Top Issues in Behavioral Health for 2022

ANNUAL NEWSLETTER FROM THE BEHAVIORAL HEALTH LAW GROUP

Behavioral Health M&A Will Remain Hot in 2022

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Behavioral health had its most active year in 2021, which came on the heels of very active years that preceded it. There are many factors that contributed to this and that indicate that 2022 is likely to involve substantial M&A activity once again. A brief summary of those factors follows below.

Growing Demand. Unfortunately, the U.S. had been experiencing significant levels of substance use disorder and mental health conditions for years before the pandemic, although there did seem to be some leveling off and greater progress made in some areas in the years immediately leading up to 2020. COVID-19 and responses to same, while aiming to help contain and limit the terrible effects of that virus, have undoubtedly resulted in other health and mental health-related damage on many levels. Substance use disorder, suicides and mental health conditions have grown substantially from already serious pre-pandemic levels.

For example, over 20% of school-aged children have experienced worsened mental or emotional health since the pandemic began.[1] Recently, the U.S. Surgeon General issued a Surgeon General's Advisory to underscore the immediate need to address the mental health crisis that our youth are facing.[2] The Advisory summarizes the severe effects that the pandemic and pandemic-related measures have had on children and families, as well as similar (but somewhat less severe) mental health challenges that already existed prior to the pandemic. Moreover, late last year, a coalition of the nation's leading experts in pediatric health declared a national emergency in child and adolescent mental health.[3]

Adults are suffering increased rates of mental health and substance use disorder-related conditions as well. For example, among adults with symptoms of anxiety and/or depressive disorder during the pandemic, over 20% report needing, but not receiving, mental health counseling or therapy.[4]

Decrease in Stigma. A noticeable decrease in stigma about having behavioral health conditions and receiving treatment for same is resulting in more pursuit of such treatment, driving demand as well. For example, HealthPartners surveyed adults in 2017 and in 2019 in communities that have launched Make It OK campaigns[5]. Results show that there has been a statistically significant decrease in stigma among survey respondents. The surveys show that from 2017 to 2019[6]:

[1] Nirmita Panchal, Rabah Kamal, Cynthia Cox, Rachel Garfield and Priya Chidabaram, *Mental Health and Substance Use Considerations Among Children During the COVID-19 Pandemic,* Kaiser Family Foundation https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/ (last visited February 1, 2022).
[2] *U.S. Surgeon General Issues Advisory on Youth Mental Health Crisis Further Exposed by COVID-19 Pandemic* https://www.hhs.gov/about/news/2021/12/07/us-surgeon-general-issues-advisory-on-youth-mental-health-crisis-further-exposed-by-covid-19-pandemic.html (last visited February 8, 2022).
[3] *AAP-AACAP-CHA Declaration of National Emergency in Child and Adolescent Mental Health,* American Academy Of Pediatrics https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/ (last visited February 8, 2022).
[4] *Id. See also, supra,* FN 9 in the *"Staffing Shortages Will Continue To Reduce Access to Behavioral Health"* article, below (suggesting that the actual number of adults in need of mental health care but not receiving it may be significantly higher).
[5] Make It Ok campaigns are designed to reduce the stigma of mental illness. *See* https://makeitok.org/ (last visited February 15, 2022).
[6] *Stigma of Mental Illnesses Decreasing, Survey Shows,* HealthPartners https://www.healthpartners.com/hp/about/press-releases/stigma-of-mental-illnesses-decreasing.html#:~:text=Results%20show%20that%20there%20has,illness%20(66%25%20to%2071%25) (last visited February 8, 2022).

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Upcoming Events

Behavioral Health Business VALUE Conference
Lori Oliver and **Ryan Morgan** are speaking on Policy and Legal Considerations.
April 26, 2022
Washington, D.C.

- More people feel comfortable talking with someone about their mental illness (66% to 71%)
- More people say they would tell friends if they had a mental illness (34% to 41%)
- Fewer people say they would be reluctant to seek help (50% to 46%)

However, stigma is still prevalent and the need to reduce it further remains:

- Only about one in four think that people are generally caring and sympathetic to individuals who live with a mental illness (24% to 26%)
- More than nine out of ten said that the Make It OK goal to reduce stigma is important (93% to 95%)

Although there is anecdotal evidence of a reduction with respect to substance use disorder-related stigma, it was more difficult to locate substantial levels of research-based evidence to support that. Clearly more work remains to be done with respect to reduction of stigma around all levels and types of behavioral health conditions. Notwithstanding, any reduction is welcome and drives greater demand, as well as greater resources to meet that growing demand.

Access Through Telebehavioral Health

As discussed in more detail within this Newsletter (below), the convergence of technology, growing patient demand, greater regulatory flexibility and greater availability of payment for behavioral health care have all converged to cause telehealth in the behavioral health sector to explode. With this development came greater access at a critical time of need, and, to a degree, contributes to both additional available supply of and demand for quality, convenient behavioral health resources. Nevertheless, demand continues to outstrip the supply that is currently available. The drive to meet that need will also continue to drive behavioral health M&A.

