelines that were not overly prescriptive, encouraging provider autonomy, with the increased billing flexibility for team-based services. Montana MOUD providers reported reduced administrative burden through the simplified billing process after transitioning from FFS billing to the bundled payment.

> *"I think it does make it easier to have some autonomy in how you provide services. If I have a good rate and I don't have to worry if my nurse is really getting paid [or] productivity for counselors. I don't like conversations about 'you should do this many units.'"*
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> —Provider, Montana MOUD

Importance of Grant Funding to Develop and Implement Novel Reimbursement Mechanisms

Although interviewees consistently emphasized the importance of sustainable reimbursement mechanisms, most interviewees reported that grant funding played a temporary but key role in the development and adoption of their current reimbursement mechanism. Early-stage funding was used to support collaboration with local universities to design evidence-based bundles of services and rates, develop technical assistance partnerships with universities, solicit information on current service utilization and associated costs from providers, and build relationships with providers for iterative feedback on the mechanism. Case studies focused on Pennsylvania COEs and Montana's MOUD bundled rate are striking examples of state and federal grant funding, respectively, playing a key role in the development and implementation of novel reimbursement mechanisms. The PMPM rate for Pennsylvania's COEs was calculated using provider expenditures acquired during the initial 3 years of the program, when the program was funded by state grants. Similarly, Montana's MOUD treatment was initially grant-funded; in developing the Medicaid bundled rate for MOUD treatment, state administrators took providers' workflow and service provision into account.

> *"We're also advocating through our department of taxation and finances to expand reimbursement to commercial payers. We plan on providing expectations and oversight, especially around sharing data with us, but [the MCT providers are] going to need funding for that."*
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> —State administrator, New York MCTs

Iterative Development through Feedback between Program Administrators and Providers

Communication and iterative feedback between administrators and providers were key facilitators in developing and implementing novel reimbursement mechanisms. In the case of New York MCTs and Pennsylvania COEs, this iterative feedback loop also included MCOs, and in the case of Aware, it included commercial payers. Multiple interviewees reported that close relationships between state administrators and providers led to more clinically appropriate reimbursement rates that eased the adoption of the new mechanism, a more responsive refinement cycle of the reimbursement mechanism, and better-informed providers. Providers receiving Montana's OUD bundled rate emphasized their personal and informal ties to the state administrators, given the size of the state, whereas providers and state administrators in New York's HH+ program emphasized a more formal relationship with state administrators, including an advisory board of HH+ providers that compiles recommendations to put forward to OMH. Based on stakeholder and provider feedback, the HH+ program has incrementally expanded the HH+ eligible populations. Stakeholder feedback and provider feedback to OMH also guided the development of the HH+ rate, determined by caseload, staffing qualifications, and contact requirements.

> *"Anytime a provider has difficulty with reimbursement, they can always contact the Office of Mental Health to get support. Because sometimes it's the provider's claims are wrong. Sometimes it's the managed care system--how it interacts with that provider is the problem. And sometimes, you know, it's just an error and has to be brought to their attention. But if a provider has a problem, we are going to help with it."*
> —State administrator, New York MCTs

Technical assistance was identified as a key facilitator of implementation and iterative development, and several state program administrators emphasized the importance of technical assistance in helping providers successfully transition to and sustain new billing mechanisms and requirements. In the Pennsylvania COEs, state funding allowed the COEs to collaborate with local universities on technical assistance efforts, facilitating rapid and ongoing responses to provider questions on the reimbursement process. The same funds supported administrators in developing data summaries and feedback for providers, with the intention of highlighting the effectiveness of the bundled rate over time and financial sustainability for providers. The technical assistance relationships also served as a conduit for providers' feedback to be incorporated into the development and evolution of rates and eligible populations.

