

Mental Health Care IS Health Care: The Basics of Guiding Providers in Integrating Behavioral Health Care into their Health Care Delivery System

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HISTORICAL PERSPECTIVE

Historically, mental health care was separate from physical health care and seen as less important and often less clinical.

“Although we live in a time when everyone from politicians to professional athletes to the woman at the grocery checkout seems willing to share their emotional struggles, we as a society often ignore the alarming obstacles that people seeking help for their mental distress face. This problem grows from a powerful root: a health care system built on the assumption that the mind and the body basically exist on different planets.”

Damon Tweedy, MD <https://www.aamc.org/news/mental-health-part-physical-health-why-isn-t-it-treated-such>



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LINK BETWEEN MENTAL/PHYSICAL HEALTH

Over the past decade, particularly, we have begun to recognize that mental health and wellness has a significant impact on physical health and wellbeing

<https://www.nimh.nih.gov/health/topics/caring-for-your-mental-health>, 2024

Prince M, Patel V, Saxena S, et al. *No health without mental health*. The Lancet 2007;370:859–77

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WHERE PEOPLE ACCESS HEALTHCARE

Primary healthcare providers (“PCPs”) and Emergency Departments are the two primary sources for healthcare for much of the country.

Primary healthcare is ‘the first level of contact of individuals, the family and community with the national health system’, the closest and easiest form of care available, located near to peoples’ homes and communities.

For those without insurance or for those facing emergency situations, the ED may be the only healthcare access they have

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IMPACT OF TELEHEALTH

Since 2020, with the impact of COVID, telehealth has surged in importance as a means of connecting patients to providers.

CMS has allowed FQHCs and RHCs to utilize telehealth for care, when those rural providers were previously prohibited from offering such care for most patients. [MM13946 - Rural Health Clinic & Federally Qualified Health Center Medicare Benefit Policy Manual Update](#)

The VA has always been a strong telehealth proponent, and continues to lead the field

Large corporate entities, like the HIMS, and HERS, and even employers like United and Amazon, provide their own telehealth services

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MODERN PRACTICE

Many clinics and providers still focus on either physical or mental health care, but not both.

Reasons:

- Lack of trained staff
- Unfamiliarity with the “other side” of practice
- Compliance questions (is this self-referral, or a kickback issue?)
- Medical/clinical education that does not emphasize synthesis
- RHC/FQHC coverage challenges
- Patient reluctance to address mental health issues

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SHOULD YOU DISCUSS INTEGRATION WITH YOUR CLIENTS?

Financial reasons

- Allows more billables, increases potential patient population

Compliance reasons

- Ensures that you are addressing all needs patients have
- Removes concerns about too many or too few referrals

Patient access to care reasons

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SO, MY CLIENTS WANT TO INTEGRATE PHYSICAL/MENTAL CARE. WHAT NEXT?

1. Inform yourself on the scope of their practice

A surgical practice might have limited need for mental health care, whereas an addiction treatment provider probably really needs to include primary care

Clients should do an internal review of what needs appear unmet and how many times they have to refer out for needs that don't require a specialist

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SO, MY CLIENTS WANT TO INTEGRATE PHYSICAL/MENTAL CARE. WHAT NEXT?

2. What new staff will be required?

This includes their review of the current staff certifications, licensures and capabilities

Do they have ready access to staff or are their healthcare staff shortages in their area/state? Example: Kentucky has a dire shortage of counselors so adding mental health coverage is not always easy

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3. Who will pay for the care

Review their insurance/payors. What care will the insurer pay for at their current location/licensure/ designation

If their primary payor is Medicare, that might influence what type of mental health services they would choose to offer

If they are direct primary or family care, will their patient base be willing to pay more, to have mental health care included

If their care is covered by an employer plan (ERISA, etc.) will that plan cover broader services?

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4. Will this impact their current referral system

Some health systems have required referral systems

An ACO or other organizational structure may already include set referral partners

In a small community, you might take services away from a friend or typical referral partner

Are you going to compete with former referral partners for work

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SO, MY CLIENTS WANT TO INTEGRATE PHYSICAL/MENTAL CARE. WHAT NEXT?

