



Health Plan Approaches For Managing The Benefits Of Consumers With Behavioral Health Conditions: The 2026 National Survey

2026 PayerTrends Guidebook Volume Two

National Trends In Health Plan
Strategies For Access, Outcomes, &
Cost Management

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About This Guidebook – Methodology^{1,2}

This guidebook presents findings from a national survey of health plan practices for managing behavioral health benefits.

In its 8th year, and with the support of Otsuka America Pharmaceutical, Inc., this guidebook is part of an ongoing analysis of the U.S. behavioral health financing and delivery system, combining industry research with survey data to track how health plans are evolving their approaches to care.

In 2025, Otsuka commissioned the 5th Annual Health Plan Survey that was distributed to more than 4,000 health plans. Responses represent 966 health plans, including many of the largest organizations in the market, covering an estimated 47% of the U.S. insured population, and an estimated 144 million lives covered.

Respondents include senior decision-makers with direct influence over behavioral health strategy and formulary decisions, including medical directors, chief executive officers, and chief policy officers.

The findings are organized across three key areas:

Expanding Consumer Access To Behavioral Health Services: Health plans are adopting non-traditional network strategies, virtual care models, and alternative workforce approaches to address capacity constraints and rising demand.

System-Level Trends Shaping Behavioral Health: Plans are increasing emphasis on measurement-based care, performance accountability, and data-driven approaches to improve clinical outcomes.

Managing Total Cost Of Care For Behavioral Health Populations: Health plans are exploring integrated care models, alternative payment structures, and population health strategies to better manage high-cost, high-need populations.

These insights highlight variation in behavioral health management approaches across payer types and identify key strategies shaping access, outcomes, and total cost of care.

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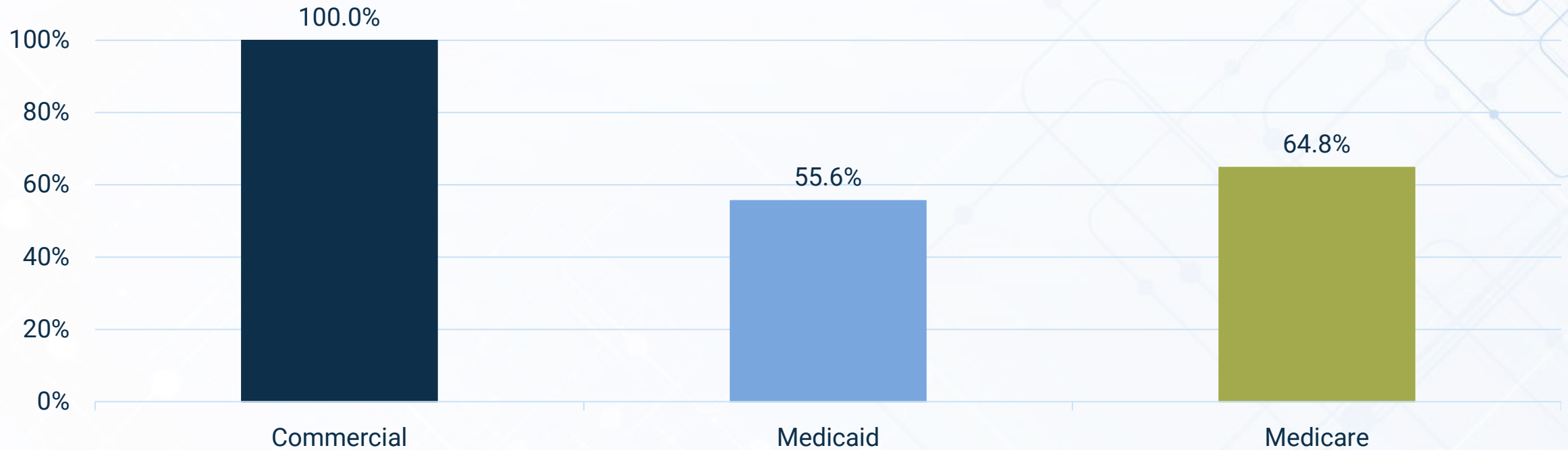
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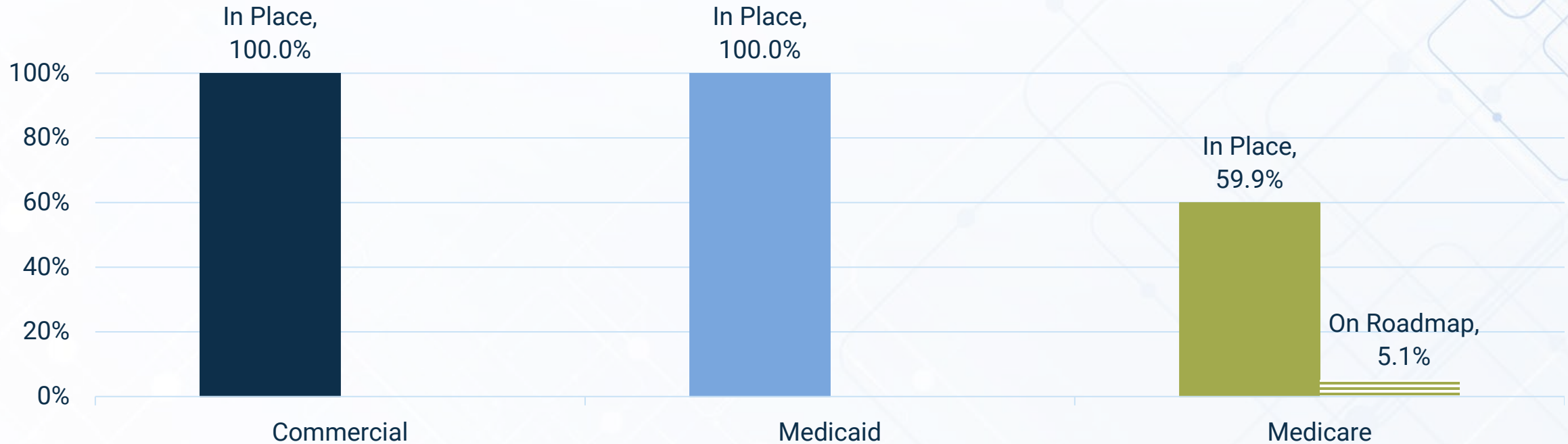
1. Strategies For Improving Consumer Access

1.a. Health Plans Offering Member Access To Virtual-Only Specialty Behavioral Health Providers Networks, Percent By Payer, 2026^{1,3}



