REPORT 3

Exploring Non-Traditional and Innovative Behavioral Health Care Models

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Executive Summary

The United States is in the midst of a behavioral health (BH) crisis, with one in three adults reporting a mental illness or substance use issue in 2023. Despite the availability of effective treatments, the traditional delivery system—which relies on patients accessing specialized facilities or siloed practitioners—is ill-equipped to meet the growing need for these services. This report, the third in a five-part series supported by the National Institute for Health Care Reform, explores non-traditional and innovative models designed to overcome these access barriers. Drawing on a literature review and 24 interviews with state officials, providers, and researchers in Michigan, New Mexico, and Virginia, this report examines the promise and challenges of scaling these models.

This report finds that innovative models are most effective when they bring care to where patients already are, overcoming barriers related to distance, transportation, stigma, and care coordination. One key strategy is integrating BH services into primary care (PC) and emergency departments (EDs). Models **integrating BH in PC settings and EDs** have demonstrated effectiveness in expanding access. However, interviewees note that this kind of integration is often hindered by a lack of sustainable reimbursement pathways, insufficient workforce training for non-BH clinicians, and the need for upfront investment to redesign clinical workflows.

Another category of non-traditional models takes BH care out of all health care facilities and directly into communities. **Mobile health units, street-based medicine, and Assertive Community Treatment (ACT)** are vital for reaching geographically and socially isolated populations, including those in rural areas and individuals experiencing homelessness. Interviewees stressed that the success of these models hinges on building trust and providing low-barrier care. Yet, their growth is often stifled by a web of complex and sometimes conflicting federal and state regulations—such as restrictions on mobile medication dispensing—and financing frameworks that fail to cover the true costs of care.

Technology-enabled models, including **telehealth** and **digital BH tools**, represent a new frontier for expanding access to BH services. The COVID-19 pandemic accelerated the adoption of

telehealth, which interviewees praised for its convenience and ability to reduce patient no-shows. Still, telehealth's potential is limited by the lack of broadband access, limited digital proficiency, inconsistent state policies on payment parity, restrictions on services provided by out-of-state practitioners, and a lack of formal provider training in virtual care. While promising, the marketplace for **patient-facing digital BH tools** remains largely underregulated. An unsettled evidence base regarding the effectiveness of these tools further complicates investment decisions by payers and states. Emerging **provider-facing digital tools** that optimize provider workflows and enable broader practice transformation show more potential in the near-term.

Ultimately, expanding these models from isolated programs or pilots to embed them into standard care delivery requires a shift from relying primarily on individual champions toward developing durable institutional infrastructure. Interviewees across all models highlighted systemic challenges that prevent promising programs from scaling. These include dependence on fragmented, short-term grant funding; navigating regulations that can stifle local adaptation; and the absence of robust technical assistance to guide implementation and help programs achieve financial sustainability. To sustain and scale, these models need predictable financing, flexible regulations that reward outcomes, and dedicated support for workforce development.

KEY RECOMMENDATIONS FOR STATE POLICYMAKERS

- **Establish Sustainable Financing:** Create stable, predictable funding that reflects the true costs of non-traditional care. Ensure adequate Medicaid reimbursement for integrated, mobile, and telehealth services.
- **Modernize Regulations:** Align state and federal regulations to support innovative models, such as by clarifying rules for mobile medication dispensing. Streamline telehealth delivery by adopting interstate licensure compacts and prohibiting restrictive prior authorization practices that limit access to telehealth. Balance regulatory structure with flexibility to encourage local adaptation of proven models.
- **Drive BH Integration in Other Health Care Settings:** Expand adoption of Collaborative Care Model billing codes in Medicaid and fund technical assistance to help PC practices integrate BH. Incentivize or require hospitals to adopt the ED Bridge model to ensure access to medication for opioid use disorders and wraparound support by peer recovery specialists.
- **Support Community-Based Outreach:** Remove scope-of-practice restrictions on advanced practice professionals, such as nurse practitioners, to expand the mobile care workforce. Allow local governments to use dedicated funding streams, such as local taxes or opioid settlement funds, to support grassroots BH initiatives.
- **Invest in Technology and Workforce Preparation:** Sustain investments in broadband infrastructure to close the digital divide. Fund the development of telehealth best practices trainings for providers. Support rigorous pilot programs to evaluate and scale effective digital BH tools.

Introduction

The United States is in the midst of a mental health crisis.[1] In 2023, one in three U.S. adults—84.5 million people—reported experiencing a mental illness and/or a substance use issue within the previous year.[2] Though clinically proven and effective treatments are available for many behavioral health conditions, too many people, especially those from underserved communities, face barriers to accessing these services. About half of adults with a mental illness and three-fourths of people aged 12 and older with a substance use disorder did not receive treatment in 2023.[3] The U.S. health care system is currently ill-equipped to equitably meet the increasing demand for mental health (MH) and substance use disorder (SUD)—collectively referred to as behavioral health (BH)—services.[4]

With support from the National Institute for Health Care Reform, we are publishing a five-part series examining how public policies affect access to behavioral health (BH) care—especially for underserved populations across the United States. The first report examined efforts to improve the supply and distribution of BH professionals.[5] The second report evaluated strategies for building the capacity of the traditional BH delivery system consisting of specialized BH facilities, clinics, and programs.[6]

This third report focuses on how public policy impacts the deployment of non-traditional and innovative BH delivery models. Subsequent reports will explore financial and insurance-related barriers (Report 4) and stigma, cultural, and awareness-related barriers to clinically appropriate BH services (Report 5).

Methodology

We began by reviewing the literature to identify innovative BH delivery models currently used to expand access. These include integration of BH into primary and emergency care, mobile and community-based outreach, community-led bespoke models, and digital approaches such as telehealth and other BH technologies.

Between April 23, 2024, and June 18, 2024, we conducted 10 interviews with state agency officials, provider association representatives, and academics with broad expertise in each state's BH landscape. Between March 11, 2025 and April 15, 2025, we conducted 14 additional interviews with individuals with specific expertise in non-traditional and innovative BH delivery models either in our study states or nationally.

Throughout this project, we have used our three states as illustrative examples. We chose these states based on recent BH policy activity, geographic and demographic diversity, and the availability of high-quality Medicaid data to support quantitative analysis.

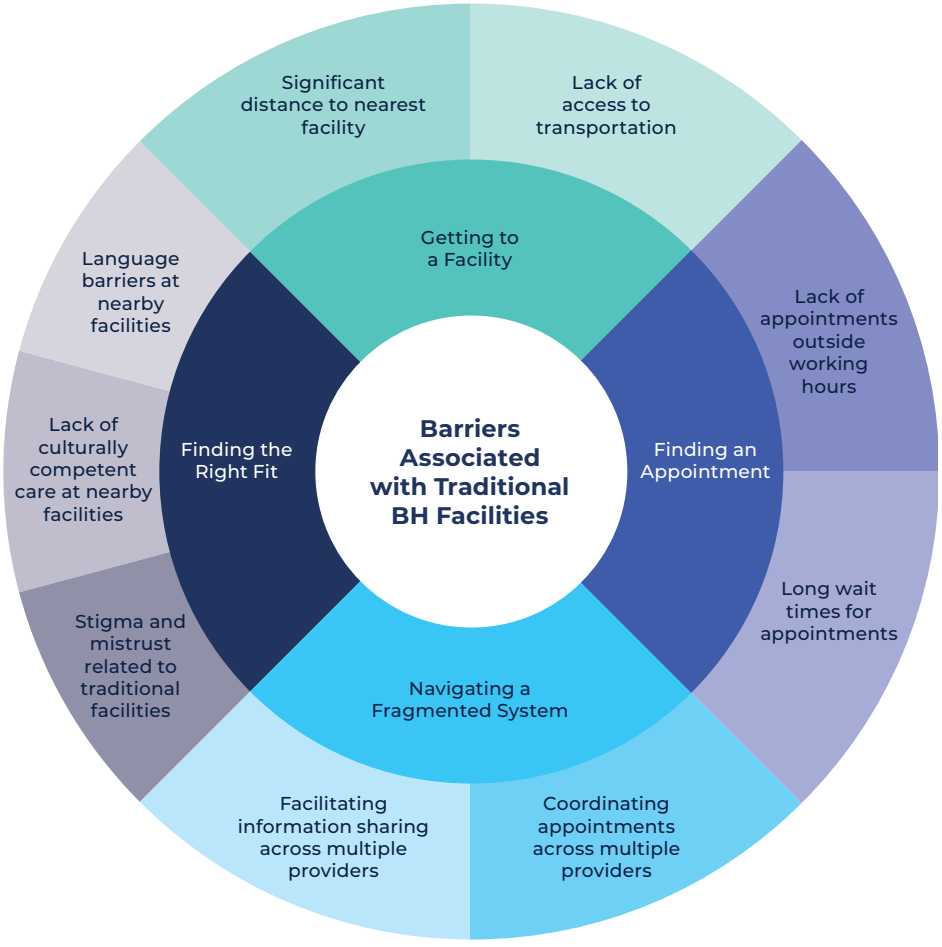
Quantitative analyses of BH facility availability and service use for each state can be found on the Urban Institute website, as well as our website and reports.[7]