5. Compliance Concerns – Clinics/smaller practices

- Do they own other healthcare entities?
- Do they own a lab?
- Do they render services on the site of another provider?

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Relevant laws: Stark, AKS and EKRA

Stark Law is a federal law that prohibits physician self-referral, to an entity for the provision of designated health services ("DHS") if the physician (or an immediate family member) has a financial relationship with that entity.

The term "referral" means "the request by a physician for the item or service" for Medicare Part B services and "the request or establishment of a plan of care by a physician which includes the provision of the designated health service" for all other services

42 USC 1332 nn

Anti-Kickback Statutes are laws that forbid payment to a patient or a provider for the purpose of inducing or rewarding referrals. Federal law: 42 USC Section 1320a-7b(b). Most states also have their own anti-kickback laws in the healthcare space

EKRA is a recent law specifically prohibiting payment for referrals for addiction treatment. Eliminating Kickbacks in Recovery Act (EKRA), 18 U.S.C. § 220

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6. Compliance Concerns – Hospitals

- What does the healthcare system/hospital structure currently allow?
- Are there multiple locations in one state?
- Are there multiple hospitals across state lines?
- Will the needs your client has be difficult to address in the hospital set up
- Can you recruit for your staffing needs, hire specialists

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SO, MY CLIENTS WANT TO INTEGRATE PHYSICAL/MENTAL CARE. WHAT NEXT?

7. Compliance Concerns – Private employers who offer care themselves

- Employee consent: Is the mental health care voluntary, or mandatory (physical care is usually mandated by the employer provided healthcare provider)
- Access/privacy: How to ensure that employees can address mental health issues without fear of gossip or employer accessing their healthcare records
- Completeness of records: Does the employer/provider have a means to obtain or update mental health records from other providers/previous care

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SO, MY CLIENTS WANT TO INTEGRATE PHYSICAL/MENTAL CARE. WHAT NEXT?

8. Employment issues

- Is the HR system able to interview, hire, and maintain records on mental health providers?
- Does the practice have space to put such providers?
- Will telehealth be used or will it be the primary means of connecting patients to the mental health care provider and does telehealth require additional aides/staff?
- Can HR update or create access to annual CMEs and CEUs and keep records of same?

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- Does the practice use staffing entities to serve as providers, hospitalists, etc., and if so, does that entity have providers who will fit your needs
- Are the current providers going to feel threatened
- Will the new providers need to practice across state lines, and if so, can the type of licensure the client needs be able to work across state lines (review interstate compacts, state licensure board regulations, etc.)

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SO, MY CLIENTS WANT TO INTEGRATE PHYSICAL/MENTAL CARE. WHAT NEXT?

9. HR Issues – Privacy and confidentiality of patient records

- Does HR understand limits on access to mental health records?
- 42 CFR Part 2, and will it apply?
- General privacy/security concerns
- Small town practices and risks of being seen at a “mental health” provider

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SO, MY CLIENTS WANT TO INTEGRATE PHYSICAL/MENTAL CARE. WHAT NEXT?

10. Billing/Coding

- Capacity and training to code for mental and physical health (staff, knowledge)
- Use a professional coder to set up codes the first time
- Ensure that the correct licensure provides the services
- Differences between Medicare, Medicaid and commercial insurers when it comes to covering mental health care, in particular

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11. Work flow and referrals

- Work flow and how the mental or physical health providers refer patients to “the other side”. Counsel needs to work with providers on appropriate guidance and language so to avoid medical necessity concerns, use appropriate language, and ensure that testing is not duplicated
- Medication management – all providers should have access to the EHR and be able to be up to date on patient progress and medications
- Intake and how to capture all patient needs
- Re-evaluation of current patients for additional needs (but watch for medical necessity documentation/overbilling)

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SO, MY CLIENTS WANT TO INTEGRATE PHYSICAL/MENTAL CARE. WHAT NEXT?

12. Referrals (and patient choice!)

- The goal today is to have patient directed care. This means that policies and procedures and legal guidance must ensure that a patient is informed about their care and involved in case planning, goals and treatment. This must be documented in the record as well as being contained in the policies and procedures
- You can't be everything to everyone – work with your providers on Stark and AKS compliant referral processes

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