Greater Recognition of Importance of Integrating Behavioral Health and Physical Health

Policy makers, payors, providers and other stakeholders are talking in more detail and with greater frequency about the need to integrate behavioral health into the larger health care spectrum and in order to better pursue whole person care. As discussed in more detail within this Newsletter (below), leveraging partnerships to integrate behavioral health services and offer services via telehealth, while also collecting and analyzing data regarding SDOH (as defined below), may better enable providers to improve health care outcomes, increase patient satisfaction and quality, and control costs. All of this requires resources and disciplined organization. That need may also help drive further investment by private equity, strategic buyers and health system partners (among others) who can bring those attributes to bear into the behavioral health care sector.

Fragmented Market and Insufficient Resources. The behavioral health market continues to be ripe for growth. Like many other health care sectors, the behavioral health market is still relatively fragmented and often rendered by small providers that have no national presence and are not part of a larger continuum of care. And there is often an insufficient number of treatment providers to meet growing demand (as discussed further below in this Newsletter), which itself also serves as a driver of increased behavioral health care M&A and investment. In some health care sectors greater consolidation and standardization has resulted in improved care, improved access to care, streamlined costs of operation, better recruitment of health care professionals and greater efficiencies. There is potential for private equity-backed and other investors and health care stakeholders to engage in further acquisitions to drive significant economies of scale, resulting in both clinical and administrative standardization and better, more accessible and more efficient care.[7]

[7] Dr. Bill Bithoney, *Behavioral Health: A Market Ripe for Growth and Consolidation,* BDO https://www.bdo.com/insights/industries/healthcare/behavioral-health-a-market-ripe-for-growth (last visited February 8, 2022).

CMS-Supported Telehealth Will Continue To Be A Driving Force – But Watch for Greater OIG Enforcement

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As mindsets pivoted to a post-pandemic life, telehealth advocates petitioned CMS to embrace telehealth as a permanent care option, and CMS responded with regulatory action at the end of 2021.

During the Covid-19 Pandemic, telehealth usage surged as patients and providers turned to it as a safer care alternative. McKinsey estimated telehealth claim volumes reached 80 times pre-pandemic levels at its peak, ultimately stabilizing at 38 times pre-pandemic levels by early 2021.[1] This increase was mostly driven by CMS' waivers and relaxation of regulatory constraints for telehealth reimbursement. But, the temporary nature of both left questions regarding telehealth's future.

In December 2021, CMS issued new regulations which, collectively, steer telehealth toward becoming a part of the telebehavioral health toolkit accepted by Medicare post-pandemic. In the CY2021 Physician Fee Schedule Final Rule[2], further discussed here, CMS broadly expanded access to telebehavioral health services. Specifically, Medicare permanently authorized payment for telehealth services furnished "for purposes of diagnosis, evaluation or treatment of a mental health disorder" under the following relaxed criteria:[3]

- First, CMS made the patient's home[4] a qualifying originating site for telehealth encounters done for diagnosis, evaluation or treatment of a mental health disorder, ***provided that*** such services were preceded and followed by a qualifying in-person visit.
- Second, CMS waived geographic restrictions on Medicare's payment for such services.[5] Now, a patient's home may serve as an originating site for telebehavioral services, even when the home isn't in a qualifying rural zip code.
- Third, CMS permanently allowed audio-only visits for the evaluation and treatment of mental health disorders when: (1) the patient's home is the originating site, and (2) the telehealth provider has audio-visual technical capabilities for the encounter, but the patient either is incapable of having or refuses to consent to a video encounter.[6] (For services other than behavioral health counseling services, CMS is still refusing to pay for audio-only encounters.[7])

Collectively, these changes are likely to significantly broaden access to behavioral health care for Medicare beneficiaries facing increased challenges accessing care. However, at the same time, one can also expect increased scrutiny and enforcement action from the Office of Inspector General ("OIG") to prevent fraud, waste and abuse in telehealth. The Department of Justice and OIG have already increased anti-fraud enforcement measures in the telehealth industry over the past few years, and this is likely to continue as telehealth becomes a permanent part of behavioral health services. As recently as September 2021, the OIG specifically evaluated telehealth's use in providing behavioral health services to Medicaid enrollees.[8] In its report[9], the OIG acknowledged telehealth's value during the pandemic, but also highlighted the importance of (i) ensuring payers can distinguish between telehealth and in-person services; (ii) evaluating the effects of telehealth on access, cost, and quality of behavioral health services; and (iii) ongoing monitoring for fraud, waste, and abuse.