Note on Scope: This report focuses on access to *diagnosis and treatment services* for *working-age adults*, particularly from *underserved communities* (rural, low-income, racial and ethnic minority populations). Due to the unique nature of the health care delivery systems serving justice-involved and veteran populations, we exclude these populations from the scope of this project. We recognize that nonclinical services—such as recovery housing, supportive employment, harm reduction, and crisis response—play a critical role in the BH care continuum. However, we exclude them from this study's scope due to practical constraints. Finally, while BH can encompass a wide range of conditions, this study mostly centers its inquiries specifically on access to services for *major mood and substance use disorders*.

The Case for Non-Traditional and Innovative BH Delivery Models

The traditional BH delivery system, which relies on patients finding and accessing services through licensed BH practitioners or at specialized BH facilities, often struggles to meet the needs of many communities. Interviewees across all three study states identified several key barriers that prevent patients and communities from accessing necessary services through the traditional system (see Exhibit 1).

Exhibit 1. Access Barriers Associated with Traditional BH Facilities



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Interviewees identified BH workforce shortages and limited system capacity (addressed in Reports 1 and 2) as significant contributors to these barriers. However, interviewees also pointed to deeper structural issues in the traditional BH delivery system. These include a fragmented health care landscape and limited capacity to serve hard-to-reach populations with specific needs. More specifically, interviewees offered examples, such as:

- **Rural patients** navigating long travel times and facing transportation barriers to reach facilities. For example, some interviewees noted that many **patients taking methadone** have to drive long distances daily to receive their dose at brick-and-mortar opioid treatment programs.
- **Patients with inflexible work schedules** struggling to find BH services outside of regular working hours.
- **Patients with co-occurring conditions** navigating multiple appointment booking systems and fragmented electronic health record systems to cobble together the care they need. One interviewee from Virginia noted that this issue is especially acute for **new and expecting mothers** with BH conditions. The providers they see most—such as obstetricians and pediatricians—are often unprepared to address their specific BH needs.
- **Indigenous populations** often preferring to receive care at Indian Health Service clinics because they feel more culturally safe and comfortable, even when those clinics lack capacity to provide consistent BH services.
- **Immigrant and non-English speaking communities** struggling to find BH services that hinge on robust communication, such as talk therapy, in their preferred languages. Some interviewees also spoke about many immigrants who avoid traditional BH facilities because they fear being targeted for their immigration status.
- **People experiencing homelessness** being either unable to reach traditional facilities or feeling unwelcome at them, which can prevent them from receiving critical ongoing care.

The Intended Role of Non-Traditional and Innovative BH Delivery Models: To mitigate these barriers, a wide range of stakeholders have developed and expanded non-traditional BH delivery models (see Exhibit 2).

Exhibit 2. Non-Traditional and Innovative BH Models and the Barriers They are Designed to Target

Model	Reduces Distance and Transportation Barriers?	Reduces Appointment-Related Barriers?	Reduces Care Coordination Barriers?	Reduces Sociocultural Barriers?
Integration into Primary Care	Yes, unless patient is in a primary care shortage area	Yes, BH care often delivered in same visit	Yes, shared health records and integrated teams are common	Yes, often reduces stigma associated with seeking BH care
Integration into Emergency Care	Yes, emergency departments are more ubiquitous	Yes, though emergency departments are constrained by capacity and wait times vary	Sometimes, depends on availability of navigators/ coordinators	Sometimes, emergency departments can lack privacy and feel distressing
Community-Led BH Models	Yes, delivered in communities	Sometimes, varies by model design	Sometimes, varies by model design	Yes, explicitly tailored to community-specific need
Mobile and Street Outreach	Yes, delivered in communities	Yes, when teams can accommodate walk-ins	Sometimes, varies by model design	Yes, designed for community-based, trust-building outreach
Assertive Community Treatment	Yes, delivered in homes and communities	Sometimes, many teams contend with strict caseload caps	Yes, often focus on delivering team-based wraparound care	Yes, designed for in-home, relationship-building care
Telehealth	Yes, wherever broadband is available	Sometimes, if there is an adequate supply of BH professionals	Sometimes, depending on the platform	Sometimes, stigma might be lower, but there might be digital barriers
Digital BH Tools	Yes, wherever broadband is available	Yes, often asynchronous and available on-demand	Sometimes, some provider-facing tools help improve coordination	Sometimes, stigma might be lower, but there might be digital barriers

Note: The information in this table reflects the authors' assessment of each model's intended design, not proven effectiveness, and assessments are based on background research and findings from interviews.

This report introduces these models, highlights their successes across settings, and offers recommendations to help state policymakers support their expansion and sustainability.

Note: The evidence base for these models varies. Some, like the integration into emergency care model, are supported by rigorous clinical outcome data, while others are primarily validated through evidence of improved patient access and engagement. This report presents the available evidence for each model on its own terms, recognizing that different models may be at different stages of evaluation.

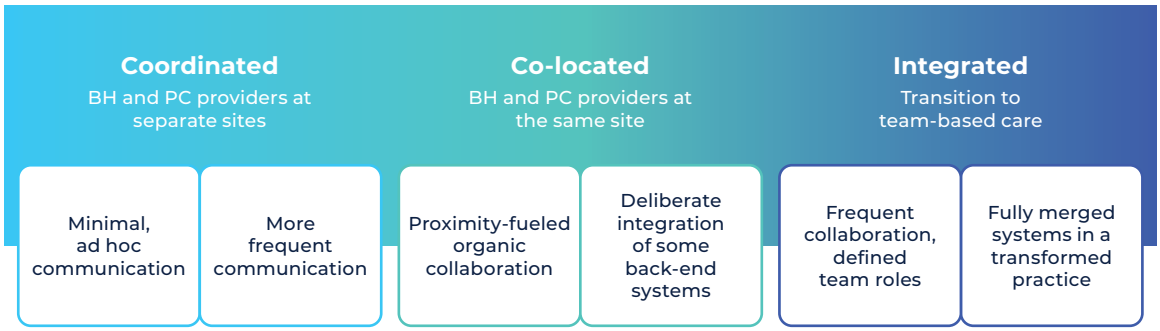
Integrated Care Models

One approach to overcoming the access barriers discussed above is to embed BH services into medical settings that patients already frequent. In this section, we examine two integration strategies that leverage two common points of patient contact: primary care practices and emergency departments.