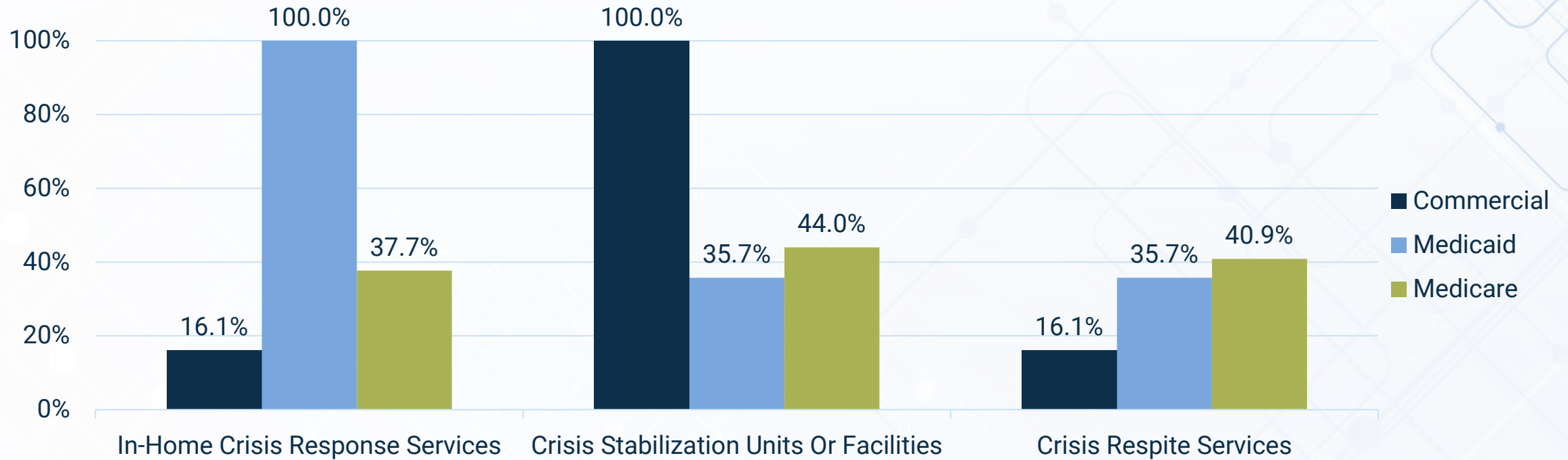
Many health plans are expanding access to behavioral health services by contracting with specialized virtual-only provider networks. These platforms offer national clinician networks, rapid access to therapy and psychiatric care, and digital tools that support screening, assessment, and patient engagement. For health plans, these partnerships provide a rapid way to address network capacity gaps without building additional local provider relationships. However, effective implementation requires strong integration with existing provider networks to ensure care coordination and continuity.

1.b. Health Plans Covering Mental Health Peer & Peer Support Services, Percent By Payer, 2026^{1,4}



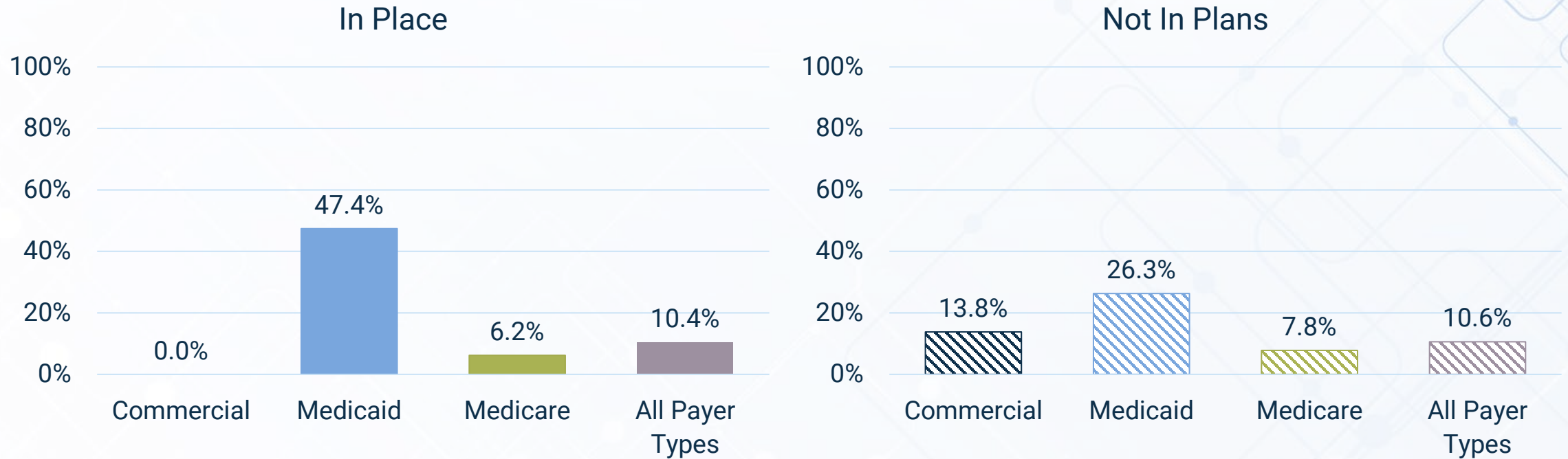
Peer support services are an increasingly important component of behavioral health care, particularly for individuals with SMI and substance use disorders. Peer specialists use lived experience to support recovery, improve treatment engagement, and assist with system navigation and care adherence. While Medicaid programs have reimbursed peer services for many years, adoption among commercial health plans has increased as payers recognize their value in expanding the behavioral health workforce. When integrated into care management models, peer services improve retention in treatment and reduce high-cost utilization, including hospitalizations and crisis services.

