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■ INSIGHT BRIEF

The Behavioral Health Playbook Is Changing

What health plan and government leaders are prioritizing next

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■ ABOUT

About BHT Impact

BHT Impact is an initiative focused on advancing meaningful progress in youth behavioral health by strengthening the people, organizations, and innovations already driving change. It connects stakeholders with the expertise, resources, relationships, and visibility needed to navigate a complex system and expand the reach of effective solutions. By bringing together innovators, providers, policymakers, advocates, families, and young people, BHT Impact helps foster collaboration, accelerate learning, and address gaps that can limit progress. Its aim is to help promising ideas and proven approaches translate into broader, more sustainable impact.

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■ THE ROUNDTABLE

Discussion facilitators



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Overview

At the 2026 Behavioral Health Tech conference, BHT Impact convened an invitation-only working roundtable with health plan and government leaders. The session created space to compare experience across markets, test assumptions, and discuss where current approaches are falling short.

The conversation focused on three issues shaping near-term decisions: proving the value of rising behavioral health investment, preparing for Medicaid and Marketplace policy shifts, and navigating AI-assisted documentation and payment integrity.

The discussion in one minute

- **Value must be specific and financeable.** The strongest cases tied a defined intervention to a measurable avoided event, a credible dollar value, and the budget holder that realizes the savings. Broad claims about access or total cost of care were less persuasive.
- **Coverage disruption will change the risk pool.** Participants expect coverage losses to leave Medicaid programs serving a smaller but higher-acuity population while more people delay care or enter through emergency and inpatient settings.
- **AI creates opportunity and new friction.** AI can reduce administrative work and improve measurement, but it can also make inflated documentation easier to produce and automated scrutiny easier to scale.

— THE COMMON THREAD

Better tools and greater access will not be enough without aligned incentives, shared definitions of success, stronger data exchange, and accountability for results.

Why this matters across the ecosystem

- Health plans are not evaluating provider value propositions in isolation. Their purchasing decisions are shaped by state and federal priorities, budget cycles, member retention, quality requirements, and operational capacity.
- For providers and vendors, understanding those upstream pressures can sharpen the case for partnership. For plans and policymakers, hearing what implementation requires on the ground can expose where otherwise sound policy or payment ideas may break down.

This brief synthesizes themes from an invitation-only working discussion. Examples are anonymized and reflect participant observations; they should not be interpreted as independently verified findings or consensus positions.

Make the financial pathway visible

Behavioral health investment is easier to defend when the intervention, outcome, financial value, and beneficiary of the savings are explicit.

What evidence landed

- **Near-term avoided events.** One participant described documenting 25,000 emergency department diversions and applying a payer valuation method to quantify the impact. The specificity mattered: an avoided event is easier to understand and price than a broad promise to lower total medical expense.
- **A clear substitute for higher-cost care.** At-home withdrawal management was discussed as a strong substitution strategy: roughly seven home-based episodes for the cost of one facility episode, with the potential for better continuity because fewer people are lost between settings.
- **A longitudinal utilization story.** One plan described lowering friction for outpatient access while holding down growth in behavioral health emergency presentations over roughly 2.5 years. Outpatient spending still rose, reinforcing that higher spend is not automatically failure when it is tied to less crisis care.
- **Outcomes beyond the health plan.** School attendance was cited as a measure with clinical, social, and financial relevance. It illustrates how states, plans, health systems, and schools can invest around a shared outcome.

What fell short

Broad total-cost-of-care assertions were difficult to isolate and did not reliably persuade financial leaders. Access expansion alone also fell short when greater service availability did not produce a visible decline in acuity. Participants noted that propensity-matched naturalistic evidence, by itself, was often insufficient for CFO-level decisions.

The time-horizon problem

Same-year break-even was described as an important threshold. A 24-month return may be meaningful, but member churn can prevent the organization funding an intervention from realizing the later savings. The value story must match the decision maker's budget cycle and retention reality.

Follow the incentive

Participants repeatedly returned to the same conclusion: payment design shapes utilization, treatment intensity, and the pace of care.

When volume becomes the outcome

- Daily, census-based, and fee-for-service structures may reward more visits, longer sessions, or services spread across multiple days. A daily prospective payment model was discussed as one example in which delivering services over several days can generate more revenue than providing the same services together.
- Savings and spending may also sit in different budgets. When one entity funds a service but another captures the downstream savings, even a clinically effective intervention can be difficult to sustain.