INTEGRATION INTO PRIMARY CARE

Many Americans regularly visit primary care (PC) practices,[8] and these providers (PCPs) are increasingly seeing patients for BH conditions.[9] However, surveys indicate that many PCPs feel underprepared to treat BH conditions without additional support.[10] Integrated care models that embed access to BH specialists, care managers, and decision-support tools into PC practices can significantly improve patient access to BH services.[11] While definitions of 'integration' have evolved since the 1990s,[12] in 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) developed a spectrum describing six levels of integration of BH into PC practices that is widely used today (see Exhibit 3).[i]

Exhibit 3. The Six Levels of Integration by SAMHSA-HRSA



Note: Adapted from Heath, B., Wise, R. P., & Reynolds, K. (2013). *A Standard Framework for Levels of Integrated Healthcare.* SAMHSA-HRSA Center for Integrated Health Solutions.

i Over the years, two evidence-backed models of integration have been validated by research and experienced wider adoption and health system integration—the Collaborative Care Model (CoCM) and the Primary Care Behavioral Health Model (PCBH). While both models share a population health focus and a team-based structure, CoCM centers the use of a care manager with access to a registry that can help manage a patient panel. In contrast, PCBH is more encounter-driven and focuses on warm hand-offs between co-located PC and BH teams. Both models fall somewhere along levels 4 and 5 on the SAMHSA-HRSA spectrum. However, it is worth noting that CoCM does not require co-location.

Despite the availability of several toolkits and resources, transitioning toward an integrated model remains challenging for many practices. A psychiatrist developing an integrated care model at a rural New Mexico family medicine clinic noted that despite available toolkits and resources, implementation remains challenging. The provider had to do "all the groundwork" themselves—developing staff workflows and referral protocols without external technical assistance or financial support beyond their existing salary. However, multiple interviewees highlighted the growing availability of technology platforms and consultancy services as a potential strategy for boosting the adoption of integrated care models.

A Virginia official with BH access research experience found that many PC practices recognize the value of integration. However, "very few" practices have actually explored integration, and many practices, at most, offer the services of a social worker or case manager to help connect patients to resources. The official explained that uptake remains low due to high initial costs and because downstream benefits, such as fewer hospitalizations, primarily accrue to other stakeholders. Consequently, practices embedded in larger health systems show greater integration—benefiting from the parent organization's funding and internal networks that support key functions like care coordination.

While the adoption of integrated models has been growing, inconsistent reimbursement pathways have limited broader uptake. Interviewees emphasized the importance of creating and deploying sustainable reimbursement pathways to support integrated practice in the long run. In 2017, the Centers for Medicare and Medicaid Services created billing pathways for BH integration services provided by PCPs, care managers, and consulting psychiatrists to Medicare beneficiaries. Since then, the number of providers billing these codes has risen sharply, though adoption varies considerably by state and region.[13] One factor contributing to this geographic variability is that, as of 2023, only 23 states† had activated these billing pathways for their Medicaid beneficiaries.[14] The psychiatrist behind an integrated BH model in New Mexico hoped to scale it to reach more patients but noted that the state's lack of billing infrastructure made expansion infeasible.

† Out of our study states, only Michigan was included in this report. Virginia began covering integration services in 2024 after the report was published; however, Virginia's Medicaid agency found that all of the state's Medicaid Managed Care Organizations had been covering these codes voluntarily, even prior to state adoption. Roberts, C. (2024). *Guidelines for Collaborative Care Model Annual Report. Virginia Department of Medical Assistance Services.*

Preparing the health care workforce is also critical to expanding the adoption of these models. Interviewees also highlighted the lack of workforce preparedness as a key barrier to the adoption of integrated models of care. The Virginia state official identified a lack of "comfort" among PCPs in handling more than basic referrals. Interviewees highlighted the importance of providing support and education to currently practicing PCPs. A New Mexico psychiatrist noted that even "a brief lunchtime session" for PC colleagues significantly increased depression screenings at the practice. Established practitioners interested in integrated models can also benefit from ongoing education on effectively using billing codes and embedding them into clinical workflows, according to interviewees.

The psychiatrist also emphasized the importance of investing in upstream education efforts for various types of health professionals. To advance this goal, they developed a curriculum for psychiatry residents and led trainings for social work students and nurse practitioner groups on integrated care.

"Reverse Integration" or BH Homes

Patients actively managing serious BH diagnoses need a different kind of PC experience. While models that integrate BH services into PC settings work well for patients with mild to moderate BH needs, those with more severe BH conditions are far more likely to see their specialized BH provider as their primary point of contact with the health care system.[15] However, patients with severe mental illnesses are at heightened risk of conditions such as hypertension or diabetes,[16] which requires them to coordinate their BH and non-BH care themselves.

A Michigan program helps providers establish BH Home services as a one-door approach to enable patients with primary BH diagnoses to seamlessly access integrated services. The BH Home model was created to make care more seamless for those with a primary BH diagnosis and a co-occurring non-BH condition. Providers implementing this model integrate PC and other wraparound health care services into their BH delivery.

Michigan established its BH Home program in 2014 (for those with severe MH conditions) and later launched an opioid health home model in 2018 (expanded in 2024 to all SUDs).[17] Two providers interviewed from the state currently operate one or both of these health home programs. One provider informed us that the state pays for these services on a case-rate basis and allows them to use any savings on real-world supports, such as "gas cards and car starters."

According to one provider, BH Home programs can save on Medicaid costs. They reported seeing $300 per member per month savings in the first year, followed by $100 per member per month savings for years 2 and 3. The provider also noted that the patients in the program had better blood pressure control. Another opioid health home provider noted that the program offers intensive follow-up after withdrawal or residential care to support whole-person health.

Long-term functionality of the health home program depends on significant investment in cross-sector collaboration. One provider operating in a rural area found that the long-term success of their health home programs depends on significant cross-sector, local collaboration. They hold monthly "human services collaborative" meetings that convene BH providers, social service organizations, and state agencies to build partnerships and address systemic issues. The provider also conducts twice-weekly "huddles" or inter-disciplinary calls with providers across the county to coordinate care for specific patients on an ongoing basis.

INTEGRATION INTO EMERGENCY DEPARTMENTS

The emergency department (ED) is another health care setting that serves a significant proportion of Americans and can provide an avenue for expanding access to and connection with BH services. EDs are open 24/7 and provide services regardless of the patient's ability to pay. In 2022, about 20 percent of adults visited the ED.[18] While a majority of patients present at the ED for primary diagnoses unrelated to a BH condition, a steeply growing proportion of ED encounters now include a primary or secondary BH diagnosis.[19]

Integrating BH services into EDs has received less systematic attention than in PC settings, partly because ED clinicians often face severe capacity constraints.[20] One pragmatic approach is to identify high-impact, evidence-backed interventions that can be overlaid onto existing ED workflows without adding an untenable burden to providers. Among the menu of ED-BH models (which includes interventions such as tele-psychiatry consults and universal suicide screenings), the strongest evidence to date supports ED-initiated medication for opioid use disorder (MOUD) (the "ED Bridge model").[21]

Developed in California, the ED Bridge model was rapidly deployed in a majority of the state's EDs within four years.[22] It involves initiating patients on MOUD in the ED, connecting them to post-discharge OUD care, and fostering a culture of harm reduction.[23] Since its development, the model along with related interventions have been shown to significantly increase treatment engagement as well as reduce self-reported illicit opioid use.[24]

States have helped expand adoption of the ED Bridge model, but achieving large-scale system change will likely require more than piecemeal funding and short-term technical assistance. Two of our study states, Michigan and Virginia, have undertaken efforts to expand the use of the ED Bridge model. The Michigan Opioid Partnership, a public-private collaborative between the state health department (with the help of federal grant funds) and several philanthropies, was launched in 2019 and went from supporting model implementation in six EDs in year one to 75 EDs in year four.[25] According to an interviewee familiar with this initiative, the Partnership awarded grants to cover implementation expenses, including staff time, training, and information technology-related changes. Over time, they stopped providing funding to EDs, but continued providing technical assistance, evaluations, and peer learning opportunities.