1.c. Health Plans Covering Behavioral Health Crisis Services, Percent By Payer, 2026^{1,5}



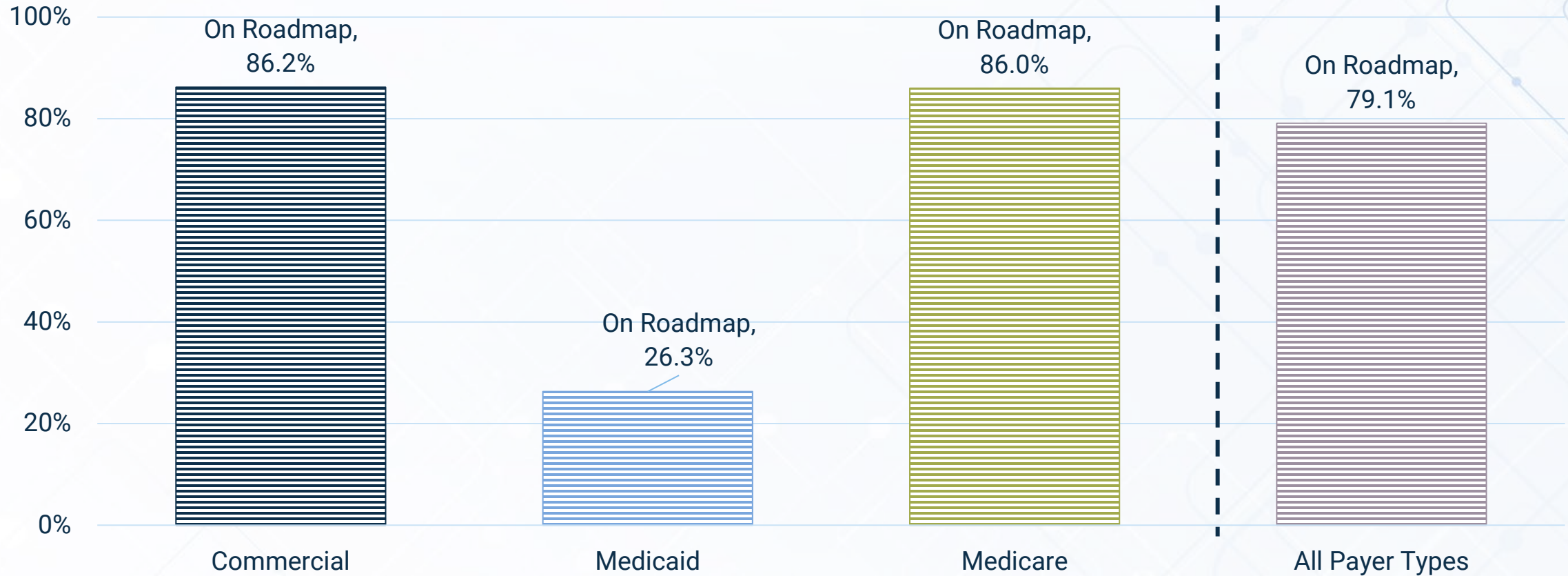
Behavioral health crisis services are receiving increased attention as health systems seek to reduce reliance on emergency departments and inpatient psychiatric hospitalization during acute crises. The rollout of the 988 crisis line has accelerated the development of broader crisis response systems, including mobile crisis teams, crisis stabilization units, and community-based crisis services. Health plans recognize that investing in crisis services improves patient outcomes while reducing high-cost utilization. Effective crisis systems require coordinated reimbursement models that support community-based response and diversion from unnecessary emergency department use.

1.d. Percent Of Payers Reimbursing For Prescription Digital Solutions For Mental Health, By Payer, 2026^{1,6}



Prescription digital therapeutics represent a newer category of behavioral health interventions designed to deliver structured therapy through clinician-prescribed software platforms. While early industry expectations were high, payer adoption has been slower due to uncertainty around reimbursement models, mixed clinical evidence, and challenges integrating digital tools into clinical workflows. Despite these barriers, health plans continue to evaluate these solutions as a way to expand access to evidence-based interventions, particularly for mild to moderate conditions. As clinical evidence and reimbursement models evolve, digital therapeutics may become a more common component of behavioral health treatment strategies.

1.e. Percent Of Payers Planning For Reimbursement For Prescription Digital Solutions For Mental Health , By Payer, 2026¹



1.f. Key Takeaways & Implications For Health Plans¹

Access Challenges Remain Persistent

Access challenges persist despite rapid expansion of new care models. Commercial adoption of virtual behavioral health networks has reached 100%, compared to 64.8% in Medicare and 55.6% in Medicaid, while peer support services are now nearly universal in Commercial and Medicaid plans at 100%, with Medicare at 59.9%.

Shift Toward Non-Traditional Care Models

Health plans are accelerating adoption of non-traditional care models, including telepsychiatry, peer workforce integration, and crisis response systems, to address workforce shortages and rising demand. However, adoption remains uneven, with Medicaid reporting near universal in-home crisis response capability at 100%, compared to 16.1% in Commercial plans and 37.7% in Medicare.

Fragmentation Continues To Limit Impact

While these models are expanding, they are often implemented as discrete solutions rather than as part of a coordinated system. This results in fragmentation across providers and care settings, with variability in care coordination, data sharing, and continuity that limits impact on access and outcomes.

Implications For Health Plans

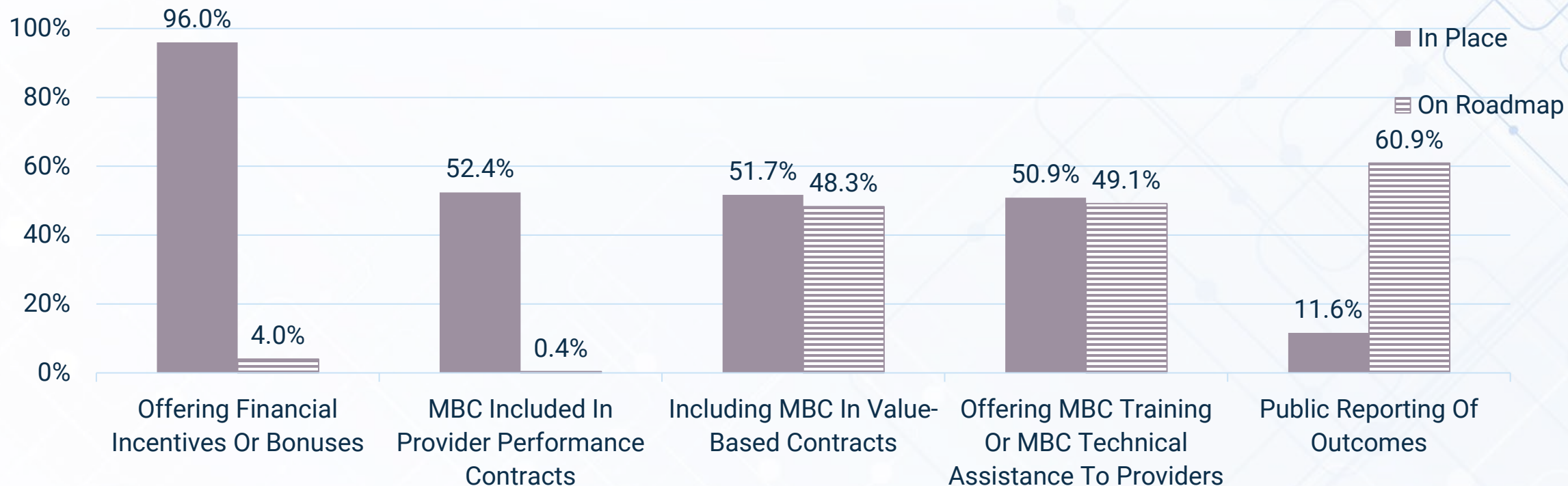
Improving access will depend less on adding services and more on how effectively plans integrate these models into coordinated care systems.