Based on these comments, providers should consider acting defensively in building out telebehavioral health services and adopt processes supportive of quality, robust documentation, and furthering the Triple Aims[10] of improving the patient care experience (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

[1] *See* Oleg Bestsenney et. al, *Telehealth: A Quarter-Trillion Dollar Post-Covid-19 Reality?* (Updated July 9, 2021) available at: https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.
[2] 86 Fed. Reg. 64996 (Nov. 19, 2021) *available* here
[3] Telehealth services must meet the conditions in 42 C.F.R. §414.65 and §410.78, as well as state requirements, to lawfully seek Medicare reimbursement.
[4] A patient's "home" may include their residence, a temporary residence (e.g. hotel, shelter), or a nearby location where the patient goes for privacy or other reasons.
[5] 86 Fed. Reg. 65057 (Nov. 19, 2021) (CMS noted a patient's home does not need have to be located in a qualifying location provided by 41 C.F.R. §410.78(b)(4) (i.e. a rural health professional shortage area)).
[6] 86 Fed. Reg. 65057 (Nov. 19, 2021).
[7] CMS justified limiting phone-only consultations to mental health services primarily involving verbal conversation between the patient and provider by noting that visualization of the patient is less necessary for such services, but important for others.
[8] *See Opportunities Exist To Strengthen Evaluation and Oversight of Telehealth for Behavioral Health in Medicaid* (OEI-2-19-00401) (Sept. 20, 2021) available at https://oig.hhs.gov/oei/reports/OEI-02-19-00401.asp
[9] *Id.*
[10] See The IHI Triple Aim, Institute for Health Improvement, available at http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx.

Expect Significant Federal Legislation on the Behavioral Health Front

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As the country marks two years of living with COVID-19, it's abundantly clear the disease-caused shutdowns, closures, and social limitations have led to a significant increase in the prevalence of mental health and substance use disorders (MH/SUD). Although pandemic life continues to take its toll on communities throughout the nation, federal policymakers are responding by pivoting away from reactionary stopgap measures in favor of forward-thinking systemic changes.

Recently three federal departments (Labor, Health and Human Services (HHS) and Treasury) issued their 2022 Report to Congress, building the case for regulatory action on one of the Biden Administration's top behavioral health priorities: to ensure that the financial requirements and treatment limitations imposed by insurers on MH/SUD benefits are no more restrictive than those that apply to medical and surgical benefits. The report indicates the Administration is concerned that insurers are not delivering the parity in care as required by the 2008 *Mental Health Parity and Addiction Equity Act* – even as demand for MH/SUD treatment services spiked during the pandemic.

In addition to rulemaking that clarifies the MH/SUD parity requirements under existing law, HHS plans to issue regulations this year that would help providers treating opioid-use disorders by increasing access to extended take-home doses of methadone and permitting medication-assisted treatment through telehealth appointments.

After infusing the behavioral health care system with billions of dollars in emergency funding through the passage of the *American Rescue Plan Act* last year, Congress is now looking to take proactive steps to strengthen federal programs that facilitate state approaches to meeting unmet behavioral health needs. And since 2022 is an election year, federal policymakers are prioritizing non-controversial, bipartisan proposals that could be enacted during what promises to be another politically polarized year.

Specifically, there are several initiatives to watch as the year progresses:

- The leaders of the Senate Finance Committee and the Senate Health, Education, Labor and Pensions Committee recently announced their intention to put together a legislative package this summer that would address MH/SUD issues. Both Senate Committees, as well as the House Energy and Commerce Committee and the Ways and Means Committee, have held hearings over the last several weeks. This recent flurry of Congressional activity from both sides of the Capitol represents a concerted bipartisan effort to develop meaningful solutions. It builds on a Senate Finance Committee initiative begun last fall in which the panel solicited public policy changes from health care stakeholders that would increase access to mental health services, make treatments more effective, and reduce the financial burdens associated with the delivery of care. This bipartisan effort continues into 2022 as a top priority for Chairman Ron Wyden (D-OR) and Ranking Member Mike Crapo (R-ID). Finding budget offsets to pay for large-scale programmatic changes, as well as navigating election year politics, will be the primary challenges for lawmakers seeking to improve the delivery of behavioral health care services.
- Another bipartisan initiative launched last year, by Sens. Bill Cassidy (R-LA) and Chris Murphy (D-CT), focuses on expanding and enhancing existing federal MH/SUD programs set to expire this year. Stemming from the 2016 *21st Century Cures Act,* improvements to these programs could be included in FDA user fee reauthorization legislation expected to be considered later this summer.
- The House Bipartisan Addiction and Mental Health Task Force continues working through its robust agenda of more than 70 pieces of MH/SUD legislation. The task force notched several legislative victories in 2021 and its leaders are hopeful the bipartisan nature of the caucus will move more bills across the goal line.
- Congress continues ongoing efforts to combat the opioid epidemic, and other SUDs, by exploring how to improve the programs started with the passage of the *Comprehensive Addiction and Recovery Act* (CARA) and the *21st Century Cures Act,* both of which became law in 2016. Many of the SUDs programs and associated funding must be reauthorized this year, so updated versions of these laws are being considered in the Congressional health committees.
- Behavioral health stakeholders are calling on Congress to pass an omnibus appropriations bill that will fund federal MH/SUD programs and MH/SUD pandemic response initiatives for the remainder of the fiscal year, which ends Sept. 30. The federal government is currently funded by a continuing resolution that will expire Feb. 18. Stakeholders are urging Congress to act quickly to ensure the passage of appropriations that will support mental health block grants to states, a new '988' national suicide hotline, 24/7 call centers staffed by mental health professionals, mobile response teams, and crisis stabilization services that connect people to follow-up care. The stakeholder community views these investments as critical to meeting pandemic-driven behavioral health needs.