The Role of State Leadership in Developing and Implementing Novel Reimbursement Mechanisms or Rates

State administrators played a key role in developing reimbursement mechanisms that appropriately reimburse for team-based care. In the case study of COEs, state leadership allotted grant funding as a rapid proof of concept for added case management capacity and to lay the groundwork for the calculation of a sustainable PMPM rate. We noted that some state administrators develop rates based on provider feedback and clinical workflow (e.g., Montana's bundled rate for MOUD services). In the case of New York's MCTs, state administrators spearheaded the effort to move from a single billing rate applied to all provider teams, regardless of team composition or location, to a rate with multiple tiers, to reflect team composition and context.

> *"At first our managed care organizations were a little bit resistant. They don't want to be told who to network with, or what they have to pay for a service. The reason that I think they've come around is that we have started to give them more of a voice in determining the direction of the program."*
> —State administrator, Pennsylvania COEs

Further, our case studies point to several instances of state administrators successfully negotiating for set rates across the state's MCOs, organizations that typically set their own rates and reimbursement processes. Both Pennsylvania and New York state officials successfully collaborated with their state's Medicaid MCOs for coverage of COE

and MCT services, respectively, and developed and set rates that MCOs adhered to. Administrators pointed to engaging with MCOs as key stakeholders, much like provider engagement, was vital to developing a reimbursement process that MCOs were amenable to as well as heading off confusion between providers and MCOs. In addition to developing mechanisms and negotiating rates, state leadership was instrumental in technical assistance efforts, which in turn, are a key facilitator of the iterative development of reimbursement mechanisms (see above). Finally, providers noted the value of state leadership providing clear guidance on team composition, billing, and reporting requirements, and the role that that guidance played in facilitating the staffing and successful reimbursement for team-based care.

Future Development of Novel Reimbursement Mechanisms

Across the sites, administrators were focused on the continuous improvement and iterative development of the novel reimbursement mechanism. All program administrators had plans for future development or innovation built off of the current reimbursement mechanism (see **Figure 1** for additional details on the development trajectories, by case study). Planned expansions or augmentations were indicative of gaps identified in the current reimbursement mechanism. Taken together, the findings across case studies showed common progressions, or next stages of development. For sites that rely on grant or local funding, we saw the focus on expanding uptake of the reimbursement mechanism. Sites that were focused on bundled payment expressed interest in exploring more-nuanced bundles, accounting for different treatment needs over time. For the sites using PMPM reimbursement, administrative interviewees indicated interest in building on PMPM by adding a pay-for-performance component, where reimbursement is tied to patient outcomes, thereby incentivizing health outcomes over service volume. Notably, service models considering a shift towards pay-for-performance cited advanced HIT infrastructure as a pre-requisite to accommodate outcome reporting requirements. We saw HIT play an important role in the success that New York had in targeting its HH+ and MCT efforts, allowing for identification of providers for targeted outreach and billing education, in addition to identifying beneficiaries eligible for HH+ enrollment or for Medicaid reimbursement of MCT services. By contrast, Montana state administrators highlighted the lack of provider or outcome data as a barrier to refining their reimbursement process.

Remaining Barriers to Sustainable Reimbursement of Team-Based Behavioral Health Care

Across the case studies, we identified several key barriers to successful and sustainable reimbursement of team-based behavioral health care. First, provider perceptions of underfunding remained, even after implementation of novel reimbursement rates. Most administrators reported an iterative development process for their reimbursement mechanisms, with the goal of developing rates that realistically reflect the costs of team-based care and were flexible enough to adapt to shifting patient needs across treatment phases. Second, several sites provided services to a broad client mix, regardless of payer. Within payer-agnostic service delivery models, billing through the novel reimbursement mechanism was often limited to Medicaid beneficiaries. Consequently, providers were generally reimbursed for team-based services provided to Medicaid beneficiaries, while reimbursement for those same services provided to non-Medicaid clients was through traditional FFS billing or went unreimbursed. Reimbursement for the Pennsylvania COEs and Montana's MOUD treatment was tied to the Medicaid (or Medicaid and Medicare, in the case of Montana) beneficiaries being served, despite providers serving a broader beneficiary mix. New York's MCTs, only reimbursed by Medicaid MCOs, are the most striking example, as Medicaid beneficiaries are a minority of the client mix. The resulting underfunding severely limits sustainable reimbursement for MCT services. Finally, even after successful development of a novel reimbursement mechanism, uptake of novel