This includes aligning virtual and in-person care, strengthening care coordination, and ensuring continuity across settings.

Plans that move beyond fragmented access strategies to integrated delivery models will be better positioned to improve both access and outcomes.

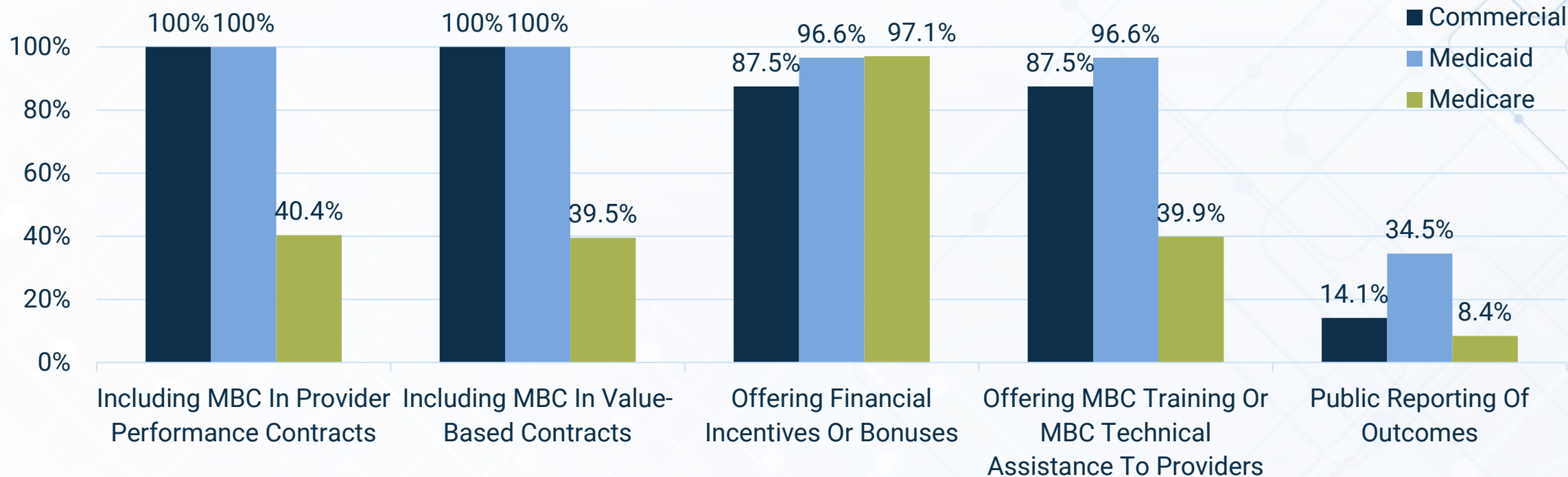
2. Strategies For Improving Consumer Outcomes

2.a. Health Plan Strategies Encouraging Use Of Measurement-Based Care (MBC), 2026^{1,7}



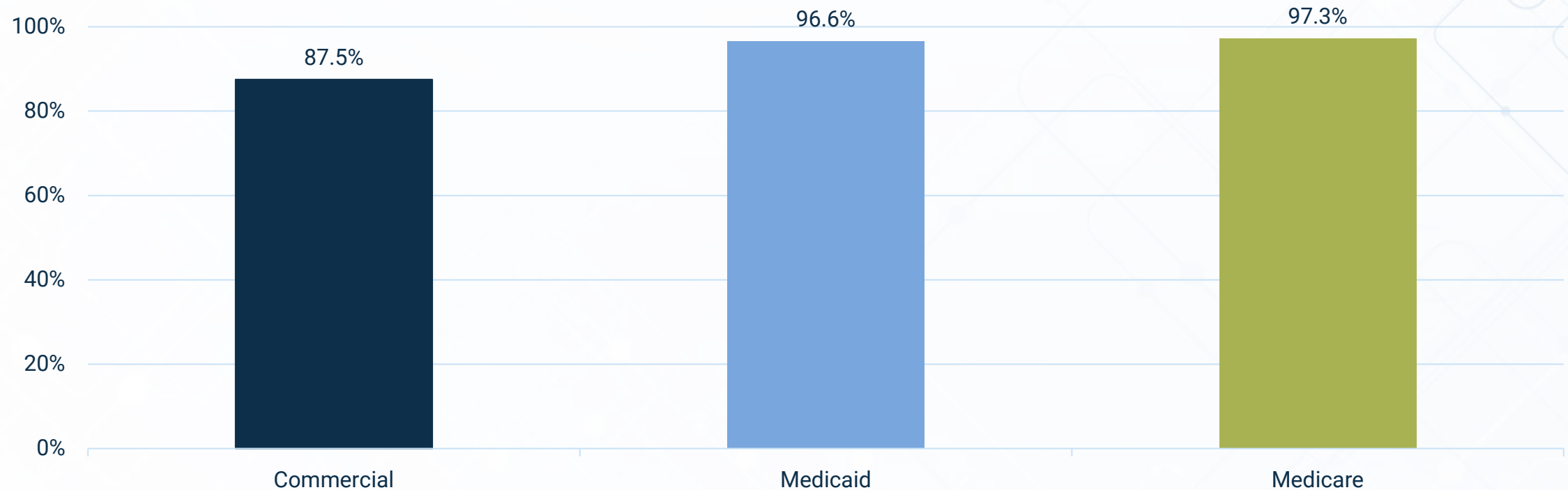
Measurement-based care (MBC) is becoming a foundational requirement for improving behavioral health outcomes, enabling providers and health plans to assess symptom severity, track progress, and adjust treatment using standardized tools. Health plans are requiring MBC to evaluate treatment effectiveness, compare provider performance, and support value-based payment models. While adoption is increasing, long-term success depends on integrating MBC into clinical workflows and aligning reimbursement with outcomes.