Value-Based Payments and Behavioral Health Integration Begin to Take Center Stage

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On January 11th of this year, three key officials of the Centers for Medicare and Medicaid Services (CMS), Meena Seshamani[1], Elizabeth Fowler[2], and Chiquita Brooks-LaSure[3] wrote in *Health Affairs Forefront* highlighting efforts to build on CMS' strategic vision for a stronger Medicare through advancing health equity.[4] The article was noteworthy on many fronts and focused on Medicare's continued commitment to health equity and accomplishments from its 2015 Equity Plan[5] for improving quality in Medicare, but also on the need to increase the clinician workforce in underserved communities, efforts to enhance culturally appropriate communication around services, and the tremendous opportunity to address health-related social needs in the community through expansion of accountable care organizations and value-based reimbursement. The authors acknowledged the need to address how social determinants of health ("SDOH") create barriers to accessing care and increase risk for chronic health conditions.[6] Equally important, CMS also has recently provided additional support and flexibility to improve patient access to health care services via telehealth and particularly telebehavioral health services, via telehealth policy updates in the 2022 Physician Fee Schedule Final Rule.[7]

For those working to transform care through value-based care delivery and value-based reimbursement models, these statements and policy updates from one of the largest national payers are important and signal the continued intention and commitment of CMS to transform from a fee-for-service reimbursement approach to a value-based reimbursement approach, and to support greater access to and integration of behavioral and physical health to achieve whole person care. These actions are also consistent with CMS's recent Innovation Center Strategy Refresh.[8]

A coordinated strategy that incorporates value-based care delivery, behavioral health integration with physical health, and SDOH has extraordinary opportunity to truly further the Triple Aim.[9] Behavioral health providers face unique challenges above and beyond those faced by physical health providers in value-based care delivery. All providers being paid under a value-based care reimbursement model must be able to access and integrate claims and practice data; report on quality metrics; use clinical and business analytics systems to identify care gaps, inform intervention strategies and real-time patient engagement; and manage population health and align clinician compensation to drive objectives. Behavioral health providers have additional challenges with regard to consensus on meaningful quality and outcome metrics[10], interoperability of data[11] and clinical integration with physical health,[12] to highlight just a few. In addition, while the data is clear on the role of behavioral health conditions in increasing the costs of

[1] Meena Seshamani, M.D., Ph.D., is the Deputy Administrator and Director, Centers for Medicare and Medicaid Services.
[2] Elizabeth Fowler, Ph.D., J.D., is the Deputy Administrator and Director of the Center for Medicare and Medicaid Innovation (CMS Innovation Center).
[3] Chiquita Brooks-LaSure is the Administrator for the Centers for Medicare and Medicaid Services.
[4] Meena Seshamani, Elizabeth Fowler, and Chiquita Brooks-LaSure, *Building On The CMS Strategic Vision: Working Together For A Stronger Medicare*, Health Affairs (January 11, 2022), https://www.healthaffairs.org/do/10.1377/forefront.20220110.198444.
[5] See also *Paving the Way to Equity: A Progress Report* (2015-2021), CMS (2021), https://www.cms.gov/files/document/paving-way-equity-cms-omh-progress-report.pdf.
[6] See Meena Seshamani, Elizabeth Fowler, and Chiquita Brooks-LaSure, *Building On The CMS Strategic Vision: Working Together For A Stronger Medicare,* Health Affairs (January 11, 2022), https://www.healthaffairs.org/do/10.1377/forefront.20220110.198444 ("Overall, we will help those who live in rural areas; cannot afford broadband access; lack access to reliable transportation; have increased risk of COVID-19 infection due to disability, ESRD, or other chronic health conditions; or may experience other barriers to accessing the care they need.").
[7] 86 Fed. Reg. 64996 (Nov. 19, 2021); see also Laura Little, Lori Oliver and Paul Gomez, *CMS Greenlights Certain Telebehavioral Health Services Beyond the Public Health Emergency and Provides Important Incentives for Further Investment,* Polsinelli (Nov. 8, 2021), https://www.polsinelli.com/intelligence/cms-greenlights-telebehavioral-health-services.
[8] *Innovation Strategy Center Refresh,* CMS, https://innovation.cms.gov/strategic-direction-whitepaper (last visited Feb. 4, 2022).
[9] *The IHI Triple Aim, Institute for Healthcare Improvement* http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx (last visited Feb. 4, 2022). The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance, the "Triple Aim": Improving the patient experience of care (including quality and satisfaction); Improving the health of populations; and Reducing the per capita cost of health care.
[10] Lauren Niles and Serene Olin, *Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care,* The National Committee for Quality Assurance (NCQA) (May 2021), https://www.ncqa.org/wp-content/uploads/2021/07/20210701_Behavioral_Health_Quality_Framework_NCQA_White_Paper.pdf.
[11] *Integrating Clinical Care through Greater Use of Electronic Health Records for Behavioral Health* (Chapter 4), MACPAC (June 2021), https://www.macpac.gov/publication/integrating-clinical-care-through-greater-use-of-electronic-health-records-for-behavioral-health/.
[12] *Id.*

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chronic physical health conditions,[13] bilateral integration of behavioral and physical health historically has been rare in care delivery and reimbursement of the same.