In Virginia, the implementation of the model was led from the ground up. In 2018, a health clinic in Roanoke independently decided to implement the program. After observing the program's successful

rollout, state agencies have funded the clinic and its staff to provide technical assistance and training to help other EDs across the state adopt the model.[26]

The long-term success of this model depends on building adequate support structures. First, ED providers may be reluctant to initiate MOUD until they are assured that patients can access ongoing treatment when they leave the ED. As discussed in our second report,[27] the capacity of local BH facilities can be insufficient to meet this need.

Second, administrators in both Michigan and Virginia pointed to the value of embedding peer recovery specialists in the ED for a "warm handoff" to help patients successfully transition to longer-term treatment. However, limited reimbursement pathways have made employing these professionals challenging. Michigan's Medicaid rules, for example, do not allow a hospital to hire and directly bill for peer recovery services. EDs must explore workarounds, such as partnering with community-based organizations that can employ and bill for peer services.

To achieve wider adoption of MOUD provision in EDs, states may need to move beyond incentives and establish requirements. As one program administrator put it, "you need a carrot to bring hospitals on board or a stick." "Carrots" in the form of state or philanthropic grants to EDs can cover start-up costs and encourage adoption up to a point. Additional levers, such as guidance from the state licensing agency, clarifying regulations, or building the model into Medicaid quality measures can further nudge uptake.

Ultimately, however, "sticks" or explicit requirements may be necessary to achieve near-universal adoption. Maryland, for example, now requires hospitals to stock MOUD, develop protocols for initiating it through the ED, and take steps to help initiated patients transition to ongoing treatment.[28]

VMAP for Moms+

AN INNOVATIVE MODEL TO INTEGRATE BH SERVICES INTO WOMEN'S HEALTH CARE

Many women, especially pregnant women or new mothers, rely on their obstetrician/gynecologist (OB/GYN) as their PCP.[29] However, despite frequent patient contact and the impact of BH conditions associated with women's health care,[30] many OB/GYN practices feel unprepared or lack the resources to treat these conditions.[31] One statewide initiative, Virginia Mental Health Access Program (VMAP) for Moms+, is improving access to BH services for pregnant and postpartum individuals by offering telephonic "curbside consultation" to the various non-BH providers who treat this population, including OB/GYNs.[32] The program also offers BH care navigation to connect patients with local resources, and provides low-cost education to prescribers to help improve screening, diagnosis, and treatment of BH conditions.

State funding has been crucial in supporting the development of this innovative program. This program launched in 2024 as an extension of a longer-running program that provides similar services to pediatricians seeking to treat BH conditions in children and adolescents. Though initial seed funding for this original program came from a one-time federal grant in 2018,[33] today, both programs are supported primarily through a $15 million annual appropriation from the state general fund. Thanks to sustained state support, these programs currently offer their consultation and navigation services free of charge.

The model is scalable and can be adapted for different populations. Interviewees familiar with the program emphasized the ease of establishing it, particularly in comparison to other BH access solutions that require substantial upfront and ongoing investments. Further, they highlighted the versatility of the model, which can be modified to meet different population needs. In 2024, Virginia expanded the model by launching an Adult Psychiatric Access Line to support PC and ED providers treating adults with BH conditions.[34] However, interviewees cautioned against relying exclusively on programs such as these to promote the delivery of integrated services. They do not replace the need for simultaneous long-term investment in workforce preparation, ensuring adequate reimbursement for integrated services, and incentivizing integration through alternative payment models.

Community Outreach Models

Some non-traditional models focus on taking BH care outside of the four walls of health care facilities and bringing care into communities, as well as directly to patients' homes. These models mitigate distance- and travel-related barriers, allowing patients to receive services in settings where they feel more comfortable. In this section, we explore two community outreach models: (1) mobile health clinics and (2) the Assertive Community Treatment model.

MOBILE HEALTH CARE

Mobile health units—often vans or buses—are a vital strategy for delivering care "outside the four walls" of a traditional clinic. Rather than a single program type, mobile health is a versatile platform that providers tailor to overcome access barriers, such as transportation, distance, and stigma. While used for decades in other health fields, they are now a critical tool for overcoming the nation's BH crisis, providing MOUD, counseling, and connections to social services. Street medicine is a related model focused on reaching people experiencing homelessness (we collectively refer to both as "mobile" in this section).

Mobile units serve as a critical lifeline for geographically and socially isolated populations. Interviewees from Virginia and New Mexico highlighted how mobile units mitigate travel distance and transportation barriers, as well as stigma and sociocultural barriers. One Virginia interviewee at a BH facility noted that in small towns, "people don't want to be seen walking in our doors." Mobile units also deliver care to New Mexico's *colonias*—rural settlements where residents face language barriers, geographic isolation, and fears of immigration enforcement, according to researchers familiar with the program. By using data to guide deployment to high-need communities, these programs can serve as a "gateway into continued PC services" for hard-to-reach populations. This on-the-ground reality is reflected in the research showing that mobile MOUD programs disproportionately serve Black, homeless, and uninsured patients missed by fixed-site clinics.[35]

Perhaps the most crucial aspect of their success is the focus on intentionally building trust. Mobile operators in Virginia spoke of partnering with food pantries

and churches to provide cover for patients and counteract the stigma of being seen accessing addiction care. Other mobile providers described leading with the provision of non-judgmental services. One Michigan program brands itself as a PC provider rather than as an "addiction clinic" to gain community acceptance. Ultimately, interviewees emphasized that creating a "safe haven"—free from negative perceptions of policing or monitoring common in traditional addiction treatment—is essential to program success.

The success of mobile units is often constrained by a web of regulatory barriers that can stifle innovation. A Michigan state official, for example, pointed to a federal Drug Enforcement Administration (DEA) rule requiring mobile methadone units to return to base every night,[36] making it difficult to serve remote regions, such as the state's Upper Peninsula. Furthermore, federal requirements for safety net providers, such as rural health clinics and federally qualified health centers, strictly define the areas of operation for any mobile units they deploy.[37] Expanding beyond these designated areas requires a lengthy federal approval process. As a result, these complex requirements effectively limit the geographic reach of local providers.

Beyond these operational rules, state-level scope-of-practice laws that require physician oversight of nurse practitioners (NPs) can limit the provider pool. One NP noted that even where state laws allow for full practice authority, insurers may still require a collaborating physician to sign off on claims, adding unnecessary cost and complexity.

One of the most complex issues around mobile MOUD services is that mobile units can often *prescribe* medications, but they cannot *dispense* them. MOUD dispensing is governed by a patchwork of federal and state regulations, including separate rules for opioid treatment programs (OTPs) that dispense methadone and office-based addiction treatment (OBAT) providers who prescribe or dispense buprenorphine. Interviewees in Virginia noted that conflicts between state licensing agency and pharmacy board rules have created a regulatory gray area for mobile providers and deterred them from dispensing medications. The board is now working on amending its rules through administrative processes.

These hurdles require providers to create inefficient workarounds. A Virginia operator described using a "sidecar" vehicle to drive patients to pharmacies. However, even after patients reach the pharmacy, their access to MOUD is not guaranteed. A New Mexico provider explained that rigid ID requirements at pharmacies are a "huge barrier" for people experiencing homelessness and that pharmacies frequently run out of MOUDs due to wholesaler volume caps, which the provider believes stems from a "misinterpretation of DEA guidance."[38]

Mobile unit operators find that while start-up funding is vital, it can be insufficient to ensure long-term financial sustainability. Providers have leveraged opioid settlement funds and federal grants to establish mobile units but find that funding day-to-day operations remains a challenge. Reimbursement frameworks established for traditional health care delivery often fail to account for non-traditional delivery models, such as mobile health care. Further, despite mobile MOUD units reducing costly ED visits and public safety spending,[39] current reimbursement frameworks do not include any mechanisms that would allow mobile unit operators to share in these savings.