2.b. Health Plan Strategies Encouraging Use Of Measurement-Based Care (MBC), Percent By Plan Type, 2026^{1,8}



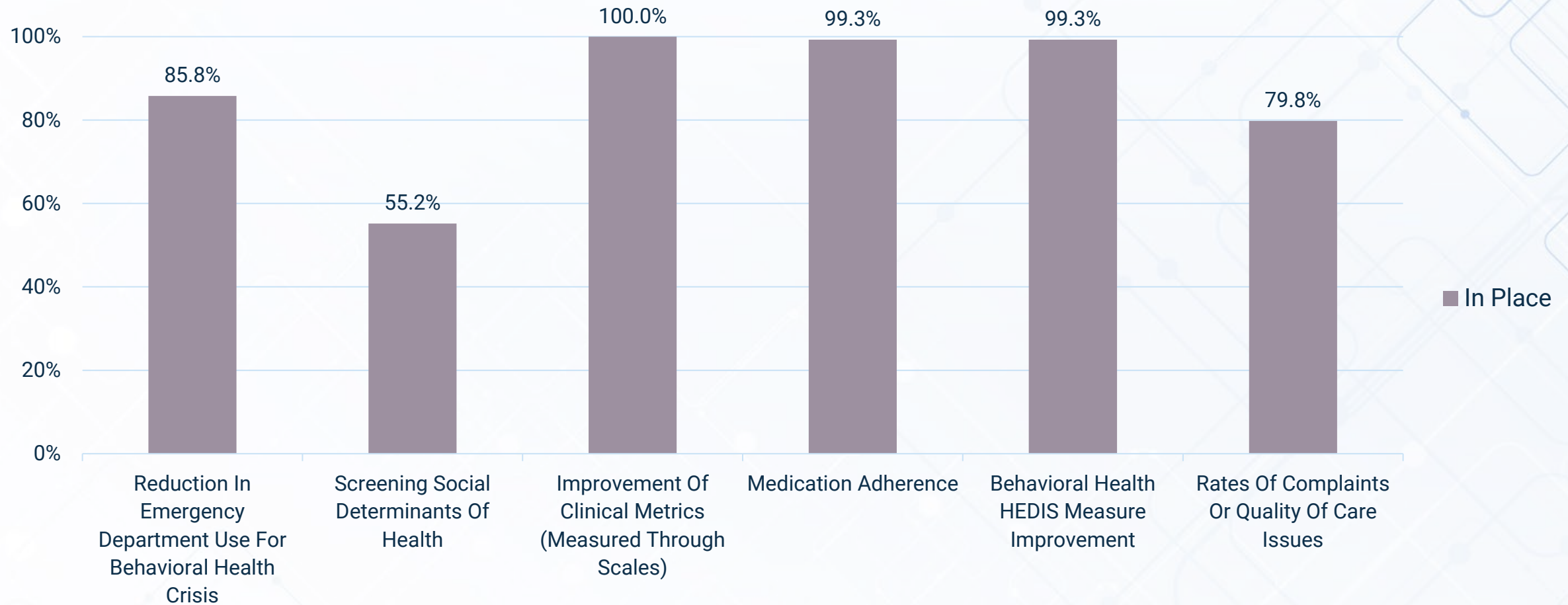
Even when MBC use is required, provider adoption remains uneven due to workflow challenges, administrative burden, and limited training or incentives. Health plans are using targeted strategies to drive adoption, including embedding measurement tools into electronic health record workflows, providing training and technical assistance, and linking use to financial incentives. Long-term success depends on normalizing measurement as part of routine clinical practice through integrated tools, streamlined workflows, and aligned incentives.

2.c. Percent Of Payers Offering Performance-Based Bonuses For Behavioral Health Provider Network Members & How They Are Measured, 2026^{1,9}

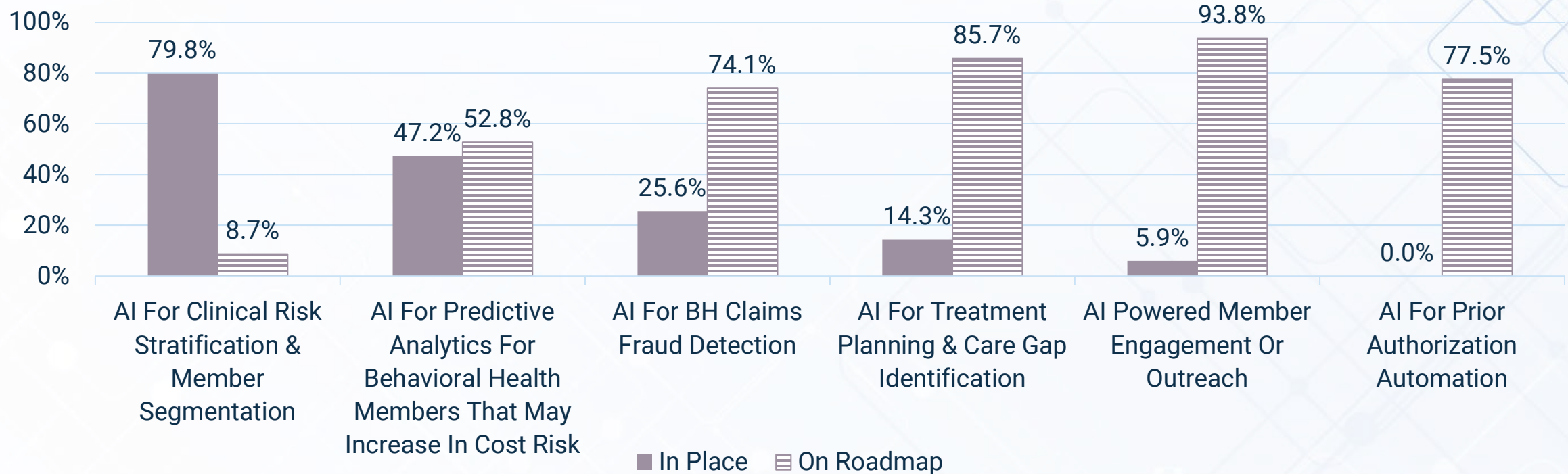


Performance-based bonuses are an early step toward value-based reimbursement, linking provider payment to outcomes such as symptom improvement, access, and follow-up care. Adoption remains limited, with most models layered on top of fee-for-service. However, plans are using these incentives to drive quality and measurement-based care. Future progress depends on stronger data infrastructure to support more advanced value-based models.

2.d. Percent Of Measures Implemented By All Health Plans For Calculating Performance-Based Bonuses, 2026¹



2.e. Health Plan Use Of Artificial Intelligence In Assessment, Treatment Planning, & Prior Authorization, 2026^{1,10}



Artificial intelligence (AI) is being used in behavioral health primarily for administrative and analytical functions, including prior authorization automation, risk stratification, and population health analytics. These applications help improve operational efficiency and support identification of high-risk members, while reducing administrative burden. Although interest in clinical use is growing, adoption remains cautious due to concerns around regulatory oversight, clinical validity, and provider trust.