CMS' current focus on health equity and greater access, together with an increasing willingness from federal, state and commercial payers to reimburse for integrated behavioral health services delivered under innovative care models,[14] [15] signal progress toward rewarding providers for whole person care. One such model, the Collaborative Care Model, is an evidence-based model used to identify and treat patients with mental illness in primary care settings with an emphasis on targeted outcomes and a patient-centered approach.[16] The Collaborative Care team is led by a primary care provider and comprised of behavioral health care managers, psychiatrists, and other mental health professionals who together implement a measurement-guided care plan with particular attention to accountability and quality improvement.[17] Some providers rely heavily on telebehavioral health services to ease both the patient access burden and clinician workforce shortage when integrating behavioral health and physical health care using this model.[18]

With its intense focus on evidence-based tools and measurement of clinical outcomes, providers delivering behavioral health services via the Collaborative Care Model also are analyzing how addressing SDOHs could impact the treatment plans for their patient populations.[19] One leading state payer takes the position that "whole person health care and health equity cannot be achieved without proactively addressing SDOH for all members of HCA [Washington State Health Care Authority] purchasing programs."[20] Some behavioral health providers who routinely incorporate engagement with community social service providers to support their patient populations may have an advantage in addressing SDOH on a patient by patient basis. At the same time, developing and using standardized SDOH metrics to measure outcomes is still evolving. For example, the Oregon Health Authority has been working since 2015 to develop measures of SDOH and incorporate the use of those metrics with its Medicaid population through its coordinated care contracting model.[21]

Achieving whole person care that incorporates value-based reimbursement for integrated physical and behavioral health care and that addresses the role of SDOH will require continued diligence and incremental progress to achieve. Leveraging partnerships to integrate behavioral health services and offer services via telehealth, while also collecting and analyzing data regarding SDOH, may better enable providers to improve health care outcomes, increase patient satisfaction and quality, and control costs. Participants in the Collaborative Care Model or other coordinated care delivery models with these capabilities may find participation in such programs a meaningful step in their value-based care journey.

[13] *Behavioral health crisis in the United States: The fallout from the COVID-19 pandemic,* McKinsey & Company, https://www.mckinsey.com/featured-insights/mckinsey-live/webinars/americas-behavioral-health-crisis-the-fallout-from-the-covid-19-pandemic (last visited Feb. 4, 2022).
[14] *Getting Paid in the Collaborative Care Model,* American Psychiatric Association, https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid (last visited Feb. 4, 2022).
[15] *Behavioral Health Integration Services,* Medicare Learning Network (March 2021), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf.
[16] *Collaborative Care,* AIMS Center, Advancing Integrated Mental Health Solutions, https://aims.uw.edu/collaborative-care (last visited Feb. 4, 2022).
[17] *Learn About the Collaborative Care Model,* American Psychiatric Association, https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn (last visited Feb. 4, 2022).
[18] *Practice-Based and Telemedicine-Based Collaborative Care,* AIMS Center, Advancing Integrated Mental Health Solutions, https://aims.uw.edu/practice-based-and-telemedicine-based-collaborative-care (last visited Feb. 4, 2022).
[19] Melissa Farzam, *A Look At Social Determinants Of Health In Collaborative Care,* Concert Health (November 2021), https://concerthealth.io/a-look-at-social-determinants-of-health-in-collaborative-care/.
[20] *Paying for Health and Value, Health Care Authority's Long Term Value-based Purchasing Roadmap (2022-2025)*, Washington State Health Care Authority (August 2020), at 15, https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf. The Washington Health Care Authority purchases health care through three state programs that serve Medicaid, public employee, and school employee beneficiaries.
[21] *Social Determinants of Health Measurement Work Group Final Report,* Oregon Health Authority (February 2021), https://www.oregon.gov/oha/HPA/ANALYTICS/SDOH%20Page%20Documents/3.%20SDOH%20measurement%20work%20group%20final%20report.pdf; see also Health Equity, Massachusetts Health Policy Commission,https://www.mass.gov/info-details/health-equity (last visited Feb. 4, 2022) (describing Massachusetts health equity activities); and Elizabeth Hinton and Lina Stolyar, Medicaid Authorities and Options to Address Social Determinants of Health (SDOH), KFF (Aug. 5, 2021), https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/ (summarizing strategies to identify and address enrollee social needs within Medicaid's regulatory authority).

Behavioral Health Joint Ventures Will Continue to Proliferate

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Joint ventures and strategic affiliations in the behavioral health care sector have begun to proliferate over the last few years and will continue to do so in 2022 to due several factors. Among these are accelerated demand for behavioral health care services, limited bed capacity and the ability for hospitals, health systems, private equity-backed providers and strategic operators to complement one another in the pursuit of greater access to quality, comprehensive behavioral health care for patients.