Tackling these financial hurdles requires rethinking traditional reimbursement frameworks, such as Medicare's 'place-of-service' (POS) code system. Medicare currently uses POS codes to decide which services to cover and how much to pay for them. Mobile units have had a unique POS code since 2003, and Medicare pays for services provided by these units at the same rate they pay for office-based services.[40] State Medicaid agencies generally follow the same POS structure.[41] This single-rate approach does not make allowances for travel time or the fact that many mobile providers see higher acuity patients.

States are beginning to build more tailored reimbursement frameworks for non-traditional delivery models. In 2023, California developed an encounter rate specifically for mobile crisis services that takes into account the unique features of mobile health care delivery.[42] Of our study states, New Mexico recently created a reimbursement pathway for health care services delivered to people experiencing homelessness. In 2025, the state issued a letter to its Medicaid Managed Care Organizations announcing its decision to adopt a recently established POS code for street-based care and requiring them to cover certain primary and BH care delivered in this setting.[43]

ASSERTIVE COMMUNITY TREATMENT

For over five decades, Assertive Community Treatment (ACT) has been a foundational, evidence-based model for delivering community-based BH care to people with serious and persistent mental illness.[44] ACT's core principles—including assertive outreach, a holistic approach, and the direct delivery of services in settings like homes or shelters—have influenced modern community-based BH delivery models. The model is built on a multidisciplinary team with a low patient-to-staff ratio that provides intensive, 24/7 support.[45] This structure has been proven to reduce psychiatric hospitalizations and be cost-effective over the long run despite its resource intensity.[46]

While many states have incorporated the ACT model into their BH delivery system, rigid rules defining which iterations of the model are eligible for reimbursement can suppress innovation. As states look to integrate proven models into their health care systems, they face a critical tension: how to maintain fidelity to the rigorously tested model while still allowing flexibility for real-world innovation.[47] While not unique to ACT, the model serves as a perfect case study of this challenge. As of today, at least 39 states cover ACT under Medicaid.[48]

Virginia's approach to covering ACT services illustrates the tradeoffs states and providers face. In 2021, the state's Medicaid agency moved to a tiered reimbursement system that phases in higher rates to programs that hew closer to the model.[49] While one provider welcomed the update, others worried that the tailored or innovative aspects of their programs could result in funding cuts. This financial pressure is compounded by the fact that state general appropriations-based funding varies from year to year,[50] which reduces the financial sustainability of innovative models. One provider cited these funding vagaries as a reason for discontinuing ACT services in a rural area.

Providers in Michigan reported that a more flexible financing structure has allowed them to innovate more effectively. One provider described the state's Medicaid reimbursement for ACT services—which provides higher reimbursement for more intensive care—as similar to a value-based payment and a structure that "works well." This flexibility has allowed providers to adapt the model to local needs. For example, some providers have deployed leaner ACT teams in rural areas or created teams for patients with co-occurring serious mental illness and SUD.

Though intensive services delivered in community settings have the potential to benefit many patients with BH conditions, rigidity around defining who qualifies for ACT services continues to limit who can access them. Both Michigan and Virginia strictly limit ACT services to a subset of individuals, including those with a history of repeat hospitalization or incarceration. While these limits help ensure the high-intensity model remains cost-effective, providers argue they stifle the development of "ACT-lite" services that could be deployed to support a broader population. One provider described the lack of an "in-between" level of care a missed opportunity. They noted that patients must often "fail" with traditionally delivered services before becoming eligible for intensive services like ACT.

Local and Grassroots-Led Models

While many innovative care models emerge from academic or centralized settings, our interviews highlighted grassroots, community-driven approaches developed in direct response to local needs.

Bernalillo County's voter-approved BH Initiative enables local leaders to respond to community needs and establish sustainable, county-wide BH infrastructure. Supported by approximately $37 million per year from a gross receipts tax,[51] Bernalillo County, home to Albuquerque, New Mexico, established the BH Initiative to give local leaders a flexible, community controlled funding stream. The county also offers operational and clinical technical assistance to smaller providers, enabling them to deliver evidence-based BH care while achieving financial sustainability. The county will soon deploy three mobile school-based clinics to provide integrated care to students lacking regular access to health services.

Grassroots models prioritize low-barrier, integrated care by deploying multidisciplinary teams directly into communities with high needs. In both urban Albuquerque and rural Virginia, providers have responded to evolving community needs by expanding their mobile service offerings. An Albuquerque provider launched two outreach vans staffed by prescribing providers, nurses, harm reduction specialists, and community health workers to meet the needs of people experiencing homelessness. They visit sites like library parking lots, delivering immediate, low-threshold care such as wound management, naloxone distribution, safer-use supplies, and prescriptions. In rural southwest Virginia, another provider is working with community partners to launch "mobile villages" that co-locate BH, dental, harm reduction, and benefit enrollment services.

Technology-Enabled Models

The models discussed thus far have focused on bringing care to where patients are physically located—in PC clinics, EDs, or their own communities. Technology-enabled models represent a third frontier, one that can transcend physical location altogether to deliver care virtually. These approaches, which range from direct video appointments to self-guided smartphone applications, hold the potential to scale access and meet the growing demand for BH services. However, evidence on the clinical effectiveness of many newer digital tools—particularly self-guided patient-facing apps—is still limited and evolving. Nonetheless, these technology-enabled approaches are being increasingly integrated with in-person models to enhance flexibility and responsiveness of care.

To analyze these models, this report divides these models into two primary categories:

- **Telehealth** – A form of provider-delivered remote care that can be
  - Ongoing, with a longitudinal provider-patient relationship conducted remotely, or
  - Episodic, where patients receive on-demand, ad hoc care from rotating clinicians.
- **Digital BH Tools** – Tools that are either patient- or provider-facing:
  - Patient-facing tools are self-guided and substitute for or augment clinician time.
  - Provider-facing tools that optimize workflow can shave critical minutes off front-end tasks (intake, triage, risk scoring) or off back-end tasks (documentation, quality reporting assistance).
  - Provider-facing tools that transform a practice's care delivery model can help providers re-arrange their practice structure to help them provide higher-quality care (integrating BH into PC practices) and/or allow them to participate in alternative payment models.

Note: See Appendix I for more detailed information on how these models affect patient access, care continuity, and provider workload, as well as the regulatory frameworks that govern them.

TELEHEALTH

During the COVID-19 pandemic, providers and policymakers turned to telehealth as a means to preserve access to essential and ongoing care during lockdowns. Federal and state regulatory flexibilities around telehealth reimbursement and remote prescribing allowed many BH providers to pivot to offering services remotely.[52] Evidence shows that telehealth can be as effective as in-person care,[53] indicating that telehealth can be a durable strategy to expand BH access even post-pandemic.

Telehealth improves convenience and access, but persistent digital, financial, and patient-specific barriers limit its reach. Across all three study states, interviewees praised telehealth's ability to reduce barriers for rural communities, shift workers, parents, and other vulnerable populations, making it easier for patients to seek care without disrupting daily responsibilities. This is especially true for episodic telehealth, which enables patients to access providers on demand at all hours. Providers credited the flexibility of telehealth to reducing no-shows and wasted time.

However, interviewed providers also expressed concerns about how certain communities have been unable to benefit from telehealth. They spoke about how some rural residents continue to struggle with accessing broadband. Post-pandemic funding cuts have contributed to this issue. A provider in Michigan recalled how her organization used pandemic-era funding to provide telehealth-enabled equipment and cover Wi-Fi costs for patients. With these resources drying up, the provider worries about losing some of these gains, especially among low-income patients. Providers also expressed concerns about individuals with developmental disabilities, limited English proficiency, and limited digital literacy who sometimes struggle to navigate telehealth technology.