2.f. Key Takeaways & Implications For Health Plans¹

Outcomes Are Becoming The Primary Measure Of Performance

Health plans are increasingly prioritizing measurable outcomes, survey results show widespread adoption of measurement-based care (MBC) strategies. More than 50% of plans have incorporated measurement into provider performance contracts and value-based arrangements, and 96% offer financial incentives or bonuses tied to performance.

Performance Based Models Are Expanding Across Payers

Performance based reimbursement is now common across payer types, with 87% to 97% of plans offering bonuses tied to clinical improvement, medication adherence, and utilization metrics such as reductions in emergency department use. These findings signal a clear shift toward outcomes driven behavioral health care. This reflects a gap between strategy and execution.

Gaps In Execution Continue To Limit Impact

While measurement and performance incentives are in place across many plans, implementation varies in practice. Fewer than 12% of plans publicly report outcomes, many have not fully integrated measurement into clinical workflows, and models are often layered on top of fee for service reimbursement, allowing fragmentation to persist and limiting the impact on outcomes and cost.

Implications For Health Plans

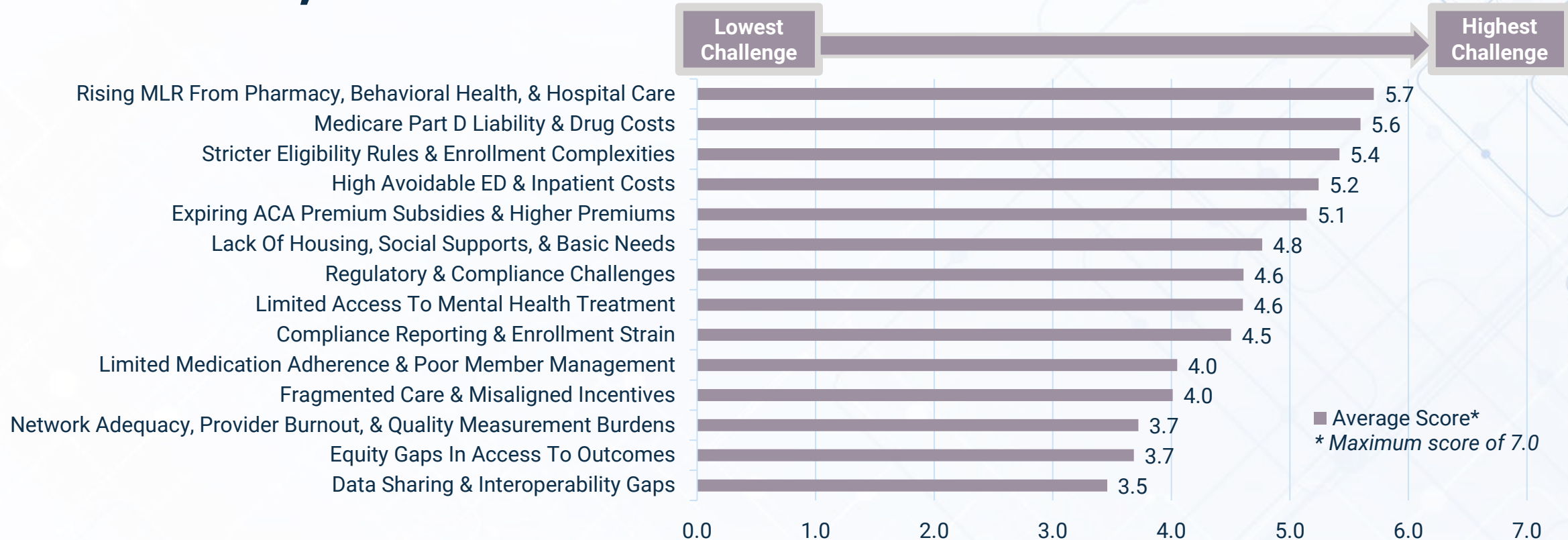
Improving outcomes will depend on moving beyond partial adoption of measurement-based care to full operational integration.

This includes embedding measurement into clinical workflows, aligning incentives with outcomes, and building the data infrastructure needed for real-time performance management.

Without this level of integration, outcomes-driven care models will remain fragmented and inconsistently applied.

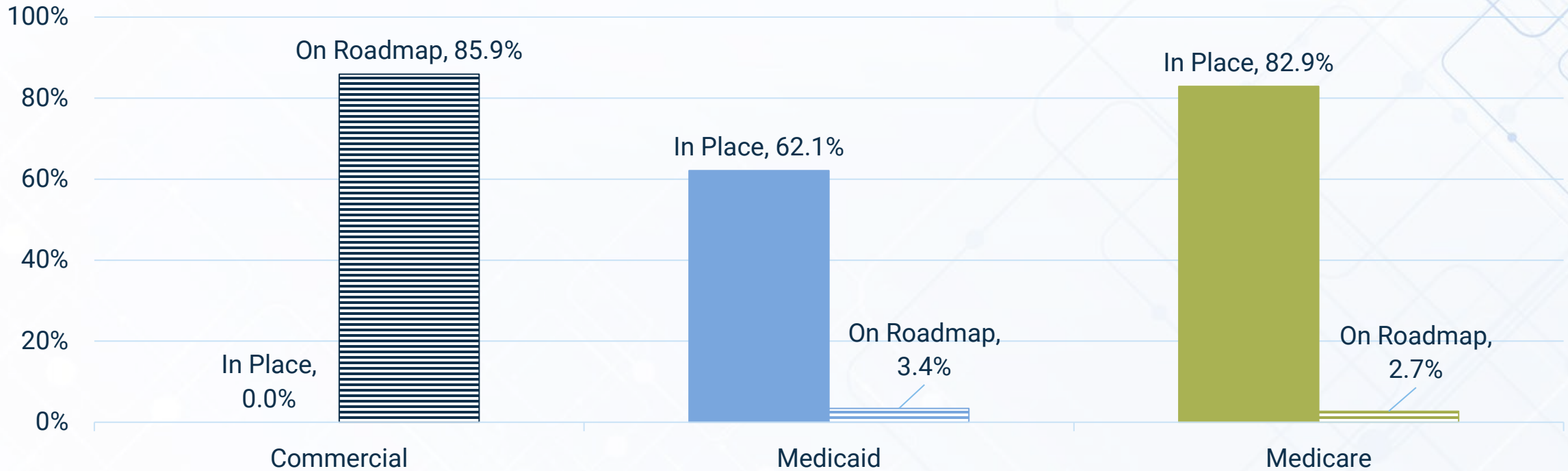
3. Strategies For Managing Total Cost Of Care