ABA as a case study

- Applied Behavior Analysis surfaced repeatedly as an example of why access must be paired with clinical and financial guardrails. Participants discussed high-intensity treatment schedules becoming a default, financial incentives tied to diagnosis and authorized hours, and the challenge of separating diagnostic judgment from service delivery.
- Approaches discussed included independent diagnosis by developmental or behavioral specialists, routing families to selected partners, school-based services when appropriate, and dedicated program-integrity capacity that combines data review with on-site oversight.
- One organization described initially receiving approval for only a small portion of the program-integrity capacity it requested. Public attention to fraud concerns later helped unlock a more complete oversight team, illustrating how difficult it can be to invest in prevention before a problem becomes visible.

Where payment could go next

- Potential alternatives included case rates, bundles, quality incentives, and phased risk arrangements. But changing the unit of payment is not enough: plans and providers still need to define the outcome being purchased, establish a baseline, and decide where accountability sits.
- Full capitation may reduce incentives to maximize billable volume, but behavioral health organizations control only part of a member's total healthcare spend. Participants discussed glide paths toward risk, quality-linked payments, and whether complexity-based reimbursement could better reflect acuity than time-based billing.
- Measurement remains a constraint. Participants described incomplete adoption of measurement-based care and inconsistent definitions of terms such as outcomes, making it difficult to compare performance or pay for results.

Prepare for Medicaid coverage losses driven by H.R. 1

Coverage changes may produce a smaller but more complex Medicaid population while pushing others toward delayed care and strained safety-net settings.

A changing risk pool

- Participants expect lower utilizers to be more likely to exit coverage while people with the greatest needs remain. The result may be higher per-member acuity, greater staffing needs, and more emergency and inpatient utilization.
- People who lose outpatient coverage may delay care and return later with more complex needs. Participants questioned whether safety-net hospitals and emergency departments have the capacity to absorb that demand.

Make renewal support operational

- Some states are moving toward more frequent eligibility renewals. One state is adding renewal dates to provider-facing systems so clinicians can see an approaching deadline and prompt action during an existing encounter.
- The public-health-emergency unwind offered a cautionary example: plans, states, community health centers, and behavioral health organizations sometimes contacted members separately with inconsistent messages, producing confusion and disengagement.
- The preferred approach combines consistent communication, provider-enabled renewal support, and triage that distinguishes members likely to renew independently from those needing hands-on help. Health information exchanges could support this work, but adoption and data quality remain uneven.

Children, ABA, and continuity

The coverage discussion also surfaced a population-specific risk: children receiving behavioral health services often depend on coordination across Medicaid, providers, schools, and families.

- Participants described pediatric behavioral health as a major cost pressure, even where incidence was lower than among adults. In ABA, independent early screening was viewed as especially important when the diagnosing organization also benefits from treatment authorization.
- Developmental pediatricians, psychologists, schools, and carefully selected ABA partners were discussed as parts of a stronger pathway. School-based ABA and individualized education programs may also support continuity and reduce pressure on families and health plans where policy allows.

Use AI to strengthen care, not coding intensity

The opportunity is meaningful, but plans and providers need shared standards before documentation tools create a new payment-integrity arms race.

What participants are seeing

- Experience was mixed. Some participants had not yet seen a material coding shift attributable to AI; others reported claims changes alongside wider adoption of ambient documentation. Smaller practices, especially substance-use providers, were described as slower to adopt because of cost and legal concerns.
- Areas of concern included longer-session billing, high treatment frequency without clear clinical rationale, high-intensity testing, cloned notes, unchanged treatment plans, unbundling, and authorization requests built around criteria language rather than clinical need.

More constructive uses

- AI could help assess whether an evidence-based protocol was actually delivered, track themes across sessions, and surface patterns a clinician may miss during crisis-focused care. A responsible workflow would include patient consent, timestamped capture, and clinician review and approval.
- Gold-carding was discussed as one way to focus oversight: providers with consistently high approval rates and utilization within expected norms could bypass some prior authorization, allowing review resources to concentrate on higher-risk patterns.

05 — PRIORITIES

Priorities for the next conversation

- Define the outcomes being purchased before debating the payment mechanism; test case rates and risk arrangements against real clinical behavior; connect coverage information to provider workflows; and develop practical AI standards that support efficiency while preserving trust.
- Small and independent providers require particular attention. They may have the fewest resources to adopt new tools, respond to automated scrutiny, or participate in increasingly complex payer-provider technology dynamics.

The roundtable reinforced the value of small working forums where leaders can move beyond prepared remarks, compare what they are seeing, and identify shared problems that no single part of the system can solve alone.