> *"There's nothing incentivizing or encouraging [providers], or even the education, because we don't know who they are in every case, to bill a bundle rate. They're still billing individual procedure codes. That's part of why I said we need greater outreach on the Medicaid side."*
> —State administrator, Montana MOUD

billing can still be challenging for providers. Our results indicated that, for both New York's MCTs and Montana's MOUD providers, the number of providers using the innovative billing mechanisms was lower than state administrators expected. In Montana, providers' reticence to bill using the bundled rate was attributed to a combination of lack of awareness of Medicaid's bundled payment compounded by familiarity with the FFS billing process among Montana providers. In New York, state administrators pointed to established reliance on local funds by many MCT providers as a barrier to billing for crisis services. These examples illustrate the important and combined role of provider outreach, education, and ongoing billing technical assistance in the successful adoption of novel payment mechanisms.

LIMITATIONS

The five case studies described in this brief are not representative of all team-based service delivery models and reimbursement mechanisms. Rather, they are selected for their exceptional reimbursement practices towards sustainably funding team-based behavioral health care. In addition, the provider interviewees were selected based on their tandem success in providing and billing for team-based care, and these findings are not intended to be representative of all providers.

CONCLUSION

Team-based behavioral health care is often unsustainable in the context of traditional FFS billing, which can limit reimbursement for team-based services. However, several alternative approaches to reimbursement allow for greater flexibility in treatment and billing and support greater provider autonomy. Within service delivery models that billed for team-based services using innovative reimbursement mechanisms, we explored the development and implementation of the following reimbursement mechanisms: enhanced FFS billing, bundled rates, and PMPM. We found that grant funding remained vital during the development and implementation stages of novel reimbursement mechanisms. Further, iterative feedback between state administrators and providers was perceived as crucial to the development and refinement of the novel reimbursement mechanisms, or, in the case of Aware, between program and commercial payers. On both the provider and the program administrator side, the impetus behind development was on flexibility and provider autonomy; and billing flexibility was cited by providers as a strong facilitator of sustainable reimbursement of team-based care. However, investment in technical assistance and active communication with providers appears necessary to encourage uptake of innovative reimbursement mechanisms. Our case study of Montana's MOUD treatment indicated that, even when alternative reimbursement mechanisms are available and reflective of team-based care costs, provider knowledge and uptake of novel mechanisms often lag behind implementation. Finally, the next steps in iterative development associated with each case study paint a larger picture of continuous development and refinement.

Our findings indicate that successful uptake of novel reimbursement mechanisms is tied to: (1) accurate reimbursement levels reflecting team-based care costs; (2) education and communication to providers; and (3) stakeholder engagement, both with providers and MCOs. State rate-setting and payer negotiations are key; we saw that the most effective development processes involved rate calculations based on a combination of actual provider costs and qualitative descriptions of provider workflow. Obtaining cost information and provider workflow and subsequent iteration on the reimbursement mechanism can be facilitated by close communication ties between administrators and providers. After setting reimbursement approach and rates, iterative refinement should draw on stakeholder perspectives for feedback on effectiveness of the mechanism; and maintaining close ties with providers also supports resolution of billing issues, which was vital in the implementation phase.