Mutual Benefits of Behavioral Health Joint Ventures

There are different types of joint ventures, but a common joint venture partnership that has emerged in the behavioral health arena is that between a hospital/health system and a for-profit behavioral health operator.

It comes as no surprise to those who operate and work in hospitals and health systems (among others) that behavioral health patients are often admitted through the emergency room. This is not new but is one of many circumstances that have been accelerated by the pandemic. It often results in placement of behavioral health patients in settings that are not best suited to serve them and causes serious occupancy issues in the emergency room and hospital that it is a part of, which impacts other patients. To help address this, forming a joint venture can, for example, spur development of a new facility off-site that is better designed to serve behavioral health patients. Concurrently, it can also help to release pressure from emergency rooms and open up medical and surgical bed capacity to the benefit of other patients as well.[1]

Additionally, many non-profit health systems have aging behavioral health facilities that need replacement or upgrading. With many hospital and health system budgets strained by pandemic-related and other demands, a joint venture with a partner that has significant "dry powder" can be helpful to facilitate much needed facility upgrades and other capital investment.

In other cases, a hospital's behavioral health unit may be poorly managed and/or unprofitable. For-profit operators with substantial experience and expertise in operating sophisticated, quality behavioral health facilities can bring that expertise to bear to help a hospital or health system that currently operates a behavioral health department that is not well-managed, is not profitable and/or does not consistently provide quality care. The for-profit operator may also be able to take on more of the administrative burden of operating the department, freeing up capital, time and other resources to focus on higher quality, greater patient satisfaction, consistency of clinical services and access to same.

As noted in more detail below within this Newsletter the acute shortage of behavioral health providers and staff is hampering efforts to improve access to quality care in clinical settings across the board. Large for-profit operators often have substantial resources dedicated to provider recruitment and often maintain a large network of behavioral health providers. These factors in a time of scarcity of behavioral health provider resources can also serve as a significant motivation for hospitals, health systems and health care providers to align with for-profit behavioral health providers in some fashion.

For-profit behavioral health operators are often motivated by, among other things, access to new markets in partnership with established providers like a local hospital or health system. This affords the for-profit behavioral health operator the opportunity to benefit from the hospital or health system's reputation, trade name and brand to gain instant credibility in the market and to more rapidly position itself, with its joint venture partner, to serve local patients with behavioral health care needs.[2]

Certain Reimbursement Considerations

Increase in demand for services, the movement by some health plans to better prioritize mental health, technology advances and some degree of enforcement of mental health parity laws have made behavioral health joint ventures more feasible and helped drive some additional revenue toward provision of behavioral health care.[3] However, joint venture partners should continue to be mindful about potential impacts on payment. For example, it may not always be possible to maintain similar reimbursement for a given behavioral health service when provided in a freestanding facility as opposed to, for example, a hospital department. The joint venture should take careful stock of how payment rates in a freestanding facility might compare with what the health system was able to achieve in that regard in the past.[4] On a related note and depending on what kind of services will be offered, type of facility, the number of patient beds and whether the joint venture will seek reimbursement from Medicaid for treatment provided, the parties need to be mindful of Medicaid-related payment restrictions with regard Institutions

[1] Patrick Connole (Guest Contributor), *Behavioral Health Joint Ventures Sprout as Demand Rises,* Behavioral Health Business (February 9, 2022) https://bhbusiness.com/2021/10/14/behavioral-health-joint-ventures-sprout-as-demand-rises/
[2] Cody Taylor, CVA and William Teague, CFA, *Behavioral Health Joint Ventures: Recent Activity & Key Considerations* (February 9, 2022) https://vmghealth.com/thought-leadership/blog/behavioral-health-joint-ventures-recent-activity-key-considerations/
[3] *Infra,* n. 1, above.
[4] *Infra,* n. 2, above.

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for Mental Disease ("IMD")[5] and develop a plan to address same to the extent such restrictions apply.

Look for More Behavioral Health Real Estate-Focused Joint Ventures.

All of the factors noted in this Newsletter that are driving demand for behavioral health services and related M&A activity are also contributing to an increase in joint ventures focused on behavioral health care real estate. Such joint ventures and other behavioral health-focused investors are making investments and working with health care and behavioral health care operators across the country to re-purpose inpatient and residential care facilities, among other things. Many such investors and joint venture partners see great opportunity to expand their current real estate footprint. The growing and non-cyclical nature of this real estate market is also drawing in more investment activity and interest.[6]

[5] 42 U.S.C. § 1905(i).
[6] Kyle Coward, *As Behavioral Health Care Demand Rises, the Need for Real Estate is Only Growing,* Behavioral Health Business (February 9, 2022) https://bhbusiness.com/2021/11/01/as-behavioral-health-care-demand-rises-the-need-for-real-estate-is-only-growing/

Staffing Shortages Will Continue to Reduce Access to Behavioral Health

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The Covid-19 Pandemic has exponentially increased demand for behavioral health services in the U.S., exacerbating existing shortages of behavioral health providers. Without corrective action, staffing shortages across care settings will remain a serious problem.