3.a. Health Plan Ranking Of Challenge In Managing Total Cost Of Care For Members With Behavioral Health Conditions, 2026^{1,11}



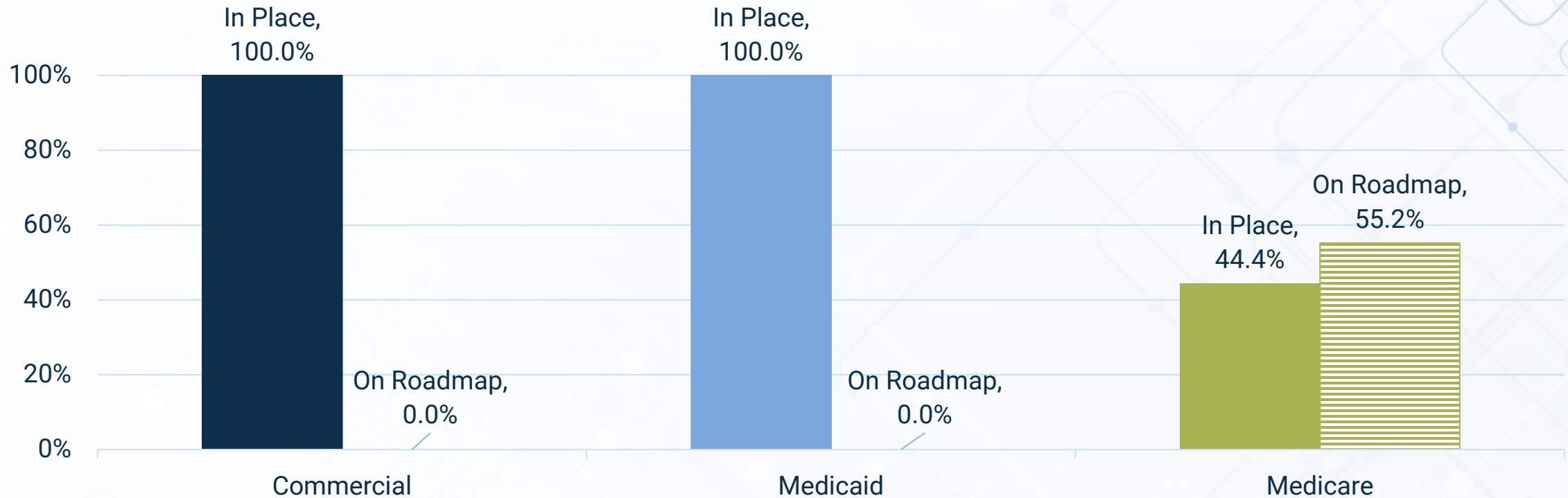
Health plans consistently identify individuals with behavioral health conditions as among the most complex and costly populations, driven by high avoidable utilization, unmet social needs, and limited access to care. Fragmented delivery, inconsistent engagement, and misaligned incentives further separate accountability for behavioral and medical costs. Managing total cost of care will require more integrated, coordinated, and accountable care models.

3.b. Health Plans With Carve-Out Models For Behavioral Health Management, Percent By Payer, 2026^{1,12}



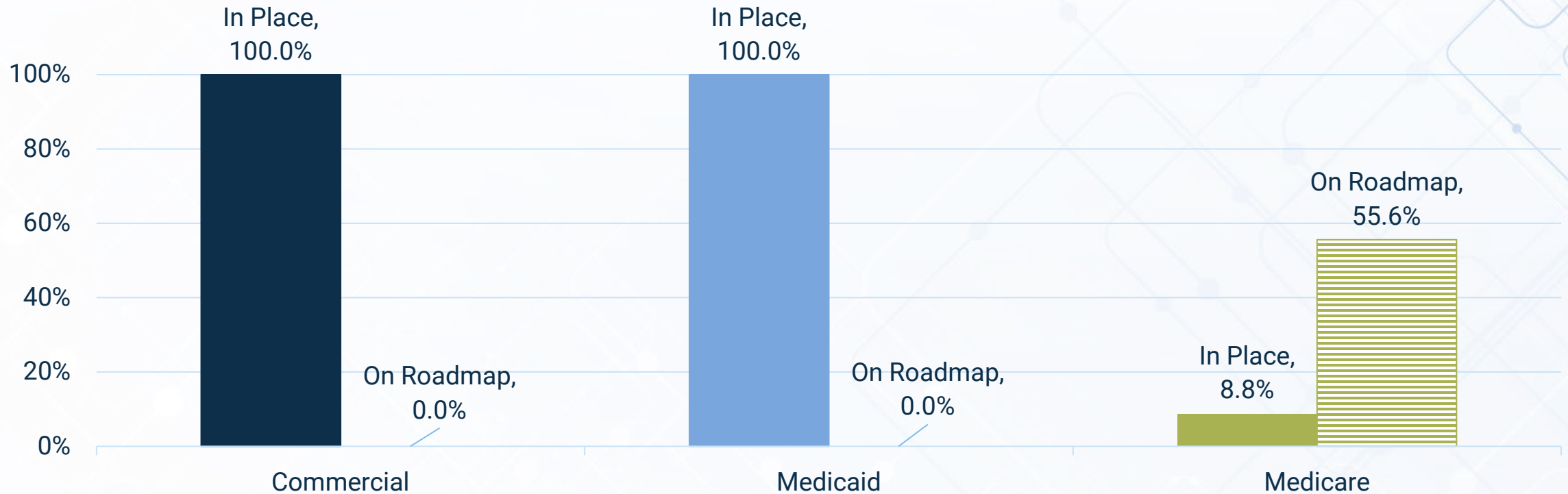
Behavioral health carve-out models have historically provided specialized management and cost control but also introduce fragmentation between behavioral and physical health care. While these models remain in place for many Medicaid and Medicare plans, Commercial plans are increasingly moving toward more integrated approaches. As plans reevaluate carve-outs, success will depend on improving care coordination, data integration, and aligning accountability across the full continuum of care.