Audio-only telehealth can resolve some of the barriers associated with video-based telehealth. Interviewees noted that older adults, youth, and individuals with privacy concerns tend to prefer audio-only options because they are easier to use and provide more privacy than video-based options. Furthermore, audio-only telehealth does not require broadband access or familiarity with telehealth applications. Existing studies show that for many, audio-only options can be as effective as video-based options, but in the case of severe mental illness or where the provider relies on non-verbal cues for diagnosis or therapy, video might offer more benefits.[54]

State policies and a lack of adequate training can limit providers' ability to adopt telehealth. Providers across states told us how, post-pandemic, states have diverged in their approach to regulating telehealth.

- Virginia, for instance, has codified many pandemic-era flexibilities and devoted significant resources to develop supportive infrastructure.[55] However, interviewees noted that the state is still debating full payment parity for audio-only visits and recognition of out-of-state licensure.

- Michigan requires payment parity between telehealth and in-person visits. However, one Michigan provider explained that, in practice, her region's Medicaid payer imposes "pretty rigid limitations" on telehealth, requiring prior authorization and proof of necessity. The provider described these restrictions as "an administrative burden" that discourages the use of telehealth.

- In New Mexico, interviewees lauded the state's longstanding investment in telehealth and broadband infrastructure. Still, one interviewee noted that an analysis of the state's Medicaid data revealed that many rural patients continue to rely on in-person care. The interviewee partly attributed this outcome to the inability of urban providers to connect with rural patients via telehealth.

Beyond regulatory friction, the lack of formal training in delivering remote care contributes to provider hesitancy in adopting telehealth. A researcher from Virginia studying telehealth trends noted that despite supportive state policies, providers have been hesitant to use telehealth for high-acuity patients and have lingering questions about billing for the service. One Michigan provider expressed a desire for more provider education on "best practices in telehealth," noting that effective virtual care requires different skills and tools than in-person treatment. They mentioned that they have not yet seen any post-pandemic efforts to train the workforce on making virtual visits "as valuable as in-person" visits.

Innovative models integrate telehealth and community-based care to extend the capacity of the BH workforce while creating a more responsive delivery system. By pairing virtual services with high-touch, community-based outreach, providers can leverage telehealth to develop a more flexible and responsive system of care.

The Virginia Telemental Health Initiative is a statewide virtual mental health clinic that offers free care and short-term therapy to underserved adults in partnership with nearly half of Virginia's free clinics.[56] The program serves a dual purpose: it pairs patients who cannot find timely BH care with aspiring BH counselors who need clinical supervision hours to get licensed. One interviewee described this "marriage" of goals as a way to strengthen the workforce pipeline while plugging critical BH access gaps. Further, the model also helps ensure that the next generation of BH clinicians is trained and competent in delivering remote BH care.

Some providers are pairing virtual services with high-touch, community-based outreach to create a more flexible system of BH care. A mobile clinic operator in Michigan uses telehealth as a "bridge" to provide immediate care for high-risk individuals. When her team encounters a person in crisis, they facilitate an instant telemedicine evaluation, initiate medication, and attempt to see the patient again during the mobile clinic's next visit to the area. The provider reports that, anecdotally, the approach has helped patients avoid ED visits. Similarly, an ACT team in Virginia reported using smartphones to deliver on-the-spot telehealth visits with various providers to people experiencing homelessness.

DIGITAL BH TOOLS

While telehealth replicates the traditional provider-patient interaction virtually, the advent and growth of digital tools, such as mobile and web applications, represent a more fundamental shift in health care delivery.¥ As described above, we have seen the proliferation of both patient-facing and provider-facing tools (some tools combine both patient- and provider-facing interfaces). However, these tools represent a rapidly evolving, mostly unregulated frontier.

The marketplace for patient-facing digital BH tools is rapidly evolving and lacks clear taxonomy and regulatory frameworks. These tools tend to range from self-guided "wellness" applications (apps) to those that claim to provide actual clinical benefits. Other apps blend self-guided components with provider oversight. The Food and Drug Administration (FDA) developed its Software-as-a-Medical-Device (SaMD) regulatory pathway in 2017 to approve digital health tools that make explicit treatment claims.[57] Under the FDA's guidance, general "wellness" apps are considered low-risk and subject only to discretionary oversight by the agency. While this offers some regulatory certainty, one national expert on these tools noted that the time and cost of FDA approval have led many startups to focus on developing products that avoid explicit regulatory oversight.

In 2023, SAMHSA produced a parallel federal advisory, introducing a nested set of terms:

- **Digital Health Interventions** – the broadest category encompassing all apps supporting health-related goals

¥ Outside the BH context, there has also been an increase in the use of wearables that enable remote patient monitoring; however, these technologies are beyond the scope of this report. Additionally, various digital BH tools have begun incorporating artificial intelligence (AI). Given the nascency of this development, AI's role in BH delivery has not been explored in this report.

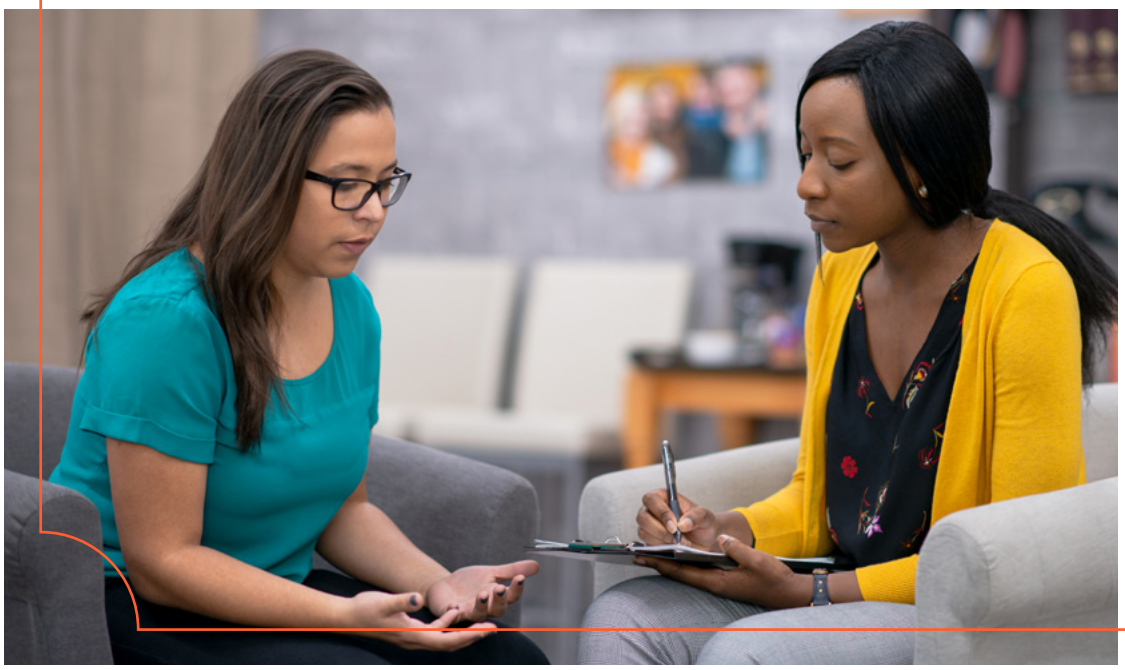
- **Digital Therapeutics** – a subset of digital health interventions that make health claims and can be subject to FDA oversight if they make clinical claims; and
  - **Prescription Digital Therapeutics** – a subset of digital therapeutics approved for prescription use by the FDA depending on their risk level.[58]

The advisory maps these tools to clinical use cases and suggests expectations for evidence and privacy safeguards.

According to an interviewee familiar with this industry, developers and purchasers may often find the overlapping guidance by the two federal agencies as unaligned.[59] This interviewee, payers, and other stakeholders active in this space have called for an inter-agency taxonomy and the development of more tailored regulatory pathways based on the taxonomy. Without this shared structure, states and payers are largely left to develop their own rules for incorporating digital health tools into their delivery systems.