Pre-pandemic, the U.S. had a noted shortage of behavioral health providers. In 2018, the U.S. government identified 5,112 Mental Health Professional Shortage Areas ("Mental HPSAs")—areas where supply of psychiatric providers did not meet demand.[1] The year before, seventy-seven percent (77%) of counties reported severe shortages in psychiatrists and fifty-five percent (55%) had no psychiatrists.[2] Since March 2020, demand for behavioral health services has increased tremendously across the U.S. due to the pandemic. Fifty-two percent (52%) of behavioral health organizations reported increased demand in 2020.[3] In a November 2021 poll by the American Psychological Association, seventy-four percent (74%) of providers said they were seeing more patients with anxiety disorders compared to pre-pandemic, sixty percent (60%) were seeing more patients with depressive disorders, and thirty percent (30%) were seeing more patients overall.[4]

Yet, the population of behavioral health providers has not kept pace with this increased demand. In December 2021, the U.S. designated 6,078 Mental HPSAs across the U.S.— 966 more areas since 2018.[5] The government estimated that twenty-eight percent (28%) of the population's mental health needs went unmet and 6,851 additional psychiatrists were required just to meet current needs.[6] While these numbers do not include other licensed behavioral health providers (LMFT, LCSW, etc.), noted shortages remain with respect to those providers as well. These provider populations increased by eight percent (8%) last year, but those increases should only marginally improve care access given the growing demand.[7] Two-thirds of primary care providers today say they have trouble finding mental health specialists accepting patient referrals.[8] Presently, over half of adults with mental illness in the U.S. do not receive any treatment.[9]

[1] Angela J. Beck et al., *Mapping Supply of the U.S. Psychiatric Workforce,* U. of Mich. Behav. Health Workforce Res. Ctr. (Oct. 2018), https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/01/Y3-FA1-P2-Psych-Mapping-Full-Report-with-Appendix.pdf.
[2] *Id.*
[3] Patricia O. Urquiaga, *7 Mental and Behavioral Health Trends of 2021,* MASC Med. Recruitment Firm (Sept. 16, 2021), https://mascmedical.com/7-mental-and-behavioral-health-trends-of-2021/.
[4] Christina Caron, *"Nobody Has Openings": Mental Health Providers Struggle to Meet Demand,* N.Y. Times (Feb. 17, 2021), https://www.nytimes.com/2021/02/17/well/mind/therapy-appointments-shortages-pandemic.html.
[5] *Mental Health Care Health Professional Shortage Areas (HPSAs),* Kaiser Fam. Found. (Sept. 30, 2021), https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[6] *Id.*
[7] United Health Found., *America's Health Rankings Annual Report 2018* at 24 (2018 ed.), https://assets.americashealthrankings.org/app/uploads/2018ahrannual_020419.pdf.
[8] Andy Smith, *Shortage of Psychiatrists & Mental Health Providers Projected to Rise,* inSync Healthcare Solutions (May 3, 2021, 12:02 PM), https://www.insynchcs.com/blog/rising-shortage-mental-health-providers.
[9] Maddy Reinert et al., *2022 The State of Mental Health in America* 28 (Mental Health Am., Oct. 2021), https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf.

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The staffing shortages derive from certain causes which include but are not limited to: (i) an aging provider population, (ii) pandemic stressors (less staff and support for daily work), (iii) pandemic-related exposure risks, and (iv) greater care demands imposed on providers.[10] Additionally, those providers staying in the profession are increasingly transferring to higher paying jobs in hospital-based mental health units and staffing agency (locums) positions, leaving traditional outpatient care settings in the lurch.[11]

An infusion of qualified behavioral health providers is needed to increase behavioral health care access. This infusion is critical to drive down avoidable hospitalizations, reduce recidivism with justice-involved clients, address the substance use epidemic, and reduce delays in access to evidence-based behavioral health services. The solution may lie in a variety of short and long-term strategies, including: (i) increasing behavioral healthcare reimbursement rates to permit salary and benefit increases for providers[12], (ii) adopting tele-behavioral health care options, (iii) deploying educational stipends to spur students to enter the field[13], and (iv) pursuing provider consolidation and capital investment through M&A activity.

[10] Ashley Brody, MPA, CPRP, *Help Wanted! Now More Than Ever,* Behavioral Health News (Fall 2021) (Vol. 9 No. 2), https://behavioralhealthnews.org/bhn-fall-2021-issue/
[11] *'In crisis mode': How short-staffed hospitals are coping with a mental health surge,* Advisory Board (Nov. 2, 2021), https://www.advisory.com/daily-briefing/2021/11/02/mental-health-crisis
[12] *See* Christopher Cheney, *Tackling the Top 3 Challenges in Behavioral Health,* healthleaders (Dec. 1, 2021), https://www.healthleadersmedia.com/clinical-care/tackling-top-3-challenges-behavioral-health (noting under-reimbursement of behavioral health providers as key issue affecting ability to attract workforce)
[13] Kyle Coward, *Landmark Recovery Revamps Benefits Strategy, Launches Program to Provide Earnings and Career Growth Transparency to Workforce,* Behavioral Health Business (Feb. 13, 2022), https://bhbusiness.com/2022/02/13/landmark-recovery-revamps-benefits-strategy-launches-program-to-provide-earnings-and-career-growth-transparency-to-workforce/?euid=cc6a82f91c&utm_source=bhb-newsletter&utm_medium=email&utm_campaign=07cc1de471