3.c. Health Plans Covering Collaborative Care Models With Fee-For-Service Reimbursement, Percent By Payer, 2026^{1,13}



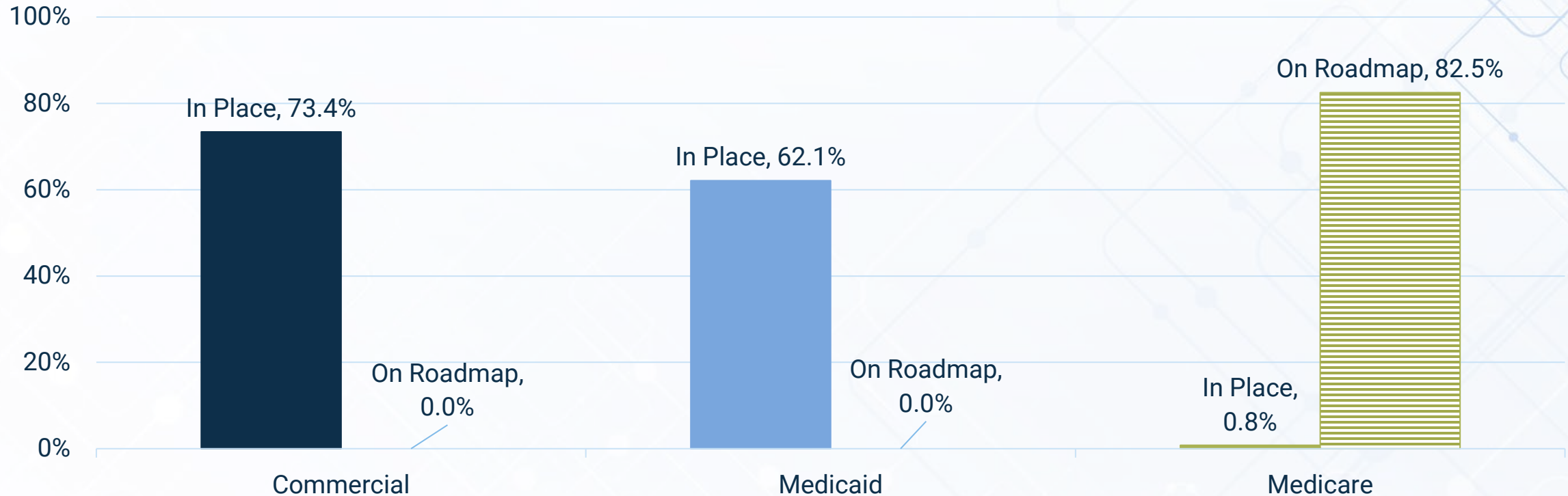
Collaborative care is one of the most evidence-based approaches to integrating behavioral health into primary care, using a team-based model to improve outcomes and reduce total cost. While fee-for-service reimbursement is supporting adoption, particularly in Commercial and Medicaid, implementation remains uneven due to workflow complexity and reimbursement variability. For health plans, collaborative care represents an important opportunity to intervene earlier and manage behavioral health conditions within primary care settings.

3.d. Health Plans With Capitated Behavioral Health Medical Homes Models, Percent By Payer, 2026^{1,14}



Behavioral health medical homes provide comprehensive, coordinated care for high-risk populations, using capitated payment models to align incentives with long-term outcomes and patient stability. Adoption is strong in Commercial and Medicaid, with Medicare still in earlier stages but progressing. These models address the need for sustained, integrated care and can reduce inpatient utilization, emergency department use, and total cost of care.

3.e. Health Plans With Capitated Behaviorally-Led Primary Care Models, Percent By Payer, 2026^{1,15}



Behaviorally led primary care models embed primary care within behavioral health settings, improving access for individuals with serious mental illness who often face barriers to traditional care. Adoption is growing in Commercial and Medicaid, with Medicare largely in earlier stages but advancing on the roadmap. By addressing both medical and behavioral health needs, these models can improve outcomes and reduce total cost of care.

3.f. Key Takeaways & Implications For Health Plans¹

Managing Cost Of Care Is A Strategic Priority

Managing total cost of care for individuals with behavioral health conditions remains a strategic priority and a persistent challenge, driven by high utilization and clinical complexity. Survey results highlight rising medical loss ratios, medication related costs, and high avoidable emergency department and inpatient utilization among the highest ranked challenges for health plans.

High Complexity Populations Drive Disproportionate Costs

A relatively small subset of high acuity individuals drives a disproportionate share of total cost of care, many with co occurring medical conditions, unmet social needs, and inconsistent engagement with care. Fragmentation between behavioral and physical health systems remains a key driver, with fragmented care and misaligned incentives identified as a significant contributor to cost and utilization.

Integrated Models Are Expanding, But Impact Remains Limited

Health plans are expanding integrated care models, with adoption of collaborative care and behavioral health medical homes approaching 100% in Commercial and Medicaid plans, compared to approximately 44% and less than 10% in Medicare, with additional growth on the roadmap. However, these models remain unevenly implemented and are often not aligned with payment structures or accountability frameworks, allowing fragmentation to persist and limiting impact on total cost of care.

Implications For Health Plans

Reducing total cost of care will require more than expanding services, it will require aligning incentives, accountability, and care delivery across the full continuum.

Plans that successfully integrate behavioral and physical health, strengthen care coordination, and adopt value-based payment models will be better positioned to manage high-cost populations and improve long-term financial care.

Conclusion

The shift in strategy for health plans serving behavioral health consumers is not conceptual—it is operational. Plans are increasingly expected to demonstrate measurable outcomes, integrate care across settings, and take accountability for total cost of care. While access remains foundational, it alone will not improve outcomes or sustain long-term affordability.

This shift is being driven by rising costs among high-acuity populations, persistent fragmentation between behavioral and physical health services, and increasing expectations from purchasers and regulators for demonstrable performance. In many systems, no single entity is accountable for coordinating care across behavioral, medical, and social needs—resulting in gaps, duplication, and avoidable cost. Without clear accountability for outcomes and cost, performance management breaks down—making it difficult for plans to know what is working, where to invest, and what to scale.

Many plans have implemented virtual care, measurement-based care, performance incentives, and integrated care models. However, these efforts are often layered onto existing systems rather than fundamentally redesigning them. The result is fragmentation—different models operating in parallel, inconsistent use of data, and limited alignment between clinical practice and financial incentives. The next phase will require moving from pilots and point solutions to coordinated, system-level models with clear accountability and aligned incentives.

This shift is also accelerating movement toward value-based models, where payment is increasingly tied to outcomes, engagement, and total cost performance—not just service delivery.

The distinction between health plans will come down to execution—specifically, the ability to align clinical models, payment structures, and performance metrics in a way that is operationally consistent across the system. Plans that effectively integrate behavioral and physical health, align incentives with outcomes, strengthen real-time care coordination, and reduce administrative burden for providers will be better positioned to manage cost, improve outcomes, and sustain long-term performance.

Behavioral health is no longer a secondary benefit—it is a primary driver of utilization, outcomes, and total cost of care. How plans manage behavioral health will increasingly define overall performance.

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