The clinical effectiveness of many patient-facing digital BH health tools remains an open question. A national expert described most digital BH tools as "evidence-informed, not evidence-based." A recent review of 130 studies evaluating the effectiveness of 15 digital BH tools intended to support patients with depression and anxiety found that most tools were only evaluated over a short 6 to 12-week follow-up period.[60] The review also found that only a handful of FDA-cleared prescription digital BH tools—and a small set of self-guided cognitive behavioral therapy apps—had the strongest evidence supporting their clinical claims. On the other hand, "wellness" or direct-to-consumer apps making broad mental health claims were rarely supported by robust evidence. A companion review evaluating the effectiveness of digital BH tools intended to support patients with opioid use disorders is forthcoming.[61]

States have started using their opioid settlements to pilot the use of SUD-specific tools. Two of our three study states have started investing in digital BH tools specifically for SUD management. In 2021, Michigan legislature appropriated $1.5 million toward developing a short-lived pilot program that offered access to an FDA-cleared prescription digital BH tool for those with SUDs.[62] Using its opioid settlement funds, Michigan is also investing in a pilot program offering "contingency management" (an evidence-based treatment for SUDs) to its Medicaid beneficiaries.[63] New Mexico has chosen to invest some of its opioid settlement funds into population-wide prevention and recovery supports. The state's health department has partnered with a digital BH tool developer to offer providers and patients in the state access to an SUD screening



platform, a peer support app, and a self-guided addiction management app (none of these tools have been cleared by the FDA).[64]

Provider-facing tools may offer a more sustainable path to enhancing BH care access without triggering concerns about claims of clinical effectiveness. While patient-facing tools dominate news stories, quietly emerging provider-facing tools have a greater potential to change the landscape of BH delivery in the near-term. The national expert we interviewed conveyed that they were "most excited" about the possibilities in this space, because these tools can help "busy clinicians do their job more effectively and efficiently." Provider-facing tools could theoretically expand a practice's panel size without increasing the need for full-time staff.

This interviewee also described there being "a lot of uptake and enthusiasm" for tools that support back-office functions, such as automated notetaking, billing, and referral management. In addition to back-office functions, emerging provider-facing tools offer clinical decision support and help practices shift to whole-person care or alternative payment models. The interviewee finds that there is moderate but growing interest among funders for these tools, given that they involve far less regulatory ambiguity. However, while these tools are less likely to be subject to FDA scrutiny, they must still adhere to federal data privacy, security, and interoperability rules.

From Innovation to Standard Practice: Scaling Successful BH Models

The innovative models explored in this report—from integrated care and community outreach to technology-enabled solutions—demonstrate significant promise in overcoming the access barriers that plague the traditional BH system. Yet, transitioning these models from isolated successes to standard practices involves overcoming a distinct set of systemic challenges. A common thread across our interviews was that many of these pioneering efforts are driven by the sheer force of mission-driven leaders. These individuals work tirelessly to navigate complex regulations, build systems from scratch, and secure patchwork funding for programs. While such champions are essential catalysts for change, relying on the leadership and persistence of individuals is not a scalable or sustainable strategy for system-wide transformation. The path from innovation to standard practice requires a deliberate shift from supporting individual projects to building institutional infrastructure.

Financial sustainability is one of the most significant hurdles for scaling non-traditional and innovative models. Many promising models discussed in this report are heavily dependent on short-term grants and cobbled-together funding streams. A mobile outreach provider in New Mexico, for instance, reported juggling over 40 distinct funding sources to sustain their services. This constant financial uncertainty hinders long-term planning, prevents investment in staff and infrastructure, and perpetuates a cycle of stop-and-start implementation that ultimately harms communities. To become embedded in standard practice, these models require predictable and sustainable financing mechanisms that accurately reflect the true costs of delivering care in non-traditional settings.

Regulatory frameworks can be particularly complex for non-traditional and innovative models. Innovative providers often have to navigate a maze of sometimes conflicting rules from federal agencies (DEA, FDA, SAMHSA), state licensing boards, and local payers, which can stifle creativity and drain resources. Additionally, this regulatory challenge extends to how states choose to define and reimburse evidence-based models. The experience with the ACT model highlights a critical tension between preserving model fidelity and allowing flexibility. While states rightfully seek to ensure that new programs adhere to a model's proven core components, overly rigid requirements can punish innovation. Scaling innovation, therefore, requires creating iterative regulatory and payment pathways that incorporate solicited feedback from providers on the ground and reward effective outcomes.

Scaling depends on preparing the workforce to operate effectively within these new models. The models described in this report require providers to expand their roles and build new skills. For example, PC clinicians must manage BH conditions, therapists must adapt to virtual care, and peers must operate effectively in EDs. Without dedicated, ongoing training built into these models or into curricula for trainees, providers may be hesitant to adopt new practices, limiting the potential reach of these models.

Attempts to scale promising models must be accompanied by adequate resources and technical assistance. The most effective path to scale involves developing "plug-and-play" models that can be adapted to local needs with the support of ongoing technical assistance. Michigan's experience with BH Homes provides a powerful case study in how to institutionalize innovation. A committed provider who was an early adopter of the model trained internal staff to provide technical assistance to other interested providers. In response, the state created a dedicated division to support a statewide learning collaborative and track outcomes, such as cost savings and improved health metrics. This intentional, state-supported strategy for replication and evaluation provides a clear blueprint for transforming a promising local innovation into a durable, evidence-based standard of care.

Recommendations for State Policymakers

State policymakers can implement targeted strategies to foster, scale, and sustain innovative and non-traditional BH delivery models. The following recommendations are organized first by cross-cutting policy levers that apply to multiple models, followed by high-impact actions tailored to specific models.

CROSS-CUTTING RECOMMENDATIONS

- Establish stable, predictable funding streams reflecting true care costs, reducing dependence on fragmented, short-term funding.
- Create iterative and flexible regulatory frameworks, incorporating provider feedback to balance fidelity to model specifications with local innovation.
- Expand and clarify reimbursement pathways for non-traditional BH models, particularly within Medicaid, with explicit guidelines on coding and billing.
- Invest in workforce preparation through comprehensive training for current practitioners and upstream education for future providers on innovative BH care delivery.
- Provide robust, ongoing technical assistance and statewide learning collaboratives to support model implementation and continuous improvement.

INTEGRATION INTO PRIMARY CARE (PC)

- Expand adoption of Collaborative Care Model (CoCM) billing codes in Medicaid; proactively train PC providers on using these billing mechanisms.
- Explore investments in technology platforms and consultant services to simplify integration by supporting workflow development and referral protocols.

REVERSE INTEGRATION (BH HOMES)

- Pilot BH Home and Opioid Health Home programs with capitated payments, permitting providers flexible use of savings for community support services.
- Foster sustained local, cross-sector collaboration to enhance integrated BH care capacity and address community-specific needs.

INTEGRATION INTO EMERGENCY DEPARTMENTS (EDS)

- Expand the ED Bridge model statewide through targeted upfront funding, technical assistance, and provider training.
- Enable hospitals to directly bill for peer recovery services in the ED, and clarify federal and state regulations around initiating MOUD.
- Integrate ED Bridge model metrics into Medicaid quality measures to incentivize adoption; consider mandates for universal ED MOUD protocols, following Maryland's example.

VMAP FOR MOMS+ MODEL

- Establish programs offering non-BH providers telephonic BH consultations and provide low-cost training opportunities to encourage non-BH providers to deliver BH services.

MOBILE AND STREET-BASED BH CARE

- Remove scope-of-practice restrictions and prohibit insurers from requiring physicians to sign off on claims by advance practice professionals.
- Align regulations across agencies governing MOUD prescription and dispensing, particularly in mobile units.
- Develop distinct reimbursement rates that recognize the true costs of delivering mobile care.
- Mandate coverage of mobile and street-based services by state-regulated insurers.
- Allow mobile providers to share savings from reduced emergency and public safety utilization.