Psychedelics Increasingly Being Explored for Mental Health Treatment

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Psychedelic therapy (the use of plant compounds that can induce hallucinations, such as LSD, DMT, MFMA, Mescaline, and psilocybin, to treat mental health diagnoses) is relatively new to, but gaining traction in, mental health treatment.

Many state and local governments have started to relax legal barriers to accessing psychedelics. Oregon, for example, legalized psilocybin (the active ingredient in magic mushrooms) in November 2021. But, at the federal level, psychedelic therapy remains heavily regulated as an experimental treatment. The FDA classifies psychedelics as Schedule 1 controlled substances—substances, drugs, or chemicals with no currently acceptable medical use and a high potential for abuse. In so doing, the FDA only authorizes their use on patients in approved clinical trials.

Nonetheless, many universities in the US are partnering with for-profit companies to research the mental health treatment potential of psychedelics.[1] Currently, 81 clinical trials are testing the efficacy of psilocybin in treating various mental health disorders (e.g. major depressive disorder, depression in Bipolar II Disorder, etc.).[2] Many trials are investigating whether psilocybin could serve as a possible treatment for substance use disorders.[3] Others are testing ketamine for efficacy in treating schizophrenia, depression, and anxiety – brain disorders characterized by prefrontal cortex atrophy.[4] Some providers have touted microdosing LSD as showing promise for enhancing treatment of alcohol addiction and depression.[5]

Private investors, such as Peter Thiel, Ronan Levy, and others as well as for-profit enterprises, have predominantly financed psychedelic research to-date.[6] Yet, this year, the NIH awarded its first grant in over 50 years for the study of a psychedelic (psilocybin on tobacco addiction)[7], suggesting the government may be finally joining the private sector's enthusiasm for and investigation of these drug classes. Depending on clinical trial results, many States could legalize the therapeutic use of psychedelics in supervised, clinical settings in the near future.

[1] *See Universities Researching Psychedelics,* Psychedelic Invest, https://psychedelicinvest.com/educational-organizations/ (last visited Jan. 20, 2022).
[2] Search performed of *Psilocybin,* ClinicalTrials.gov, https://clinicaltrials.gov/ct2/results?cond=&term=Psilocybin&cntry=&state=&city=&dist= (last visited Jan. 20, 2022).
[3] *See* Michael P. Bogenschutz, *It's Time to Take Psilocybin Seriously as a Possible Treatment for Substance Use Disorders,* 43 The Am. J. of Drug & Alcohol Abuse 4, 4–6 (2016), https://www.tandfonline.com/doi/abs/10.1080/00952990.2016.1200060?journalCode=iada20.
[4] *Id.*
[5] *See* Kat Eschner, *The Promise and Perils of Psychedelic Health Care,* N.Y. Times (Jan. 5, 2022), https://www.nytimes.com/2022/01/05/well/psychedelic-drugs-mental-health-therapy.html.
[6] *See* Will Feuer, *Oregon Becomes First State to Legalize Magic Mushrooms as More States Ease Drug Laws in 'Psychedelic Renaissance,'* CNBC (Nov. 4, 2020, 10:55 AM), https://www.cnbc.com/2020/11/04/oregon-becomes-first-state-to-legalize-magic-mushrooms-as-more-states-ease-drug-laws.html.
[7] *See* Eschner, *supra* note 5.

About Polsinelli's Behavioral Health Law Group

Behavioral health providers have unique regulatory, clinical and business issues that require both federal and state legal experience and real-world knowledge of the behavioral health industry and health care law generally. Polsinelli's Behavioral Health Law Group, one of the largest in the country, is devoted to representing investors and operators in the behavioral health space including:

- Private equity and venture capital funds
- Acute care psychiatric hospitals and units
- Substance abuse and eating disorder treatment providers
- Residential, outpatient and adolescent treatment facilities
- Community mental health centers
- Digital and telehealth treatment providers
- Autism treatment providers

Polsinelli's experienced behavioral health law group includes lawyers with deep experience representing leading behavioral health providers in all facets of their legal affairs. Our extensive industry experience spans corporate and M&A, regulatory, privacy, payer relations, real estate and other legal disciplines that allow us to fully partner with investors and providers to help them effectively achieve their business goals.

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Behavioral Health Business Value Based Conference
Lori Oliver and **Ryan Morgan** are speaking on Policy and Legal Considerations.
April 26, 2022
Washington, D.C.

Contact Sinead McGuire, smcguire@polsinelli.com, for more information about any upcoming Polsinelli Behavioral Health Law Group events.

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