APPENDIX

Team-Based Behavioral Health Model Payers, Peers, Reimbursement Mechanisms and Gaps				
Model	**Primary Payer**	**Common Reimbursement Mechanism**	**Reimbursement Issues**	**Peer Role**
Coordinated Specialty Care (CSC)	Medicaid	**FFS** for billable individual services in the model. Grant funding is used to cover providers and services not reimbursable by payer, or those services are omitted from the model.	Uninsured patients must be covered by grant funding. Outreach and engagement activities, supported education, and supported employment are often not reimbursed.	Some state CSC programs include peers on care teams.
Mobile Crisis Teams (MCTs)	Medicaid	Although state and local funds are the most common source of financing, Medicaid **FFS billing** is the most common reimbursement mechanism. Some **commercial payers** cover MCTs.	Difficulty reimbursing for travel time. Many Medicaid state plans do not cover outreach and team supervision. Service delivery is payer-agnostic but not uniformly covered across payers.	A handful of state models include peer roles but have trouble reimbursing for the full costs of peer services within MCTs.
Pediatric-Child Psychiatry Teleconsult	Direct Funds	Providers receive **direct payments** from state governments for participating in grant-funded services rather than through a reimbursement-based payment. Instances of reimbursement through **Medicaid MCOs**.	Payments are made as direct payments to specialists for their available time on call; does not operate under a traditional reimbursement mechanism.	This model does not use peers.
Sustained Addiction Recovery	Commercial	Sustained addiction recovery models rely on **bundled payments**. The ARMH program combines a **brief FFS** during the stabilization phase, followed by **tiered bundled payments**, in addition to incentivizing performance on recovery-linked quality measures. Aware Recovery Care reimburses through monthly, **bundled payments**.	The ARMH-APM bundled payment does not cover community assessment and referral and requires billing Screening, Brief Intervention, and Referral to Treatment services ad-hoc with FFS payments. Aware rates and billing details are proprietary information. Coverage is restricted to commercially enrolled population.	ARMH-APM includes peer recovery coaches as one of the roles covered in its bundled payment. Aware does not include a peer role.
Emergency Department-based Treatment and Support	Medicaid	Medicaid **FFS billing**. Some states have added **enhanced FFS** to cover long-term services provided by peer support specialists.	Waivers and state-specific certification processes are often needed to reimburse peer recovery specialists.	Central role for peer recovery specialists.
Opioid Treatment Programs (OTP)	Medicaid, Medicare	Weekly **bundled payment** under Medicare and, more recently, a daily bundled payment under Medicaid.	For Medicare, only Medicare-enrolled OTPs can be reimbursed; some constraint on supply of providers for Medicaid benefit.	Medicaid OTP benefit includes coverage of peer support services, but Medicare does not.
Opioid Health Homes (OHHs)	Medicaid	Medicaid **PMPM** pays for Health Home services, whereas medication provision is generally billed FFS.	Changing patient-mix make it difficult to gauge economic viability.	Some state OHHs cover peer recovery coaches.
Behavioral Health Homes (BHHs)	Medicaid via SPA	Medicaid **PMPM** care management fee that is tiered by disease severity.	Changing patient-mix make it difficult to gauge economic viability.	Some state plans have a role for peer support specialists.

Team-Based Behavioral Health Model Payers, Peers, Reimbursement Mechanisms and Gaps (*continued*)				
Model	**Primary Payer**	**Common Reimbursement Mechanism**	**Reimbursement Issues**	**Peer Role**
Collaborative Care Model (CoCM)	Medicare, Medicaid, Commercial	Time-based **enhanced FFS** billing codes that allow for reimbursement of care outside of face-to-face encounters, including consultation services, care coordination, and patient outreach.	Variable current procedural terminology code adoption by payers; variable co-pays by payer can require billing differentially; uptake by Medicaid and commercial payers lags behind Medicare.[1]	CoCMs do not include a peer role.
Assertive Community Treatment (ACT)	Medicaid	**Enhanced FFS** where the FFS billing code is a unified billing code covering a range of services by the ACT team.	Variable reimbursement for supported employment and supported education.	Most state models include a role for peer specialists.
Certified Community Behavioral Health Clinics (CCBHCs)	Medicaid	**Demonstration CCBHCs** use a **bundled rate** for Medicaid enrollees for any of 9 covered services. **Expansion CCBHCs** use **FFS billing**, where FFS must be applied before grant funding can be used.	**Demonstration CCBHCs** generally require additional payments from MCOs to match PPS rates in states with MCOs. PPS-2 requires reporting requirements on quality measures. **Expansion CCBHCs** cannot use state Medicaid PPS to bill for services.	Many state models, both demonstration and expansion CCBHCs, include peer support specialists.

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