ASSERTIVE COMMUNITY TREATMENT (ACT)

- Ensure consistent funding for ACT programs, allowing for local innovation within proven ACT frameworks.
- Loosen eligibility criteria and pilot ACT-lite services to expand access to community-based services to a broader population.

LOCAL AND GRASSROOTS MODELS

- Permit counties to levy dedicated local taxes to fund tailored health initiatives and community-driven BH solutions.
- Provide continuous funding to nurture local cross-sector collaborations that can spur creative responses to community-specific challenges.

TELEHEALTH

- Adopt a clear, statewide taxonomy defining tech-enabled BH models that can serve as the basis for a thoughtful regulatory and investment strategy.
- Sustain investments in broadband and smart-device distribution, accompanied by patient education on technology use.

- Guarantee access to audio-only telehealth when video-based services are impractical or equally effective.
- Streamline out-of-state provider telehealth practice through flexible upfront licensure arrangements, coupled with backend enforcement.
- Prohibit restrictive prior authorization practices that hinder telehealth utilization.
- Fund development of telehealth best practice training programs.
- Invest in programs, such as the Virginia Telemental Health Initiative, that can simultaneously plug access gaps and provide free clinical supervision hours to graduate-level BH providers seeking licensure.

DIGITAL BH TOOLS

- Convene an advisory council to establish a working taxonomy and evaluation framework for digital BH tools to guide state decision-making.
- Implement rigorous, ethical, and evidence-based pilot programs leveraging academic partnerships to evaluate real-time effectiveness of patient-facing digital BH tools.
- Create and distribute guidelines for identifying provider-facing tools to aid in adoptions (such as checklists for meeting regulatory standards, data privacy, etc.) to ensure best use/fit. From these guidelines, curate and distribute lists of vetted provider-facing tools meeting regulatory standards to aid practice adoption.
- Explore bulk purchasing of high-value provider-facing digital tools to support practice transformation efforts statewide.

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Appendix I

TELEHEALTH AND DIGITAL BEHAVIORAL HEALTH MODELS: DEFINITIONS, IMPACTS, AND REGULATORY OVERSIGHT

Telehealth and digital behavioral health tools are promising options for mitigating workforce shortages and patient access gaps. This typology distinguishes provider-delivered remote care (telehealth) from digital behavioral health tools, helping policymakers better understand how each model functions. It outlines how each model affects patient access, care continuity, and provider workload, while summarizing their regulatory interactions.

Model	Description	Impact on Patient and Provider Experience	Regulatory Interactions
Telehealth (Provider-Delivered Remote Care)			
Ongoing Telehealth	Longitudinal provider-patient relationship conducted remotely. **Sub-types:** (a) In-person to remote (continuity extender); (b) Starts and stays remote (fully remote); (c) Remotely initiated short-term care as a bridge to ongoing, potentially in-person care (bridge programs) *Modality overlays:* (a) Live vs. Asynchronous (video, phone, secure chat); (b) by provider type; (c) by type of service – individual therapy, group therapy, etc.	Patient experience – Access – Removes geography + scheduling barriers for longitudinal care Patient experience – Continuity – Preserves therapeutic alliance Provider experience – Greater scheduling flexibility; modest panel growth via fewer no-shows	Licensure and *Interstate Compacts* – State medical and psychology boards; state policymakers Privacy and Security – *HIPAA Privacy and Security Rules, 42 CFR Part 2* (privacy rules specific to substance use-related patient information) – HHS Payment – *Telehealth billing codes*; required telehealth coverage; telehealth parity laws[i] – HHS + state DOIs DEA rules for controlled substance e-prescribing[ii]

i *Some states* require insurers to cover telehealth services to the same extent as in-person services (coverage parity); *some states* require insurers to pay the same rate for a service when it's delivered by telehealth vs. in-person (payment parity).

ii Under the *Ryan Haight Act of 2008*, a telehealth provider is first required to perform an in-person evaluation of a patient prior to prescribing a controlled substance (with certain limited exceptions). During the COVID-19 public health emergency, DEA adopted temporary flexibilities for telehealth prescribing of controlled substances, which have been extended on an annual basis (currently in place until *Dec 31, 2025*).

Model	Description	Impact on Patient and Provider Experience	Regulatory Interactions
Episodic Telehealth	On-demand, ad hoc encounters with rotating clinicians. **Sub-types:** (a) Virtual urgent/ after-hours care; (b) Prescription-driven visits *Modality overlays:* (a) Live vs Asynchronous; (b) by provider type	Patient experience – Access – Removes geographic and scheduling barriers for one-off needs; 24/7 availability Patient experience – Continuity – Heightened risk of fragmented care and over-prescribing; difficulty establishing an ongoing relationship with provider Provider experience – Allows flexible shifts leveraging provider idle-time; difficulty establishing ongoing relationships with patients	Same as above plus: Consumer Protection – state AGs, DOJ, FTC Utilization Management – payers may impose tighter standards for prescription-driven episodic visits PDMP registration and standard query – prescriber must enroll in each patient's state PDMP and run the usual check before prescribing – higher burden for episodic visits – state medical/pharmacy boards
Digital Behavioral Health Tools The categories below are not mutually exclusive. Some tools blend patient- and provider-facing features.			
Patient-Facing Tools	Self-guided or low-touch tools that **substitute or augment** clinician time. **Sub-types:** (a) Apps providing fully digital therapeutic services like cognitive behavioral therapy; (b) Symptom tracking and passive remote monitoring; (c) Apps providing adherence nudges/behavioral prompts	Patient Experience – Access – Eliminates geography + scheduling barriers for mild/moderate cases; enables early-relapse detection Patient Experience – Continuity – Therapeutic alliance optional; data may be shared directly with a clinician Provider experience – One clinician can supervise far more patients; lowers direct-care minutes	Oversight over medical devices making clinical claims – FDA, when not considered a general "wellness product"[iii] Privacy, security & data interoperability – *HIPAA, 42 CFR Part 2* – HHS; ONC rules and guidance on *interoperability* and *health IT certification* Payment and coverage/billing codes – HHS, states, payers Consumer Protection – state AGs, DOJ, FTC

iii For the most part, FDA only *regulates* digital applications that make diagnostic or treatment claims ("Software as a Medical Device, SaMD"); most wellness or documentation apps are exempt.

Model	Description	Impact on Patient and Provider Experience	Regulatory Interactions
Provider-Facing Tools: Workflow Optimization	Tools that **shave time off** front-end (intake, triage, risk scoring) and back-end (documentation, quality reporting) tasks.	Patient experience – Access – Cuts admin bottlenecks resulting in shorter waitlists Patient experience – Continuity – Richer longitudinal data capture and follow-up Provider experience – Reduces workload; enables clinicians to handle moderately larger patient panels or visit volumes	Oversight over medical devices – FDA, for certain clinical decision support tools Privacy, security & data interoperability – *HIPAA, 42 CFR Part 2* – HHS; ONC rules and guidance on *interoperability* and *health IT certification* Payment & coverage/billing codes – documentation & quality measures – HHS, states, payers
Provider-Facing Tools: Care Model Transformation	Tools that **re-engineer practice structure**—e.g., integrating BH into primary care or supporting alternative payment models (APMs).	Patient experience – Access – Shared PCP + BH responsibility provides one-stop care Patient experience – Continuity – Team registry tracks patients across settings, enhancing hand offs and follow through Provider experience – Eases transformation admin burden; supports financial sustainability; extends BH reach via PCPs, but may shift worload on to an already-strained primary care workforce	Privacy, security & data interoperability – *HIPAA, 42 CFR Part 2* – HHS; ONC rules and guidance on *interoperability* and *health IT certification* Payment and coverage – *billing codes supporting practice transformation* – HHS, states, payers Quality/care delivery accreditation standards – *PCMH*, CCBHC, and *BH-integration standards*; *APM metrics* – third-party entities, such as NCQA

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